Inter-Tribal Council of Michigan, Inc. Three Fires Comphrehensive Cancer Control Plan

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Inter-Tribal Council of Michigan, Inc.
Three Fires Comprehensive Cancer Control in Michigan

MISSION

Reduce the cancer burden and enhance the quality of life for cancer survivors among American Indians in Michigan.

GOALS

For American Indians in Michigan:

- Prevent the incidence of Cancer.
- Promote early detection and increase screening rates for Cancer
- Diagnose and treat those with cancer in a timely and efficient manner; increase access to the most appropriate treatment modalities and methods.
- Improve the quality of life for cancer survivors.

PHILOSOPHY & FRAMEWORK

- Implement a Culturally appropriate comprehensive cancer control program.
- Use adapted evidence based and promising practices interventions
- Employ Policy, Systems and Environmental change strategies.
- Use of appropriate and reliable surveillance measures.
- Utilize strategic partnerships

EXECUTIVE SUMMARY

The ***Three Fires Cancer Consortium*** will address the cancer burden among American Indians residing in Michigan, with targeted efforts in six tribal communities. Four Tribes are located in the rural and isolated Upper Peninsula: The 1) Keweenaw Bay Indian Community, 2) the Hannahville Indian Community, 3) the Bay Mills Indian Community, and 4) the Sault Ste. Marie Tribe of Chippewa Indians, where we have identified higher rates of cancer incidence and mortality among the AI/AN population compared to AI/AN in the Lower Peninsula. One tribe is located in the northern Lower Peninsula: 5) The Little Traverse Bay Bands of Odawa Indians and 6) the Match-E-Be-Nash-She-Wish-Potawatomi Tribe is located in the south western Lower Peninsula of the state – both of which have unique cancer disparities. While the efforts are focused on these six tribal communities, work plans, reports, outcomes and recommendations will be routinely shared with ALL 12 Tribal Health Directors during quarterly meetings, to support a statewide effort. It is important to note, that the remaining six tribes are also implementing small scale cancer prevention and control initiatives and will benefit from lessons learned via the Three Fires Cancer Consortium.

ITCM has developed a Cancer Control Plan from reliable data sources, including 1) the State Cancer Registry, 2) individual tribal cancer profiles, and 3) Tribal Specific Behavioral Risk Factor Surveys, and 4) Tribal GPRA screening rates. Results of these sources have identified significantly higher incidence and mortality rates for Lung, Colon, and Liver Cancer; we also see a younger age and later stage of diagnosis for breast and colon cancer. Behavioral risk factors such as higher rates of smoking, obesity and lack of nutrition and physical activity, needs of cancer survivors and promoting health equity are all addressed in our plan.

Past efforts have prepared the ITCM and member tribes to successfully implement the Cancer Control Plan across multiple tribes using Policy, Systems and Environmental change strategies and culturally tailored evidence based interventions. Specific to screening and diagnosis, the ITCM and some member tribes have worked to strengthen access to and coordination of care through quality improvement projects to increase screening rates. Lessons learned from these tribes will be shared so that others can implement similar strategies, thus increasing screening rates among AI/AN communities statewide.

Outcomes include: Increased access to lifestyle programs, clinical preventive services, and cancer care among cancer survivors; Increased access to health care and preventive services; Increased availability of evidence-based lifestyle programs to increase healthy living; Increased delivery of clinical preventive services; Increased delivery of appropriate cancer screening, specifically colonoscopy, sigmoidoscopy, and mammogram; Increased use of evidence-based lifestyle programs, clinical preventive services, and cancer care among cancer survivors; and increased use of population specific health data for cancer prevention and control programming

Prevention

This plan address the most prominent risk factors experienced by Michigan's American Indian population: ***High Smoking Rates, Excessive Drinking, Obesity and poor nutrition and lack of physical activity***.

The primary risk factor for lung cancer is smoking. According to national survey data, commercial tobacco use is higher in AI/AN populations than in any other racial/ethnic group in the U.S.[viii] Tobacco use surveillance data collected by Tribes with their tribal members, like that of the American Indian Adult Tobacco Survey (AI-ATS) can more accurately measure and identify priorities. A sampling of the 2012-2012 AI-ATS results among 5 Michigan tribes:

- The range of current smokers varied from a low of 34% to a high of 72% compared to Michigan's 2012 BRFSS rate of 23% for the general population.
- The majority of commercial tobacco users, smoked cigarettes,
- 60% to 90% of participants reported yes, there are health benefits to quitting smoking.
- 71 % to 90% of participants agreed that exposure to secondhand smoke causes lung cancer in adults.

By June 29, 2022, decrease the percent of adults who are current smokers by 10% among the target population. Baseline: 46%; Target: 36%

- **Strategy 1:** Environmental Approaches/ EBI: Mass Media for tobacco objective. The Mass Media strategy is proven to increase quit attempts by current smokers. Given the extremely high rates of smoking and lung cancer among the target population, the evidence based *Tips from Former Smokers* intervention will be used as our foundation for the campaign and supportive referrals to cessation services including the AI/AN quit line. Media includes articles in tribal newspapers, flyers, fact sheets at community events, in clinic waiting areas, and on social media platforms.

According to the American Cancer Society, several risk factors are known to be related to cancer including links between nutrition, obesity, smoking and exercise. Because Michigan's Behavioral Risk Factor Survey (BRFS) does not adequately sample the American Indian population, the ITCM has developed culturally appropriate strategies to collect accurate risk factor data for local tribal communities using CDC funded surveys. The ITCM recently published a Michigan Tribal Health Data Report that is a compilation of several rigorous tribal population based surveys conducted as part of three large Centers for Disease Control grant programs completed between 2007 and 2013. Results include:

- 41.9% of respondents were obese, compared to 28.7% of the MI general population.
- 29.5% of respondents had no leisure time activity, compared to 22.8% of the general pop.

- 39% of participants reported consuming more than one but less than three servings of fruits and vegetables per week. Less than one quarter (24%) had more than five servings of fruits and vegetables per week.
- 22.8% of respondents reported binge drinking compared to 17.5% for the general population; and 8.6% reported heavy drinking compared to 4.9% of general population.
- The range of current smokers varies from a low of 34% to a high of 72% compared to Michigan's 2012 BRFSS rate of 23% for the general population.

By June 29, 2022, decrease the adult prevalence of obesity by 15 % among the target population. Baseline: 44.85%; Target: 29.85%

- **Strategy 2**: Healthy Systems Change/ EBI: Screening for obesity in adults objective. This strategy addresses the high rates of obesity as a cancer risk factor, including breast and colorectal cancers, among the unique AI/AN population. As patients attend the tribal clinic, they will be screened for BMI, and if necessary, provided education on obtaining a healthy body weight and the dangers of obesity and referred to local tribal nutritionists and physical fitness experts and facilities i.e. community-clinical linkages. This will be documented in the electronic health record. This strategy will affect access to healthy food options and increased physical activity.

By June 22, 2022, decrease the percent of adults who report excessive drinking by 10% within the target population. Baseline: 22.8%; Target: 12.8%

- **Strategy 3** Health Systems Change/ EBI: Screening for excessive drinking objective. As patients utilize the tribal clinic, providers will screen for alcohol use and provide education. The additional strategy to provide personalized feedback on the risks of excessive drinking rounds out the intervention. Those patients who are identified as excessive drinkers will be provided direct education with contact information for local resource agencies. This will be documented in the E.H.R and will help to decrease drinking rates through social environment changes.

Early Detection and Screening:

The current plan focuses on the most prominent cancers experienced by Michigan's American Indian population: Colon Cancer, Breast Cancer, and Liver Cancer.

Colorectal Cancer: Among Michigan American Indian communities, cancer – colorectal cancer in particular – remains a top public health priority due to well-documented disparities in incidence and prevalence of cancer even among people younger than 50 years of age. An analyses in 2012 of American Indians within the State Cancer Registry documented a higher **incidence rate and mean age of diagnosis** of all cancers was younger for the AI population at 56.98 years compared to all races ages of 62.23 years. The younger age diagnosis is also documented in specific cancers for the AI population compared to the general population. This was highly evident in the **colon cancer incidence rates** for American Indians in Michigan by age group. Table 2 shows invasive colorectal cancer age specific incidence rates (per 100,000 population) by racial group and hazard ratios.[x] This data indicates an urgent need for improved screening among the AI/AN population and suggests a need to assess individual risk factors for colon cancer along with adjusted screening recommendations for those outside the recommended age of 50.

Age Group	AI Specific Incidence Rate	95% Confidence Interval	White Specific Incidence Rate	95% Confidence Interval	Hazard Ratio (AI:White)	95% Confidence Interval
30-34	7.07	(0.00, 16.88)	3.41	(2.74, 4.07)	2.08	(0.29, 14.7)
35-39	14.3	(0.29, 28.32)	8.13	(7.15, 9.11)	1.76	(0.49, 6.36)
40-44	10.97	(0.00, 23.39)	13.91	(12.65, 15.18)	0.79	(0.29, 2.16)
45-49	37.83	(13.12, 62.54)	28.14	(26.27, 30.01)	1.34	(0.63, 2.87)
50-54	66.29	(28.8, 103.79)	56.11	(53.24, 58.98)	1.18	(0.64, 2.19)
55-59	111.8	(55.25, 168.34)	92.79	(88.64, 96.94)	1.2	(0.69, 2.1)
60-64	138.62	(63.32, 213.93)	160.02	(153.87, 166.18)	0.87	(0.52, 1.44)
65-69	225.84	(111.68, 340)	239.11	(230.99, 247.22)	0.94	(0.58, 1.55)
70-74	382.17	(205.95, 558.38)	317.17	(307.22, 327.12)	1.2	(0.73, 2)
75-79	239.89	(62.39, 417.39)	405.04	(392.16, 417.91)	0.59	(0.34, 1.04)

By June 29, 2022 decrease the incidence of colon cancer by 10% among the target population
Baseline: 123.48/ 100,000; Target: 111.18/ 100,000

- **Strategy 1**: Patient Navigation to facilitate timely access to screening for colon cancer objective has been proven effective at increasing screening rates and will be implemented within each of the tribal health systems. Navigators will send patient reminder post cards, letters and phone calls; assist in scheduling screenings; and educate on screening prep (FOBT or colonoscopy). A local trusted navigator bridge the screening process, increasing follow through and reducing no-show rates for colonoscopy and increasing return rates for FOBT kits. Formal agreements with screening facilities are helpful to ensure capacity, access to screening and coordination of care.

- **Strategy 2**: Small media to increase community demand for cancer screening services will address the need for culturally appropriate colon cancer screening messages. Small media will include tailored post card reminders, tribal newsletter articles and personal digital stories. Dissemination outlets include community gatherings, direct mailings and clinic waiting rooms.

Nationwide studies have suggested that there is a greater burden of late-stage and early on-set breast cancer in the AI/AN population compared to whites. Following a series of linkages between Michigan tribes and the State Cancer Registry, a study was done to assess cancer disparities for the American Indian/Alaska Native population. Results supported the findings at the national level, which found that among breast cancers, AI/AN women in Michigan had a greater late-stage cancer burden and a younger mean age of diagnosis as compared to whites.[xi] This data supports an urgent need to improve culturally specific education targeting AI/AN women so that cancer can be caught and treated earlier.

By June 29, 2022, decrease the incidence of advanced stage breast cancer by 10% among the target population; Baseline: 31%; Target: 21%.

- **Strategy 3**: Patient navigation to facilitate timely access to screening for breast cancer objective. While the incidence rate of breast cancer among AI/AN women is not higher than the general population; advanced stage of diagnosis and younger age onset is significantly higher. This strategy will increase timely screening among women in the target population. As many tribal members distrust outside health agencies, local tribal Navigators will provide support for timely screening. Navigators will send patient reminder post cards, phone calls, assist in scheduling screenings, and ensure that screening reports are returned to tribal clinics and the patient is notified. Formal agreements with screening facilities will also ensure capacity and access.
- **Strategy 4**: Small Media to increase demand for screening services. Small media has been provide to be effective in past projects addressing breast cancer, but need a more consistent presence. Culturally adapted small media will include tribal newspaper articles, women's health newsletters, brochures and fact sheets disseminated at community events and gatherings.

Quality of Life for Survivors:

For the American Indian population in Michigan, physical, emotional, spiritual and practical support can be offered by family members, friends, other cancer patients, traditional healers and tribal community health programs and services and our health care providers.

- Native cancer survivors often get lost in the fragmented system during diagnosis, treatment and beyond and have difficulty navigating through the health care system

- Cancer treatment facilities are often far away and there is little money available for food, gas and lodging expenses for the cancer survivor and their caregivers.
- Cancer treatment is expensive and contract health care services may be limited or a patient is ineligible.
- Cancer survivors and their caregivers are in need of more social, mental, spiritual support.
- Faith, spirituality and traditional methods are not always understood or accepted by cancer care providers.
- Cancer survivors have difficulties with missing work and running out of vacation/leave time.

A recent assessment on the viability of survivorship care plans and services have indicated the ability to improve all areas of survivorship services within tribal health systems.

By June 29, 2022, increase the percent of cancer survivors who self-report a favorable health status by 15% among the target population. Baseline: TBD by SCRBS in Y1

- **Strategy**1: Health Systems Change/ EBI for survivors with a favorable health status objective: Provide information to survivors, providers and the public about cancer survivorship and their needs. A recent assessment among three tribal health systems, found that no survivors were given a survivorship care plan, but that components of survivorship services did exist locally. Educating tribal provider's on survivor's needs and available resources, and will help them to support their patients and to improve quality of life. Examples include smoking cessation, nutrition and physical therapy, stress management i.e. massage and yoga, spiritual/traditional medicine, social-emotional support, behavior health services, and financial assistance resources.

- **Strategy 2:** Community-Clinical Linkages/ EBI**:** Develop and promote patient navigation programs to facilitate optimum care. In follow up to strategy one, providers may refer their patients to navigation services to facilitate referrals to local survivorship resources.

- **Strategy 3:** Environmental Approaches/ EBI: Implement evidence based cancer plans that include all stages of cancer survivorship. Building from provider education in strategy 1; we will provide tribal clinics with a template of survivorship care plan and instructions. With this support and navigator assistance, the survivor may have an improved quality of life.

Health Equity:

By June 29, 2022, increase the number of tribal health systems that routinely utilize population specific health data for cancer prevention and control: Baseline 6; Target 7.

- **Strategy 1:** Environmental Approaches/ EB for health systems with population specific health data objective. We will link a least one additional tribe to the registry, resulting in a Tribal Specific Cancer Profile and conduct one statewide AI/An analysis to further identify cancer specific and regional disparities
- **Strategy 2:** Health Systems Change/ EBI: Culturally specific health care setting to promote health equity. Cancer reports with evidence based interventions will be presented to the Tribal Health Directors for consideration and implementation within the Trial Health Clinic.
- **Strategy 3:** Environmental Approaches/ EBI: Education-related recommendation from the community guide to promote health. We will adapt breast and colon cancer education materials, for the tribal culture to increase knowledge/awareness of prevention and screening guidelines.

Evaluation and Surveillance

The evaluation follows the six-step process of CDC's Framework for Program Evaluation in Public Health.[1] The first step of the evaluation will involve ***engaging stakeholders***. Consistent with the history of our partnership, ITCM and Michigan Public Health Institute (MPHI) will engage program partners and stakeholders in evaluation following a community based participatory approach[2], including:

- Recognizing community as a unit of identity;
- Building on strengths and resources within the community;
- Facilitating collaborative, equitable involvement of all partners in all phases;
- Integrating knowledge and intervention for mutual benefit of all partners;
- Promoting a co-learning and empowering process that attends to social inequalities;
- Involving a cyclical and iterative process;
- Addressing health from both positive and ecological perspectives;
- Disseminating findings and knowledge gained to all partners; and
- Promoting long-term commitment by all partners.

By engaging tribal communities in the process of creating and disseminating knowledge, participatory approaches have been successful in building trust and transitioning power from evaluators to community members when applied in the tribal context. The evaluation team will ensure meaningful opportunities for the Leadership Team, tribal health agencies, and the CDC, to inform the evaluation priorities and methods. MPHI staff have used Technology of Participation facilitation methods during in-person meetings and support the use of data for program improvement. Performance measurement data will be shared back with project partners in concise user-friendly formats for a wide variety of stakeholders.

Potential **data sources** have also been identified for measurement of LIDs and program indicators for relevant strategies, as well as progress toward intermediate outcomes. ITCM and MPHI have worked in collaboration with these tribes to successfully conduct several population-level surveys, including a tribal-BRFS, AI-ATS, and community-wide health surveys. As mentioned, we will conduct a **Special Cancer Behavior Risk Factor Survey (SCBRFS)** with all participating tribes twice, in year 1 and year 5 of the program. The SCBRFS methods will utilize existing CDC instruments and modules and will be tailored to each tribal community to ensure they are culturally competent, while following best practices for population-level surveys with regards to sampling, standardized data collection, data quality monitoring, and analysis.

Several indicators will be drawn from **GPRA Tribal Clinic Data**. GPRA data is generated through Electronic Health Record systems of each tribal health clinic. Standard definitions developed by Indian Health Service are used to query EHR systems and generate GPRA reports for patient populations. Tribal health clinics will be provided with a reporting template semi-annually to run queries and submit GPRA data reports for monitoring and evaluation purposes.

[1] Centers for Disease Control and Prevention (2014). Program Performance and Evaluation Office: A Framework for Program Evaluation. Retrieved online: http://www.cdc.gov/EVAL/framework/

[2] Israel B, Schulz A, Parker E and Becker A. (1998). Review of community-based research: Assessing partnership approaches to improve public health. Annual Review of Public Health, 19, pp. 173-22

Michigan **Cancer Registry** data will be used to monitor and report on several LIDS indicators. Accuracy of the Cancer Registry data will be ensured by conducting linkages between tribal enrollments lists and the State Cancer Registry. Each participating tribal community will complete a linkage process at/near the beginning of the project period, and again at/near the end of the project period. This data source is considered highly feasible to collect due to successful outcomes with multiple tribal communities in the past 10 years.

A collection of **Program, Service Delivery, and Media Tracking and Report Forms** will be developed by MPHI in collaboration with ITCM, partners, and tribal agency staff in order to collect evaluation data needs and satisfy program indicators. The forms will be programmed into the REDCap system (described previously) and data collection will occur on a continuous or quarterly basis, depending upon the specific form. Forms will be completed by the coordinator of each agency named in the program workplan. Data quality monitoring will be conducted by MPHI. This system of data collection and monitoring is known to be highly feasible based upon current and past experiences using this system with both ITCM REACH PPHF tribal communities and partner agencies for the National Native Network cooperative agreements.

Additional data needed to answer process evaluation questions will be collected through key informant interviews with program partners, focus groups with community members, and pre-post training evaluation forms with participants. These data collection activities are "standard" practice for ITCM grant programs and have been highly successful in generating useful and meaningful information for revising workplans and informing program improvements.

[viii] http://www.cdc.gov/nchs/data/nhsr/nhsr020.pdf

[x] Roen, E. L., Copeland, G. E., Pinagtore, N. L., Meza, R. and Soliman, A. S. (2014), Disparities of cancer incidence in Michigan's American Indians: Spotlight on breast cancer. Cancer, 120: 1847–1853. doi: 10.1002/cncr.28589

[xi] Roen, E, Copeland G, Pingatore N, Meza, R, Soliman A; Disparities of Cancer Incidence in Michigan's American Indians – Spotlight on Breast Cancer; *Cancer*; June 15, 2014.