

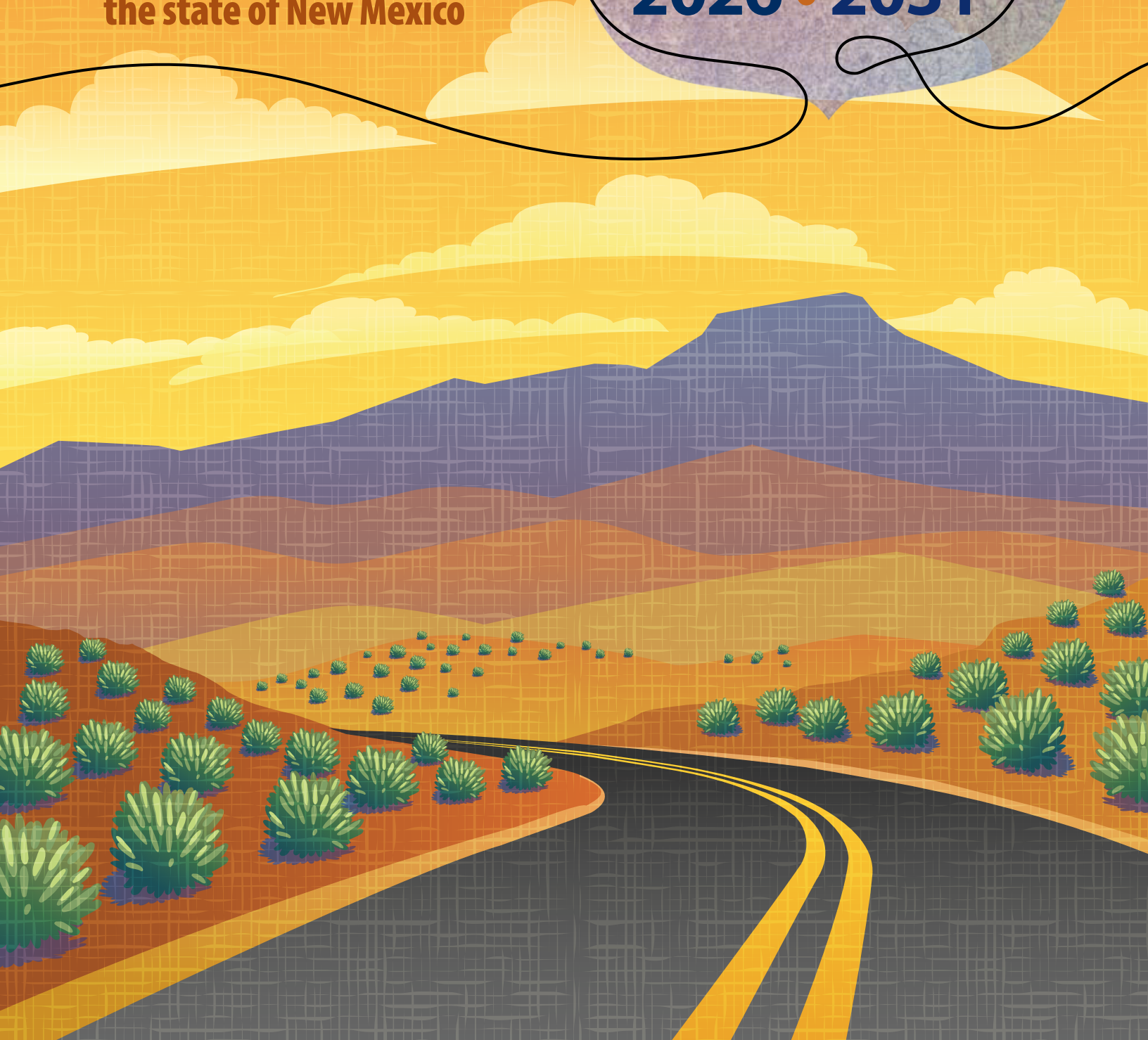


NEW MEXICO  
CANCER  
COUNCIL

*Partnerships. Possibilities. Progress.*

**A roadmap to guide  
collaborative cancer control  
efforts throughout  
the state of New Mexico**

**NEW  
MEXICO  
CANCER  
PLAN  
2026 • 2031**



The **NEW MEXICO CANCER PLAN 2026-2031** is a roadmap towards progress. Since **2026 marks the centennial of Route 66**, we want to acknowledge the journey that our communities have already made and provide clear signposts for our journey towards improved health. Here are some highlights of what to expect from this cancer plan:

- **A great starting point:** New Mexico has the lowest rate of new cancer cases in the US.
- **Who is on this journey?** We've included children, adolescents, young adults, and caregivers in this version of the cancer plan, because they deserve support.
- **What are the rules of the road?** We've included policy goals to help make sure that the rules benefit patients and address critical challenges, such as the health worker shortage.
- **Warning signs:** New Mexico's low cancer screening rates and health worker shortage are major obstacles to a successful journey towards health and healing.
- **The goals:** We'll know we've reached the end of our journey when New Mexico's screening rates and survival rates align with or exceed national averages.

**Please join us on this journey together to achieve lasting progress for all New Mexicans.**



**DEDICATION**

The **New Mexico Cancer Plan 2026-2031** is dedicated to all cancer survivors, and the providers who care for them, in the state of New Mexico.

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**SURVIVOR STORIES**

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| Cynthia | 7  |
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| Jeff    | 41 |
| Lea     | 51 |
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| Jade    | 61 |

**HEALTHCARE PROVIDER STORIES**

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| Dr. Bee     | 6  |
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**POPULATIONS IN FOCUS**

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## Contributors to the Plan

Many organizations and individuals generously volunteered their time and expertise to the development of this plan. We thank the following people for their contributions:

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Members of the New Mexico Cancer Plan Executive Committee were involved in all aspects of the revision process, generously donating their time and expertise to produce the final document.

### Executive Committee of the NEW MEXICO CANCER COUNCIL 2025-2026

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## NEW MEXICO CANCER COUNCIL

The **New Mexico Cancer Council** is a public/private partnership working together to reduce the burden of cancer in New Mexico. The New Mexico Cancer Council works collaboratively with member organizations and state, regional, and local counterparts to create a Cancer Plan every five years.

Membership in the New Mexico Cancer Council is open to anyone interested in reducing the negative impact cancer takes on the people of New Mexico and to people with different backgrounds, including public health, education, research, treatment, academic, and business sectors. There is no fee to join the Council. For more information about the New Mexico Cancer Council, its workgroups, its governance structure, and for membership applications, please go to the website: [nmcancercouncil.org](http://nmcancercouncil.org).

In addition to the Cancer Plan, the New Mexico Cancer Council also produces the New Mexico Cancer Support and Treatment Directory, a searchable online directory of resources for people facing cancer and for their families. The Directory is available on the New Mexico Cancer Council website.

For more information, visit: [nmcancercouncil.org](http://nmcancercouncil.org)



## LETTER OF SUPPORT

Dear New Mexicans:

When I was diagnosed with cancer, I was just a young college student who had moved to Albuquerque from the Navajo Nation. I experienced feelings of uncertainty, fear, and countless questions about what lay ahead. At the time, I could not imagine how I would get through treatment or what my future would look like.

As the journey unfolded, I discovered strength I did not know I possessed. I also found deeper connections with family and friends, a greater appreciation for life, and a renewed sense of purpose. Through every challenge, I learned that resilience is not about never feeling afraid — it is about continuing forward despite fear.

As a cancer survivor, I carry that lesson with me every day. The strength, gratitude, and purpose I found through my journey inspire me to support and advocate for others facing cancer, helping them find hope and resilience during some of life's most difficult moments. My experience has reinforced my commitment to ensuring that all New Mexicans have access to the care, resources, and support they need throughout their cancer journey.

It is with that commitment in mind that we are pleased to share the 2026–2031 New Mexico Cancer Plan. This plan is the culmination of the work of the New Mexico Cancer Council and its partners to develop a comprehensive strategy for addressing the impact of cancer on communities throughout our state.

The New Mexico Cancer Plan outlines actionable strategies to address these challenges and to extend greater support to rural communities.

We extend our sincere gratitude to the members of the New Mexico Cancer Council, the Steering Committee, and our many partners who dedicated their time, expertise, and passion to developing this plan. We look forward to supporting its successful implementation and to the lasting positive impact it will have on the health and well-being of New Mexico's communities.

Sincerely,



Remona Benally  
Chair, New Mexico Cancer Council



## EXECUTIVE SUMMARY

New Mexico has made meaningful progress in reducing its cancer burden. In 2024, the state had the lowest rate of new cancer cases in the United States. That achievement reflects the hard work of communities, healthcare providers, public health professionals, and advocates across the state.

However, cancer is still taking a heavy toll on New Mexico families. It is the second leading cause of death statewide and, for many cancers, five-year survival rates are among the lowest in the country. Progress is not evenly distributed among certain populations and for specific cancer types. Cancer screening rates are among the lowest in the United States, which leads to delays in diagnosis and poor health outcomes. Across the state, people are waiting too long for appointments, diagnostic procedures, and treatment. Health care workforce shortages and limited specialty capacity mean that some cancers are diagnosed at later stages, when outcomes are likely to be worse. These challenges are not just statistics; they are lived experiences for families in every region of New Mexico.

The **NEW MEXICO CANCER PLAN 2026-2031** is a *wake-up call*.

Developed by the New Mexico Cancer Council in partnership with survivors, caregivers, health professionals, tribal and community leaders, and policymakers, this plan outlines a shared path forward. It focuses on practical and collaborative strategies to reduce the cancer burden and mobilize resources for this effort.

The **PLAN** is organized around **5 Strategic Priorities**:

- 1. POLICY and SYSTEMS:** Reduce cancer mortality through policy and systems changes that support integrated, patient-centered, and fully staffed health services for cancer screening, diagnosis, and care and treatment.
- 2. PREVENTION and RISK REDUCTION:** Support all New Mexicans to engage in healthful behaviors that reduce their risk of cancer.
- 3. SCREENING and EARLY DETECTION:** Improve early detection and management of screenable cancers by increasing equitable access to evidence-based screening services, strengthening screening-to-diagnostic pathways, and supporting informed, patient-centered decision-making across New Mexico.
- 4. CARE and TREATMENT:** Improve availability, quality, and timeliness of cancer diagnosis, care, and treatment for all New Mexicans, including children, as well as rural and underserved populations.
- 5. SURVIVORSHIP:** Improve quality of life for all New Mexicans facing cancer.

This plan belongs to all of us. It is intended for policymakers, public health practitioners, providers and healthcare systems, health insurers and payers, employers, county and tribal health councils, cancer survivors and their families, researchers, and communities across the state. Reducing the cancer burden will require partnership, accountability, and sustained commitment.

Together, New Mexico can build on its progress, close gaps in care, and ensure that every community has a fair opportunity to prevent, detect, treat, and survive cancer.

# DR. BEE

## PEDIATRIC ONCOLOGIST

I was born in New Mexico and grew up in a military family, so we moved all over. I completed my medical school and residency training in pediatrics at the University of New Mexico, then went to Iowa for my fellowship in pediatric oncology. I came back to work in Albuquerque eight years ago because I love New Mexico, and it is where I call home.

The health worker shortage in New Mexico leads to decreased access for pediatric cancer patients. It puts a strain on patients and their families. The waiting times to see a doctor are longer. The longer it takes for a child to be seen by a healthcare provider, the longer it takes before they reach our office so that we can make a diagnosis of cancer.

Children in rural parts of the state really suffer, because the only pediatric oncologists are in Albuquerque at two hospitals. We do not have a statewide program in pediatric oncology; care for children is only offered in Albuquerque. Another significant challenge is we are trying to serve the same number of patients with fewer oncologists, nurses, and support staff available. It's hard on children and their parents.



It is a tremendous burden on families to have to travel to Albuquerque for care. Many families have more than one child, so they pull the other children out of school to come to Albuquerque for the appointment. Travel can take five or six hours from some parts of New Mexico, and they can't get to the appointment and back on the same day.

I work late most nights and take my work home with me. I miss out on a lot of family time at home. It's difficult to try and find a work-life balance when you don't have enough people in your job field to help you. We need more support in recruiting physicians to New Mexico so we can provide the comprehensive care that New Mexicans deserve.

I love pediatric hematology/oncology. It is similar to primary care in that we maintain relationships with our patients for years, even after they turn 18.

The field of pediatrics, and especially its pediatric subspecialties, needs more support in New Mexico. Despite children being our future, state resources are focused primarily on adult care. The difference between the compensation for an adult subspecialist and a pediatric subspecialist is staggering, and pediatric subspecialties are suffering more each year. In pediatric oncology we have an aging physician population, high physician burnout rates, and a decreasing number of graduates, with no solutions to these problems on the horizon.

**"We do not have a statewide program in pediatric oncology; care for children is only offered in Albuquerque."**

# CYNTHIA

## FROM LAS CRUCES

Cancer was the last thing I expected. I was 26 years old, just starting my teaching career. It began in May of 2022 when I went to see my gynecologist in Albuquerque for a standard visit. When I explained that my paternal grandmother had breast cancer, she wanted to be proactive and referred me for an ultrasound. The ultrasound tech talked me out of it because of my age and that it was an expensive out-of-pocket cost. That summer, I moved to Las Cruces. By August, I noticed a lump and scheduled an appointment with a gynecologist there. He too felt the lump and scheduled me for both an ultrasound and biopsy but told me it was probably a cyst and that I should be fine.

Two weeks later, while I was at a music festival in Texas, I got an email telling me that I had Stage 2 breast cancer. I met with my doctor two days after I got home ... and I was angry because he had said I'd be fine.

As I was talking with my oncologist about treatments, I mentioned that I wanted to have children someday. He suggested that I have my eggs harvested and frozen before I began chemotherapy. I saved up some money ... and one of my friends set up a fundraiser to help with the costs. There's a lot of prep to doing this, but it was important to me to do it.

**"If you want to have children, find out about having your eggs frozen."**

I really leaned on my family throughout my treatments. My parents live in Albuquerque, but my mom traveled to Las Cruces every other Wednesday to be with me during chemo treatments. This has definitely brought my mom and me closer.

One surprise for me, though, was that I learned who my support system was. I experienced 'cancer ghosting'. People don't know how to deal with cancer, so they avoid you. That's very hard on your mental health.

I also continued to teach throughout my treatments. The kids were very helpful. I developed a routine, and the school was very supportive. They appreciated that I communicated with them. But the district doesn't give a lot of sick days, so my pay was cut.

Having cancer is financially difficult. There are resources available, but they are hard to find.

If you have a friend who has cancer, don't leave your friend. If you can't handle it, communicate that ... don't just disappear.

One last thing ... I tell my own family to do breast self-exams regularly. It might help discover cancer earlier.



# CHAPTER 1: BURDEN OF CANCER IN NEW MEXICO

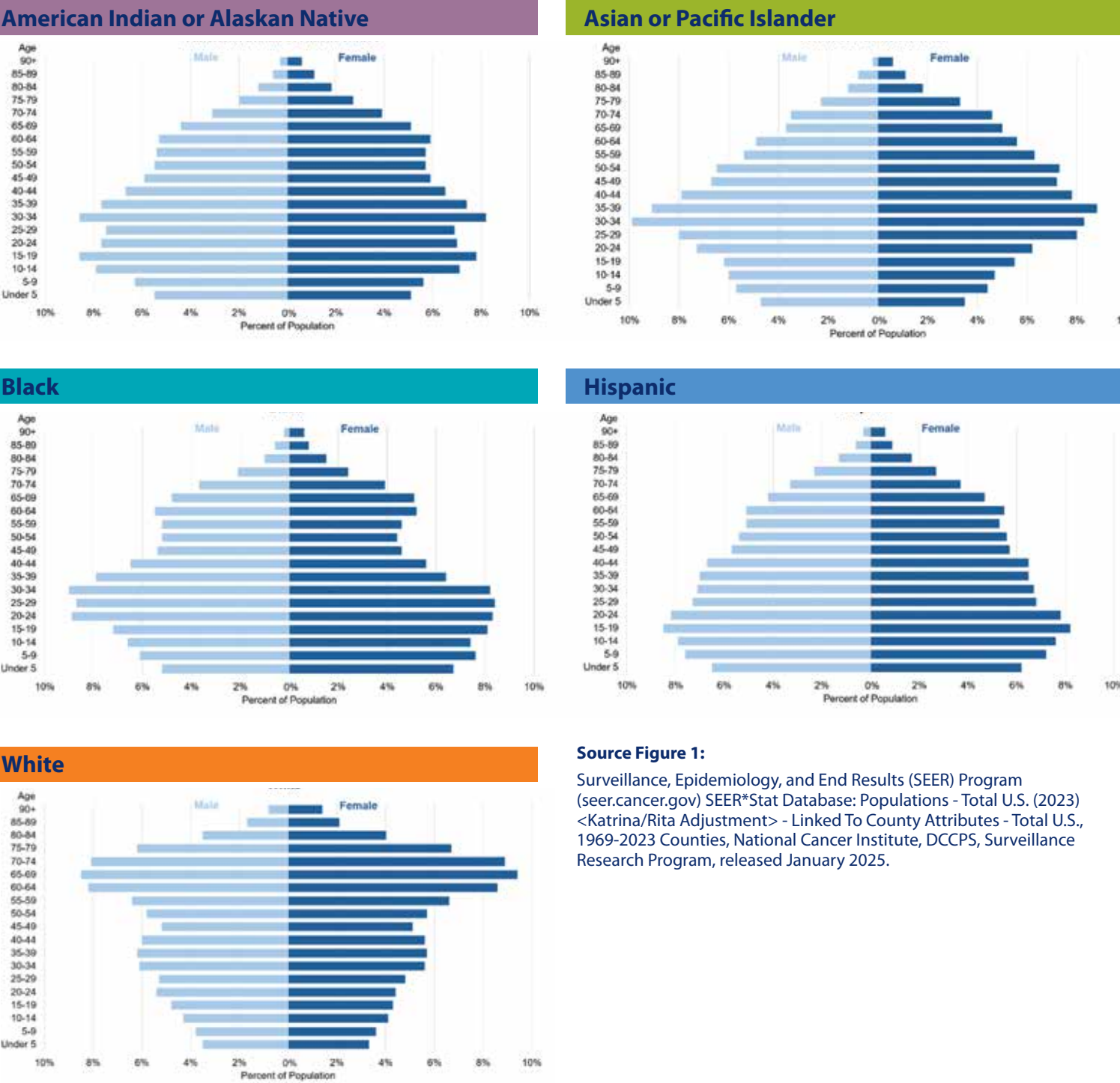
## Demographics, Social Drivers of Health, and Health Behaviors Impact Cancer Risk

Approximately 2.1 million people call New Mexico home. New Mexico has a diverse population, as one of only seven minority-majority states in the U.S. Almost half (48.6%) of New Mexicans identify as Hispanic (Table 1) (the highest percentage of any state), while 37.6% are White, and 9.3% American Indian or Alaska Native (AIAN) (Table 1) (the 3rd highest percentage of any state). The percentage of New Mexicans ages 65 years and older is 19.8%; however, this varies by race. The percentage of the White population 65 and older is 30.7%, whereas the percentage for all other groups ranges from 13.2% to 14.3% (Table 1). Understanding the race, ethnicity, and age profiles in New Mexico (Figure 1) is critical to understanding our state’s cancer burden, since risk of cancer varies by race/ethnicity and increases with age. Therefore, younger populations will be less likely to experience cancer than older populations.

TABLE 1: Demographic and Socioeconomic Drivers of Health in New Mexico.

| INDICATOR                                                                 | NEW MEXICO | UNITED STATES |
|---------------------------------------------------------------------------|------------|---------------|
| <b>Race and Ethnicity</b>                                                 |            |               |
| American Indian or Alaska Native (AIAN)                                   | 9.3%       | 0.8%          |
| Asian or Pacific Islander                                                 | 2.0%       | 6.8%          |
| Black                                                                     | 2.5%       | 13.3%         |
| Hispanic                                                                  | 48.6%      | 19.5%         |
| White                                                                     | 37.6%      | 59.6%         |
| <b>Aged 65+ years</b>                                                     |            |               |
| AIAN                                                                      | 13.4%      | 14.5%         |
| Asian or Pacific Islander                                                 | 14.3%      | 13.9%         |
| Black                                                                     | 13.2%      | 12.9%         |
| Hispanic                                                                  | 13.2%      | 8.6%          |
| White                                                                     | 30.7%      | 22.2%         |
| <b>People living in rural areas</b>                                       |            |               |
|                                                                           | 25.4%      | 20.0%         |
| <b>Median Income</b>                                                      |            |               |
|                                                                           | \$63,400   | \$81,100      |
| <b>Adults aged 25y+ with at least a high school diploma or equivalent</b> |            |               |
|                                                                           | 87.7%      | 89.3%         |
| <b>Medically uninsured</b>                                                |            |               |
|                                                                           | 9.1%       | 7.9%          |
| <b>Poverty</b>                                                            |            |               |
|                                                                           | 18.1%      | 12.7%         |
| <b>Children in poverty</b>                                                |            |               |
|                                                                           | 24.6%      | 16.3%         |
| <b>Food insecurity</b>                                                    |            |               |
|                                                                           | 19.1%      | 14.9%         |
| <b>Utility services threat</b>                                            |            |               |
|                                                                           | 10.2%      | 8.2%          |
| <b>Limited English proficiency</b>                                        |            |               |
|                                                                           | 31.6%      | 22.7%         |

FIGURE 1: Race-Specific Population Pyramids Demonstrate that Populations Differ in the Percentage of Older Individuals. Risk and Rates of Cancer Increase with Age.



Source Figure 1: Surveillance, Epidemiology, and End Results (SEER) Program (seer.cancer.gov) SEER\*Stat Database: Populations - Total U.S. (2023) <Katrina/Rita Adjustment> - Linked To County Attributes - Total U.S., 1969-2023 Counties, National Cancer Institute, DCCPS, Surveillance Research Program, released January 2025.

Sources Table 1: Surveillance, Epidemiology, and End Results Program (seer.cancer.gov) SEER\*Stat Database: Mortality - All COD, Aggregated With State, Total U.S. (1990-2023)<Katrina/Rita Population Adjustment>, National Cancer Institute, DCCPS, Surveillance Research Program, released February 2025. Underlying mortality data provided byNCHS (cdc.gov/nchs).

UCSF Health Atlas. University of California, San Francisco School of Medicine Dean’s Office of Population Health and Health Equity, 2024. Accessed from: healthatlas.ucsf.edu.

**Note for Table 1:** Racial and ethnic classifications for demographic and statistical data are following the standard used by the New Mexico Department of Health. Persons designated as Hispanic ethnicity, regardless of race, are categorized as “Hispanic.” Persons not designated as Hispanic are categorized by their single race. **The term American Indian or Alaska Native is used in this section alone because it corresponds to the categories used to collect demographic data. Throughout the rest of the plan, the term Native American is used.**

There are also social drivers of health that may be important to cancer risk and burden among New Mexicans. For example, 18 of New Mexico’s 33 counties are considered persistent poverty counties. The proportion of people in New Mexico living in poverty (18.1%) is substantially higher than the U.S. average (12.7%); further, almost one quarter of New Mexico’s children live in poverty. There are also differences in factors that impact healthcare access: compared to the U.S. average, New Mexico has a higher proportion of people who are medically uninsured, a higher proportion living in rural areas, and a higher proportion with limited English proficiency (Table 1). Again, understanding the sociodemographic profile and social drivers of health among New Mexicans helps us to better understand observed patterns in cancer risk.

In turn, social drivers of health impact health behaviors, including those behaviors that may impact later life risk of cancer. Table 2 gives the proportions of New Mexicans, by race, who report selected cancer risk and protective factors.

TABLE 2: Age-Adjusted Percentages of New Mexicans with Selected Cancer Risk/Protective Factors, by Race.

| RISK/ PROTECTIVE FACTOR                                            | American Indian or Alaska Native | Asian or Pacific Islander | Black               | Hispanic             | Non-Hispanic White   | New Mexico Overall (age-adjusted) |
|--------------------------------------------------------------------|----------------------------------|---------------------------|---------------------|----------------------|----------------------|-----------------------------------|
| Meets physical activity recommendations (2019 + 2021) <sup>a</sup> | 65.8% (59.7% - 71.4%)            | 66.7% (54.9%-76.7%)       | 72.1% (59.8%-81.8%) | 60.1% (57.5%- 62.7%) | 71.4% (68.9%- 73.8%) | 65.7% (64.0%-67.4%)               |
| Eats 5+ fruits and vegetables daily (2019 + 2021) <sup>a</sup>     | 18.5% (15.3%-22.1%)              | 10.4% (5.4%-19.2%)        | 13.4% (7.7%-22.3%)  | 12.2% (10.9%-13.6%)  | 11.8% (10.4%-13.2%)  | 12.5% (11.6%-13.5%)               |
| Obese body mass index (BMI 30.0-99.8) (2024) <sup>b</sup>          | 45.4% (36.8%-54.1%)              | *                         | *                   | 39.9% (35.7%-44.1%)  | 28.0% (24.8%-31.2%)  | 35.5% (32.8%-38.2%)               |
| Current cigarette smoking (2024) <sup>b</sup>                      | 10.5% (5.4%-15.6%)               | *                         | *                   | 12.1% (9.7%-14.6%)   | 12.2% (9.8%-14.5%)   | 11.7% (10.1%-13.4%)               |
| Former cigarette smoking (2024) <sup>b</sup>                       | 27.7% (19.3%-36.1%)              | *                         | *                   | 18.8% (15.9%-21.8%)  | 33.5% (30.4%-36.7%)  | 23.9% (21.7%-26.0%)               |
| Heavy drinking** (2024) <sup>b</sup>                               | *                                | *                         | *                   | 3.3% (1.8%-4.8%)     | 6.1% (4.6%-7.6%)     | 4.9% (3.7%-6.1%)                  |
| Annual PCP visit (2024) <sup>b</sup>                               | 62.4% (54.1%-70.7%)              | *                         | *                   | 70.5% (66.6%-74.4%)  | 70.9% (67.6%-74.2%)  | 70.3% (67.9%-72.8%)               |

\* Prevalence estimate is not available if the unweighted sample size for the denominator was < 50 or the Relative Standard Error (RSE) is > 0.3.

\*\* In 2024, 47.2% of NM adults reported current drinking (≥1 drink in the past 30 days), 15.2% reported binge drinking (≥5 drinks on one occasion for males, ≥4 drinks on one occasion for females), and 4.7% reported heavy drinking (>14 drinks/week in the past year for males, >7 drinks/week in the past year for females). While binge drinking was more prevalent among Hispanics, heavy drinking was more prevalent among Non-Hispanic Whites.

Sources for data table:

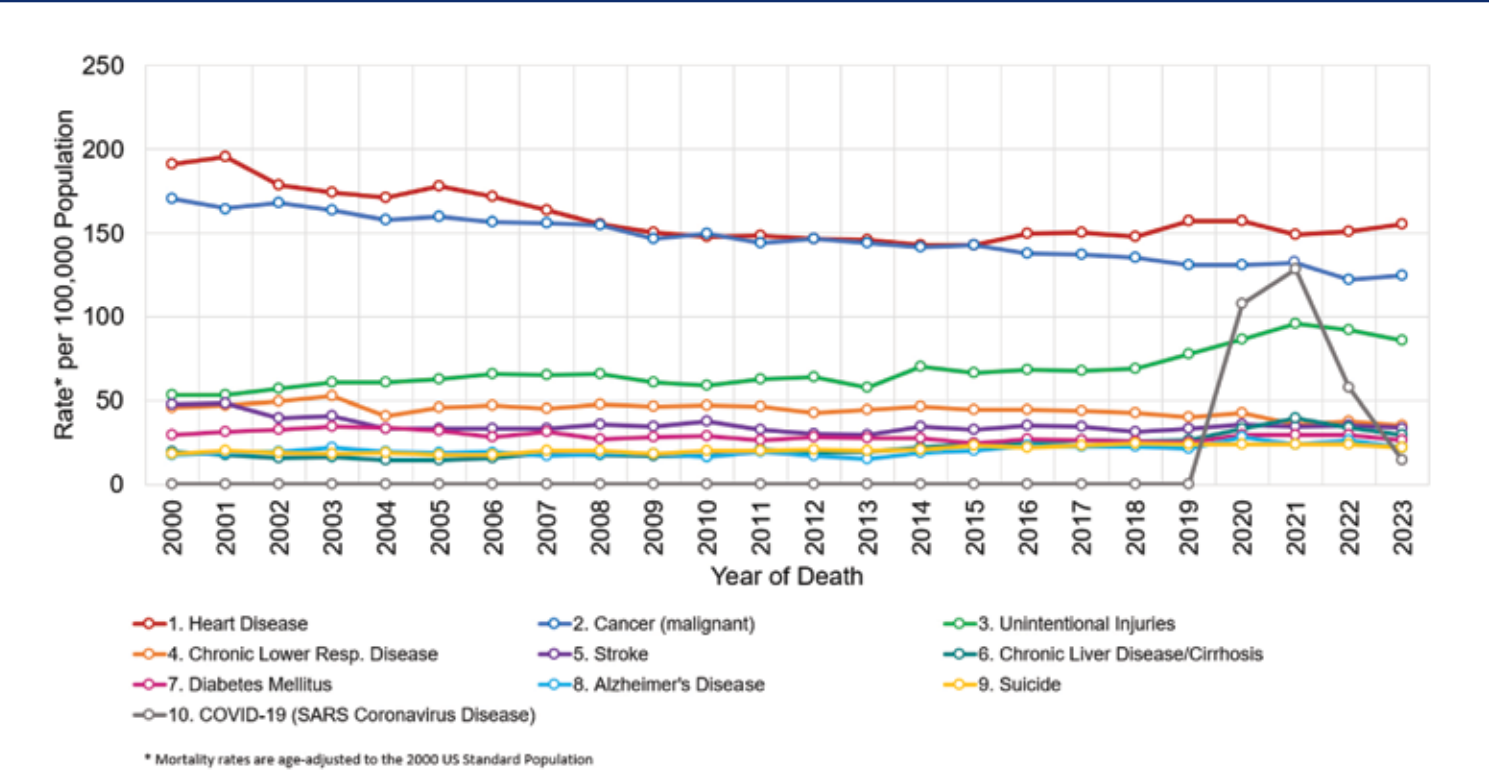
- (a) New Mexico Behavioral Risk Factor Surveillance System, Injury and Behavioral Epidemiology Bureau, New Mexico Department of Health and U.S. Centers for Disease Control and Prevention (CDC). Retrieved on Tuesday, 13 Jan 2026, from New Mexico Department of Health, Indicator-Based Information System for Public Health website: [ibis.doh.nm.gov](https://ibis.doh.nm.gov).
- (b) Behavioral and Risk Factor Surveillance System, 2022, available at Disability and Health Data System Explore by Location ([dhds.cdc.gov/SP?LocationId=35&CategoryId=DISEST&ShowFootnotes=true&showMode=&IndicatorIds=STATTYPE,AGEIND,SEXIND,RACEIND,VETIND&pnl0=Chart,false,YR7,CAT1,BO1,,,,AGEADJPREV&pnl1=Chart,false,YR7,DISSTAT,,,,PREV&pnl2=Chart,false,YR7,DISSTAT,,,,AGEADJPREV&pnl3=Chart,false,YR7,DISSTAT,,,,AGEADJPREV&pnl4=Chart,false,YR7,DISSTAT,,,,AGEADJPREV&t=1780874472823](https://dhds.cdc.gov/SP?LocationId=35&CategoryId=DISEST&ShowFootnotes=true&showMode=&IndicatorIds=STATTYPE,AGEIND,SEXIND,RACEIND,VETIND&pnl0=Chart,false,YR7,CAT1,BO1,,,,AGEADJPREV&pnl1=Chart,false,YR7,DISSTAT,,,,PREV&pnl2=Chart,false,YR7,DISSTAT,,,,AGEADJPREV&pnl3=Chart,false,YR7,DISSTAT,,,,AGEADJPREV&pnl4=Chart,false,YR7,DISSTAT,,,,AGEADJPREV&t=1780874472823)) (Accessed on 2/4/2026).

Cancer is a Leading Cause of Death in New Mexico

Cancer is the second leading cause of death among New Mexicans, behind heart disease. Between 2000 and 2023, mortality rates from cancer declined approximately 27%, from 170.5 to 124.9 deaths per 100,000 population, respectively (Figure 2). This pattern matches a decline observed nationwide, and is likely due to a combination of factors, including reduced tobacco use, uptake of vaccinations against cancer-causing agents, earlier cancer detection through screening, and advances in treatment.

As with social drivers of health and health behaviors, it is important to examine leading causes of death by race and ethnicity in New Mexico. For example, in 2023, cancer was the leading cause of death for Asian or Pacific Islander New Mexicans and the second leading cause of death for White, Hispanic, and Black New Mexicans. However, it was the fourth leading cause of death among AIAN New Mexicans, behind unintentional injuries, heart disease, and chronic liver disease/cirrhosis. Further, cancer mortality rates were highest among Black New Mexicans (149.4 per 100,000 population), similar among White (129.8) and Hispanic (121.0) New Mexicans, but lower among AIAN (103.7) and Asian or Pacific Islander (75.3) populations.

FIGURE 2: Age-Adjusted Mortality Rates for 10 Leading Causes of Death by Year and Cause of Death, 2000-2023.



Source: “Death Rates for the 2023 New Mexico Overall 10 Leading Causes of Death by Year and Cause of Death, New Mexico, 2000 to 2023. Retrieved on February 22, 2026, from New Mexico Department of Health, Indicator-Based Information System for Public Health website: [ibis.doh.nm.gov](https://ibis.doh.nm.gov).

## New Mexicans Face Among the Worst Cancer Survival in the Country

The national average for five-year relative survival is 67.5%, but in New Mexico, it is 64.4% (Table 3). Within New Mexico, males have poorer survival rates compared to females and Hispanics have poorer survival rates compared to White people.

Cancer survival is influenced by a multitude of factors, including the type of cancer, underlying health and age of the person diagnosed, stage of diagnosis, genetics, and other factors, including timely access to diagnosis and care. Further, it is important to note that examining five-year relative survival (such as those given in this paragraph) obscures potentially important variations, such as by cancer site and stage at diagnosis. For example, in New Mexico, 89.2% of women diagnosed with breast cancer and 92.7% of men diagnosed with prostate cancer will live five years beyond their diagnosis. In contrast, lung and colorectal cancers, which are also among New Mexico’s most common cancers, have five-year relative survival of 24.8% and 60.9%, respectively. Detecting cancers earlier (e.g., through screening) is one of the best ways to improve an individual’s likelihood of survival.

TABLE 3: Five-Year Relative Survival by State.

| STATES WITH HIGHEST FIVE-YEAR SURVIVAL |               |                               | STATES WITH LOWEST FIVE-YEAR SURVIVAL |               |                               |
|----------------------------------------|---------------|-------------------------------|---------------------------------------|---------------|-------------------------------|
| RANK                                   | STATE         | % FIVE-YEAR RELATIVE SURVIVAL | RANK                                  | STATE         | % FIVE-YEAR RELATIVE SURVIVAL |
| 1                                      | Utah          | 72.9%                         | 36                                    | Missouri      | 65.3%                         |
| 2                                      | Massachusetts | 72.2%                         | 37                                    | Tennessee     | 65.0%                         |
| 3                                      | Oregon        | 71.6%                         | 38                                    | Louisiana     | 64.5%                         |
| 4                                      | New Hampshire | 71.0%                         | 40                                    | Indiana       | 64.4%                         |
| 5                                      | Connecticut   | 70.8%                         | 40                                    | New Mexico    | 64.4%                         |
| 6                                      | Montana       | 70.6%                         | 41                                    | Oklahoma      | 63.8%                         |
| 7                                      | Rhode Island  | 70.5%                         | 42                                    | Alabama       | 63.2%                         |
| 8                                      | Minnesota     | 70.2%                         | 43                                    | West Virginia | 62.7%                         |
| 9                                      | Colorado      | 70.1%                         | 44                                    | Kentucky      | 62.6%                         |
| 10                                     | Nebraska      | 69.9%                         | 45                                    | Mississippi   | 62.0%                         |
| 10                                     | New Jersey    | 69.9%                         |                                       |               |                               |

**Source:**  
CiNA Explorer: An interactive tool for quick access to key NAACCR cancer statistics based on the Cancer in North America (CiNA) dataset from the North American Association of Central Cancer Registries. Available atnaaccr.org/interactive-data-on-line. (Accessed on 2/22/2026). Registry data for Alaska, Arkansas, Florida, and South Dakota were excluded because either they were not submitted or did not meet the Fit for Use Criteria for Survival.

## Overview of Cancer Among New Mexicans

More than 90,000 people living in our state have a history of cancer. On average, there are approximately 9,850 cases of newly diagnosed cancer, and 3,645 deaths due to cancer each year. As of 2024, New Mexico has the lowest rate of new cancers in the United States. The average annual age-adjusted rate of new cancers (all sites combined, 2018-2022) is 372.9 (369.5, 376.3) in New Mexico, compared to the U.S. average of 447.5 (447.2, 447.8) per 100,000 population. Our rate of new cancers is currently declining at a rate of approximately -0.5% (-0.8%, -0.1%) per year. The average annual age-adjusted death rate from cancer in NM (2019-2023) was 131.4 (129.5, 133.4), compared to the U.S. average of 145.4 (145.2, 145.6) per 100,000 (rank 45/50). Our cancer death rate is currently declining at a rate of approximately -1.3% (-1.9%, -0.7%) per year.

Yet, examining overall rates of new cancers and cancer deaths can mask important differences in cancer burden between population groups and among different cancers. For example, while New Mexico overall ranks 50th out of 50 states in terms of cancer incidence (which means that people in New Mexico are less likely to be newly diagnosed with cancer than people in other states), we rank 50th for incidence among White, but 47th among Black, 31st among AIAN, and 15th among Hispanic people. This reflects differences in cancer incidence by race and ethnicity: average annual age-adjusted incidence was 385.8 per 100,000 among White, 358.1 among Hispanic, 329.7 among Black, 288.4 among AIAN, and 257.0 among Asian or Pacific Islander populations. Furthermore, when we look at our rank by cancer site for some of the leading cancers, we rank 49th for incidence of female breast, 45th for colorectal, 49th for lung and bronchus, and 49th for prostate cancer, which are the most common cancers in the U.S. Yet we rank higher for some of the less common cancers; for example, 4th for liver cancer, 12th for stomach cancer, and 15th for cervical cancer.

## Leading Cancers Among New Mexicans

Cancers of the female breast, prostate, lung and bronchus, and colon and rectum are the most common types of cancer diagnosed in New Mexico. This is similar to the patterns observed nationwide.

Breast cancer is the most common cancer among New Mexican women. An average of 1,584 women is diagnosed with breast cancer annually. Prostate cancer is the most common cancer among men in New Mexico. On average, 1,297 men are diagnosed with prostate cancer each year.

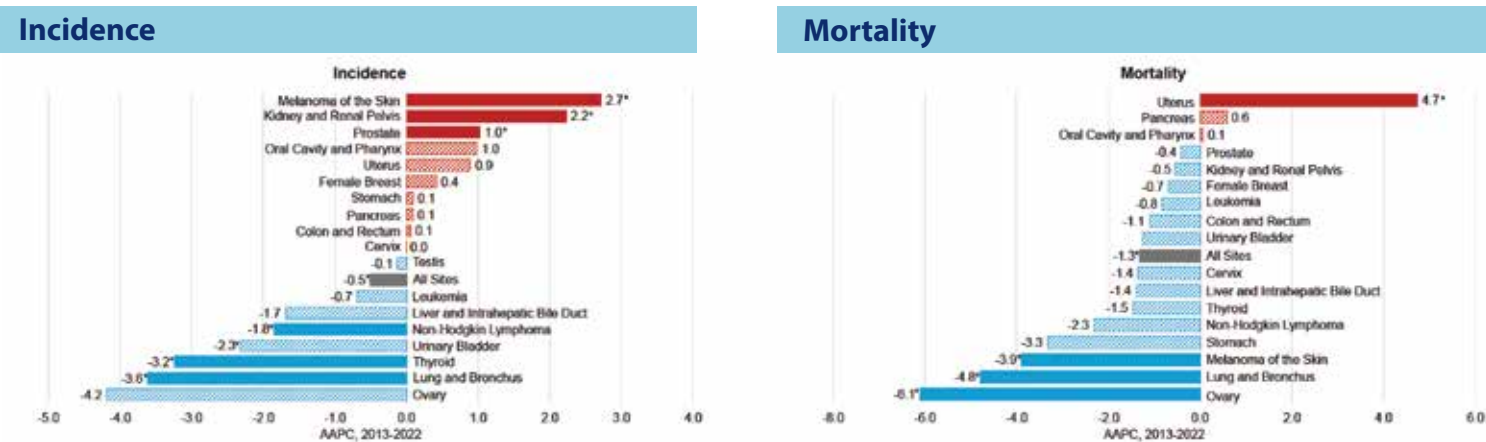
An estimated 920 New Mexicans are diagnosed with lung cancer every year. Lung cancer incidence rates in our state (31.8 per 100,000) are lower than national rates (40.5 per 100,000), with American Indian residents having some of the lowest incidence rates in the country (11.4 per 100,000).

Further, an average of 864 residents is diagnosed with colorectal cancer each year (33.2 per 100,000). Females are 25% less likely to be diagnosed with colorectal cancer than males, and more than half of patients are diagnosed over the age of 65 years.

## Changes in Cancer Burden Over Time

Cancer incidence and mortality rates in New Mexico are declining an average of 0.5% and 1.3% per year, respectively (Figure 3). Specifically, incidence of cancers of the lung, thyroid, and non-Hodgkin lymphoma are declining, and prostate, melanoma of the skin, and kidney and renal pelvis are increasing. Mortality rates for the most common cancer types are stable or decreasing, whereas deaths from cancers of the uterus are on the rise.

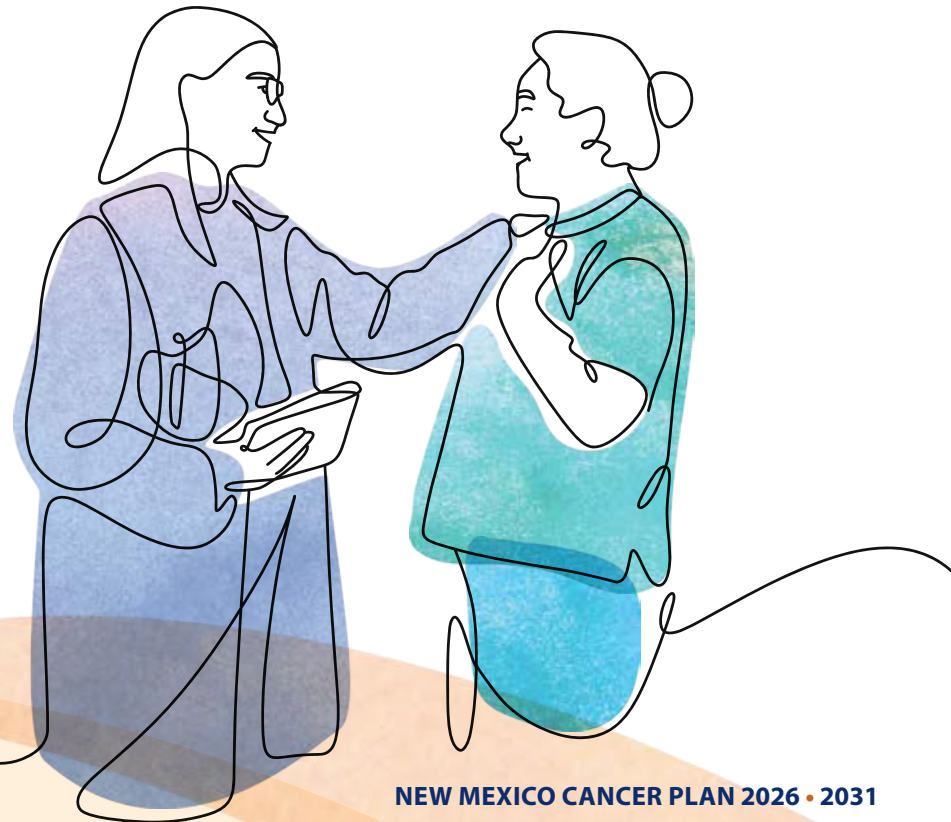
**FIGURE 3: Average Annual Percent Change (AAPC) of Cancer Incidence and Mortality, 2013-2022.**



### Sources:

Surveillance, Epidemiology, and End Results (SEER) Program ([seer.cancer.gov](https://seer.cancer.gov)) SEER\*Stat Database: Incidence - SEER Research Plus Data, 12 Registries, Nov 2024 Sub (1992-2022) - Linked To County Attributes - Total U.S., 1969-2023 Counties, National Cancer Institute, DCCPS, Surveillance Research Program, released April 2025, based on the November 2024 submission.

Surveillance, Epidemiology, and End Results (SEER) Program ([seer.cancer.gov](http://seer.cancer.gov)) SEER\*Stat Database: Mortality - All COD, Aggregated With State, Total U.S. (1990-2023) <Katrina/Rita Population Adjustment>, National Cancer Institute, DCCPS, Surveillance Research Program, released February 2025. Underlying mortality data provided by NCHS ([cdc.gov/nchs](http://cdc.gov/nchs)).

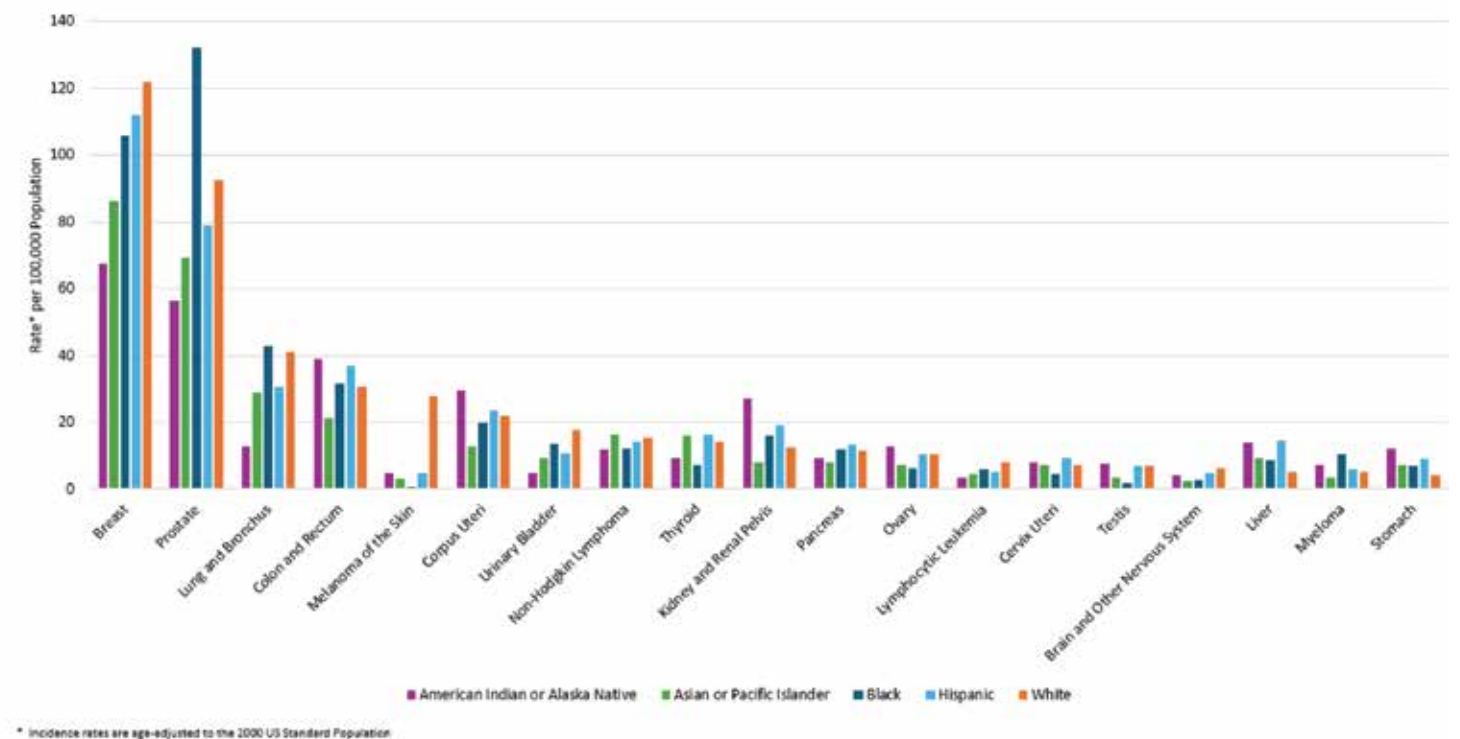


## Cancer Disparities in New Mexico: Race and Ethnicity

The burden of cancer is different by race and ethnicity in New Mexico (Figure 4). For example, the White population has the highest rates of female breast cancers and melanoma; in contrast, the Black population has the highest rates of prostate and lung cancers; AIAN people have higher rates of uterine and kidney cancers, and both AIAN and Hispanic people have a high burden of liver cancer.

Differences in the rate of new cancers by race are likely due to a combination of factors. Importantly, differences in the social and structural drivers of health (i.e., underlying or upstream factors) impact health behaviors and healthcare access, which in turn impacts cancer risk. There may also be some biological differences between races that account for a smaller proportion of race-based differences in cancer burden.

**FIGURE 4: Incidence of Select Cancers Among New Mexicans, 2013-2022.**



\* incidence rates are age-adjusted to the 2000 US Standard Population

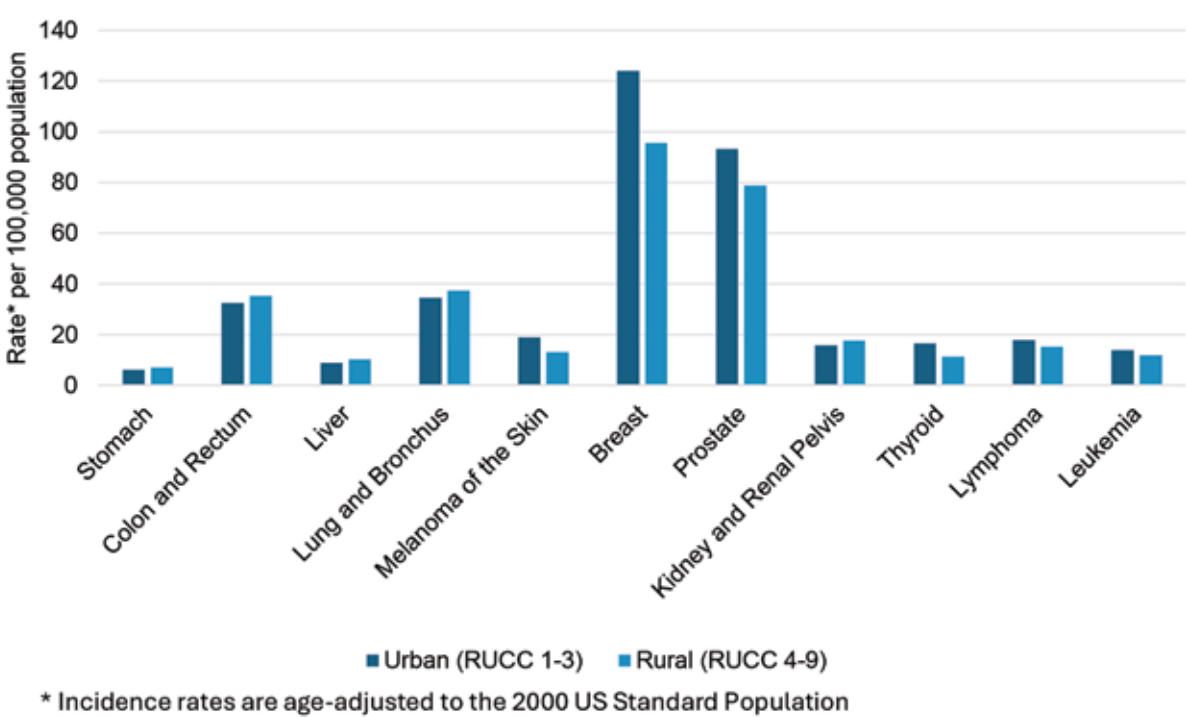
**Source:**

Surveillance, Epidemiology, and End Results (SEER) Program ([seer.cancer.gov](https://seer.cancer.gov)) SEER\*Stat Database: Incidence - SEER Research Plus Data, 12 Registries, Nov 2024 Sub (1992-2022) - Linked To County Attributes - Total U.S., 1969-2023 Counties, National Cancer Institute, DCCPS, Surveillance Research Program, released April 2025, based on the November 2024 submission.

### Cancer Disparities in New Mexico: Rurality

The burden of cancer also differs by rurality in New Mexico. For example, the burden of breast and prostate cancers, as well as skin melanoma, lymphomas, and leukemias is higher in urban areas in New Mexico, compared to rural areas (Figure 5). In contrast, the burden of stomach, colorectal, liver, lung, and kidney cancers is higher in rural areas. Like with race and ethnicity-based differences in cancer burden, a combination of factors leads to these observed differences, including social and structural drivers of health, which in turn impact health behaviors. Further, individuals in rural counties may have reduced access to healthcare, including cancer preventive services such as screening, as well as specialty cancer care once a cancer has been diagnosed. Importantly, many of New Mexico’s rural residents will have to travel, some great distances, to receive specialty care to treat their cancer.

**FIGURE 5: Incidence of Select Cancers Among New Mexicans by Rurality, 2013-2022.**



**Source:** Surveillance, Epidemiology, and End Results (SEER) Program ([seer.cancer.gov](https://seer.cancer.gov)) SEER\*Stat Database: Incidence - SEER Research Plus Data, 12 Registries, Nov 2024 Sub (1992-2022) - Linked To County Attributes - Total U.S., 1969-2023 Counties, National Cancer Institute, DCCPS, Surveillance Research Program, released April 2025, based on the November 2024 submission.

### Cancers Among Children, Adolescents, and Young Adults

An average of 58 New Mexican children ages 0-14 years are newly diagnosed with cancer each year, which accounts for approximately 0.6% of all cancer cases. Among diagnoses in this age group, 42% are under 5 years old. The most common cancer types diagnosed among children in New Mexico are leukemias (37%), malignant brain tumors (19%), and lymphomas (15%). Although cancer is the leading cause of disease-related death among children in our state, five-year survival for most cancer types is improving as is seen nationally.

In New Mexico each year, approximately 31 new cancers are diagnosed among adolescents (defined as ages 15-19 years) and 445 among young adults (defined as ages 20-39 years), which together account for less than 5% of all cancer diagnoses in the state annually. The most common types of cancer among adolescents are testis (5.1 per 100,000), thyroid (3.5 per 100,000), leukemia (3.5 per 100,000), Hodgkin lymphoma (2.3 per 100,000), ovary (1.7 per 100,000), bones and joints (1.4 per 100,000), malignant brain (1.2 per 100,000), and non-Hodgkin lymphoma (1.2 per 100,000). The most common types of cancer for young adults are female breast (23.8 per 100,000), testis (16.4 per 100,000), thyroid (15.4 per 100,000), cervix uteri (10.8 per 100,000), colon and rectum (5.3 per 100,000), melanoma of the skin (4.6 per 100,000), leukemia (3.8 per 100,000), and kidney and renal pelvis (3.8 per 100,000).

Nationally, the incidence of many cancer types is increasing among young adults. Similar to pediatric cancers, survival rates for adolescents and young adults have improved, but not for many types of cancer. The data indicate that similar trends are occurring in New Mexico, although numbers are too small in our state to confirm with statistical confidence.

#### KEY TAKEAWAYS

- Overall, New Mexico has among the lowest rates of new cancers of any state in the country.
- Cancer rates, and the types of cancer diagnosed, vary significantly by race, ethnicity, gender, and rurality.
- More than 90,000 people in New Mexico are living with a previous diagnosis of cancer.
- New Mexicans are more likely to be diagnosed with certain less common cancers, such as liver, thyroid, stomach, and cervical cancers compared to other states.
- New Mexicans diagnosed with cancer have among the lowest five-year relative survival rates in the country, with New Mexico tied for 6th worst.
- Cancer is the second leading cause of death for all New Mexicans and the leading cause of disease-related death for New Mexicans ages 0 to 14 years.
- Rates of newly diagnosed cancers are declining for all age groups except for adolescents and young adults (15-39 years), whose rates of newly diagnosed cancers are increasing in New Mexico and nationwide.

## DR. L PEDIATRIC HEMATOLOGIST/ONCOLOGIST

I moved to New Mexico in 2004. I trained at Memorial Sloan Kettering Cancer Center in New York City and at The New York Hospital.

I love the patients here. They are amazing. They're so thankful to have care. Thankful for your efforts. And they try, too. When I talk to them about eating right, they try. They'll try to exercise too. The parents are grateful too; I have so many good relationships with families here.

Children who have undergone cancer treatment require more complex follow-up care for the rest of their lives. Their primary care provider needs to understand that a 30-year-old who was treated for cancer has different risks than other 30-year-olds. There's the risk of recurrence, or new cancers, or just the treatment side effects.

No one has a primary care provider anymore. It's getting worse every year. It's a problem nationwide but worse here. Childhood cancer survivors need to spend an hour with their primary care providers, but they have only 10 minutes. For all these reasons, I have a lot of trouble finding a primary care provider who is skilled and interested in providing care for these young people.



We have excellent pediatricians in New Mexico, but not enough of them. Parents are taking their children to urgent care centers. The problem is that these children are being seen by providers who do not have a range of experience with childhood illnesses.

Another major challenge is the quality of care during and after treatment because cancer care should be multidisciplinary. We need comprehensive care including pediatric endocrinologists, neuropsychologists, surgeons, cardiologists, pediatric palliative care, and many more. Children with cancer undergo complex care and they need a team to manage their care; it's not just about the pediatric oncologist.

For the mothers of children who have cancer, I always tell them this: "You didn't pick it up too late. You didn't cause this." Because mothers blame themselves for their child's illness. And of course, it's not their fault.

The parents of children with cancer need financial resources. They can't work. It's a full-time job to take care of a child with cancer. You cannot even safely leave a 13-year-old on cancer treatment at home alone. The child's immune system is affected by chemotherapy so severely that they are at risk of life-threatening infections some weeks 24/7.

Young adults with cancer in many ways are in the worst shape. They do not qualify for the pediatric programs, and they don't always have the family support that little children usually have. We need specific programs for young adults with cancer that help with financial support.

**"A big challenge is the struggle to find quality care after treatment ends. I have many young adult patients who cannot find a primary care provider."**

## TERESA FROM ALBUQUERQUE

It was Mother's Day in 2013. We were preparing for a celebration at home because my daughter was going to Nicaragua. I hadn't been feeling well, but not bad enough to go to the doctor. That morning, I decided to go to urgent care. They took X-rays, then asked if I was alone. My husband took me to the ER, where they did a CT scan. The doctor told me they would have to admit me to the oncology unit.

I had a radical hysterectomy. Within a few weeks, I started chemotherapy. After a couple of rounds of chemo, they did genetic testing and recommended I have a preventive double mastectomy, which I did the following year.

Six years later, I was having some abdominal issues. After testing, they found the cancer had recurred ... this time, ovarian cancer. They did six rounds of chemo. The first three were brutal ... my body felt like it was on fire.

I have to say that, psychologically, the recurrence was much harder than the original diagnosis. I thought it was one and done, but now it's a chronic disease. Physically, I feel okay, but the emotional part is hard.

**"The financial burden of having cancer is incredible. Understanding how to get things paid for, where to find resources, how to navigate the system ... these things are harder than the treatment itself."**

I've continued to work throughout my cancer journey. The meds are ridiculously expensive ... even the copays. I'll work as long as I can because I have a chronic disease.

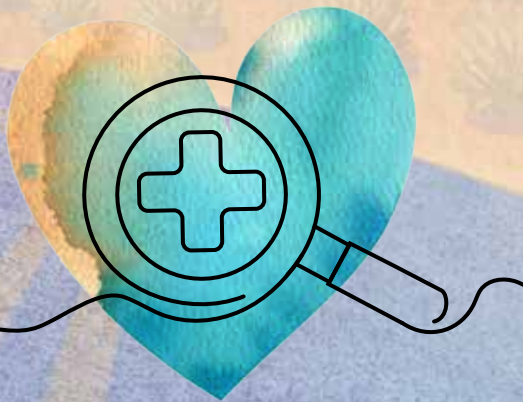
The system is brutal. The financial burden of having cancer is incredible. Understanding how to get things paid for, where to find resources, how to navigate the system ... these things are harder than the treatment itself.

I'm pushing for patient navigation services.

I'm from Isleta Pueblo. I've learned that the services and navigation need in native communities is more difficult because of the way Indian Health Services defines borders. It's very complicated. Navigation services are practically nonexistent.



# CHAPTER 2: POLICY AND SYSTEMS



## OVERALL GOAL

Reduce cancer mortality through policy and systems changes that support integrated, patient-centered, and fully staffed health services for cancer screening, diagnosis, care, and treatment.

### Overview

New Mexicans are facing a healthcare crisis that makes progress toward reducing the cancer burden a growing challenge unless fundamental system and policy issues are addressed. New Mexico’s fragmented and under-resourced healthcare system fails to serve the needs of most New Mexicans, with 90% of people surveyed in a study of 11 counties between 2021 and 2023 reporting that they faced difficulties in accessing medical care.

Although this chapter focuses primarily on the health workforce and health systems, policy changes are highlighted throughout the plan to address gaps across the cancer continuum of care, including prevention. Table 4 on the next page provides a summary of the key challenges and policy solutions for the entire cancer plan.

A fundamental challenge is the state’s critical shortage of healthcare workers and allied professionals. In New Mexico, there is an average of 5.0 primary care physicians (PCP) per 10,000 people, which is far below the national benchmark of 9.3 PCPs per 10,000 people and translates to only one PCP for every 2,000 people. In rural areas, it is especially challenging to find care, with the lowest per capita availability of PCPs in Harding, Union, and Guadalupe counties. Primary care physicians are a critically important part of the cancer continuum of care. They counsel eligible patients about the importance of cancer screening; conduct cervical cancer screening; refer patients to oncologists; and provide care for people with a history of cancer during and after treatment is completed.

Although the New Mexico Health Care Workforce Committee does not provide data on key oncology specialties, data about other specialties, such as gastroenterology, provide insights into the challenges in having enough qualified health workers for diagnosis, care, and treatment. Gastroenterologists conduct colonoscopies, which can detect and prevent colon cancer. New Mexico’s physician-to-patient ratio is 29% worse

in gastroenterology than the national average. For rare cancers and for certain pediatric cancers, specialists may not be available in New Mexico. Seeking care outside the state may not be an option for critically ill patients too sick to travel long distances by plane or car.

#### Impact of the Healthcare Worker Shortage on the Cancer Burden in New Mexico

The shortage of healthcare workers increases the cancer burden in New Mexico on patients, families, and communities in the following ways:

- Limits access to preventive services, including cancer screenings and prevention vaccines, obesity prevention and management, and behavioral health and nicotine cessation programs.
- Long wait times for cancer diagnostic tests and treatment.
- Delays in diagnoses with missed opportunities for timely and potentially more effective care and treatment.
- Increased emotional and financial burden on patients, families, and caregivers.
- Increased burnout of healthcare workers in New Mexico.

Cancer survival is influenced by a multitude of factors, including the type of cancer, stage at diagnosis, genetics, age and overall health of the person at diagnosis, and timely access to diagnostic testing and treatment. New Mexicans face among the worst cancer survival in the country, as described in Chapter 1: Burden of Cancer in New Mexico. Within New Mexico, males have poorer survival compared to females and Hispanics have poorer survival compared to non-Hispanic whites. Timely and equitable access to high-quality cancer screening, diagnosis, and treatment services will help improve New Mexicans’ cancer survival.

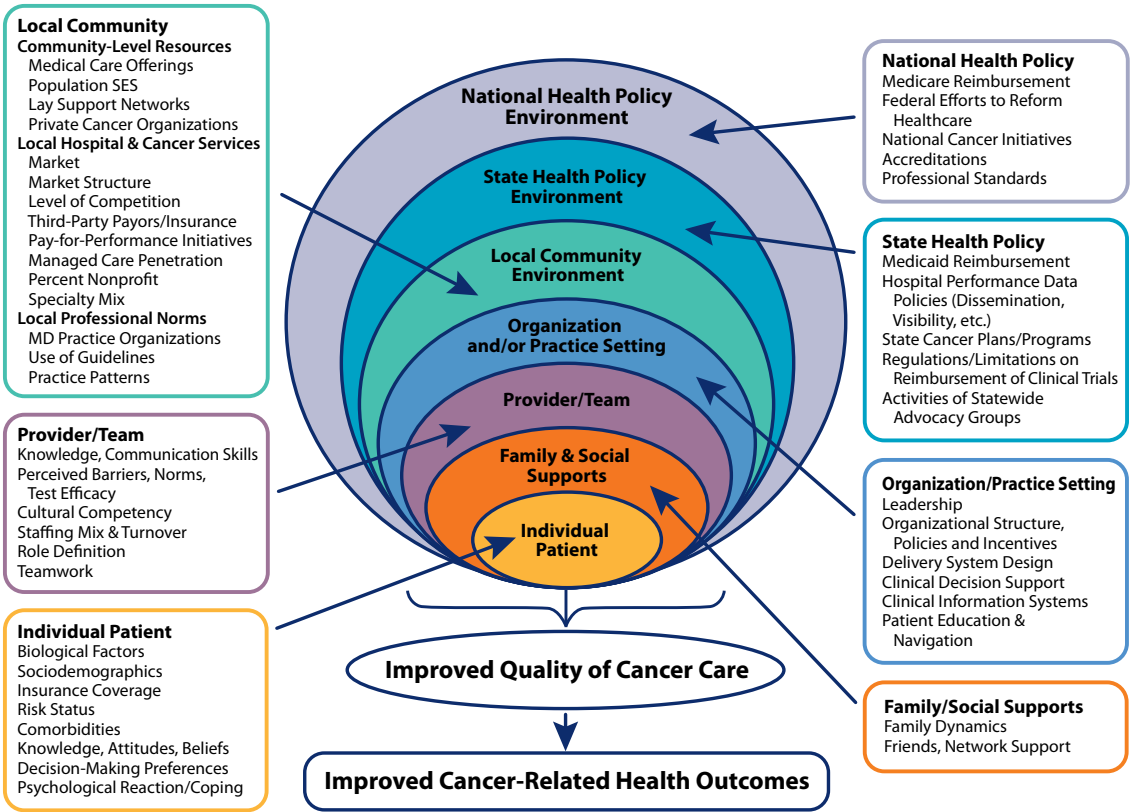
TABLE 4: Summary of Policy Priorities across the Cancer Continuum of Care.

| POLICY AREA                   | PROBLEM                                                                                                                                                                                                                                            | POLICY SOLUTION                                                                                                                                                                                         | SECTION OF CANCER PLAN         |
|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| Health Workforce              | Shortage of healthcare workers                                                                                                                                                                                                                     | Join interstate licensure compacts; assistance with loan repayment for student debt, etc.                                                                                                               | Chapter 2, Objective 1         |
| Health System                 | Fragmented health system; difficult for patients to navigate                                                                                                                                                                                       | Improve remuneration for patient navigation services and community health workers                                                                                                                       | Chapter 2, Objectives 2 and 3  |
| Prevention and Risk Reduction | Indoor tanning beds expose people to ultraviolet radiation (UV) which is associated with increased risk of skin cancer                                                                                                                             | Adopt law to prohibit minors from using indoor tanning devices                                                                                                                                          | Chapter 3, Objective 4         |
| Prevention and Risk Reduction | Radon exposure is associated with increased risk of lung cancer; the main exposure is at home                                                                                                                                                      | Adopt laws or policies to increase awareness of importance of radon testing during real estate transactions                                                                                             | Chapter 3, Objective 5         |
| Screening and Early Detection | New Mexico’s cancer screening rates are among the lowest in the country; for colorectal cancer, New Mexico’s screening rate is the lowest in the U.S.                                                                                              | Advocate for state resources to be used for statewide cancer screening programs to address gaps in coverage                                                                                             | Chapter 4, Objective 1         |
| Screening and Early Detection | New Mexicans face financial barriers to cancer screening and follow-up for positive test results                                                                                                                                                   | Advocate for comprehensive insurance coverage across Medicaid, Medicare, and private plans for all recommended cancer screening services, including follow-up diagnostic testing after abnormal screens | Chapter 4, Objective 5         |
| Care and Treatment            | There is no statewide analysis of gaps in availability and quality of cancer treatment and support services, including pediatric cancer services                                                                                                   | Advocate for resources to develop a strategic plan to identify and address gaps in availability and quality of cancer treatment and support services, including pediatric cancer services               | Chapter 5, Objectives 1 and 11 |
| Care and Treatment            | Palliative care services are not adequately reimbursed                                                                                                                                                                                             | Advocate for increased reimbursement for palliative care services across Medicaid, Medicare, and private insurance plans                                                                                | Chapter 5, Objective 9         |
| Survivorship                  | People diagnosed with cancer often need to take time off from work longer than their sick leave allows or to receive care from unpaid family caregivers. The federal Family and Medical Leave Act allows employees up to 12 weeks of unpaid leave. | Advocate for a New Mexico Family Medical Leave Act with greater financial protection                                                                                                                    | Chapter 6, Objective 4         |

New Mexico is taking important steps to address the most serious policy issues that are negatively impacting healthcare worker recruitment and retention by passing legislation to reform medical malpractice laws, to enter interstate medical licensure compacts, and to strengthen financial incentives for healthcare workers who choose to practice in underserved areas. The Interstate Medical Licensure Compact (IMLC), an agreement in which 40 states (and the District of Columbia) participate and which New Mexico will join in 2026, enables doctors to provide consultations via videoconference. Medical malpractice reform is another major legislative win in 2026 that will reduce the malpractice insurance burden on physicians and healthcare systems while still protecting patients from the harms of malpractice. Joining the IMLC and reforming medical malpractice laws are important steps that will help address New Mexico’s healthcare worker shortage. Corresponding investments in the education of medical students and residents and recruitment and retention strategies that enable health systems to provide competitive salary and benefits packages to targeted specialists critical to cancer diagnosis, care, and treatment are still needed. The nationwide shortage of physicians makes it increasingly challenging to recruit and retain a well-trained healthcare workforce.

New Mexico’s steps in 2026 toward policy reform are critically important, but it will take a sustained, multiyear effort to fully recover from the crisis in availability of healthcare workers that worsened during the years 2021-2026 when the New Mexico legislature changed medical malpractice laws. In 2026, however, Gov. Michelle Lujan Grisham signed House Bill 99 into law. This legislation imposes new caps on punitive damages in medical malpractices cases and is designed to decrease the cost of medical insurance for providers, creating a more favorable environment for retention of healthcare workers. To build an integrated, patient-centered health system will also require strategic investments in patient navigation services and community health workers to build trust in the health system and address barriers to care, such as distance to services, lack of transportation, and insurance barriers. Multilevel interventions that address policy, institutional, community, and provider barriers to care are more effective than interventions aimed at only one level, as illustrated in Figure 6.

FIGURE 6: Multilevel Interventions to Improve Quality of Cancer Care and Outcomes.



Source: Taplin SH et al. Introduction: Understanding and influencing multilevel factors across the cancer care continuum (2012).

# JEANNA

## ADVANCED PRACTICE REGISTERED NURSE

I am deeply committed to the work I do. There has never been any doubt that this is my calling. Yet fulfilling that calling becomes increasingly challenging when the necessary resources are lacking.

The shortage of healthcare providers has significantly impacted patients’ access to timely and appropriate care. Limited provider availability contributes to delays in diagnosis, which in turn reduces the range of timely treatment options and may shorten life expectancy.

One of my patients presented to his primary care provider with complaints of difficulty swallowing due to a lump in the back of his tongue. It took several months before he was able to see an otolaryngologist. By that time, he had developed a large throat ulceration. Initially, he might have been eligible for surgical intervention, but due to the delay, those options were no longer viable. Unfortunately, curative therapy is no longer an option for him. He expressed feeling as though he had lost years of his life simply because he resides in New Mexico.

Patients in rural areas are disproportionately affected. Some must travel over four hours one way to access cancer care. These geographic and systemic barriers exacerbate disparities and delay critical interventions.

Providers are doing their best, but the volume of patients and complexity of cases often exceed what the current workforce can manage. Without adequate time and resources, even well-trained clinicians may miss critical signs, especially in complex or subtle presentations.

New Mexico should look to successful models in other states that have implemented more sustainable patient volume strategies. For instance, a colleague who relocated to Texas now sees a maximum of 16 patients per day — a workload that, while still demanding, is far more manageable than the 30 patients she was expected to see daily in New Mexico. Excessive caseloads contribute directly to provider burnout and compromise the depth and quality of patient care, particularly in oncology, where continuity and attentiveness are essential.

We must also improve compensation and institutional support for key interdisciplinary team members, especially social workers who help provide the psychosocial support systems that are vital in cancer care and palliative settings.

“Recruiting and retaining medical providers in New Mexico remains a persistent and complex challenge.”



To address the challenges of New Mexico’s overburdened healthcare system, the **New Mexico Cancer Plan for 2026-2031** includes the following policy and systems-level priorities and strategies:

Objective 1

Address the policy barriers contributing to the healthcare worker shortage.

Why This Matters

Policies and their unintended consequences can promote or impede the recruitment and retention of qualified healthcare workers who are instrumental to the provision of quality care for cancer patients in New Mexico.

Strategies

- Raise awareness of the impact of the healthcare worker shortage, especially physicians, and corresponding policy barriers on the cancer burden in New Mexico.
- Support advocacy efforts to improve healthcare worker recruitment and retention, including loan repayment for student debt, continued medical malpractice reform, and participation in interstate licensure compacts for health professionals, including psychologists and other health professionals critical to cancer care.
- Raise awareness of the gaps in expertise in pediatric oncology and allied pediatric specialties in New Mexico and advocate for resources specifically designated for recruitment and retention of qualified pediatric oncologists and allied pediatric specialties.
- Develop a policy and advocacy workgroup in the New Mexico Cancer Council to identify priority policies that impact the cancer burden and opportunities for collaboration with lawmakers and patient advocacy groups to address policy barriers.
- Improve county and Tribal health councils’ ability to advocate for and provide improved access to cancer screening, follow-up to screening, and linkages to care, treatment, and support services for newly diagnosed patients and their families.
- Advocate for resources to develop a strategic plan to increase availability and accessibility of quality cancer care and treatment services, including for rural patients (see also Chapter 5: Care and Treatment).

Objective 2

Increase implementation of cancer navigation services at community and facility levels, including screening and follow-up.

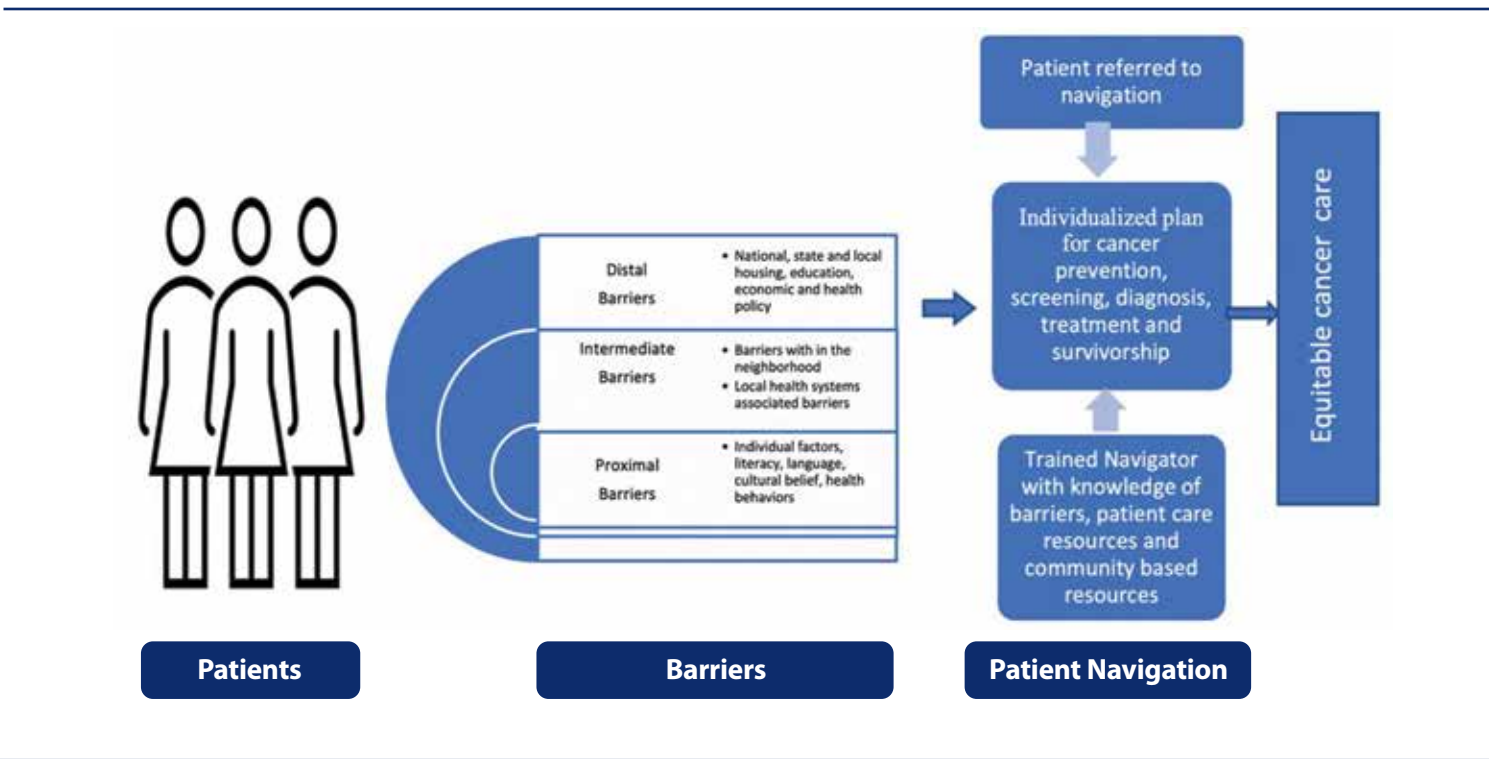
Why This Matters

Patient navigation is associated with improved cancer patient well-being and helps patients and their caregivers overcome financial, transportation, and practical barriers to care, including supporting them to navigate insurance. Patient navigation is one of the key strategies to ensure equitable and timely access to diagnosis and treatment. As shown in Figure 7 below, patient navigators are trained to address the barriers to care at the individual, community, and policy/ system level.

Strategies

- Promote understanding of the value of patient navigation services.
- Increase training and certification of patient navigators.
- Promote collaboration among patient navigators, community health workers, community health representatives, and others providing navigation support services.

FIGURE 7: Role of Patient Navigation in Health Equity.



Source:  
Dixit N., Rugo, H., Burke N. (2021). Navigating a Path to Equity in Cancer Care: The Role of Patient Navigation. Am Soc Clin Oncol Educ Book 41, 3-10.  
DOI: 10.1200/EDBK\_100026.

Trained navigators in cancer care can address a variety of barriers, as shown in Table 5.

TABLE 5: Barriers Addressed by Patient Navigation.

| BARRIER | DESCRIPTION OF BARRIERS                                                                | EXAMPLE OF NAVIGATION STRATEGIES                                                                                       |
|---------|----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| 1       | Insurance: uninsured, underinsured, copays, inability to get procedures or medications | Help identifying resources for insurance coverage, help filling out forms for insurance                                |
| 2       | Language and cultural barriers                                                         | Interpretation and addressing fears and beliefs about cancer treatments                                                |
| 3       | Communication                                                                          | Making sure that patients understand the recommendation and that providers are aware of patient preferences and values |
| 4       | Care coordination                                                                      | Making sure appointments are scheduled and multidisciplinary care is coordinated, facilitating primary care referral   |
| 5       | Transportation                                                                         | Assistance with transportation                                                                                         |
| 6       | Financial problems                                                                     | Referral for housing and food assistance services                                                                      |
| 7       | Symptoms burden and survivorship care needs                                            | Facilitate communication with provider, referral to community-based resources                                          |
| 8       | Lack of social support                                                                 | Provide additional layer of support and referral to support groups and community resources                             |

Source:  
Dixit N., Rugo, H., Burke N. (2021). Navigating a Path to Equity in Cancer Care: The Role of Patient Navigation. Am Soc Clin Oncol Educ Book 41, 3-10.  
DOI: 10.1200/EDBK\_100026.

TABLE 6: Support Services that Promote Screening and Follow-up Care.

| MEASURE                                                                                                                                   | BASELINE | TARGET FOR 2031 |
|-------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------------|
| Number of counties below the benchmark for the number of primary care physicians per population                                           | 25*      | 20              |
| Number of cancer care centers with patient navigation services                                                                            | TBD      | TBD             |
| Availability of cancer specialty track training for community health workers in New Mexico                                                | No       | Yes             |
| Number of County and Tribal Health Councils that include cancer prevention, screening, or support to cancer survivors in their priorities | 0        | 3               |

\* New Mexico Health Care Workforce Committee Report, 2025, p. 8

Objective 3

Strengthen statewide community health outreach and support services to promote appropriate screening and follow-up care.

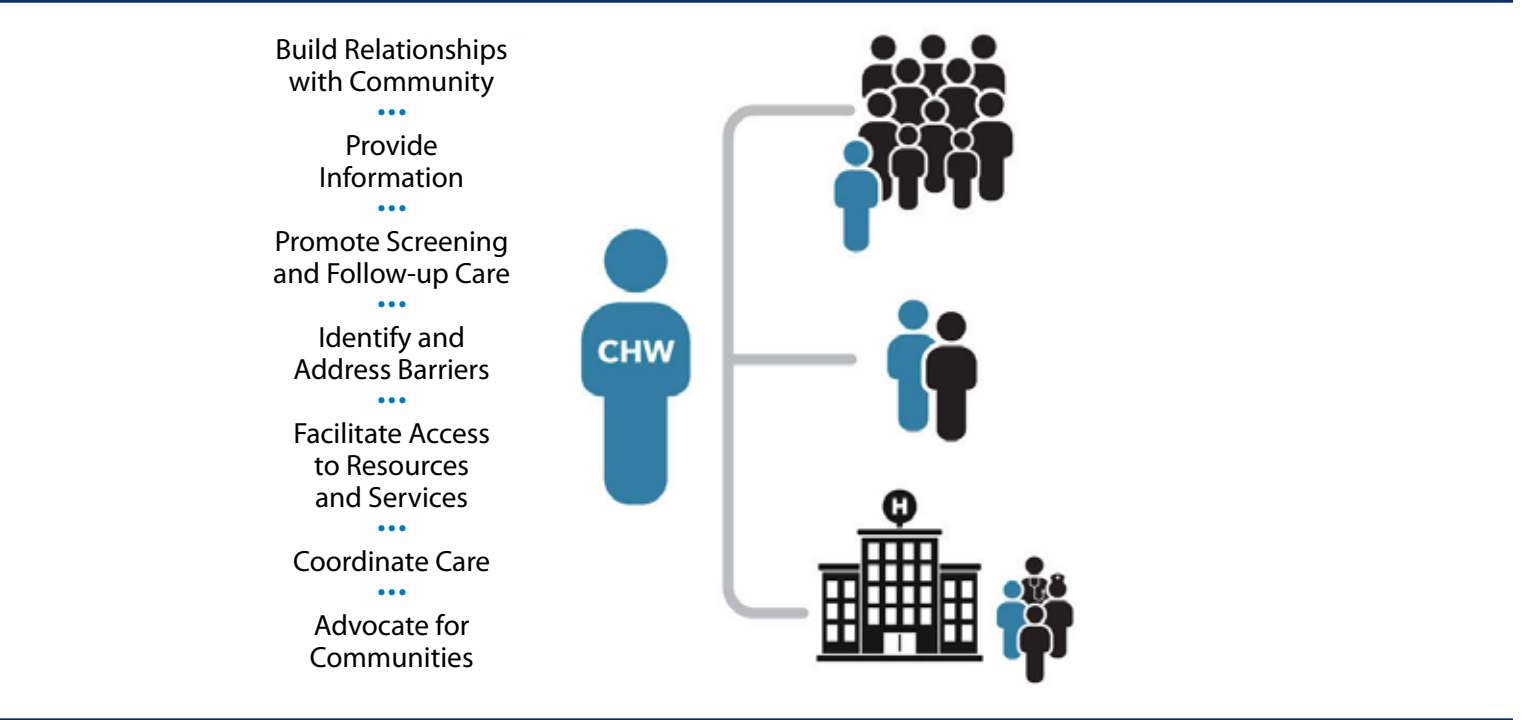
Why This Matters

As shown in Figure 8 below, community health workers are critical in addressing gaps in screening coverage because of their close ties to communities and cultural literacy. They also conduct follow-up after screening to ensure appropriate linkages to care.

Strategies

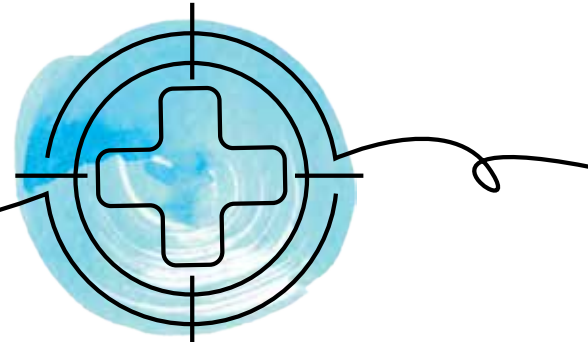
- Develop cancer specialty track curriculum for community health workers for adoption by the New Mexico Department of Health’s Office of Community Health Workers and advocate for recommending completion of the curriculum for all community health workers working in screening and early detection programs.
- Improve remuneration for community health workers and develop career pathways for community health workers to advance their skills.
- Encourage recruitment, hiring, and professional development of community health workers from underserved communities.

FIGURE 8: How Community Health Workers Facilitate Access to Cancer Screening and Follow-up.



Source:  
President’s Cancer Panel, Closing Gaps in Cancer Screening: Connecting People, Communities, and Systems to Improve Equity and Access (2022), available at [prescancerpanel.cancer.gov/reports-meetings/cancer-screening-report-2022](https://prescancerpanel.cancer.gov/reports-meetings/cancer-screening-report-2022) (Accessed on 1/27/2026).

# POPULATIONS IN FOCUS

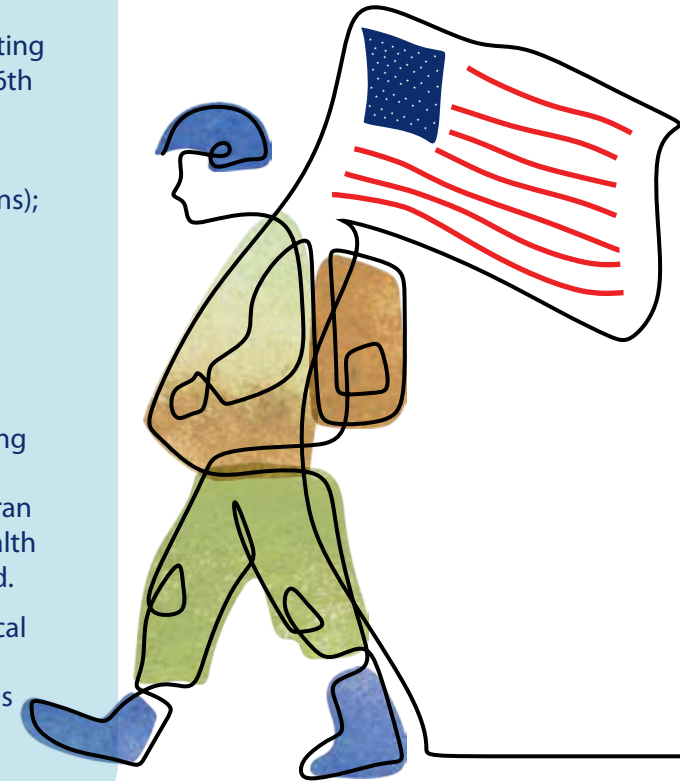


## Population in Focus: LGBTQ+ People

- LGBTQ+ refers to people who identify as Lesbian, Gay, Bisexual, Transgender, Queer, and any other sexual and gender identities. Approximately 4.5% of New Mexicans identify themselves as LGBT.
- LGBTQ+ people may not have a regular doctor to advise on cancer screenings. Settings may not have environmental indicators that help create a welcoming environment and thus reduce participation in cancer prevention and treatment.
- Fear of stigma and discrimination may impact LGBTQ+ individuals from seeking regular care and checking for early signs of cancer.
- Capturing sexual orientation and gender identity can cue providers to help create inclusive clinical environments and help assess patients' needs for cancer prevention services.
- The National LGBTQ Cancer Network ([colorectalcancer.cancer-network.org/risk-reduction/](https://colorectalcancer.cancer-network.org/risk-reduction/)) helps educate LGBTQ+ adults about colorectal cancer screening. Local organizations supporting the LGBTQ+ community include the Transgender Resource Center of New Mexico, ([tgrcnm.org](https://tgrcnm.org)), PFLAG of Silver City ([pflagsilver.org](https://pflagsilver.org)), NM Rising ([pflagabq.org](https://pflagabq.org)), and UNM Truman Health Services ([unmhealth.org/services/hiv-aids/](https://unmhealth.org/services/hiv-aids/)).

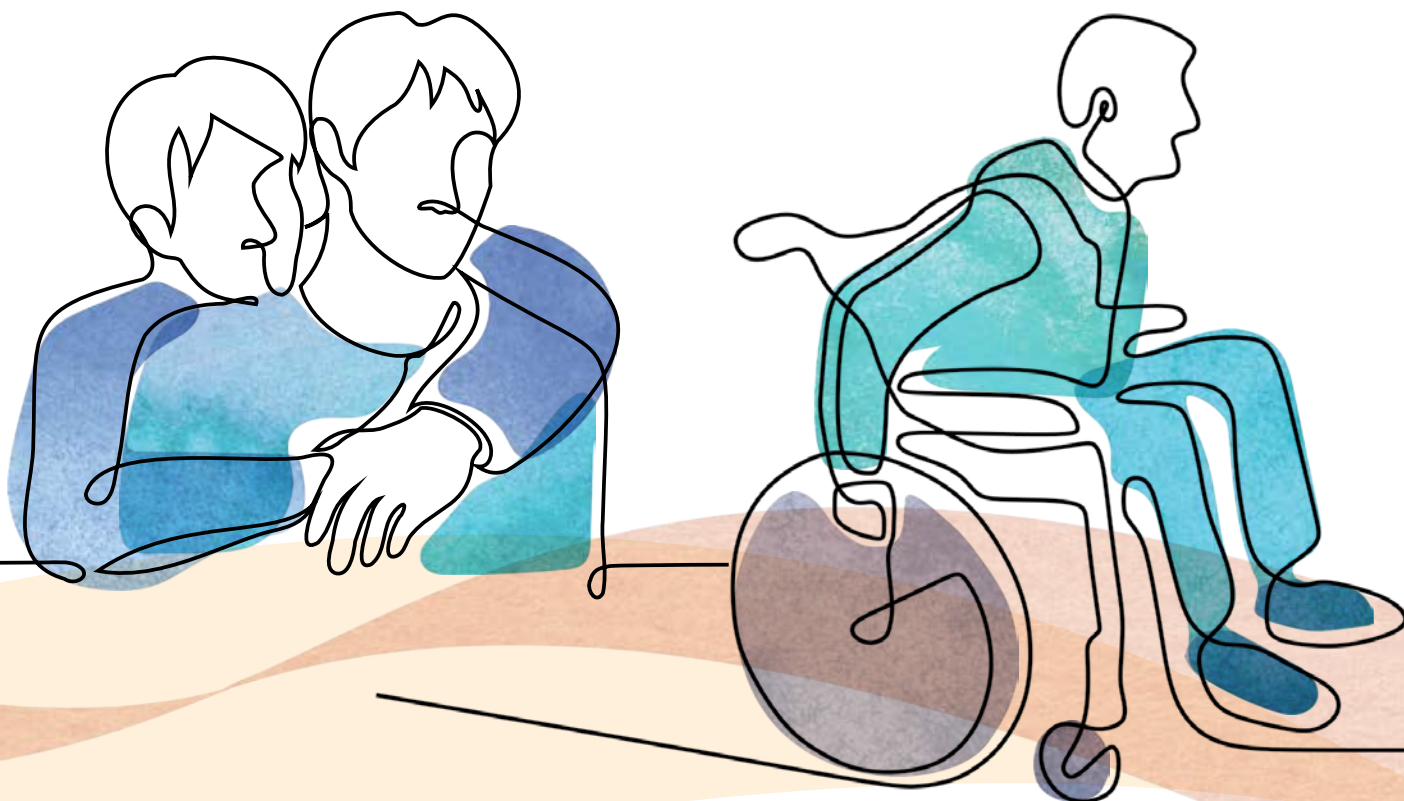
## Population in Focus: Veterans

- As of 2024, New Mexico is home to 124,674 veterans, representing 5.9% of the total population. This puts New Mexico in a tie for 6th place for the highest percentage of veterans.
- Veterans are more likely than non-veterans to report having a disability (35.6% of veterans compared to 20.2% of non-veterans); 88% of New Mexico's veterans are male.
- In the Veterans Affairs Cancer registry, approximately 50,000 cases are reported annually, with the most frequent diagnoses being prostate, lung, and colorectal cancers.
- Some military veterans may have been exposed to substances that increase their risk of developing cancer later in life including burn pits, asbestos, radiation, and PFAS chemicals. To get more information about potential exposures based on where a veteran served, healthcare providers can reach out to the Veteran's Health Administration, which created a mobile app called Exposure Ed.
- The Raymond G. Murphy Department of Veterans Affairs Medical Center is a Commission on Cancer-accredited facility in Albuquerque offering care for certain types of cancers. Veterans can access cancer care at other cancer care centers as well through TRICARE health insurance (TRICARE).



## Population in Focus: People with Disabilities

- In New Mexico, 29.1% of the population 18 years of age or older, approximately 500,000 people, has some type of disability.
- People with disabilities experience worse cancer outcomes than people without disabilities, with the greatest inequality among people with intellectual and developmental disabilities.
- Screening rates for breast, cervical, and colorectal cancers are lower for people with various disabilities than for those without, which suggests that improving cancer screening rates among this diverse population would improve cancer outcomes.
- Primary care and oncology care teams might benefit from focused trainings in how best to care for these populations across the care continuum.
- For cancer patients during or after treatment who want or need to continue working and are experiencing impairments, the Americans with Disabilities Act can help protect employees.
- Local organizations that provide support and services to people living with a disability include Disability Rights New Mexico ([drnm.org](https://drnm.org)), the Governor's Commission on Disability ([gcd.nm.gov](https://gcd.nm.gov)), and the Independent Living Resource Center ([ilrcnm.org](https://ilrcnm.org)).



# CHAPTER 3: PREVENTION AND RISK REDUCTION

## OVERALL GOAL

**Support all New Mexicans to engage in healthful behaviors that reduce their risk of cancer.**

Improvements in cancer prevention and screening have averted more deaths than treatment advances for five major cancer types (breast, cervical, colorectal, lung, and prostate) in the United States in the period from 1975 to 2020. Smoking cessation interventions drove significant decreases in lung cancer mortality, averting 3.45 million deaths.

Approximately 44% of cancer deaths in the United States in individuals aged 30 years and older in 2019 were estimated to be attributable to potentially modifiable risk factors.

These findings underscore the importance of cancer prevention and risk reduction. This section focuses on efforts that will support all New Mexicans to engage in healthful behaviors that reduce their risk of cancer.

**FIGURE 9: Cancer Prevention Interventions That Reduce Exposure to Modifiable Risk Factors for Cancer.**



\* PFAS refers to per- and polyfluoroalkyl substances, which are toxic, man-made chemicals that do not break down in the environment.  
\*\* The sharing of syringes and other drug preparation and injection equipment is a risk factor for Hepatitis B and Hepatitis C transmission.  
\*\*\* A recent study found evidence for indoor tanning use as a behavioral addiction; however, further research is needed.

## Principles Informing the NEW MEXICO CANCER PLAN'S Prevention and Risk Reduction Objectives and Strategies

- Effective prevention programs are based on scientific evidence about what works. Refer to resources such as the Evidence-Based Cancer Control Programs ([ebccp.cancercontrol.cancer.gov/index.do](http://ebccp.cancercontrol.cancer.gov/index.do)) website and the Community Guide ([thecommunityguide.org](http://thecommunityguide.org)) to develop and implement effective prevention programs.
- Cancer prevention encompasses a wide range of strategies and programs because of the complexity of the causes of cancer. Collaboration with other health programs and across sectors is critical to the success of cancer prevention efforts, as illustrated in Figure 9. Cancer survivors often have other health conditions or diseases that reinforce the need for collaboration and coordination between programs, providers, and services.
- Human behavior is influenced by a combination of individual, interpersonal, community, environmental, and policy factors, as illustrated in public health models/frameworks such as the Social Ecological Model, initially developed in the 1970s and 1980s. This model has been adapted and utilized by a wide range of public health programs and is critical in helping design interventions that address the multiple influences on people's behavior and on health outcomes. Programs that seek to change behavior by focusing only on the individual level are not as effective as those that additionally incorporate strategies at the community and policy levels. For example, the Social Ecological Model has been adapted to improve rates of prostate cancer genetic screening among African American men by incorporating policy and advocacy, institutional, community, and interpersonal changes and interventions.
- A related concept is the social determinants or social drivers of health (SDOH), which is the idea that the conditions in which people live, work, and play can affect health opportunities and outcomes. In New Mexico, for example, access to safe drinking water can be considered an SDOH. As discussed below in the section on environmental factors, there are associations between exposure to unsafe drinking water and increased risk of developing certain cancers.
- Leading modifiable risk factors for cancer (nicotine product use, excess body weight, and alcohol use) can be associated with stigma and judgment. Effective prevention strategies need to take steps to combat the stigma related to preventable causes of cancer, because stigma can limit participation in cancer prevention programs and interventions among the people who would most benefit from these programs. Empathetic communication can help reduce stigma and improve participation rates in cancer risk reduction activities.
- Prevention strategies need to be tailored to specific populations based on epidemiological burden and delivered through trusted channels, utilizing culturally and linguistically appropriate messages.
- Rather than adopt independent goals and measures for cancer prevention (e.g., nicotine product use, human papillomavirus (HPV) vaccination, and other contributors to cancer risk), the New Mexico Cancer Plan emphasizes that these are shared goals with other public health programs which cancer programs support.

Objective 1

Reduce the leading preventable causes of cancer.

NICOTINE PRODUCTS:

Reduce initiation and use of nicotine products\*, especially among young people.

Why This Matters

The leading cause of preventable cancer in the United States is tobacco use (particularly cigarette smoking). Tobacco cigarette smoke contains at least 70 carcinogens (cancer-causing chemicals). Cigarette smoking is associated with increased risk of cancers of the lung, larynx (voice box), pharynx (throat), mouth, esophagus, stomach, pancreas, liver, bladder, kidney, colon and rectum, cervix, and acute myeloid leukemia. Cigars and smokeless tobacco products have also been linked to cancer. In recent decades, other nicotine-containing (highly addictive) products have emerged. Aerosol from e-cigarettes/vapes contains chemicals that can be carcinogenic. These products have been associated with other health effects. Long-term health effects of e-cigarettes/vapes and nicotine pouches are not yet known.

Strategies

- Support expanded access to and use of evidence-based tobacco cessation services, particularly the **New Mexico Quitline (1-800-Quit-Now, [quitnownm.org](http://quitnownm.org))**.
- Promote health systems changes to support screening for nicotine and tobacco use and referral to evidence-based tobacco cessation services, particularly the New Mexico Quitline.
- Decrease exposure to secondhand smoke and e-cigarette emissions.
- Enhance collaboration with the New Mexico Department of Health’s Nicotine Use Prevention and Control (NUPAC) program, the Air is Life Health Coalition, the New Mexico Allied Council on Tobacco (NMACT), and other key stakeholders to explore opportunities for collaboration, such as integrating lung cancer screening referrals into the Quitline.
- Support the development of policies and media and educational campaigns to prevent nicotine product use among children and adolescents and promote the **Live Vape Free program ([livevapefreenm.com](http://livevapefreenm.com))** to help with cessation.

EXCESS WEIGHT:

Increase opportunities for New Mexicans to eat nutritious, minimally processed (and avoid ultra-processed)\*\* foods, to be physically active, and to maintain a healthy weight.

Why This Matters

Having excess body weight (i.e., overweight or obesity) has been found to be associated with a higher risk of 13 types of cancer including adenocarcinoma of the esophagus, breast cancer (in post-menopausal women), colon and rectal cancer, endometrial (lining of the uterus) cancer, gallbladder cancer, (upper) stomach cancer, kidney cancer, liver cancer, ovarian cancer, pancreatic cancer, thyroid cancer, meningioma, and multiple myeloma. Overweight is defined as having a Body Mass Index (BMI) of 25.0 to 29.9, while obesity is defined as having a BMI of 30.0 or higher.

Beyond their relationship to body weight, it has been suggested that diet and physical activity themselves have associations with risk for certain cancers. For example, eating red and processed meat is associated with a higher colorectal cancer risk. Higher levels of physical activity have been linked to lower risk of bladder, breast, colon, endometrial, esophageal, kidney, and stomach cancers. More research is needed to clarify specific associations and underlying mechanisms.

Strategies

Healthy Eating

- Support Food as Medicine\*\*\* initiatives, including advocacy for funding, reimbursement (including for medically tailored meals), and inclusion of nutrition education.
- Support Healthy Universal School Meals in New Mexico, along with opportunities to expand and emphasize nutrition education standards in core K-12 science and health curricula.
- Advocate for maintenance and expansion of the Double Up Food Bucks program in New Mexico.
- Advocate for continued federal funding for the Supplemental Nutrition Assistance Program (SNAP), SNAP-Ed, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and Cooperative Extension.
- Support training programs to grow New Mexico’s agricultural workforce and access to locally produced nutritious foods, especially in rural areas.
- Support research examining effects of ultra-processed foods on cancer risk.

Physical Activity

- Support healthy community design initiatives and engage communities in design of parks and trails to increase physical activity.
- Promote use of evidence-based digital health/telephone interventions (such as text messages, one-on-one telephone calls, mobile apps, emails, etc.) to increase physical activity and healthy eating among adults. Interventions typically include coaching from a trained peer or professional, goal setting, self-monitoring to record daily habits, and computer-generated feedback.
- Expand the reach of the Healthy Kids, Healthy Communities Initiative to all counties in New Mexico.
- Advocate for increasing the number of units of physical education for high school students.

Stigma Reduction and Support for People with Excess Weight

- Advocate for consistent access to primary care providers and health plans to assist with weight management\*\*\*\*, as well as workplace wellness program coverage.
- Decrease obesity-related stigma through education of providers and communities on the multifactorial causes of obesity and impact of weight bias on patients’ health.

\* Encompasses smoked tobacco products, smokeless tobacco products, and other nicotine-containing products that have emerged such as e-cigarettes/vapes and nicotine pouches.

\*\* According to the American Cancer Society ([cancer.org/cancer/risk-prevention/diet-physical-activity/how-diet-and-physical-activity-impact-cancer-risk/processed-food-and-cancer.html](http://cancer.org/cancer/risk-prevention/diet-physical-activity/how-diet-and-physical-activity-impact-cancer-risk/processed-food-and-cancer.html)), foods that are unprocessed or minimally processed are not very different from the source food and contain the same nutrients, while foods that are ultra-processed are very different from the source food, contain food additives and preservatives, often have added sugars, salt, and saturated fat; and many of the nutrients have been lost.

\*\*\* Also known as food is medicine “[nutrition.org/food-as-medicine](http://nutrition.org/food-as-medicine)” Food as Medicine - American Society for Nutrition. The similarly named Food is Medicine is also the name of a specific Medicaid initiative “Food is Medicine – New Mexico Health Care Authority ([hca.nm.gov/food-is-medicine](http://hca.nm.gov/food-is-medicine)).

\*\*\*\* Including but not limited to access to GLP-1 medications when needed. An early study suggests that GLP-1 medications are associated with lower overall cancer risk, however more research is needed. (Dai H, Li Yongqiu, Lee Ya et al. GLP-1 Receptor Agonists and Cancer Risk in Adults with Obesity. JAMA Oncol. Aug. 21, 2025. DOI: 10.1001/jamaoncol.2025.2681).

## ALCOHOL: Decrease alcohol consumption.

### Why This Matters

The U.S. Surgeon General's Advisory on Alcohol and Cancer Risk released in 2025 states that alcohol consumption increases the risk of at least seven cancer types (mouth [oral], throat [pharynx], esophagus, voice box [larynx], breast [in women], liver, and colon and rectum). Yet, only 45% of Americans are aware that consuming alcohol increases the risk of cancer, and the risk of cancer increases the higher amount of alcohol consumed consistently over time (though even one or fewer drinks per day has been found to start to increase the risk for mouth, throat, and breast cancers). More than one in five New Mexicans' alcohol consumption is classified as binge drinking or heavy drinking.

### Strategies

- Educate the public and health providers on the association between alcohol and risk of developing cancer.
- Support the development and enforcement of laws designed to reduce alcohol sales, including sales to minors.
- Encourage collaboration with other chronic disease programs to promote awareness of alcohol use as a risk factor for cancer.
- Increase access to harm reduction and treatment services for those with excessive drinking.
- Increase Screening, Brief Intervention, and Referral to Treatment (SBIRT) for alcohol abuse across healthcare settings, including primary care, emergency care, and maternal health services.
- Promote statewide access to electronic screening, brief intervention, and referral to treatment (eSBIRT).
- Increase Medications for Alcohol Use Disorders (MAUD) services statewide.
- Raise community awareness of MAUD effectiveness and availability.
- Promote campaign efforts to combat social normalization of alcohol consumption, promoting alcohol-free alternatives for youth and communities.

## ADDICTIVE BEHAVIORS: Decrease stigma associated with addictive behaviors that are associated with increased cancer risk.

### Why This Matters

- Increase awareness of the New Mexico 5-Actions ([nm5actions.com](https://nm5actions.com)) program for support with addictive behaviors.
- Improve provider communication skills about addictive behaviors.

## Objective 2

Increase immunization rates for vaccines shown to reduce the risk of cancer.

### Why This Matters

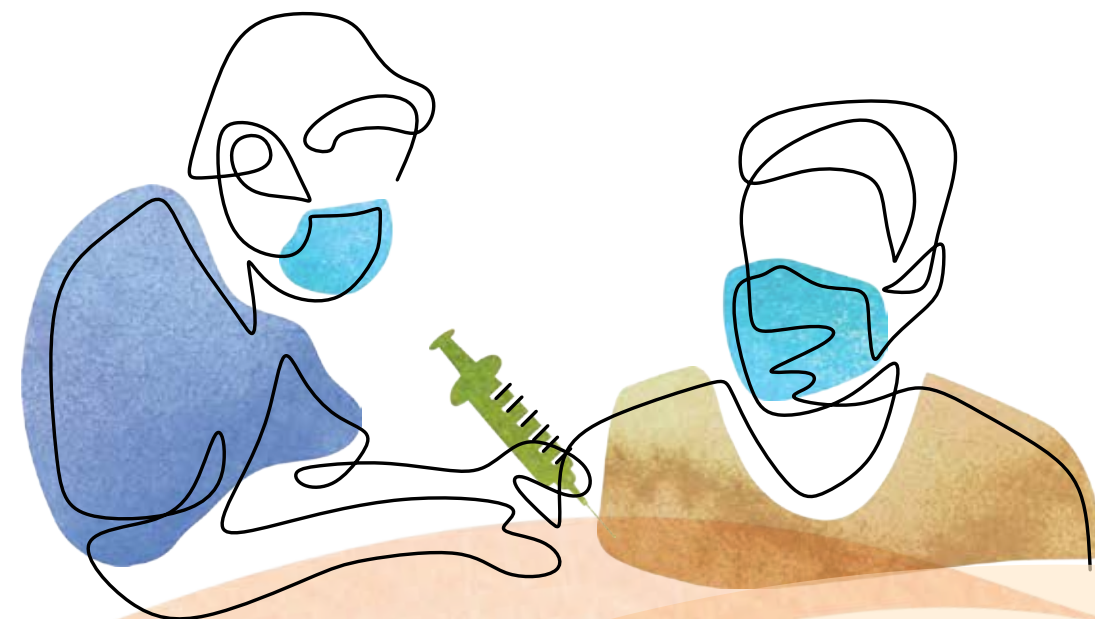
Immunizations are an important part of cancer prevention. The human papillomavirus (HPV) vaccine protects against the types of HPV that cause most cervical, vulvar, vaginal, anal, penile, and oropharyngeal cancers and is widely available in New Mexico. The American Academy of Pediatrics recommends children ages 11-12 years receive HPV vaccination so that they receive the protection before they are exposed to the virus which can cause cancers later in life.\*

Chronic infection with hepatitis B virus or hepatitis C virus (HBV and HCV, respectively) is a leading risk factor for liver cancer. The American Academy of Pediatrics recommends all infants receive a hepatitis B vaccination including the first dose within 24 hours of birth, followed by two additional doses to complete the series. There is no vaccine to prevent HCV.

### Strategies

- Increase public awareness of and demand for vaccines that prevent cancer.
- Increase primary care physician and advanced practice provider awareness of vaccine recommendations and schedules from recognized sources such as professional medical society guidelines.
- Address misconceptions and rumors about vaccine safety and efficacy.
- Improve public awareness of where to access HPV, hepatitis B, and other vaccines, including use of the **DOH Helpline at 1-833-SWNURSE (1-833-796-8773)**.

\* According to the CDC, it is recommended that those up to age 26 years who did not start or finish the HPV vaccine series receive HPV vaccination and that some adults age 27 to 45 years who are not already vaccinated may choose to receive HPV vaccination after speaking with their doctor.



## Objective 3

Prevent, diagnose, and treat hepatitis B and C viruses and other infectious causes of cancer.

### Why This Matters

Chronic infection with hepatitis B virus or hepatitis C virus is a leading risk factor for liver cancer. Other infections can also increase the risk of cancer, such as *Helicobacter pylori* (*H. pylori*), a type of bacteria. Chronic infection with *H. pylori* increases the risk of stomach cancer (gastric adenocarcinoma in particular) and gastric mucosa-associated lymphoid tissue (MALT) lymphoma. A relatively high prevalence of the bacteria *H. pylori* has been identified on the Navajo Nation.

### Strategies

#### Hepatitis B

- Promote hepatitis B vaccination for all individuals who meet eligibility guidelines.
- Individuals with active HBV infections should be referred for antiviral therapy.

#### Hepatitis C

- Promote testing of all eligible adults aged 18-79 who meet current guidelines for testing.
- Refer all HCV-positive cases for curative treatment.
- Support the implementation of New Mexico's hepatitis C elimination plan (End HepC-NM Eliminating Hepatitis C Virus in New Mexico by 2030) and its goals to reduce the new infection rate to 350 new infections per year by 2030 through innovative approaches being led by Medicaid Managed Care Organizations (MCOs) to meet targets for hepatitis C treatment.

#### *Helicobacter pylori*

- Increase public and provider awareness of the association between chronic *H. pylori* infection and increased risk of stomach cancer and gastric (MALT) lymphoma.
- Increase provider awareness of appropriate *H. pylori* testing and treatment guidelines from recognized sources such as professional medical societies (e.g. American College of Gastroenterology).

## Objective 4

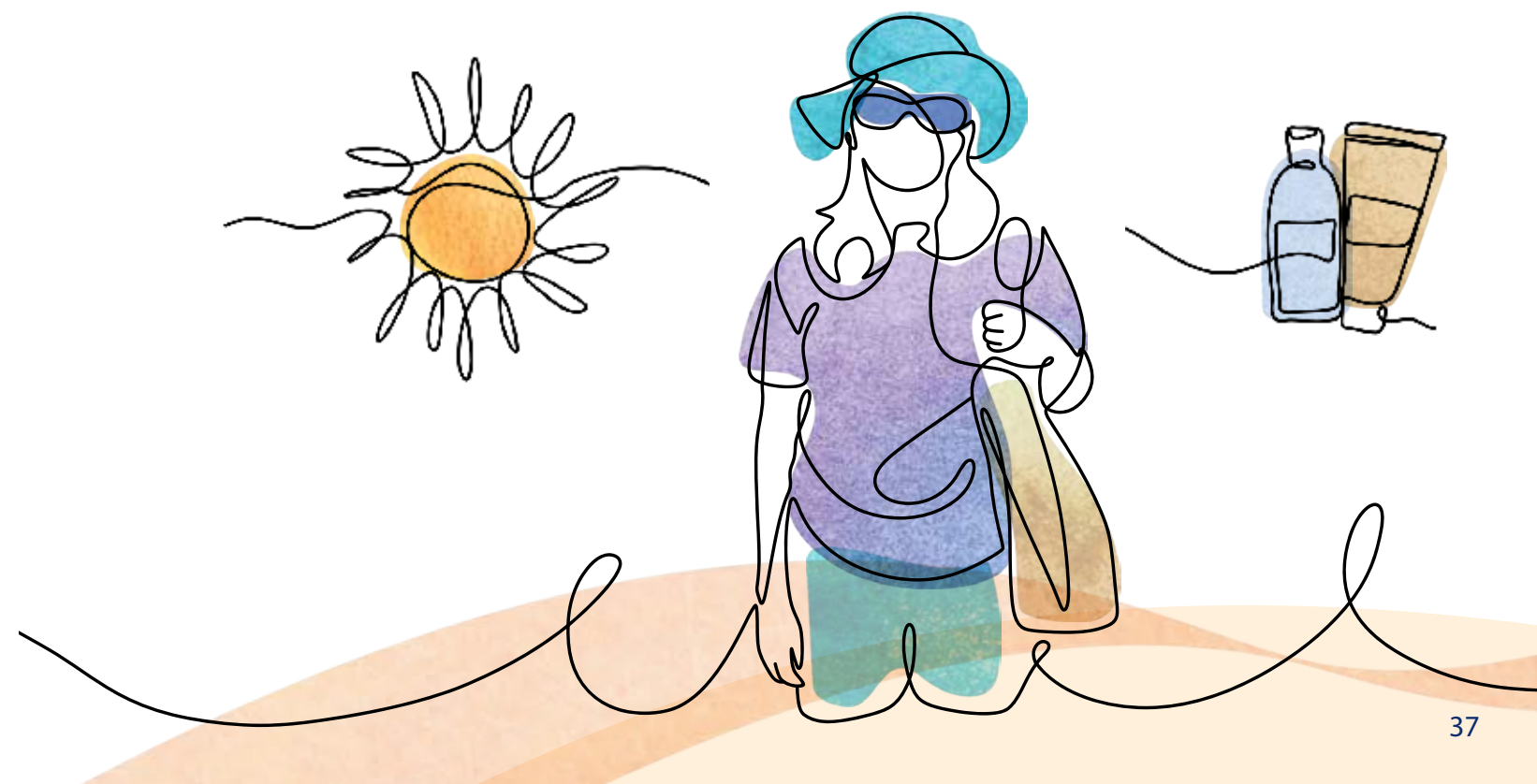
Reduce exposure to ultraviolet radiation from the sun and indoor tanning devices.

### Why This Matters

Exposure to ultraviolet (UV) radiation is a risk factor for skin cancer. New Mexico has the second-highest annual average daily ultraviolet (UV) radiation from the sun in the United States (Arizona has the highest). Indoor tanning beds also expose users to UV radiation. Nationwide, many states have enacted legislation to protect users from potential harm of indoor tanning devices, such as prohibiting minors from using these services. Bills have been introduced in New Mexico in the past to prohibit minors from accessing indoor tanning devices, but legislation has not been enacted.

### Strategies

- Increase awareness of sun safety strategies including avoiding intense or high solar UV exposure when UV index is moderate (UV index is 3 or higher) by:
  - Taking shade;
  - Using physical protection with clothing, a wide-brimmed hat, and sunglasses; and
  - Using sunscreen for uncovered skin, reapplying every two hours and after sweating, swimming, and toweling off. The American Academy of Dermatology recommends sunscreen with a Sun Protection Factor (SPF) of 30 or higher.
- Support public education about the risks and importance of avoiding indoor tanning devices.
- Promote education about sun safety and sun protective policy, systems, and environmental (PSE) changes (e.g., shade structures) in schools, outdoor workplaces, and community areas.
- Support advocacy for the enactment of laws prohibiting minors from using indoor tanning beds.



Objective 5

Decrease household exposure to carcinogens.

**RADON:**  
Increase awareness of the connection between household radon exposure and lung cancer, as well as about radon testing and mitigation programs.

Why This Matters

Radon is a naturally occurring radioactive gas that comes from uranium in soil. It can enter homes through cavities and cracks inside walls and floors, gaps around service pipes and in suspended floors, construction joints, sump pumps, and private wells and groundwater supplies. Since you can’t see or smell radon gas, the only way to know if your home has a radon problem is to test for it. All homes should be tested because radon is the number one cause of lung cancer among people who do not smoke and the second leading cause of lung cancer among people who smoke. Smoking and radon act synergistically to cause cancer (meaning the effect of both together is greater than the sum of their separate effects). The U.S. Environmental Protection Agency (EPA) estimates that radon is the cause for 21,000 cancer deaths in the U.S. annually. For more information, refer to **NM-Tracking - Radon** ([nmtracking.doh.nm.gov/environment/air/Radon](https://nmtracking.doh.nm.gov/environment/air/Radon)). According to the EPA Map of Radon Zones, Bernalillo, Colfax , Mora, Rio Arriba, San Miguel, Santa Fe, and Taos counties are classified as Zone 1 (red zones) with the highest potential for elevated indoor radon levels. The rest of New Mexico counties are classified as Zone 2 (orange zones) with moderate potential for elevated indoor radon levels.

Strategies

- Increase awareness of the association between radon and lung cancer and the importance of radon testing and mitigation.
  - A limited number of radon test kits are available to New Mexico residents for free through the state Environment Department’s Indoor Radon Outreach Program. See **Indoor Radon Outreach** ([env.nm.gov/rcb/indoor-radon-outreach-program](https://env.nm.gov/rcb/indoor-radon-outreach-program)).
  - Inexpensive test kits are available from many radon specialty vendors, hardware stores, and DIY (Do-It-Yourself) stores. Cost of the kits usually includes lab analysis to get results.
  - New Mexicans can also call the EPA-supported hotline to purchase radon test kits by phone. Call **1-800-SOSRADON (1-800-767-7236)**.
- Support access to radon testing and mitigation, including for those with low income.
- Support advocacy for the enactment of laws and regulations in New Mexico regarding radon.\*

\* For example, other states have enacted codes and laws regarding radon testing, disclosure, and mitigation in real estate transactions, new home construction, rental dwellings, schools, and childcare facilities; as well as radon professional certification and financial assistance programs to for those with low-income for radon testing and mitigation. ([eli.org/buildings/indoor-exposure-radon](https://eli.org/buildings/indoor-exposure-radon), [eli.org/sites/default/files/files-pdf/2025%20Radon.pdf](https://eli.org/sites/default/files/files-pdf/2025%20Radon.pdf)).

**PFAS:**  
Increase awareness of the connection between environmental carcinogens and cancer risk, especially per- and polyfluoroalkyl substances (PFAS).

Why This Matters

PFAS — short for per- and poly-fluoroalkyl substances — are toxic, man-made chemicals that do not break down in the environment. They are often called “forever chemicals” because once they enter our bodies, they stay there forever. PFAS exposure has been linked to increased risk of kidney and testicular cancers and other health conditions.

In New Mexico, PFAS contamination is most severe near military bases where firefighting foams were used for decades, including at Cannon Air Force Base in Curry County and Holloman Air Force Base in Otero County. The New Mexico Environment Department has a list of ways to protect yourself and your family from PFAS no matter where you live in the state. This list is available at **PFAS in New Mexico** ([env.nm.gov/pfas](https://env.nm.gov/pfas)).

In 2025, New Mexico lawmakers passed two key bills that will help New Mexico tackle PFAS contamination. These bills were signed into law by Gov. Michelle Lujan Grisham. **House Bill 212** ([nmlegis.gov/Legislation/Legislation?Chamber=H&LegType=B&LegNo=212&year=25](https://nmlegis.gov/Legislation/Legislation?Chamber=H&LegType=B&LegNo=212&year=25)), or the **PFAS Protection Act**, phases out consumer products with intentionally added PFAS, ensuring these chemicals do not enter New Mexicans’ homes. The other bill (House Bill 140) amended the Hazardous Waste Act by classifying discarded firefighting foams containing PFAS as hazardous waste subject to regulatory measures.

Strategies

- Support awareness of the risks of PFAS exposure.
- Support implementation of PFAS-related legislation in New Mexico.

**ARSENIC:**  
Increase awareness of the connection between environmental carcinogens and cancer risk, especially arsenic.

Why This Matters

About 20 percent of New Mexicans receive their water from private wells, which are not tested routinely. Arsenic exposure through contaminated well water is a risk factor for certain cancers. On the Navajo Nation (which spans areas of Arizona, New Mexico, and Utah), elevated levels of uranium and arsenic have been found in well water. Approximately 30% of the people living on the Navajo Nation do not have access to quality drinking water.

Strategies

- Raise awareness of options for New Mexicans to test their water, including certified laboratories and community events posted on the **New Mexico Environmental Public Health Tracking** website ([nmtracking.doh.nm.gov/environment/water/private\\_wells/Testing.html](https://nmtracking.doh.nm.gov/environment/water/private_wells/Testing.html)).
- Advocate for remediation of uranium mines in the northwestern part of the state to address continued intergenerational exposure to uranium.
- Reduce water insecurity and reliance on unregulated water sources for drinking water in rural, frontier, and reservation regions, including expanded water infrastructure to ensure piped water in all homes.

Objective 6

Improve collaboration between public health programs, among chronic disease organizations, with community organizations, and across sectors to increase resources for and impact of cancer prevention efforts.

Why This Matters

Many risk factors for cancer are cross-cutting areas of focus for public health programs, chronic disease organizations, community organizations, and multiple sectors. Collaboration is key to generating ideas, sharing expertise, pooling resources, and making a greater impact.

Strategies

- Improve collaboration, coordination, and communication between chronic disease, behavioral health, environmental health, school health, infectious diseases, and cancer programs to address cancer risk factors.
- Facilitate collaboration among major chronic disease organizations (American Cancer Society, American Heart Association, etc.).
- Support development and implementation of multisectoral preventive health plans, such as the **New Mexico Shared Strategic Plan 2022-2026**.

TABLE 7: Organizations and Activities that Address Prevention of Health Conditions.

| MEASURE                                                                                                                                  | BASELINE | TARGET FOR 2031 |
|------------------------------------------------------------------------------------------------------------------------------------------|----------|-----------------|
| Number of chronic disease organizations that are members of the New Mexico Cancer Council                                                | 1        | 3               |
| Number of multisectoral annual prevention conferences, workshops, or summits to address prevention of cancer and other health conditions | 0        | 1               |

JEFF  
FROM ALBUQUERQUE

I was diagnosed with prostate cancer — a very aggressive, high-risk type — just as the shutdowns for COVID were over. I went to a different healthcare provider for an unrelated health concern, and they did a PSA test as a routine. My PSA tested through the roof. It was not my first high PSA test, but my regular provider did not refer me right away to a urologist or test me again the following year. I was diagnosed three years later than I could have been and when my cancer had progressed to stage 3c.

The late diagnosis made everything much harder on me and on my family. It’s more trauma. The treatment is harder if you’re diagnosed at a later stage.

I was working full time as a Research Engineer at Sandia Labs. I had to undergo two years of hormone therapy. When you undergo hormone therapy, your memory goes down the tubes. All these passwords and complex processes I had to know for my job ... it was really a struggle.

There’s a stigma about prostate cancer. Some men think you’ll never be sexually active again. That’s not true for everyone. Especially if you catch it early.

But the stigma is more than that. It’s about cancer itself. Men tell me that they don’t want other people to know so they won’t be treated differently; they don’t want to be excluded at work or treated like they can’t do things.

And they don’t want to join survivor groups because they don’t want to sit around and cry in a corner. I explain to them that survivor groups aren’t like that. At my prostate cancer survivor groups, we don’t cry at all. We’re very practical. Our prostate cancer survivor group is about mentoring each other and helping each other get the best care.

Prostate cancer should be talked about more. It should be more like breast cancer. Prostate cancer is relatively common in men just like breast cancer is relatively common in women, but we don’t talk about prostate cancer enough.

“The healthcare system is so overburdened right now. You can’t expect them to know the best treatment option for you. You must figure out the best option for you.”



# CHAPTER 4: SCREENING AND EARLY DETECTION

## Overview

Early detection through evidence-based cancer screening tests can be one of the most effective strategies for reducing cancer morbidity and mortality in New Mexico. Breast, cervical, colorectal, lung, and prostate cancer together account for a substantial proportion of the state’s cancer burden, yet screening uptake, follow-up, and stage at diagnosis vary significantly by geography, race/ethnicity, insurance status, and health system capacity. Rural and frontier communities, American Indian and Hispanic populations, and uninsured New Mexicans experience disproportionate barriers to timely screening and diagnostic resolution.

Breast, cervical, and colorectal cancer screening rates in New Mexico are among the lowest in the country.\* According to the 2024 BRFSS data, New Mexico’s colorectal cancer screening rates are the lowest in the United States (see Figure 10).

Screening and early detection in New Mexico require coordinated, multilevel action, including community outreach, practice-level quality improvement, data-driven targeting of disparities, and sustained policy advocacy, to ensure that screening is accessible, acceptable, timely, and linked to appropriate diagnostic and treatment services. This section emphasizes both population-based screening (measured through surveillance system such as the Behavioral Risk Factor Surveillance System or BRFSS) and practice-based performance improvement, while recognizing the importance of shared decision-making for cancers where screening benefits and harms must be weighed carefully.

### SCREENING

Refers to looking for early signs of cancer in asymptomatic, average-risk people. This is not meant to serve as a diagnosis of cancer.

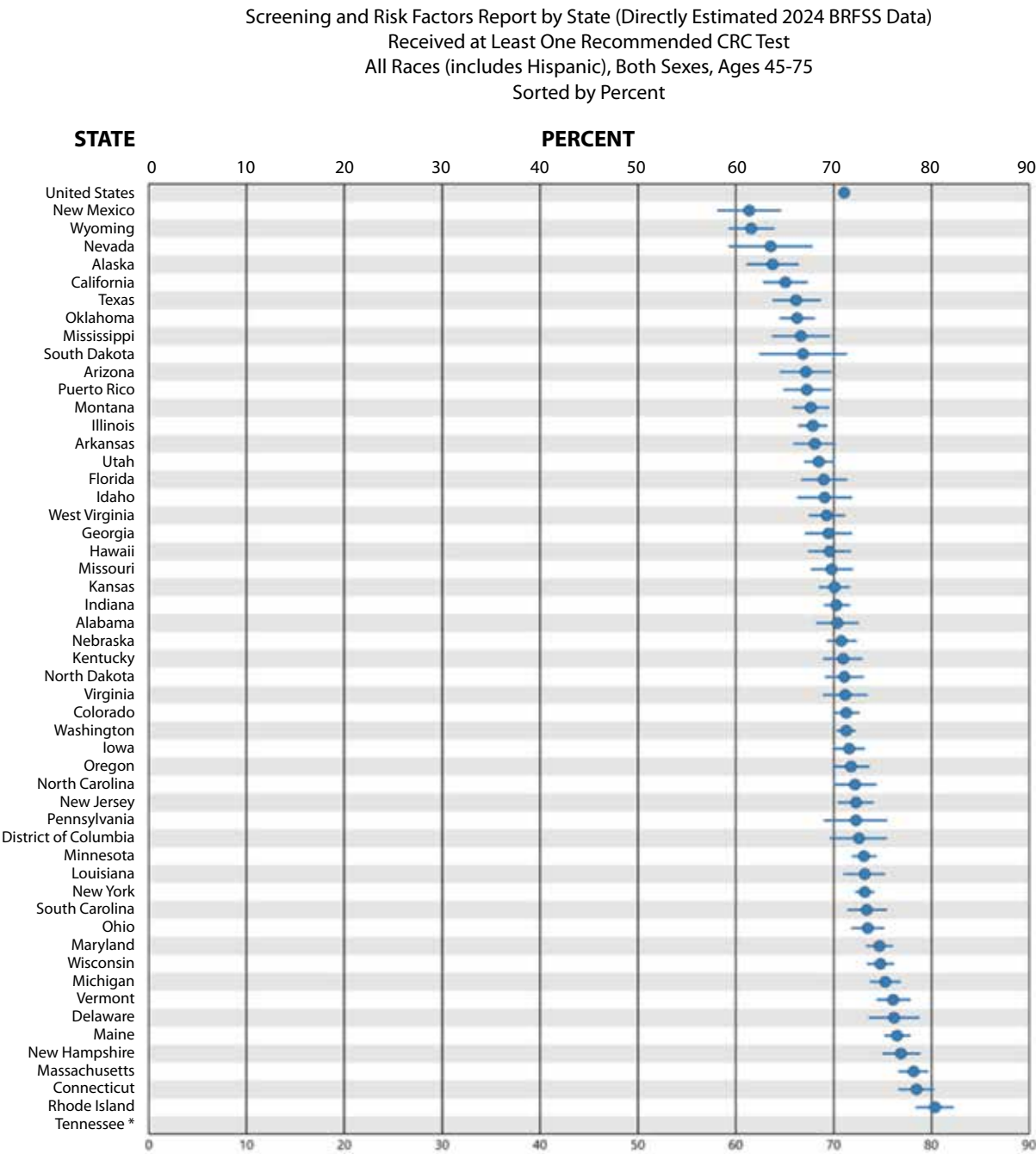
### SURVEILLANCE

Refers to “watchful waiting” with minimally invasive tests for those with elevated risk (e.g. family history).

**Reference:**  
Marcus PM. Assessment of cancer screening: a primer [Internet]. Bethesda (MD): National Cancer Institute (US); 2019 Nov. Chapter 1, Foundations. Available from: [ncbi.nlm.nih.gov/books/NBK550210](https://ncbi.nlm.nih.gov/books/NBK550210)

\* According to BRFSS 2024 data, New Mexico has the 3rd lowest overall breast cancer screening rate (i.e., mammogram in past 2 years among women ages 40 years and older) and the 2nd lowest overall cervical cancer screening rate (i.e., Pap test in past 3 years among women ages 21-65 years); see [statecancerprofiles.cancer.gov](https://statecancerprofiles.cancer.gov).

FIGURE 10: Colorectal Cancer Screening Rates by State (according to BRFSS 2024 data).



- NOTES:**
- Created by [statecancerprofiles.cancer.gov](https://statecancerprofiles.cancer.gov) on 4/1/2026.
  - 2024 BRFSS Survey Data is the source for this data collected by the Behavioral Risk Factor Surveillance System (BRFSS) sponsored by the Centers for Disease Control and Prevention. Data for the US is a median and not a percent.
  - BRFSS Prevalence estimates presented here may vary from other published estimates due to differences in the methodology used to generate estimates.
  - Data for United States does not include Puerto Rico.
  - For more information about Received at Least One Recommended CRC Test, see the dictionary.
  - \* Data not available for this combination of geography, cancer site, age, and race/ethnicity.

OVERALL GOAL

To improve early detection and management of screenable cancers by increasing equitable access to evidence-based screening services, strengthening screening-to-diagnostic pathways, and supporting informed, patient-centered decision-making across New Mexico.

The following objectives outline a coordinated approach to improving cancer screening and early detection in New Mexico across populations, healthcare systems, and policy levels. Together, these objectives prioritize equitable access to evidence-based screening, timely diagnostic follow-up, and informed decision-making, with a focus on populations and communities experiencing disproportionate cancer burden.

Objective 1

By 2031, increase population-level screening rates to the national screening rate for breast, cervical, and colorectal cancer among age-eligible New Mexicans, as measured by the Behavioral Risk Factor Surveillance System, with an emphasis on reducing disparities by race, ethnicity, geography, and insurance status.

Why This Matters

Increasing population-level screening is essential to detecting cancer earlier, reducing preventable death, and closing persistent disparities in cancer outcomes across New Mexico communities.

Strategies

- Support statewide, culturally, and linguistically tailored public awareness campaigns emphasizing the importance of routine breast, cervical, and colorectal cancer screening, with messaging adapted for rural, tribal, and frontier communities.
- Develop a statewide colorectal cancer screening program similar to the **Breast and Cervical Cancer Program** ([nmhealth.org/about/phd/pchb/bcc](https://nmhealth.org/about/phd/pchb/bcc)) and drawing on lessons learned from other states’ colorectal cancer screening programs.
- Leverage BRFSS data to identify geographic and population-level screening gaps and prioritize outreach to populations with persistently lower screening rates.
- Partner with community-based organizations, community health workers, and patient navigators to conduct trusted, community-embedded education and referral to screening services.
- Promote mailed outreach, mobile clinics, and home-based screening options where appropriate (e.g., stool-based tests for colorectal cancer or self-collected vaginal samples for cervical cancer), particularly for populations facing transportation barriers.
- Align statewide screening efforts with national initiatives such as the American Cancer Society’s Cancer Roundtables, while adapting strategies to New Mexico’s sociocultural and geographic context.

Objective 2

By 2031, increase practice-based breast, cervical, and colorectal cancer screening rates across New Mexico primary care settings including Federally Qualified Healthcare Centers, Indian Health Services facilities, as measured by the Uniform Data System (UDS) and the Government Performance and Results Act (GPRA), with improvements prioritized for clinics serving populations with historically lower screening uptake.

Why This Matters

Improving screening performance through focused implementation support or quality improvement efforts within healthcare practices can strengthen health systems where screening occurs and ensure timely follow-up and diagnostic care, particularly for patients served by safety net and tribal clinics.

Strategies

- Support primary care settings, including Federally Qualified Healthcare Centers and Indian Health Service facilities, in implementing evidence-based interventions such as reminder systems, standing orders, and provider assessment and feedback.
- Encourage health systems to use electronic health record tools to systematically identify patients overdue for screening and track completion and follow-up.
- Promote bundled or integrated screening approaches (e.g., addressing multiple cancer screenings during a single visit or outreach effort) to improve efficiency and uptake.
- Strengthen screening-to-diagnostic pathways by supporting patient navigation and care coordination for abnormal results, reducing delays in diagnostic resolution.
- Collaborate with Medicaid, Medicare, and commercial payers to align quality metrics and incentives with evidence-based screening practices.
- Address provider shortages through regional referral coordination and workforce strategies to improve wait times for colonoscopies.

TABLE 8: Facility-Level Data on Cancer Screening Rates, 2024.

| 2024 UNIFORM DATA SYSTEM (UDS) and INDIAN HEALTH SERVICE GOVERNMENT PERFORMANCE REPORTING ACT (GPRA) | BREAST CANCER SCREENING: Percentage of Women ages 40-74 who have had a mammogram within the past two years | CERVICAL CANCER SCREENING: Percentage of Women ages 21-65 who have fully met the USPSTF Recommendations | COLORECTAL CANCER SCREENING: Percentage of Men and Women ages 45-75 who have fully met the USPSTF Recommendations |
|------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|
| UDS                                                                                                  |                                                                                                            |                                                                                                         |                                                                                                                   |
| Overall New Mexico                                                                                   | 47.9%                                                                                                      | 37.9%                                                                                                   | 35.1%                                                                                                             |
| Overall United States                                                                                | 54.0%                                                                                                      | 55.4%                                                                                                   | 42.7%                                                                                                             |
| GPRA                                                                                                 |                                                                                                            |                                                                                                         |                                                                                                                   |
| Albuquerque Area                                                                                     | 32.6%                                                                                                      | 33.8%                                                                                                   | 24.6%                                                                                                             |
| Navajo Area                                                                                          | 39.7%                                                                                                      | 36.3%                                                                                                   | 25.5%                                                                                                             |
| All Areas Combined                                                                                   | 38.9%                                                                                                      | 34.4%                                                                                                   | 23.6%                                                                                                             |

Sources:  
National Health Center Program Uniform Data System (UDS) Awardee Data, Health Resources and Services Administration. UDS Clinical Data [online]. 2026. (Accessed 1/9/2026). [data.hrsa.gov/topics/health-centers/uds](https://data.hrsa.gov/topics/health-centers/uds).  
Government Performance and Results Act (GPRA). Indian Health Service. US Department of Health and Human Services. FY24 GPRA National and Area Results. 2026. (Accessed 1/8/2026). [ihs.gov/quality/government-performance-and-results-act-gpra](https://ihs.gov/quality/government-performance-and-results-act-gpra).

### Objective 3

By 2031, increase the proportion of age- and risk-eligible New Mexicans who receive evidence-based lung cancer screening with low-dose computed tomography (also known as low-dose CT), while improving timely follow-up and diagnostic evaluation, particularly among rural communities and populations with a higher smoking prevalence.

#### Why This Matters

Lung cancer screening can significantly reduce mortality, but only if eligible individuals are identified, screened, and supported through timely follow-up and diagnosis.

#### Strategies

- Increase community awareness and education among providers and eligible patients about evidence-based guidelines for lung cancer screening using low-dose CT, with particular attention to high-risk populations and underserved communities.
- Address lung cancer-related stigma, fear, and fatalism through an emphasis on the benefits of early detection and supportive, non-judgmental care.
- Support the integration of lung cancer screening workflows within primary care settings, including eligibility assessment, shared decision-making visits, and referral pathways using evidence-based interventions and policies.
- Expand the use of health educators, promotoras, community health workers, community health representatives, and patient navigators, along with insurance enrollment and benefits navigation, to address transportation and follow-up adherence.
- Partner with tobacco-cessation programs, including the New Mexico Quitline, to integrate smoking cessation support into lung cancer screening initiatives and vice versa in a potential Lung Cancer Action Plan.
- Address system-level capacity constraints, such as radiology workforce shortages, availability of screening, cross-training on screening guidelines, and expanding community-clinical linkages to local support services.
- Seek partnerships to increase access to lung cancer screening through mobile low-dose CT services, where feasible and aligned with federal policy opportunities such as the MOBILE Health Care Act and regional referral networks to ensure timely diagnostic follow-up.

### Objective 4

By 2031, increase the use of informed and shared decision-making for prostate cancer screening among age-eligible men in New Mexico, ensuring that higher risk individuals receive clear, culturally, and linguistically appropriate information about the potential benefits and harms of screening.

#### Why This Matters

As recommended by the United States Preventive Services Task Force, shared decision-making respects patient values, improves the quality of care, and helps ensure that prostate cancer screening services are used appropriately and equitably.

#### Strategies

- Promote provider training and clinical tools that support high-quality shared decision-making conversations about prostate cancer screening, including discussion of potential benefits, risks, and uncertainties.
- Develop and disseminate culturally appropriate decision aids that reflect literacy, language, and cultural considerations relevant to New Mexico populations.
- Encourage documentation of shared decision-making in clinical workflows to ensure patient preferences are respected and captured appropriately.
- Support targeted education for populations at higher risk for prostate cancer, including Black men and those with a family history, to facilitate informed discussion with healthcare providers.



Objective 5

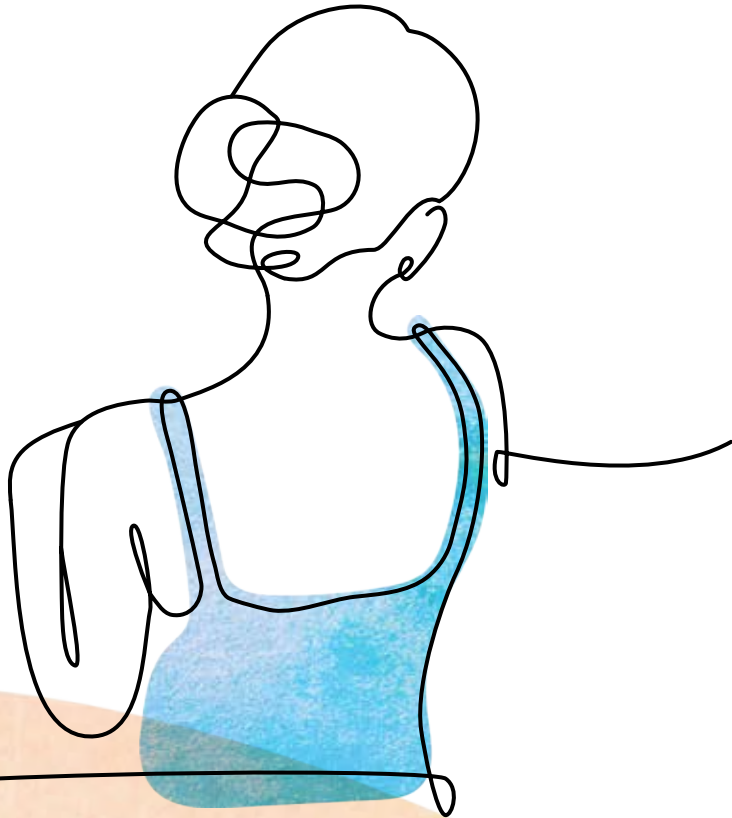
By 2031, strengthen and sustain state-level policies and payer practices that ensure comprehensive coverage for recommended cancer screenings and necessary diagnostic follow-up, with the goal of reducing financial and structural barriers to early detection for uninsured and underinsured New Mexicans.

Why This Matters

Insurance coverage for screening and diagnostic follow-up is a foundational requirement for equitable early detection and prevents cost-related delays in cancer diagnosis and treatment.

Strategies

- Advocate for comprehensive insurance coverage across Medicaid, Medicare, and private plans for all recommended cancer screening services, including follow-up diagnostic testing after abnormal screens.
- Support policies that eliminate cost-sharing and non-financial barriers (e.g., prior authorization, transportation) that deter screening uptake.
- Collaborate with policymakers, insurers, and advocacy organizations to sustain funding for safety-net screening programs and navigation services.
- Monitor and respond to emerging screening technologies and guideline updates to ensure equitable and timely coverage for New Mexicans.



Coordinated Approach:

Together, these objectives, measures, and strategies reflect a coordinated approach to cancer screening and early detection that integrates community engagement, health system improvements, and policy action to advance equity and reduce late-stage cancer diagnosis.

Measures

- Percentage of age-eligible adults who are up to date with colorectal cancer screening (BRFSS) [see data table below]
- Percentage of age-eligible adults who are up to date with breast cancer screening (BRFSS) [see data table below]
- Percentage of age-eligible adults who are up to date with cervical cancer screening (BRFSS) [see data table below]
- Percentage of eligible adults who are up to date with lung cancer screening (BRFSS) [see data table below]

TABLE 9: Adults Who Are Up to Date with Screenings.

| BRFSS 2024                       | BREAST CANCER SCREENING:<br>Percentage of Women ages 40-74 who have had a mammogram within the past two years | CERVICAL CANCER SCREENING:<br>Percentage of Women ages 21-65 who have fully met the USPSTF Recommendations | COLORECTAL CANCER SCREENING:<br>Percentage of Men and Women ages 45-75 who have fully met the USPSTF Recommendations | LUNG CANCER SCREENING:<br>Percentage of Men and Women ages 50-80 who have fully met the USPSTF Recommendations |
|----------------------------------|---------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|
| Overall New Mexico               | 68.8% (64.6%-72.9%)                                                                                           | 71.7% (66.6%-76.3%)                                                                                        | 61.4% (58.1%-64.7%)                                                                                                  | 21.2% (11.4%-31.0%)                                                                                            |
| Overall United States            | 74.5%*                                                                                                        | 79.0%*                                                                                                     | 71.1%*                                                                                                               | 22.1%*                                                                                                         |
| RACE/ETHNICITY                   |                                                                                                               |                                                                                                            |                                                                                                                      |                                                                                                                |
| American Indian or Alaska Native | 61.6% (48.9%-74.3%)                                                                                           | 62.1% (45.3%-76.5%)                                                                                        | 46.1% (34.8%-57.5%)                                                                                                  | **                                                                                                             |
| Hispanic                         | 71.0% (63.8%-78.3%)                                                                                           | 70.1% (62.3%-77.0%)                                                                                        | 60.0% (54.5%-65.5%)                                                                                                  | **                                                                                                             |
| White/ Non-Hispanic              | 67.9% (62.4%-73.5%)                                                                                           | 77.8% (71.1%-83.3%)                                                                                        | 65.4% (61.0%-69.9%)                                                                                                  | 20.3% (10.0%-30.6%)                                                                                            |
| HEALTH INSURANCE                 |                                                                                                               |                                                                                                            |                                                                                                                      |                                                                                                                |
| No Health Insurance              | 27.1% (12.9%-48.4%)                                                                                           | 59.7% (42.6%-74.8%)                                                                                        | 27.5% (16.3%-42.3%)                                                                                                  | 0.0% (na)                                                                                                      |
| Has Health Insurance             | 72.5% (68.5%-76.1%)                                                                                           | 73.0% (67.6%-77.8%)                                                                                        | 64.6% (61.1%-68.0%)                                                                                                  | 23.6% (14.5%-35.9%)                                                                                            |

\* Median value reported with no confidence intervals.  
\*\* Prevalence estimates are not available if the unweighted sample size for the denominator was < 50.

Sources:  
Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2025. (Accessed 12/17/2025). [cdc.gov/brfss/brfssprevalence](https://cdc.gov/brfss/brfssprevalence).  
Stata analysis on United States 2024 BRFSS dataset.

## DR. ANTHONY PALLIATIVE MEDICINE DOCTOR

Many cancer patients in New Mexico do not have access to palliative care. And some of these cancers are very painful, especially head and neck cancers. It's not just a lack of physicians. We cannot see the number of patients we should be seeing. We do not have enough nurses to check patients in, to do things like get basic histories and check vitals, so we cannot accept more patients than we have.

We must triage patients based on the severity of their symptoms and prognosis. The patients experiencing the most pain are the ones we try to prioritize, and others must wait. That's not best for quality of care.

I had a patient in his early 50s with head and neck cancer and his pain was so severe he couldn't work. His wife became his full-time caregiver and went on the Medicaid paid caregiver program. But she was paid so little. They couldn't afford a car. It was difficult for him to get to his pain clinic and oncology appointments.

One of the biggest challenges I see is the delay in diagnosis. I've had many patients who spent many, many months waiting for tests because they couldn't get timely appointments. And their cancer progresses to the point that it's harder to treat and less likely that they will survive. It's heartbreaking. I've had patients with metastatic cancers whose cancers may not have progressed if they had been treated earlier.

I did my residency at UCLA (the University of California, Los Angeles). I could get an MRI for patients within 24 to 72 hours. Here I've had patients wait two or three months for something I would consider urgent.

Seeing bad things happen to people repeatedly bears down on you. It's a moral injury. You feel powerless as a doctor, and that leads to burnout. In palliative care, health workers talk about the importance of bearing witness to patients. You can only bear witness for so long.

We need full, multidisciplinary palliative care teams here — doctors, nurses, social workers, psychologists, chaplains, and resources for patients to address their practical needs like food, lodging, and transportation costs when they go home. Cancer patients need support. We need to strengthen psychosocial support for patients.

We need to do more for the family caregivers. Everyone who goes through cancer treatment needs assistance. There should be more resources for caregivers: caregiver training, respite options, and reasonable financial assistance if they must quit their jobs to provide care for family members.

**"There should be more resources for caregivers: caregiver training, respite options and reasonable financial assistance if they must quit their jobs to provide care for family members."**



## LEA FROM LAS CRUCES

My cancer journey is a complicated one. I'm 42 years old, and it started with bowel issues when I was a teenager.

About three years ago, I was experiencing excruciating pain, so I started tracking the issues I was having with my bowels. When I shared them with my doctor, he just prescribed meds. I finally went to the hospital and they believed I had uterine fibroids. Back and forth to the hospital three times, they finally admitted me because my white blood cell count was too low.

I was in the hospital for six weeks. They placed two drains, then did exploratory surgery. Following that surgery, I was transferred to a hospital in El Paso where they gave me two blood transfusions and told me my colon was punctured. My next surgery was six and a half hours long. The surgeon did a hysterectomy and also removed a tumor that was invading my uterus from my colon. That's when I found out I had cancer. I learned later that one of the drains they had placed when I was in the hospital hit the tumor and punctured my colon. That's why I was bleeding internally and needed the transfusions.

I still get angry thinking about this. I knew something was wrong, but no one listened to me. I think the tumor came from a polyp they ignored. They never did a colonoscopy.

**"Advocate for yourself.  
Demand answers, tests. Use your voice.  
Your doctors don't know your body  
and how you feel."**

If they had, they would have found it. And I don't think I needed the hysterectomy. I feel like they brushed me aside because I look okay when I go to my appointments. Unfortunately, I trusted that my doctors knew what they were doing and didn't use my voice.

I kept quiet about my cancer for months. When I finally told my mom, she told me that she had been diagnosed with stage IV breast cancer. We were both diagnosed the same year. Because of that, she and I both had genetics testing done; it came back negative for cancer.

I want others to know NOT to let anybody tell them something isn't wrong with them. You know your body. Advocate for yourself. Demand answers, tests. Use your voice. Your doctors don't know your body and how you feel. Don't let anyone silence you.

My faith is incredible. Church ... support groups ... advocacy groups. These are all very important. Survivors need to know ... there is community and support. I didn't let anyone know I had cancer for a year. I wanted to be treated the same. But I robbed myself of a support system. I was so sick and had no one to talk to about it.



# CHAPTER 5: CARE AND TREATMENT

## OVERALL GOAL

Improve availability, quality, and timeliness of cancer care and treatment for all New Mexicans, including children, and rural and underserved populations.

New Mexicans face critical challenges in accessing care and treatment services when diagnosed with cancer. Compared to other health conditions and diseases, cancer treatment requires more frequent visits with clinicians with ongoing monitoring. The management of treatment side effects also involves frequent interactions between patients, caregivers, and oncology care teams. New Mexico requires a skilled and well-supported healthcare workforce to deliver timely and high-quality care. As discussed in the section on Policy and Systems, our state is facing a healthcare workforce crisis. **To achieve the care and treatment objectives, New Mexico must also address the healthcare workforce crisis and implement the strategies outlined in Chapter 2: Policy and Systems.**

New Mexico has only five Commission on Cancer (CoC)-accredited hospitals: three of them in Albuquerque, one in Santa Fe, and one in Las Cruces. In comparison, Nebraska, a state with a similar population size to New Mexico and similar numbers of people diagnosed with cancer annually, has 16 CoC-accredited hospitals. Given Nebraska’s smaller geographic size, access to a CoC-accredited hospital is much easier in Nebraska than in New Mexico. Additionally, New Mexico has one National Cancer Institute-designated Comprehensive Cancer Center, located at the University of New Mexico.

National trends show that cancer care is increasingly being delivered in outpatient settings, which are lower cost. For example, ambulatory sites accounted for 59% of infusion therapies between 2017 to 2023; surgeries are also moving to outpatient settings, with the proportion of mastectomies performed at ambulatory surgery centers reaching 9% by the end of 2023.

Delivering quality cancer care for rural patients is a nationwide challenge and especially challenging for states with large numbers of rural residents, such as New Mexico. Nationwide, rural residents face higher cancer mortality rates and have limited access to cancer treatment and supportive care services.

Currently, a complete picture of cancer care and treatment in New Mexico is not available. The New Mexico Health Workforce Committee’s Annual Reports do not include specialties of greatest importance to oncology, such as medical oncologists, surgical oncologists, and radiation oncologists, among others. As the provider and survivor stories in this cancer plan and other anecdotal reports suggest, however, the shortage in availability of quality cancer treatment and support services in New Mexico demands solutions.

Addressing this shortage will require a strategic investment in resources based on careful, in-depth analysis of how to optimize equitable service delivery without compromising quality of care. Although beyond the scope of this cancer plan, a strategic plan to improve access to and quality of care would help identify the gaps, resources, and strategies needed, including where public and private investment could make the most impact. Options could include the following:

- Satellite clinics in which oncology care teams from a metropolitan hub visit on a regular but periodic schedule can provide quality care in areas where patient volume is not high enough to support full-time practices. However, this would also require investment in the satellite clinic infrastructure and willingness of clinical teams to undertake regular overnight travel (with accompanying costs).

- Telemedicine visits can be useful but do not fully replace in-person visits with complete physician exams and often require investments in infrastructure. A recent study found that telemedicine care took additional staff time and effort to have patients successfully engage with the platform. In addition, older patients and other vulnerable or marginalized patients (with limited English proficiency, lower socioeconomic status, etc.) are often less likely to use telemedicine.
- Hub-and-spoke models in which community cancer centers are linked to major cancer centers with appropriate triage and referral is another way to improve access to quality care. In this model, identifying which patients most urgently need access to specialty hospitals versus those who can be treated at outpatient settings could help make better use of scarce resources. For many patients with stage 1 female breast cancer, for example, 5-year survival rates exceed 90%, and treatment is often highly successful with standard therapies. While excellent outcomes are achievable at various facilities—including satellite clinics affiliated with major centers—evidence generally shows better adherence to guidelines and slightly superior survival at high-volume or NCI-designated comprehensive cancer centers.

Palliative care focuses on the comfort and quality of life of people facing serious illness and is an important part

of cancer care. Hospice care is a specific type of palliative care that is provided in the final months or weeks of life. New Mexico is below regional and national averages in access to palliative care with only 72.7% of urban hospitals providing palliative care services, compared to 86% in the mountain west and 81% nationally. The situation in rural hospitals is worse, with no rural hospitals in New Mexico providing palliative care according to a 2022 study, compared to 33.3% in the mountain west and 34.5% nationally.

Hospice care is considered the standard for compassionate care when patients face a life-limiting illness. New Mexico ranks 35th in the nation for percentage of Medicare deaths occurring while the patient was on hospice at 45.4%. Although the number of hospice care providers in New Mexico increased from 41 in 2018 to 53 in 2023, services are not available in all rural areas. In rural areas, 32.7% of rural Medicare deaths occurred while patients were using hospice compared to the statewide average of 49% for Medicare deaths on hospice. This gap suggests that hospice services are less available to rural New Mexicans.

Addressing social determinants of health is critically important to increasing access to quality care and treatment for all New Mexicans. Table 10 provides an example of how to address barriers for rural populations and lower socioeconomic status. For other populations, see the reference.

TABLE 10: The Role of Social Determinants in Cancer Care.

| SOCIAL DRIVERS OF HEALTH   | KEY IMPACTS ON CANCER CARE                                                                                                      | KEY EXAMPLES                                                                                                                                                                      | INTERVENTIONS AND FUTURE RECOMMENDATIONS                                                                                                                                                                                                                                                                                          |
|----------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Socioeconomic Status (SES) | Lower SES increases advanced-stage diagnoses, cancer mortality, and barriers to treatment.                                      | Patients in the lowest-income bracket have a <b>13% higher risk of death</b> . Low-income colorectal cancer patients are <b>40-60% less likely</b> to receive targeted therapies. | <ul style="list-style-type: none"><li>• <b>Expand Medicaid coverage</b> and <b>reduce out-of-pocket costs</b> to improve access.</li><li>• <b>Community outreach initiatives</b> (e.g., <b>Screen to Save</b>) to increase screenings.</li><li>• <b>Integrate SDOH data into EHRs</b> to enable targeted interventions.</li></ul> |
| Geographic Location        | Rural populations experience higher cancer mortality, reduced access to screenings, and longer travel distances to specialists. | Rural patients are <b>15-30% more likely</b> to present with late-stage cancer. Long travel distances contribute to <b>delayed chemotherapy and radiation therapy</b> .           | <ul style="list-style-type: none"><li>• <b>Expand telemedicine oncology services</b> to reduce travel burdens.</li><li>• <b>Subsidize rural specialty providers</b> and <b>increase funding for mobile cancer clinics</b>.</li><li>• <b>Improve transportation infrastructure</b> for rural patients.</li></ul>                   |

Source:  
Abdullah, A.; Liu, Z.; Molinari, M. From Diagnosis to Survivorship: The Role of Social Determinants in Cancer Care. Cancers 2025, 17, 1067. doi.org/10.3390/cancers17071067.

Objective 1

Advocate for resources to develop a strategic plan to identify and address critical gaps in availability and quality of cancer treatment and support services, especially for rural patients, including routine follow-up assessments of equitable availability and access to services.

Why This Matters

A strategic plan is needed to guide New Mexico’s public sector leadership and private sector investors on the most impactful investments to improve equity and availability of quality cancer care for all New Mexicans.

Strategies

- Inform policymakers and the public about the need for a plan to address gaps in cancer care.
- Liaise with the **Policy and Advocacy Workgroup** of the **New Mexico Cancer Council** about the importance of this issue as part of their advocacy agenda.
- Reach out to academic institutions about the need for research on the availability and quality of cancer treatment and support services statewide, including for rural patients.

Objective 2

Reduce time between diagnosis and treatment.

Why This Matters

Delays in treatment have been associated with worse outcomes and lower survival.

Strategies

- Establish benchmarks or targets for diagnosis-to-treatment intervals (e.g., aim for ≤30–60 days for most solid tumors, depending on cancer site and stage, informed by national guidelines).
- Prioritize multidisciplinary coordination (such as tumor boards, streamlined referral pathways, and patient navigation) to address common bottlenecks like staging delays, insurance approvals, or scheduling.
- Implement quality improvement or health services research/implementation science activities to reduce the time between diagnosis and treatment.
- Enhance provider-to-provider communication by promoting adoption and use of **New Mexico’s Health Information Exchange** to enable real-time access to patient records, diagnostic results, imaging, and care history across facilities, reducing delays in information sharing and supporting faster treatment initiation.

Objective 3

Improve availability of high-quality, evidence-based diagnostic and treatment services adherent to national standards.

Why This Matters

Treatment at accredited cancer care centers is associated with improved outcomes for several cancer sites.

Strategies

- Promote and support innovative models of delivering high-quality cancer care to rural and underserved patients, including satellite clinics, outpatient facilities, telemedicine for follow-up care, appropriate use of incentives for providers to deliver care outside of major metro areas (including compensation for regular travel), and participation in initiatives such as the **Centers for Medicare and Medicaid Services’ Innovation Center’s** models for oncology care (EOM (Enhancing Oncology Model) | CMS ([cms.gov/priorities/innovation/innovation-models/eom](https://www.cms.gov/priorities/innovation/innovation-models/eom)), the ONCare Alliance ([oncarealliance.com](https://oncarealliance.com)), and other initiatives).
- Facilitate collaboration between cancer care centers through the development of partnerships, Project ECHO series on cancer care, and virtual tumor boards to improve quality and availability of care.
- Promote and support the efforts of New Mexico cancer care centers to meet accreditation/certification standards, such as the **American College of Surgeons’ Commission on Cancer® (CoC)** accreditation program and/or the **American Society of Clinical Oncology’s Quality Oncology Practice Initiative (QOPI)** program.
- Support rural and community cancer centers’ efforts to achieve quality improvement goals through partnerships and joint quality improvement/quality assurance activities with major cancer care centers.

Objective 4

Strengthen access to innovative and targeted treatments.

Why This Matters

Access to biomarkers and the utilization of precision oncology is associated with improved outcomes for several cancer sites.

Strategies

- Support education about and use of biomarker testing for the most effective cancer treatment, including awareness of New Mexico’s 2024 policy requiring coverage of biomarker testing by state health insurance which provides coverage of many common genetic tests for cancer.
- Promote adoption and utilization of clinical decision support tools for biomarker testing that incorporate evidence-based clinical guidelines at the point of care to guide testing and treatment decisions.

## Objective 5

Enhance patient engagement in care and treatment.

### Why This Matters

Cancer care and treatment are ultimately about what matters most to patients and their families, who may prioritize quality of life, survival, or other concerns.

### Strategies

- Promote shared decision-making between patients, families, and providers about treatment options and goals of care.
- Educate cancer care teams on how to effectively and compassionately communicate with patients and families about diagnosis and treatment.
- Offer counseling and support services to caregivers and family members on how to support their loved one through the decision-making process about cancer treatment and the entire treatment journey.
- Support patient education to improve their health literacy, their ability to ask questions of their care teams, and their ability to make informed decisions about their treatment.

## Objective 6

Provide or refer patients for comprehensive support services.

### Why This Matters

Patients' health and well-being are significantly impacted by their comorbidities, non-health needs, and personal and social circumstances; patient navigation and other support services are associated with improved patient well-being.

### Strategies

- Increase the awareness of cancer care teams on the importance of routinely screening cancer patients for current smoking/nicotine use and referring patients to cessation programs.
- Increase the awareness of cancer care teams on the importance of screening cancer patients for psychosocial distress and referring them to services as appropriate.
- Encourage and support health systems to have supportive care team members on staff to minimize referrals needed, such as patient navigators, social workers, genetic risk counselors, nutritionists, psychiatrists, exercise oncologists, and rehabilitation therapists.
- Support advocacy efforts to make comprehensive support services reimbursable by insurance plans.
- Identify and address gaps in access to non-clinical support services for underserved populations, and provide referrals as needed, including access to transportation, lodging, childcare, opportunities for physical activity, and access to healthy food while receiving cancer care.
- Ensure that behavioral health services and treatment of substance use disorders are included as standard of care to improve cancer treatment outcomes.

## Objective 7

Address fertility and sexual health as part of cancer treatment.

### Why This Matters

Fertility preservation and sexual intimacy are often important to patients who need to be informed of the potential impact of different cancer therapies and treatment on fertility/sexual health to make informed decisions about their care. It should not be assumed that only younger patients are concerned about sexual health.

### Strategies

- Develop protocols for protecting the fertility options of cancer patients prior to treatment and include cancer patients in decision-making about fertility.
- Address sexual intimacy and other quality-of-life concerns as they relate to treatment options.

## Objective 8

Support efforts to increase access and comprehensive coverage for cancer research and clinical trials.

### Why This Matters

Participating in clinical trials may offer newer treatment options to patients; in addition, patients receive frequent visits and support. From a societal perspective, it is important for people of different races and ethnicities to participate and for both women and men to participate so that scientists can understand how cancer therapies work in people with different genetic profiles and whether they work effectively for women as well as men.

### Strategies

- Decrease barriers to participating in cancer-related clinical trials, including transportation, insurance status, and other barriers.
- Identify and address barriers to clinical trial participation such as fear, cultural beliefs, and potential medical and non-medical expenses.
- Promote education about clinical trials among patients, families and caregivers, and providers to encourage participation among diverse populations, including Native Americans, Hispanics, and women.
- Build trust between healthcare providers and underserved populations by educating providers on the history of clinical trials within these communities and changes in how clinical trials are now conducted.
- Support the development and dissemination of culturally and linguistically appropriate materials about clinical trials.

Objective 9

Promote early access to palliative care for all ages.

Why This Matters

Palliative care is associated with improved quality of life for most cancer patients.

Strategies

- Integrate palliative care into cancer care teams, including onsite specialists in palliative medicine to provide care as part of the oncology team.
- Educate providers, patients, and caregivers that palliative care is available for symptom relief during treatment, not just at end of life.
- Educate healthcare providers on how to assess physical, psychological, social, and spiritual distress in their patients.
- Educate the entire clinical team on palliative care and its benefits in cancer care.
- Support advocacy efforts to recruit and retain palliative medicine physicians and to provide reimbursement for palliative care services.

Objective 10

Promote utilization of hospice services for terminally ill patients.

Why This Matters

Hospice services are underutilized among patients with cancer despite evidence that hospice care services provide quality end-of-life care.

Strategies

- Support culturally and linguistically appropriate education and outreach efforts to increase awareness and understanding of hospice and end-of-life care.
- Promote the establishment of a healthcare power of attorney, living will, and end-of-life wishes early in diagnosis, so that the patient’s wishes will be known.
- Support advocacy efforts to improve timely access to and utilization of hospice and end-of-life care, especially in rural areas.

Objective 11

Support advocacy efforts to increase resources for childhood, adolescent, and young adult cancer care and treatment in New Mexico.

Why This Matters

Cancer is the leading cause of illness-related death in New Mexico for children aged 0-14 years. Cancer incidence rates are rising in adolescent and young adults, but resources are limited for research, comprehensive care and treatment, and support services (including financial resources and palliative care). Young survivors are especially vulnerable to financial distress.

Strategies

- Work with state and national partners to support increased funding for childhood, adolescent, and young adult cancer research in the New Mexico context.
- Increase awareness of the need for a dedicated children’s health center appropriately resourced to hire a range of specialists for comprehensive pediatric cancer care and treatment.

TABLE 11: Measures for Care and Treatment.

| MEASURE                                                                                                                                    | BASELINE | TARGET |
|--------------------------------------------------------------------------------------------------------------------------------------------|----------|--------|
| Number of cancer care centers utilizing QI/health systems/implementation science methods to improve quality, timeliness, or access to care | N/A*     | TBD    |
| Number of cancer care centers participating in tumor boards, including virtual tumor boards                                                | N/A*     | 2      |
| Percent of cancer patients screened for psychosocial distress                                                                              | N/A*     | 60%    |
| Percent of cancer patients screened for current smoking and referred for smoking cessation treatment                                       | N/A*     | 60%    |
| Number of reports on the availability and quality of cancer care in New Mexico                                                             | 0        | 1      |

\* There is currently no information available.

## SYLVIA FROM LAS CRUCES

The day after my 40th birthday party, I was very tired and just couldn't bounce back. I also noticed unusual pain in my pelvis. My PCP sent me to a gastroenterologist. He recommended pelvic floor exercises, but nothing else. Five months later, in January, I did a breast self-exam, and everything felt fine. But the next month, I found a large lump. I had a mammogram, which led to an ultrasound and a biopsy. I was quickly referred to the oncology department at my local hospital.

When my treatments were finished, they told me I was cancer-free. But two months later, I had a severe headache with fever and no appetite. We went to the ER and my husband had to fight to get them to do a CT scan on my head. When they found something, they did an MRI. That's when I was diagnosed with a stage 4 brain tumor.

I feel like a cancer diagnosis brings some things to the surface. I decided to just roll with the punches. I decided I could fight against chemo or accept it and have it be my partner working against cancer. I decided to embrace it.

My sisters both told me they felt frozen at times and weren't sure how to act.

Getting a cancer diagnosis is scary, but you don't have to face it alone. There's so much support out there from expected and unexpected places.

**"They call us warriors, survivors. We are forever, equivocally and unequivocally changed."**

But ... not everyone in my life has come through as they said they would. Some friends told me to let them know if they could do anything to help. But when the day came that I needed something, they weren't there. On the other hand, the people who DO support have been amazing. Cancer, unlike other diseases, is a team effort.

You'll be surprised how resilient your body is. But ... long after treatment is over, you'll still feel different. You'll tire more easily. You have survived a traumatic event. This is why they call us warriors, survivors.



## JADE FROM ALBUQUERQUE

I was first diagnosed with Stage 3 cervical cancer in February of 2021. I was 36 years old. They did very aggressive treatment because of my age, and because they felt I could handle it. They did chemotherapy, regular radiation, and targeted radiation where I couldn't move at all for 5 to 6 hours. It was tough.

Unfortunately, I had to go through most of the treatment alone. My Dad traveled to be with me as often as he could. But family members can burn through paid time off quickly, especially when they live outside the area. I was physically not capable of doing anything during treatment and took leave from work.

After treatment, it took about 10 months to start to rebuild stamina. I had to learn to eat again ... I learned what my body could and couldn't handle. I have scans every three or four months, so I live with anxiety.

**"Check in on the survivor. Don't go away. Cancer is very isolating."**

### What Advice Do You Have for Survivors?

Don't compare your new life to what it was before. You'll never go back to life the way it was. Embrace what you went through ... allow it to be a stepping-stone to move on in life. Be an advocate for survivorship, for others going through what you went through.

I helped start a group called Out Living for adolescent/young adult cancer survivors, ages 15 to 39. We needed a community for young adult survivors, a place where we can have someone to talk to. We go out and do things ... go to baseball games, breweries, dinner, escape room. We do fun things together.



# CHAPTER 6: SURVIVORSHIP

## Overview

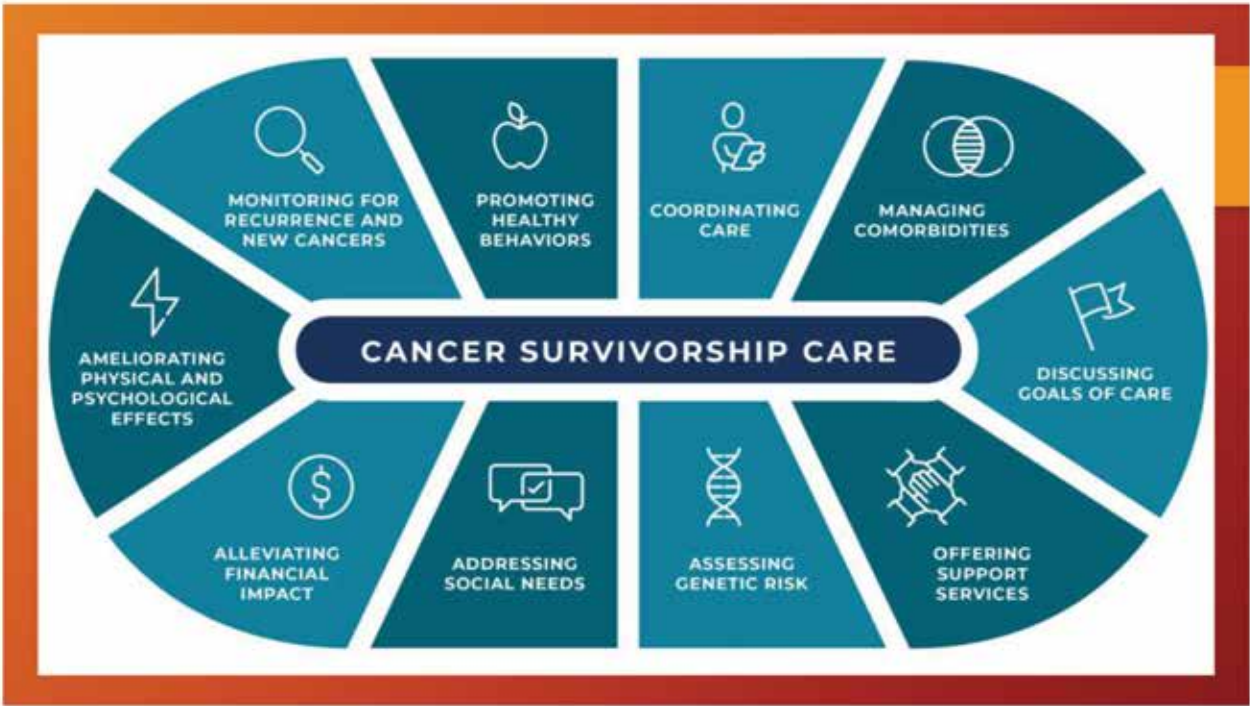
New Mexico has a diverse and growing population of cancer survivors with more than 90,000 people who have a history of cancer. It is important for New Mexico’s providers and health systems to be prepared to care for cancer survivors throughout their lives. This section of the cancer plan is designed to support New Mexicans and their families on their cancer journey and make practical recommendations on how policymakers, healthcare organizations, communities and local government, and other organizations can improve quality of life for cancer survivors.

Perspectives on cancer diagnoses differ according to a range of factors—each individual’s personal history and life circumstances, age at diagnosis, their identity (often shaped by their ethnicity, race, gender, and other factors), and their overall health. Stage at diagnosis and cancer type influence individuals’ perspectives on cancer and treatment goals. Breast and prostate cancer survivors are the most numerous nationwide, with approximately 3.5 million prostate cancer survivors and 4.3 million breast cancer survivors.

Despite the heterogeneity of survivors and their perspectives, several key themes emerged from New Mexico cancer survivor stories that inform the goals and objectives of this section, namely: the financial burden of cancer care; the challenges in navigating health systems and insurance, social isolation and loneliness affecting survivors and caregivers; and the need for a smooth transition from active treatment to post-treatment primary care. In New Mexico, research studies show that Latino cancer survivors are more likely to experience financial hardship than non-Latinos; food insecurity is also a challenge.

Survivorship care includes multiple domains to address the complex medical, social, psychological, and practical needs of cancer survivors. In addition, people diagnosed during childhood, adolescence, or early adulthood often have experiences distinctive from those diagnosed later in life; therefore, this section also includes subsections for these age groups. Figure 11 provides an illustration of 10 domains of survivor care, ranging from alleviating financial impact of cancer to monitoring for recurrence and new cancers.

FIGURE 11: Domains of Cancer Survivorship Care.



Source: American Cancer Society; Adapted from Nekhlyudov 2019 10.1093/jnci/djz089.

### WHO IS A SURVIVOR?

According to the National Cancer Institute, an individual is considered a cancer survivor from the time of diagnosis through the rest of their life. Some survivors are currently living with cancer, while others are free of cancer. Some people do not like or identify with the term survivor. The New Mexico Cancer Plan includes perspectives from survivors in their own words. No one word fits them all.

### WHO IS A CAREGIVER?

Caregivers are critical members of survivors’ care teams. Studies report high levels of depression and anxiety among family caregivers of cancer patients. Because of their importance, this section also includes recommendations directed toward health systems and cancer support organizations to “care for the caregiver.”

OVERALL GOAL

To improve quality of life for all New Mexicans living with a cancer diagnosis.

The following objectives outline a coordinated approach to improving cancer survivorship in New Mexico across populations, healthcare systems, and policy levels. The goals and strategies for patient navigation are included in **Chapter 2: Policy and Systems**.

Objective 1

By 2031, increase the availability and use of evidence-based comprehensive survivorship services statewide that address survivor-identified priorities including financial toxicity, legal/insurance needs, psychosocial support, opportunities for physical activity, and food security with focused improvement for rural, frontier communities, and populations experiencing disparities.

Why This Matters

Survivors often face long-term physical, emotional, and financial challenges after treatment; access to coordinated survivorship services improves quality of life, reduces avoidable hardship, and supports equitable recovery.

Strategies

- Disseminate and promote routine use of the **New Mexico Cancer Support and Treatment Directory** across health systems, primary care practices, and community organizations statewide.
- Conduct survivor needs assessments (including rural, frontier, and culturally diverse communities) to identify priority services and gaps.
- Increase awareness of programs that help cancer survivors address financial, legal, and insurance issues, such as **Cancer Services of New Mexico’s Legal, Insurance, and Paperwork (LIPA) Program** at (505) 999-9764 or toll-free at 1 (888) 668-2766.
- Encourage cancer care facilities to provide financial education and assistance on-site or through referral pathways.
- Encourage referrals to survivor support groups and peer support programs to reduce social isolation.
- Improve food security for cancer survivors through partnerships with food banks, food pantries, and cancer care centers.
- Improve opportunities for physical activity through partnerships with physical therapists.

Objective 2

By 2031, increase the proportion of cancer survivors who receive structured support from active treatment to post-treatment care, including survivorship care planning and guideline-concordant follow-up and surveillance and targeted supports to reduce financial barriers, across New Mexico cancer care centers and affiliated practices.

Why This Matters

The post-treatment period is a vulnerable transition marked by long-term and late effects of treatment and often unmet mental and emotional health needs and financial barriers. Survivorship care plans are written/electronic documents provided to individuals explaining the treatment they received, what follow-up care they need, and whom to contact for ongoing support. Such care planning efforts improve continuity of care, timely identification and management of complications, and quality of life.

Strategies

- Ensure that all cancer centers provide every cancer patient with a treatment summary and clear, accessible information on recommended follow-up care and surveillance, including what symptoms to watch for, whom to contact, and what appointments and tests are needed.
- Increase survivors’ awareness of the need for follow-up care and surveillance after cancer and promote trusted resources to guide conversations with physicians.
- Promote survivorship care planning using nationally recognized best practices and tools through webinars, Project ECHO sessions, conferences, written materials, and workshops.
- Increase medical providers’ awareness of post-treatment mental and emotional health needs through trainings, clinical tools, and referral pathways, including normalizing mental health screening as a part of survivorship care.
- Address financial barriers to follow-up care by expanding routine financial screening and referral to financial navigation, charity care programs, and community-based supports, and by strengthening connections to legal/insurance assistance programs when needed.

## Objective 3

By 2031, improve long-term follow-up care and supportive services for childhood, adolescent, and young adult cancer survivors and their families.

### Why This Matters

Childhood and adolescent cancer survivors can experience lifelong late effects that require risk-based monitoring, while their families face caregiving burden and financial strain that can be mitigated through coordinated resources. Additionally, caregivers are essential to survivorship yet often experience high levels of emotional distress, financial strain, and social isolation; strengthening caregiver support improves well-being for caregivers and supports better outcomes for patients.

### Strategies

- Improve long-term follow-up care for childhood cancer survivors through risk-based monitoring and coordinated referral pathways based on national guidelines.
- Increase the availability of support services and networking opportunities targeted to adolescent and young adult (AYA) cancer survivors statewide.
- Increase access to fertility counseling and fertility preservation services for adolescent and young adult cancer survivors by integrating timely fertility discussion and referral pathways into oncology care.
- Increase access to programs supporting childhood cancer survivors and their families for education, psychosocial support, and navigation.
- Increase screening for depression among caregivers and referral for psychosocial support.
- Strengthen support for services connecting New Mexicans to appropriate patient and caregiver advocacy groups specifically for childhood, adolescent, and young adult cancer survivors.
- Increase awareness of the **New Mexico Medicaid Family Paid Caregivers Program**.

## Objective 4

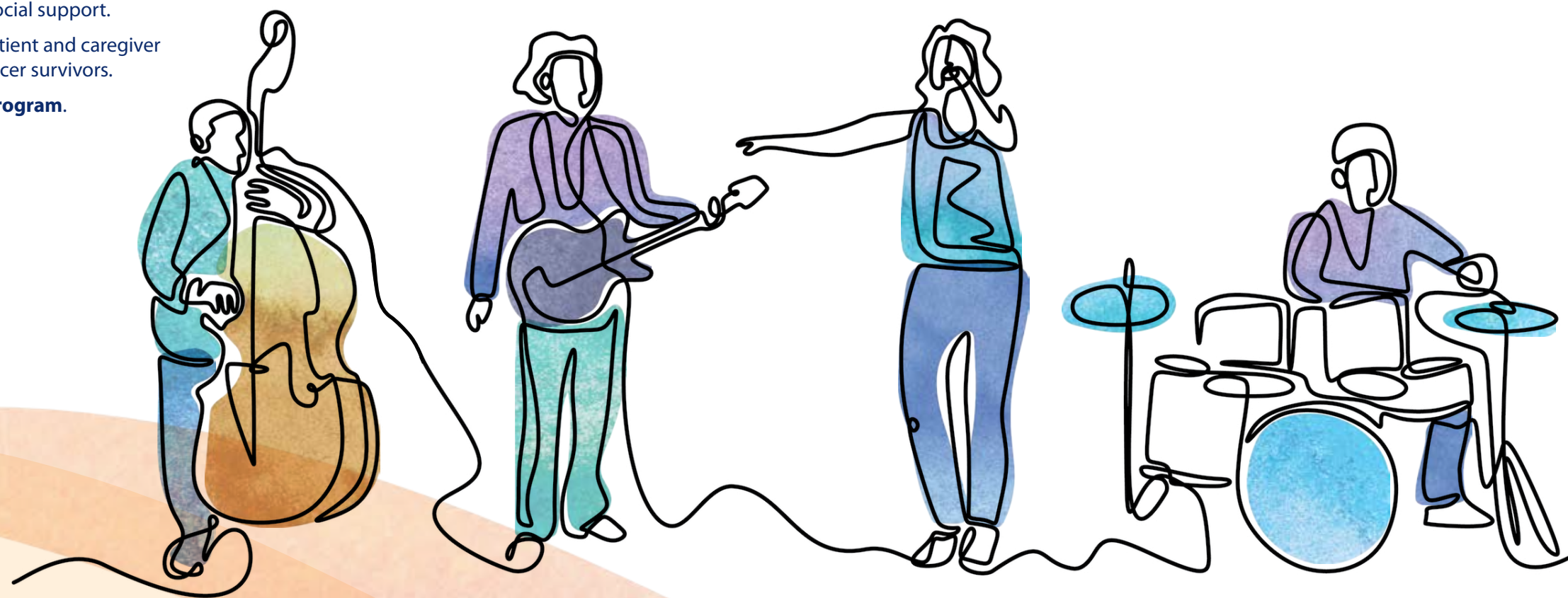
Provide support to caregivers at cancer care centers and cancer support organizations.

### Why This Matters

Family members are often primary caregivers for their loved ones who need long-term care. Caregivers of cancer patients can be at risk for depression.

### Strategies

- Increase screening for depression among caregivers and referral for psychosocial support.
- Increase awareness of the **Family and Medical Leave Act**, which requires most employers to provide up to 12 weeks of unpaid, job-protected leave for family members who need time off to care for a loved one.
- Advocate for a **New Mexico Family and Medical Leave Act**.
- Increase awareness of the **New Mexico Medicaid Family Paid Caregivers Program**.



## WHAT YOU CAN DO

Everyone can have a role in preventing and controlling cancer and making a positive difference in the lives of all New Mexicans affected by cancer. The success of the New Mexico Cancer Plan will depend on the cooperation, collaboration, and resources of many stakeholders across our state.

### LOCAL PUBLIC HEALTH ENTITIES and COMMUNITY-BASED ORGANIZATIONS CAN:

- Collaborate to reduce barriers to cancer prevention, screening, treatment, and support.
- Assist community members with signing up for health coverage and other public benefits.
- Provide culturally sensitive cancer information and resources.

### COUNTY and TRIBAL HEALTH COUNCILS CAN:

- Promote Community Health Workers and Community Health Representatives to assist with screening, treatment, and survivorship services.
- Encourage the development and implementation of culturally and linguistically appropriate interventions.

### PROVIDERS and HEALTHCARE SYSTEMS CAN:

- Offer education and navigation services for screening, treatment, and survivor care.
- Refer to or integrate mental health services for those affected by cancer.
- Use electronic medical records and other systems to help individuals stay up to date on cancer screenings and vaccinations.
- Implement interventions to improve individual health behaviors.

### CANCER EXPERTS CAN:

- Provide public and professional education.
- Participate in the New Mexico Cancer Council and its workgroups.
- Partner with and elevate community-led initiatives that promote cancer prevention, timely access to cancer treatment and survivorship resources.

### HEALTH INSURERS and POLICYMAKERS CAN:

- Support access to and coverage of smoking cessation classes, nutrition programs, palliative care services, mental health services, and cancer treatment drugs.
- Ensure that all recommended cancer screenings and immunizations are provided without cost.
- Support implementation efforts, policies, and initiatives to increase the number of healthcare providers in New Mexico.
- Support policies that encourage healthy choices and reduce exposure to environmental carcinogens.

### EMPLOYERS CAN:

- Educate the public, employees, and policymakers about best practices for cancer screening, treatment, and survivorship support.
- Support employees who are dealing with cancer, including providing resources about the **FMLA** (Family Medical Leave Act).
- Offer employee benefits that encourage wellness.
- Provide paid leave for recommended cancer screenings and immunizations or preventive care days in the workplace.

### SURVIVORS CAN:

- Participate in the New Mexico Cancer Council and its workgroups.
- Use the New Mexico Cancer Plan as a tool to educate yourself, find resources, and advocate for improving cancer care across the continuum.
- If comfortable, share stories to provide hope and help normalize fear of a cancer diagnosis.

### THERE ARE THINGS ANY NEW MEXICAN CAN DO TO REDUCE THEIR PERSONAL and FAMILY CANCER RISK:

- Quit tobacco use and support smoke-free environments.
- Maintain a healthy weight by eating well and moving more.
- Get cancer-preventing immunizations for yourself and your family.
- Get screened for cancer according to national recommendations.
- Stay safe in the sun and refrain from indoor tanning.



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