NEVADA CANCER COALITION

Nevada Cancer Plan

2026–2030

In honor of all Nevadans whose lives have been touched by cancer, and with heartfelt gratitude to those supporting, treating, and caring for our cancer survivors and their care partners each and every day.

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Executive Summary

In Nevada, we envision a future where cancer is no longer a leading cause of death and all communities across the state have equitable access to innovative disease prevention and care. While the COVID-19 pandemic seems to be far behind us, we remain grateful for the lessons learned, progress made, and the collaborations and partnerships that were formed in response–all strengthening our resolve and ability to accomplish our vision moving forward.

According to the American Cancer Society, each year an estimated 17,540 Nevadans are diagnosed with cancer and 5,450 die from the disease. Despite the number of cancer diagnoses rising, Nevada continues to rank among the states with the lowest cancer incidence, which speaks to the meaningful strides made in cancer prevention and control over the past years.

Youth tobacco use has declined, more adults are quitting smoking, and access to health insurance and healthcare professionals has improved. Policy successes—such as expanded screening coverage, protections for patients, and enhanced access to genetic counseling—demonstrate the power of collaboration and advocacy. Yet, we recognize persistent challenges: disparities in screening and outcomes, rising obesity rates, and barriers to care in rural and underserved communities. These challenges underscore the urgency and importance of this new plan.

Nevada stands at a pivotal moment. Medical innovation, community engagement, and policy reform are converging to create unprecedented opportunities for cancer prevention, early detection, treatment, and survivorship. By working together, we can bridge gaps, eliminate disparities, and ensure that every Nevadan—regardless of who they are or where they reside—has the opportunity to live a life free from the burden of cancer.

With gratitude for the dedication of so many, and with optimism for the future, we invite all Nevadans to join us in this transformative effort.

Together, we can and will build healthier communities in every region across the great Silver State!

Acknowledgments

Thank you to all who graciously gave their time and expertise to envision and develop this plan. This is by no means an exhaustive list of each and every stakeholder who provided input, ideas, and guidance to the plan in various forms.

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In Nevada, there are numerous partners and state agencies whose work supports cancer control or complements this plan.

Direct Link to Cancer	Partner or Complementary Plan
Human Papillomavirus	Nevada State Immunization Program
Tobacco Use and Exposure	Nevada Tobacco Control and Smoke-free Coalition, Nevada Tobacco Control Program, Nevada Tobacco Control Plan, 2024-2029
Physical Activity and Nutrition	Nevada Early Childhood Obesity State Plan, 2021-2026
Radon Exposure	Nevada Radon Education Program
Healthcare Workforce	Nevada Office of Statewide Initiatives
Rural Health	Huntsman Cancer Institute at the University of Utah & Nevada State Office of Rural Health
BIPOC Individuals	Nevada Minority Health and Equity Coalition
Head and Neck Cancers	State of Nevada Oral Health Program

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Introduction

The 2026–2030 Nevada Cancer Plan is a framework for Nevadans to take action in reducing the burden of cancer. Based on the most current data and scientific evidence, successes and lessons from previous cancer plans, and the contributions of dozens of individuals from across the state, this five-year plan provides a common set of goals spanning the cancer continuum with a focus on health equity throughout.

Goals

Prevent cancer
by reducing exposure to risk factors.

Improve quality of life
for cancer survivors and their care partners.

Promote and expand the use and knowledge of genetics
as a risk factor for cancer.

Provide high-quality data and proactive surveillance
to support and inform cancer control efforts.

Increase early detection of cancers
to reduce late-stage diagnosis.

Increase cancer research
to improve cancer prevention, detection, diagnosis, treatment, and survivorship.

Support access to high quality, affordable cancer care
for all Nevadans.

Improve access to quality care and supportive resources
for children, adolescents, and young adults impacted by cancer.

Plan Development

Nevada Cancer Coalition (NCC) is a non-profit collaboration of organizations and individuals dedicated to reducing the burden of cancer in our state. NCC, in partnership with Nevada Division of Public and Behavioral Health's Comprehensive Cancer Control Program, Breast and Cervical Cancer Early Detection Program, and Nevada Central Cancer Registry, develops the plan, carries out various plan components, and evaluates the plan.

This plan was developed over the course of more than a year, beginning in March 2024 with a survey of coalition members to identify new and continuing priorities, opportunities, and challenges for cancer control in Nevada. A series of in-person and virtual meetings followed, bringing together clinical and public health professionals, survivors, advocates, and caregivers to refine the results of the survey, rank priorities, and provide insights. To secure additional feedback on communities disproportionately affected by cancer, smaller virtual meetings were held with representatives from tribal, rural, Black, and LGBTQ+ communities.

During NCC's annual Cancer Control Summit in August 2024, attendees formed groups to discuss crosscutting issues that influence cancer control in the state. This brainstorming session resulted in a more comprehensive understanding of how these issues affect cancer—from risk to survivorship and end of life—and provided additional context for development of the plan's goals. Eight workgroups were formed, each working across a series of virtual statewide meetings to develop objectives, strategies, and indicators using data secured from the Nevada Central Cancer Registry. Throughout the process, a steering committee of cancer control leaders from across the state provided direction and support.

Objectives outlined in this plan were developed using a SMARTIE framework: Specific, Measurable, Attainable, Relevant, Timely, Inclusive, and Equity-minded. Each objective can be measured by one or more indicators with progress charted annually or over the plan's five-year timeline. Baseline indicators use the most recently available data, and targets were established using one of three methods. Where available, U.S. data was included for comparison.

Annual percentage change:

Some targets were set by calculating a 1% increase or decrease from the baseline per year for each year of the plan. This method can be seen in indicators such as screening rates.

National average:

Some targets were set to bring Nevada's measure to the same level as the current (plan development year) national average. This method was used in measures such as those for workforce development.

Reasonable estimate:

Targets for indicators that are not rates or percentages and do not have an equivalent national measure were set using a reasonable estimate of what should or could be achieved within the timeframe. This was used for measures such as reports, resources, and educational opportunities.

This plan embraces policy, systems, and environmental (PSE) change strategies—a way of creating community-wide conditions that make healthy choices practical and available to everyone. By changing policies and systems, and shaping physical environments, communities can have larger impacts on health outcomes such as cancer and other chronic diseases with a relatively small investment of time and resources.

Policy, Systems, and Environmental (PSE) Change

Policy Change

Involves creating or modifying laws, regulations, or organizational policies to support healthy behaviors and reduce cancer risk. Examples include tobacco-free workplace policies or legislation to increase access to cancer screenings. Often policy change is necessary before systems or environmental changes can be implemented.

Systems Change

Focuses on altering the rules, structures, or processes within organizations or communities to improve cancer outcomes. This might involve integrating cancer screening into routine health care visits or using electronic reminders for vaccinations.

Environmental Change

Modifies the physical or social environment to make healthy choices easier, such as building safe walking paths or increasing access to healthy foods.

Ultimately, an effective PSE approach should seek to enact broader level change and further cancer control.

Plan Implementation, Evaluation, and Limiting Factors

As collaboration is at the core of comprehensive cancer control, cancer control partners, the coalition and its work groups, and community members are essential to successful implementation of the plan. Everyone has a role to play in decreasing the burden of cancer. **If you're inspired to act, you can:**

- Join or volunteer with the Nevada Cancer Coalition
- Serve on a committee, task force, or collaborative group
- Work on implementing a cancer-related strategy
- Form a new action group or network
- Take care of your personal health, and encourage friends and family to do the same
- Champion effective wellness policies at your workplace or within your community
- Contact decision makers in your community and encourage them to use the plan to improve health outcomes
- Use the plan as a guide to develop organizational, community, or statewide policies

Learn about these and other options by visiting the Nevada Cancer Coalition website: **NevadaCancerCoalition.org**

Evaluation of the plan is performed annually by the State of Nevada's Comprehensive Cancer Control Program in partnership with Nevada Cancer Coalition, documenting progress, successes, and challenges for each objective. Through this annual evaluation, stakeholders can identify areas where greater emphasis needs to be applied to achieve objective targets, while also highlighting effective or ineffective strategies that may require modification to reach the desired outcome. The success of the evaluation depends, in part, on the ability to collect both quantitative and qualitative data on progress made over the course of each year.

The availability of data limits some evaluation. Consistent across all states, reported cancer data is delayed due to elapsed time for cancer registries to collect and report case data, update case information, and provide information to the Centers for Disease Control and Prevention (CDC) or National Cancer Institute (NCI), and then for those entities to compile and disseminate said data. As such, 2022 and 2023 are the most recent years of incidence and mortality data available for this plan. Additionally, some data sources used to set indicators are only available every other year, limiting consistent annual evaluation for some measures.

Data limitations and challenges are discussed in greater depth in the crosscutting issues section of the plan.

About Demographic Categories Used in This Plan

Nevada is home to a rich diversity of people with distinct cultures, preferences, experiences, and socioeconomic conditions. The nature of data collection, however, often does not completely delineate these differences, and we acknowledge that the data presented does not fully reflect the complexity of Nevada's residents.

In some cases, data collection methods have not progressed in capturing or reporting certain characteristics, such as sexual orientation or gender identity. For decades, data has been collected and guidelines have been developed using a gender binary—male or female—which has failed to account for transgender, non-binary, and other gender-diverse individuals. This binary framework may contribute to inaccurate screening, incidence, and mortality data, and assuredly results in research gaps, missed screenings, and barriers to care. We acknowledge that this does not fully reflect the lived experiences or identities of all individuals and advocate for more inclusive data collection and guideline practices moving forward.

Additionally, none of the racial and ethnic groups discussed in this report are monolithic. These broad categories often mask important differences within groups, such as the wide variation in cancer outcomes and access to care among subpopulations identified as Asian American. Individuals may also identify as more than one race or ethnicity, leading to less specific data or underrepresentation. This is often the case for Native Americans, who identify as two or more races more frequently than other groups, may consider their race over their indigenous identity, and may also be classified as Hispanic or Latino—all of which can result in their omission from Native American counts.

Aggregation of these categories is necessary to achieve sufficient sample sizes for meaningful analysis of cancer screening rates, incidence, and mortality.

We urge partners to interpret and implement this plan within the unique context of their own communities.

Our Progress

The previous cancer plan, covering the years 2021–2025, outlined 16 objectives measured through 22 indicators. The latest available data was used to determine progress toward each objective.

Improving

- ↓ **Decrease** in percentage of youth who use vapor products
- ↑ **Increase** in percentage of adults who are former smokers
- ↑ **Increase** in homes tested and mitigated for radon or built radon-resistant
- ↓ **Decrease** in percentage of Nevadans without health insurance
- ↑ **Increase** in number of healthcare professionals including physicians, advance practice registered nurses, and oncology certified nurses
- ↑ **Increase** in number of community and clinical navigators

Little or No Change

- — Percentage of Nevadans screened for lung or colorectal cancer
- — Annual education opportunities for healthcare professionals
- — Annual number of state cancer data reports

Worsening

- ↓ **Decrease** in HPV vaccination completion rate among adolescents
- ↑ **Increase** in percentage of youth and adults who are obese
- ↑ **Increase** in incidence of melanoma
- ↓ **Decrease** in percentage of Nevadans screened for breast cancer

Measurement of several objectives was challenging, and in one case not possible, due to a lack of available or consistent data. For example, although cervical cancer screening is included as a core question on the Behavioral Risk Factor Surveillance System, the questions about screening were adjusted for the 2022 survey and data has not been published since the 2020 survey. The report card used to measure palliative care programs in hospitals was also discontinued, eliminating the data source used to measure that indicator.

Policy Successes

Policy change remains one of the most effective tools in improving the health of a population and establishing a progressive healthcare infrastructure. As such, advocating for best-practice policies to prevent and control cancer and provide equitable access to care has remained a steadfast component of Nevada's cancer plans. From developing and supporting legislation to educating policymakers about bills that would be detrimental to public health, we have accomplished much in all areas of the cancer continuum. Below are some of the policy successes achieved during the 2021, 2023, and 2025 legislative sessions.

2021

SB 460—Re-established funding lost during COVID-19 for essential work to prevent youth vaping.

AB 187—Designated the month of September as "Ovarian and Prostate Cancer Prevention and Awareness Month."

AB 471—Clarified who is required to report data to the Nevada Central Cancer Registry and established consistent funding to the registry program.

AB 191—Added Medicaid coverage for the services of community health workers.

2023

SB 194—Provided critical patient protections for step therapy protocols.

SB 330—Provided access to all breast cancer screening and diagnostic testing options by eliminating out-of-pocket costs for all approved modalities.

AB 255—Established provisions for biomarker testing providing coverage for the diagnosis, treatment, management, and monitoring of cancer.

2025

SB 170—Provided access to annual health screenings, including cancer screenings, for firefighters and other first responders.

SB 189—Provided for the licensure and regulation of genetic counselors.

SB 312—Established the Tribal Health Authority Council to adopt a plan to address and eliminate barriers to healthcare for Native Americans in the state.

SB 387—Required state-regulated insurers to cover lung cancer screening.

AB 234—Protected Medicaid coverage for screening for lung, prostate, and colorectal cancers.

AB 428—Required state-regulated insurers to cover fertility preservation for individuals diagnosed with breast or ovarian cancer.

Cancer In Nevada

Understanding Surveillance Data Terms

The following definitions have been adapted from the National Cancer Institute.

Incidence rate

The number of new cases of disease diagnosed among a defined population and during a specified time.

Crude rate

A measure that expresses the number of events within a population without taking age, gender, race, or other factors into consideration.

Age-adjusted rate

A statistical measure that allows groups of people to be compared in a way that ensures the age distribution differences between the groups in a study do not affect what is being measured.

Mortality rate

The number of deaths from a certain disease or cause in a defined population and during a specified time.

Stage at diagnosis

A way to categorize the amount of spread of cancer in the body based on physical exams, imaging or laboratory tests, or biopsies. Staging is usually based on the size of the tumor, whether lymph nodes contain cancer, and whether the cancer has spread from the original site to other parts of the body.

Early stage

A term used to describe cancer that is early in its growth and may not have spread to other parts of the body. What is called early stage may differ between cancer types.

Late stage

A term used to describe cancer that is far along in its growth and has spread to the lymph nodes or other places in the body.

Metastatic

Cancer that has spread from the primary site (where it started) to other places in the body.

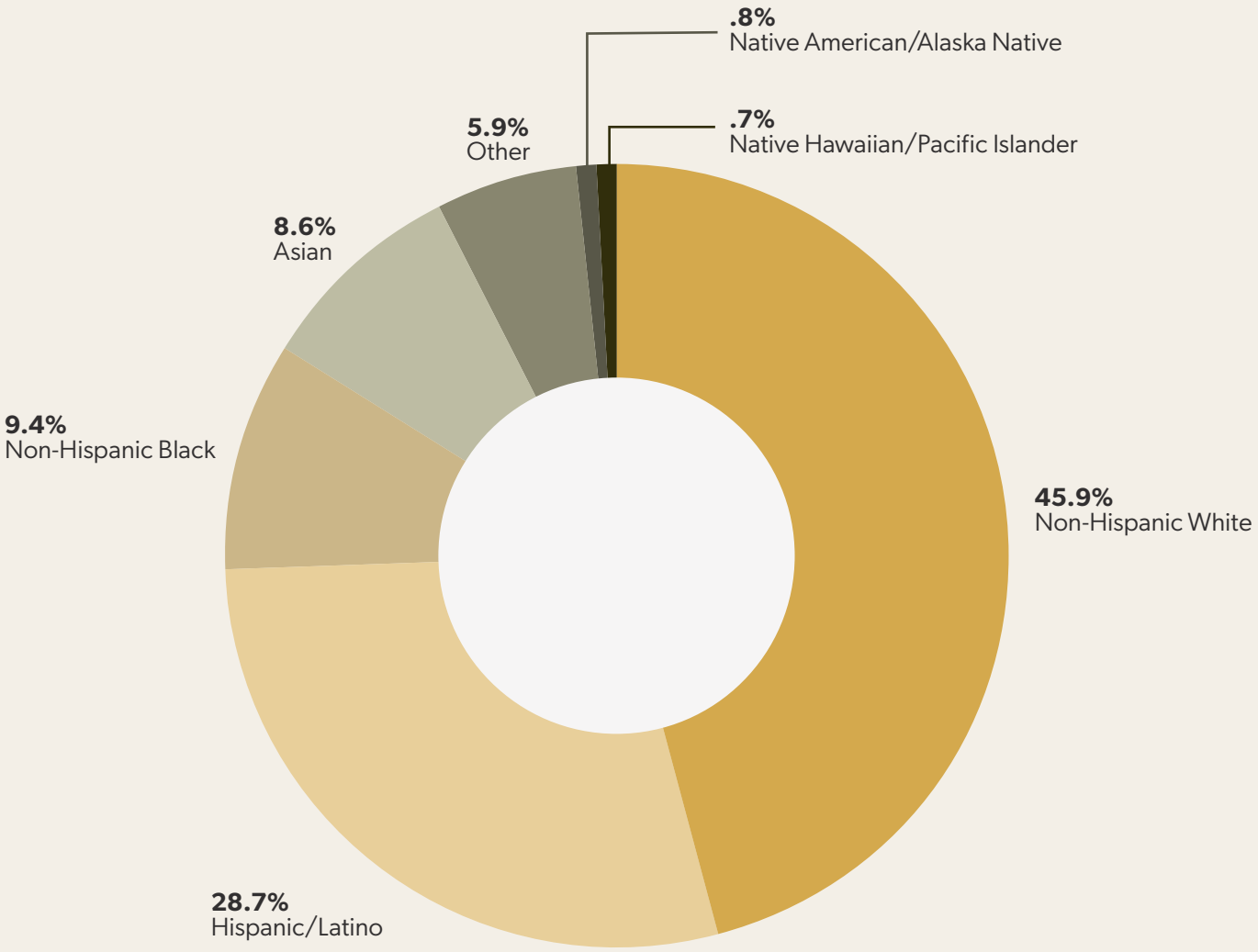
Rural vs. frontier

There are a variety of definitions for rural, but in general rural communities have lower population density and lie within non-metropolitan counties and census tracts. Frontier areas are those with sparse populations and isolated from population centers and services.

About Nevada and Its People

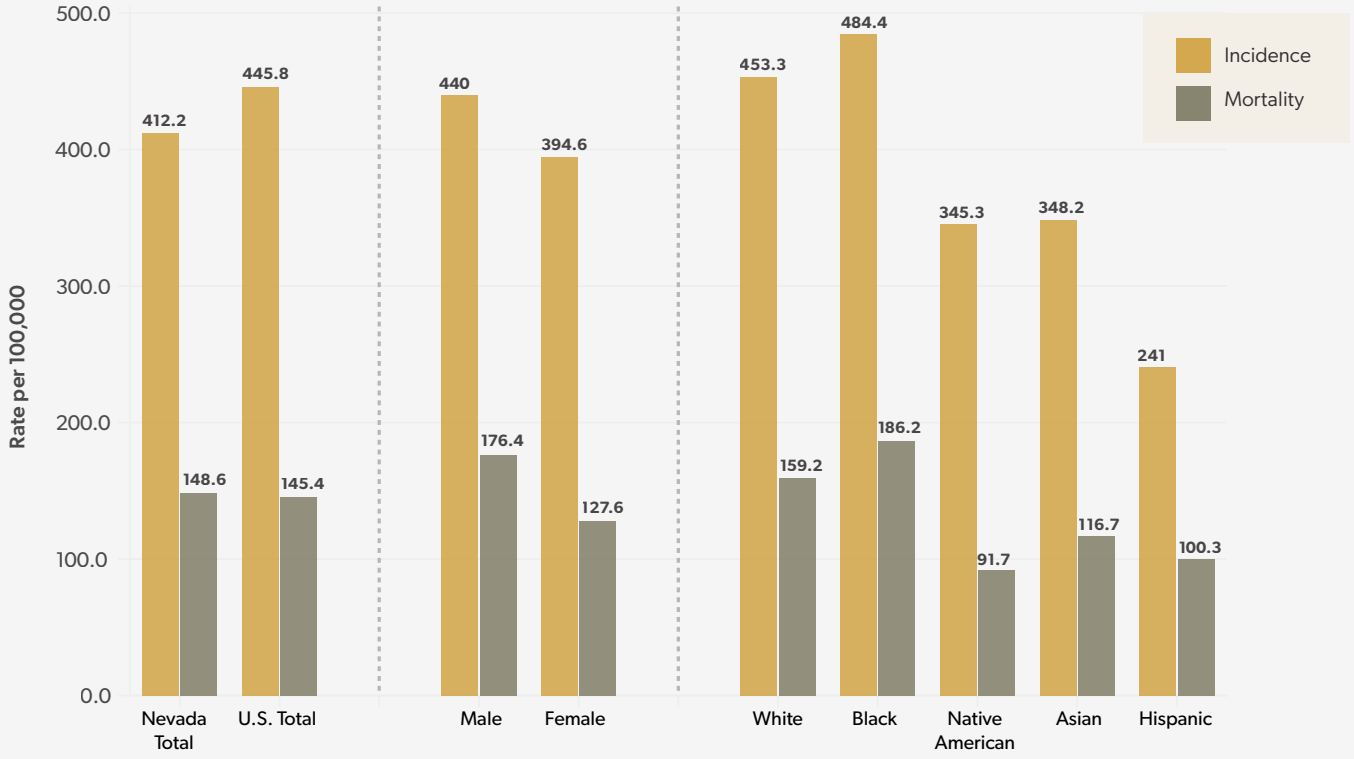
Nevada is the seventh largest state geographically. Much of its population is concentrated in three urban counties—Clark, Washoe, and Carson City—with the remainder dispersed throughout rural and frontier counties covering 87% of Nevada's land mass. Census estimates for 2023 indicate Nevada's population is more than 3.19 million people, with more than half the population composed of people who have traditionally been categorized as minorities.

State Population by Race/Ethnicity



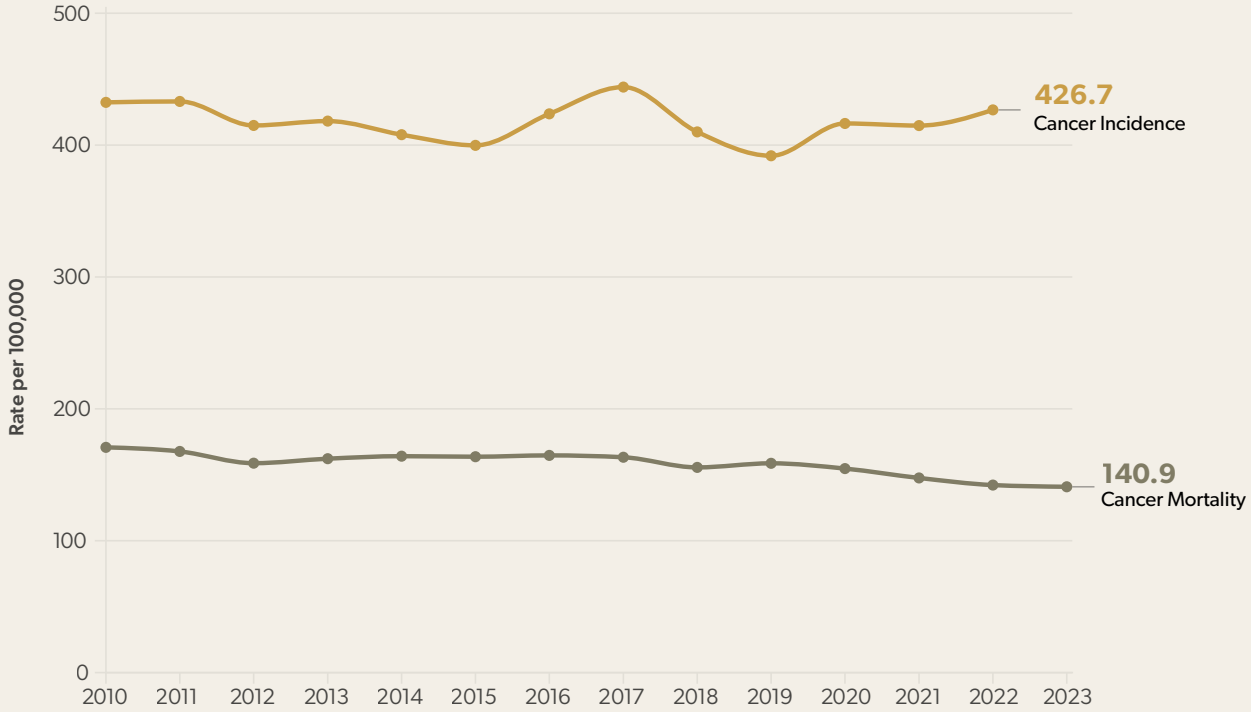
Overall Incidence and Mortality

Nevada's cancer incidence is lower than the national rate, but mortality is higher. Black and white Nevadans are more likely to be diagnosed with and die from cancer than people of other races/ethnicities.



Incidence and Mortality Trend

While Nevada's cancer incidence has remained somewhat steady, deaths from cancer have seen a gradual decline since 2010.

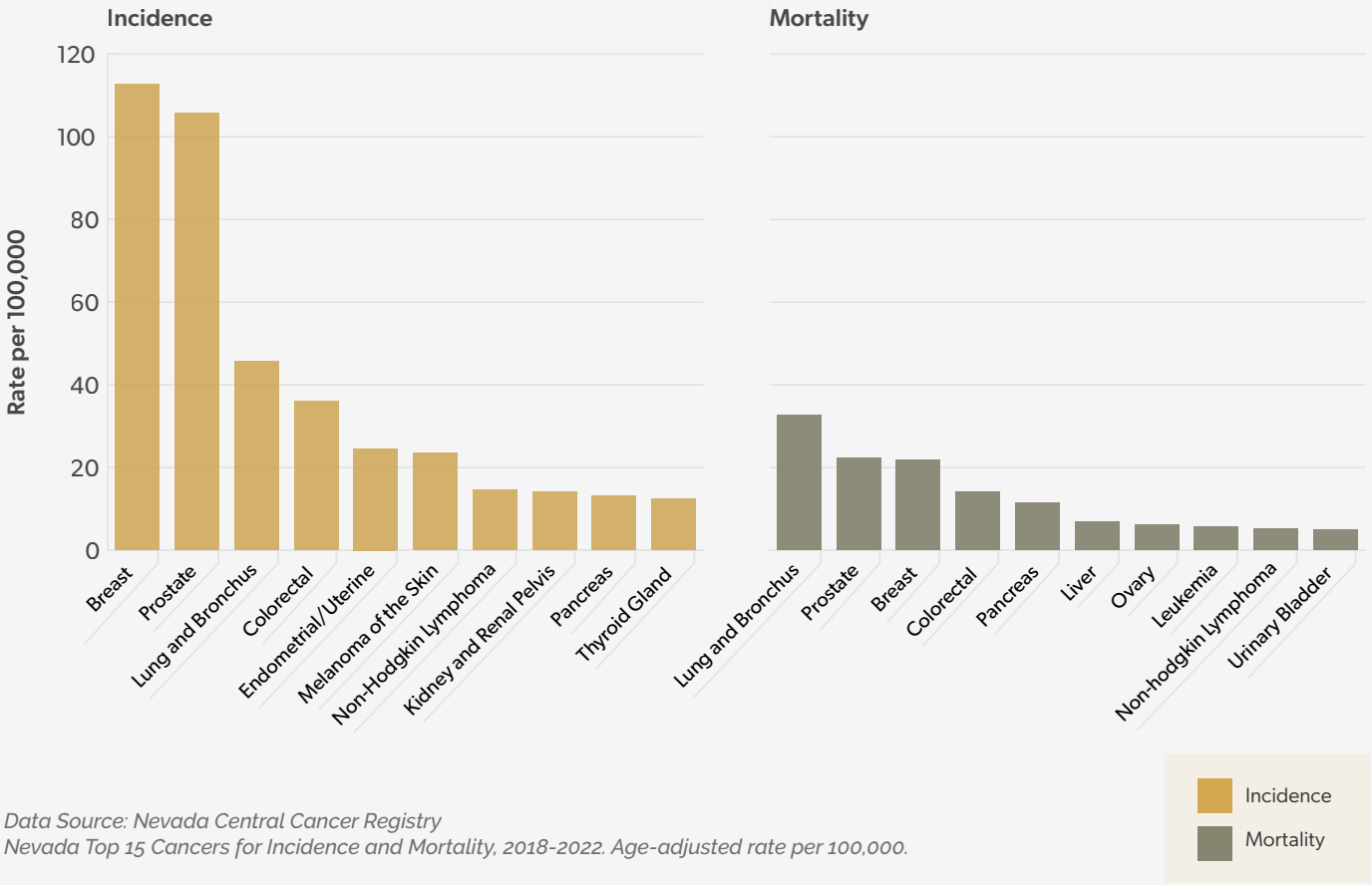


Top Chart: Data Source: Nevada Central Cancer Registry, SEER Age-adjusted annual cancer incidence per 100,000, 2018-2022 and annual cancer mortality 2019-2023.

Bottom Chart: Data Source: Nevada Central Cancer Registry Nevada Cancer Incidence and Mortality, 2010-2023. Age-adjusted rates per 100,000.

Top 15 Cancers Incidence and Mortality

Breast and prostate cancer are by far the most commonly diagnosed cancers in Nevada. However, lung cancer takes more lives.



Data Source: Nevada Central Cancer Registry
Nevada Top 15 Cancers for Incidence and Mortality, 2018-2022. Age-adjusted rate per 100,000.

The Cost of Cancer

Cancer not only affects the daily lives and current and long-term health of Nevadans—it places a significant economic burden on those who are diagnosed, their caregivers and families, employers, and the healthcare system. Data from the National Cancer Institute (NCI) confirms that cancer is among the most costly medical conditions to treat in the U.S., with cost varying by stage at diagnosis, type of cancer, and type of treatment.[i]

Using national benchmarks from the NCI and adjusted for Nevada's population, the annual cost of cancer in Nevada exceeds $1.9 billion, with about $765 million in direct medical expenses and more than $1.1 billion in lost productivity and early mortality.[ii] In addition to cancer treatment costs covered by insurers, patients and their families are burdened with out-of-pocket costs for treatment such as through deductibles and coinsurance, illness-associated costs such as medications and transportation, and long-term costs for disease surveillance and management of late effects of cancer.

This financial burden comes at a time when income is often reduced for both the patient and their care partner, leading to potential difficulty paying for necessities such as housing and food along with possible long-term medical debt. According to the CDC's Chronic Disease Cost Calculator, a 1% reduction in tobacco use, obesity, and late-stage diagnoses could save Nevada tens of millions in medical and productivity costs each year.

Bridging Gaps

Addressing the Factors That Shape Cancer Risk and Outcomes

The crosscutting issues affecting cancer control in Nevada can be attributed largely to social determinants of health (SDoH), including access to healthcare, public health infrastructure, race and ethnicity, and environmental factors.

A two-track approach to overcoming the negative ramifications of SDoH in cancer control involves both mainstreaming these issues into all policy, systems, and environmental (PSE) change initiatives and implementing targeted interventions to address specific challenges. This dual strategy ensures that crosscutting issues like health equity, climate change, housing, and food insecurity are considered at every stage and level of community action, rather than being treated as isolated concerns.

Strategies to address crosscutting issues are embedded throughout this plan to ensure solutions benefit all Nevadans, and targeted interventions are recommended to address unique challenges faced by particular groups, such as supporting access to culturally affirming and trauma-informed care.

What is Trauma-Informed Care?

Trauma-informed care is a framework for understanding and responding to the effects of trauma in individuals, systems, and organizations. It aims to create safe and supportive environments that promote healing and recovery for people who have experienced trauma.

Social Determinants of Health (SDoH)

Social determinants of health are the conditions in which people are born, grow, live, work, and age, shaped by factors such as income, education, geography, access to healthcare, and social environments. These non-medical determinants play a crucial role in cancer risk, prevention, detection, treatment, and survivorship in Nevada. Recent research has found that SDoH may contribute to up to 70% of cancer cases and should be a significant focus, alongside clinical interventions, for cancer control efforts.[iii]

Key SDoH factors in Nevada include:

- **Race and Ethnicity**
- **Income and Insurance Status**
- **Health Literacy and Education**
- **Public Health Infrastructure**
- **Housing and Food Insecurity**
- **Environmental Exposures**
- **Access to Healthcare and Geography**

Race and Ethnicity

Race and ethnicity as a SDoH reveal disparities that are not simply the result of biological differences, but reflect a complex interplay of social, economic, environmental, and systemic factors. People who are racial and ethnic minorities are more likely to be uninsured, be of lower socioeconomic status, and have lower health literacy and trust in the healthcare system. They are also more likely to face discrimination in the healthcare system, in part because of a lack of racial and ethnic diversity in medical professions and a lack of representation in clinical research.

Hispanic Nevadans **are more than twice as likely to have never been screened for colorectal cancer** than white Nevadans, and those who have been screened are less likely to be up to date with screening.[iv]

Black women ages 40 and over **are more likely to be screened for breast cancer** than white or Hispanic women, but are also **more likely to die from the disease** despite better uptake of early detection.[v]

Black, Hispanic, and Native American women **are more likely to be diagnosed with breast cancer** at a later stage than white women.[vi]

Native Americans **are more likely to be diagnosed with and die from liver cancer** than white Nevadans. More than half of liver cancer cases are diagnosed at a late stage.[viii]

Black men **are more likely to be diagnosed with prostate cancer** and more than twice as likely to die of the disease than white men.[vii]

Cancer doesn't affect all Nevadans equally

Racial and ethnic disparities persist in cancer screening, diagnosis, and outcomes.

Individuals from minority populations, including Black and Hispanic communities, are less likely to undergo recommended cancer screenings, such as those for colorectal cancer. For certain malignancies, including breast and prostate cancers, Black individuals are more frequently diagnosed with more aggressive tumor subtypes compared to their white counterparts.[x] Early detection is particularly critical for these cancers, as it increases the likelihood of successful treatment. Notably, while Black women in Nevada are more likely to be screened for breast cancer than white women,[xi] they continue to be diagnosed and die from the disease at much higher rates[xii] highlighting ongoing inequities in cancer outcomes despite timely screening.

Health Literacy and Education

Other people who are part of racial and ethnic minority groups may have language and cultural barriers that can keep them from accessing healthcare. This is compounded by a complex healthcare system that at times doesn't take into account individuals with lower health literacy. The use of plain language, translators, multi-lingual and culturally tailored materials, and navigators can be solutions to these challenges,[xiii] but must be broadly applied to create a system that is both welcoming and accessible for all Nevadans.

Housing and Food Insecurity

Housing and food insecurity have sharply increased in Nevada over the past decade with significant consequences for cancer prevention, treatment, and outcomes. Housing costs have outpaced income growth across the state, and Nevada now ranks second in the nation for cost-burdened renters and fifth for excessively cost-burdened homeowners. Extremely low-income households have fewer affordable housing options than any other state.[xiv] Data from the CDC shows an average of nearly 13% of Nevadans across all counties are housing insecure. Additionally, research from Feeding America shows that 15% of Nevadans are food insecure, and in some rural counties 18-22% of residents are food insecure.[xv]

Insecure housing and lack of nutritious food can lead to chronic stress, which is linked to biological changes that can increase cancer risk and progression. Additionally, they can lead to unhealthy behaviors, such as tobacco and drug use, sedentary lifestyle, and poor diet, further elevating cancer risk.[xvi] Both issues can also create a situation where an individual must choose between basic needs and healthcare, resulting in skipped and postponed appointments, delayed treatments, and poor medication adherence. The lack of stable housing can also lead to frequent moves resulting in the lack of a primary care physician and foregoing recommended cancer screenings, reducing opportunities for early detection.

Researchers have found that people who are unhoused have a cancer incidence four times higher than those who are housed, with mortality rates twice as high.[xvii] The financial burden of cancer care can further destabilize those who are already struggling to meet basic needs, and cancer survivors with housing and food insecurity face greater difficulty in managing their health, leading to poorer quality of life.

13% of Nevadans face housing insecurity

15% of Nevadans face food insecurity

4x Individuals with housing insecurity experience four times the rate of cancer compared to those with stable housing.

Access to Healthcare and Geography

Access to healthcare is a challenge for many Nevadans, including those living in rural communities, who are uninsured or underinsured, who lack reliable transportation, or who have lower health literacy or lack of trust in the existing healthcare landscape. Nevada's healthcare system is decentralized throughout much of the state, with cancer care delivered almost entirely in urban centers and cancer screening services limited in rural and frontier communities.

In many states, healthcare systems offer an organized network of people, institutions, and resources to deliver coordinated and comprehensive care. However, **in Nevada there are very few of these systems in place**, and they are almost wholly focused in urban centers, leaving many to navigate the healthcare landscape with less support.

Nevada has also long faced a shortage of healthcare professionals, with the majority of Nevadans living in federally designated healthcare professional shortage areas. Over the past decade, the number of active licensed primary care physicians per 100,000 population has declined after a short-lived increase in 2019. In 2024 there were 65.9 active primary care physicians per 100,000 residents in Nevada, with just 60.1 per 100,000 in rural and frontier counties,[xviii] whereas the national average is closer to 86 direct patient care primary care physicians per 100,000.[xix] Specialists, including oncologists, geneticists and genetic counselors, pediatric specialists and subspecialists, radiologists, and many others, are also in short supply across the state.

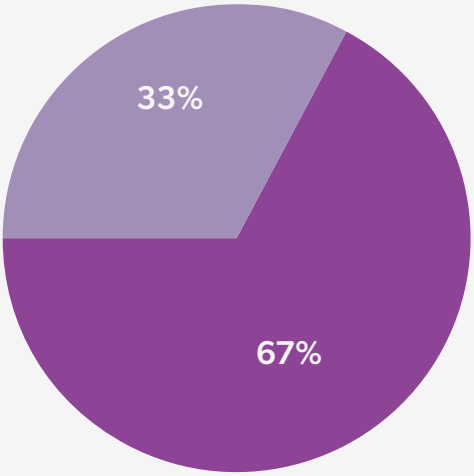
65.9 active primary care physicians per 100,000 residents in **Nevada**

86 active primary care physicians per 100,000 residents **nationwide**

Nevada's Division of Insurance adopted the Federal 2026 Network Adequacy Standards for qualified health plans to require insurers maintain a network of healthcare professionals that is sufficient to provide a plan's covered services. The baseline standards set adequate access to primary care clinicians as within 10 miles in metropolitan counties and within 30 miles in rural counties. However, 11 of Nevada's rural counties qualify for alternative standards for many clinician types. In six counties, adequate access according to standards could result in a 60–80 mile drive to visit a primary care clinician for adults and up to 240 miles for a pediatrician. Access to oncology services is considered adequate at a distance of anywhere from 60 to 90 miles in some rural counties, or as much as 240 miles for counties with extreme access considerations.[xx]

Nevada's congressional and state representatives have championed numerous policies designed to train, attract, and retain qualified physicians and nurses, including incentives to practice in rural communities and tuition reimbursement in exchange for a commitment to work in a health professional shortage area. State legislators have passed bills to expand licensure of health professionals, among other efforts, resulting in many more advanced practice registered nurses in the state. Nevada has seen a 56% increase in medical school enrollment over the past decade,[xxi] nearly twice the national average, and Nevada's senators are advocating for a greater allotment of graduate medical education slots.

Access to Healthcare and Geography



However, Nevada must also work to retain physicians trained in the state. In 2023, barely 33% of medical school graduates stayed in Nevada to practice medicine and just 53% of those who completed graduate medical education in Nevada stayed in the state.[xxii] While there is room for improvement, these results show that with continued effort the state can attract and retain medical students and physicians to reduce healthcare professional shortages.

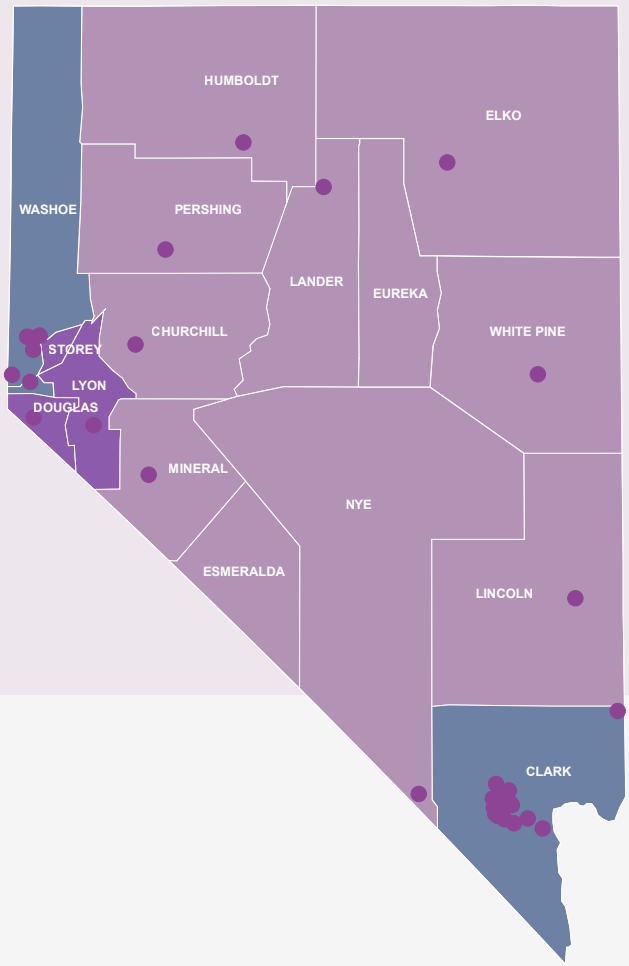
Medical graduate students who stayed in Nevada

Medical graduate students who left Nevada

Accessing healthcare, however, is more than just being able to make an appointment with a doctor. Many people face transportation barriers that keep them from seeking the care they need. In a 2024 survey of people living in rural and frontier communities across the West, researchers at Huntsman Cancer Institute found that 49% of those in Nevada could not get the healthcare they needed near their home.[xxiii] More than half of respondents in rural and frontier communities in Nevada visited a doctor or other health professional in the last year, but the likelihood decreased as their remoteness increased. Fewer than a third had seen a doctor in the past year for a check-up or physical.[xxiv]

The same study found that Nevadans in rural and frontier communities often traveled 45 minutes—and sometimes up to 2 hours and 45 minutes—to get screened for cancer. Treatment for a serious condition, such as cancer, requires on average three hours of travel, but for some it can be up to four hours. Residents who responded said they were willing to travel for these services, but often the time to reach healthcare was more than they would like to spend traveling.[xxv] Expansion of telehealth is a way to bring healthcare closer to home, and about half of rural and frontier Nevadans said they used email or the internet to communicate with a doctor's office or look up test results. However, 7% of survey respondents in Nevada's rural and frontier communities said they didn't have internet access at home, restricting their ability to use telehealth.[xxvi] Nevada's Office of Science, Innovation, and Technology has prioritized expanding high-speed internet to underserved and unserved areas across the state. Yet, development of infrastructure and deployment of service takes time, and telehealth access will continue to remain a challenge for some during this plan's timeframe.[xxvii]

Access to Healthcare and Geography



The majority of Nevada counties are rural or frontier, but most hospitals are in one of two urban counties.

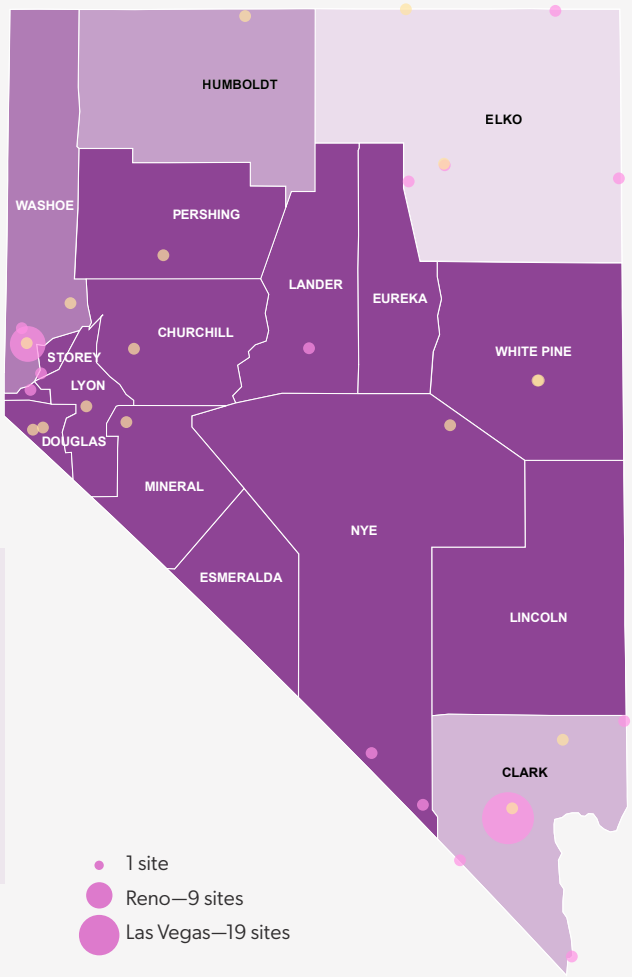
- Hospitals
- **Urban Counties** (Carson City, Clark & Washoe — highest population centers)
- **Transition Counties** (Douglas, Storey & Lyon — fast-growing suburban/rural mix)
- **Rural Counties** (all other counties — lower population density)

The majority of Nevada's counties have 100% of their residents living in Primary Medical Care Health Professional Shortage Areas.

Percentage of county residents living in a primary medical care HPSA:

46.5 — 100

- Federally Qualified Health Center
- Tribal Health Center



Data Source: Nevada Health and Human Services, Indian Health Services, HRSA, Nevada Rural and Frontier Health Data Book 12th Edition

Income and Insurance Status

A lack of health insurance is another barrier to accessing healthcare, affecting 10.8% of Nevadans based on the U.S. Census Bureau's 2023 American Community Survey.[xxviii] This figure represents a steady decline in the percentage of uninsured Nevadans over the past 15 years following implementation of the Affordable Care Act (ACA) and Medicaid expansion in Nevada. Nevadans ages 19-54 are more likely to be uninsured, as are individuals who lack a high school diploma, or who are Hispanic or Latino, American Indian, or mixed race.[xxix] Additionally, although people who are Hispanic or Latino account for 30% of Nevada's population, they account for more than half of those who are uninsured.[xxxi]

More than one-third of Nevadans who are uninsured have incomes two to four times the federal poverty level, earning enough to disqualify them from Medicaid but not enough to afford health insurance—and not receiving employer-sponsored health insurance.[xxx]

During the COVID-19 pandemic, the rate of people who were uninsured increased slightly, due largely to job loss and either the loss of employer-sponsored healthcare or the inability to pay for marketplace insurance policies. But the increase was short-lived. The public health emergency also suspended typical re-enrollment eligibility requirements, greatly expanding the number of people who were able to access healthcare with Medicaid coverage. The number of Nevadans covered by Medicaid has declined gradually since mid-2023, and enrollment as of January 2025 was just under 792,000.[xxxii]

Medicaid is a cornerstone of cancer control efforts in Nevada, particularly for low-income, uninsured, and underserved populations. Nevada is one of 41 jurisdictions that approved Medicaid expansion under the Affordable Care Act. The state's Medicaid program provides routine healthcare, including cancer screening and treatment, for hundreds of thousands of Nevadans. This helps to alleviate the financial burdens associated with treatment of cancer and other chronic diseases, for the state and those who are insured, by supporting disease prevention and early detection, both of which lead to lower costs for treatment and improved outcomes.

7.9%

decline in people covered by Medicaid since 2023

Data Source: usafacts.org/answers/how-many-people-are-on-medicaid-in-the-us/state/nevada/

Public Health Infrastructure

Over the past five years, Nevada's public health infrastructure has seen notable developments driven by both necessity and strategic planning. The COVID-19 pandemic spotlighted the importance of healthcare and public health and resulted in numerous changes. These included modernization and expansion of local health districts, a first-ever statewide health improvement plan, investment in new health facilities, and data and technology enhancements to improve surveillance, reporting, and decision-making with regard to infectious and chronic diseases. This progress, however, is tempered by ongoing funding challenges and political upheaval.

Nevada's Silver State Health Improvement Plan (SSHIP), released in 2023, called for modernization and improvement of the state's data collection, analysis, and dissemination and resulted in investments in the Nevada Central Cancer Registry and the Department of Health and Human Service's Office of Analytics. Together, these two departments have moved to enhance cancer data collection through improvements to cancer reporting systems and have launched online dashboards to share cancer incidence and mortality data. However, opportunities are available to increase data collection through cloud-based and interoperable systems, and by collecting additional data, such as sexual orientation, gender identity, and clinical trials participation. More extensive data reporting, including robust epidemiological review, would improve Nevada's ability to understand its cancer burden and respond accordingly. In fact, the lack of thorough epidemiologic review of Nevada's cancer burden limits the ability of cancer control and other public health professionals to respond to the needs of Nevadans.

Nevada's SSHIP also called for greater investment in the state's public health system with funding that is "appropriate, flexible, and sustainable." Much of Nevada's public health infrastructure—notably, state program staff—is funded through federal grants, with inadequate investment from the state. Federal funds from the Centers for Disease Control and Prevention (CDC) support the Nevada Central Cancer Registry, Women's Health Connection breast and cervical screening program, Comprehensive Cancer Control Program, and much of its Tobacco Control Program, and, through subgrants from the State, community nonprofits tasked with leading and executing much of Nevada's cancer control efforts.

Limited epidemiologic review hampers understanding of cancer and other health burdens.

Data systems remain fragmented, not fully interoperable, and lack cloud-based infrastructure.

Important demographic and clinical trial data are missing.

Heavy reliance on federal grants; state funding is insufficient and unstable.

Public health staffing capacity is limited.

Political and funding instability threaten continuity and sustainability of programs.

Environmental Exposures

Often called "ecological determinants of health," planetary health and environmental factors have a wide-ranging impact on human health, cancer control, and the ability for healthcare systems to operate. These factors are often interconnected and can include extreme weather, air and chemical pollution, biodiversity loss, habitat degradation, or resource scarcity, and they have the potential to affect human health directly or indirectly, or to cause disruptions to infrastructure and systems that are vital to healthcare.

Nevada is home to the two fastest warming cities in the nation.

Climate change, characterized by long-term shifts in global temperatures and weather patterns, is a well-documented environmental factor in Nevada. The state is home to the two fastest-warming cities in the nation: Las Vegas and Reno. Both cities are affected by urban heat islands, which are areas within a city that experience higher temperatures than surrounding rural areas, particularly during the night. These urban heat islands are caused by a combination of development and built environments such as buildings and roads that attract and retain heat and human activity that generates heat, such as operating vehicles. In comparing the past 30 years to the previous 30 years, National Weather Service data shows that annual mean low temperatures in Las Vegas increased up to seven degrees and mean high temperatures increased up to one degree. Elevated temperatures in these zones increase ozone and particulate pollution, both linked to higher cancer risks, particularly lung cancer. Extreme heat also prevents people from participating in outdoor physical activity and can limit mobility. Recent research has mapped urban heat islands in both cities[xxxiii] and shows that areas most affected by heat islands are more likely to be found in predominately lower-income and non-white communities.[xxxiv]

More extreme weather—including drier conditions, more intense winds, and rising temperatures—have also contributed to more frequent and larger wildfires across the West. Wildfire smoke is now the dominant source of particulate pollution during fire season in Nevada. This particle pollution is known as PM2.5, which refers to particulate matter with a diameter of 2.5 micrometers or less, has increased from about 11 days of high PM2.5 every four years to about 17 days each year.[xxxv] There is a 9% increase in lung cancer incidence or mortality for every 10 µg/m3 increase in PM2.5. Wildfires, especially those that burn through buildings, vehicles, and other non-plant materials, also emit pollutants, including human carcinogens, that can contaminate water and soil and thus remain in the environment long after air quality improves.[xxxvi]

518%

increase in days with high particle pollution in Nevada

Environmental Exposures

Threats from heat, extreme weather, and wildfire have the potential to affect more than just air quality and ambient temperatures. These factors can result in disruptions to community infrastructure including power, water, and roads, which can threaten access to healthcare, disrupt supply chains, and hamper food production at farms and ranches. Industrialized food production, which is threatened by climate change-related disruptions, also contributes to climate change through the clearing of land, greenhouse gas emissions from machinery and animals, emissions from production and transportation, and pollution from fertilizers, herbicides, pesticides, packaging, and production.[xxxvii] Researchers have linked agricultural pesticides to increased rates of bladder cancer, leukemia, and lymphoma in Nevada, and to a lesser extent increased rates of lung, pancreatic, and colorectal cancers, and have suggested the association between cancer and pesticides is comparable to smoking for some cancer types.[xxxviii] Agriculture contributes significantly to Nevada's economy, specifically to many rural communities, and is primarily focused on cattle and alfalfa production. Although, several crops are grown in the state including potatoes, barley, wheat, corn, oats, onions, garlic, and smaller crops of fruits and vegetables.[xxxix]

Some pesticides in Nevada have cancer risks comparable to smoking.

Legacy mining contamination continues to affect water, soil, and air decades later.

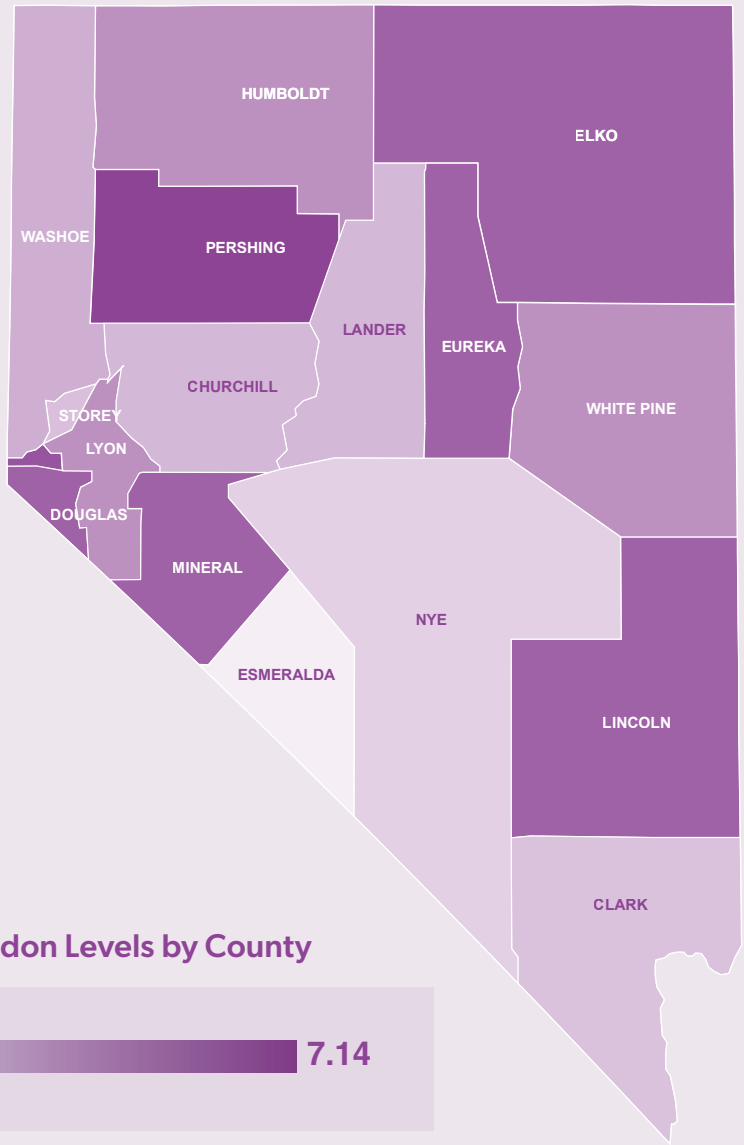
Mining is another key industry in Nevada, with gold, copper, and lithium extracted from the earth, among other ores. Many types of mining use chemicals that have the potential to pollute the water, soil, and air, and that have been linked with increased risk of cancer. These chemicals include cyanide, mercury, arsenic, cadmium, and lead, some of which are linked to skin, lung, bladder, kidney, prostate, and breast cancer.[xl] There are more than two dozen gold mines in the state, including some of the largest open-pit gold mines in North America and open-pit gold mining is one of the highest potential mining threats to the environment.[xli] While Nevada regulates emissions in modern mining operations to mitigate risk, legacy contamination remains a challenge.

Many of these ecological determinants intersect with social and economic factors, amplifying cancer disparities. Often, the use of chemicals in the environment—whether for agriculture, mining, military, or some other use—affects individuals of color, those in indigenous or rural communities, and those with less access to healthcare. For example, the Yerington Paiute Tribe's water supply is contaminated with carcinogens including arsenic, chromium, and uranium from the former Anaconda Copper Mine in Lyon County, now designated by the Environmental Protection Agency as a Superfund site because of the contamination.[xlii] Residents at the Duck Valley Indian Reservation in Owyhee, who are members of the Shoshone Paiute Tribe, have been exposed to years of contamination from two federal Bureau of Indian Affairs buildings that in 1985 leaked thousands of gallons of heating oil, and also were the source of contamination from arsenic, copper, lead, cadmium, and the two chemicals that make up Agent Orange, which were both used in the 1970s as herbicides in the area's canal system. Epidemiologists from American Cancer Society have said linking specific cancer cases to the chemical exposure would be complicated and more research needs to be conducted. Despite this, the tribe has logged hundreds of illnesses over more than three decades that could be cancer.[xliii]

Environmental Exposures

While naturally occurring, radon is no less threatening than other environmental factors in its risk for causing lung cancer. Radon is a colorless, odorless, tasteless radioactive gas that is formed from the breakdown of uranium and radium in soil, rock, and water. It is present at varying levels in Nevada with some communities more affected than others. The best way to reduce the risk of radon-related lung cancer is to test and mitigate homes, schools, and workplaces for radon gas.[xliv]

Research is ongoing as to the carcinogenic effect of many substances in our environment. However, cancer control efforts can address this broad spectrum of ecological determinants while prioritizing health equity for the state's most vulnerable populations. This can be achieved through ongoing research and policy action to mitigate risks and improve access to effective prevention, early detection, treatment, and survivorship resources across diverse environments.



Nevada Average Radon Levels by County

1.4 — 7.14

Map: Nevada Cancer Coalition
Data Source: NV Radon Education Program
Averages are for homes and buildings tested

Navigating Change

Innovation and Policy Reform

Cancer control in the United States is being transformed by rapid advancements in technology that are improving outcomes, expanding access, and creating more personalized care. At the same time, shifts in policy have created a more dynamic environment in which cancer researchers, physicians, and public health professionals operate.

Innovations in screening technology, methods, and modalities have improved physicians' ability to detect cancers early while also reducing potential patient harms and improving specificity and sensitivity. Some examples include:

Innovations in Screening Technology

- Artificial intelligence and machine learning have improved imaging analysis and accuracy to reduce false positives and helped clinicians to develop risk stratification models to personalize screening schedules.
- Advanced imaging, such as 3D mammography and low-dose CT have improved cancer detection rates, improved comfort, and lowered radiation doses.
- Non-invasive blood-based, stool-based, and liquid biopsy cancer detection tests identify cancer-specific biomarkers, such as DNA, RNA, or proteins, for numerous cancers that lack current screening protocols.
- At-home screening options, such as HPV self-collection for cervical cancer or stool-based testing for colorectal cancer, have reduced barriers to screening including for those with limited access to healthcare or who have been exposed to trauma.
- Regulatory and guideline improvements have updated protocols to improve risk-based screening, such as in instances where the patient has a family history, dense breast tissue, or other risk factors.

Many of these same innovations have impacted treatment as well. Artificial intelligence and machine learning are being used to predict therapy outcomes and develop advanced imaging for robotic-assisted procedures. Genome editing and precision medicine is paving the way for targeted therapies and cancer vaccines. And large-scale data integration and research collaboration is allowing national data ecosystems and tumor atlases to be aggregated and analyzed, accelerating research and enabling more personalized care.

It is important to recognize that changes in public health policy and funding can have significant effects on clinical research, cancer control efforts, and patient care. Federal investment has been the foundation of nearly every major advancement in cancer research, prevention, detection, and treatment in the U.S. over the past five decades. Reducing resources available to research institutions slows the pace of scientific discovery and limits opportunities for innovation. Additionally, federal funding and support have played a crucial role in Nevada's cancer control initiatives and have improved access to healthcare for thousands of Nevadans. Changes in public health policy and broader federal policy have also affected the collection and dissemination of public health data. These developments may impact the availability and reliability of data, which is essential for monitoring cancer trends, setting measurable goals, and evaluating progress.

To ensure the long-term stability and growth of cancer control efforts, a diversified approach to public health funding—including contributions from state and local sources—would be beneficial. This would enable Nevada to address state-specific priorities and strengthen its public health infrastructure and data collection capabilities while also aligning with broader public health objectives and ensuring sustainability.

Regardless of the specific mix of funding sources, continued partnership, expertise, and support from federal health agencies such as the CDC remain vital. These resources help sustain Nevada's progress in cancer prevention, early detection, survivorship, and surveillance, building on more than two decades of dedicated work in the state.

Funding Cancer Control in Nevada

National Comprehensive Cancer Control Program

National Breast and Cervical Cancer Early Detection Program

National Program of Cancer Registries

National Tobacco Control Program

Substance Abuse and Mental Health Services Administration

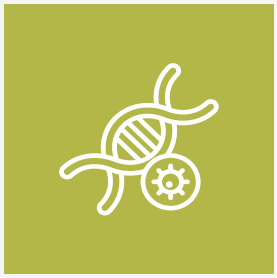
U.S. Environmental Protection Agency

Fund for a Healthy Nevada – Tobacco Control Funding

State of Nevada Division of Public and Behavioral Health – Breast and Cervical Screening and Cancer Registry Funding

Goals and Objectives

Prevention



Genetics

Early Detection

Diagnosis & Treatment

Survivorship & Palliative Care

Cancer Surveillance

Clinical Research

Pediatric and AYA Cancers

Prevention

Goal: Prevent cancer by reducing exposure to risk factors.

Reducing Nevada's cancer burden begins with prioritizing prevention. The latest research finds that at least 40% of cancers cases and almost half of cancer deaths are caused by modifiable risk factors—those that can be prevented.[xlv] The direct behavioral, physical, and environmental risks for cancer include smoking and tobacco use, excess body weight, alcohol consumption, physical inactivity, poor diet, exposure to ultraviolet radiation and radon, and infections such as human papillomavirus (HPV) and hepatitis C. Less direct, yet still important to acknowledge, are environmental factors such as exposure to secondhand smoke, occupational exposure to carcinogens, and cancer-causing contaminants in our air, water, and food.

Risk Factor	Cancer Cases Attributable	Cancer Deaths Attributable	Top Cancer Types
All risk factors combined	40%	44%	
Tobacco smoking and secondhand smoke	23.1%	29.2%	Lung, larynx, pharynx, oral cavity, esophagus, bladder, and kidney
Excess body weight	7.6%	7.3%	Colorectal, breast, esophagus, gallbladder, kidney, liver, and pancreatic
Alcohol consumption	5.4%	4.1%	Liver, breast, mouth, throat, esophagus, and colon
Ultraviolet radiation	4.6%	1.3%	Skin
Poor diet	4.2%	4.3%	Colorectal, stomach, breast, and pancreatic
Infections	3.4%	3.5%	Liver, cervix, stomach, oropharyngeal, penile, anal
Physical inactivity	3.1%	2.5%	Colorectal, endometrial, lung, and breast

Proportion of cancer cases and deaths attributable to selected preventable risk factors for U.S. adults age 30 or older. Cancer cases attributable to radon exposure are not included due to inadequate data/data limitations.[xlvi]

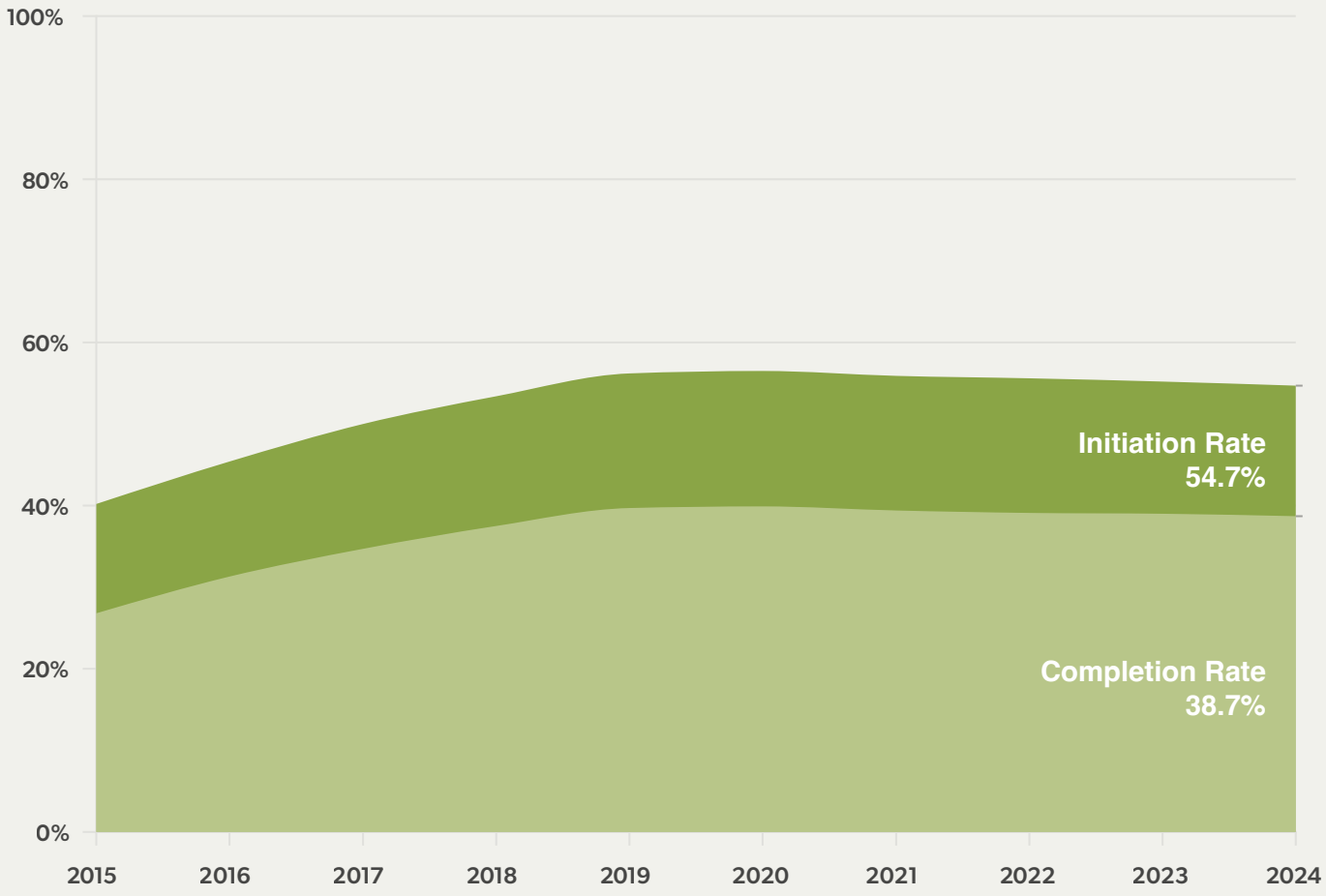
40% **of cancer cases and almost half of cancer deaths could be prevented.**

Reversing the Trend for HPV Vaccination

HPV vaccination rates in Nevada improved steadily until the COVID-19 pandemic, which caused progress to stall and decline slightly, especially among adolescents and young adults in rural areas. Recent years have not seen a full recovery to pre-pandemic coverage levels, and disparities by geography and gender persist. Nearly half of Nevada adolescents ages 13–17 haven't received a first dose of HPV vaccine, and of those who did receive a first dose, nearly one-third did not receive a second. Policy changes have expanded adult vaccination, but adolescent coverage—critical for cancer prevention—remains below optimal levels.

HPV Initiation and Completion: 2015-2024

HPV vaccination rates in Nevada have stalled after several years of growth.



Data Source: Nevada WebIZ • Data provided by Nevada DPBH Office of Analytics

Prevention: HPV Vaccine

Objective: Increase HPV vaccine series initiation and completion among Nevada youth.

Strategies

- Establish standard recommendation language for HPV vaccination regarding age of initiation.
- Support efforts and campaigns to increase HPV vaccination among Nevada youth.
- Ensure language accessibility and equity in all HPV vaccination material and campaigns.
- Recruit experts and champions to participate in HPV vaccination campaigns, support educational opportunities, and participate in other collaborative efforts.
- Educate clinicians on evidence-based strategies to increase initiation and completion of the HPV vaccination series.
- Support ongoing policy and advocacy efforts to increase HPV vaccination rates.

HPV Indicators		
Percentage of 9-year-olds who received at least one dose of HPV vaccine[1]	Baseline: 9.1%	Target 9.6%
Percentage of youth age 17 or younger who have completed the HPV vaccination series[1]	Baseline: 38.7%	Target 66.1%

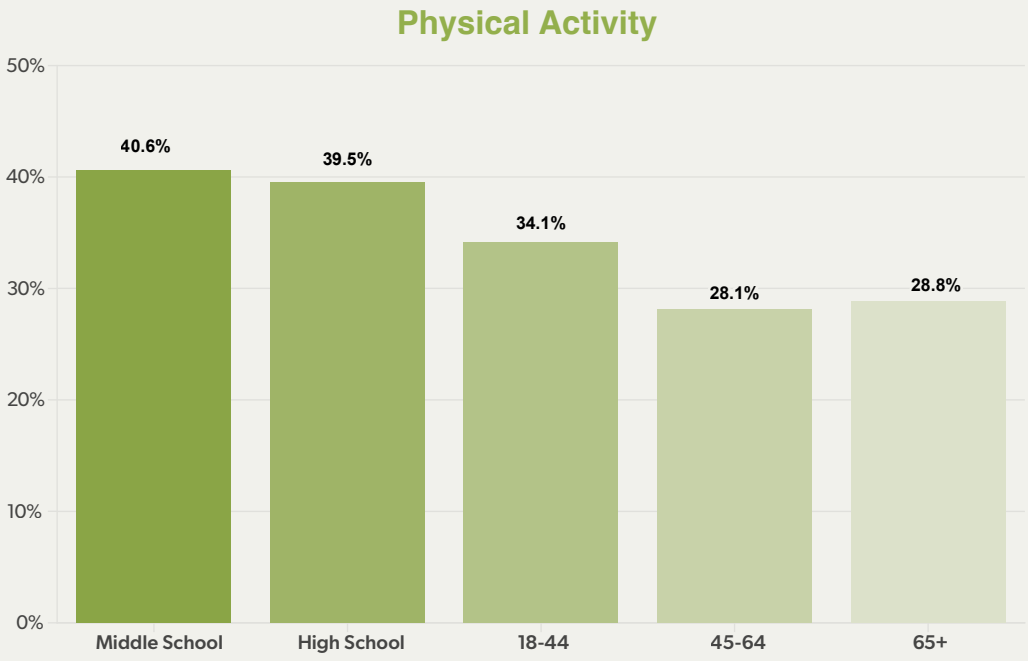
[1]*Data source: Nevada State Immunization Program*

Physical Activity and Nutrition to Reduce Cancer Risk

While no single food or type of physical activity can prevent cancer, evidence strongly demonstrates the cumulative effect of healthy diet and regular physical activity on reducing cancer risk. Years of research have found diets high in fiber that prioritize plant-based foods, whole grains, lean meats and fish, and limit processed and red meats, refined sugars, and alcohol are linked to reduced overall cancer risk. Multiple studies have also shown that physical activity—from light-intensity activities such as household chores or walking to moderate to vigorous exercise—can reduce risk for multiple cancers, regardless of body weight or other health conditions.[xlviii, xlix, l]

Physical activity among Nevadans, on average, is at its highest among youth and tapers as people age. Fewer than half of middle school students, and one-third of middle aged and older adults, get the recommended amount of physical activity and less than one-third of middle-aged and older adults do.

Data Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, BRFSS, 2023 and YRBS 2023



Percentage of each group meeting physical activity recommendations.

Both a healthy diet and physical activity can play a role in maintaining a normal body weight and avoiding obesity and its related health complications. However, innovations in the treatment of obesity with GLP-1 receptor agonists, such as semaglutide, should also be recognized as tools to reduce the risk of obesity-associated cancers and address some biological mechanisms that increase cancer risk, such as inflammation and poor metabolic health.[li] Researchers have found GLP-1 RAs can significantly reduce the risk of at least 10 obesity-related cancers including colorectal, kidney, liver, ovarian, and pancreatic cancers.[lii]

There are also factors beyond an individual's personal behaviors that may influence one's ability to engage in physical activity and consume a nutritious diet. Broader community approaches to address the root causes of inactivity and poor nutrition require engagement with community leaders to foster active transportation and access to parks and outdoor recreation, reduce air pollution and heat islands, increase tree canopy, and develop food systems that improve access to grocery stores, farmers markets, and community gardens.

Alcohol and Cancer

Alcohol is a known carcinogen, increasing the risk for at least seven types of cancer including mouth, throat, larynx, esophagus, breast, liver, and colorectal. Researchers first established the link between alcohol and cancer in the 1980s, and the body of research showing the causal link between alcohol and cancer has only grown since then. Despite this, fewer than half of U.S. adults are aware that alcohol can increase cancer risk, and in some instances, they mistakenly believe it can reduce cancer risk. An estimated six in 10 U.S. adults say they consume alcohol, and in Nevada, 17% of adults report heavy or binge drinking.[liii, liv]

Heavy Drinking and Binge Drinking

Heavy drinking is defined as 14 drinks per week for men or seven drinks per week for women. Binge drinking focuses on a large quantity of drinks on a single occasion, measured as five or more drinks for men or four or more drinks for women. A standard drink of alcohol is generally 12 ounces of beer, five ounces of wine, or 1.5 ounces of distilled spirits.

Alcohol increases cancer risk by:

- Breaking down into substances that damage DNA and increase oxidative stress and inflammation in the body.
- Altering hormone levels, including estrogen, which can increase breast cancer risk.
- Dissolving carcinogens from other sources, especially particles from tobacco smoke, that are more easily absorbed into the body.

Alcohol and tobacco use together increases cancer risk even more, and interventions that address both can be especially effective at reducing Nevada's cancer burden. Lessons learned from tobacco control can be applied to reducing alcohol use, and best practices, such as reducing stigma and de-normalizing consumption, may be especially effective.

Prevention: Fitness and Nutrition

Objective: Improve the fitness and nutrition of children, adolescents, and adults in Nevada.

Strategies

- Educate the public on obesity and alcohol consumption as risks for cancer.
- Expand access to free, safe, and appealing water sources in schools and eliminate access to sugar-sweetened drinks.
- Promote education and resources for lactating parents to increase chest/breastfeeding rates to reduce childhood obesity.
- Support and implement evidence-based strategies that promote healthy behaviors in places where people live, learn, work, play, and worship.
- Support efforts to strengthen evidence-based school wellness policies to improve nutrition and physical activity, including universal school lunches.
- Support policies and programs for active living, including built environment and community design.
- Support policies and programs that increase access to nutritious food and reduce food insecurity.
- Advocate for sustainable funding to support obesity surveillance, prevention, and treatment programs.
- Support efforts to expand insurance coverage for evidence-based healthy weight management programs and anti-obesity medications.

Physical Activity and Nutrition Indicators

Percentage of elementary, middle, and high school students who have a healthy weight based on BMI[1]	Baseline: 71.1% | 65.6% | 62.8%	Target: 75% | 69% | 66%	
Percentage of adults who are physically active[2]	Baseline: 31%	Target: 35%	US: 30.4%
Percentage of adults who are heavy drinkers[2]	Baseline: 6.7%	Target: 5.5%	US: 6.1%

[1]Data source: School Screening in Nevada Dashboard; [2]Data Source: BRFSS

A Look at Tobacco Disparities

The tobacco industry has targeted some communities more than others for decades through advertising and promotions, often focusing on individuals who are people of color or members of the LGBTQ+ community. Menthol products have been heavily marketed to Black and LGBTQ+ people and are known to be more appealing to new or younger tobacco users and harder to quit. Data from the 2023 Adult Tobacco Survey shows that Black, Pacific Islander, American Indian and Hispanic Nevadans smoke tobacco at higher rates, with menthol tobacco smoked by more than half of Black tobacco users. People who are not heterosexual use tobacco at more than twice the rate of heterosexual people in Nevada, are seven times as likely to use smokeless tobacco, and are more than four times as likely to use e-cigarettes. However they are less likely to have been advised to quit tobacco at their last doctor's visit.[lv]

The CDC notes that increased stress and discrimination faced by many people in communities of color or who are LGBTQ+ makes individuals in these groups more likely to smoke or use tobacco and e-cigarettes.[lvi]

E-Cigarettes: Should We Worry?

While decades of research have firmly established the link between smoking and tobacco use to cancer, research on the cancer risks caused by vaping and e-cigarettes remains preliminary but increasingly concerning. The aerosols inhaled when vaping contain harmful chemicals that are known carcinogens which can damage DNA and increase inflammation—both key factors in cancer development. Dual users of cigarettes and e-cigarettes have a significantly higher risk of lung cancer than smoking alone.[vii, lviii]

Objective: Decrease the percentage of youth (grades 9–12) who have reported smoking cigarettes or using electronic vapor products in the past 30 days.

Strategies

- Decrease youth and young adult exposure to commercial tobacco, vapor, and related products.
- Expand and promote awareness of cessation resources designed for youth and young adults.
- Promote stronger tobacco retail licensure requirements to increase compliance with laws and policies restricting minors' access to tobacco and electronic smoking devices.
- Advance policy to further regulate and curtail the sale and use of tobacco, vapor, and related products to reduce youth access.

Prevention: Tobacco and Vaping

Objective: Reduce the percentage of adults who smoke and increase the percentage of adults who are former electronic smoking device users.

Strategies

- Increase access and referrals to tobacco cessation services and resources in health care settings and via educational campaigns.
- Educate stakeholders and decision-makers about evidence-based policies and programs to increase cessation.

Objective: Improve the Nevada Clean Indoor Air Act (NCIAA) that prohibits smoking in public places and worksites by decreasing the number of exemptions.

Strategies

- Collect, evaluate, and share data on secondhand smoke and emissions from electronic smoking devices.
- Support modernization of the NCIAA and related statutes.
- Support policies for smoke-free and vape-free workplaces by continuing to educate lawmakers, business owners, and the general public on the benefits of smoke-free workplaces.

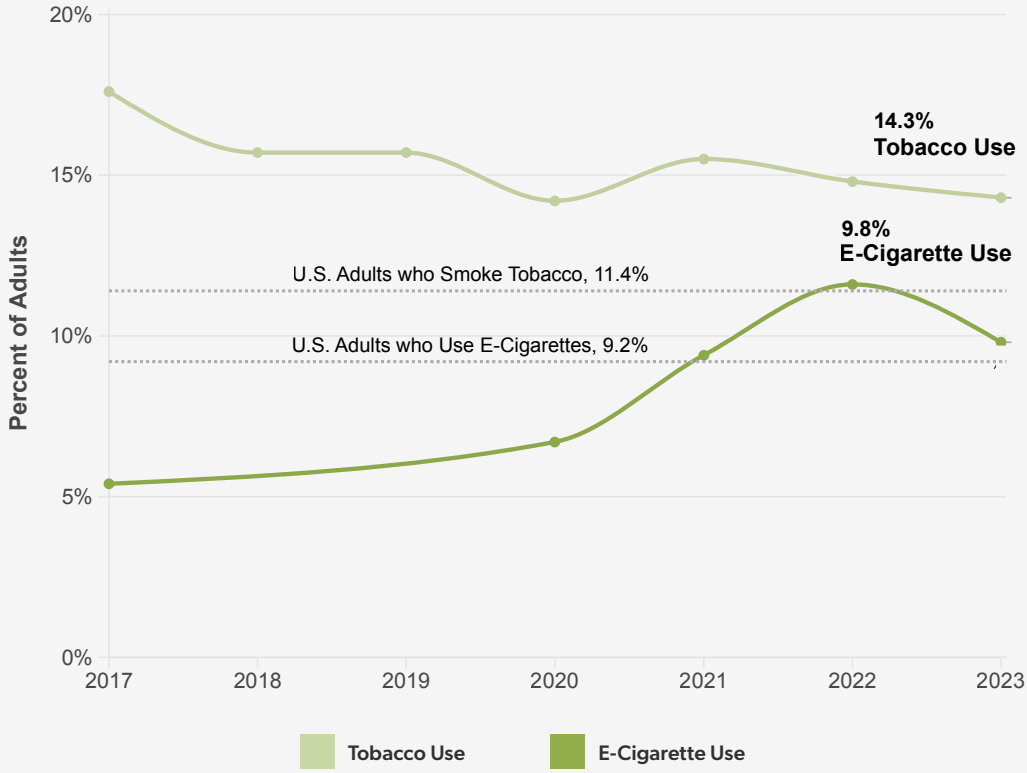
Tobacco Indicators			
Youth Who Smoked Tobacco, past 30 days[1]	Baseline: 2.9%	Target: 2.5%	US: 3.5%
Youth Who Used Vapor/E-Cigarette Products, past 30 days[1]	Baseline: 15.1%	Target: 14.5%	US: 16.8%
Adults Who Smoke Tobacco[2]	Baseline: 14.2%	Target: 13.5%	US: 12.1%
Former Electronic Vapor Users[2]	Baseline: 22.1%	Target: 23.9%	US: 19.4%
NCIAA Exemptions Eliminated[2]	Baseline: 0%	Target: 2%	

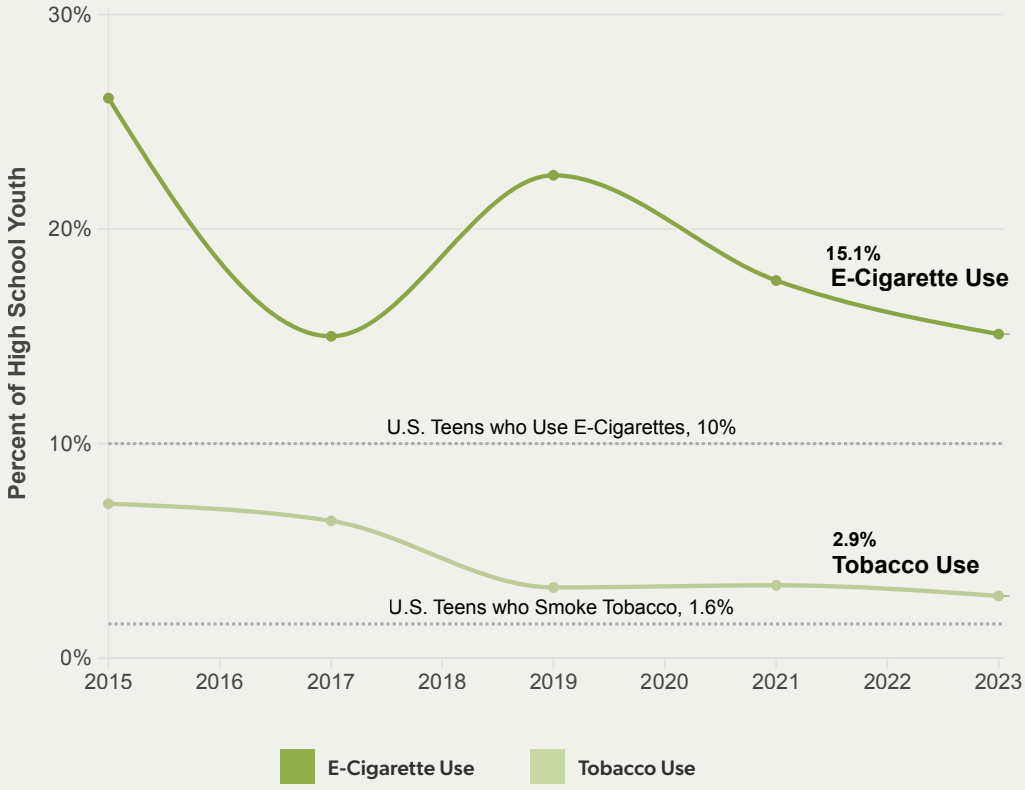
Prevention: Tobacco and Vaping

Percent of Adults Who Smoke or Use E-Cigarettes

The percentage of adults in Nevada who smoke tobacco has declined steadily over the past seven years but is still higher than the national average. E-cigarette usage in Nevada is also higher than the national average, but has started to decline.

Data Source: CDC Behavioral Risk Factor Surveillance System, via Nevada Office of Analytics





Youth Who Smoke or Use E-Cigarettes

High school students in Nevada smoke cigarettes and e-cigarettes at rates higher than the national average. Use has declined in recent years, however youth use e-cigarettes at a rate much higher than adults.

Data Source: CDC Youth Risk Behavior Survey, High School

Prevention: Decrease Radon Exposure

What is Radon?

Radon is a naturally occurring, colorless, odorless radioactive gas that can cause lung cancer when it becomes trapped indoors after entering a building through tiny cracks in the foundation. Testing homes, offices, schools, and other workplaces for the presence of radon can help to identify elevated levels of the gas. Once identified, systems can be put in place to mitigate radon exposure, such as by venting the gas outside.

Objective: Decrease exposure to elevated levels of radon.

Strategies

- Educate healthcare professionals and partners on radon risks, integrating testing questions into patient questionnaires and clinic practices.
- Distribute awareness materials in healthcare facilities.
- Support partner promotional campaigns on radon education, testing, and mitigation.
- Integrate radon education into broader public health initiatives, such as tobacco cessation efforts and the Nevada Tobacco Quitline.
- Train individuals in every county on radon testing and provide test kits for local distribution.
- Expand radon testing access in underserved and rural communities through targeted programs.
- Introduce a public library lending program for radon test kits.
- Promote certification programs to expand the radon mitigation workforce, especially in underserved areas.
- Collect, analyze, and publish data on radon testing, mitigation, and radon-resistant construction adoption.
- Track and set targets for radon testing in real estate transactions to improve compliance and awareness.
- Support policies requiring radon-resistant construction in new homes and for licensing of radon mitigation professionals.

Radon Indicators		
Valid radon home tests completed[1]	Baseline: 46,100	Target: 61,000
Existing homes mitigated for radon[1]	Baseline: 2,814	Target: 3,800
Valid new homes built radon-resistant[1] radon home tests completed[1]	Baseline: 719	Target: 900

[1]*Data source: Nevada Radon Education Program*

Sun Smart for Skin

Given Nevada's average elevation of 5,500 feet, around 250 sunny days per year, and our shared love of the outdoor lifestyle, Nevadans are at higher risk for skin cancer. Historically, the rate of melanoma diagnoses has shown an upward trend, yet so have sun smart efforts in many communities. Skin cancer takes a number of years to develop, so progress made now to improve sun safety will not yield results for a number of years. Expanded partnerships with dermatologists and medical schools at both University of Nevada, Reno and University of Nevada, Las Vegas, have increased the state's ability to engage with Nevadans and build a community of sun safety champions.

Objective: Reduce the incidence of skin cancer.

Strategies

- Promote sun safety and skin cancer prevention and early detection education through Sun Smart Schools and Sun Smart Nevada programs.
- Collaborate with event coordinators to integrate shade and sunscreen access into community events.
- Partner with communities to foster sun-safe environments and education.
- Advocate for sun-safe built environments, especially in preK-12 schools.
- Work with businesses to promote sun and heat safety for outdoor workers and others with occupational risk of UV radiation.
- Educate the public on indoor tanning restrictions for minors and ensure tanning establishments comply with state law.

Sun Safety Indicator			
Incidence of melanoma[1]	Baseline: 23.5 per 100K	Target: 22.3 per 100K	US: 23.8 per 100K

[1]*Data source: NCRR*

Genetics

Goal: Promote and expand the use and knowledge of genetics as a risk factor for cancer.

It's estimated that 5–15% of cancers are linked to inherited genetic mutations, with specific genes increasing a person's risk of certain cancers. The risk of genetic-driven cancers can vary by genetic variation and type of cancer. For example, carriers of the BRCA1/2 mutation have a 45–85% risk of breast cancers compared to 13% for the general population, and a 10-60% risk of ovarian cancer compared to 1-2% for the general population.[lix]

Genetic counseling is an essential service for identifying individuals at increased risk of genetically-driven cancer and can help guide clinical decisions. This can include evaluating family history to determine the likelihood of cancer, guiding a patient on the benefits and limitations of genetic testing, and engaging providers to establish a risk-based screening plan for patients.

Access to genetic counseling in Nevada is limited, but recent state legislation to establish licensure for genetic counselors shows promise that this field of healthcare will expand. Along with licensure, opportunities to improve the use of genetics to assess cancer risk must be coupled with policy change to expand insurance coverage for genetic screening and counseling, clinician and patient education, systems change to ensure family history is collected and documented, workforce development to ensure genetic counselors are available, and telehealth integration to ensure access for those living in rural or underserved communities.

Tumor suppressor gene mutations	→	Disable cellular repair mechanisms	Example: BRCA1/2, TP53
Oncogene activation	→	Drive uncontrolled cell growth	Example: HER2
DNA repair gene defects	→	Allows mutations to accumulate	Example: Lynch Syndrome

Genetics

Objective: Increase access to genetic counseling in Nevada.

Strategies

- Promote evidence-based practices for genetic testing and counseling across the cancer continuum.
- Support development of genetic counseling training programs in Nevada.
- Assess Nevada health insurance coverage for genetic counseling and genetic testing by comparing Nevada health plan policies.
- Support policies to increase access to genetic testing and counseling services in Nevada.

Objective: Expand public and healthcare professional awareness of genetic counseling and testing.

Strategies

- Educate Nevadans on the importance of understanding family history of cancer and sharing that information with healthcare professionals.
- Educate healthcare professionals on the importance of collecting family cancer history and how that information can be used.
- Work with the Healthy Nevada Project to publish cancer data and reports.

Genetics Indicators		
Number of reports on genetic counseling and testing coverage	Baseline: 0	Target: 1
Number of educational resources for Nevadans	Baseline: 0	Target: 1
Number of educational opportunities for healthcare professionals	Baseline: 1	Target: 2

Early Detection

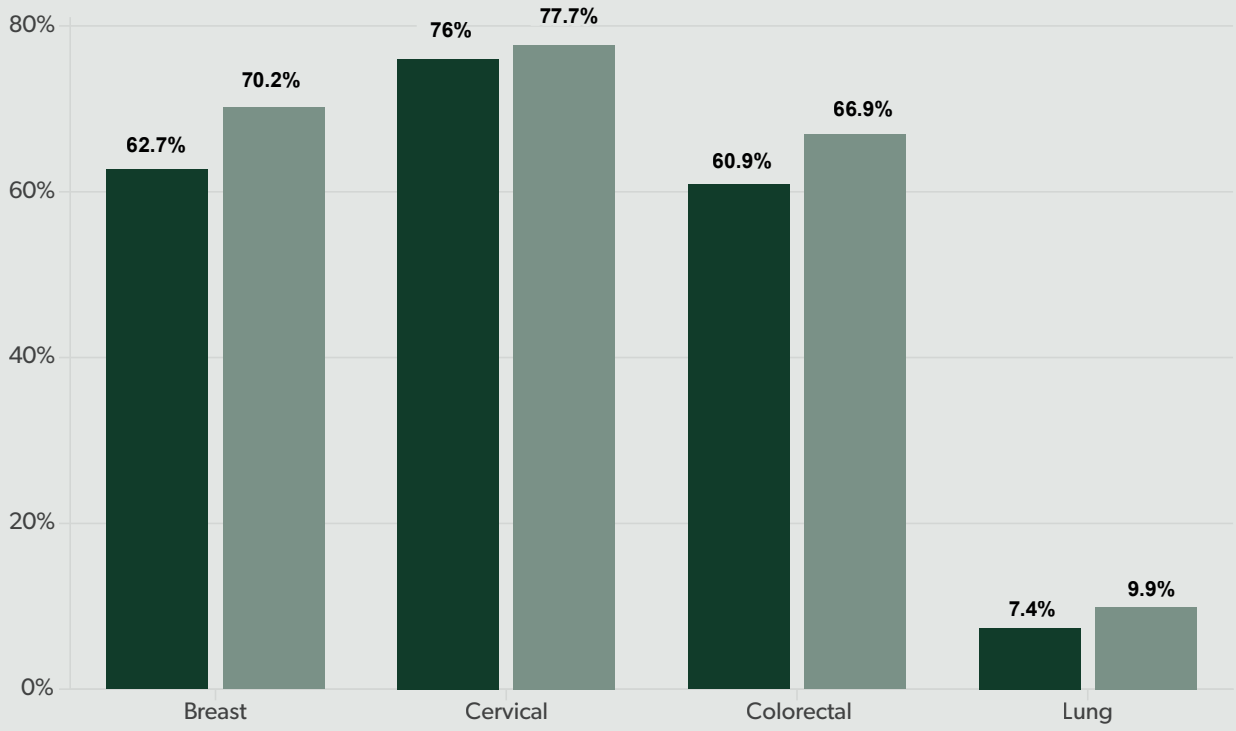
Goal: Increase early detection of cancers to reduce late-stage diagnosis.

The goal of screening and early detection of cancer is to find cancer at its most treatable stage, and often before a person has symptoms. Finding cancers earlier, in addition to reducing mortality, can improve quality of life for survivors by subjecting them to less aggressive treatments, thereby minimizing side effects and maintaining quality of life.

Screening programs for breast, cervical, colorectal, lung, and prostate cancers have contributed to the notable decline in cancer mortality and improvement in survival rates over the past several decades, demonstrating the power of early detection in reducing the burden of cancer. One example of the success of early detection is reflected in national data available for breast cancer. Since 1976, following the American Cancer Society's recommendation for annual mammograms to detect breast cancer, incidence for the disease has increased, in part due to the increase in screening. Deaths since that time, however, have consistently decreased as more cancers are found earlier and successfully treated. Breast cancers found at the localized stage now have a 100% five-year relative survival rate, whereas breast cancers found at a distant, or late stage, have just a 32.6% five-year relative survival rate.[lx]

Nevada vs U.S. Screening

Nevadans are less likely to be screened for cancer than the average U.S. adult.



Data Source: CDC Behavioral Risk Factor Surveillance System •
Most recent available data for percentage of eligible adults screened for cancer based on USPSTF guidelines.

Early Detection

The objectives contained here for cervical, colorectal, and lung cancer follow screening guidelines issued by the United States Preventive Services Task Force (USPSTF), which grades a variety of health interventions using a letter scale. Early detection objectives align with evidence-based practices with USPSTF A and B grades for recommended services where there is high certainty the net benefit is substantial, or moderate certainty of moderate or substantial benefit, respectively.[lxi] Nevada's cancer control partners have unified in following the American Society of Breast Surgeons' 2019 screening mammography guidelines.[lxii]

Objective: Increase the percentage of adults screened for breast, cervical, colorectal, and lung cancers.

Strategies

- Educate Nevadans on the importance of early detection and evidence-based screening guidelines and encourage screening advocacy among peer and influencer groups.
- Develop and share evidence-based public messaging on cancer screenings.
- Recognize and promote cancer awareness months.
- Promote culturally tailored messaging about early detection, including a focus on "body part first" messaging and personal risk.
- Improve access to cancer screening for low-income, uninsured, geographically isolated, and other medically underserved populations through financial assistance, navigation to medical homes, mobile screening services, and health literacy education.
- Train clinicians on evidence-based interventions and trauma-informed approaches to improve screening rates.
- Support technology initiatives for clinician access and sharing of screening data.
- Expand reimbursement and clinical education for navigation and community health worker services.
- Support the expansion of telehealth and telemedicine for cancer screening referral and follow-up.
- Support workforce development efforts to increase the number of practicing screening clinicians in Nevada.
- Advocate for diversified funding and policies to support access to recommended cancer screenings for all eligible Nevadans.

While prostate, skin, and oral cancer screenings have not received A or B grades from USPSTF, they are included here with a focus on reducing late-stage diagnosis and encouraging use of screening for those who, after discussion with their physician, may determine they are at higher risk for incidence of any of these cancer types.

Early Detection

Early Detection Indicators			
Percentage of women aged 40+ who received a mammogram in the last two years[1]	Baseline: 62.7%	Target: 66%	US: 70.2%
Percentage of women aged 21-65 who have been screened for cervical cancer based on USPSTF guidelines[1]	Baseline: 76%	Target: 80%	US: 77.7%
Percentage of people aged 45+ who have been screened for colorectal cancer based on USPSTF guidelines[1]	Baseline: 60.9%	Target: 64%	US: 66.9%
Percentage of people aged 50-80 eligible for lung cancer screening who have been screened[1]	Baseline: 7.4%	Target: 15%	US: 9.9%

[1]*Data source: BRFSS*

Early Detection: Prostate Cancer

Prostate cancer screening, often performed as a blood test to detect levels of prostate specific antigen or PSA, has a USPSTF C-grade recommendation for those with a prostate, aged 55 to 69 who are at increased risk such as due to race/ethnicity or family history. Screening should be done only after a discussion of the potential harms and benefits of screening. Several factors led to this recommendation, primarily overdiagnosis and overtreatment of low-risk prostate tumors that might never have become clinically significant yet could result in treatment that exposes patients to unnecessary risks, such as impotence and incontinence.[lxiii]

While prostate cancer screening does not earn an A or B grade, it is particularly important for Black men, who face a disproportionately higher incidence, earlier onset, more aggressive disease, and elevated mortality rates compared to other racial groups. In Nevada, Black men are more than 50% more likely to be diagnosed with prostate cancer than white men (184.1 vs. 107.6 per 100,000) and are more than twice as likely to die from the disease (47.8 vs. 21.9 per 100,000). Despite these risks, national data shows Black men are less likely to receive PSA screening and often encounter barriers such as mistrust of the healthcare system, poor physician-patient communication, limited knowledge about prostate cancer, and significant economic and geographic obstacles to care.

Screening rates among Black men declined more sharply than among white men following the USPSTF's shift away from recommending PSA testing and no recommendation for Black men specifically, such as for earlier screening or PSA monitoring, has been adopted. In Nevada, the rate of late-stage diagnosis of prostate cancer among Black men is similar to the state average and that of men of other races or ethnicities. As such, this plan seeks to reduce late-stage diagnosis of prostate cancer through a variety of strategies that, while not tailored to Black men, focus on the barriers to screening they encounter.

74% **higher risk of being diagnosed with prostate cancer for Black men in Nevada.**

114% **higher risk of dying from prostate cancer for Black men in Nevada.**

Early Detection: Prostate Cancer

Objective: Decrease the rate of late-stage prostate cancer diagnoses.

Strategies

- Educate Nevadans on prostate cancer risk and family history, early detection, and shared decision-making.
- Advocate for best practices in shared decision-making for screening.
- Recognize and promote Prostate Cancer Awareness Month in September.
- Strengthen collaboration with prostate cancer organizations.
- Develop a prostate cancer data report with an epidemiological review.
- Increase referrals for genetic counseling.
- Support policies for research and insurance coverage of screenings.

Prostate Cancer Indicator		
Percentage of late-stage prostate cancer diagnoses[1]	Baseline: 21.7%	Target: 20%

[1]*Data source: NCRR*

Early Detection: Skin Cancer

The USPSTF has ruled that there is insufficient evidence for skin cancer screenings in asymptomatic individuals, however not against screening for those who present with signs of skin cancer or who should be surveilled because of increased risk of skin cancer. The USPSTF also recommends sun safety and skin cancer prevention counseling for youth, adolescents, and young adults. As such, strategies provided in this plan to increase the early detection of melanoma focus on education on sun safety and the signs of skin cancer, risk factors, and access to skin cancer screening.

Objective: Decrease the rate of late-stage melanoma diagnoses.

Strategies

- Educate Nevadans, including primary care clinicians, on the signs of skin cancer, including in skin of color, and the importance of regular skin checks and early detection.
- Recognize and promote Skin Cancer Awareness Month in May.
- Identify and train community influencers, such as hairdressers, barbers, and massage therapists, on the signs of skin cancer and how to discuss skin cancer screening with their clients.
- Recruit experts and champions, including individuals from communities of color, to participate in skin cancer early detection campaigns to support educational opportunities, and participate in other collaborative efforts.
- Support community skin checks, including skin checks at employee health fairs.
- Support policies and programs to expand the dermatology professional workforce in Nevada.

Skin Cancer Indicator		
Percentage of late-stage melanoma diagnoses[1]	Baseline: 12.7%	Target: 11.4%

[1]*Data source: NCRR*

Early Detection: Head and Neck Cancers

Oral cancer and oropharyngeal cancer are two often overlooked cancers, despite increasing by about 1% per year since the mid-2000s according to national statistics, largely driven by cancers occurring in the oropharynx. After decades of decline, mortality rates for these cancers have increased by 0.6% per year since 2009. In Nevada, incidence of cancers of the lip, oral cavity, and pharynx have remained steady over the past 15 years, however, similar to national rates, mortality has increased among both men and women in Nevada. The distribution of oral cavity cancers has shifted because of changing patterns in risk factors and because of an increase of about 2% per year in deaths from HPV-associated cancers of the base of the tongue, tonsils, and oropharynx.

Dentists can play significant roles in detecting oral cancers early by performing comprehensive extra-oral and intra-oral examinations. This involves feeling the head and neck for lymph nodes and masses and closely examining every specific area of the oral cavity methodically using a mouth mirror, tongue depressor and gauze. Every patient should visit their dentist twice a year and ask for their oral cancer screening if they do not receive one. In addition, patients should regularly examine as much of their mouth as possible and bring any white patches, red patches, lumps, bumps, swellings or non-healing sores to the attention of their dentist.

The vast majority of oropharyngeal cancers are associated with the human papillomavirus. Therefore, HPV vaccination at an early age will greatly help with prevention for future generations.

Key Facts

In Nevada, as with the U.S. as a whole, head and neck cancer is more common in men than in women, with an incidence ratio approximately equal to 3:1 and is most commonly diagnosed among those ages 50 and older.[lxv]

Of the cases of head and neck cancer diagnosed in the United States, it is estimated that nearly 70% will be attributed to HPV infection.[lxvi]

Diagnosis & Treatment

Goal: Support access to high quality, affordable cancer care for all Nevadans.

Access to healthcare and rapid progression from cancer diagnosis to treatment represent two of the most critical factors influencing cancer survival rates. Evidence increasingly demonstrates that even short delays in treatment initiation can significantly impact patient outcomes, while barriers to healthcare access continue to create profound inequalities in cancer care delivery.

While there's no standard setting a specific time from diagnosis to treatment, researchers have confirmed that the risk of death for several types of cancer—including breast, colorectal, lung, cervical, head and neck, and bladder cancers—increases with delays in treatment, regardless of the type of treatment. A one-month delay in treatment can increase mortality risk by 6-13%. Longer delays can increase that risk even more.[lxvii] Conversely, shorter time to treatment has shown to decrease mortality[lxviii] and timely treatment has the potential to reduce the need for aggressive treatment and improve quality of life.

There are a number of factors that impact time to treatment, including financial barriers, health system complexity, geographical disparities, low health literacy, and lack of supports including for transportation and caregiving responsibilities. Greater travel distance to oncology services has been shown to often result in later stage diagnosis, lower likelihood of receiving adjuvant chemotherapy,[lxix] less guideline-concordant treatment, worse prognosis, and lower quality of life for survivors.[lxx] Patient navigation, both in clinical and community settings, has emerged as an evidence-based intervention that can guide patients through complex healthcare and insurance systems and help to address barriers to care by providing individualized support. However, navigation services must be combined with other interventions, including policies to reduce barriers that delay or prevent access to treatment, and be paired with a greater availability of oncology care across the state overall.

Objective: Reduce time between diagnosis and treatment.

Strategies

- **Support development of designated National Cancer Institute cancer center(s) in Nevada.**
- **Support navigation services to streamline patient access to cancer care.**
- **Support policies reducing healthcare barriers that delay or prevent access to physician-recommended treatments, imaging, lab testing, and other procedures and services.**

Objective: Increase Nevada's physician workforce with an emphasis on oncology-related fields.

Strategies

- Support development and expansion of oncology/hematology training programs at Nevada's medical schools.
- Support efforts to secure additional graduate medical education residency and fellowship slots in Nevada.
- Support access to trauma-informed and culturally affirming care for people who identify as LGBTQ+ including through professional education and clinician listings.
- Support policies to attract and retain healthcare professionals in Nevada.
- Support policies to expand the legal practice of physician assistants in Nevada.

Diagnosis And Treatment Indicators

Number of state policy changes	Baseline: 0	Target: 2	
Active Licensed MDs/DOs per 100,000[1]	Baseline: 230	Target: 245	US (2023): 282.3
Active Licensed MDs/DOs per 100,000 in rural/frontier communities[1]	Baseline: 89.3	Target: 110	
Annual GME graduates[1]	Baseline: 272	Target: 300	
Physician assistants per 100,000[1]	Baseline: 38.5	Baseline: 51	

Survivorship & Palliative Care

Goal: Improve the quality of life for cancer survivors.

A person is considered a cancer survivor from the time of diagnosis and continues to be one for the remainder of their life. Survivorship can include living free of cancer or living with cancer. It brings a complexity to one's life, and has "physical, mental, emotional, social, and financial consequences that start at diagnosis and continue through treatment and beyond."[lxxii] Helping survivors meet and overcome the challenges cancer brings to their lives is vital to reducing the burden of the disease and enhancing quality of life overall.[lxxiii]

Access to supportive resources for cancer survivors, however, can be a challenge, especially for those without access to patient navigation and for those living in rural and frontier communities. In a 2024 survey of rural and frontier Nevadans, the majority of respondents said they were unaware of community resources available for survivors. Of those who were aware of resources, many found it was not easy to access those resources, and in the case of mental health resources and transportation, childcare, or financial assistance, accessing resources was difficult.[lxxiv]

Patient navigators are an integral part of enhancing a survivor's quality of life from pre-diagnosis and diagnosis through treatment, and, if necessary, into hospice care. The term "patient navigator" encompasses different roles including oncology nurse and patient navigators, lay navigators, social workers, care coordinators, and community health workers. These navigators can not only help survivors and their care partners efficiently move through the complex healthcare system, but also identify available resources to improve outcomes. In essence, patient navigators can facilitate screening and diagnosis as well as access to oncology and palliative care services.

All survivors, but especially those in underserved communities, can greatly benefit from the support and assistance of a patient navigator who can help to address systemic inequities by coordinating care, helping to identify and remove barriers, and identifying supportive resources. These services may be delivered by clinical- or community-based navigators, and may be effective both in-person or via tele-navigation.

> "Patient navigators are increasingly recognized as an essential component of comprehensive cancer care, serving as the lynchpin for facilitating a coordinated and seamless experience for cancer patients and their families." [lxxv]

Another essential component to support quality of life for cancer survivors is palliative care delivered in coordination with oncologic treatment. Palliative care addresses many of the non-oncology needs of cancer survivors, focusing on "quality of life, emphasizing whole-person care by addressing physical, psychosocial, family and spiritual concerns as well as planning for future care."[lxxvi] Cited as a patient-centered approach to specialized medical care by Nevada's Advisory Council on Palliative Care and Quality of Life, palliative care provides survivors autonomy and additional health care support in addition to oncology treatments, taking into account a patient's goals and values to tailor care to their specific needs.

Survivorship & Palliative Care

The American Society of Clinical Oncology (ASCO) notes that "one cannot overstate the trauma of receiving a cancer diagnosis" and that "patients and/or caregivers should also be able to request palliative care at any stage, with any prognosis, based on their needs."[lxxvii] ASCO, in 2024, issued a new guideline for palliative care recommending all oncology clinicians understand the structure and significance of palliative care, have primary palliative care knowledge and skills, and know when to refer a patient to specialty palliative care when additional expertise is required. The introduction of a specialty palliative care team should come "soon after the diagnosis of advanced cancer." [lxxviii] This approach has been shown to result in less aggressive end-of-life care, more timely referrals, longer median survival, reduced use of invasive interventions, and lower hospital charges along with improved pain management, fewer symptoms of depression, and better quality of life for patients.[lxxix, lxxx, lxxxi]

Objective: Increase equitable access to survivorship and palliative care services for survivors and their care partners from diagnosis through end-of-life care.

Strategies

- Encourage survivor enrollment in programs that promote health, well-being, and quality of life, with a focus on rural and multimedia accessibility.
- Identify gaps in resource awareness and launch educational campaigns to enhance knowledge and use of supportive care services.
- Support care partners as essential members of the cancer journey, addressing burnout and fostering resilience.
- Support community and clinical navigation services to streamline access to resources and supportive care.
- Promote behavioral health and substance use interventions to promote long-term health of survivors.
- Strengthen collaboration between community resources, cancer centers, and palliative care programs to improve access.
- Evaluate Nevada's network of navigators to better understand how services are delivered and to whom.
- Support policies for navigation reimbursement, including Principal Illness Navigation (PIN).

Objective: Expand education on survivorship and palliative care services for patients, care partners, and healthcare professionals.

Strategies

- Educate Nevadans on the distinction between palliative and hospice care, leveraging resources from the Palliative Care Council and other national entities.
- Promote use of National Cancer Survivorship Standards of Care to providers throughout Nevada.
- Identify, document, and promote survivorship and palliative care educational opportunities, including partnerships with medical, nursing, and health sciences schools.
- Integrate survivorship and palliative care education, including vital talk training, into curricula and training programs for healthcare professionals, including primary care physicians, oncology specialists, and community health workers.
- Promote education on navigation through Medicaid, disability applications, supportive care referrals, and stabilizing post-treatment.
- Promote simplified terminology and evidence-based tools to improve patient-physician communication and care planning.
- Encourage early palliative care discussions as part of a comprehensive care approach.
- Support development of a hospice and palliative care fellowship program to expand professional expertise.
- Support research opportunities to improve the availability of data on survivorship in Nevada.

Survivorship & Palliative Care Indicators

Number of navigators in Nevada Navigation Network[1]	Baseline: 157	Target: 200
Annual educational opportunities for health care professionals[1]	Baseline: 3	Target: 3

[1]*Data source: NCC*

Cancer Surveillance

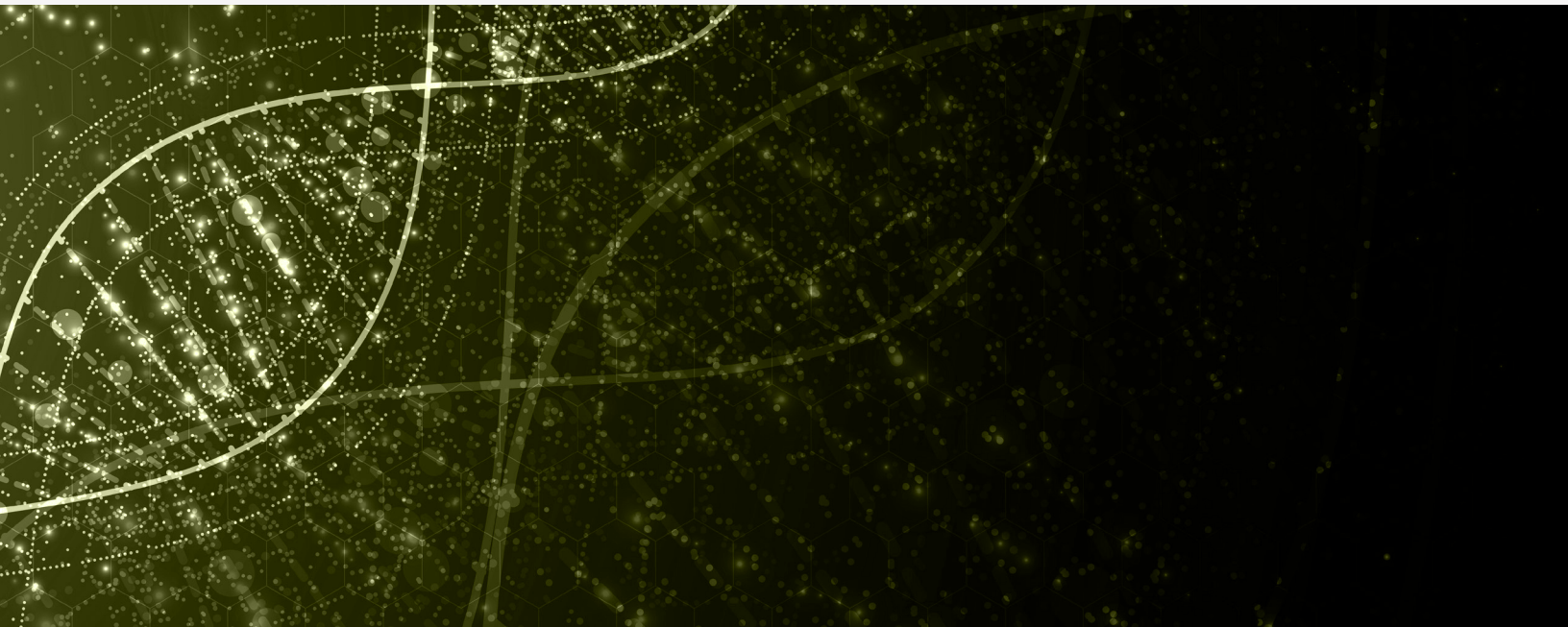
Goal: Provide high-quality data and proactive surveillance to support and inform cancer control efforts.

Cancer surveillance is based on timely and comprehensive collection, analysis, and reporting of population-based cancer incidence and survival. The data provides a critical profile of the cancer burden in a region and serves as the foundation for cancer prevention and control efforts, planning and resource allocation, and policies needed to reduce disease and death.

In the United States, the Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR) is the largest surveillance system representing 97% of the U.S. population. Together with the National Cancer Institute's (NCI) Surveillance, Epidemiology, and End Results (SEER) Program, data for the entire U.S. population is collected on new cancer cases. This cancer data is primarily provided by state and territory central cancer registries.

The Nevada Central Cancer Registry (NCCR) is the central statewide, population-based registry maintaining data on all cancer patients residing in Nevada. NCCR collects cancer case data from multiple sources including hospitals, medical laboratories, screening facilities, and healthcare professionals diagnosing and treating cancer. NCCR submits data each year to NPCR and the North American Association of Central Cancer Registries (NAACCR), of which all central cancer registries in the U.S. and Canada are members. NAACCR annually reviews data from member registries to assure the quality, accuracy, and completeness of incidence data most recently awarding NCCR Silver Certification for 2021 and Gold Certification for 2022 data submissions.

As both the delivery of healthcare and collection of quality data are rapidly changing, so are the demands for maintaining and expanding high-quality surveillance systems. Also, there is a growing need to enrich cancer surveillance and research efforts to further identify different/dissimilar communities, including those located in frontier and remote areas of the state. The following objectives and strategies have been developed to strengthen Nevada's capacity to collect, analyze, and disseminate cancer surveillance data.



Cancer Surveillance

Objective: Increase Nevada's cancer data quantity and quality.

Strategies

- Promote complete, accurate, and timely reporting to Nevada Central Cancer Registry (NCCR) for adult, adolescent, and pediatric cancers, including leveraging electronic health records (EHRs).
- Maintain Silver-Gold certification for NCCR.
- Increase the number of Oncology Data Specialists (ODS-C) working in Nevada through collaboration with community colleges that have Health Information Technology programs.
- Support policies expanding requirements for data collection including collection of patient sexual orientation and gender identity (SOGI) and clinical trials participation.
- Advocate for funding to support NCCR's implementation of technology standards and SEER certification requirements.
- Support legal efforts to implement a centralized cloud-based data collection, processing, and storage option for state and regional central cancer registries.

Cancer Registry Certification

Cancer registries can receive certification from the North American Association of Central Cancer Registries (NAACCR) to indicate the quality and completeness of the cancer data collected and maintained by the registry. A gold certification requires 95% or higher data completeness while silver certification requires 90% or higher data completeness, among other accuracy requirements.

Cancer Surveillance

Objective: Increase infrastructure for and timely use of Nevada's data sources for proactive cancer epidemiological reporting to inform cancer control efforts and policy work.

Strategies

- Use relevant socio-demographic and geographic indicators in cancer data analysis to highlight disparities in cancer incidence, detection, and outcomes.
- Incorporate health survey data from various sources, including the Nevada Behavioral Risk Factor Survey (BRFSS), Youth Risk Behavior Survey (YRBS), Nevada Adult Tobacco Survey, and WebIZ, to expand the analysis of trends in cancer incidence, mortality, and survival as they correlate with health behaviors, prevalence of cancer risk factors, and adherence to cancer prevention and screening guidelines.
- Integrate census-derived measures of socioeconomic status into the analysis of NCCR data to produce reports and maps characterizing and evaluating disparities in cancer risk, access and barriers to screening and proper cancer care, treatment and outcomes.
- Promote the availability and accessibility of de-identified cancer data from NCCR and statewide surveys through a variety of media, including user-friendly web applications to graphically display measures of cancer risk, mortality, detection, and outcomes statewide, by region, and zip code.
- Localize national cancer-related news using Nevada-specific data.
- Educate policymakers by distributing cancer data reports by legislative district prior to each legislative session.
- Advocate for funding for a position focused on cancer surveillance located at a research institution.

Cancer Surveillance Indicators

Number of years NCCR achieves silver or gold certification from National Program of Cancer Registries (NPCR) reports/USCS[1]		Target: 5
Number of cancer surveillance professionals at Nevada research institutions[2]	Baseline: 0	Target: 1
Annual number of cancer reports with epidemiological review produced	Baseline: 0	Target: 5

[1]Data source: NCCR; [2]Data Source: NCC

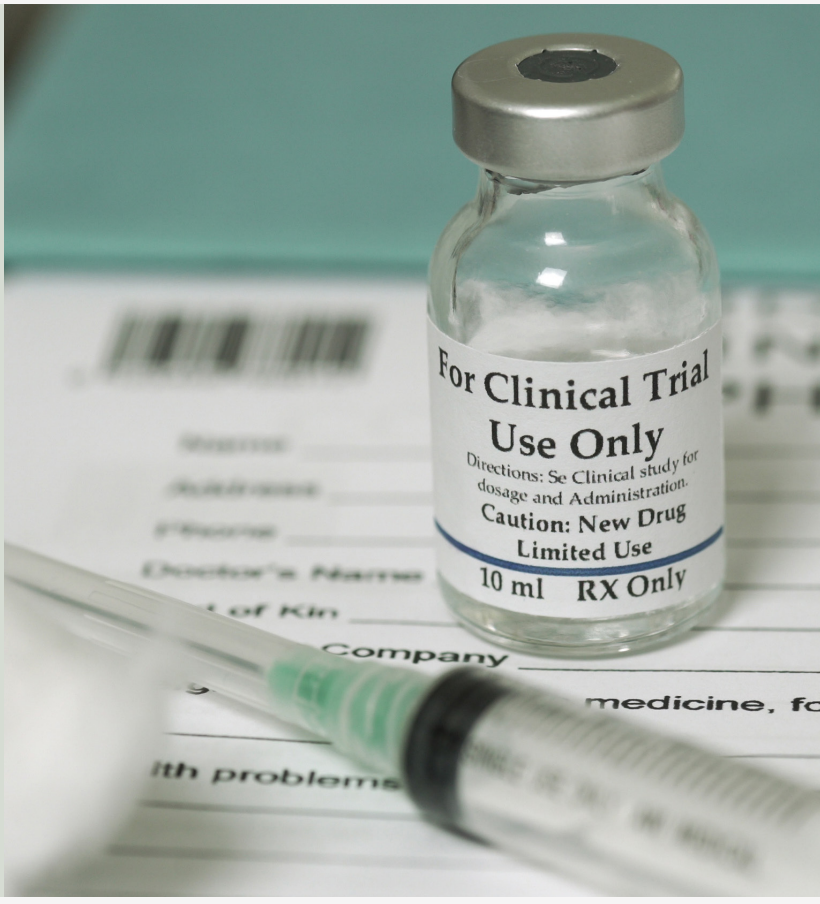
Clinical Research

Goal: Increase cancer research to improve cancer prevention, detection, diagnosis, treatment, and survivorship.

Central to the cancer research cycle is clinical research, most often conducted through clinical trials. Vital for moving new methods of preventing, diagnosing, and treating cancer from the lab to people, clinical trials safely and methodically test new drugs, devices, methods, approaches, and other interventions.[lxxxii] Clinical trials also offer people the opportunity to try promising new treatments or drugs before they are readily available.

Clinical trial participation remains difficult to measure, however a recent study reported in the Journal of Clinical Oncology suggests that the overall estimated patient enrollment rate to cancer treatment trials had reached 7.1% from 2013-2017, higher than historical estimates of 2%-3%.[lxxxiii] The majority of treatment trial enrollment at 21.6% was at National Cancer Institute (NCI) designated centers, with 11% enrolled at non-NCI designated cancer programs and networks.

The number of clinical trials professionals in Nevada has trended slightly downward in recent years. Barriers to providing clinical trials noted by our partners include the associated costs to an organization, lack of available staffing and support, and clinician time. When physicians offer clinical trial participation to patients, almost 50% report participating.[lxxxiv] According to NCI, there are multi-level barriers to patients participating in trials which include concerns about costs, time burden, and lack of transportation. These challenges are coupled with historical mistrust, medically underserved racial and ethnic groups, and, in Nevada, a lack of knowledge regarding clinical trials to further disparities in clinical trial enrollment.[lxxxv]



Clinical Research

Objective: Increase professional participation in cancer research.

Strategies

- Establish a statewide network of cancer research and clinical trial professionals to improve Nevada's research infrastructure, share resources, and mentor future clinical trial professionals.
- Develop a model and resources for physicians who wish to offer clinical trials.
- Educate physicians on providing access to clinical trials for patients in their practice.
- Promote centralized resources for healthcare teams to identify clinical trials for patients.

Objective: Increase the community's awareness and understanding of cancer research and clinical trials.

Strategies

- Promote centralized resources for cancer research opportunities for public use.
- Identify barriers and facilitators for patients to participate in clinical trials in Nevada.
- Develop and disseminate education campaigns to inform the public about cancer research, including clinical trials.
- Develop a toolkit for how patients can participate in clinical trials and community-based research, including mobile phlebotomy, decentralized trials, home self-collection, and self-enrollment.

Clinical Research Indicators		
Individual members in clinical research network	Baseline: 0	Target: 30
Annual number of professional educational opportunities	Baseline: 0	Target: 1
Number of educational campaigns	Baseline: 1	Target: 3

[1]*Data source: NCC*

Pediatric and AYA Cancers

Goal: Improve access to quality care and supportive resources for individuals and families impacted by cancer among children, adolescents, and young adults.

Childhood cancer is the leading cause of death from disease in children, according to the CDC.[lxxxvi] Cancer is often considered a disease of aging, and cancers in children are rare compared to cancers diagnosed in older adults. Despite this, thousands of children, adolescents and young adults are diagnosed with cancer each year. In Nevada in 2022, the most recent year in which data is available, there were 551 cancer diagnoses among children, adolescents, and young adults up to age 34.[lxxxvii] Data from the National Childhood Cancer Registry shows that incidence of CTYA cancers has gradually increased over time, especially among people of color.[lxxxviii] The most common types of cancer in children and adolescents are leukemias, lymphomas, and cancers of the brain, central nervous system, and bones. Young adults are most commonly diagnosed with breast cancer, lymphomas, melanoma, sarcomas, thyroid cancer, cervical and ovarian cancers, testicular cancer, colorectal cancer, and brain and spinal cord tumors.

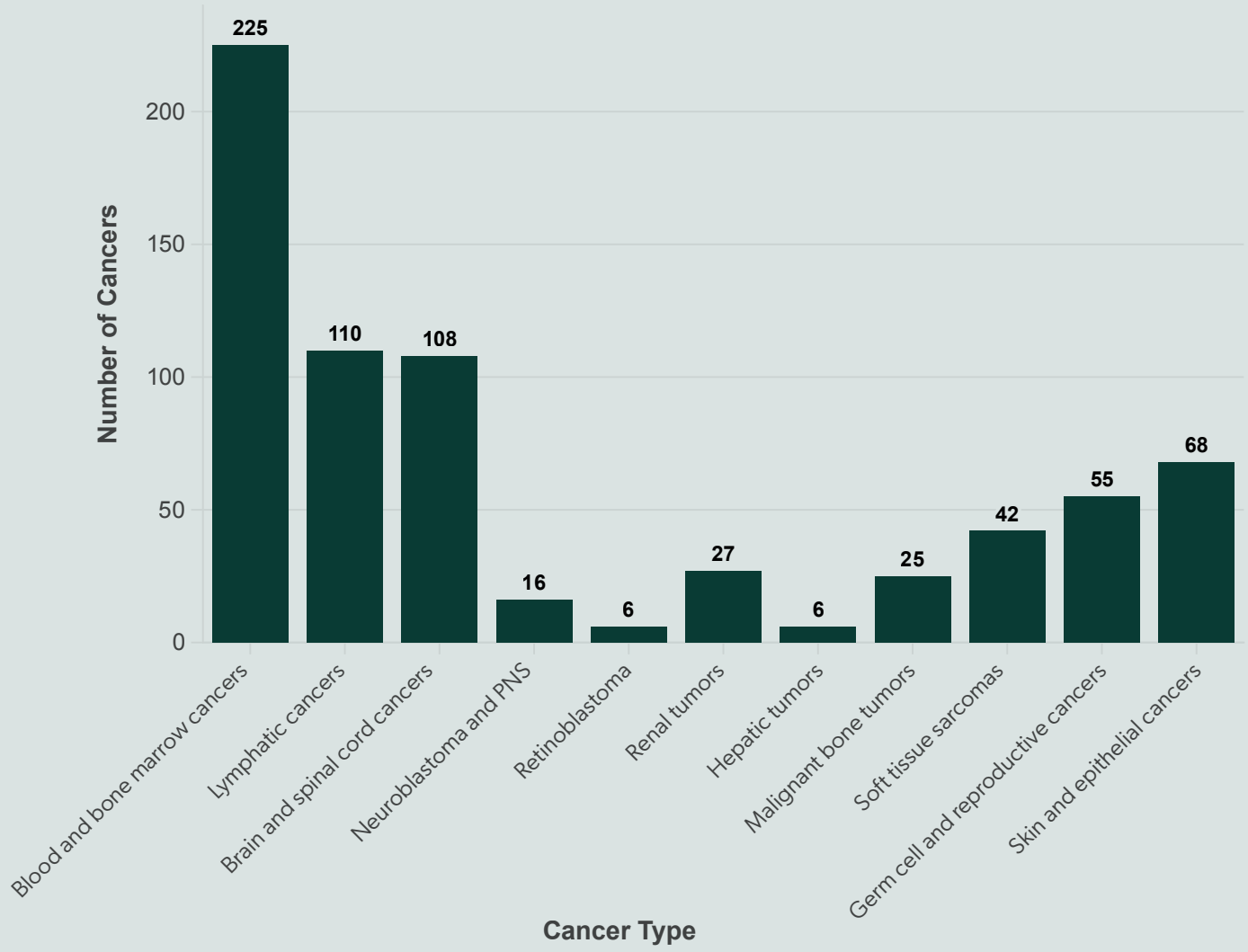
Key Facts

Childhood, adolescent, and young adult cancer (CTYA) refers to cancers diagnosed in early life. Adolescent and young adult cancers, or AYA, are a specific category within the CTYA population.

- **Pediatric or Childhood: Birth to 14 years**
- **Adolescent: 15-19 years**
- **Young Adult: 20-39**

Childhood Cancer Incidence

A variety of cancers can affect young people, but in Nevada nearly one-third of pediatric and adolescent cancers are leukemias and other bone marrow cancers.



Data Source: Nevada Central Cancer Registry •
Pediatric and Adolescent Cancers in Nevada, 2018-2022. Age-adjusted 5-year counts and annualized incidence rates for those ages 0-19. Cancers are grouped using the International Classification of Childhood Cancer and the dataset includes all childhood cancers recorded in the Nevada Central Cancer Registry that meet this classification for those ages 0-19 when diagnosed.

Pediatric and AYA Cancers: Physician Workforce

Advances in treatment and supportive care have improved cancer survival among the CTYA population and have also contributed to a growing number of cancer survivors, many of whom live with the long-term impacts of treatment and require lifelong surveillance. CTYA survivors may experience "premature/accelerated aging, cardiotoxicity, endocrine dysfunction, reproductive health issues, secondary cancers, financial toxicity, neurocognitive deficits, and psychosocial concerns," according to data from the National Cancer Institute.[lxxxix] The survivorship needs of CTYA cancer survivors differ from those of adults, and the need for support extends beyond the patient, to parents, siblings, and care partners.

Cancer treatment options for individuals in the pediatric and adolescent populations are limited in Nevada, with in-state treatment confined to Reno and Las Vegas. Additionally, Nevada does not have a standalone children's hospital or a centralized and integrated system of care and is lacking many of the services that are available in other states. Nevada's healthcare workforce, and especially the pediatric workforce, is severely limited with just 456 general pediatric physicians—about half of the national average,[xc] and data is not available on physician counts for pediatric sub-specialties. Because of these limitations, many of those in the CTYA population must travel out of state for cancer treatment, increasing the burden on families and care partners, creating challenges for coordination of care, and contributing to adverse outcomes including financial toxicity and limited access to psychosocial and long-term support.

General Pediatrics Physician Workforce in Nevada

	Total Physicians	Office Based	Hospital Based	Other
Clark County	256	269	75	12
Washoe County	79	63	12	4
Carson City	10	7	3	0
Rural/Frontier Counties	11	9	2	0
State Total	**456**	**348**	**92**	**16**

Data source: American Medical Association, 2025

A survey of pediatric oncology professionals practicing in Nevada identified a number of key needs to improve cancer care and survivorship for individuals in the CTYA population. Recommendations included expanding the state's pediatric healthcare workforce—including general pediatrics practitioners and a variety of sub-specialties—and establishing a freestanding comprehensive cancer hospital or National Cancer Institute-designated facility, resulting in collaborative, multi-disciplinary, and trauma-informed care and a teaching facility for residents and fellows. A more robust menu of treatments and services must also become available in-state to treat CTYA cancers, including bone marrow transplant, gene therapy, CAR-T therapy, immunotherapy, pediatric radiology, and pediatric anesthesia services for radiology and radiation therapy.

Pediatric and AYA Cancers: Physician Workforce

Additionally, supportive services for CTYA patients and their families are essential to improving quality of life during and after treatment. In the clinical setting, identified supports to improve care include more robust mental health screening and access to counseling for patients and their families, including siblings; increased access to palliative care; and expanded telemedicine including for care coordination, genetic counseling, clinical trials enrollment consultation, and mental health/psychosocial support. Nevada also has just one long-term follow-up clinic to evaluate the health of survivors following treatment and identify any late effects of treatment. Regular follow-up allows for early detection and management of these late effects, potentially mitigating their impact, but is not available to all CTYA survivors in Nevada.

In the community setting, a number of non-profit organizations support pediatric and adolescent survivors and their families and have done so for decades. Their support includes helping to reduce or remove transportation barriers, providing financial assistance, increasing access to counseling, and offering activities and camps for survivors and siblings. These organizations also advocate for increased funding to support pediatric cancer research and supportive programs. However, opportunities exist to expand the support CTYA survivors receive, including providing financial counseling and navigation, along with financial literacy education, and navigation to community services and resources.

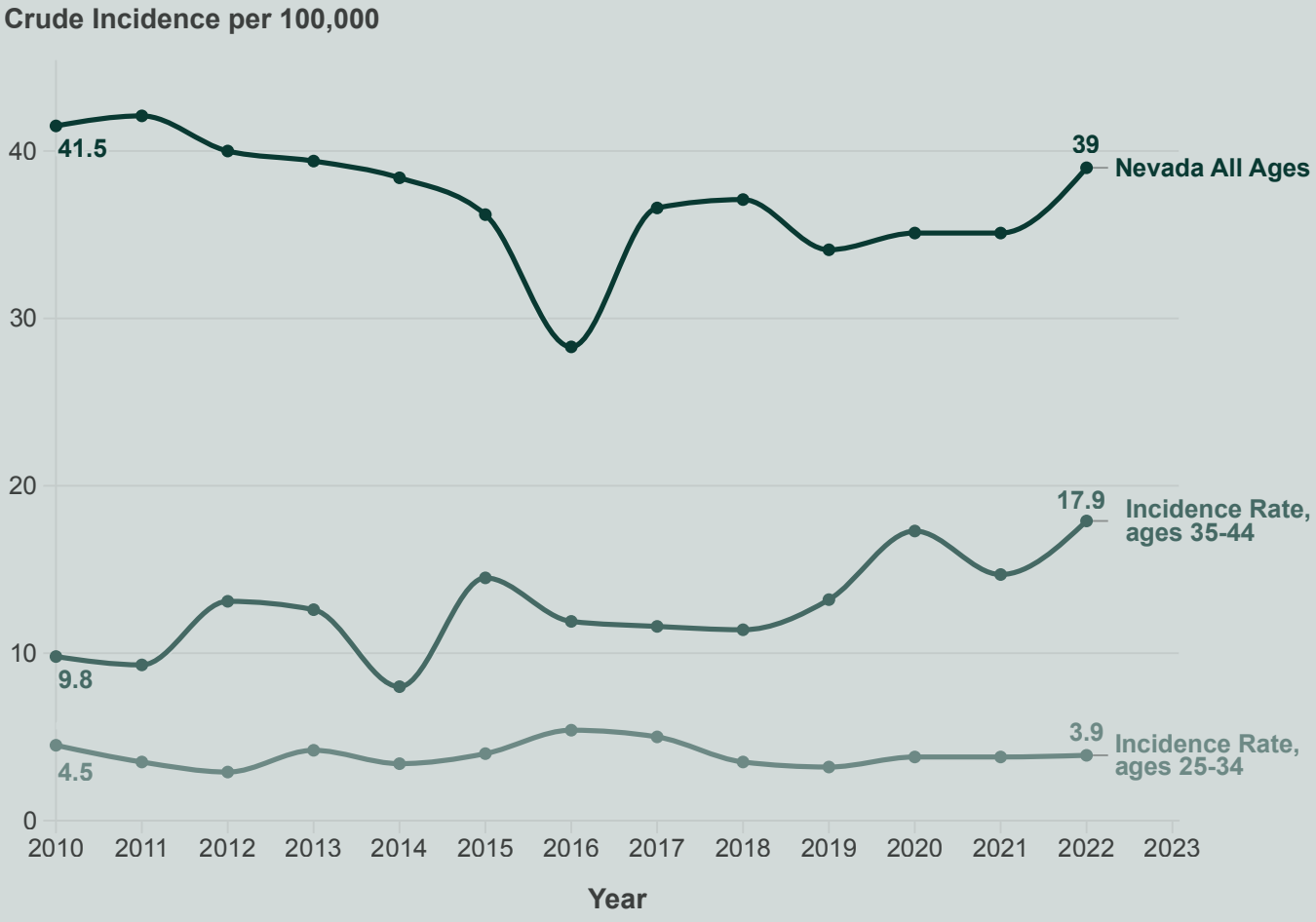
A newly-formed Pediatric and AYA Cancer Collaborative aims to increase collaboration among organizations serving CTYA survivors and their families, creating opportunity to make substantial progress in reaching this plan's objectives.

Pediatric and AYA Cancers: Early Onset Cancer

Cancer is most frequently diagnosed among people ages 65-74, and the median age at diagnosis is 67, according to data from the National Cancer Institute.[xcii] However, some cancers are being increasingly diagnosed among young adults, such as breast and colorectal cancer. These early-onset cancers are often diagnosed at later stages in young adults than they would be for older adults, in part because younger adults are less likely to seek primary care unless they have symptoms and are generally not eligible for recommended cancer screenings which help to detect cancers early. Additionally, because cancer is often considered a disease of aging, it is not usually the first thing a physician may test for.

Young Onset CRC

The rate of colorectal cancer among young adults in Nevada, between 35–44 years old, has nearly doubled since 2010.



Data Source: Nevada Central Cancer Registry/Nevada Office of Analytics

Pediatric and AYA Cancers: Data and Research

Researchers have yet to identify the exact cause of some early-onset cancers, however genetic and other risk factors may play a role. Maintaining a healthy diet that limits processed meats and alcohol, getting regular exercise, avoiding tobacco and secondhand smoke exposure, and getting vaccinated for HPV are risk reduction strategies everyone should employ, but may be helpful in avoiding early-onset cancer. Individuals should also be aware of their family history of cancer and discuss that history with their primary care physician, who may then recommend genetic counseling and/or initiating screening at a younger age.

Objective: Increase the availability of data for pediatric, adolescent and young adult cancers through complete, accurate, and timely reporting to Nevada's Central Cancer Registry and proactive epidemiological reporting.

Strategies

- Educate stakeholders, including policymakers and organizations like the Rare Disease Advisory Council and Patient Protection Commission, on pediatric and AYA cancer impacts.
- Support data reporting to Nevada Central Cancer Registry.
- Support collaboration among community-based organizations to report qualitative data on the impact of pediatric and AYA cancers on families.
- Increase published cancer data reports on pediatric and AYA cancers, including data on incidence, mortality, survival, regional data, financial toxicity, supportive services or other data points critical to improving outcomes.
- Work with federal agencies including the CDC, NCCR (National Childhood Cancer Registry), CCDI (Childhood Cancer Data Initiative), and NPCR to enhance Nevada's participation in federal pediatric and AYA cancer data initiatives.

Data Indicator		
Annual number of pediatric and AYA cancer reports produced[1]	Baseline: 1	Target: 2

[1]*Data source: NCCR and Childhood Cancer Community Organizations*

Objective: Expand access and participation in research and clinical trials for pediatric and AYA patients.

Strategies

- Develop and disseminate education campaigns to inform the public about pediatric cancer research, including clinical trials, and the importance of participation.
- Develop and disseminate a toolkit for how pediatric and AYA patients can participate in research and clinical trials that includes education for parents and caregivers.
- Educate healthcare professionals on best practices in discussing clinical trials with AYA patients.
- Share survivor mentor stories on participation in clinical trials.
- Increase support for research teams through improved administrative and research infrastructure.
- Support participation in tumor boards to facilitate participation in clinical trials.
- Increase the use of telemedicine for clinical trial enrollment.
- Identify barriers and facilitators for patients to participate in clinical trials in Nevada and publish findings.

Clinical Research Indicators		
Number of Nevada-focused resource repositories housing information and tools for AYA participation in clinical trials	Baseline: 0	Target: 1
Number of educational sessions for clinicians on pediatric or AYA clinical trials	Baseline: 2	Target: 6

Objective: Expand access to timely and comprehensive treatment for pediatric and AYA cancers within Nevada.

Strategies

- Increase clinician education on recognizing the signs and symptoms of pediatric cancers and available family support resources.
- Support efforts to retain pediatric health professionals and graduating physicians within the state.
- Assess the need for sub-specialists based on the volume of pediatric and AYA oncology patients seeking out-of-state care and survivorship support.
- Foster collaboration between pediatric and adult oncologists for coordinated adolescent and young adult care.
- Support the development of programs providing psychosocial, palliative care, and survivorship support.
- Support policies ensuring parity in reimbursement for telehealth and in-person visits, with an emphasis on expanding access to rare disease care via telehealth.

Access to Treatment Indicators		
Number of pediatric physicians, including oncologists and sub-specialists, in Nevada[1]	Baseline: General Pediatrics 52.2; Pediatric Sub-Specialities: 23.9	Target: General Pediatrics 57.5; Pediatric Sub-Specialities: 26.3
Number of reports assessing pediatric subspecialty needs for Nevada	Baseline: 0	Target: 1
Percentage of pediatric and adolescent patients annually who leave the state for treatment[2]	Baseline: 19.27%	Target: 18%

[1]Data source: Nevada Physician Workforce Data Book, UNR Office of Statewide Initiatives. U.S., 2022[xci]: General Pediatrics 87.6; Pediatric Sub-Specialties: 45.2; [2]Data Source: NCCR

Objective: Increase access to psychosocial support for pediatric and AYA cancer patients, their caregivers/parents, and siblings.

Strategies

- Promote the value of mental health support for patients and families to navigate cancer diagnoses and long-term impacts through educational materials and workshops.
- Promote psychosocial support, including one-on-one, in group settings, and clinical settings, as a standard of care from the time of diagnosis.
- Expand the geographic availability of supportive services, including mental health, nutrition support, and tele-navigation, through telehealth.
- Develop tools for healthcare administrators and decision-makers that make the case for providing supportive resources and services as a standard of care.

Objective: Increase access to formalized long-term follow-up and survivorship care for pediatric and AYA survivors.

Strategies

- Support the development and expansion of survivorship resources tailored to pediatric and AYA survivors.
- Educate primary care physicians on the survivorship needs of pediatric and AYA survivors to better support the transition to adult care.
- Promote use of the Children's Oncology Group Passport for Care to develop follow-up screening recommendations for survivors.

Pediatric and AYA Cancers: Access to Treatment

Objective: Reduce the financial burden on families impacted by a pediatric or AYA cancer diagnosis.

Strategies

- Educate families and healthcare professionals about free or reduced-price drug programs and other financial resources.
- Raise awareness among Nevadans about the financial impacts of pediatric or AYA cancer to encourage solutions that reduce the burden on patients and families.
- Assist caregivers of uninsured children in applying for insurance.
- Ensure state financial resources are included in major directories like Nevada 211.
- Educate payors on the needs of AYA patients.
- Support efforts to eliminate gaps in health insurance coverage for protocol services or prescribed treatments.

Access to Treatment Indicators			
Number of psychosocial professionals who provide pediatric/AYA cancer support[1]	Baseline: 7	Target: 10	
Percentage of children without health insurance[2]	Baseline: 7.9%	Target: 5.4%	US: 5.4%
Number of collaborative groups for pediatric cancer organizations	Baseline: 1	Target: 1	
Number of formalized long-term follow-up programs	Baseline: 1	Target: 2	

[1]Data source: Renown, C4TK, Candlelighters; [2]Data Source: US Census Bureau's American Community Survey

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