

Health Equity
Community-Clinical Linkages



Strategic Planning (State/Local)
Communications (Tailored)

Delaware: Cancer Consortium Retreat

*Closing Gaps Along the Cancer Control Continuum To Advance
Health Equity Among the Nation's Vulnerable Low-Income
Populations*

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SelfMade Health Network (SMHN)
April 11, 2022**



National Cancer Institute (NCI): *Cancer Disparities*

Cancer disparities (sometimes known as cancer health disparities) are differences in cancer measures such as:

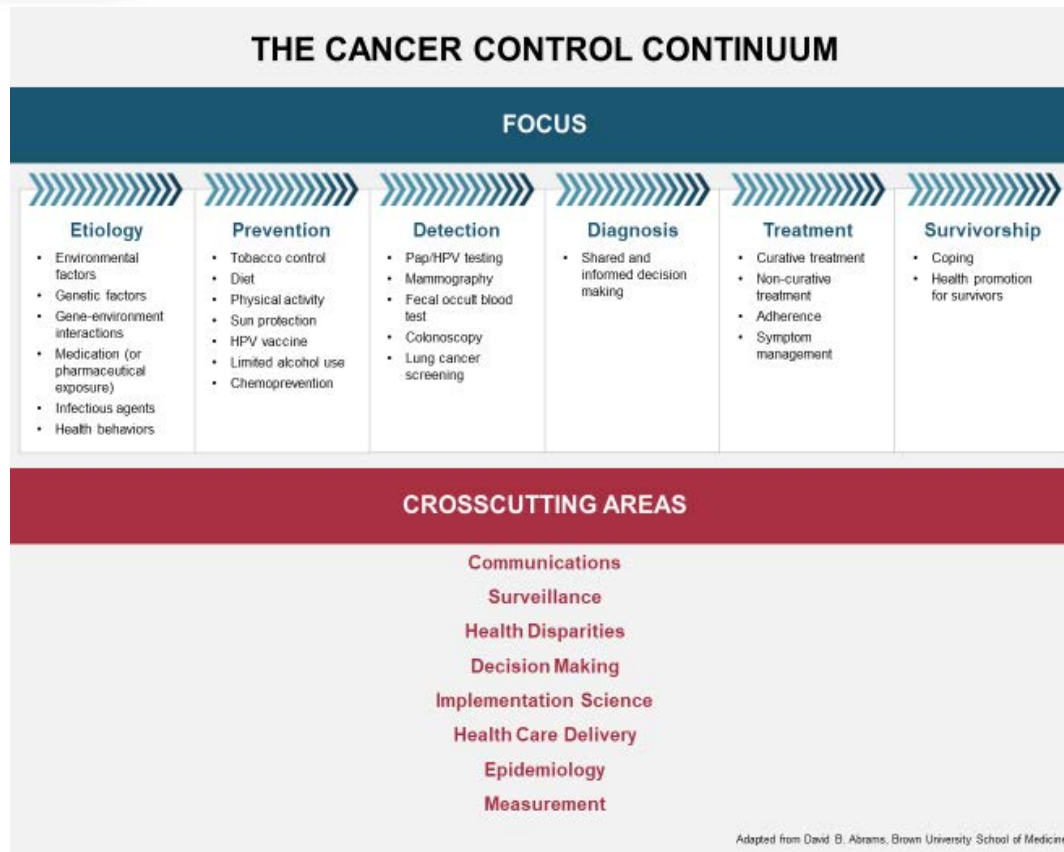
- incidence (new cases)
- prevalence (all existing cases)
- mortality (deaths)
- survival (how long people survive after diagnosis)
- morbidity (cancer-related health complications)
- survivorship (including quality of life after cancer treatment)
- financial burden of cancer or related health conditions
- screening rates
- stage at diagnosis

“Cancer disparities can also be seen when outcomes are improving overall but improvements are not seen in some populations relative to other populations.”

Certain populations “bear a disproportionate burden of cancer” compared with other populations.



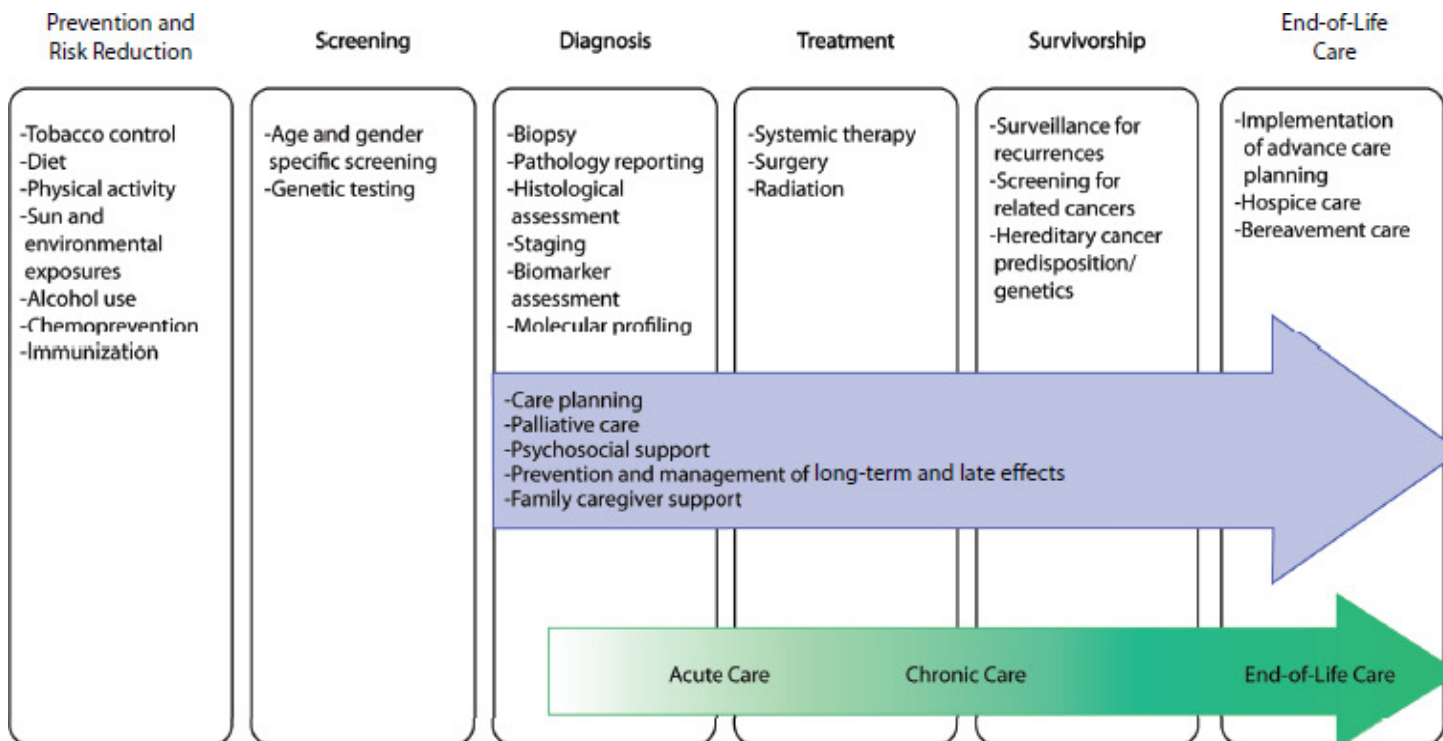
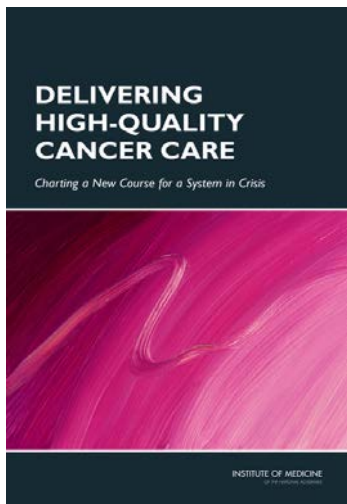
National Cancer Institute (NCI): Cancer Control Continuum



Reference: National Cancer Institute (NCI)-Cancer Control Continuum

<https://cancercontrol.cancer.gov/od/continuum.html>

National Cancer Institute (NCI): Cancer Control Continuum



Reference: Institute of Medicine. 2013. *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/18359>

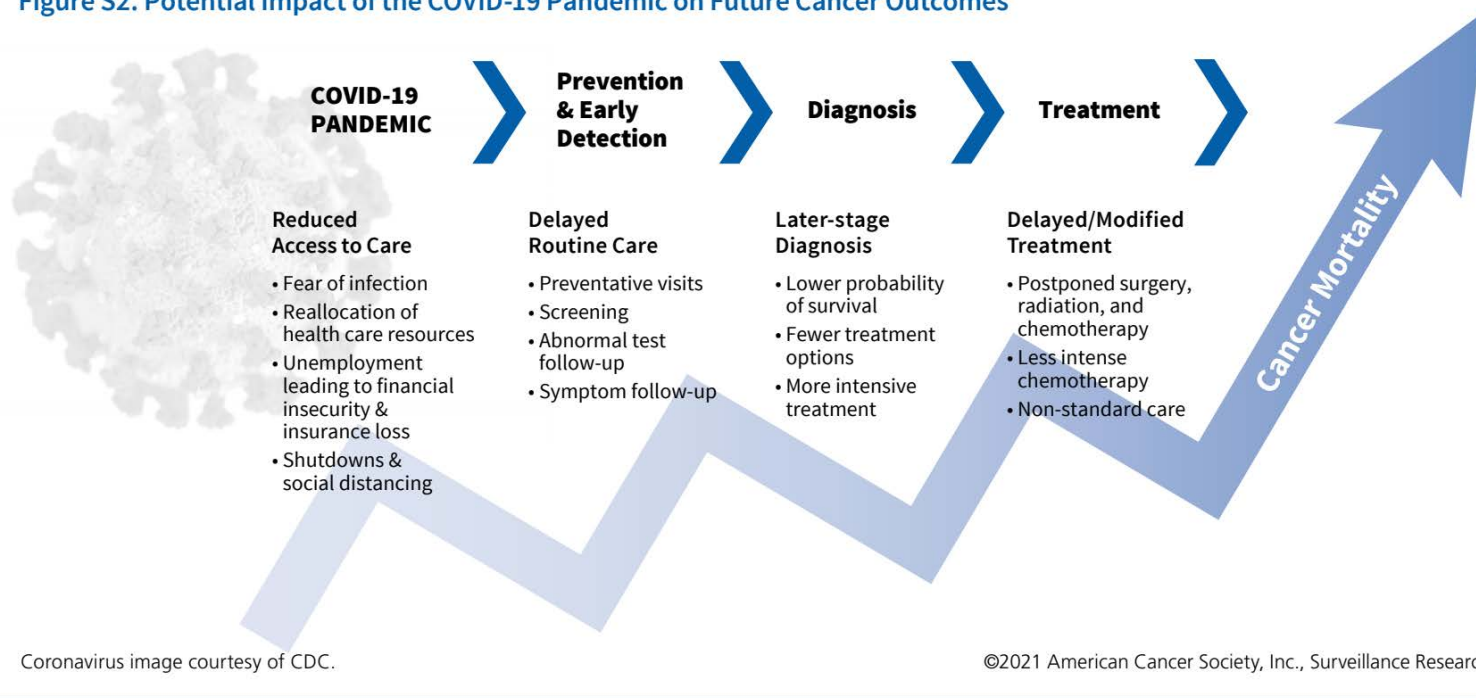
Differences and overlap similarities for the pathogenesis, incidence, and mortality risks between cancer and COVID-19

<u>CANCER</u>	<i>common to both</i>	<u>COVID-19</u>
<ul style="list-style-type: none"> • Series of genetic diseases <ul style="list-style-type: none"> • Germline predisposition • Somatic DNA mutations • Local environmental influences <ul style="list-style-type: none"> • Inflammation • Microbiome • Onset over months to years • Asymptomatic screening is part of routine health care 	<ul style="list-style-type: none"> • Socioeconomic disparity <ul style="list-style-type: none"> • Level of Income and employment • Housing and location • Level of medical insurance • Level of education • Lifestyle factors and comorbidities <ul style="list-style-type: none"> • Tobacco • Alcohol • Diet and obesity • Reduced access to medical care <ul style="list-style-type: none"> • Delayed prevention or care • Fear of clinical trial participation • Higher risk of acquiring disease • Higher risk of death from disease • Survivorship medical and socioeconomic issues 	<ul style="list-style-type: none"> • Single infectious disease • Local environmental influences <ul style="list-style-type: none"> • ACE2 receptor • Onset over hours to days • Symptomatic screening <ul style="list-style-type: none"> • With widespread testing, can move to asymptomatic screening

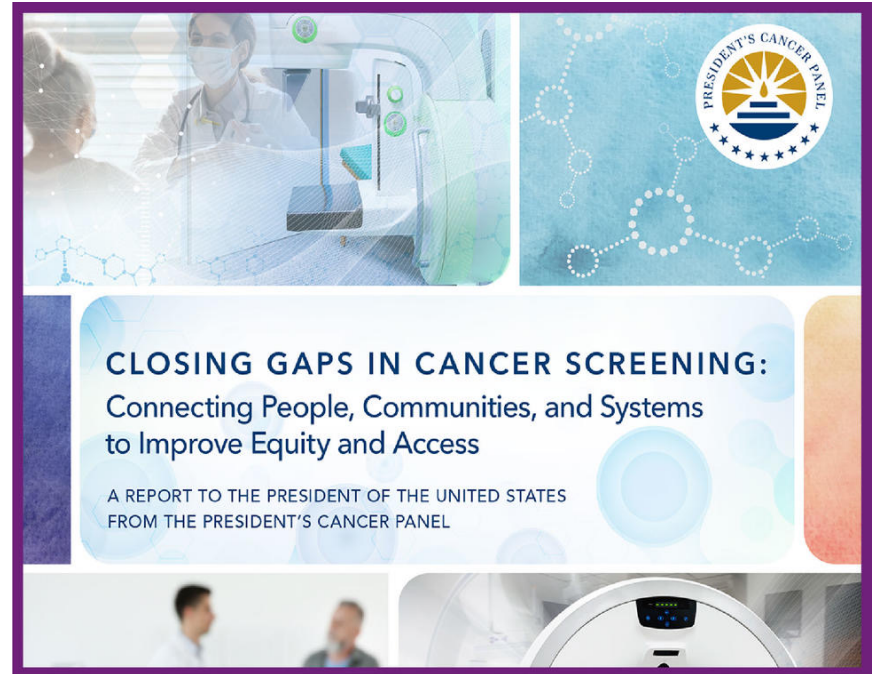
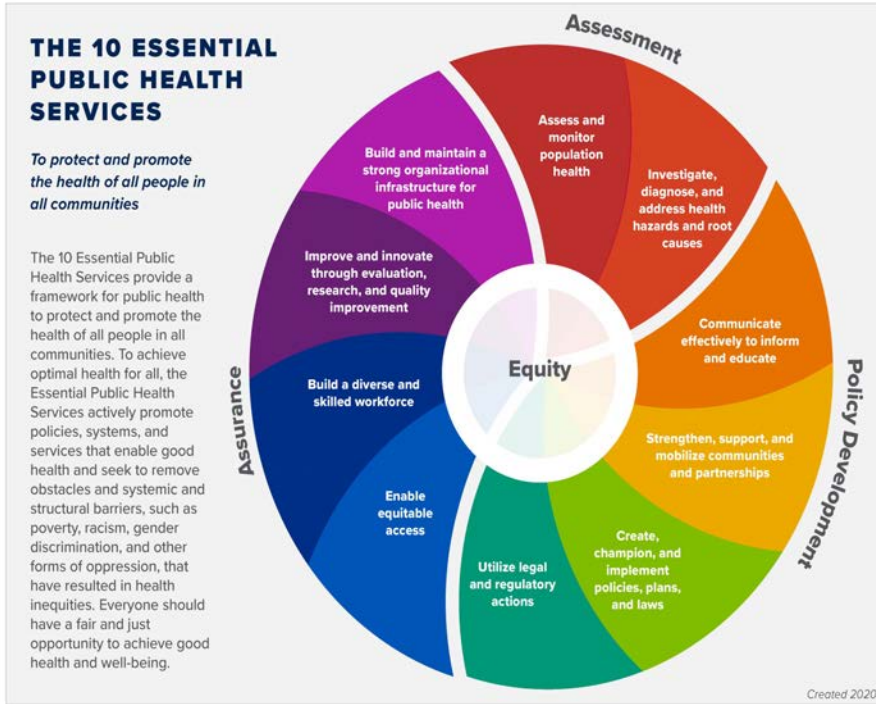
Reference: Lisa A. Newman et al. Similarities in Risk for COVID-19 and Cancer Disparities Clin Cancer Res 2021;27:24-27

COVID-19 and Future Cancer Outcomes

Figure S2. Potential Impact of the COVID-19 Pandemic on Future Cancer Outcomes



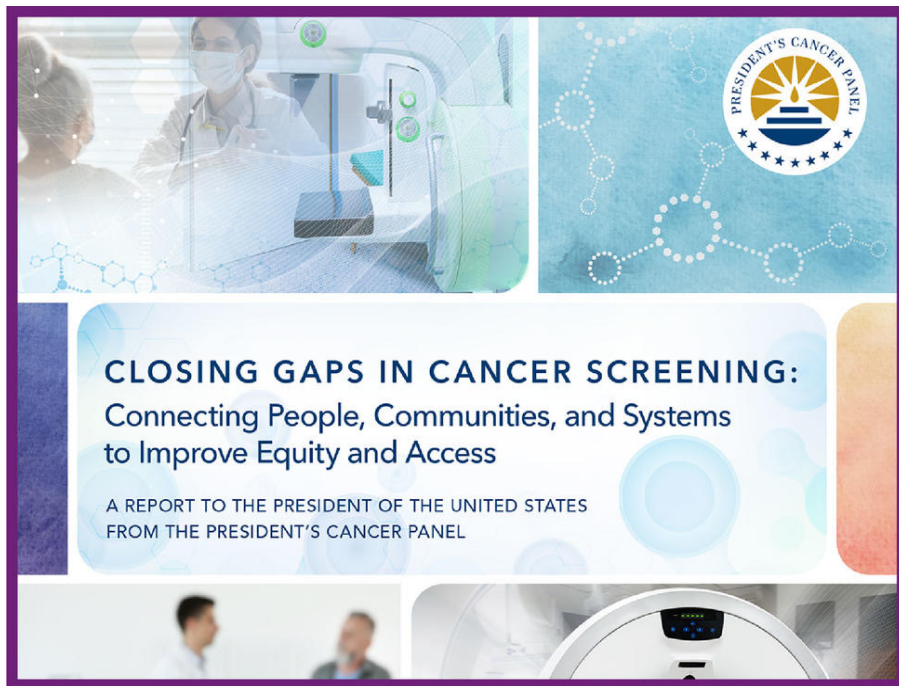
Reference: American Cancer Society. Cancer Facts & Figures 2021. Atlanta: American Cancer Society; 2021.



References:

Closing Gaps in Cancer Screening: Connecting People, Communities, and Systems to Improve Equity and Access. A Report from the President's Cancer Panel to the President of the United States. Bethesda (MD): President's Cancer Panel; 2022.

Centers for Disease Prevention and Control (CDC) 10 Essential Public Health Services (2021 Version) at: <https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html>



Goal #2: Facilitate Equitable Access to Cancer Screening

Build relationships
with community

...

Provide
information

...

Promote screening
and follow-up care

...

Identify and
address barriers

...

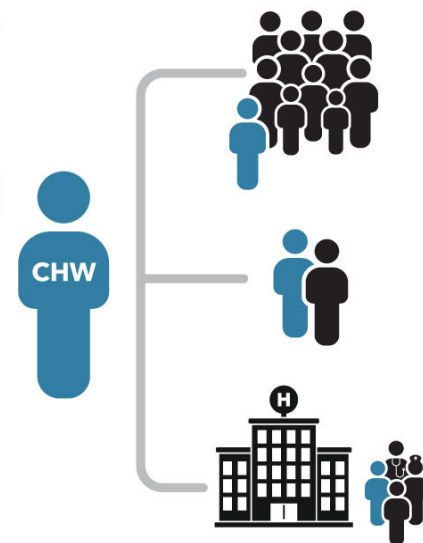
Facilitate access
to resources
and services

...

Coordinate care

...

Advocate for
communities



Reference: Closing Gaps in Cancer Screening: Connecting People, Communities, and Systems to Improve Equity and Access. A Report from the President's Cancer Panel to the President of the United States. Bethesda (MD): President's Cancer Panel; 2022.

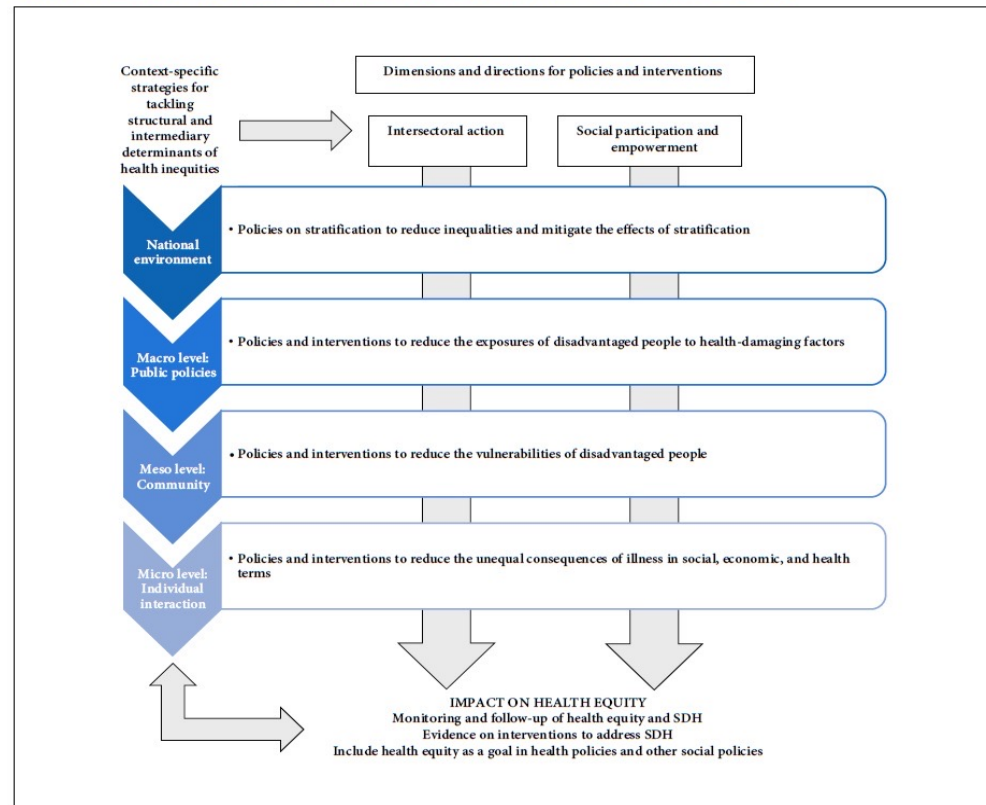
Figure 1
Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

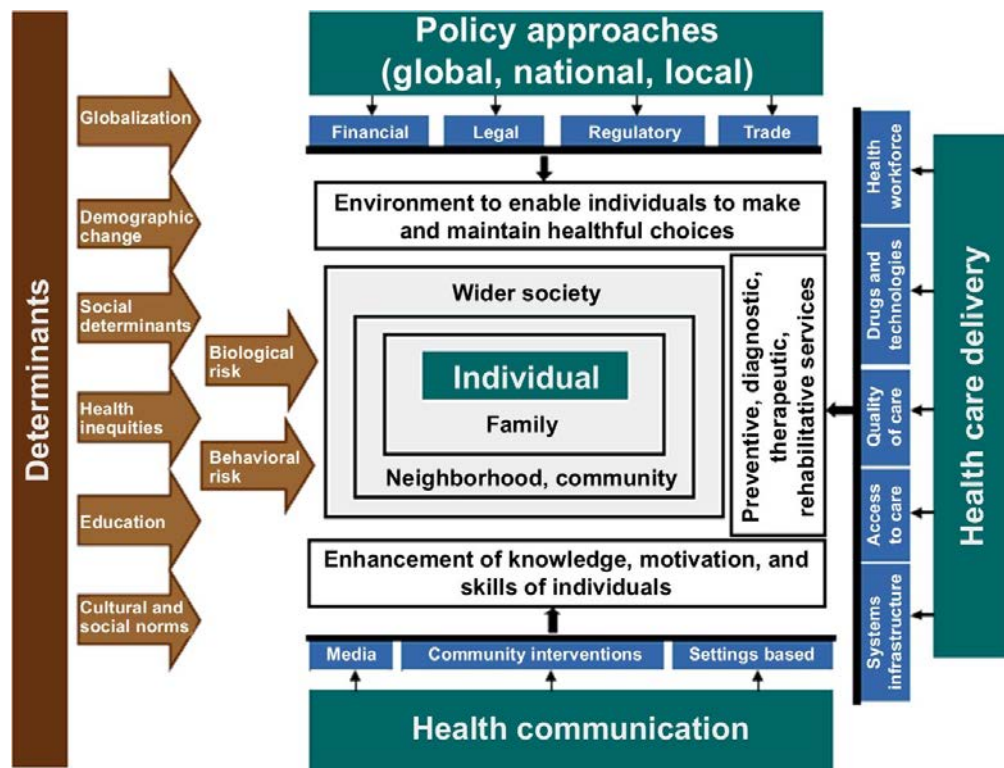
Health Equity (2)

FIGURE 1. Framework for tackling structural and intermediary determinants of health inequities



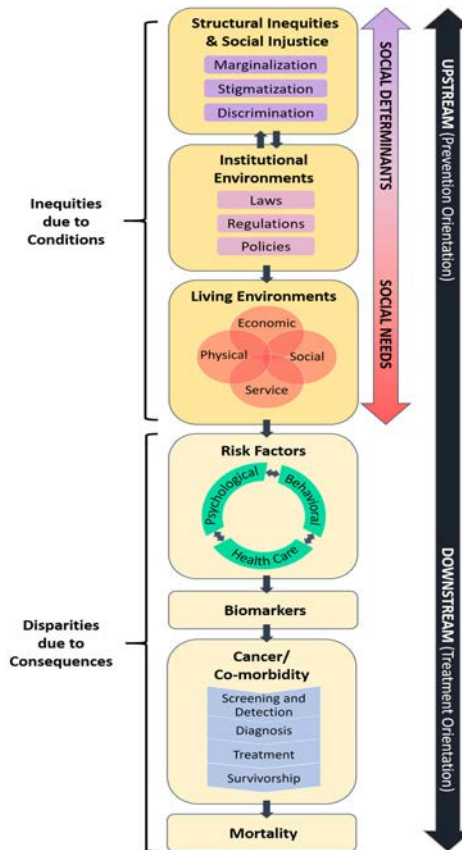
Source: O. Solar and A. Irwin, A conceptual framework for action on the social determinants of health, Social Determinants of Health Discussion Paper 2 (Policy and Practice) 2010, World Health Organization, Geneva, Switzerland.

Cancer Prevention: Social Determinants of Health (SDoH)



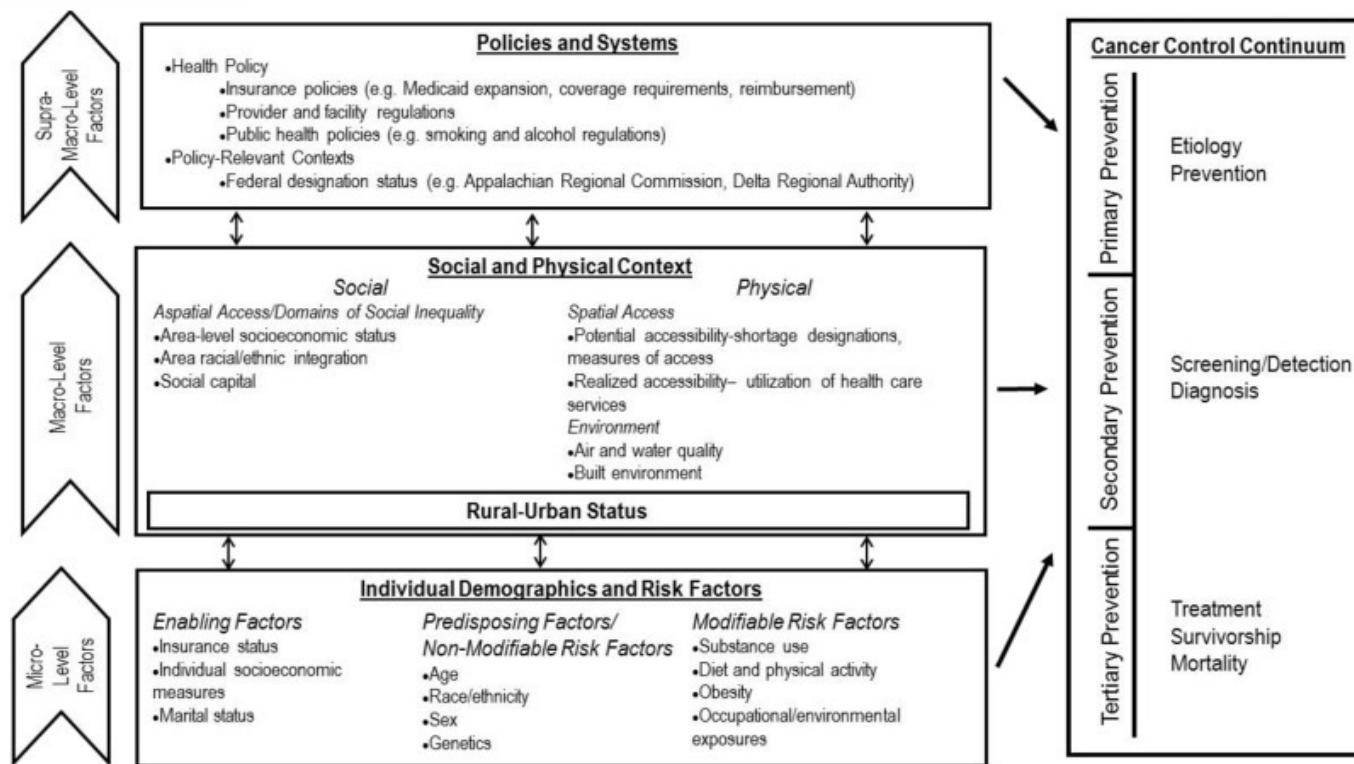
Reference: Accelerating the Pace of Cancer Prevention- Right Now. Graham A. Colditz and Karen M. Emmons
Cancer Prev Res April 1 2018 (11) (4) 171-184; DOI: 10.1158/1940-6207.CAPR-17-0282

Social Determinants of Health to Advance Cancer Health Equity



Reference: CA A Cancer J Clinicians, Volume: 70, Issue: 1, Pages: 31-46, First published: 29 October 2019, DOI: (10.3322/caac.21586)

Across the Cancer Continuum: Low Socioeconomic Status (SES) Factors



Reference: Whitney E. Zahnd, Sara L. McLafferty, Jan M. Eberth. Multilevel analysis in rural cancer control: A conceptual framework and methodological implications, Preventive Medicine, Volume 129, Supplement, 2019, 105835, ISSN 0091-7435, <https://doi.org/10.1016/j.ypmed.2019.105835>



Across the Cancer Continuum: Low Socioeconomic Status (SES) Factors-Part 2

Counties with **persistent poverty**:

- Persistent poverty is associated with the strongest risk of cancer mortality.
- Counties that have experienced persistent poverty face health risks that have *accumulated for decades*, and they have fewer *current or past* resources to protect public health.

Counties with **current poverty**:

- Defined as 20% or more of the population living in poverty.

Neighborhood socioeconomic status (nSES) including neighborhood deprivation factors are correlated with cancer outcomes.

Area deprivation index (ADI) factors are also associated with cancer outcomes (including breast, prostate, lung and colorectal cancers) via multiple pathways.

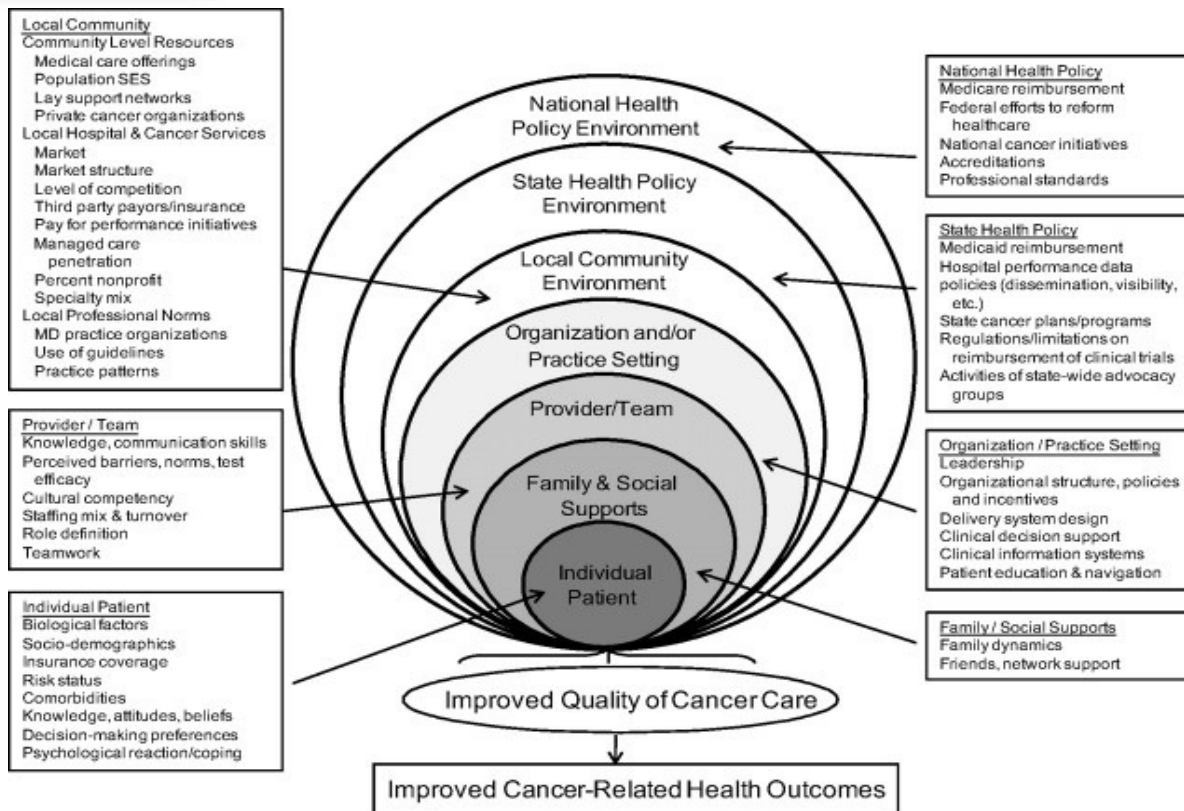
References:

Moss JL, Pinto CN, Srinivasan S, Cronin KA, Croyle RT. Persistent Poverty and Cancer Mortality Rates: An Analysis of County-Level Poverty Designations. *Cancer Epidemiol Biomarkers Prev.* 2020 Oct;29(10):1949-1954. doi: 10.1158/1055-9965.EPI-20-0007. PMID: 32998949; PMCID: PMC7534551.

Cheng E, Soulos PR, Irwin ML, et al. Neighborhood and Individual Socioeconomic Disadvantage and Survival Among Patients With Nonmetastatic Common Cancers. *JAMA Netw Open.* 2021;4(12):e2139593. doi:10.1001/jamanetworkopen.2021.39593

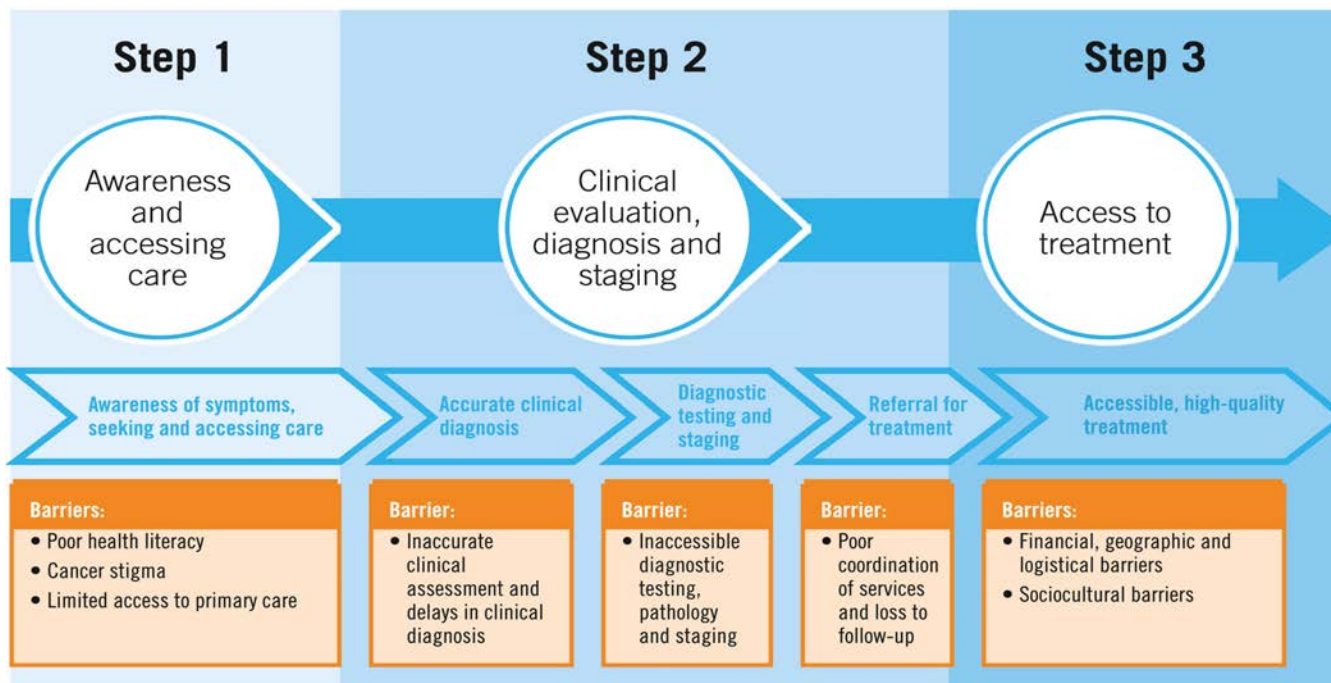
Obrochta CA, Murphy JD, Tsou MH, Thompson CA. Disentangling Racial, Ethnic, and Socioeconomic Disparities in Treatment for Colorectal Cancer. *Cancer Epidemiol Biomarkers Prev.* 2021;30(8):1546-1553. doi:10.1158/1055-9965.EPI-20-1728.

Multi-level Influences on the Cancer Care Continuum



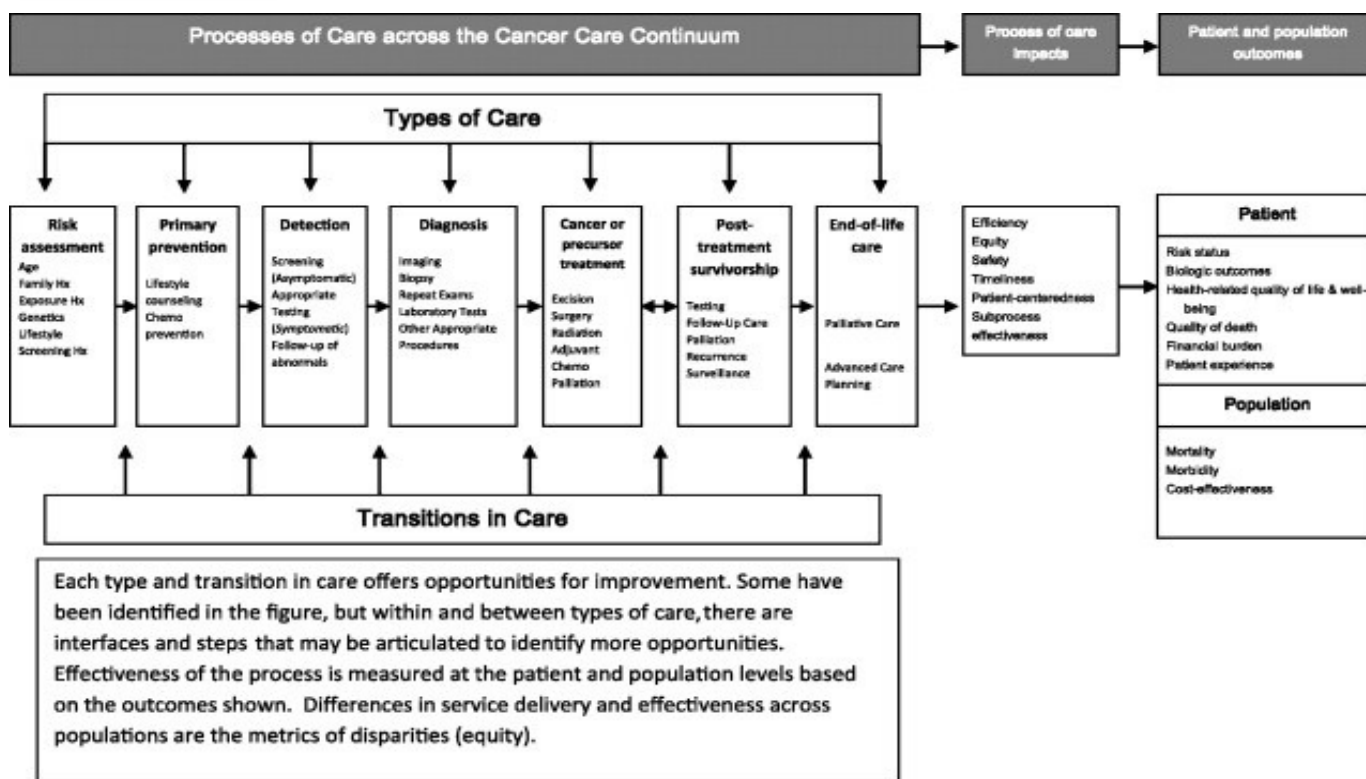
Reference: Taplin SH, Anhang Price R, Edwards HM, et al. Introduction: Understanding and influencing multilevel factors across the cancer care continuum. *J Natl Cancer Inst Monogr.* 2012;2012(44):2-10. doi:10.1093/jncimonographs/lgs008

Common Barriers to Early Diagnosis



Reference: Ginsburg O, Yip CH, Brooks A, Cabanes A, Caleffi M, Dunstan Yataco JA, Gyawali B, McCormack V, McLaughlin de Anderson M, Mehrotra R, Mohar A, Murillo R, Pace LE, Paskett ED, Romanoff A, Rositch AF, Scheel JR, Schneidman M, Unger-Saldaña K, Vanderpuye V, Wu TY, Yuma S, Dvaladze A, Duggan C, Anderson BO. Breast cancer early detection: A phased approach to implementation. *Cancer*. 2020 May 15;126 Suppl 10(Suppl 10):2379-2393. doi: 10.1002/cncr.32887. PMID: 32348566; PMCID: PMC7237065.

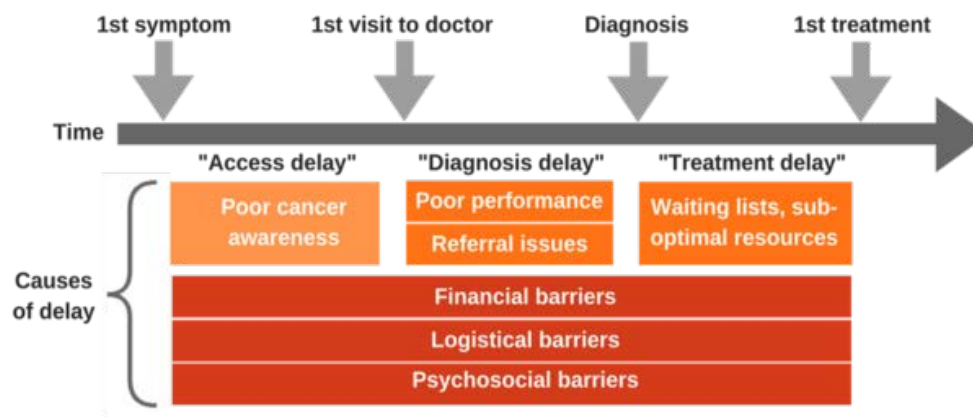
Opportunities to Influence the Process of Care: Cancer Continuum



Reference: Taplin SH, Anhang Price R, Edwards HM, et al. Introduction: Understanding and influencing multilevel factors across the cancer care continuum. *J Natl Cancer Inst Monogr.* 2012;2012(44):2-10. doi:10.1093/jncimonographs/lgs008

Contributing Factors Associated with Cancer Diagnosis and Treatment Delays

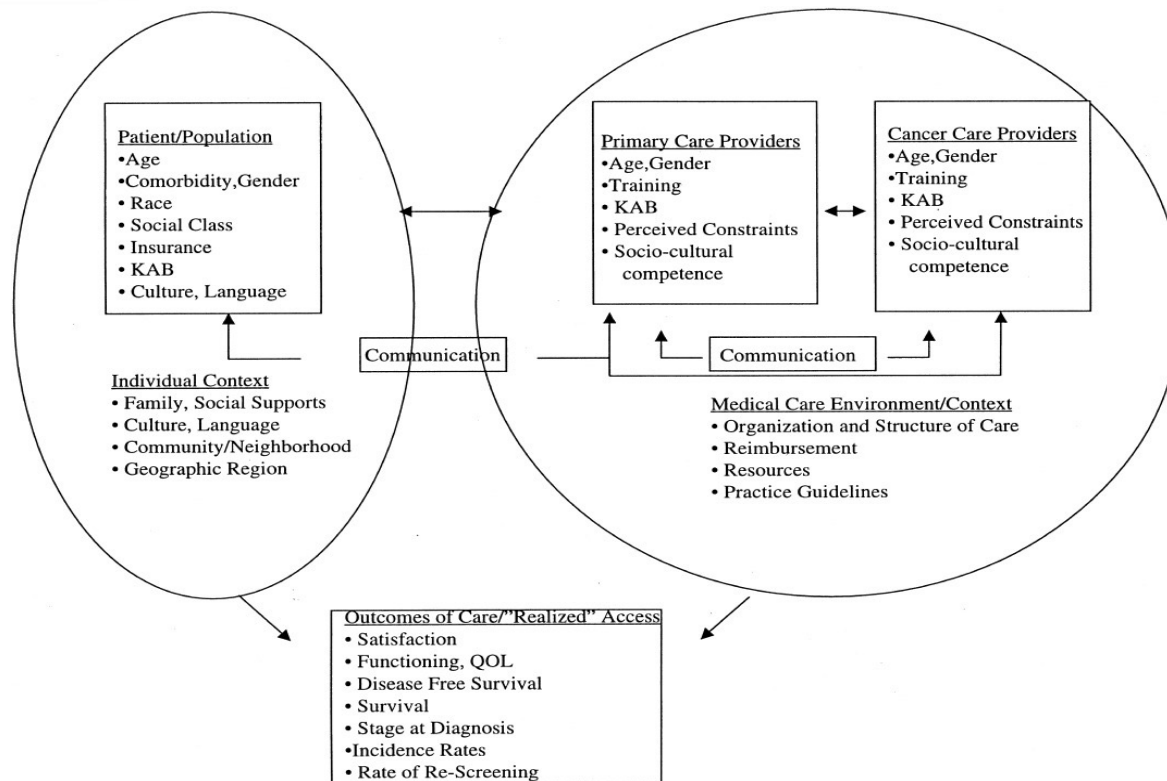
What causes delays in cancer diagnosis and treatment?



Reference: World Health Organizations (WHO) Barriers to early cancer diagnosis and treatment.

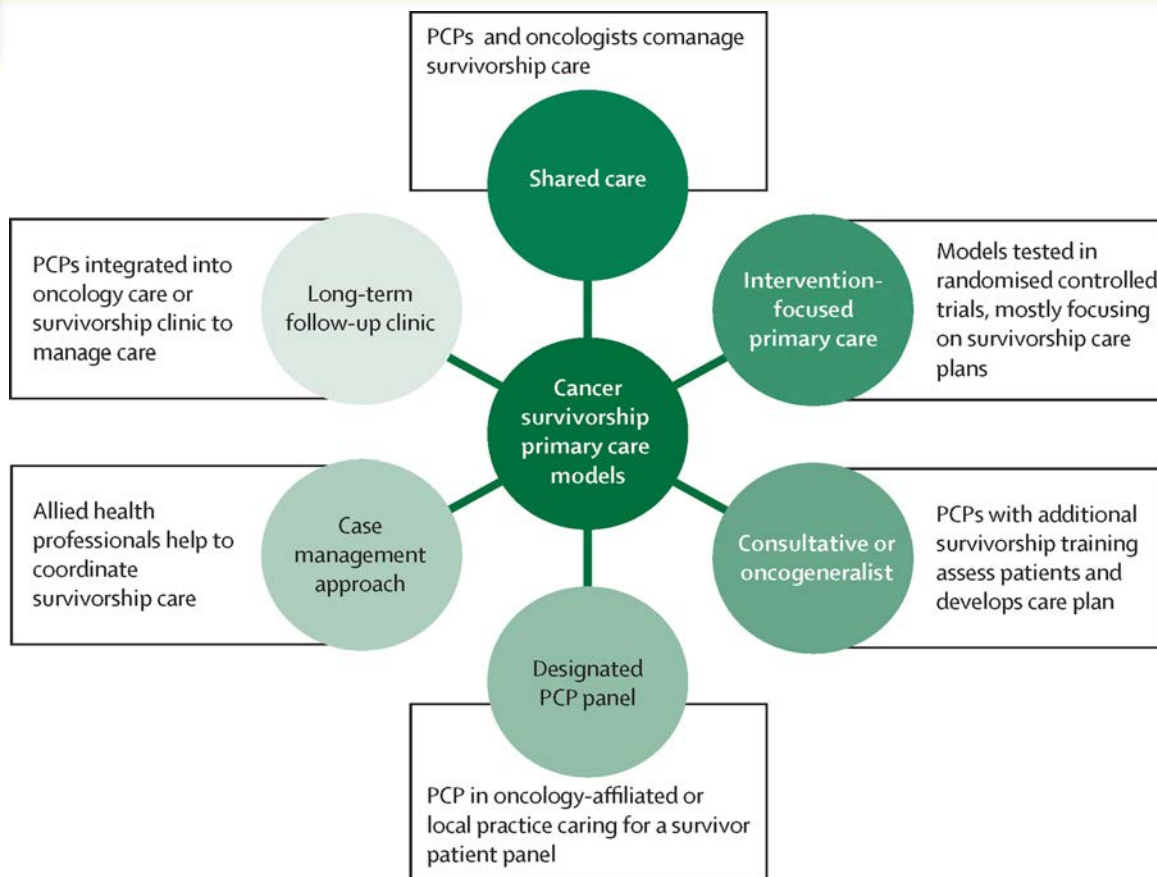
<https://www.euro.who.int/en/health-topics/noncommunicable-diseases/cancer/policy/screening-and-early-detection/barriers-to-early-cancer-diagnosis-and-treatment>

Collaborative Care Model (2)

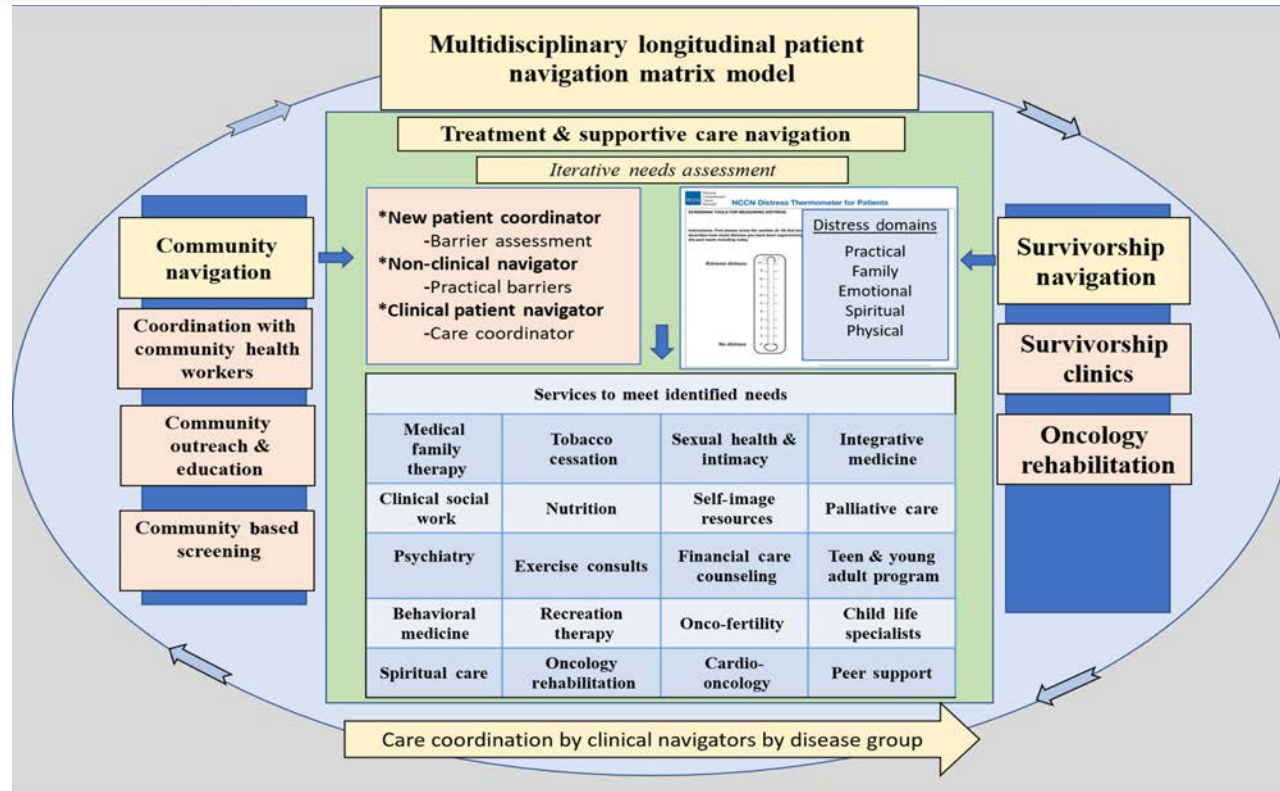


Reference: Mandelblatt, J.S., Yabroff, K.R. and Kerner, J.F. (1999), Equitable access to cancer services. *Cancer*, 86: 2378-2390. [https://doi.org/10.1002/\(SICI\)1097-0142\(19991201\)86:11<2378::AID-CNCR28>3.0.CO;2-L](https://doi.org/10.1002/(SICI)1097-0142(19991201)86:11<2378::AID-CNCR28>3.0.CO;2-L)

Collaborative Care Models



Reference: Nekhlyudov L, O'malley DM, Hudson SV. Integrating primary care providers in the care of cancer survivors: gaps in evidence and future opportunities. *Lancet Oncol.* 2017;18(1):e30-e38. doi:10.1016/S1470-2045(16)30570-8



Reference: Corbett CM, Somers TJ, Nuñez CM, et al. Evolution of a longitudinal, multidisciplinary, and scalable patient navigation matrix model. *Cancer Med.* 2020;9(9):3202-3210. doi:10.1002/cam4.2950

TABLE 1. Barriers Addressed by Patient Navigation

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

Reference: Navigating a Path to Equity in Cancer Care: The Role of Patient Navigation, Niharika Dixit, Hope Rugo, and Nancy J. Burke. American Society of Clinical Oncology Educational Book 2021 :41, 3-10.



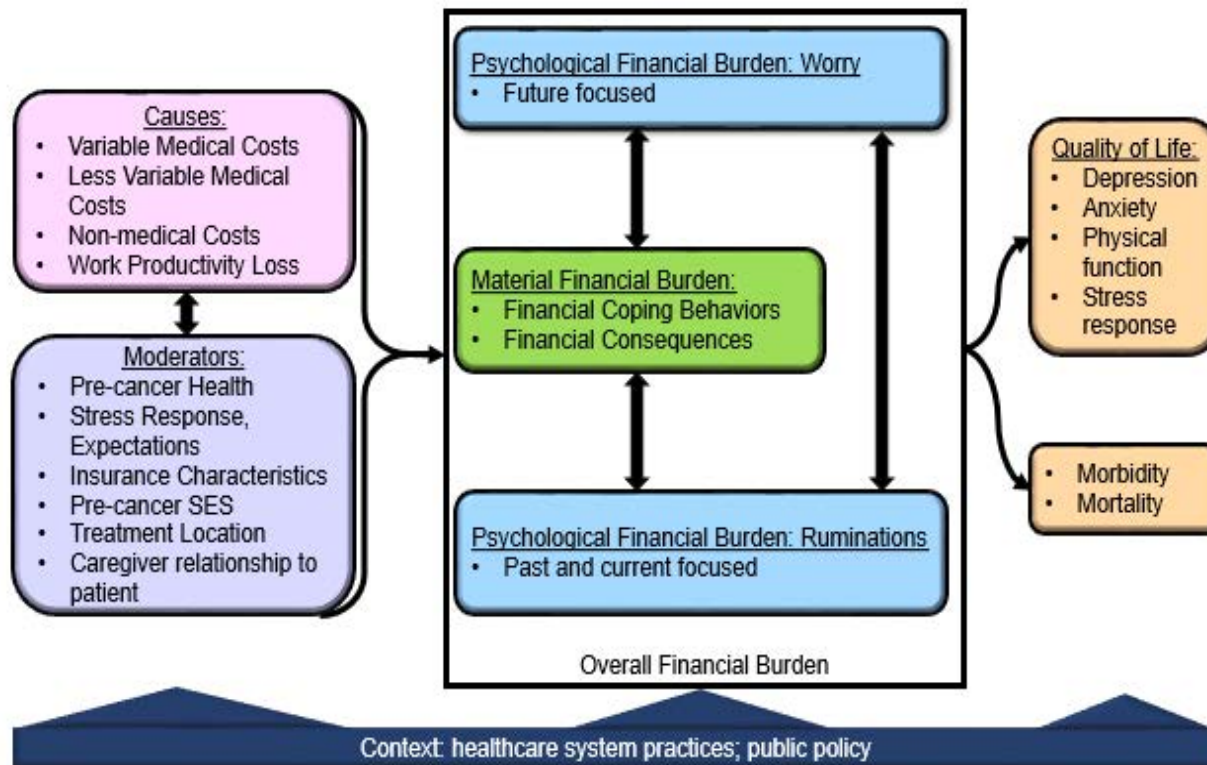
Patient Navigation (3)

Steps to implement a navigation program with a health equity lens:

- Development of a current comprehensive assessment to establish baseline metrics of local health inequities and gaps in cancer care;
- Documentation of Patient Navigation Program—track identified barriers in the electronic medical records and implementation of social risk factor screeners to direct patient navigation;
- Establishment of patient navigation programs with structures responsive to the patient population (e.g., low health literacy support), social determinants of health barriers (e.g., links with housing and food security resources, transportation support) and other barriers;
- Creation of a competency-based patient navigation training program, including communication training, overview of cancer care, local community context, and resources within the healthcare systems and community-based resources and partnerships; and
- Ongoing evaluations specifically addressing implementation to understand how well the intervention works for the intended population, how effective it is in addressing social determinants of health, and improving treatment adherence/completion, and what barriers and facilitators exist to patient navigation.

Reference: Navigating a Path to Equity in Cancer Care: The Role of Patient Navigation, Niharika Dixit, Hope Rugo, and Nancy J. Burke
American Society of Clinical Oncology Educational Book 2021 :41, 3-10.

Theoretical Model: Financial Burden Following Cancer Diagnosis



Reference: Jones SM, Henrikson NB, Panattoni L, Syrjala KL, Shankaran V. A theoretical model of financial burden after cancer diagnosis. *Future Oncology*. 2020 Aug (0). <https://doi.org/10.2217/fon-2020-0547>



Planning Ahead: Health Equity (Organizational Capacity)

How can funding decisions advance our health equity efforts?

- How do the funds we typically seek align with identified health equity needs in the community?

How can we integrate health equity into our products and service offerings?

- What structural and operational modifications are needed for our services to be more accessible and of better quality?
- How are we tracking and evaluating our efforts to determine if populations experiencing health inequities are benefiting from the services or resources we provide?

How can our partnerships and community outreach efforts help to advance health equity?

- What existing partnerships do we have with organizations serving populations experiencing health inequities?
- What new partnerships should we consider exploring to fulfill our commitment to health equity?

What can we do differently to improve or enhance our organization's capacity to advance health equity?

Reference: Centers for Disease Control and Prevention – Division of Community Health. A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. Atlanta, GA: US Department of Health and Human Services; 2013.



Planning Ahead: Health Equity (Partnerships)

What existing relationships do we have with populations experiencing health inequities?

- What is our current process/plan for engaging community members, particularly those experiencing health inequities?
- Are we using language that facilitates or creates barriers to engaging the intended communities?
- How will we identify barriers to community participation? How can we overcome these barriers?

How do our current partnerships/coalitions reflect the populations experiencing inequities in our community?

- What is the current commitment to advancing health equity among these partners/coalitions?
- How does this commitment translate into identifiable and measurable activities?

What tools and resources can we use to identify and understand health inequities?

- What combination of data sources do we need to better understand experiences of populations affected by health inequities?

What process can we put in place to routinely engage populations affected by health inequities in collecting and analyzing data?

Reference: Centers for Disease Control and Prevention – Division of Community Health. A Practitioner’s Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. Atlanta, GA: US Department of Health and Human Services; 2013.



Equitable Cancer Care: Resources and Evidence-based Interventions(1)

American Society of Clinical Oncology (ASCO) Cancer Treatment and Survivorship Care Plans

<https://www.cancer.net/survivorship/follow-care-after-cancer-treatment/asco-cancer-treatment-and-survivorship-care-plans>

Implementing the Commission on Cancer Standard 8.1: Addressing Barriers to Care (George Washington University Cancer Center)

<https://smhs.gwu.edu/cancercontroltap/resources/implementing-commission-cancer-standard-81-addressing-barriers-care>

National Cancer Institute (NCI)- Repository of resources featuring guidelines cancer survivorship guidelines

<https://cancercontrol.cancer.gov/ocs/resources/health-care-professionals#guidelines>

American Academy of Family Physicians (AAFP) –Social Determinants of Health (SDoH) Screening Guide and Tool

<https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/assessment.html>

Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE)

<https://www.nachc.org/research-and-data/prapare/>

Centers for Disease Control and Prevention – Division of Community Health. A Practitioner’s Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. Atlanta, GA: US Department of Health and Human Services; 2013

Ramachandran A, Freund KM, Bak SM, Heeren TC, Chen CA, Battaglia TA. Multiple barriers delay care among women with abnormal cancer screening despite patient navigation. *J Womens Health (Larchmt)*. 2015;24(1):30-36. doi:10.1089/jwh.2014.4869



Equitable Cancer Care: Resources and Evidence-based Interventions (2)

Patel MI, Lopez AM, Blackstock W, Reeder-Hayes K, Moushey EA, Phillips J, Tap W. *Cancer Disparities and Health Equity: A Policy Statement From the American Society of Clinical Oncology*. J Clin Oncol. 2020 Oct 10;38(29):3439-3448. doi: 10.1200/JCO.20.00642. Epub 2020 Aug 12. Erratum in: J Clin Oncol. 2020 Nov 20;38(33):3976. PMID: 32783672; PMCID: PMC7527158.

National Academies of Sciences, Engineering, and Medicine 2021. *Advancing Progress in the Development and Implementation of Effective, High-Quality Cancer Screening: Proceedings of a Workshop*. Washington, DC: The National Academies Press.
<https://doi.org/10.17226/26019>

Committee on the Recommended Social and Behavioral Domains and Measures for Electronic Health Records; Board on Population Health and Public Health Practice; Institute of Medicine. *Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2*. Washington (DC): National Academies Press (US); 2015 Jan 8. 4, Measures Reviewed for Each Candidate Domain. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK269339/>

Hilary Daniel, Sue S. Bornstein, Gregory C. Kane. *Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper*. Ann Intern Med.2018;168:577-578. [Epub ahead of print 17 April 2018]. doi:[10.7326/M17-2441](https://doi.org/10.7326/M17-2441)

Shusted CS, Barta JA, Lake M, et al. The Case for Patient Navigation in Lung Cancer Screening in Vulnerable Populations: A Systematic Review. *Popul Health Manag*. 2019;22(4):347-361. doi:10.1089/pop.2018.0128

Centers for Disease Control and Prevention. ScreenOut Cancer. *Reducing Structural Barriers Planning Guide*. Accessed at: <https://www.cdc.gov/screenoutcancer/ebi-planning-guides/reducing-structural-barriers-planning-guide.htm>



Equitable Cancer Care: Resources and Evidence-based Interventions (3)

National Colorectal Cancer Roundtable (NCCRT)

<https://nccrt.org/resource-center/>

Rivera, M. & Katki, Hormuzd & Tanner, Nichole & Triplette, Matthew & Sakoda, Lori & Wiener, Renda & Cardarelli, Roberto & Carter-Harris, Lisa & Crothers, Kristina & Fathi, Joelle & Ford, Marvella & Smith, Robert & Winn, Robert & Wisnivesky, Juan & Henderson, Louise & Aldrich, Melinda. (2020). *Addressing Disparities in Lung Cancer Screening Eligibility and Healthcare Access. An Official American Thoracic Society Statement*. American Journal of Respiratory and Critical Care Medicine. 202. e95-e112. 10.1164/rccm.202008-3053ST.

Accessed at: <https://www.atsjournals.org/doi/full/10.1164/rccm.202008-3053ST>

National Academies of Sciences, Engineering, and Medicine. 2019. *Investing in interventions that address non-medical, health-related social needs: Proceedings of a workshop*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25544>

SelfMade Health Network Webinars at: <http://www.selfmadehealth.org/>

[Exploring Opportunities to Reduce Risks Along the Cancer Control Continuum](#)

[Men's Health: The Intersection of Cancer Survivorship, Health Equity and Socioeconomic Factors](#)

[Colorectal Cancer: Opportunities to Advance Health Equity with Healthy People 2030 Objectives from a Low Socioeconomic Status \(SES\) Perspective](#)

[Policy and Practice Interventions from a Health Equity Perspective: Men's Health, COVID-19 and Low Socioeconomic Status \(SES\)](#)



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Membership Information: Sign-up to become a national network member organization

SMHN Quarterly Newsletter: Available to member organizations

Send questions or contact us at anytime via shared SMHN mailbox:

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