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)
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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

THE CANCER CONTROL CONTINUUM

FOCUS

- **Etiology**
  - Environmental factors
  - Genetic factors
  - Gene-environment interactions
  - Medication (or pharmaceutical exposure)
  - Infectious agents
  - Health behaviors

- **Prevention**
  - Tobacco control
  - Diet
  - Physical activity
  - Sun protection
  - HPV vaccine
  - Limited alcohol use
  - Chemoprevention

- **Detection**
  - Pap/FPV testing
  - Mammography
  - Fecal occult blood test
  - Colonoscopy
  - Lung cancer screening

- **Diagnosis**
  - Stages and informed decision making

- **Treatment**
  - Curative treatment
  - Non-curative treatment
  - Adjuvant
  - Symptom management

- **Survivorship**
  - Coping
  - Health promotion for survivors

CROSSCUTTING AREAS

- Communications
- Surveillance
- Health Disparities
- Decision Making
- Implementation Science
- Health Care Delivery
- Epidemiology
- Measurement

Reference: National Cancer Institute (NCI)-Cancer Control Continuum
https://cancercontrol.cancer.gov/od/continuum.html
National Cancer Institute (NCI): Cancer Control Continuum

COVID-19 Pandemic: Impact on Cancer Screening

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

<table>
<thead>
<tr>
<th>CANCER</th>
<th>common to both</th>
<th>COVID-19</th>
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</thead>
<tbody>
<tr>
<td>• Series of genetic diseases</td>
<td>• Socioeconomic disparity</td>
<td>• Single infectious disease</td>
</tr>
<tr>
<td>• Germline predisposition</td>
<td>• Level of Income and employment</td>
<td>• Local environmental influences</td>
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<tr>
<td>• Somatic DNA mutations</td>
<td>• Housing and location</td>
<td>• ACE2 receptor</td>
</tr>
<tr>
<td>• Local environmental influences</td>
<td>• Level of medical insurance</td>
<td>• Onset over hours to days</td>
</tr>
<tr>
<td>• Inflammation</td>
<td>• Level of education</td>
<td>• Symptomatic screening</td>
</tr>
<tr>
<td>• Microbiome</td>
<td>• Lifestyle factors and comorbidities</td>
<td>• With widespread testing, can move to asymptomatic screening</td>
</tr>
<tr>
<td>• Onset over months to years</td>
<td>• Tobacco</td>
<td></td>
</tr>
<tr>
<td>• Asymptomatic screening is part of routine health care</td>
<td>• Alcohol</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diet and obesity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reduced access to medical care</td>
<td></td>
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<tr>
<td></td>
<td>• Delayed prevention or care</td>
<td></td>
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<tr>
<td></td>
<td>• Fear of clinical trial participation</td>
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<tr>
<td></td>
<td>• Higher risk of acquiring disease</td>
<td></td>
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<tr>
<td></td>
<td>• Higher risk of death from disease</td>
<td></td>
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<tr>
<td></td>
<td>• Survivorship medical and socioeconomic issues</td>
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COVID-19 and Future Cancer Outcomes

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

COVID-19 PANDEMIC
- Reduced Access to Care
  - Fear of infection
  - Reallocation of health care resources
  - Unemployment leading to financial insecurity & insurance loss
  - Shutdowns & social distancing

Prevention & Early Detection
- Delayed Routine Care
  - Preventative visits
  - Screening
  - Abnormal test follow-up
  - Symptom follow-up

Diagnosis
- Later-stage Diagnosis
  - Lower probability of survival
  - Fewer treatment options
  - More intensive treatment

Treatment
- Delayed/Modified Treatment
  - Postponed surgery, radiation, and chemotherapy
  - Less intense chemotherapy
  - Non-standard care

Cancer Mortality

References:
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

# Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing, Transportation, Safety, Parks, Playgrounds, Walkability, Zip code / geography</td>
<td>Literacy, Language, Early childhood education, Vocational training, Higher education</td>
<td>Hunger, Access to healthy options</td>
<td>Social integration, Support systems, Community engagement, Discrimination, Stress</td>
<td>Health coverage, Provider availability, Provider linguistic and cultural competency, Quality of care</td>
</tr>
</tbody>
</table>

**Health Outcomes**

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

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

- Context-specific strategies for tackling structural and intermediary determinants of health inequities
  - National environment
    - Policies on stratification to reduce inequalities and mitigate the effects of stratification
  - Macro-level: Public policies
    - Policies and interventions to reduce the exposures of disadvantaged people to health-damaging factors
  - Mezo-level: Community
    - Policies and interventions to reduce the vulnerabilities of disadvantaged people
  - Micro-level: Individual interaction
    - Policies and interventions to reduce the unequal consequences of illness in social, economic, and health terms

Dimensions and directions for policies and interventions
- Intersectoral action
- Social participation and empowerment

Impact on health equity
- Monitoring and follow-up of health equity and SDH
- Evidence on interventions to address SDH
- Include health equity as a goal in health policies and other social policies

Cancer Prevention: Social Determinants of Health (SDoH)

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

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:


Multi-level Influences on the Cancer Care Continuum

Common Barriers to Early Diagnosis

Opportunities to Influence the Process of Care: Cancer Continuum

Contributing Factors Associated with Cancer Diagnosis and Treatment Delays

What causes delays in cancer diagnosis and treatment?

Multi-disciplinary Team: Patient Navigation (1)

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

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.

Theoretical Model:
Financial Burden Following Cancer Diagnosis

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?

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?

Equitable Cancer Care: Resources and Evidence-based Interventions

American Society of Clinical Oncology (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

Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE)
https://www.nachc.org/research-and-data/prapare/


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


National Colorectal Cancer Roundtable (NCCRT)
https://nccrt.org/resource-center/


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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