Comprehensive Cancer Control
Collaborating to Conquer Cancer

COMPREHENSIVE CANCER CONTROL PLAN

TIP SHEET

HEALTH EQUITY

The Comprehensive Cancer Control National Partnership (CCCNP) is a 20+ year collaboration of diverse national organizations working together to build and strengthen Comprehensive Cancer Control (CCC) efforts across the nation. This Tip Sheet is part of a series offered through the CCCNP to assist Comprehensive Cancer Control (CCC) programs charged with developing, implementing, and evaluating cancer control plans tailored to their state/tribe/territory/jurisdiction. CCC Plans focus coalition efforts on evidence-based interventions (EBIs) that impact cancer prevention and control across the cancer continuum.

How to Use This Tip Sheet

Tip Sheets are designed to help CCC program staff, coalition staff, and volunteers update CCC plans. Each tip sheet focuses on a specific topic (e.g., colorectal cancer screening, tobacco control, risk factors for cancer survivors). Follow the steps throughout the Tip Sheet to help guide your process in updating your cancer plan for that specific topic area. Some ideas:

- Incorporate the Tip Sheet into your plan update process – share it with your coalition workgroups and use it to help guide your decisions.
- Identify a lead person to ensure that the Tip Sheet is used by the workgroup or team assigned to update the plan section that addresses each Tip Sheet topic.
- Use the Tip Sheet to check that the topic is appropriately addressed in your plan and that the elements outlined on the next page are covered (objective, data, strategies).
- Use the **worksheet** at the end of this document with your partners to ask and answer critical questions related to the topic as you update your plan.

This guide was produced and was supported through funding to the George Washington University Cancer Center from the Centers for Disease Control and Prevention Cooperative Agreement #NU58DP006461-03. Content is solely the responsibility of the authors and does not necessarily represent the official policies of the Centers for Disease Control and Prevention or the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Definitions

- **SMART Objective** – is an objective in the cancer plan that is Specific, Measurable, Achievable, Relevant, and Time-bound.
- **Evidence-Based Strategy** – is a specific activity that is designed to achieve the objective and is based on evidence that the strategy is expected to work in your situation, i.e., it has been evaluated and shown to work.
- **Crude vs. Age-adjusted Rates** – Crude rates are influenced by the age distribution of the state's population. Even if two states have the same age-adjusted rates, the state with the relatively older population will generally have higher crude rates because incidence or death rates for most cancers increase with age. Age-adjusting the rates ensures that differences in incidence or deaths from one year to another, or between one geographic area and another, are not due to differences in the age distribution of the populations being compared. Find out more **here**.
- **Populations of Focus** – are those groups experiencing the greatest cancer disparities in your region. Disparities might include higher cancer incidence or mortality; greater challenges accessing cancer screening, treatment, and/or survivorship care services; or populations experiencing bias in society and the health care system.
- **Health Equity** – occurs when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.
- **Health Disparity** – is a type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systemically experienced greater social or economic obstacles to health. These obstacles stem from discrimination or exclusion that is historically linked to characteristics such as race or ethnicity, socioeconomic status, disability, sexual orientation, and many other factors.[1]
- **Social Determinants of Health (SDoH)** – are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[2]

[1] U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020 [Internet]. Section IV: Advisory Committee findings and recommendations [cited 2010 January 6]. Available from: **http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf**.

[2] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 12/04/2020, from **https://health.gov/healthypeople/objectives-and-data/social-determinants-health**.

Tips for Updating Your CCC Plan

- **Use your current cancer plan as a starting point:** Think of this process as updating the current plan instead of starting a new plan from scratch.
- **Be systematic:** Assign workgroups to review and update certain sections of the plan. Create a process that is common across all workgroups tasked with updating the plan, which should include a standard set of criteria for the inclusion of plan goals, objectives, and strategies.
- **Focus workgroups on assessing and updating the "guts" of the plan:** the goals, objectives, and strategies.
- **Identify someone to take the lead** on writing the introduction, connecting text, and putting the document together for publication.
- **Use data to determine the focus of the plan:** Which cancers are most prevalent in the population? What subpopulations experience the most disparities?
- **View through a health equity lens:** Be intentional and proactive in keeping health equity issues at the forefront in every step of the cancer plan process – when engaging partners, collecting data, and setting goals. Include representatives from your population of focus in the writing of your cancer plan.

Use these resources to explore more cancer control planning tips and examples:

- **Nine Habits of Successful CCC Coalitions**
- **CCC Implementation Building Blocks** (see page 7 of the Appendices for more tips on updating your plan)

Additional resources you can use:

- Search other CCC plans to get ideas – **CDC's CCC Plan Map and Search Tool**
- **CDC Cancer Plan Self-Assessment Tool**
- **GW State Cancer Plans Priority Alignment Resource Guide and Tool**
- **A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease**

Checklist for Updating Your CCC Plan

- ☐ **Ensure that your workgroup is familiar with your current cancer plan.**
- ☐ **Create a systematic process for the workgroup to follow; a process that is intentional about addressing issues of health equity throughout.**
- ☐ **Use data to focus on the populations with the highest cancer burdens.**
- ☐ **Focus workgroups on assessing and updating goals, objectives, and strategies.**
- ☐ **Identify someone to write the introduction and assemble the final document.**

Health Equity

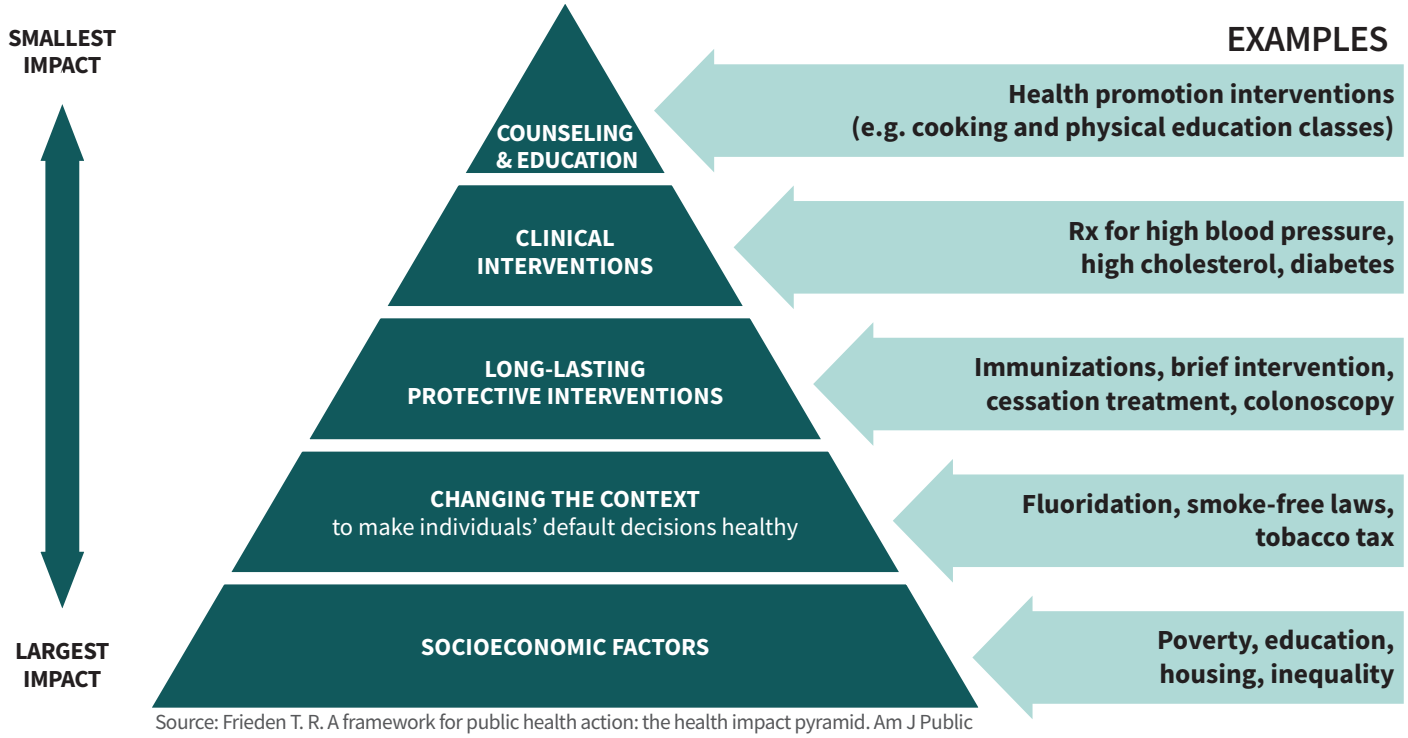
Why Health Equity is Important when Revising Your Comprehensive Cancer Control (CCC) Plan

The COVID-19 pandemic has broadened awareness of the societal-level inequities affecting racial, ethnic and other minority groups in the U.S. Addressing health equity is imperative to effectively prevent and control cancer for all communities.

The Centers for Disease Control and Prevention (CDC) promotes the use of a health equity lens in your cancer control planning, implementation, and evaluation. Comprehensive Cancer Control stakeholders are encouraged to prioritize populations that endure a high burden of cancer incidence, long-term or late effects, or mortality compared to the general population. Health equity is important to ensure every person has the opportunity to attain their full health potential.

While many interventions focus on health disparities, going further upstream to address the underlying social determinants of health (SDOH) can achieve health equity by focusing on structural policies and practices as well as social norms that have led to systemic health inequities. Recently the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) at CDC released its **framework** for achieving health equity. The framework addresses the following five priority SDOH: built environment, community-clinical linkages, food insecurity, social connectedness and tobacco free policy.

CDC HEALTH IMPACT PYRAMID: FACTORS THAT AFFECT HEALTH



Source: Frieden T. R. A framework for public health action: the health impact pyramid. Am J Public Health. 2010 Apr;100(4):590-5. doi: 10.2105/AJPH.2009.185652.Epub 2010 Feb 18.

Here are Some Tips for Using a Health Equity Lens

Use Inclusive Terminology

Avoid the following terms, which can be stigmatizing and may imply that the health condition is inherent to the population rather than the underlying causal factors when used as adjectives: target population, vulnerable, marginalized and high-risk.

Consider using one or more of these terms: disproportionately affected, groups placed at higher risk/put at higher risk, groups experiencing disadvantages, groups experiencing disproportionate effects, population of focus, and under-resourced communities.

Engage With Key Stakeholders

Addressing SDOH to achieve health equity requires multi-sectoral and multi-level collaboration. It is critical to engage diverse members of your Population(s) of Focus in your planning, implementation and evaluation processes. These include:

- Trusted community leaders from your Population(s) of Focus
- Community members experiencing cancer health outcome disparities
- Staff from non-profit and community-based organizations centered on your Population(s) of Focus
- Cancer centers with an interest in reducing cancer health disparities
- Researchers who are from and/or reflect the Population(s) of Focus
- Academic partners with an interest in reducing cancer health disparities, especially those who have demonstrated community-based participatory research
- Community Health Centers
- Representatives from your Medicaid Office
- Staff from governmental agencies across various sectors
- Other multi-sectoral and multi-level partners with common interests (e.g., education, justice, urban planning, etc.)

Use Data to Prioritize Action Plans

Data is essential to your cancer plan. Be sure to:

- Identify populations that experience higher incidence and mortality rates of leading cancers in your state, tribe, or territory. Examine cancer screening rates as well as cancer incidence, mortality, and – if possible – quality of life data by race/ethnicity, sex assigned at birth, gender identity, sexual orientation, health insurance status, and geographic area. Resources include:
  - **Making the Case for Health Equity**
  - **National Environmental Public Health Tracking Network Query Tool (cdc.gov)**
  - **Places: Local Data for Better Health**
  - **U.S. Cancer Statistics Public Use Databases**
  - **U.S. Cancer Statistics Data Visualizations Tool**
- Examine cancer rates by subgroups within Population(s) of Focus to assess differences in incidence and mortality rates.
- Compare local data with national data to highlight key areas of need, or areas where progress is lagging
- Identify policies and environmental factors that contribute to health disparities

Align With National Goals

It is helpful to show how your cancer plan goals contribute to national goals. Develop a local objective that is based on and supported by the national objective, including a special focus on populations that experience health disparities or addressing the systemic underlying social determinants of health that affect priority populations.

Consider the degree of change you are seeking when refining your objectives. For example, assessing a cancer center's policies, procedures, and strategic initiatives through a racial equity lens may be more effective in building community trust than a community outreach event focused on nutrition or cancer screening.

- Identify objectives to reduce the greatest disparities experienced by your Population(s) of Focus.
- Consult **Healthy People 2030** goals, your health department's chronic disease plan, and **Behavioral Risk Factor Surveillance System (BRFSS)** data to see what baselines and targets are already being used by your partners. Remember to cite your data sources.
- Refer to NCCDPHP's list of SDOH. Improvements to SDOH are a priority for CDC and Healthy People 2030.[1]
- Refer to **NCI's Evidence-Based Cancer Control Programs**.

[1] Healthy People 2030. **https://health.gov/healthypeople**

EXAMPLE 1 – BASELINE DATA COLLECTION

National Objective	Local Objective
Increase the number of states (including the District of Columbia), territories, and tribes that include sexual orientation and gender identity questions in the BRFSS (Healthy People Objective LGBT-03)	Include sexual orientation and gender identity questions in the state BRFSS each year over the next 5 years

EXAMPLE 2 – RISK REDUCTION

National Objective	Local Objective
Reduce the lung cancer death rate (Healthy People Objective C-02)	Reduce tobacco use among Black men in Washington, DC from 20% to 10% in 5 years by initiating a peer counseling program to change social norms around tobacco use

EXAMPLE 3 – CANCER SCREENING

National Objective	Local Objective
Reduce the female breast cancer death rate (Healthy People Objective C-04)	Increase the number of women, ages 50+ living in rural or frontier Colorado counties, who had a mammogram in the last two years from 66% to 76% within 5 years by extending policies for paid time off for cancer screening and employee-sponsored mobile cancer screening services

EXAMPLE 4 – TREATMENT QUALITY

National Objective	Local Objective
Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis (Healthy People Objective C-11)	By 2020, increase the number of cancer treatment centers in Puerto Rico accredited by the American College of Surgeons Commission on Cancer from 3 to 4 by contracting for supportive care services with community-based organizations

EXAMPLE 5 – QUALITY OF LIFE

National Objective	Local Objective
Increase quality of life for cancer survivors (Healthy People Objective C-R01)	By June 29, 2022, increase the percent of American Indian cancer survivors in Michigan who self-report a favorable health status by 15% by educating oncologists about the importance of traditional healers and spiritual health for survivors (Baseline: TBD)

Go Upstream

Consider how policies, systems and environments (PSE) perpetuate or create cancer disparities. Include a health equity focus in your PSE change efforts to have the largest change effect. Be sure to tailor information to your Population(s) of Focus.

GOAL	UPSTREAM STRATEGY
Increase cancer screening by 20% among age-eligible hourly employees within one year	▶ New York State is working with cancer services programs, health systems, local health departments, community organizations to build support for paid leave policies for cancer screenings.[2]
Eliminate the disparity in time to cancer treatment between Medicaid and Medicare beneficiaries diagnosed with cancer	▶ Washington, DC Department of Health Care Finance requested a State Plan Amendment for Medicaid to match Medicare reimbursement rates for cancer and supportive care drugs, resulting in significant expansion of the oncology provider network and fewer care delays for beneficiaries.[3]
Reduce lung cancer incidence in rural Iowa by 25% in 5 years	▶ Iowa Cancer Consortium tested 53 homes of low-income families for indoor radon levels; 16 homes received radon mitigation and a resource list was created to support low-income families for radon testing in their homes.[4]

[2] New York: Expanding Paid Leave for Cancer Screening Policies. **http://action4psechange.org/new-york-expanding-paid-leave-for-cancer-screening-policies**
[3] DC Policy Advances to Improve Medicaid Patient Access to Care. **http://action4psechange.org/d-c-policy-advances-to-improve-medicaid-patient-access-to-cancer-care**
[4] Iowa Radon-Free Homes Initiative. **http://action4psechange.org/iowa-radon-free-homes-initiative**

Use a Combination of Evidence-Based Initiatives (EBIs) to Maximize Intended Change

STRATEGIES TO INCREASE COMMUNITY DEMAND

Train community health workers or non-clinical patient navigators within communities disproportionately affected by cancer mortality for group education, 1:1 education, client reminders for screening, and small media (including social media)

STRATEGIES TO INCREASE COMMUNITY ACCESS

Reduce barriers to accessing screening by offering non-clinical settings for screening (i.e, communities, worksites) and modifying clinic hours to offer evening screening options

STRATEGIES FOR HEALTH SYSTEM CHANGES

- Systematize client reminders for cancer screenings
- Create rapid audit and feedback mechanisms to give providers real-time feedback on differences by sociodemographic factors in screening uptake and loss to follow up
- Support patient navigation programs and simplify patient access by offering "one stop shopping," such as FLU-FIT clinics that offer colorectal screening tests at the same time as the flu vaccine
- Ensure that information provided to patients is culturally and linguistically appropriate

WHERE TO FIND EBIs:

- Your own program evaluations and your partners' evaluations
- **The Community Guide**
- **NCI's Evidence-Based Cancer Control Programs**
- **Cochrane Reviews**

For information and tools on adapting strategies to fit your location, start with the **Cancer Prevention and Control Research Network (CPCRN) site**, including the training, "Putting Public Health Evidence Into Practice."

Evaluate Strategies Through a Health Equity Lens

Evaluating with a health equity lens requires attention to who is doing the evaluation, who the greatest beneficiaries are, what is being evaluated, and how evaluation is conducted, as well as outcomes.

- Hire staff for program planning, implementation, and evaluation from a variety of backgrounds, perspectives, and cultures
- Engage your Population(s) of Focus in planning, implementation and evaluation
- Require cultural competency training of staff, volunteers and evaluators
- Measure outcomes that are important to your Population(s) of Focus
- Ensure wording of any evaluation instrument (surveys, focus group or interview guides, etc.) is affirming and uses bias-free language
- Consider the context in which your program or initiative is operating – does eligibility of services, location, processes, or other factors unintentionally disadvantage certain Population(s) of Focus?
- Consider system-wide and sustainable changes that can be made to improve opportunities and outcomes for your Population(s) of Focus
- Report back findings to your Population(s) of Focus
- Use lessons learned to continually improve and advance health equity[5]

[5] Public Policy Associates, Inc. (2015). **https://publicpolicy.com/wp-content/uploads/2017/04/PPA-Culturally-Responsive-Lens.pdf**

Resources

American Medical Association	**Use of the words Tribe and Tribal** Considerations for using/capitalizing the terms Tribe and Tribal
American Public Health Association	**APHA Health Equity Fact Sheets, Briefs and Reports** APHA Health Equity Fact Sheets
Build Health Places, Robert Wood Johnson Foundation (RWJF)	**What is Health Equity? And What Difference Does a Definition Make?** Brief to promote greater consensus about the meaning of health equity and the implications for action within the RWJF Culture of Health Action Framework
Centers for Disease Control and Prevention/NCBDDD	**Communicating With and About People with Disabilities** Preferred (person-first) terms for person/people with disabilities
CDC/ Emerging Infectious Disease Journal	**Preferred Usage** Preferred usage for terms and group descriptions
Engage for Equity	**Engage for Equity Website** Resources and tools for Community-Based Participatory Research
Frameworks Institute	**Talking about Disparities: The Effect of Frame Choices on Support for Race-Based Policies** Description of framing strategies that do and do not work to improve support for policies related to race/ethnicity
GLAAD	**GLAAD Media Reference Guide** Definition of LGBTQ terminology and terms to avoid
Health and Human Services (HHS) 508 Compliance	**Accessibility @ HHS** HHS's role in accessibility - includes compliance checklist, Office of the Secretary of Accessibility Program, and other resources
Human Impact Partners' Health Equity Guide	**Health Equity Guide** Set of strategic practices that health departments can apply to advance health equity
Office of Management and Budget (OMB)	**OMB Standards** Revisions to the standard classifications of federal data on race and ethnicity
Public Policies Associates, Inc.	**Considerations for Conducting Evaluation Using a Culturally Responsive and Racial Equity Lens** Suggestions for evaluators, evaluation process and diversity using a racial equity lens
Public Policies Associates, Inc.	**Is My Evaluation Practice Culturally Responsive?** This document is a cultural diversity and cultural competency self-assessment checklist designed for research and evaluation services to be viewed through a lens of diversity, inclusion, and equity.
Race Matters	**Racial Equity Impact Assessment Toolkit** Toolkit to help you to systematically conduct a Racial Equity Impact Assessment (REIA) in order to reduce and prevent racial inequities.
Robert Wood Johnson Foundation	**A New Way to Talk about the Social Determinants of Health** Guidance on framing issues related to the social determinants of health
University of New Hampshire, University Center on Disability	**Person-First Language** Partial glossary of person-first disability terms

Worksheet: Questions to Ask and Answer[6]

Use this worksheet to ensure that each of your CCC objectives is advancing health equity.

Which populations in your area experience cancer disparities? Consider age, level of ability, race/ethnicity, population subgroups, housing status, language, socioeconomic status, faith, geographic residence, sexual orientation, gender identity and other characteristics. Define who in your region experiences significant cancer disparities. These are your "Population(s) of Focus":

Assess each of your cancer control plan goals, objectives and strategies using the following questions:

1. What is the intended effect of the objective, activity, process, program, policy or practice?

2. How does the initiative address aspects of equity? Consider:

   - Access to nutritious food close to home and/or work or improvements to food security
   - Access to safe and healthy spaces for living, playing, and working (e.g., tobacco-free housing, parks, playgrounds)
   - Access to cancer care close to home and/or work
   - Access to convenient hours for cancer care
   - Access to patient-centered, culturally-affirming cancer care
   - Improvements to built environments (i.e., access to transportation)
   - Improvements in community economic development, job training or other financial supports
   - Improvements in community-clinical linkages
   - Improvements in social supports and connectedness
   - Other aspects of inequity

[6] Questions adapted from the Health Equity Framework presented in Peterson, A., Charles, V., Yeung, D., and Coyle, K. (2020). The Health Equity Framework: A Science- and Justice-Based Model for Public Health Researchers and Practitioners. Resources, Frameworks, and Perspectives. DOI: 10.1177/1524839920950730 and the Race Forward Racial Equity Impact Assessment Toolkit.

3. At which level of the pyramid does the activity live (i.e., counseling and education, clinical interventions, long-lasting protective interventions, changing the context, socioeconomic factors)?

4. Which sectors and partners need to be engaged to implement the initiative successful.

5. What is the history of the issue addressed within the community?

   - What inequities exist and how did they arise?
   - What data is being used to describe the inequity?
   - Where did the data come from?
   - What data are not available or needed to understand the context of the issue?

6. How will the Population(s) of Focus be affected?

   - Which groups may experience greater burden or be left out if the initiative is implemented? If so, how could this be addressed?
   - Will any groups disproportionately benefit? If so, are they the Population(s) of Focus?
   - What unintended consequences might result? Is it possible that inequities can be made worse?

7. How are the Population(s) of Focus involved in determining the metric(s) for success?

8. How will results be measured?

9. How will results be shared with the Population(s) of Focus?

10. How will the initiative remove unfair social, economic, or environmental advantages for certain groups?

11. How are access to resources or opportunities improved for the Population(s) of Focus?

12. Are support systems strengthened that encourage health-promoting choices (e.g. healthy eating, physical activity, coping skills, self-efficacy) for the Population(s) of Focus?

13. Will bias and/or discriminatory behaviors among health care providers and/or public health practitioners be reduced?

14. Will skills and abilities be improved that could enhance the quality of life of the Population(s) of Focus?

    - Are physical abilities of the Population(s) of Focus maximized?
    - Are cognitive functions of the Population(s) of Focus maximized?
    - Are other psychological functions of the Population(s)s of Focus maximized?