NACDD Peer-to-Peer Learning SME Webinar

Addressing the Social Determinants of Health to Elevate Equity: Moving Cancer Prevention Upstream

June 25, 2020
4:00-5:30 p.m. EDT

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Agenda

- Welcome
- Webinar Format
- Introduction of Facilitators
- Presentations
- Q&A

Tiffany Pertillar
Public Health Consultant, NACDD

Robyn Taylor
Public Health Consultant, NACDD

Facilitators

The Fierce Urgency of Now

The Social Determinants of Health are the conditions in which people are born, grow, work, and age and the wider set of forces and systems shaping the conditions of daily life.

World Health Organization

Upstream interventions and strategies focus on ways to advance deep-rooted social and economic structures that decrease barriers and improve support systems in order to help people achieve their full health potential.

The Root Cause Coalition

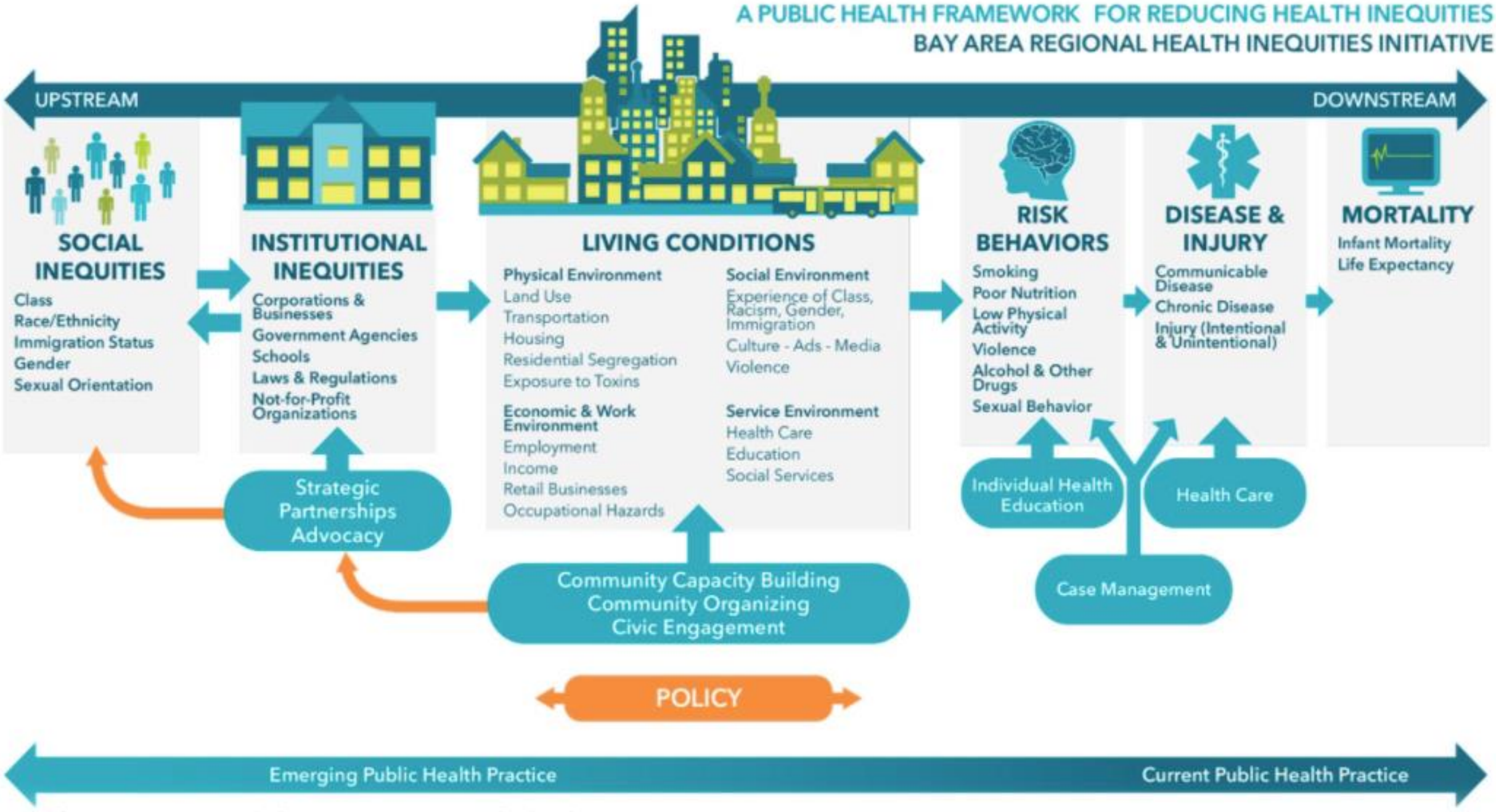

Figure 1: A Public Health Framework for Reducing Health Inequities – Bay Area Regional Health Inequities Initiative3

THE ROOT CAUSE COALITION™

Barbara J. Petee

Executive Director

The Root Cause Coalition

The Root Cause Coalition

Mission

We bring awareness and coordinated leadership to address the social determinants of health and their resulting barriers. We do this by articulating, demonstrating and advocating for bold and innovative solutions and polices that lead to improved health outcomes and economic stability.

Vision

Reverse and end the systemic root causes of health inequities for individuals and communities through cross-sector approaches and partnerships

FOUNDING PARTNERS

AARP Foundation
For a future without senior poverty.

PROMEDICA

INAUGURAL PARTNERS

American Hospital Association.

ASCENSION

BlueCross BlueShield Minnesota

CHLPI CENTER for HEALTH LAW and POLICY INNOVATION HARVARD LAW SCHOOL

COMMUNITY SERVINGS FOOD HEALS

cmhc Connecticut Mental Health Center

Dignity Health

FEEDING AMERICA

Humana.

CareNET

LOMA LINDA UNIVERSITY HEALTH

MHA Michigan Health & Hospital Association

OSF HEALTHCARE

PARAMOUNT

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PARTNERS

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Allegany Franciscan Ministries

Alliance

Ardmore Institute of Health

bdt

BGSU

California Primary Care Association

CareSource

CENTENE

Cheshire Medical Center Dartmouth-Hitchcock

Children's Hospital of Michigan Foundation

Collaborative Consulting

Credit Adjustments, Inc.

Enterprise

FAIRVIEW

houston foodbank

Kansas City

Lake Health

LISC LOCAL INITIATIVES SUPPORT CORPORATION

Methodist LeBonheur Healthcare

Montefiore

NATIONAL HEALTH FOUNDATION

Nonprofit Finance Fund

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RWJBarnabas HEALTH

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NOKID HUNGRY

SISTERS of CHARITY FOUNDATION

St. Mary

THE UNIVERSITY OF TENNESSEE

THE UNIVERSITY OF TOLEDO

UPMC HEALTH PLAN

Our Core Values

We believe…

- our work should lift up and highlight the equality and dignity of all individuals;
- that authentic collaboration, in which decision making and learning are reciprocal, is essential to achieving health equity; and
- that innovative solutions must be tested, validated, scaled, and supported through organizational and public policy.

The Root Cause Coalition: *Crafting a New Culture of Health*

Facilitates Shared Learning

Lifts up SDoH best practices

Advocates on relevant policy

Join us
https://www.rootcausecoalition.org/

THE ROOTCAUSE COALITION™

What is Health Equity?

Health equity means everyone has the opportunity to obtain the highest level of health.

Gaps in health equity are caused by societal barriers and lack of access.

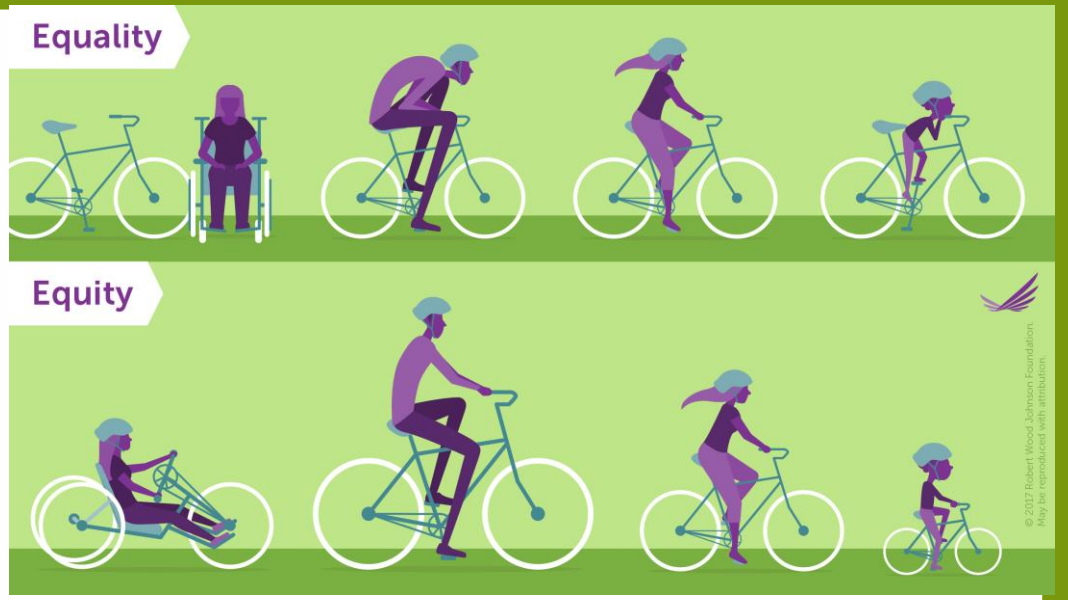


Image: Robert Wood Johnson Foundation

How do we achieve Health Equity?

Achieving health equity means removing socioeconomic barriers to ensure safe housing, food security, financial stability, a quality education and more; which ultimately leads to economic mobility.

THE ROOTCAUSE COALITION™

A Pathway to Better Care

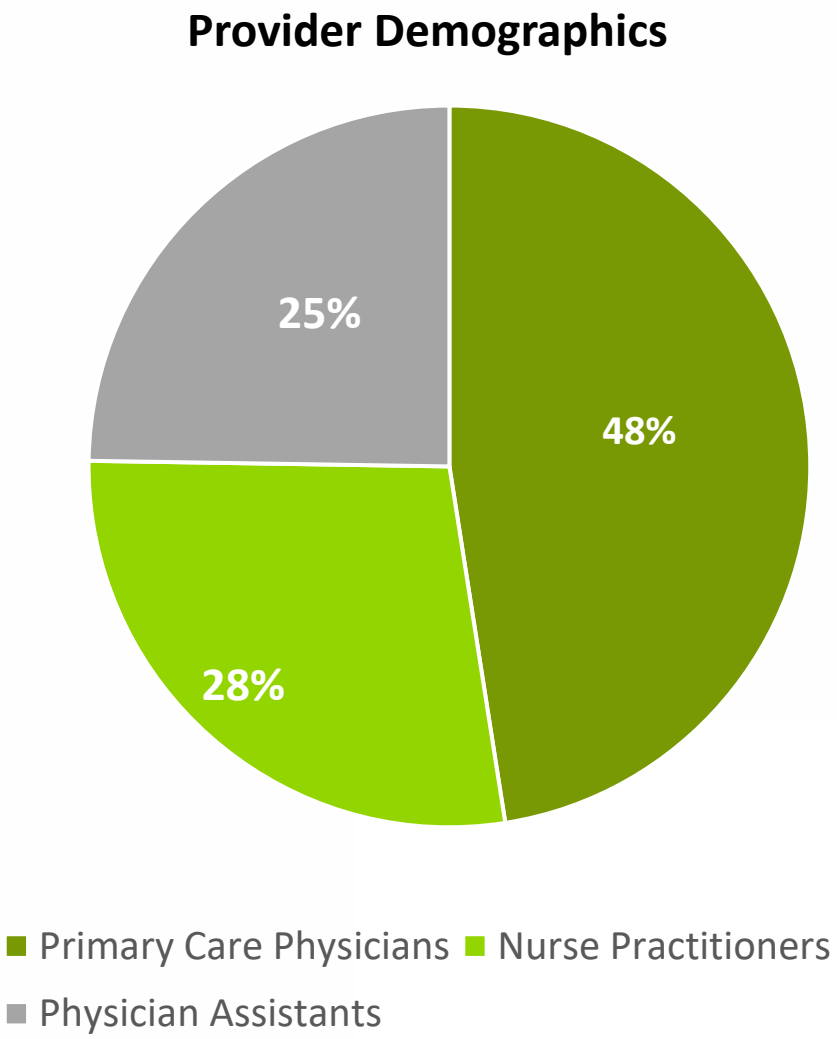
2020 Status of Health Equity Report

- Examines both the progress and the gaps in addressing health disparities influencing health and well-being
- Three Actionable Strategies to Achieve Health Equity
  - Scale innovative solutions to drive a new and sustainable model of care that improves health outcomes as it ensures health equity.
  - Align communities and advance authentic collaboration to address the root causes of health inequities.
  - Engage and learn from communities most affected by inequities of health and social conditions.
- Eight Point Call to Action

Provider Survey

Key Findings

- Providers must have additional training on the societal factors that impact health
- Providers need to have clearer guideline on what their role is in addressing SDoH
- Providers will benefit from specific intervention models and strategies to implement interventions
- Providers should benefit from cultural competency training
- Two Key Challenges in discussing SDoH with patients
    1. Limited Time and Resources
    2. Little integration between health/clinical and community resources



Sector Silos= Threat to Health Equity

Cross-sector Collaboration is Key

Actionable Strategy Examples from the Report

Actionable Strategy #1 *Scale innovative solutions to drive a new and sustainable model of care that improves health outcomes as it ensures health equity.*

- LISC and ProMedica: Health Impact Fund

Actionable Strategy #2 *Align communities and advance authentic collaboration to address the root causes of health inequities*

- National Health Foundation: Cross-Sector Recuperative Care Program

Actionable Strategy #3 *Engage and learn from communities most affected by inequities and health and social conditions*

- RWJBarnabas Health: Social Impact and Community Investment Practice Community Co-design

8 Point Call to Action

1. In payment reform, include methods and processes to ensure payment to care providers and non-clinical community-based organizations for demonstrated value related to addressing health inequity as a result of the social determinants of health. As part of this, develop a reimbursement model from Medicare and Medicaid for services provided by providers and community-based organizations that demonstrate value related to reducing costs, enhancing health outcomes and improving efficiencies while addressing the social determinants of health and health inequities.
2. Create a standardized integrated health benefit technology platform that connects patients, payors, providers and community organizations in order to consolidate fragmented programs and services into an integrated network.
3. Increase by 50 percent the number of commercial health plans and health systems nationally that embed social determinants of health and health inequities goals into their strategic plans, programs and services.
4. In all medical and clinical education programs nationwide, create a more robust system of educating and training providers about health equity and the role health care providers play in addressing these issues and how to effectively integrate that role into their current practice. In addition, ensure that cultural competency training is included in the curriculum.
5. Define a national target for healthcare expenditures (i.e., 15% of the GDP).
6. Develop a comprehensive plan to address our nation's deficits in infant mortality, mental health services and substance use disorders.
7. For health care organizations and corporations nationally, encourage the need to change ongoing education among board members, leaders and employees related to racial equity and cultural competency issues within the workplace.
8. Establish clearer, standardized metrics for measuring health outcomes related to racial disparities and the social determinants of health.

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THE ROOTCAUSE COALITION™

Cross-sector Collaboration

Poll

Where would you rate your progress in cross-sector collaboration related to social determinants of health?

Answer 1: Very siloed and have not started to collaborate with other sectors on social determinant interventions

Answer 2: Started engaging in conversations with at least one other sector for social determinant interventions

Answer 3: Have at least one cross-sector collaboration for social determinant interventions, but I am still new at it

Answer 4: Cross-sector collaborations are the key to my work and I am engaged in many partnerships with at least one other sector

Racial Equity in Practice

Child TRENDS

Today's Agenda

1. Importance of Racial Equity
2. Guiding Principles
3. Operationalize Racial Equity
4. Communicate Equitably

Child TRENDS

Why is this important now?

COVID-19 and Other Examples of Racial Inequities

It is important to connect data to context **now**.

What is a racial equity perspective?

Thinking through BIPOC's experiences with unequal power differentials and access to opportunity, while considering institutional racism

Why is racial equity important for…?

<u>Researchers and Policymakers</u>

It will likely produce findings that more accurately present the issues BIPOCs face.

Why is racial equity important for…?

Program Implementers and Practitioners

It affects implementation success

Guiding Principles

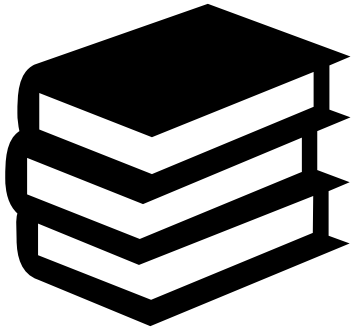
1. Examine your own background and biases
2. Dig deeper into the data
3. Recognize the power you hold and the impact you have on communities
4. Engage the community as partners
5. Guard against the assumption that white is the standard

Principle 1: **Examine our own background and biases**

- We are not neutral
- Bias affects what you do and how you do it

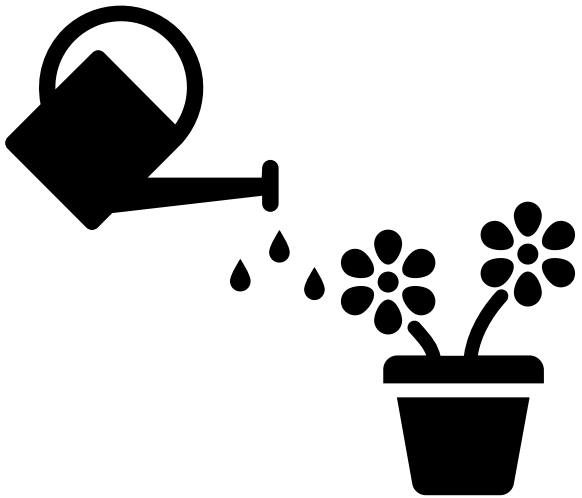
Principle 2: **Dig deeper**

- Get to the truth
- Active effort
- Intentional focus



Principle 3: **Your work has an impact**

- Your actions have an impact on communities
- How are you ensuring that your actions benefit communities



Principle 4: **Engage the community as partners**

- Early engagement is ideal
- Authenticity and perspective
- Balancing power

Child TRENDS

Principle 5: **Don't assume white is the norm**

- Often apply positive values to cultural norms associated with whiteness
- Beyond closing gaps

How do you integrate racial equity in your organizational culture?

1. Establish a shared vocabulary
2. Identify race equity champions at the board and senior leadership levels.
3. Name race equity work as a strategic imperative for your organization.
4. Open a continuous dialogue about race equity work
5. Disaggregate data

https://www.equityinthecenter.org/wp-content/uploads/2019/04/Equity-in-Center-Awake-Woke-Work-2019-final-1.pdf

How do you integrate racial equity into your programs?

1. Identify who is and who is not getting access to your program

2. Bridge community with program implementers
   - Engage BIPOC communities to hear what they want in a program and build the program for them

3. Build better data systems
   - Get feedback on how you are doing to serve communities

Communicate Equitably

- Say what you mean
- Use “person-first” language
- Don’t assume differences
- Acknowledge intersectionality and within group differences

https://www.childtrends.org/publications/equitable-research-communication-guidelines

Thank you!

www.childtrends.org

kandrews@childtrends.org

A Few Helpful Resources….

Books:

White Fragility

Kendi, I. X. (2019). ***How to be an antiracist***. First Edition. New York: One World.

Rothstein, R. (2017). ***The Color of Law***. New, NY: Liveright.

DiAngelo, Robin J. (2018). ***White Fragility: Why It's so Hard for White People to Talk About Racism.*** Boston: Beacon Press.

Online Tools:

www.Racialequitytools.org

Great online video:

Race the Power of an Illusion

Powerful Ted Talks:

Mellody Hobson

Beverly Tatum

In Person Trainings:

Undoing Racism

Courageous Conversations

Child TRENDS

Comfort Level with Centering Racial Equity

Poll

What is your comfort level with centering racial equity in your work or within your organization?

Answer 1: Not at all comfortable

Answer 2: A little comfortable

Answer 3: Pretty comfortable

Answer 4: Very comfortable

The Influence of the Social Determinants of Health Iceberg on Colorectal Cancer Disparities among Men

Charles R. Rogers, PhD, MPH, MS, CHES®

Tenure-Track Assistant Professor, Division of Public Health

Founding Director, Men's Health Inequities Research Lab

Associate Member, Huntsman Cancer Institute & University of Michigan-Mixed Methods Program

University of Utah School of Medicine

Peer-to-Peer Learning Webinar

National Association of Chronic Disease Directors

Thursday, June 25, 2020

@crrogersPhD


#triggerwarning

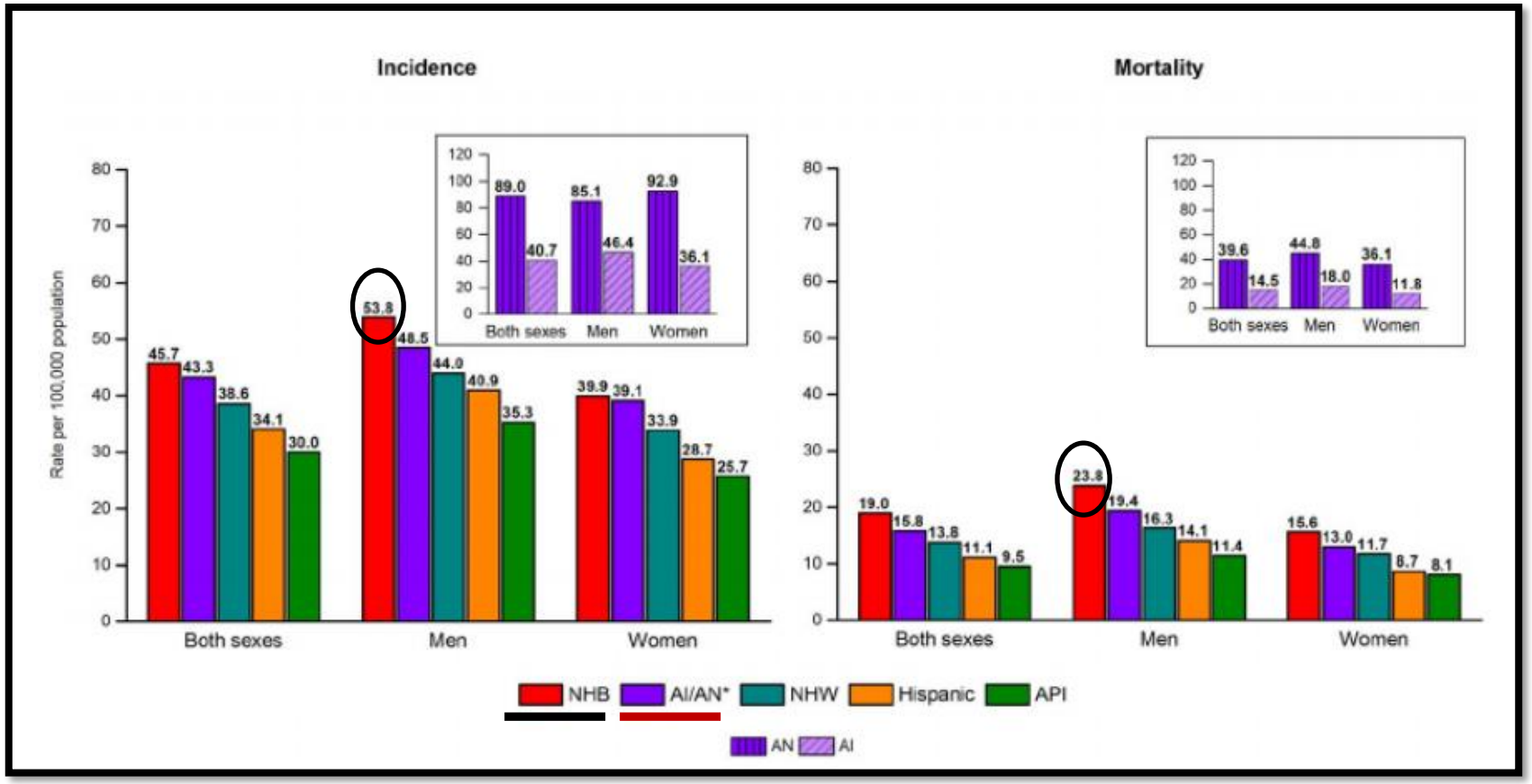
Age 52

ACS, 2019

24%

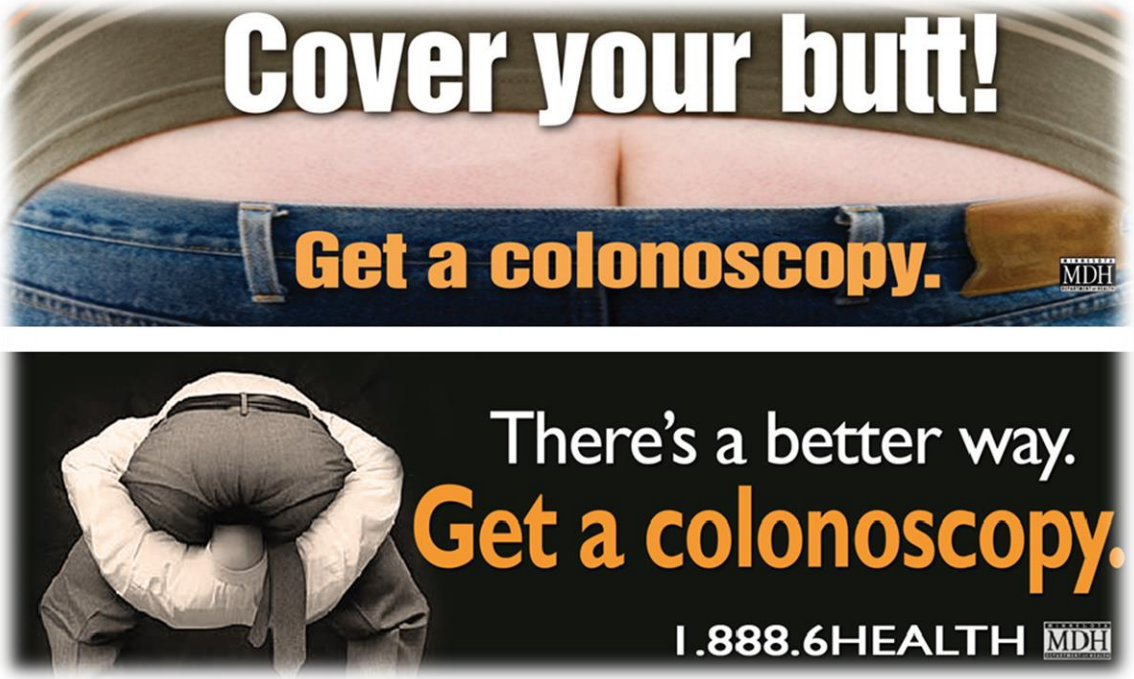
47%

COLORECTAL CANCER (CRC) INCIDENCE (2012-2016) & MORTALITY (2013-2017) RATES BY RACE/ETHNICITY & SEX, U.S.



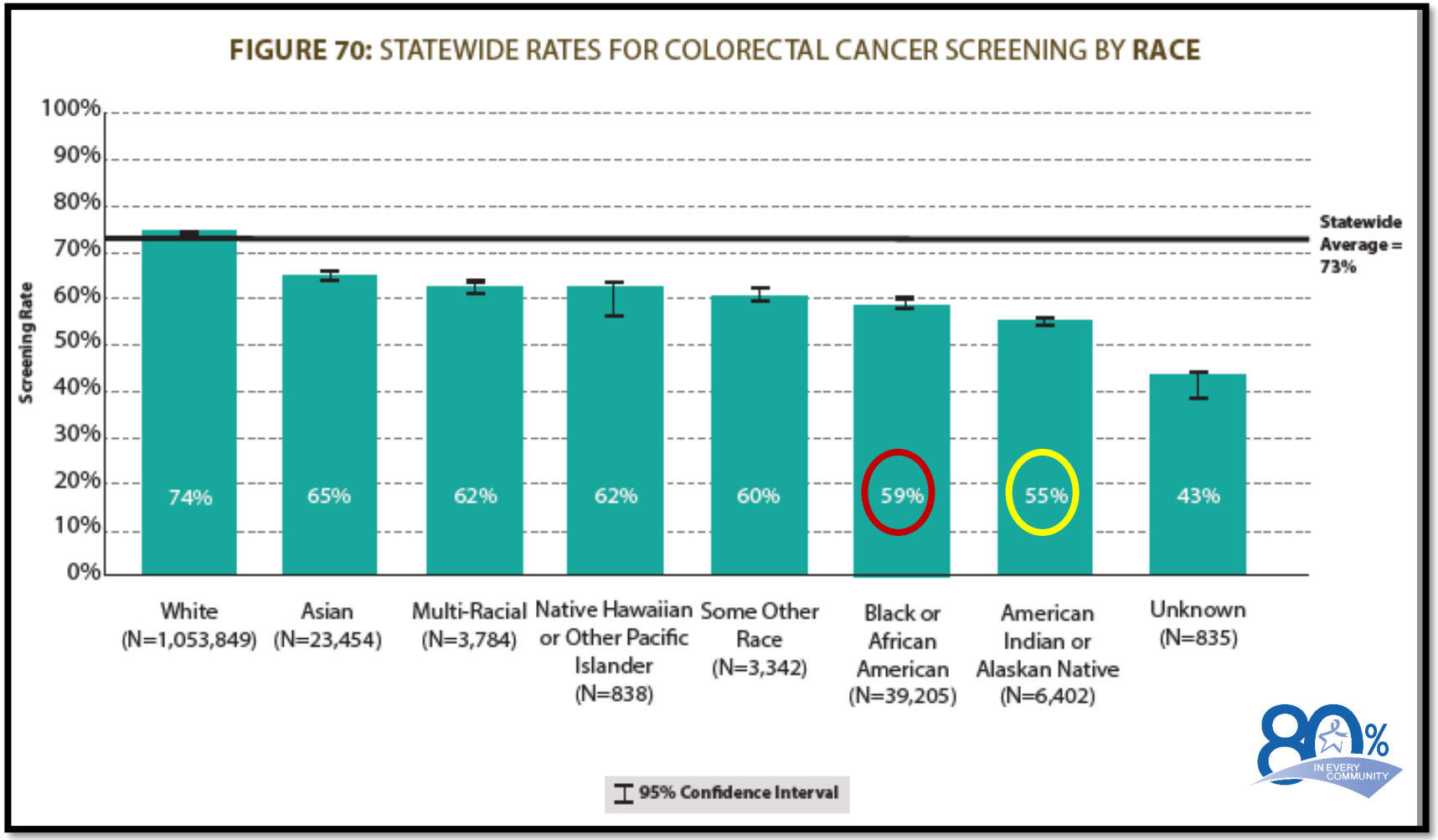
Source: Siegel, R. L., Miller, K. D., Sauer, A. G., Fedewa, S. A., Butterly, L. F., Anderson, J. C., Cercek, A., Smith, R. A., & Jemal, A. (2020). Colorectal Cancer Statistics, 2020. *CA: A Cancer Journal for Clinicians*, *70*, 145–164.

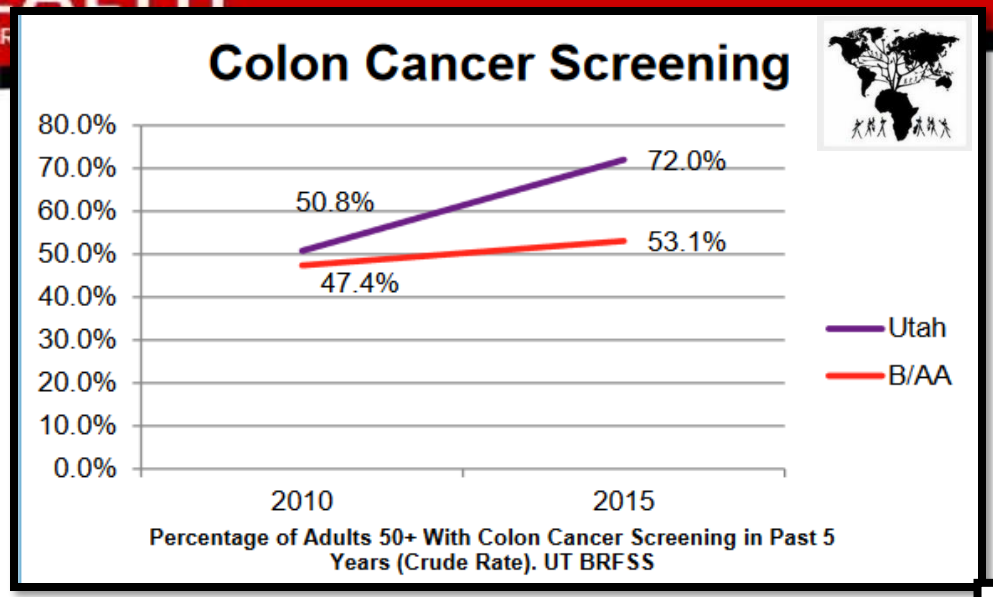
Colorectal cancer (CRC) is preventable & curable,
yet **disparities** across the country exist



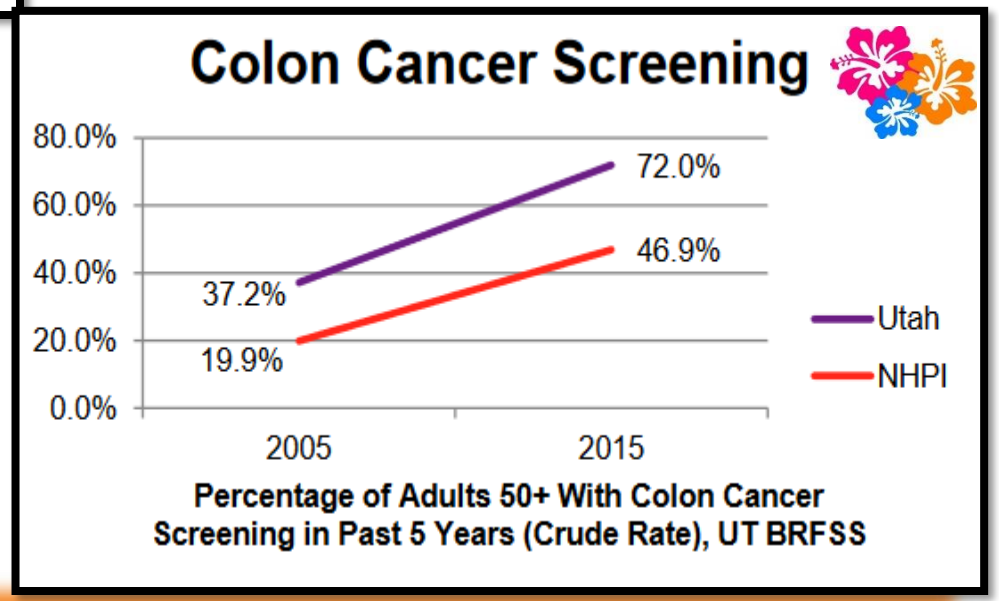
Screening: effective test to detect precancerous polyps so they can be removed before turning into cancer.

CRC Screening Disparities across MN





CRC SCREENING DISPARITIES ACROSS UT



80% IN EVERY COMMUNITY

UTAH DEPARTMENT OF HEALTH

Office of Health Disparities

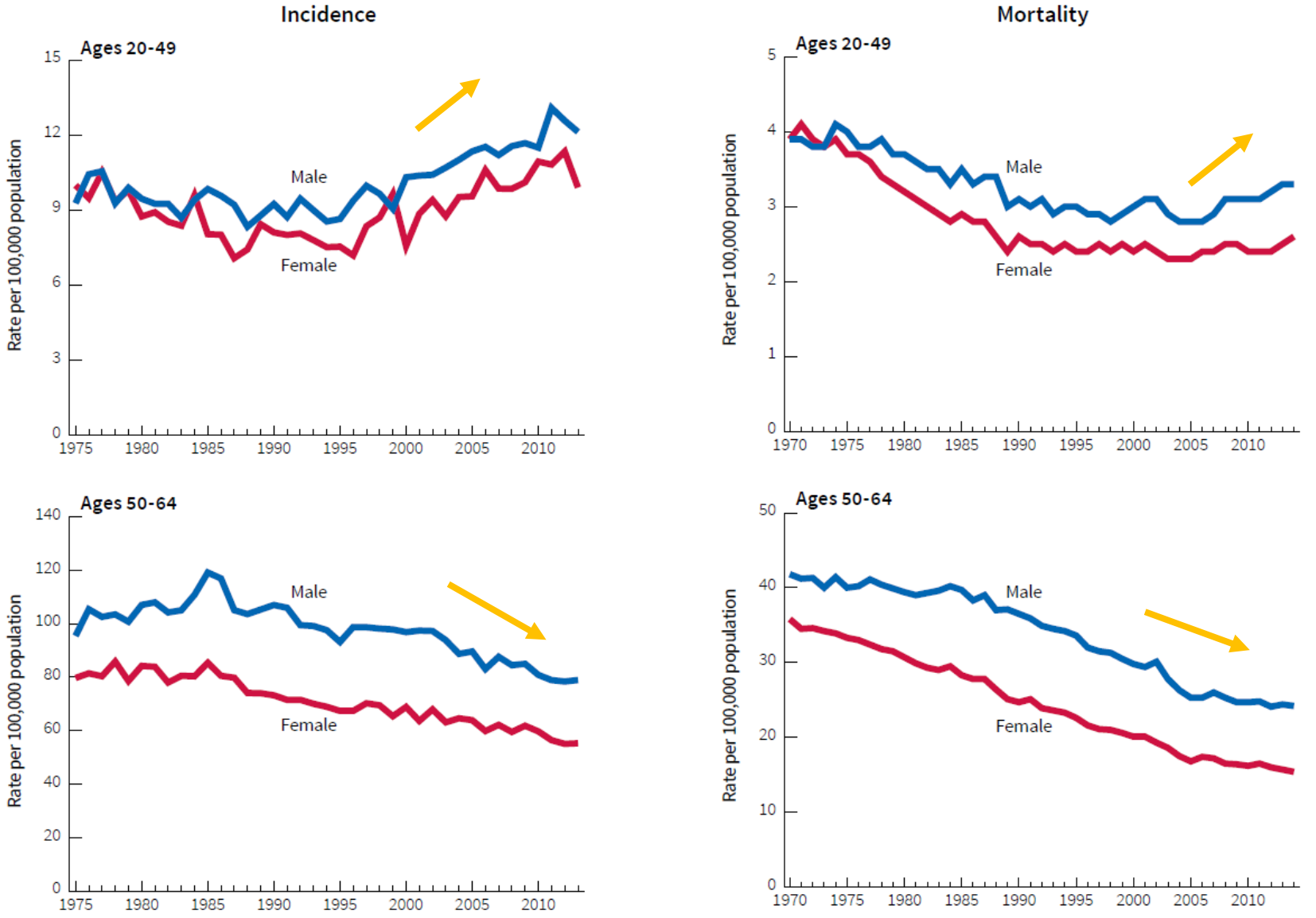
AGE 50 OR AGE 45?

- **2008:** American College of Gastroenterology (ACG) recommended CRC screening at age **45** rather than 50 for AAs (Agrawal et al., 2005; Rex et al., 2009)
  - *ACG is typically the 1st organization to make CRC screening related recommendations*

THE PROBLEM

ACS, 2017

Figure 5. Trends in Colorectal Cancer Incidence (1975-2013) and Mortality (1970-2014) Rates by Age and Sex, US



Health Disparities & the Social Determinants of Health (SDoH)

On average, which of the following conditions is the *strongest* predictor of your health?

A. **Whether or not you smoke**
B. **What you eat**
C. **Whether or not you are wealthy**
D. **Whether or not you have health insurance**
E. **How often you exercise**

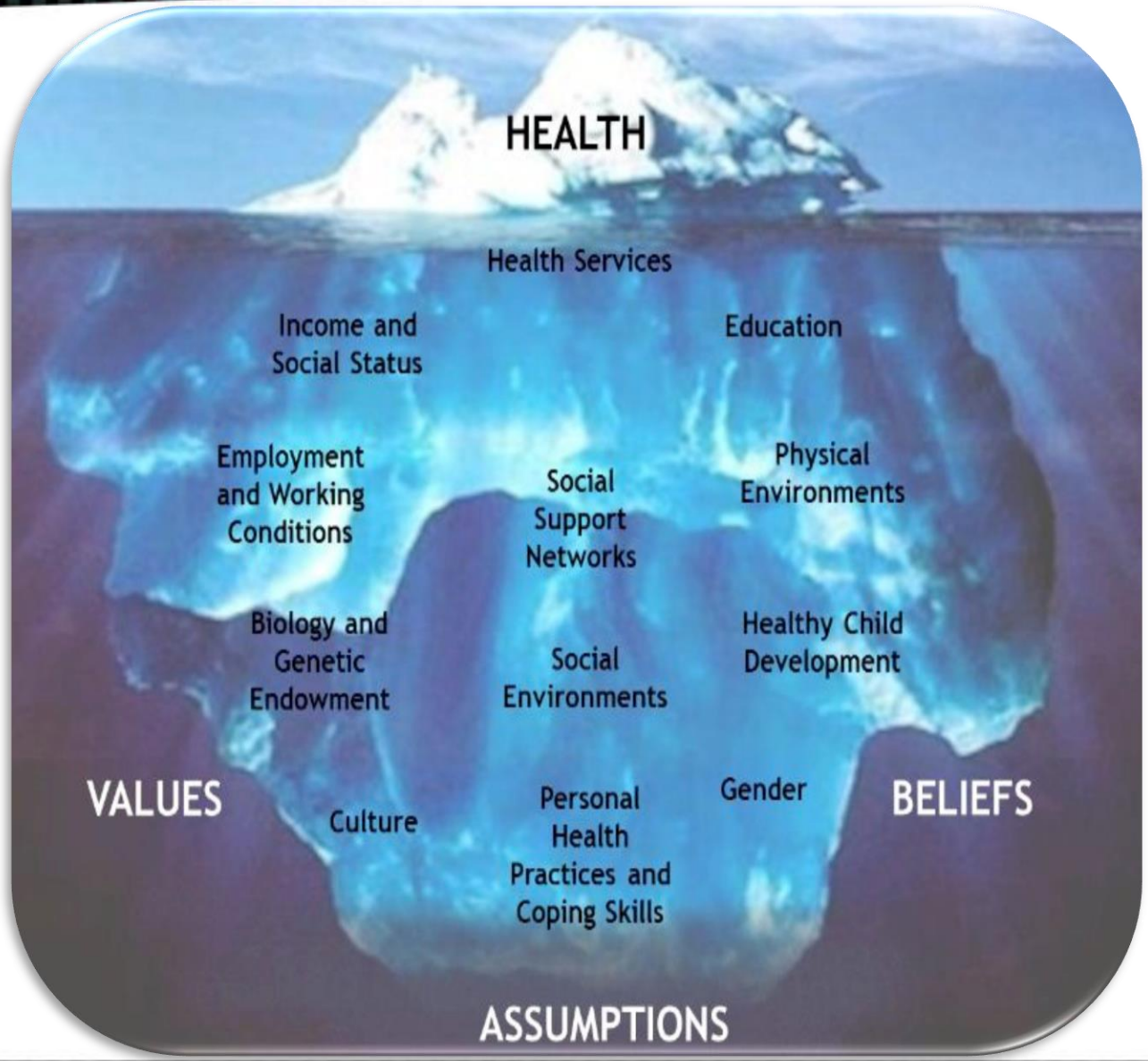
ANSWER:

C. Whether or not you are wealthy

The wealthier you are, on average, the better your health, from the bottom all the way to the top.

Genes, diet, exercise, & other behaviors are important. But a poor smoker still stands a greater chance of getting ill than a rich smoker.

(Based on 2005 data reported in the 2007 United Nations Human Development Report)

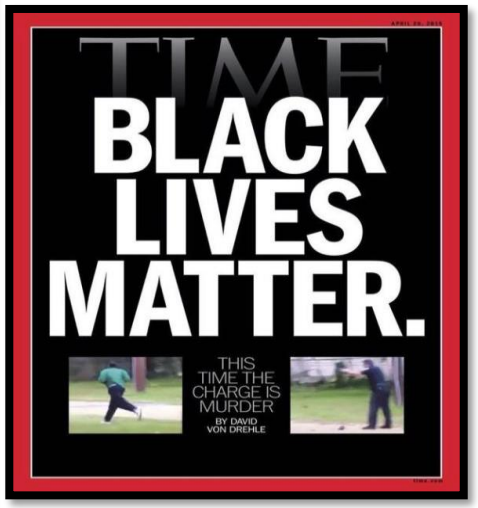


Health Disparities & the SDoH

SDoH: the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

– World Health Organization (WHO)

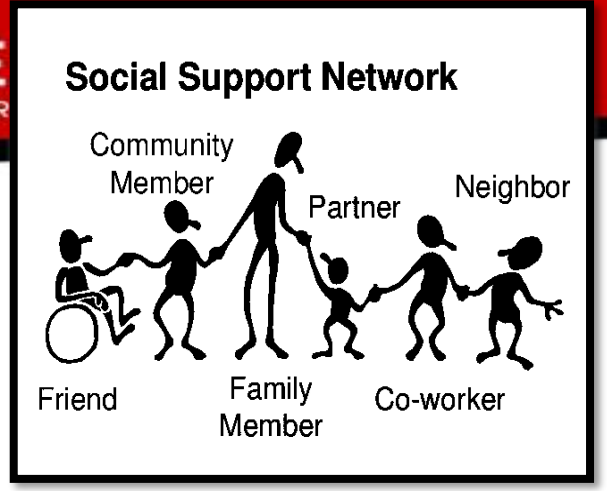
Do BLACK LIVES MATTER Really?



“Please, #ICantBreathe”

DO BLACK LIVES MATTER REALLY?

- **30%** more likely to ***die*** from heart disease
- **47%** more likely to ***die*** from CRC
- **2x** more likely to ***die*** from prostate cancer
- **2.2x** more likely to ***die*** from diabetes
- **9x** more likely to ***die*** from AIDS
- We ***suffer*** disproportionately from
  - Asthma
  - Stoke
  - Drug & Alcohol Addiction
  - Motor Vehicle Crash Deaths


Social Support Network
Community Member
Partner
Neighbor
Friend
Family Member
Co-worker


RACISM


BLACK MASCULINITY
WHAT DOES IT MEAN?

"Developing a Barbershop-Based Trial on Masculinity Barriers to Care and CRC Screening Uptake among African-American Men using a Mixed Methods Approach"

K01 goal: to design & pilot a theory-driven, culture-specific intervention on masculinity barriers to care to improve CRC screening uptake among African-American men (ages 45-75).

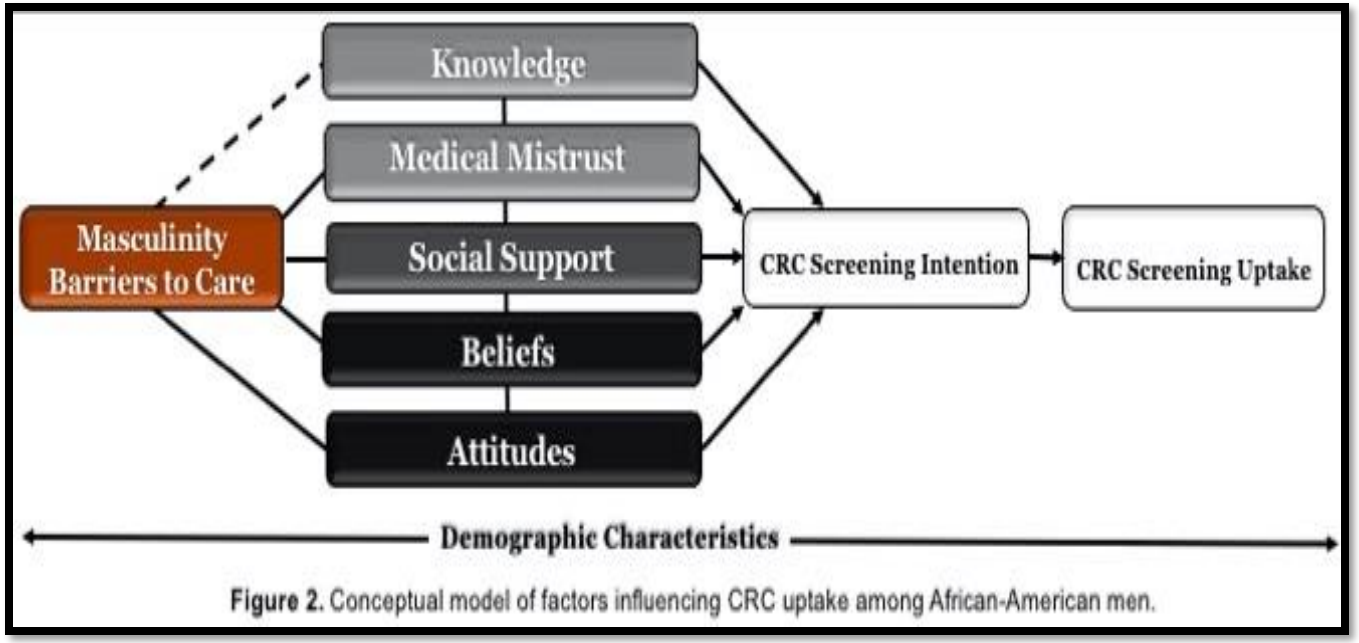


Figure 2. Conceptual model of factors influencing CRC uptake among African-American men.

Theory of Planned Behavior [& Behaviour Change Wheel (BCW)]

#CuttingCRC

I'M INTERESTED IN #CUTTINGCRC IN:

OH

MN

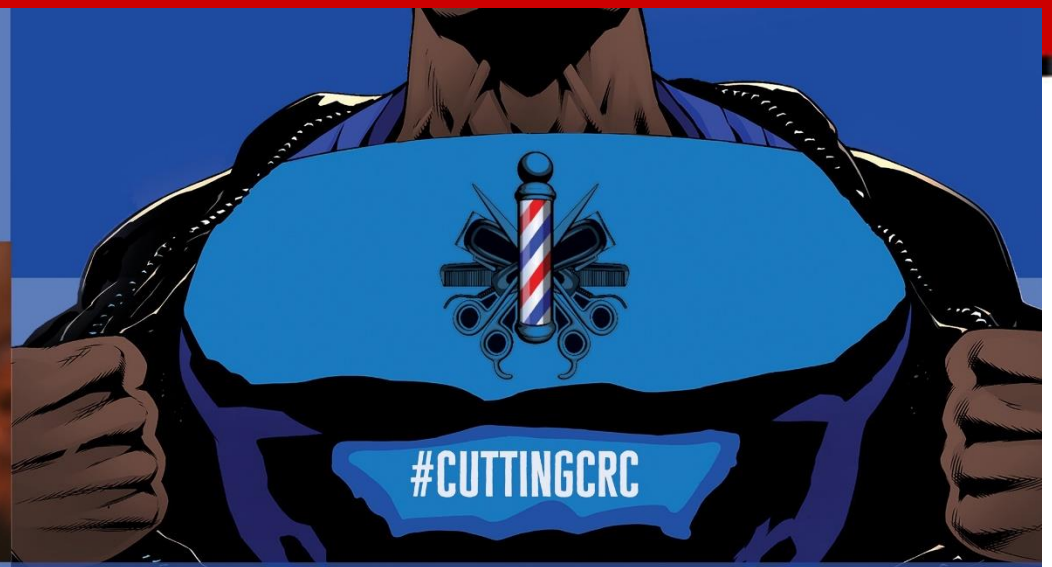
UT

#CuttingCRC Overview

IRB #: 00113679

DAPD.

CHAT & CHEW II



Did you know that Black/African-American men have a 52% higher chance of dying from colon cancer compared to white men?

Help us figure out **WHY** over conversation & food.

WWW.CUTTINGCRC.COM

April 2019
10AM-Noon & 2PM-4PM
Location: Salt Lake City Metro

Am I qualified?

-Must be a Black/African-American male.
-Must be between 45 and 75 years old.
-Must be born in the US.
-Must speak English.
-Must have a working telephone.
-Must live in Utah.

For more information,
contact the Primary Investigator,
Dr. Charles R. Rogers
email - charles.rogers@utah.edu
phone - 801-581-5752

IRB #: 00113679

Where do I sign up?

Visit **www.cuttingCRC.com** by March 31st. **Space is limited!!!**
Participants receive **free food** and a **$20 gift card.**
Additional opportunity to enter a random drawing for 1 of 3 prizes below.

$100 Visa Gift Card

2 Utah Jazz Tickets

Samsung 55” 4K UHDTV

Thanks to our supporters:

HEALTH UNIVERSITY OF UTAH
MINNESOTA COMMUNITY CARE
NATIONAL CANCER INSTITUTE
Award #: K01CA234319
CALVARY BAPTIST CHURCH
FIGHT COLORECTAL CANCER
dapd
HUNTSMAN CANCER INSTITUTE UNIVERSITY OF UTAH
CANCER HEALTH EQUITY NETWORK
ILI
DBRAND DESIGNS

Locations:

- Libraries (*n*=4)
- Churches (*n*=3)
- Hotels (*n*=2)
- Barbershops (*n*=2)

“The things I value most are…”

What words, feelings, or ideas come to mind when you think about colon cancer?

When it comes to making decisions about your health, how do your normally go about doing so?

What kinds of things might cause one not to visit a doctor for care?

What kind of things might make an African-American male <u>MORE</u> likely to obtain a colonoscopy?

What kind of things might make an African-American male LESS likely to obtain a colonoscopy?

Key Takeaways:

Open access Protocol

BMJ Open

Study protocol for developing #CuttingCRC: a barbershop-based trial on masculinity barriers to care and colorectal cancer screening uptake among African-American men using an exploratory sequential mixed-methods design

Charles R Rogers,[1] Kola Okuyemi,[1] Electra D Paskett,[2] Roland J Thorpe,[3] Tiana N Rogers,[4] Man Hung,[5] Susan Zickmund,[6] Colin Riley,[1] Michael D Fetters[7]

To cite: Rogers CR, Okuyemi K, Paskett ED, *et al*. Study protocol for developing #CuttingCRC: a barbershop-based trial on masculinity barriers to care and colorectal cancer screening uptake among African-American men using an exploratory sequential mixed-methods design. *BMJ Open* 2019;**9**:e030000. doi:10.1136/bmjopen-2019-030000

► Prepublication history and additional material for this paper are available online. To view these files, please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2019-030000).

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ABSTRACT

Introduction Colorectal cancer (CRC) is preventable, as screening leads to the identification and removal of precancerous polyps. African-American men consistently have the highest CRC mortality rates, and their CRC-screening uptake remains low for complex reasons. Culture-specific masculinity barriers to care may contribute to the low uptake among African-American men. Examining these barriers to care is vital as CRC screening may challenge cultural role expectations of African-American men, whose tendency is to delay help-seeking medical care. Barbershops provide a pathway for reaching African-American men with masculinity barriers to care who are not regularly receiving healthcare services and CRC screening. This study aims to develop and pilot test a theory-driven, culture-specific, barbershop-based intervention targeting masculinity barriers to care and CRC-screening uptake among African-American men ages 45–75.

Methods and analysis Guided by the theory of planned behaviour and the behaviour change wheel, we will use a multistage mixed-methods study design, beginning with an exploratory sequential approach to validate items for subsequent use in a pilot mixed-methods intervention. First, we will collect and analyse qualitative data from focus groups, cognitive interviews and expert item review to validate and test a culture-specific Masculinity Barriers to Care Scale (MBCS) among African-American men. Next, we will administer the MBCS to our target population as an online quantitative survey and evaluate the association between scores and CRC-screening uptake. Then, we will consider existing evidence-based approaches, our integrated results (qualitative +quantitative), and community input to design a culture-specific, behavioural intervention aimed at increasing CRC-screening uptake among African-American men and feasible for barbershop delivery. We will test the peer intervention in a pilot study with a two-arm cluster randomised design (six barbershops, randomised by site) to reduce contamination and account for barbershop culture differences. Our primary outcomes for the pilot are recruitment, sample size estimation, preliminary efficacy and acceptability.

Ethics and dissemination Ethics approval was obtained from the University of Utah Institutional Review Board (00113679), who will also be responsible for receiving communication updates regarding important protocol modifications. To ensure confidentiality, data dispersed to project team members will be blinded of any identifying participant information. Study results will be disseminated

Strengths and limitations of this study

- By drawing on constructs of the theory of planned behaviour and the behaviour change wheel, our study will be among the first to offer a structured approach to designing a behavioural change focused, culture-specific arm for our pilot intervention, while considering a range of psychosocial factors associated with colorectal cancer (CRC) screening among African-American men.
- Our study proposes a new, culture-specific Masculinity Barriers to Care Scale for understanding and reducing CRC-screening disparities among African-American men.
- Given the rising CRC burden among young adults, our study engages African-American men starting at age 45 years.
- Though self-report questionnaires are a common behavioural science methodology, social desirability and non-response bias are potential concerns that we will offset by testing the reliability and validity of the data, while collecting it electronically and securely.
- Additional research will be needed to ascertain the generalisability of the findings to other settings, since this study limits involvement to African-American men from two metropolitan areas in Utah and Minnesota.

WANT TO KNOW MORE?

#FoodForThought

According to ACS researchers (2019), more than half (55%) of CRC in the U.S. is attributable to potentially modifiable risk factors:

- Obesity
- Physical inactivity
- *Long-term smoking*
- Low calcium intake
- Moderate to heavy alcohol consumption
- High consumption of red or processed meat
- Very low intake of fruits and vegetables and whole-grain fiber

According to the CDC (2018):

- American Indians/Alaska Natives have the **highest** prevalence of cigarette smoking compared to all other racial/ethnic groups in the U.S.
- Diabetes is the 4th leading cause of ***death*** among AI/ANs.
  - The risk of developing diabetes is 30–40% ***higher*** for smokers than nonsmokers.

ACKNOWLEDGMENTS

- Participants who made these studies possible
- Community Partners
- Co-Authors, Mentors, Research Teams
- Funders
- National Associate of Chronic Disease Directors
- Rebecca Shimkets, Tiffany Pertillar
- **YOU!**

Questions and Answers

CRROGERSPHD.com

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Conclusion

Please join us for 15 minutes after the concluding remarks to hear speaker responses to questions that were submitted in the Q&A box throughout the webinar.

Q&A

Speakers are responding to questions that were submitted in the Q&A box throughout the webinar.

NACDD Peer-to-Peer Learning SME Webinar

Addressing the Social Determinants of Health to Elevate Equity: Moving Cancer Prevention Upstream

June 25, 2020
4:00-5:30 p.m. EDT

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