



NATIONAL ASSOCIATION OF  
CHRONIC DISEASE DIRECTORS

Promoting Health. Preventing Disease.

# Improving Equity in Cancer Screenings: A Partnership Approach

**Key takeaway:** As cancer program directors seek to improve equity and increase cancer screening, consider how to address the social needs and social determinants of health that make it difficult for some people to access screening programs. Consider creating or joining partnerships with health care, social services, and other organizations in your region that are well positioned to address, or are already addressing, the health-related social needs of individuals and the underlying social determinants of health (SDOH) in a community.

## Introduction

Health equity, and the need to address long standing barriers to achieving it, has never been more relevant. Though many have worked in this area for a long time, the increased focus on health equity now is both due to enhanced Presidential priorities and the realities of the COVID-19. Both of these factors have caused health, policy, and other diverse professionals to look beyond the things that individuals may do to impact their health and look more upstream at the systemic factors that influence equity.

At the federal level, equity has become a priority guiding Administration action. This started with an Executive Order signed by President Biden on Inauguration Day directing the entire federal government to find solutions to advance racial equity and support for underserved communities.<sup>1</sup> This announcement was followed the next day with another executive order promoting health equity by seeking to guarantee an equitable pandemic response and

<sup>1</sup> EO 19985; Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government; 20 January 2021. [whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government](https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government)

- **HEALTH EQUITY:** Every person, regardless of their color, creed, or background, having a fair chance to be healthy. Equity goes beyond demographics and includes all elements that can determine access to health and wellbeing including socioeconomic, geographic, environmental, and social factors.
- **SOCIAL NEEDS:** The immediate non-medical needs of an individual. Efforts to address social needs provide invaluable assistance to individuals – for example, providing food, housing, and transportation to a person or their family – but not the underlying economic or social conditions that lead to social needs.
- **SOCIAL DETERMINANTS OF HEALTH:** The conditions in the environments where people are born, grow, live, work, and age that affect health outcomes and risks; and the broader systems that shape those conditions, including social, political, and economic programs, and policies. Efforts to address SDOH prioritize the underlying social and economic conditions in which people live, rather than the immediate needs of any one individual.

recovery and created the COVID-19 Health Equity Task Force to oversee this work.<sup>2</sup> Secretary of Health and Human Services (HHS) Xavier Becerra has stated that equity and justice are the *north star* at HHS,<sup>3</sup> and that he and other HHS leaders strive to place equity at the center of every decision that they make.<sup>4</sup>

The COVID-19 pandemic has also placed a spotlight on the need for health equity. Early in the pandemic, more than half the COVID-19 cases reported to CDC were missing data on race and ethnicity.<sup>5</sup> As data reporting improved, it revealed what was already being observed by many; COVID-19 unequally affected many racial and ethnic minority groups, putting them at higher risk of contracting and dying from the disease.<sup>6</sup> These disparities in COVID-19 health outcomes are the same disparities that have historically been seen in almost every chronic and infectious disease. Black and American Indian/Alaska Native individuals are less likely to survive a cancer diagnosis compared to white individuals, with the risk of death after adjusting for sex, age, and stage at diagnosis is 33 percent higher in Black people and 51 percent higher

<sup>2</sup> EO 13995; Executive Order on Ensuring an Equitable Pandemic Response and Recovery; 21 January 2021.


[whitehouse.gov/briefing-room/presidential-actions/2021/01/21/executive-order-ensuring-an-equitable-pandemic-response-and-recovery](https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/21/executive-order-ensuring-an-equitable-pandemic-response-and-recovery)

<sup>3</sup> Heath, S. "Becerra: Health Equity, Justice Remain "North Star" for HHS." *Patient Engagement HIT*; xtelligent Healthcare Media. 9 February 2022; [patientengagementhit.com/news/becerra-health-equity-justice-remain-north-star-for-hhs](https://patientengagementhit.com/news/becerra-health-equity-justice-remain-north-star-for-hhs)

<sup>4</sup> Southwick, R. "HIMSS 2022: HHS, CMS leaders talk about health equity, sharing data." *Chief Healthcare Executive*. 15 March 2022. [chiefhealthcareexecutive.com/view/himss-2022-hhs-cms-leaders-talk-about-health-equity-sharing-data](https://chiefhealthcareexecutive.com/view/himss-2022-hhs-cms-leaders-talk-about-health-equity-sharing-data)

<sup>5</sup> Krieger, N., Testa, C., Hanage, WP., Chen, JT. US racial and ethnic data for COVID-19 cases: still missing in action. *The Lancet*. Vol. 386., Iss. 10261., E. 81. Oct 22, 2020. DOI: [doi.org/10.1016/S0140-6736\(20\)32220-0](https://doi.org/10.1016/S0140-6736(20)32220-0)

<sup>6</sup> Centers for Disease Control and Prevention; "Health Equity Considerations and Racial and Ethnic Minority Groups." 25 January 2022. [cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html#:~:text=The%20COVID%2D19%20pandemic%20has,and%20dying%20from%20COVID%2D19.](https://cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html#:~:text=The%20COVID%2D19%20pandemic%20has,and%20dying%20from%20COVID%2D19.)



in American Indian/Alaska Native people.<sup>7</sup> Statistics like these, combined with what has been seen during the pandemic, have brought the need to focus on equity to the forefront of the health sector.

## Barriers to Health Equity in Cancer Screening and Care

A key strategy in pursuing greater equity is addressing the underlying drivers of health, often known as the social determinants of health.<sup>8</sup> While looking at the social determinants allows researchers, policymakers, and advocates see opportunities to achieve health equity, it also reveals the barriers to achieving that goal.

Access to insurance is a barrier that can prevent certain individuals from obtaining cancer screenings and care.<sup>9</sup> However, directly addressing health insurance access is not the only way to improve health equity. Interventions and policies can be crafted to address the social determinants of health that increase cancer risk, as well as the individual social needs that make it difficult to access cancer screenings. These include but are not limited to the following:<sup>10</sup>

- **ACCESS AND QUALITY CARE:** Low or inconsistent income or employment instability may prevent individuals from seeking regular cancer screenings for fear of not being able to afford the cost of screening, since most Americans receive health insurance through their employer, or the treatments that will be needed if results indicate cancer. Additionally, individuals working in jobs that do not offer paid time off, sick leave, or scheduling flexibility often cannot attend screening or medical appointments during working hours.
- **EDUCATION ACCESS AND QUALITY:** Whether due to limited English proficiency or low health care literacy, many individuals require, yet often do not have, a support system to help them understand their screening and care options, or services available in health systems to help communicate with providers (e.g., interpreters).

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<sup>7</sup> Siegel, RL, Miller, KD, Fuchs, HE, Jemal, A. Cancer statistics, 2022. *CA Cancer J Clin.* 2022. doi.org/10.3322/caac.21708

<sup>8</sup> Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. [health.gov/healthypeople/objectives-and-data/social-determinants-health](https://health.gov/healthypeople/objectives-and-data/social-determinants-health)

<sup>9</sup> Zhao G, Okoro CA, Li J, Town M. Health Insurance Status and Clinical Cancer Screenings Among U.S. Adults. *Am J Prev Med.* 2018 Jan;54(1):e11-e19. doi: 10.1016/j.amepre.2017.08.024. PMID: 29102459.

<sup>10</sup> Artiga, S. "Health Disparities are a Symptom of Brader Social and Economic Inequities." *Policy Watch*; Kaiser Family Foundation. June 1, 2020. [kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities](https://kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities). See also Hojat LS. Breaking down the barriers to health equity. *Ther Adv Infect Dis.* 2022;9:20499361221079453. Published 2022 Feb 16. doi:10.1177/20499361221079453

- **SOCAL AND COMMUNITY CONTEXT:** Not all neighborhoods are equally served by health care services, including access to specialists. Too often these same neighborhoods lack services that would improve health, including fresh groceries, walkable sidewalks, and screening services to identify health risks early. In addition, living in neighborhoods with high crime rates produces chronic stress and a disincentive to go outside more than is necessary. This is a barrier to patients who need to leave their homes to have cancer screenings or annual physicals performed, or even engaging in physical activity.
- **ECONOMIC STABILITY:** Structural and institutional racism and bigotry prevent many individuals and families from being promoted and receiving higher salaries in their jobs, or own homes in particular neighborhoods. This hinders the ability of many people to grow generational wealth through savings and home ownership, live in areas with good schools that could lead to high paying jobs that can help to pay off debts, and establish economic stability.
- **NEIGHBORHOOD AND BUILT ENVIRONMENT:** Underserved neighborhoods may not have regular public transit services and may have crumbling infrastructure that can make walking unsafe, which also makes it difficult getting to the physician for visits. Many times, rural areas do not have transit options other than cars, which can be expensive to maintain.

## Social Determinant of Health Focused Interventions to Address Cancer Screening

Because there are so many potential barriers keeping individuals from receiving regular breast, cervical, and colorectal cancer screenings, cancer program directors can feel overwhelmed at where to start. The CDC has created materials intended to reduce structural barriers and increase cancer screening participation. The [Reducing Structural Barriers Planning Guide](#) is an evidence-based resource produced by CDC which is designed to help planners reduce or eliminate many of the non-economic social determinant related barriers that are frequently overlooked such as access to transportation, convenience of location, and health literacy.<sup>11</sup> The intervention asks practitioners to (1) identify patients and community members due for screenings, (2) identify barriers to screenings, (3) design barrier-specific resolutions that take

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<sup>11</sup> Centers for Disease Control and Prevention; "Reducing Structural Barriers Planning Guide." 10 November 2021. [cdc.gov/screenoutcancer/ebi-planning-guides/reducing-structural-barriers-planning-guide.htm](https://cdc.gov/screenoutcancer/ebi-planning-guides/reducing-structural-barriers-planning-guide.htm)

# Reducing Structural Barriers Planning Guide



**Implement and integrate**  
structural changes to  
reduce obstacles to screening



**Reduce or eliminate structural barriers**

**OUTPUTS AND MEASURES** for implementation and integration will be specific to the intervention design

Patients **seek** screening services



**Potential challenges:**  
Long distance to screening facility, limited transportation, burdensome scheduling process, community distrust of the medical field, facility not disability-friendly or lacks translation services

**OUTPUT:**  
Increased screening appointments made by patients

- **Measure:** The number of patients with appointments divided by the number of patients due for screening
- Example: The number of patients with appointments divided by the number of patients due for screening
- Example: The number of patients showing up for screening appointments divided by the number of patients scheduled for screening appointments

Patient **completes** cancer screening



**Potential challenges:**  
inconvenient clinic hours, limited capacity or resources to follow-up abnormal screening results, patient fear, cost, lack of transportation

**OUTCOME:**  
Increased screening and diagnostic tests completed by patients

- **Measure:** Screening completion
- Example: The number of patients completing screening divided by the number of patients referred for screening
- Example: The number of patients completing diagnostic follow-up divided by the number of patients with positive screening tests

**Increased** cancer screening



**OUTCOME:**  
Increased clinic-level rates of cancer screening

- **Measure:** Age-eligible clinic population up-to-date with recommended cancer screening
- Example: Uniform Data System (UDS), Healthcare Effectiveness Data Information Set (HEDIS), National Quality Forum (NQF) 12-month measure used to calculate screening rate

stakeholder input, working relationships, and feasibility into account, and (4) track individuals through screening completion.<sup>12</sup>

Interventions that take a similar approach and address different social needs to increase access to cancer screenings have been implemented with success in state, territorial, and tribal settings including:

- **Vermont**, where state breast cancer program staff worked with partners to identify barriers to screenings for women with disabilities (i.e., lack of accessible parking spaces and wheelchair prohibitive waiting room seating arrangements, etc.), produced a report, and helped partners implement the changes;<sup>13</sup>

<sup>12</sup> *Id.*

<sup>13</sup> Centers for Disease Control and Prevention; "Vermont Clinics Become More Accessible to Increase Cancer Screening." 10 November 2021. [cdc.gov/screenoutcancer/success/vermont-clinics-become-more-accessible.htm](https://cdc.gov/screenoutcancer/success/vermont-clinics-become-more-accessible.htm)

- **Guam**, where, during the pandemic, breast and cervical territorial cancer detection staff addressed financial and transportation barriers by changing the service sign-up to allow women to make appointments for services at different partner clinics instead of at the single program office, resulting in higher participation and screenings than the pre-pandemic year before;<sup>14</sup> and
- **The Ponca Nation in Oklahoma**, where the tribal-run health center, struggling to help women keep appointments for its mobile mammography unit, worked with clinic staff to address health literacy concerns by creating colorful, informative materials, made a list of patients who met criteria but has not been screened, and brainstormed ways to increase screenings, which resulted in a significant increase in kept mammogram appointments in both the mobile and standard clinics.<sup>15</sup>

Interventions that follow a model seeking to address the social needs that make it particularly difficult for some individuals to access cancer screening have not only been shown to be successful at increasing screening participation, but they are also cost effective. A systematic review of breast, colorectal, and cervical cancer screening studies showed that interventions that focused on improving cancer screenings by addressing the surrounding social determinants in underserved, vulnerable populations *enhanced* health equity and economic efficiency.<sup>16</sup> Some of these interventions included addressing factors related to the neighborhood and built environment such as providing transportation assistance to attend screening appointments, addressing access by providing vouchers and free screening services, addressing health literacy through distributing different educational materials, or addressing community support systems by providing childcare assistance and patient navigators.<sup>17</sup>

[The Guide to Community Preventive Services](#), which is a collection of evidence-based findings designed to help communities select interventions to improve health and prevent disease, adds to this through their review of strategies to increase cancer screening in breast, cervical, and colorectal cancer. The Guide recommends that to increase cancer screening participation, multicomponent interventions have the greatest effect when they are combined with strategies that increase community demand and access for screenings. The Guide recommends combining different approaches such as:

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<sup>14</sup> Centers for Disease Control and Prevention; “Guam Makes Program Enrollment Easier During the Pandemic.” 10 November 2021. [cdc.gov/screenoutcancer/success/guam-makes-enrollment-easier.htm](https://cdc.gov/screenoutcancer/success/guam-makes-enrollment-easier.htm)

<sup>15</sup> Centers for Disease Control and Prevention; “Clinic Staff Boosts Cancer Screening Efforts in Kaw Nation.” 10 November 2021. [cdc.gov/screenoutcancer/success/kaw-nation-boosts-cancer-screening.htm](https://cdc.gov/screenoutcancer/success/kaw-nation-boosts-cancer-screening.htm)

<sup>16</sup> Mohan G, Chattopadhyay S. Cost-effectiveness of Leveraging Social Determinants of Health to Improve Breast, Cervical, and Colorectal Cancer Screening: A Systematic Review. *JAMA Oncol.* 2020;6(9):1434-1444. doi:10.1001/jamaoncol.2020.1460

<sup>17</sup> *Id.*

- Increasing community demand (i.e., client reminders, group education, small and large media, etc.);
- Increasing community access (i.e., reducing out of pocket costs, etc.);
- Increasing provider delivery of screening services (i.e., provider incentives, provider assessment and feedback, etc.); and
- Reducing structural barriers (i.e., reducing administrative barriers, addressing transportation barriers, providing language translation services, offering childcare, etc.).<sup>18</sup>

## Creating Multi-Sectoral Partnerships to Coordinate Care and Address Social Needs

When state, territorial, and tribal cancer program directors identify barriers to screening, it can be overwhelming to think about ways to address them with limited program dollars and resources. While cancer program directors may have the ability to address some social needs and even some social determinants of health, many of these deep-rooted barriers are beyond what a single program can take on. However, there is an opportunity to address some of these systemic issues at a community level by forming or joining partnerships with other parts of government, community-based organizations, health care providers, faith leaders and businesses.

As state, territorial, and tribal cancer program directors think about how to best address the social determinants of health, as well as the social needs of their populations of interest, a resource that they should look to are comprehensive cancer coalitions. These existing organizations can be leveraged to support cancer program initiatives by leaning on the coalition's membership's experiences and insights. Membership can also be grown and diversified to maximize the coalition's ability to create culturally sensitive and well-rounded solutions that promote cancer screenings.

Cancer program directors can also look for other possible partners by looking for examples of how government entities are working in collaboration with health care providers and social service organizations to creatively address social needs. In some areas these collaborations are organized to address immediate social need, perhaps to avoid a crisis or keep someone afloat.

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<sup>18</sup> The Community Guide; Cancer Screening: Multicomponent Interventions—Cervical Cancer. August 2016. [thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-cervical-cancer](https://thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-cervical-cancer). See The Community Guide; Cancer Screening: Multicomponent Interventions—Colorectal Cancer. August 2016. [thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-colorectal-cancer](https://thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-colorectal-cancer). See also The Community Guide; Cancer Screening: Multicomponent Interventions—Breast Cancer. August 2016. [thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-breast-cancer](https://thecommunityguide.org/findings/cancer-screening-multicomponent-interventions-breast-cancer).

- In Wisconsin, **Marshfield Clinic Health System** collaborates with community partners and uses technology to connect rural patients with services. Marshfield has its community resource partners use a social care technology platform to screen patients for social needs ranging from food and shelter to transportation and childcare, and the technology helps identify potential needs while also helping coordinators link patients to nearby social services.<sup>19</sup> By forming partnerships with these local organizations, the hospital can meet patients' needs and improve their health care outcomes.
- **UC Health** in Denver, Colorado utilizes social workers and primary care clinics to coordinate patients' care, while also assisting the patients in getting the resources that they need every day. Social workers have helped patients secure stable housing, fill out Medicaid applications, connect with translators, and get reliable transportation.<sup>20</sup>
- Large Western regional health provider and plan groups like **Intermountain Healthcare** and **Kaiser Permanente** have made finding ways to address patients' social needs a priority by screening patients to look for potential food inadequacy, lack of transportation, unstable housing, poor safety, past due utility payments, and lack of access to care. These groups then take this information and actively connect patients to the resources that they need to thrive outside of the hospital.<sup>21</sup>

Other collaborations focus on addressing upstream determinants of health – not so much an urgent or acute need of an individual, but an intervention aimed at improving the underlying conditions that drive social need, and that can change someone's direction toward a healthier outcome.

- In Columbus Ohio, the not-for-profit organization **Community Development for All People** has partnered with Columbus' safety-net provider for low-income children, **Nationwide Children's Hospital**, to rehabilitate up to 75 homes over five years in low-income neighborhoods. The two organizations have also continued to partner to expand Community Development for All People's fresh-food market program that offers free produce to low-income residents who are food insecure.<sup>22</sup>

<sup>19</sup> Mulio, D. "Marshfield Clinic Health System taps NowPow to connect its rural patients to social services." *Fierce Healthcare*. 28 June 2021. [fiercehealthcare.com/hospitals/marshfield-clinic-health-system-taps-nowpow-to-connect-its-rural-patients-to-social](https://www.fiercehealthcare.com/hospitals/marshfield-clinic-health-system-taps-nowpow-to-connect-its-rural-patients-to-social)

<sup>20</sup> Smith, T., "Beyond medicine: Primary care clinics heighten attention to patients' social needs." *UHealth*. 3 February 2016. [uchealth.org/today/beyond-medicine-primary-care-clinics-heighten-attention-to-patients-social-needs](https://www.uchealth.org/today/beyond-medicine-primary-care-clinics-heighten-attention-to-patients-social-needs)

<sup>21</sup> National Alliance to impact the Social Determinants of Health. "Integrating Clinical and Social Care." [nasdoh.org/integrated-clinical-and-social-care](https://www.nasdoh.org/integrated-clinical-and-social-care)

<sup>22</sup> Johnson, SR. "Hospitals address social determinants of health through community cooperation and partnerships." *Modern Healthcare*. June 2, 2018. [modernhealthcare.com/article/20180602/TRANSFORMATION03/180609978/hospitals-address-social-determinants-of-health-through-community-cooperation-and-partnerships](https://www.modernhealthcare.com/article/20180602/TRANSFORMATION03/180609978/hospitals-address-social-determinants-of-health-through-community-cooperation-and-partnerships)



- **Lankenau Medical Center**, located outside of Philadelphia Pennsylvania, partnered with **Greener Partners**, a not-for-profit advocate for local food systems, to build a half-acre farm on its campus to provide healthy foods to its patients at no cost. Since its creation, the farm has produced more than 4000 pounds of food for the hospital's patients.<sup>23</sup>
- **Indiana University Health** is a large health system with 17 locations around the state of Indiana. Through a community health needs assessment process, they identified access to affordable health care, obesity prevention, behavioral health, and pre-K-12 education as priority health concerns in their community. The health system has built partnerships within their community to address these underlying drivers of health. For example, in partnership with the largest foodbank in the state, a mobile health pantry provides 6,000 nutritious meals per week in six targeted neighborhoods affected by high rates of poverty, food insecurity, unemployment and violent crime. Additionally, the health system has partnered with the local **United Way** to improve literacy among at-risk kindergarten students by providing books, supplies, backpacks and other supplies and camps to reinforce social and intellectual skills required to be successful in schools.<sup>24</sup>

These are just a few examples of the many multi-sector alliances and partnerships that can help cancer program directors connect with the community partners who are also working to help improve the lives of those most at risk of developing cancer. To facilitate the creation and sustainability of these partnerships, the National Alliance to Impact the Social Determinants of Health (NASDOH) created a [resource guide](#) that emphasizes that multi-sectoral partnerships are essential to addressing the social determinants of health and provides advice on how to create and sustain successful partnerships.<sup>25</sup>

Cancer program directors should consider partnering with health and community-focused organizations that work with underserved populations that experience disparities in cancer screening rates. Many of these organizations are working to break down barriers and improve health and wellbeing for vulnerable populations and also have equity as a driving focus. There are great opportunities to engage with these organizations, as each brings different strengths and expertise to find and engage with hard-to-reach individuals where they are. (See Table 1).

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<sup>23</sup> "This Hospital Prescribes Fresh Food From Its Own Organic Farm." *EcoWatch*. Dec 20, 2016. [ecowatch.com/urban-farm-hospitals-2151088898.html](http://ecowatch.com/urban-farm-hospitals-2151088898.html)

<sup>24</sup> Health Research & Educational Trust. (2016, August). *Creating effective hospital-community partnerships to build a Culture of Health*. Chicago, IL: Health Research & Educational Trust. pg. 37. [hpoe.org/Reports-HPOE/2016/creating-effective-hospital-community-partnerships.pdf](http://hpoe.org/Reports-HPOE/2016/creating-effective-hospital-community-partnerships.pdf)

<sup>25</sup> National Alliance to impact the Social Determinants of Health. "Multi-Sectoral Alliance Resource Compendium." 2021. [leavittpartners.com/wp-content/uploads/2021/03/LPCA\\_NASDOH-Compendium\\_FINAL.pdf](http://leavittpartners.com/wp-content/uploads/2021/03/LPCA_NASDOH-Compendium_FINAL.pdf)



## Conclusion

As cancer program directors seek to increase screenings, they can consider ways to address the social needs and social determinants of health that make it difficult for vulnerable individuals to access screening programs. As the directors seek to reduce barriers to screening and access, consider using existing partnerships, or establishing new partnerships, with health care, social services, and other organizations in the community that are well positioned to address, or already addressing, the social determinants of health. Some of the partnership activities available to cancer program directors to help them equitably increase cancer screenings across all populations include:

- Utilizing the insights and expertise of existing comprehensive cancer coalitions.
- Seeking to diversify the membership of the comprehensive cancer coalitions.
- Partnering with local organizations that work with underserved communities.
- Leveraging connections with designated rural health, local health, and primary care offices.
- Reaching out to entities responsible for conducting community health surveys and assessments.
- Engaging with local and regional health care systems, particularly those who serve as safety-net providers.
- Building long-term multi-sectoral partnerships that are made up of organizations who provide social, health, government, and cultural services.

Through multi-sectoral coalitions and partnership, state, territorial, and tribal cancer program directors will be able to more effectively address the barriers preventing different populations from accessing and utilizing cancer screening resources. By reaching out to others, and not working alone, cancer program directors can increase their impact, improve wellness, and save lives.

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Table 1: Partnership Opportunities to Advance Equity and Address SDOH

	OPPORTUNITY	PUBLIC HEALTH AGENCIES	HEALTH CARE PROVIDERS	PAYERS	COMMUNITY BASED ORGS
FOUNDATIONAL	Organizational commitment to Health Equity	X	X	X	X
	Building and maintaining a culturally diverse workforce	X	X	X	X
	Delivering services in a culturally responsive way	X	X	X	X
	Implementing payment arrangements that support sustainability of Health Equity and SDOH strategies		X	X	
	Screening for Social Determinants of Health (potential drivers of health disparities)	X	X	X	
COLLABORATIVE	Collecting data to identify and evaluate health disparities and SDOH needs.	X	X	X	X
	Analyzing data and other information to inform program design	X		X	
	Community interventions that address SDOH and health disparities	X			X
	Delivering interventions to individuals to mitigate SDOH		X	X	X
	Finding new ways to reach populations in need	X			X