NORC at the University of Chicago

Final Evaluation Report

Building a Culture of Health through the Cancer Lens: More Intentionally Integrating Health Equity and Social Determinants of Health into the American Cancer Society and Select Communities

NORC at the University of Chicago

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Overview

The American Cancer Society (ACS) and the American Cancer Society Cancer Action Network (ACS CAN) received a three-year grant from the Robert Wood Johnson Foundation (RWJF) to further integrate health equity into organizational policies, practices, and research, and collaborate with communities to address the social determinants of health that contribute to cancer disparities. The grant had two populations of focus:

- ACS and ACS CAN organizational staff and volunteers (e.g., leadership staff and partners such as the National Advisory Council, workgroups, and Health Equity Champions); and
- Selected communities, including staff, volunteers, partners, and community members.

In 2018, ACS contracted with NORC at the University of Chicago to evaluate the grant program and determine the extent to which ACS' and ACS CAN's efforts advanced health equity through a cancer lens and made health equity a shared value within ACS and ACS CAN and in selected community sites. NORC conducted a mixed-methods process and outcome evaluation of organizational and community-level activities undertaken by ACS and ACS CAN.

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Acronym List

ACRONYM	MEANING
ACS	American Cancer Society
ACS CAN	American Cancer Society Cancer Action Network
CLT	Community Leadership Team
GHQ	Global Headquarters
IRB	Institutional Review Board
KII	Key Informant Interview
NAC	National Advisory Council on Health Equity
NORC	NORC at the University of Chicago
OCRI	Office of Cancer Research and Implementation
RWJF	Robert Wood Johnson Foundation
SDOH	Social Determinants of Health

Executive Summary

Building a Culture of Health through the Cancer Lens:
Evaluation Executive Summary

The American Cancer Society (ACS) and its nonpartisan advocacy affiliate, the American Cancer Society Cancer Action Network (ACS CAN), have a vision to achieve a society where everyone has a fair and just opportunity to be healthy and cancer-free. With the support of the Robert Wood Johnson Foundation, ACS and ACS CAN advanced health equity (HE) by increasing organizational capacity and collaborating with communities to improve social determinants of health (SDOH) that affect cancer. This executive summary describes findings from a process and outcome evaluation conducted by NORC at the University of Chicago, which includes data from surveys, interviews, and document review throughout the duration of the work from January 1, 2018, to June 30, 2021. For more information on these findings, please see the Evaluation Report.

ACS and ACS CAN advanced health equity by:

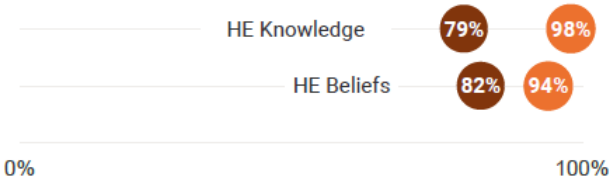
- Training over 2,000 staff and volunteers
- Conducting public opinion research and an organizational assessment
- Developing a marketing, communications, and messaging strategy
- Funding 12 Pilot Community Projects
- Engaging 41 regional staff members to provide local support to community partners
- Convening stakeholders from the North, North Central, and South regions

Health equity trainings and collaborative work sessions significantly increased knowledge, attitudes, and beliefs.

ACS and ACS CAN staff, volunteers, and community partners have strong knowledge and beliefs related to health equity, particularly among those who participated in training and grant-related activities.

Within the Organization

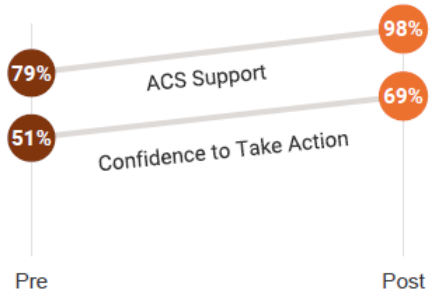
Trained staff and volunteers were significantly more knowledgeable about health equity and expressed significantly stronger health equity beliefs than **those who were not trained**.



As a result of ACS' and ACS CAN's health equity training, most trained staff and volunteers reported they were more motivated to act to advance health equity.

In Pilot Communities

Community leaders reported significantly increased confidence and feelings of support from ACS **after the Health Equity Institute,** where they participated in training and collaborative sessions to develop community action plans during the community projects launch.

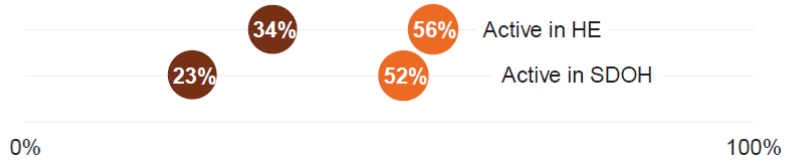


ACS and ACS CAN put health equity into action.

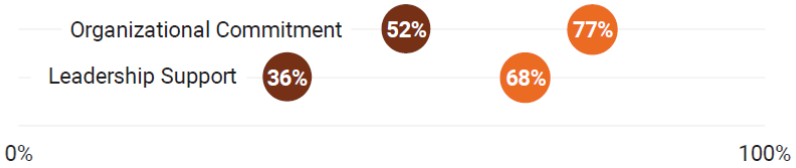
Within the Organization

ACS and ACS CAN integrated health equity into organizational culture by embedding health equity as a value in the strategic plan and in organizational policies.

Trained staff and volunteers reported significantly more active involvement than **those who were not trained**.



Trained staff and volunteers also perceived significantly more organizational commitment and support to address health equity than **those who were not trained**.



In Pilot Communities

Given the relationship between cancer and nutrition and physical activity, 10 out of 12 Pilot Community Projects focused on food insecurity. These projects resulted in:

- Increased awareness
- New and stronger partnerships
- New tools and resources
- Expanded community infrastructure

The remaining two Pilot Community Projects addressed financial insecurity and community needs assessment.

Pilot Community Project Success Factors:

- Partners from diverse sectors that are actively engaged within their communities
- Flexible program structure that can be adapted to meet community needs and leverage community resources
- Tangible goals and data to inform program development and evaluate progress
- Willingness to learn about communities and build trust within them among ACS and ACS CAN staff

COVID-19

The pandemic simultaneously **increased needs** and **generated challenges**.

Within the organization, the pandemic created **resource constraints** that prompted staff restructuring and reductions.

In pilot communities, the pandemic caused **delays** and necessitated **changes in implementation**, particularly for the second cohort.

Social Justice Movement

The social justice movement in 2020 **increased awareness and interest in health equity-related work.**

ACS and ACS CAN were in the **right place at the right time** to use the momentum generated by this movement.

ACS and ACS CAN will increase their relevance by developing a clear strategy that staff and volunteers understand and are trained and empowered to implement in a sustainable way.

Takeaways	Looking Ahead
There is a role for ACS and ACS CAN in addressing health equity. To be most impactful, this work needs a clear strategy that is practically aligned with mission priorities. Public opinion research from 2018 indicates that 92 percent of people think it is important for ACS to increase opportunities for all people to prevent, find, treat, and survive cancer. Nationally, engaging in health equity work contributes to and demonstrates relevance. In communities, health equity work contributed to stronger partnerships, diverse networks, and greater visibility for ACS and ACS CAN. Staff supporting both cohorts of Pilot Community Projects agreed that the organization should work to address social determinants of health. However, as the pandemic caused resource constraints within the organization, staff supporting Cohort 2 expressed some reservations about the relative priority of work addressing broad, upstream social determinants of health compared to more cancer-specific work.	Clearly identify how the organization will be most effective in addressing health equity while also achieving mission priorities both nationally and in communities.
Health equity training is effective. Future training opportunities should focus on skill building to achieve strategic results. Survey results indicate that trained staff and volunteers understand what health equity and related concepts mean, and why they are important. Staff and volunteers expressed a need to better understand how health equity concepts can be put into action in their own work through their individual roles.	Continue to train new staff and volunteers, and develop additional trainings to build on knowledge and develop skills and capacity to apply it.
ACS and ACS CAN are powerful conveners. An intentional focus on sustainability will increase impact over time. Pilot Community Project participants praised the momentum ACS and ACS CAN catalyzed in communities, but raised concerns about sustainability. While pilot projects benefitted from working with organizations that were already active and connected in the community, ACS and ACS CAN staff functioned in a project management capacity, coordinating their efforts.	Prioritize developing strategies for sustainability to ensure continued strong partnerships and relevance.

Introduction

The American Cancer Society (ACS) and its nonprofit, nonpartisan advocacy affiliate, the American Cancer Society Cancer Action Network (ACS CAN) have a vision to achieve a society where everyone has a fair and just opportunity to be healthy and cancer-free. As part of achieving this vision, ACS and ACS CAN believe that improving disparities in cancer outcomes requires addressing social determinants of health (SDOH) and advancing health equity. Supported by a three-year grant from the Robert Wood Johnson Foundation (RWJF), the nation's largest philanthropy focused solely on health, ACS and ACS CAN are committed to advancing the culture of health and making health equity a shared value by increasing organizational and community capacity and fostering cross-sector collaborations to improve social, economic, and environmental conditions that affect cancer.

The goal of the grant was to address and integrate social, economic, and environmental factors that contribute to cancer disparities into ACS' and ACS CAN's work and collaborate with national and community leaders to improve cancer outcomes by:

1. Establishing and bolstering an institutional commitment to advance health equity;
2. Strengthening and supporting the case for health equity action within ACS and ACS CAN and in communities; and
3. Spreading key lessons and outcomes related to health equity within ACS and ACS CAN and to public health and organizational development fields.

Exhibit 1: Stakeholders Involved in Organizational and Community Efforts

- ACS Global Headquarters (GHQ) Health Equity Team
- National Advisory Council (NAC) on Health Equity
- ACS and ACS CAN GHQ and regional staff
- ACS and ACS CAN volunteers
- Community members
- Multi-sector partners in communities
- NORC evaluation team

ACS' and ACS CAN's ongoing efforts are underscored by the belief that mitigating disparities in cancer outcomes requires addressing lack of trust and perceptions of limited engagement by ACS and ACS CAN in communities that have been marginalized through reprioritizing organizational strategies, establishing a consistent and welcoming presence, and increasing education and awareness of their work and research on health equity and cancer disparities.

A broad range of stakeholders from within and outside of ACS and ACS CAN were involved in these efforts (see Exhibit 1). The grant had two areas of focus:

- **ACS and ACS CAN staff and volunteers** (e.g., leadership staff and partners such as the National Advisory Council, workgroups, and Health Equity Champions): ACS and ACS CAN trained their staff and volunteers; worked to develop a common language around health equity; integrated health equity into the organization's strategic priorities; and fostered a supportive organizational culture that embraces health equity.

- **Selected communities**, including staff, volunteers, partners, and community members: ACS and ACS CAN established the Health Equity Pilot Community Projects (referred to as Pilot Community Projects throughout this report) to empower ACS and ACS CAN staff, volunteers, partners, and community members to drive action planning and implementation of health equity projects in their local communities. ACS funded and tasked two cohorts of communities to develop and implement strategies that address one of the following SDOH: (1) financial toxicity among cancer survivors; (2) access to foods that support cancer prevention, treatment, and survivorship (i.e., food insecurity); and (3) transportation and mobility to cancer prevention, early detection, treatment, and survivorship care.

This report describes findings from a process and outcome evaluation of ACS' and ACS CAN's efforts to more intentionally integrate health equity and SDOH within the organization and in selected communities.

Overview of the Evaluation

In 2018, ACS contracted with NORC at the University of Chicago to evaluate the grant activities and determine the extent to which ACS and ACS CAN efforts advance health equity through a cancer lens and make it a shared value within ACS and ACS CAN and in selected community sites. NORC and ACS developed a logic model outlining the inputs, activities, outputs, and outcomes relevant to ACS' and ACS CAN's organizational and community efforts (Appendix A).

NORC conducted a mixed-methods process and outcome evaluation of organizational and community-level activities undertaken by ACS and ACS CAN to understand how the program was implemented and to assess the short-, medium-, and long-term outcomes of these efforts. Process measures assessed what and how activities were implemented, who the efforts reached, the extent to which efforts were implemented as planned (fidelity), and the contextual factors influencing implementation. The outcome evaluation assessed the degree to which grant activities contributed to expected changes in 1) staff's, volunteers', and community leaders' knowledge, attitudes, and behaviors; and in 2) community collaboration, integration of health equity, and ACS and ACS CAN relevancy. Evaluation questions are listed in Exhibit 2. The evaluation relied on data obtained from ACS and ACS CAN staff, volunteers, partners, community leaders, and others, as well as primary data collected by NORC to document implementation processes, organizational and community needs related to health equity, and the extent to which the ACS and ACS CAN effort contributed to expected outcomes. See Appendix B for a crosswalk demonstrating the connection between these evaluation questions and the logic model.

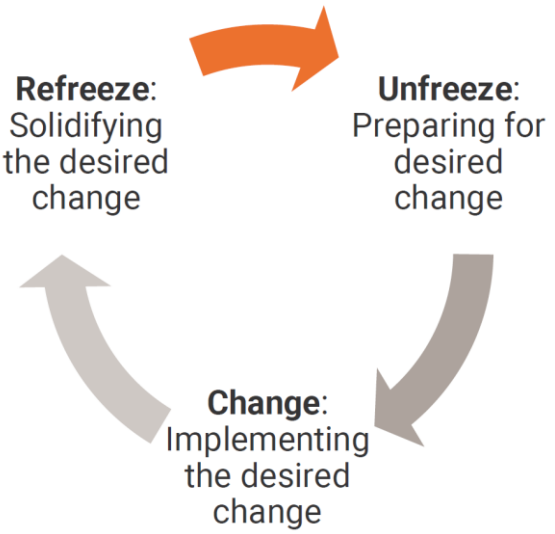
Exhibit 2: Evaluation Questions

Organizational	Community-Level
Process Evaluation	
Q1: How did ACS and ACS CAN **advance health equity actions** within its organization?	Q1: How did selected communities **advance health equity actions**? Q2: What **factors for success** can be derived from the Health Equity Community Projects model?
Outcome Evaluation	
Short: Q2: To what extent have ACS' and ACS CAN's efforts increased staff's and volunteers' health equity **knowledge, attitudes, beliefs, and skills**? **Medium:** Q3: To what extent has ACS and ACS CAN **enhanced its organizational activities** to advance health equity? **Long:** Q4: To what extent have ACS' and ACS CAN's efforts contributed to increases in **ACS' relevancy?**	**Short:** Q3: To what extent have ACS' and ACS CAN's efforts increased selected communities' health equity **knowledge, attitudes, beliefs, and skills?** **Medium:** Q4: To what extent did community projects **increase action in advancing health equity** and addressing SDOH in communities? Q5: To what extent have selected communities increased **collaboration across sectors and teams**? **Long:** Q6: To what extent did ACS' and ACS CAN's efforts in selected communities increase its **relevancy**?

Two theoretical frameworks guide the evaluation: Lewin's Change Management Model and the Social Ecological Model. The **Lewin's Change Management Model** (see Exhibit 3) recognizes that individual- or group-level change is dynamic and involves unlearning and relearning to promote desired behavior. Using this theory, ACS developed a plan to:

- **Unfreeze:** Increase knowledge, skills, confidence, and collective efficacy around health equity, SDOH, and the need for change *(short-term outcomes)*.
- **Change:** Increase organizational policies, practices, and research to advance health equity and address SDOH, and conduct a series of interventions at the local, state, and national levels *(medium-term outcomes)*.

Exhibit 3: Lewin's Change Management Model

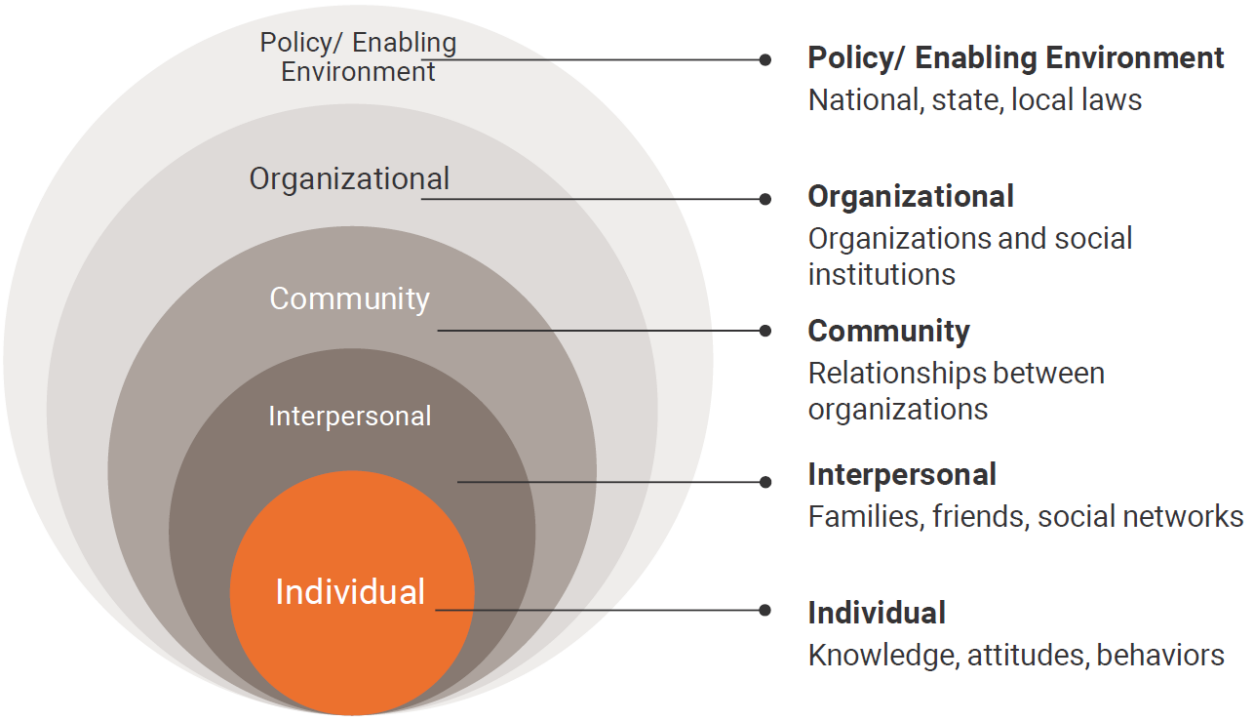


Source: Hussain ST, Lei S, Akram T, Haider MJ, et. al. (2018). Kurt Lewin's Change Model: A Critical Review of the Role of Leadership and Employee Involvement in Organization Change. *Journal of Innovation & Knowledge*, 3(3):123-127.

- **Refreeze:** Establish a common vocabulary and health equity communications strategy, and foster a supportive organizational culture and cross-sector collaborations to advance health equity *(long-term outcomes)*.

The **Social Ecological Model** (see Exhibit 4) acknowledges the effects of personal and environmental factors in determining behaviors to achieve outcomes at the individual, community, organizational, and policy levels. ACS and ACS CAN sought to address the varying factors at play in the model by shifting individual mindsets around cancer disparity reduction interventions and working with medical and non-medical partners at the community, organizational, and policy levels to promote health equity.

Exhibit 4: Social Ecological Model



Source: UNICEF. (2018). What is the Social Ecological Model? Retrieved 7/10/2018 from https://www.unicef.org/cbsc/files/Module_1_SEM-C4D.docx.

Methods

NORC implemented a multi-phase, mixed-methods process and outcomes evaluation to assess how ACS and selected communities implemented health equity efforts and resulting short-, medium-, and long-term outcomes. NORC used qualitative data to answer process questions and synthesized qualitative and quantitative data to answer questions about changes in outcomes. The evaluation also took a rapid-cycle approach to provide ACS with timely and actionable information. In December 2018, NORC received a determination of non-human subjects research by its Institutional Review Board (IRB) for this evaluation.

Quantitative Methods

Enterprise-wide Annual Survey. ACS and NORC conducted three annual Enterprise Surveys (fall 2018-2020) to gather data on staff and volunteers across four domains: general understanding of health equity; understanding of health equity in relation to cancer; beliefs about health equity; and training experience and needs. The web-based survey included 27 multiple choice questions and achieved an average response rate of 28 percent among staff and 8 percent among volunteers. See Exhibit 5 below for detailed response information.

Exhibit 5: Staff and Volunteer Responses to Enterprise Survey

	Staff		Volunteers	
Survey Year	Total	Response Rate	Total	Response Rate
Year 1	1,807	39%	202	18%
Year 2	1,044	23%	52	5%
Year 3	590	22%	28	.1%
Total	**3,441**	**-**	**282**	**-**

Pilot Community Projects Surveys. Surveys were also administered before and after the Pilot Community Projects Co-Chairs Meetings and Institutes. These two convenings provided 12 community leadership teams (CLTs)—comprised of staff, community partners, and volunteers—key learnings about health equity and health disparities concepts (e.g., cancer disparities data, research, and solutions to address disparities), and collaborative time to determine elements of their individual action plans to address their community's unique needs. Survey items were intended to measure changes in health equity knowledge, attitudes, and beliefs, and teams' comfort/confidence in taking actions to advance health equity. Survey data were collected anonymously, prohibiting matching of cases from pre- and post-surveys. See Exhibit 6 for distribution of responses to the surveys. There was a 53 percent response rate among Co-Chairs Meeting participants and 41 percent response rate among Institute

participants across both cohorts[1]. Due to the relatively low number of responses to these surveys, generalizations about the broad applicability of the results to the Pilot Community Projects should not be made.

Exhibit 6: Number of Responses to Pilot Community Projects Surveys

	Co-Chairs Meeting Survey		Institute Survey	
	Pre-Survey	Post-Survey	Pre-Survey	Post-Survey
Cohort 1	10	11	32	30
Cohort 2	18	15	31	26
Total	**29**	**26**	**63**	**56**

Quantitative Data Analysis

Enterprise-wide Annual Survey. For the Enterprise Survey, goodness-of-fit tests were conducted to examine the similarity in demographics between the sample and population proportions. Each wave of survey data was then weighted for analysis based on the population demographics of ACS staff and volunteers. Analysis of Enterprise Survey data presented in this report focuses on changes over time for staff respondents from three waves of data collection and comparisons between staff and volunteer respondents who reported participating in health equity training or activities provided by ACS and those who did not at the Year 3 follow-up.

Pilot Community Projects Surveys. For the Pilot Community Projects survey, weighting was not conducted, and analysis was restricted to frequency distribution and pre-to-post analysis. Changes over time were assessed for statistical significance using non-overlapping 95 percent confidence intervals, and differences between groups and pre-to-post analyses were assessed using Chi Square tests of significance at $p<.05$.

Qualitative Methods

Key Informant Interviews (KIIs). NORC conducted KIIs with stakeholders from all 12 Pilot Community Project locations in two rounds: from March to September 2020 for Cohort 1 projects and from January to May 2021 for Cohort 2 projects. NORC worked with ACS to select a stratified purposive sample of ACS leadership overseeing the Pilot Community Projects, ACS and ACS CAN staff working directly with Pilot Community Project teams, and community members, with a goal of interviewing at least two individuals from each community. An interviewer followed a semi-structured interview guide built around evaluation goals and tailored to each community based on information from community progress reports. Due to the COVID-19 pandemic, interviews were conducted virtually. NORC conducted both group (90-minute) and individual (60-minute) KIIs with stakeholders from Cohort 1 Pilot Community Project field staff, community partners, and community leaders. Group discussions were

[1] The Cohort 2 Institute was held through four virtual sessions, and attendance across all sessions was not tracked in detail, so the base of the response rate for this session reflects anyone who was invited to attend any of the virtual sessions.

location-specific and were by stakeholder type (leadership, staff, community member). A senior NORC staff member conducted each interview while a junior staff member took transcript-style notes. Interviews were audio recorded to support notetaking. In total, we spoke to 57 individuals representing all 12 community projects, consisting of ACS leadership (28 percent), ACS and ACS CAN staff (26 percent), and volunteers and community members (46 percent).

ACS and ACS CAN Senior Leadership Open-Ended Responses Data. In March 2021, ACS fielded an open-ended, written response survey to senior leaders from ACS and ACS CAN to capture their perspectives on organizational efforts to make health equity a shared value, including what organizational efforts they have undertaken to enhance organizational capacity and ACS and ACS CAN relevancy, partnership and support provided to staff, and factors influencing implementation of these health equity activities. Thirteen ACS and ACS CAN leadership representatives were asked to participate, of whom eight (62 percent) responded to the written response survey.

Document Review. NORC and ACS worked together to gather relevant documents for the evaluation, including documents related to ACS' and ACS CAN's organizational efforts and the Pilot Community Projects. Appendix C provides a list of documents compiled and reviewed by NORC.

Qualitative Data Analysis

NORC conducted thematic analysis of stakeholder and leadership data, examining themes both deductively based on evaluation questions, and inductively based on patterns and themes arising in the data. We used content analysis during the document review to assess the frequency and counts of materials (e.g., research monitoring, relevancy), as well as the extent to which health equity themes were present and integrated into the materials.

Data Limitations

Quantitatively, the number of responses to the third wave of the Enterprise Survey were much lower than previous years. The changes in ACS' organizational structure and the reductions in staff that occurred in 2020 reduced the pool of respondents who were available to complete the Enterprise Survey and may have impacted the response rates. Weighting procedures aimed to limit the impact of these organizational and staff changes on responses. Additionally, some respondents to the Co-Chairs Meeting Survey for the Pilot Community Projects also completed the Institute Survey, so the results for these groups may include overlapping samples. Further, the respondents to the Pilot Community Projects surveys were anonymous and therefore not matched, so the pre-to-post analyses reflect only aggregate information and should not be interpreted as matched case comparisons.

Qualitative data were limited by the availability and comprehensiveness of certain documents. Among Pilot Community Projects, communities differed in the completeness and level of detail of their progress reports. One Cohort 1 six-month progress report was missing at the time the evaluation was conducted and therefore is not included in the analysis.

Key Findings

This section highlights key findings based on each of the evaluation questions, beginning with those related to ACS' and ACS CAN's organizational efforts, followed by findings related to the Pilot Community Projects.

Organizational Efforts

As part of their organizational efforts, ACS and ACS CAN trained their staff and volunteers, worked to develop a common language around health equity, integrated health equity into the organizations' strategic priorities, and fostered a supportive organizational culture that embraces health equity.

Process Evaluation

This section describes the implementation, reach, and fidelity of organizational efforts, as well as contextual factors influencing implementation.

Q1: How did ACS advance health equity actions within its organization?

Implementation & Reach: ACS' Health Equity Team convened stakeholders; conducted research to develop a common language, messaging strategy, and strategic vision around health equity; and trained staff and volunteers. These activities had broad reach among staff and volunteers, and the proportion of staff reached increased steadily and significantly over time.

The ACS Health Equity Team convened over 450 stakeholders—including headquarters and regional staff, volunteers, and partners—to discuss ACS' current work and capacity for health equity and opportunities to better integrate health equity into the organization. These participants represented a broad range of departments, including staff and volunteer training, diversity and inclusion, advocacy, field operations, research, colorectal cancer screening, regional cancer control, volunteer engagement, employee engagement groups, and development/ fundraising. These conversations helped to build relationships, generate awareness around health equity efforts, and garner buy-in for the work. In total, 69 staff and volunteers participated in workgroups and councils, including the National Advisory Council and Health Equity Workgroup. In addition, ACS' organizational assessment documented current policies and practices, which informed the health equity strategic plan and related activities.

Public opinion research was conducted in 2018 to identify messages about cancer, health equity, and social determinants of health that resonate with the general public and how the public views ACS working to advance health equity and address the social determinants of health. Eighty-eight members from the community public and 40 ACS and ACS CAN volunteers participated in 16 focus groups related to this message testing (see Exhibit 7). Focus group participants were comprised of

different groups of people to ensure that diverse perspectives were sought and heard (e.g., Latinx adults with limited income, conservative White voters in rural areas, Native American adults, people who were mixed race with limited incomes). In addition, 1,000 people participated in a national online survey to test health equity messages. Findings from the public opinion research resulted in language that has been adopted throughout the organization: "No one should be disadvantaged in their fight against cancer because of how much money they make, the color of their skin, their sexual orientation, their gender identity, their disability status, or where they live." This research also informed the development of health equity resources and materials, including the health equity definition and principles.

Exhibit 7: Number of Message Testing Focus Groups

	Number of Focus Groups	Number of Focus Groups with Volunteers
Lexington, KY	3	1
Milwaukee, WI	2	1
Jackson, Pearl, and Vicksburg, MS	3	1
Houston, TX*	3	1
Billings, MT	2	0
Gainesville, GA	3	1
Total	**16**	**5**

*One focus group in Houston was conducted in Spanish.

The team trained over 2,000 ACS and ACS CAN staff and volunteers around health equity knowledge and skills;[2] the share of staff and volunteers participating in trainings increased steadily and significantly over time from Year 1 to Year 3 (see Exhibit 8). In total, 798 staff and volunteers participated in trainings, including Regional Health Equity Trainings. Some of the participants from these trainings, called Health Equity Champions, then held Health Equity in Action Workshops with approximately 235 additional ACS staff and volunteers in late 2019 through early 2020. ACS staff also hosted two webinars with over 700 attendees in each of them. Additionally, 156 members of the Pilot Community Projects teams participated in Institutes and Co-Chairs Meetings where training about health equity work in communities was provided by the ACS GHQ Health Equity Team. Furthermore, 1,200 ACS staff members were exposed to or educated about the ACS GHQ Health Equity Team's work through meetings, discussions and other informal engagements. In Year 1, 25 percent of staff and volunteers had been trained, with this share increasing to over half in Year 3. Staff and volunteers represented departments/groups such as cancer control, advocacy, field operations, research, development/fundraising, finance, and employee engagement groups (including Asian American Pacific Islander, Mi ACS: Latino, genACS: Millenial, LGBTQ & Allies, and African American/Black) and

[2] This total number represents the sum of reported attendance for each of the trainings described here. As individual-level attendance was not tracked across training engagements, there is potential for double counting participants who attended more than one of the training opportunities listed in this section.

included headquarters and the regions. ACS also conducted an organizational assessment of its current policies and practices around health equity to inform strategic planning.

Exhibit 8: ACS' Organizational Activities and Reach

Context & Fidelity: While the project experienced minor delays in implementation, overall ACS was able to manage challenges related to the COVID-19 pandemic and leverage the broader social justice movement to keep the project on track.

The COVID-19 pandemic and staff reorganization at ACS and ACS CAN contributed to minor delays in implementation of organizational efforts. For example, ACS experienced delays in the development of videos and trainings due to the need for additional time to gather and digest information needed to inform a training plan and to align them with communication goals. Furthermore, public opinion research work was delayed by a few months given the contractor had competing demands. However, the staff changes also resulted in increased opportunities for the ACS Health Equity Team to collaborate across different parts of the organization. In addition, due to the pandemic, planned in-person trainings were delayed as they were shifted to an online training format. This shift to virtual training allowed ACS and ACS CAN to engage more staff and volunteers. Further, 69 percent of training participants noted the trainings were very good or excellent.

ACS and ACS CAN leaders noted that the broader social justice movement and spotlight around the country on health equity and racial inequities fueled ACS' organizational efforts. They described how the murder of George Floyd and broader conversations about race and discrimination have led ACS to also have conversations about health equity. A few ACS leaders described how ACS has long had a commitment to health equity, but the social justice movement in 2020 provided impetus and momentum for the organization to intensify its focus on health equity efforts.

Outcome Evaluation

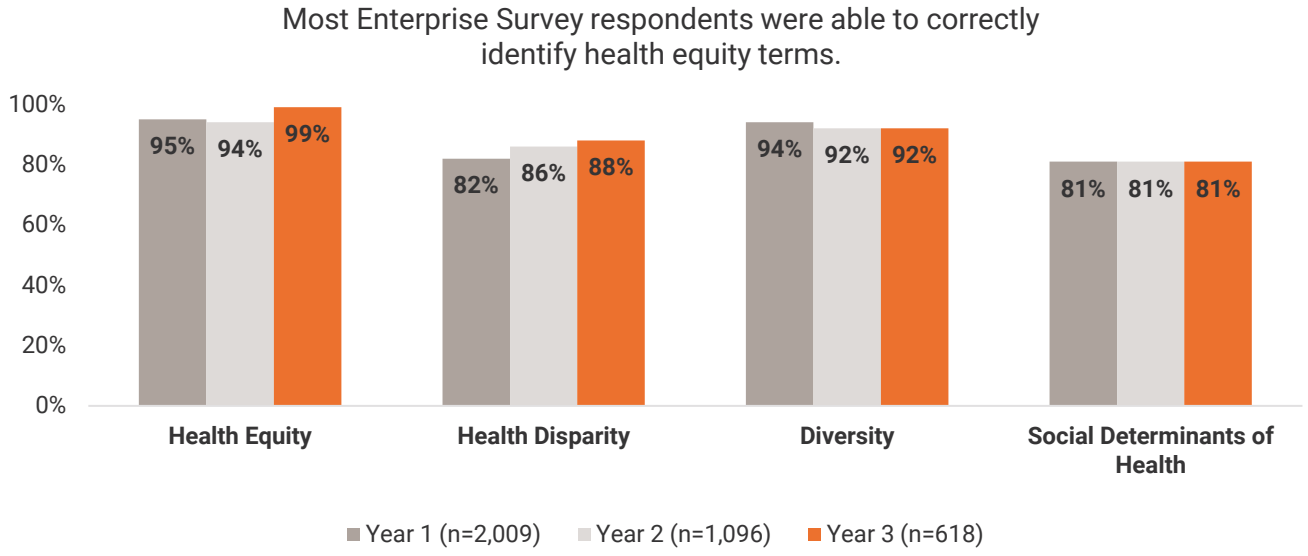
This section describes outcomes related to increases in knowledge and skills (short-term), enhancement of organizational activities to advance health equity (medium-term), and changes to relevancy (long-term). For detailed descriptions of each measure and the associated items on the survey, see Appendix D, Section A.

Q2: To what extent have ACS' AND ACS CAN'S efforts increased health equity knowledge, Attitudes, Beliefs, and skills among staff and volunteers?

Knowledge: ACS and ACS CAN staff showed a high level of knowledge about terms related to health equity, and participation in ACS' health equity training was significantly associated with greater knowledge.

Enterprise survey respondents demonstrated high levels of knowledge (see Exhibit 9), with over 80 percent able to accurately identify the terms "health disparity, health equity, social determinants of health, and diversity." Notably, by Year 3 virtually all staff (99 percent) correctly identified the term "health equity." They were the least knowledgeable about "social determinants of health," which held steady over time at 81 percent correct identification. Increased knowledge of the term "health equity" over time was statistically significant. Observed changes for other terms were not statistically significant.

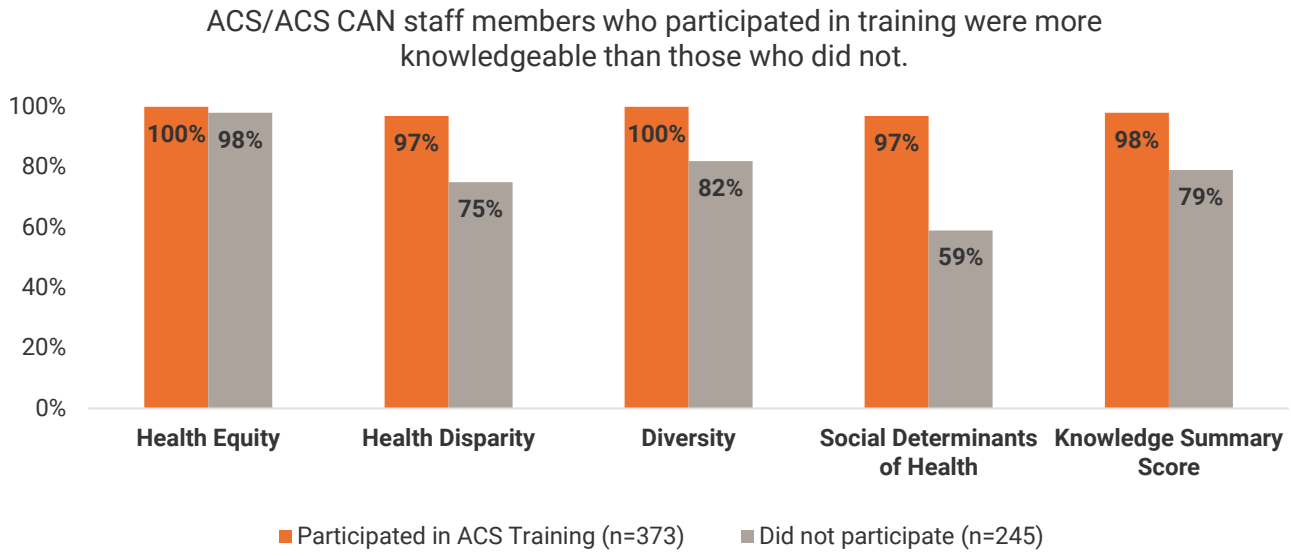
Exhibit 9: Proportion of Respondents who Correctly Identified Health Equity Terms on the Enterprise Survey



Respondents who participated in ACS trainings were statistically significantly more likely than those who did not to correctly identify all the terms, except "health equity," which was correctly identified by virtually all participants regardless of training. The Knowledge Summary score reflects the average

proportion of respondents who correctly identified each term across all four terms. Clear differences in knowledge emerged when comparing ACS staff who participated in trainings with those who have not (see Exhibit 10). In Year 3, approximately 40 percent of respondents reported that they had not participated in ACS training on health equity within the last year.

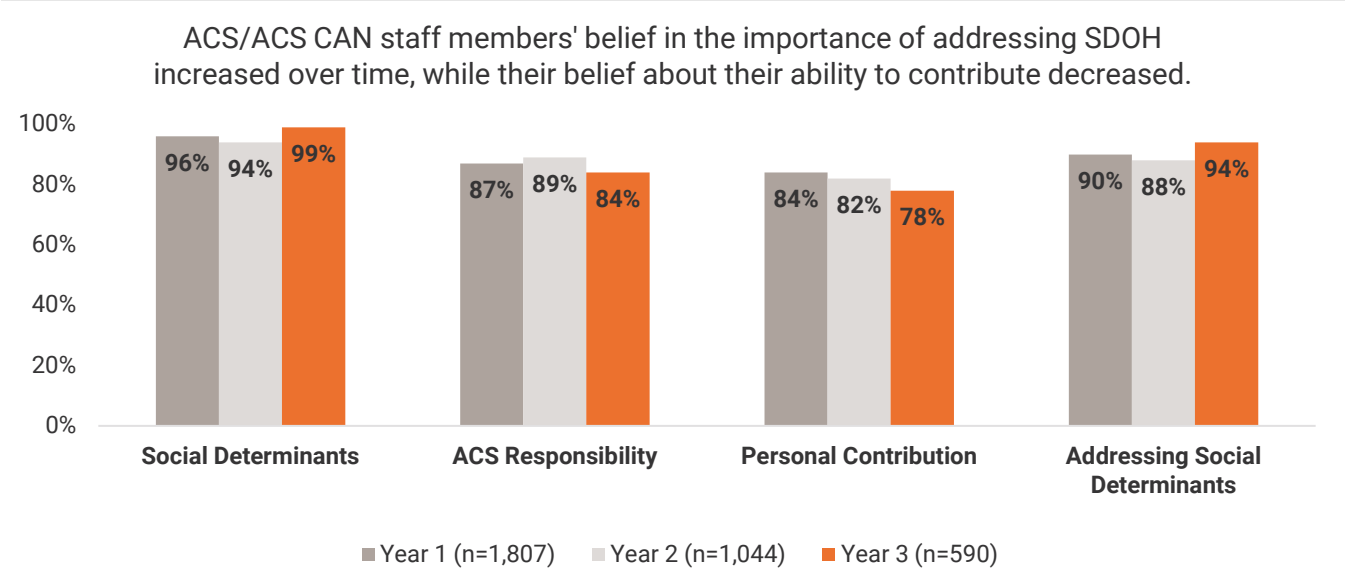
Exhibit 10: Knowledge Scores for Respondents by Training Participation Year 3



Attitudes & Beliefs: Staff who participated in ACS and ACS CAN training were more likely to believe they could advance health equity through their work.

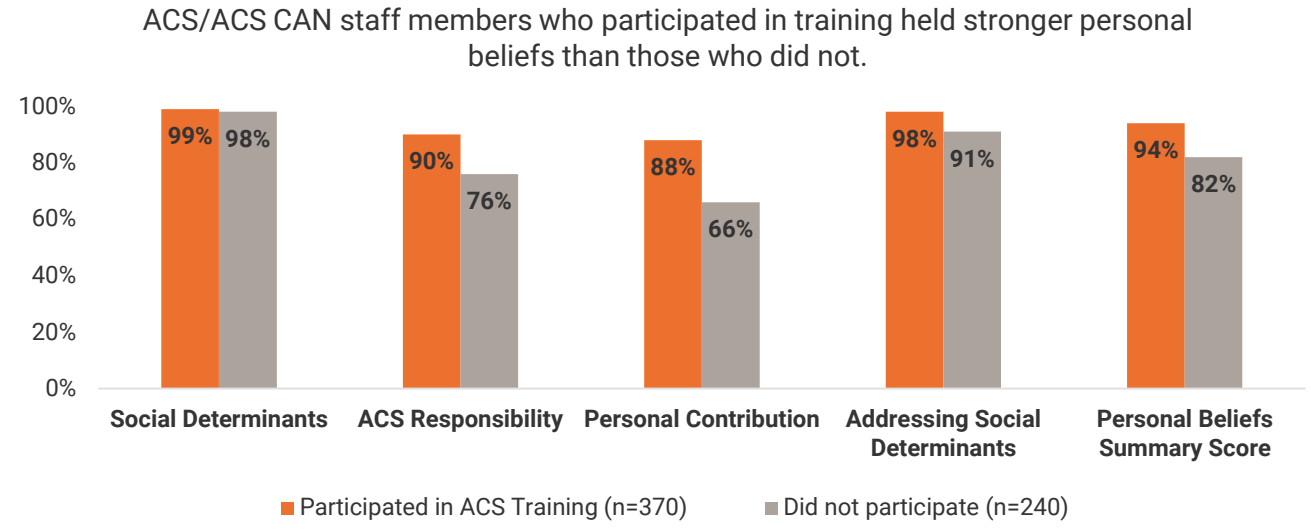
ACS and ACS CAN staff members hold strong personal beliefs about health equity, with the majority of survey respondents (78 percent to 99 percent) reporting agreement with all statements across all three years (see Exhibit 11). Changes from Year 2 to 3 were statistically significant for the statements: "The health of our society, including the ability to prevent, detect, treat and survive cancer, is determined by a combination of social, economic and physical environment factors" (Social Determinants); "I believe addressing the social, economic and physical environment factors that impact cancer is important to my work at ACS/ACS CAN" (Addressing Social Determinants); and "I believe my ACS/ACS CAN work can contribute to advancing health equity" (Personal Contribution). There were no significant changes in agreement with the statement: "It is part of ACS/ACS CAN's responsibility to make sure that everyone has the same opportunity to prevent and survive cancer regardless of the social, economic and physical environment factors" (ACS Responsibility). Notably, over time, fewer staff reported the belief that their work can contribute to advancing health equity.

Exhibit 11: Agreement with Personal Beliefs about Health Equity among ACS and ACS CAN Staff over Time



Respondents who participated in ACS training hold stronger personal beliefs than those who did not, indicating that exposure to ACS and ACS CAN health equity activities and training may be a way to increase ACS and ACS CAN staff and volunteer feelings about their personal ability to advance health equity (see Exhibit 12). All differences between the two groups in their agreement with the statements are statistically significant, except for agreement with "Social Determinants" (99 percent for those who participated in training and 98 percent for those who did not). The Personal Beliefs Summary Score represents the average agreement with personal beliefs statements across all four statements and is significantly higher among trained participants.

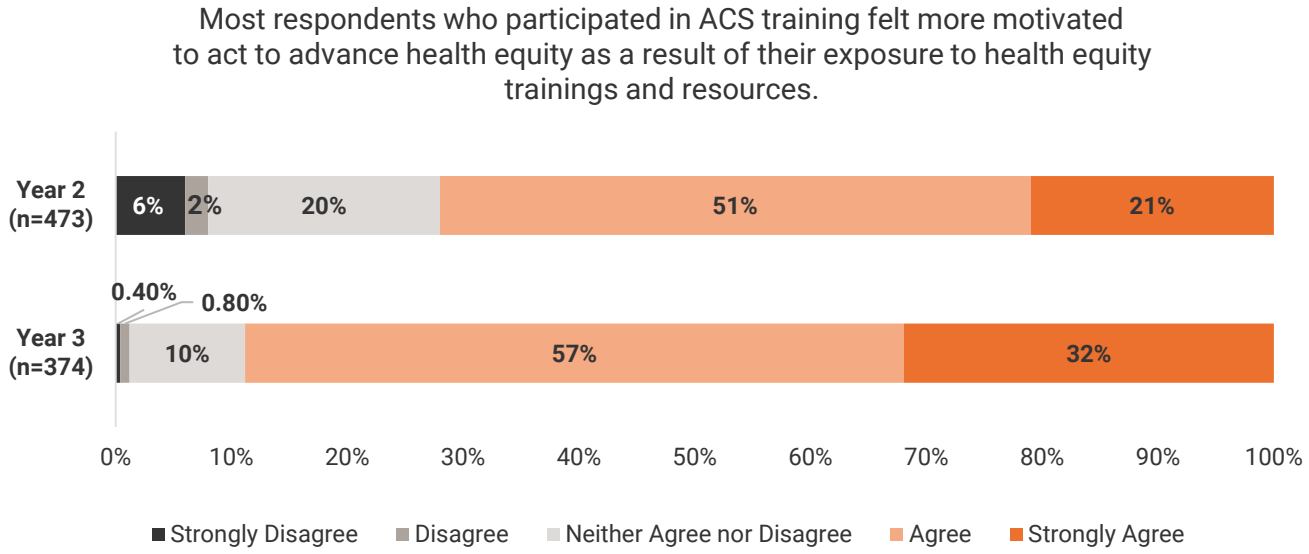
Exhibit 12: Agreement with Personal Beliefs by Training Participation



Skills: Staff who participated in training felt more motivated to act to advance health equity as a result of their exposure to ACS' GHQ Health Equity Team's training and resources.

On the Year 2 survey, 72 percent of respondents agreed or strongly agreed that, as a result of their exposure to ACS/ACS CAN's health equity resources and training, they felt more motivated to act to advance health equity, and this significantly increased to 89 percent in Year 3 (p<.001). Respondents to the Year 2 and Year 3 Enterprise Survey who reported that they had participated in ACS GHQ Health Equity Team training were asked if they agreed with this (see Exhibit 13). Respondents' motivation to act is one indication of their confidence in their ability to actively apply their health equity skills.

Exhibit 13: Feelings of Motivation to Act to Advance Health Equity among Training Participants



Q3: To what extent has ACS enhanced its organizational activities to advance health equity?

Organizational Policies, Programs, and Practices: ACS and ACS CAN established health equity as an organizational value throughout their strategic plan, and they demonstrated that value through inclusion in other organizational guidance documents and an increase in engagement of health equity volunteers.

Health equity was integrated into ACS' and ACS CAN's strategic plan and in mission prioritization. ACS' and ACS CAN's 2020-2022 strategic plan embeds a health equity value statement along with measurable goals related to health equity and indicates that health equity must cut across the organization's work, including research, programs, services, and ACS CAN's advocacy. ACS/ACS CAN senior leadership describes working closely with the ACS Health Equity Team on strategic planning and mission prioritization to form the organization's overall strategy for health equity work. In addition, ACS/ACS CAN leadership reported that relationships built with staff and volunteer leaders helped make health equity a priority in the National Colorectal Cancer Roundtable's strategic plan, which provides guidance on screening, prevention, and early detection of colorectal cancer.

> "Health equity has been raised as one of our organization's top four strategic priorities, not just for our cancer control and policy work but for our research and fundraising goals as well. Hearing our staff and volunteers throw around the acronym SDOH as easily as they would football scores or screening guidelines is the evidence of [the Health Equity Team's] work. And the raised level of awareness in just three years… shows the whole organization's desire to embrace change and make it not just what we do but how we do our work."
>
> **- ACS Senior Leadership Open-ended Response Data**

Health equity was also integrated into other organizational policies, programs, and practices. The ACS GHQ Health Equity Team used input from its organizational assessment and convenings to develop an ACS and ACS CAN health equity definition through the cancer lens and guiding principles that inform how staff and volunteers can practice health equity and take action to advance health equity (see Exhibit 14). Other relevant documents include a fact sheet to increase staff and volunteer awareness about health equity, a document laying out opportunities for ACS Area Board Plans to advance health equity, and documents laying out how ACS and ACS CAN are working on the federal, state, and local level to eliminate disparities in cancer.

Exhibit 14: ACS' Health Equity Definition and Principles

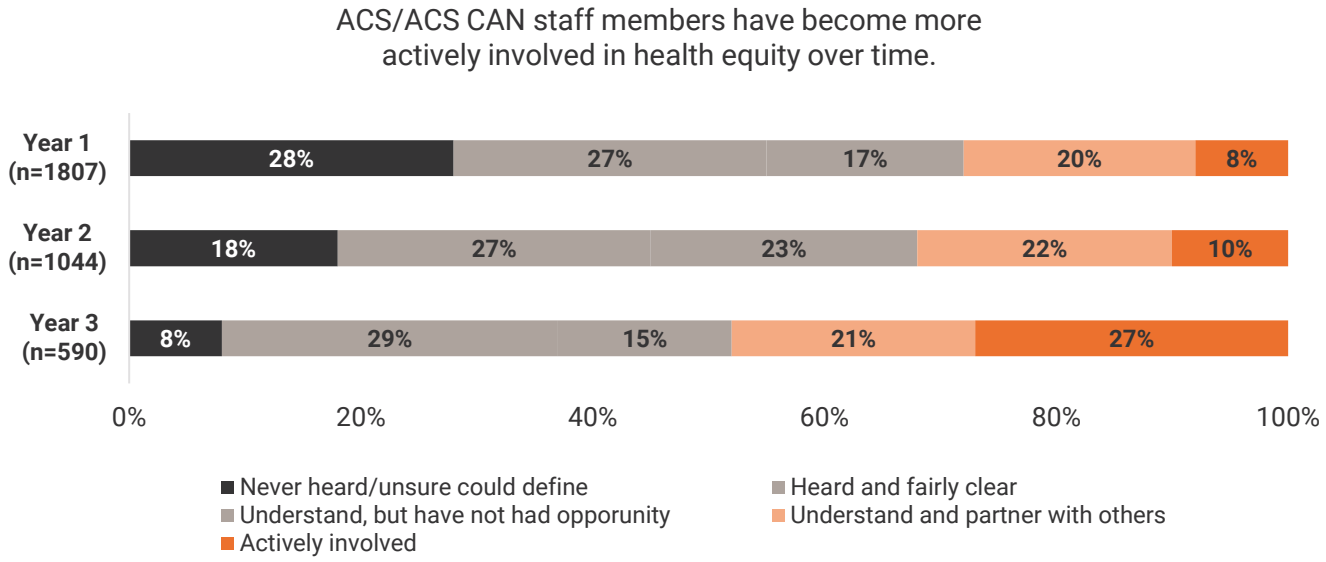
In addition, ACS and ACS CAN have engaged and leveraged the expertise of volunteers who have a variety of experiences and backgrounds to advance health equity. An example of

this is the National Advisory Council on Health Equity, which was used for over two years. It is comprised of over a dozen national and local experts who have expertise in the areas of health equity, data, transportation, and health systems, and represent different racial and ethnic groups and geographic locations.

Integration into social norms and core functions: Understanding of and involvement in health equity and social determinants of health have increased over time, with significant differences between those who were and were not trained.

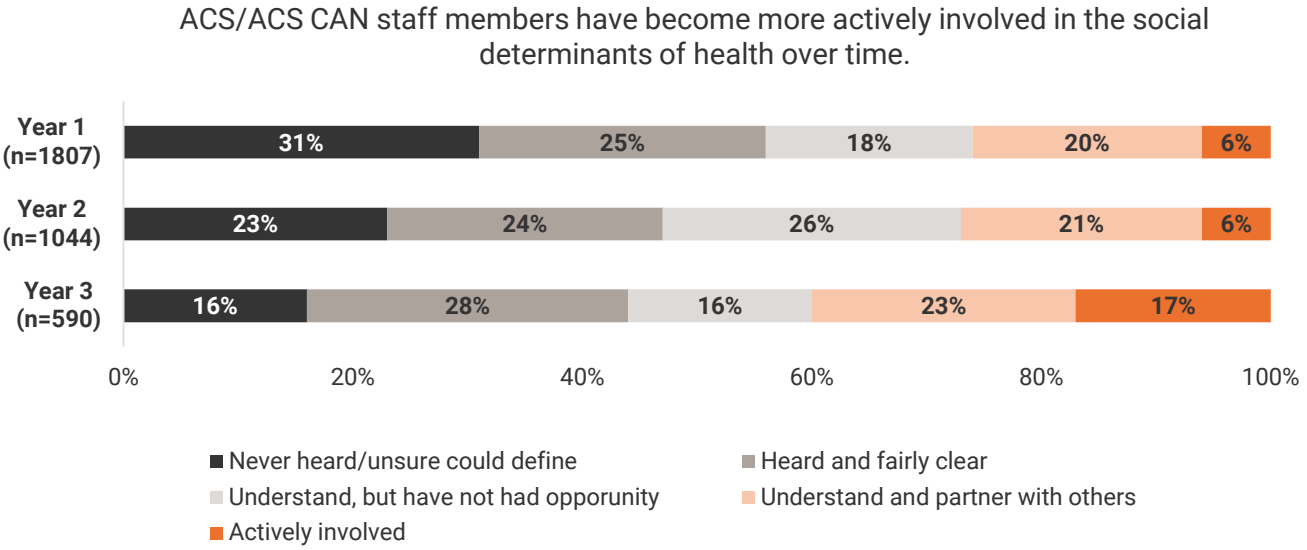
The proportion of ACS and ACS CAN staff who reported that they are actively involved in advancing the ideas of health equity and would consider themselves a Health Equity Champion increased significantly from Years 1 (8 percent) and 2 (10 percent) to Year 3 (27 percent). Over time, ACS and ACS CAN staff familiarity with and involvement in health equity and the social determinants of health have increased (see Exhibit 15). At the same time, there were statistically significant decreases in the proportion of ACS and ACS CAN staff who had never heard of health equity (from 8 percent in Year 1 to.01 percent in Year 3) and in those who had heard of it but were not sure if they could define it (from 21 percent in Year 1 to 7 percent in Year 3), indicating a general shift among ACS and ACS CAN staff from low understanding of health equity to higher-level involvement and integration of health equity into their work.

Exhibit 15: Familiarity and Engagement with Health Equity among ACS and ACS CAN Staff over Time



The proportion of respondents who reported that they were actively involved in addressing the social determinants of health increased significantly from 6 percent in Year 2 to 17 percent in Year 3 (see Exhibit 16). The proportion of respondents who had never heard of social determinants and those who had heard of it but were not sure what it meant decreased significantly from Year 1 to Year 3 (10 percent to 5 percent and 20 percent to 11 percent, respectively).

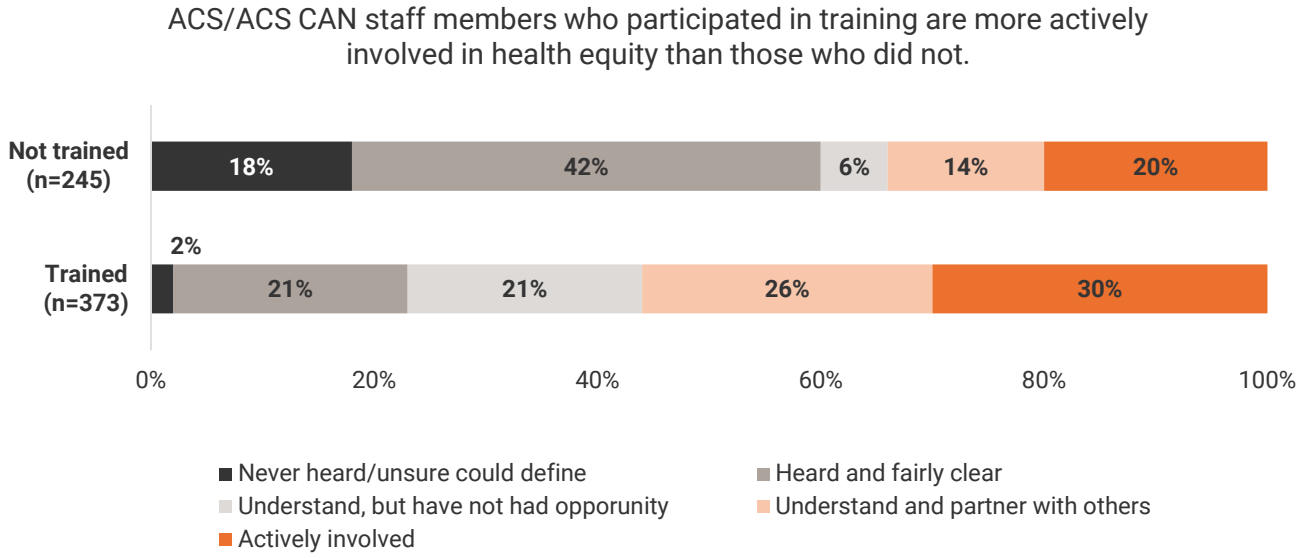
Exhibit 16: Familiarity and Engagement with Social Determinants of Health among ACS and ACS CAN Staff over Time



The responses to the questions about how familiar individuals are with health equity and social determinants of health were also analyzed as a scale ranging from 1 (I have never heard of health equity/social determinants of health) to 6 (I am actively involved in advancing the ideas of health equity/social determinants of health and would consider myself a health equity/social determinants of health champion).

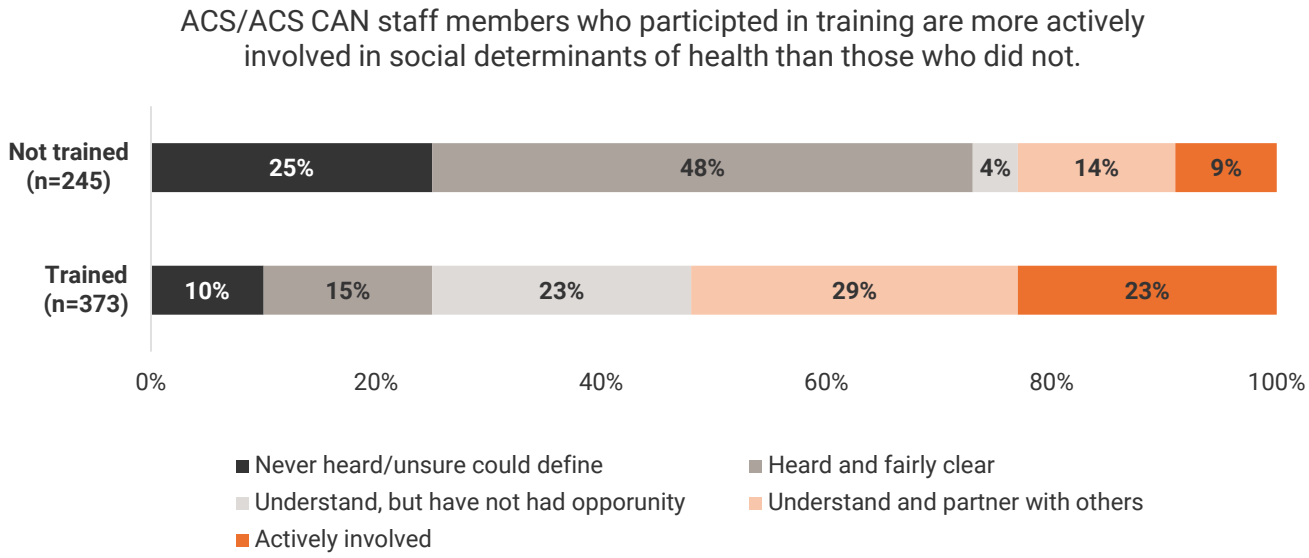
On average, respondents who participated in ACS training scored a 4.7 out of 6, meaning that the average respondent reported that they are somewhere between "understanding and not having the opportunity to incorporate it" and "understanding and partnering with others through their work with ACS/ACS CAN." This is statistically significantly higher than those who were not trained, who had an average score of 3.8 (meaning that most had either heard of health equity and are clear on what it means or had heard of health equity and have not had the opportunity to incorporate it into their work). In examining differences between those who participated in ACS training and those who did not, significant differences emerged between groups (see Exhibit 17).

Exhibit 17: Familiarity and Engagement with Health Equity by Training Participation



Respondents who participated in ACS training had statistically significantly greater average understanding and involvement with SDOH than those who did not (4.4 compared to 3.2 out of 6). Similarly, differences in familiarity with social determinants of health between the respondents who participated in ACS training and those who did not emerged in the survey data (see Exhibit 18).

Exhibit 18. Familarity and Engagement with Social Determinants of Health by Training Participation



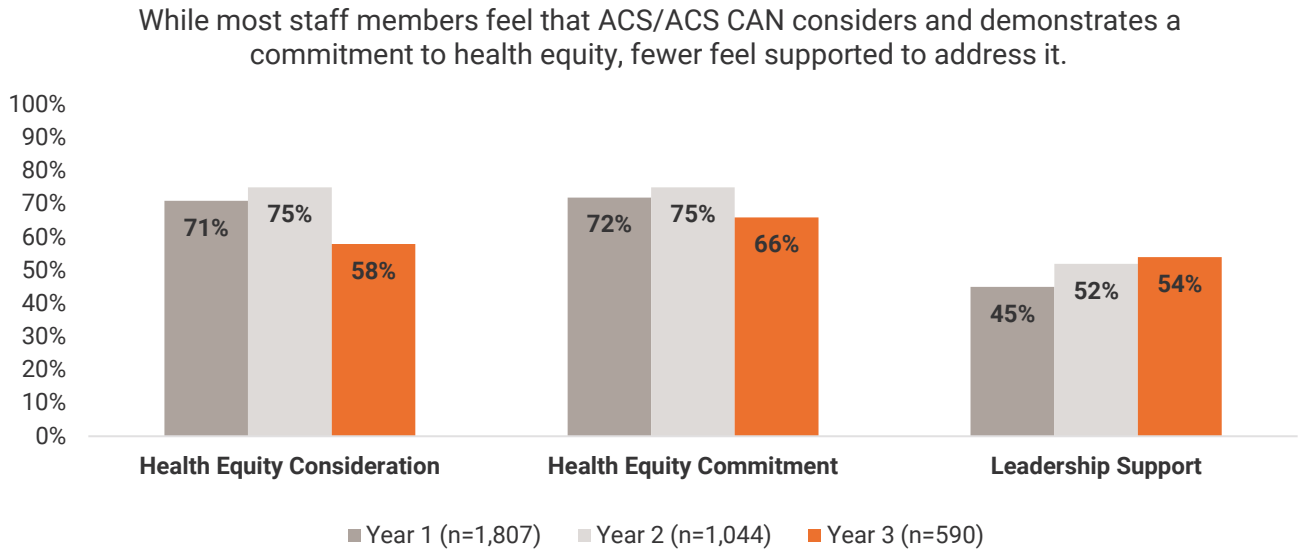
Results from the Enterprise Survey demonstrate that ACS and ACS CAN have increased their integration of health equity into core functions and social norms of their organizations by enhancing staff's familiarity and involvement in health equity and SDOH. The greater proportions of ACS and ACS CAN staff who are familiar with and actively involved in advancing health equity over time mean that the efforts made by the ACS GHQ Health Equity Team have been felt by staff across the organization.

Further, the fact that over half of the respondents who participated in ACS training reported that they were either actively involved or understood and partnered with others to advance health equity (56 percent) or address the SDOH (52 percent) indicates that exposure to ACS training through the health equity initiative can further increase the organizations' capacity to address health equity by integrating these topics and issues into the core functions performed by staff at the organization.

Organizational Commitment: Most staff, particularly those who have been through training, believe that ACS and ACS CAN value health equity, but fewer feel supported to address it.

While Enterprise Survey results demonstrate that most ACS and ACS CAN staff think that the organizations value health equity, fewer feel supported to address it (see Exhibit 19). Around three-quarters of respondents across all three years agreed that "ACS/ACS CAN demonstrates a commitment to addressing the social, economic and physical environment factors that impact cancer" (Health Equity Commitment). However, while fewer than half of respondents on the Year 1 survey agreed that they "had the support that I need from leadership to focus on the social, economic and physical environment factors that impact cancer through my work with ACS/ACS CAN" (Leadership Support) (45 percent), this increased significantly to 52 percent in Year 2. The increase in agreement with the statement "I think ACS/ACS CAN considers health equity when making decisions on programs, policies and services" (Health Equity Consideration) from Year 1 (71 percent) to Year 2 (75 percent) was statistically significant; however, agreement significantly decreased to 58 percent in Year 3. This shift in attitudes could be due to the significant organizational changes that ACS/ACS CAN underwent between Years 2 and 3 and the impact that had on staff perceptions of decision-making during that time.

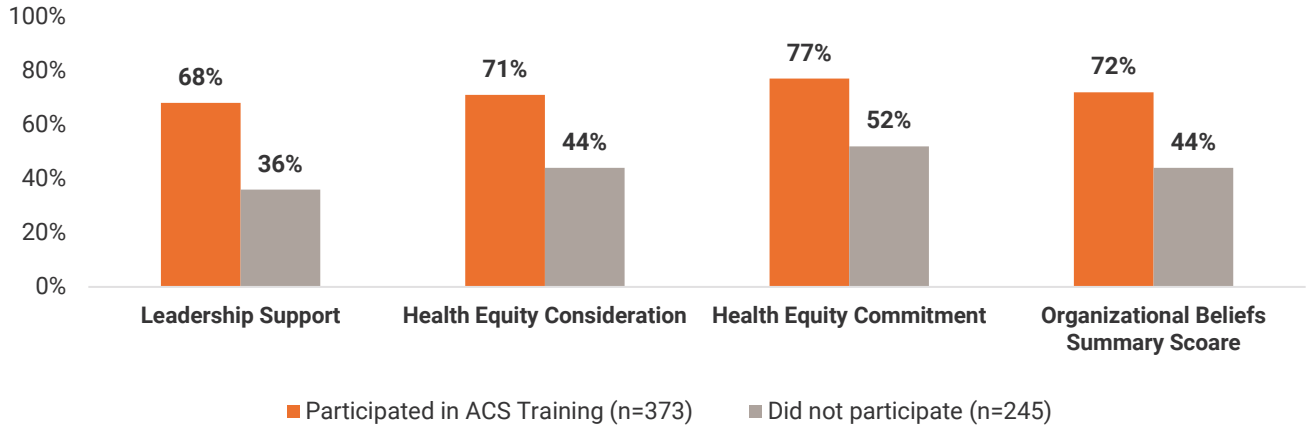
Exhibit 19. Agreement with Organizational Beliefs Statements among ACS/ACS CAN Staff over Time



Staff who participated in training reported higher agreement with statements about organizational support to address health equity (see Exhibit 20). Specifically, 68 percent of respondents who participated in training felt they had the support they needed from leadership, compared to only 36 percent of those who were not trained. The Organizational Beliefs Summary Score reflects the average agreement with organizational beliefs statements across all three statements. The score was significantly higher for training participants (72 percent) than those who had not participated in training (44 percent).

Exhibit 20. Agreement with Organizational Beliefs Statements by Training Participation

ACS/ACS CAN staff members who participated in training felt more strongly that the organization values health equity and felt more supported by leadership than those who did not.



ACS/ACS CAN leaders noted they have supported their staff in various ways to advance health equity. These include encouraging collaboration with the ACS GHQ Health Equity Team; changing their own behavior, language, and approach to health equity, including putting health equity goals into performance measures; assigning staff to work on Health Equity Teams or workgroups in the organization; and incorporating health equity topics and language in workgroups and meetings. ACS/ACS CAN leaders also noted that the ACS GHQ Health Equity Team, leadership, and staff buy-in were instrumental in creating a process and pathway for the organization to increase its health equity commitment and impact by laying the groundwork and demonstrating a commitment to health equity. Senior leadership and staff buy-in were also noted by leaders as key facilitators of health equity efforts.

Leadership survey respondents also noted that internal agitators, such as Health Equity Champions, the work of the ACS GHQ Health Equity Team, and having staff and funding from the RWJF, were key facilitators in changing the organization's commitment to health equity. ACS/ACS CAN leaders also described the key to success of the efforts was building a foundation of knowledge around health equity,

> "The American Cancer Society is deeply committed to addressing health disparities and we recognize that health equity cannot be fully achieved without equity in all aspects of American life."
>
> **- Gary Reedy, ACS CEO**, February 2021 https://www.linkedin.com/in/gary-reedy-66742ab8/detail/recent-activity/

which builds confidence and interest in the health equity space. Having consistent communication and messaging, using a common language around health equity, providing funding, and developing resources were also noted as critical.

Research and Data Monitoring: ACS investments include funding for health equity and cancer disparities research.

ACS investments include an increased emphasis on health equity research. Over the last 20 years, ACS has had 552 grants focusing on cancer disparities and health equities with $300 million invested in cancer disparities and health equity research. In addition, currently (as of April 2021) ACS has invested $52 million in extramural grants focusing on cancer disparities and health equities research. Most recently, the ACS Extramural Research and Training Grants Department revised the language used in seeking health equity research in cancer control and prevention based on feedback provided by the Health Equity Team. ACS staff members have also published and presented research related to cancer disparities (see Exhibit 21).

Exhibit 21: Examples of ACS' and ACS CAN's Cancer Disparities Publications

- **Understanding and Addressing Social Determinants to Advance Cancer Health Equity in the U.S.: A Blueprint for Practice, Research, and Policy**. The Altmetric research outputs tracking system gave the article an Attention Score of 62, placing it in the top 3 percent of all articles ranked by Altmetric.
- **Cancer Disparities**: A Chartbook
- **Reducing Social Inequalities in Cancer**: Setting Priorities for Research

Q4: To what extent have ACS' and ACS CAN's efforts contributed to increased relevancy?

Internal Relevancy: ACS' Health Equity Team worked with various stakeholders within the organization to increase internal marketing and communications efforts to ACS and ACS CAN staff and volunteers related to health equity and enhanced the presence of health equity information on various organizational platforms to expand their reach.

Through the ACS Health Equity Team's efforts, ACS and ACS CAN have taken a more robust approach to promoting health equity in internal communications, resulting in increased reach of health equity-related communications to internal staff and volunteers in 2020. For example, views on ACS' internal intranet page on health equity, which serves as a repository for employees to get access to resources, tools, and information, increased by 961 percent from 2019 to 2020 after ACS re-launched the health equity page in the second quarter of 2020 with new content. In 2020, the ACS Health Equity Team also developed a "one-stop shop" collection of 20 unique print-on-demand resources, engagement tools, and multimedia products with the health equity tag within its Brand Toolkit, an online resource repository for volunteers and staff. Staff use of the Brand Toolkit for information on health equity

increased from 2018 to 2020 (see Exhibit 22). In addition, ACS made access to information on health equity more available to staff via ACS2Go, an employee social media platform accessible via any mobile device or desktop computer. Health equity-related communications also had broader reach to volunteer leaders and partners. Other types of internal communications included intranet posts, news blasts, weekly newsletters, webcasts, and advocacy updates. ACS/ACS CAN senior leadership identified increased discussion and staff education around health equity, staff incorporation of health equity into their work, funding, and raising health equity as a strategic priority in the organization and critical in increasing ACS' internal relevancy.

Exhibit 22: Reach of ACS' Health Equity Internal Communications

Brand Toolkit

"Health Equity"

- searched **1,313** times
- ranks **24** out of top 100 searches

Top utilized health equity assets:

Asset	Views	Downloads
Learn the Mission – Health Equity	316	98
Making the Case for Health Equity	264	80
Health Equity Principles	229	75

Communications

Health equity-related posts on ACS2Go and by CEO in communication to staff, volunteer leaders, and partners **increased**

Year	ACS2Go Posts	CEO Communications	Unique Views on Health Equity intranet
2018	38	6	n/a
2019	104	10	86
2020	95	190	913

External Relevancy: ACS has worked to expand its presence in the health equity space through external communication channels.

ACS integrated health equity into external communications, including health equity-related webpages, campaigns, and posts on social media and digital advertising; these efforts had broad reach with external audiences. In September 2020, ACS launched its external webpage on health equity available on its cancer.org website; the site had 3,315 views over a four-month period in 2020, including an

average visit time of five minutes and a bounce rate of 48 percent. Website bounce rates typical range from 26 percent to 70 percent, with average bounce rates ranging between 41 percent and 55 percent.[3] The webpage includes an overview of health equity concepts and links to additional resources. The ACS Health Equity and Diversity and Inclusion teams also provided expertise for two social media campaigns: one focused specifically on Black and African American cancer disparities and the other focused on disparities in general, with some posts reaching over 100,000 impressions and over 2,000 engagements. ACS' health equity themed End-of-Year Campaign resulted in above-average overall engagement and impression rates (3 to 5 percent on average, considered high engagement by industry standards) with both core and emerging audiences.[4] ACS also undertook health equity messaging using social media, including Facebook, Twitter, Instagram, TikTok, and YouTube (see Exhibit 23). Increases in activities occurred over time, with most of these social media activities occurring in 2020.

Exhibit 23: Social Media Health Equity Posts

Mode	2018		2019		2020	
	# of posts	Average reactions	# of posts	Average reactions	# of posts	Average reactions
Facebook	2	Reactions: 373 Shares: 78 Comments: 38	2	Reactions: 278 Shares: 106 Comments: 41	14	Reactions: 773 Shares: 157 Comments: 118
Twitter	2	Likes: 92 Retweets: 78 Quote Retweets: 3	6	Likes: 25 Retweets: 26 Quote Retweets: 1	4	Likes: 38 Retweets: 21 Quote Retweets: 4
Instagram	-		-		5	Reactions: 653 Comments: 14
TikTok	-		-		1	Likes: 19,200 Shares: 61 Comments: 400
YouTube	-		-		7	Views: 242 Likes: 5

[3] Peyton J. What's the Average Bounce Rate for a Website? *The Rocket Blog: Good, Bad, Ugly, and Average Bounce Rates.* Rocket Fuel 2021. https://www.gorocketfuel.com/the-rocket-blog/whats-the-average-bounce-rate-in-google-analytics/. Accessed July 28, 2021.

[4] See Theiss SK, Burke RM, Cory JL, Fairley TL. Getting beyond impressions: an evaluation of engagement with breast cancer-related Facebook content. mHealth 2016;2:41. doi: 10.21037/mhealth.2016.10.02; Jaakonmaki R, Muller O, vom Brocke J. The impact of content, context, and creator on user engagement in social media marketing. Proceedings of the 50th Hawaii International Conference on System Sciences, University of Hawaii. 2017. doi: 10.24251/HICSS.2017.136; or Sehl K, Tien S. 6 Ways to Calculate Engagement Rate. June 29, 2021. https://blog.hootsuite.com/calculate-engagement-rate/. Accessed on Jul 19, 2021.

ACS and ACS CAN leadership also released press statements, advocacy leadership statements, blogs, speaking engagements, and presentations (see Exhibit 24). For example, ACS' marketing and communications efforts included a National Colorectal Cancer Roundtable campaign, "80% in Every Community," which focused on reducing disparities in screening rates, and which the ACS Health Equity Team has been part of. Independent of the ACS Health Equity Team's work, ACS CAN undertook discussions around equity within state policy forums, is pushing for more policy change around health care coverage and Medicaid expansion, and is exploring policies with government and health plans that integrate components of health equity. In addition, campaigns were launched, such as the Medicaid Covers U.S. documentary to inform, support, advance, and promote the value of Medicaid. ACS and ACS CAN senior leadership has been quoted in multiple sources, include Forbes Magazine and PR Newswire, highlighting the organizations' health equity efforts.

"We wanted to create an integrated strategy for the organization that would be sustainable and really drive outcomes that would have an impact."

- Tawana Thomas Johnson, VP of Diversity and Inclusion, October 30, 2020, https://www.forbes.com/sites/davidhessekiel/2020/10/30/doing-better-on-racial-justice-a-framework-for-brands-and-nonprofits/?sh=1b6b19e23d3f

Exhibit 24: Examples of ACS and ACS CAN External Presentations and Statements Related to Health Equity

Communication Type	2018	2019	2020
Press releases	5	8	18
Presentations by OCRI leadership	7	25	11
Articles mentioning health equity and mentioning or quoting ACS leadership	1	-	11

Table note: COVID-19 greatly impacted the number of presentations in 2020

External Relevancy: Public opinion research shows that a majority of people believe there is a role for ACS in advancing health equity and addressing social determinants of health that contribute to cancer.

In initial research efforts, individuals noted ACS has a role to play in addressing the various factors that contribute to cancer; the majority of ACS senior leadership noted that perception of ACS as an organization relevant in advancing health equity is increasing among partners and the general public, with the remaining leaders noting it is a work in progress. In 2018, a public opinion survey found that the majority (75 percent) of survey respondents believed ACS should address obstacles to cancer prevention, treatment, and survivorship, including the various factors that contribute to cancer. In addition, most (90 percent) of survey participants had a positive impression of ACS, and a majority (61 percent) were familiar with ACS. Almost all (92 percent) of survey respondents noted that it is important for ACS to increase opportunities for all people to prevent, find, treat, and survive cancer.

Community-level Efforts: Pilot Community Projects

After a detailed assessment of nominated communities' cancer disparities, community momentum, and staff and volunteer capacity, ACS funded 12 communities across two cohorts (see Exhibit 25). Cohort 1 communities received $40,000[5] each from March 2019-May 2021 and Cohort 2 received $25,000[5] each from November 2019-May 2021 to work on projects addressing one of three SDOH: food insecurity; financial toxicity; or conducting a community needs assessment by tribal members to better understand their needs. The ACS Pilot Community Projects explore, design, and implement promising community-driven solutions to advance health equity. Each Community Leadership Team (CLT) team determined what SDOH focus area made sense depending upon data, existing momentum of health equity work happening in the community, and available leadership assets to focus on community-based activities. Each CLT co-created an action plan based on their community's data, needs, and collaboration, and received funding to implement their plan. ACS' Health Equity Team provided funding, training, ongoing technical assistance, and facilitated convenings via Institute, Co-Chairs Meetings, and ongoing monthly check-in calls with community projects. ACS and ACS CAN regional staff led collaborative efforts with community partners and community members.

Pilot Community Projects Overview

Leadership Structure

- Each project is led by a **Community Leadership Team (CLT)**, comprised of community members, cross-sector partners, and ACS and ACS CAN staff, volunteers, and partners.
- Each CLT is led by **two or three Co-Chairs**, made up of one volunteer and two ACS or ACS CAN staff.
- The ACS Global Headquarters **Health Equity Team** provided training, technical assistance, and facilitated convenings for projects.

Program Structure

- **Co-Chairs Meeting:** A Preliminary Meeting with project Co-Chairs to establish program expectations
- **Institute:** A multi-day meeting of key CLT members who build knowledge, skills, and confidence about strategies to advance health equity and create an initial community action plan
- **Ongoing technical assistance** through monthly check-in calls, trainings, and other support from the Health Equity Team.

[5] One cohort 1 received an additional $15,000 and two cohort 2 communities received an additional $10,000 each.

Exhibit 25: Locations of Funded Pilot Community Projects

This section describes findings from the process and outcome evaluation of community-level ACS efforts.

Process Evaluation

Process measures described in this section included how ACS and selected communities advanced health equity actions in their communities and the demonstrated success factors that can inform a community projects model for increasing health equity actions and result in additional funding for these efforts.

Q1: How did ACS and selected communities advance health equity actions?

Implementation: Most communities opted to address food insecurity. A flexible program structure, supportive Health Equity Team, broader societal movements toward health equity, and ACS' credibility and gravitas were key facilitators to implementation progress.

The majority (83 percent) of Pilot Community Projects teams worked on addressing food insecurity within their communities. In KIIs, stakeholders reported selecting food insecurity for numerous reasons: the existence of food deserts; underutilization or lack of awareness of available neighborhood food resources; zip codes with high shares of people with low or limited incomes; well-documented

prevalence of cancer in the area; high indices of other chronic disease risk factors; and underlying drivers of health. Interview participants noted that the COVID-19 pandemic further increased community need for programs addressing food insecurity in these areas while also increasing attention to SDOH due to job losses, school closures, and disproportionate health care access and outcomes disparities highlighted by the pandemic. Some communities focused not just on increasing access to foods but also increasing access to healthy foods like fruits and vegetables. One Cohort 1 community focused on financial toxicity. Its work involved a needs assessment, development of a website on available programs and services, and identification of evidence-based solutions based on community needs. Another conducted a needs assessment to understand community needs, strengths, and assets, since the cohort identified an overall lack of data representing its community—an inequity in itself—rather than focusing on a specific SDOH.

Overall, ACS and ACS CAN staff, leadership, and community members had positive opinions of the Pilot Community Projects, noting multiple factors that facilitated their implementation efforts. KII participants described the program structure as flexible and adaptable, allowing sufficient leeway for communities to adapt their projects to local needs. In addition, KII participants described the ACS Health Equity Team leading the community projects efforts as supportive, approachable, accessible, and knowledgeable. They noted the team provided good direction and technical assistance on rolling out the program and communicating with partners and perspectives on how to drive decision-making at the community level. Community members reported that regional ACS staff members were also flexible in allowing communities to inform the direction of the projects, even as they logistically drove projects forward. Furthermore, KII participants noted that projects are part of a broader societal movement toward health equity, citing broader efforts by payers, providers, health centers, and other clinics serving members' SDOH needs to offer the potential for continued health equity action in communities beyond the end of ACS funding. Finally, the ACS brand enhanced community projects' credibility and gravitas. By working at external and neutral organizations, ACS and ACS CAN staff helped community projects avoid local politics. In KIIs, participants also described how the increased credibility attached to having the ACS brand associated with projects could help communities seek additional funding beyond ACS funding.

Facilitators for the Health Equity Pilot Community Projects

- Flexible and adaptable program structure allows leeway to adapt projects to local needs.
- Supportive and approachable Health Equity Team overseeing the program and local and regional ACS staff leading community efforts
- Broader societal movement toward addressing health equity and social determinants of health
- The ACS brand provided credibility and gravitas to community projects.

Challenges for the Health Equity Pilot Community Projects

- Expectations for success were unclear, causing uncertainty around guidelines.
- Some regional staff members were inaccessible or lacked understanding of local context.
- Implementation of community projects in areas of high disinvestment and a history of mistrust created challenges for garnering buy-in.
- Lack of local-level data in some communities led to gaps in understanding around needs.
- Misaligned missions across organizations and competing interests led to ACS and ACS CAN staff mainly driving projects forward.

Despite general positive experiences with the program, ACS and ACS CAN staff, leadership, and community members reported that various factors posed barriers for implementation efforts. Interview participants noted the program's flexibility was helpful but also led to uncertainty around program expectations and guidelines. A few Cohort 1 community members reported mixed experiences with regional ACS staff, noting that ACS and ACS CAN regional staff members were less accessible, lacked an understanding of local context, or were unable to engage in person (pre-COVID-19). Some Cohort 2 communities noted they expected more interactions, meetings, and check-ins with the ACS Health Equity Team, and thought that they would benefit from additional technical assistance, meetings, and support. In addition, implementation of community projects in areas of significant disinvestment and with a history of mistrust of external organizations created challenges for garnering buy-in as some community members had experiences with external organizations imposing projects on communities and then leaving. Some communities also lacked local-level data on community needs, which made it difficult to understand the current needs, gaps, and direction the project should take to bolster existing community efforts at the outset. Furthermore, misaligned missions across organizations, partners' bureaucracy, and ACS and ACS CAN regional staff's and community members' competing priorities led to challenges with implementation and with community engagement. Others described that some community partners required a lot of education and technical assistance to understand grant processes and requirements. As a result, project responsibilities often fell to ACS and ACS CAN staff, given community members' limited capacity. This posed a greater challenge during the pandemic, since some ACS and ACS CAN staff did not live in the pilot communities, and they were not able to travel due to COVID-19. This resulted in Pilot Community Projects relying on the CLT members that did live in the community to establish connections and drive decisions.

Reach: Pilot Community Project activities reached many community members through food distribution and data collection activities, with support from 41 ACS and ACS CAN regional staff.

While Pilot Community Projects did not systematically provide the number of participants reached for all of their activities, in progress reports, some described food distribution and data collection activities that reached many community members. In final reports, one Cohort 1 community reported distributing at least 450 healthy food boxes to 150 people and providing coupons to 470 people. Another noted it had distributed 101,651 pounds of food to 10,595 individuals and 4,826 families. In final reports, two Cohort 1 communities reported providing at least $30,000 from the RWJF grants in total sub-grants across the two communities to community organizations for cancer-related care, repairs to markets, and a FoodFARMacy.

Context & Fidelity: The Pilot Community Projects program experienced initial delays to allow for additional pre-launch planning and engagement. During implementation, the COVID-19 pandemic and resulting organizational changes spurred further delays and programmatic adjustments.

Though Cohort 1 activities were generally implemented as planned, there were delays in launching the program to allow for additional community engagement in the planning process; Cohort 2 activities were delayed and switched to virtual due to COVID-19 and other factors. Prior to launching the first cohort of Pilot Community Projects, the ACS Health Equity Team collaborated with regional leadership to implement a more involved and deliberate engagement process with communities, delaying project launch. The information gathered during this delay, however, allowed the ACS Health Equity Team to finalize its approach, factor in organizational circumstances, and garner buy-in from needed stakeholders. In addition, data acquisition was delayed as the team felt it first needed to finalize its approach to the program in order to identify which data sets were needed. In addition, the COVID-19 pandemic resulted in changes to planned activities and timelines for Cohort 2. Institute, intended to occur in-person in March 2020, was switched to eight virtual sessions from July through October 2020. Cohort 2 KII participants noted that holding Institute virtually reduced engagement among participants as attendees were going to sessions while at work, or not attending all of the sessions. They noted a need for more flexible times and options for virtual sessions to account for CLT members who are working 9-to-5 and could attend only in the evenings and weekends. Overall, Cohort 2 participants described a preference for attending an in-person Institute, COVID-19 permitting, or providing more flexible virtual session options that are closer together and not spread out over months.

Timelines and funding were also changed because of the pandemic. Planned submissions of Cohort 2 six-month progress reports were delayed until March 2021, at 16 months after cohort launch. In addition, the amount of funding originally intended for community grants for Cohort 2 was reduced from $40,000 to $20,000-$25,000. In KIIs, participants noted that this reduction in funds was demoralizing for CLTs who had expected the full grant amount, and it led to teams having to recalibrate their plans for their Pilot Community Projects.

COVID-19 posed implementation delays and challenges for participating Pilot Community Projects, particularly for those in Cohort 2. The COVID-19 pandemic resulted in changes to planned community action plans. In KIIs, Cohort 1 stakeholders described making significant progress with planning and other action plan tasks, including acquiring IRB approvals, trainings, establishing partnerships, planning events, launching subcommittees, and starting collection for needs assessments prior to the pandemic. However, Cohort 1 projects were on the verge of launching events and data collection for needs assessments when COVID-19 hit, delaying efforts. In-person activities and events and work with clinics/hospitals were suspended or delayed, given clinics and hospitals were focused on treating COVID-19 patients. In addition, CLT members had competing interests given they were navigating work-from-home situations and helping children navigate online school due to the pandemic. As a result, planning was paused in many communities until team members could figure out a way to meet virtually.

"We understand there have been so many factors impacting our efforts on this project, i.e., COVID, staff transitions, etc.; however, for those of us in Cohort 2, everything from the [Institute] timeline to decreasing the amount of the funding opportunity to reporting schedules to receiving information on a need-to-know basis has made this process difficult."

- Community Progress Reports

Cohort 2 projects were supposed to launch and attend the Institute in March 2020. As a result of the pandemic, Cohort

2 KII participants reported experiencing even more delays with project launch: the Institute occurred in August through October 2020, and most communities noted they plan to implement most of their action plan after the end of their grant cycle (Summer-Fall 2021). Because of these delays, Cohort 2 KII participants reported that the timeline for implementation felt too short as most teams did not get their projects fully started until January 2021. Furthermore, the price of materials and supplies needed to build community gardens, mobile markets, and food pantries, like trailers, appliances, and lumber, increased during the pandemic due to supply chain issues, leading Pilot Community Projects to change course in terms of what they were able to purchase.

Communities developed workarounds to overcome the lack of in-person contact due to COVID-19 and to pivot to address urgent issues. In KIIs, interview participants described identifying workarounds for maintaining community engagement as some communities were harder to reach due to limited access to technology and phones. Traveling to these communities became more challenging given lack of in-person contact. In addition, community projects also pivoted plans for in-person events and data collection. Modifications included conducting phone interviews and surveys as opposed to in-person data collection; dropping off tablets to community members to encourage participation in data collection for needs assessments; and having social distancing guidelines for events (e.g., gardening). For a few communities, COVID-19 highlighted urgent issues that needed to be addressed (e.g., increased food insecurity) and resulted in changing planned tasks to focus on food distribution to meet communities' immediate needs instead. KIIs and progress reports revealed that Pilot Community Projects had to make adjustments and be flexible to account for these changes.

Reorganization of ACS and ACS staff caused turnover in staff leading and participating in Pilot Community Projects activities. In progress reports, Cohort 2 described a lot of change and transition across ACS and ACS CAN staff, resulting in delays in implementation as new individuals needed to be identified to join CLTs and serve as Co-Chairs. In KIIs, Cohort 2 participants noted that staff reorganization and transitions among the Health Equity Team led to lapses in communication with the Pilot Community Projects when teams were still formulating their plans and determining the direction of their projects, which delayed budget approval and implementation. Cohort 2 participants reported that while these changes were understandable, they also posed challenges for communities as they had to restructure action plans, rethink planned in-person activities, and manage competing interests. In progress reports, Cohort 2 noted that lack of in-person meetings proved challenging for convening CLTs and conducting planned activities.

Q2: What factors for success can be derived from the Health Equity Pilot Community Projects Model?

Demonstrated Success Factors: Pilot Community Projects benefited when they partnered with those who were already active in the community to build upon existing work with tangible goals, had a diverse cross-section of partners, and had action-oriented leadership.

In KIIs, interview participants described various factors for success that led to their successful implementation of their community projects (see Exhibit 26). Projects leveraged community organizations' existing efforts, capacity, and reach, which increased partner engagement, reduced the likelihood of projects existing in silos, and promoted sustainability of efforts. Having strong and action-oriented CLTs allowed projects to align skill sets with tasks, leverage existing connections and trust in the community, stay on track, and remain flexible to address unforeseen challenges like the COVID-19 pandemic. Including a strong and diverse cross-section of partners in CLTs that covered a broad range of sectors and expertise allowed each member to leverage their strengths and experience. In addition, KII participants described the importance of setting tangible goals, ensuring that all members feel valued, and being flexible in order to maximize engagement while helping teams overcome challenges to achieve incremental progress. This was important particularly given that communities were tackling large, socio-economic challenges like food insecurity which require a longer timeframe to achieve impact.

Exhibit 26: Factors for Success for the Pilot Community Projects Model

Success Factor	Description
Leveraging communities' existing efforts and capacity helped projects maximize resources and promote sustainability of Pilot Community Projects.	• Projects did not start from scratch. Instead, they focused on expanding community organizations' capacity and reach and leveraged existing data or conducted needs assessments to inform development of projects and identification of community partners to be part of CLTs. • Building on the goals and objectives of community organizations increased community partner engagement with projects, reduced the likelihood that community projects existed in silos or as competition to existing work, and encouraged communities to adopt projects to continue health equity work after ACS funding expired. "The fact that we aligned our project with [community] organizations' goals is a huge success for us… because if we didn't do that, and had gone into the community to do our own thing… we would have been viewed as a competitor rather than a partner… that structuring… [of] adding capacity versus competing was important." **- ACS Leadership**
Strong, action-oriented leadership with aligned but complementary skill sets were considered assets for successful implementation of community action plans.	• CLTs and Co-Chairs with passion and commitment for success were assets; those with *"strong and credible reputation in the community"* and who are *"movers and shakers"* were most successful. Working with well-network partners who have prior experience in the topic or community outreach and engagement can help provide expertise in those areas. • Selecting Co-Chairs with skill sets that aligned with project needs helped move activities forward more quickly. • Having a committed CLT with complementary skill sets ensured that the right people were in the right roles for leading committees; however, teams should understand that value comes in *"all shapes and sizes."*
Partnerships should include diversity in sectors, alignment in mission, and incorporation of	• Diverse representation of partners and sectors in CLTs allowed each member to leverage their strengths, offering complementary and varied expertise; knowledge and prior experience in public health, health equity, and communication; and expertise in community engagement and trust building. • Key partners within CLTs include: – Community organizations and leaders with strong communications skills.

Success Factor	Description
community members not tied to specific organizations.	– Strong representation of people living in communities, who may not be tied to organizations, to understand community needs and increase engagement and empowerment. – Local and state government representatives who add a strong policy component to the work, allow teams to leverage resources to influence policy, and can give further credibility to efforts. – Topic experts (e.g., food insecurity experts, survey development experts) who are key members to provide technical skills and knowledge for project tasks. • CLT members and organizations should have aligned missions and willingness to give time, and not work solely in their own self-interest.
Setting tangible goals, ensuring all members feel valued, and being flexible allowed community projects to keep CLT members engaged and find creative solutions to overcome challenges while achieving incremental progress.	• Setting tangible goals and action items helped communities achieve incremental progress and measurable results while staying on track toward the larger goal. • Key strategies included: – Setting feasible metrics and establishing project timelines to monitor progress. – Celebrating small wins. – Ensuring every member felt heard. – Developing subcommittee structures to focus tasks and make meetings more productive. – Entering meetings with a focus and a goal and leaving meetings with tangible outcomes and action items. – Maintaining regular communication, including regular follow-ups and no long lapses between meetings. – Being flexible and transparent, adjusting to community members' preferred method of contact (e.g., social media, email), and being flexible in times and modes for meetings (e.g., weekend hours, set meeting times for advance planning, convening over phone/video). • CLTs that remained flexible and nimble enough to adjust plans were able to overcome unforeseen challenges while staying on track to meet the overall project goals and monitoring progress.

> "Time management and being organized and having [a Co-Chair who] will make outlines and goals to accomplish during our meeting time so we have action items… and follow up with them and constantly engage each other on."
>
> **- Community Member**

Demonstrated Success Factors: Regional ACS and ACS CAN staff and leadership were most valuable as a partner when they educated themselves about communities beforehand and engaged in intentional conversations and relationship building to continue to learn and build trust.

Regional ACS' and ACS CAN's staff's and partners' self-education of a community's history, culture, and context helped communities feel valued and understood, increasing community engagement. It is important to not lose sight of the multitude of barriers communities may face that may influence level of engagement and project direction. As a result, KII participants described how self-education of ACS

and ACS CAN staff and partners ensures that community members are not being relied on to do the educating. Understanding a community's cultural context can help understand that traditional mechanisms of research, data collection, and engagement may look different for certain communities. In addition, KII participants described that projects should engage communities to understand their needs and help them achieve their goals, not tell them what to do. This requires having the right people at the table and using data and community needs assessments to inform direction of the project.

Relationship building and communication are key to engendering trust; both require time and patience. In KIIs, regional ACS and ACS CAN staff and leadership noted that relationship building with new partners and community members takes time and patience as they get to know each other and build trust. Participants described that consistent, transparent, and honest communication helps build that trust. In addition, KII participants and progress reports described the importance of one-on-one conversations with partners to allow them to open up and be honest about their capabilities and capacity, as having those hard conversations helps overcome challenges.

Evaluating efforts and showing results are critical, particularly for sustainability. In KIIs, participants noted a need for outcomes and results to show the value of the projects to the community and to other potential funders to fuel sustainability. In addition, communities are planning efforts for tracking results, not just for sustainability, but also to learn what is and what is not working in communities.

Funding Opportunities: All Pilot Community Projects were interested in accessing additional funding to continue their work; as of May 2021, at least four Pilot Community Projects have successfully acquired funding to continue their work.

A few communities reported increased opportunities for health equity funding. Limited data were available about Pilot Community Projects' acquisition of additional funding for their community project efforts. Nevertheless, in KIIs, many participants described working with organizations to try to secure additional funding. Pilot Community Projects expressed interest in expanding their efforts to other zip codes or areas within their state. In addition, in its 2020 Annual Report to RWJF, ACS health equity staff noted that the Milwaukee, Wisconsin, CLT secured funding over three years from a local community foundation to utilize community health workers to train community members on how to plant, preserve, and prepare foods using community gardens, and provide intensive chronic disease management training. In progress reports, the Gary, Indiana, project described that a foundation had committed $50,000 in additional funding to the project. At least two other Cohort 2 community projects noted in final reports that they had secured additional funding through health system sponsorship or through fundraising. However, in KIIs, some participants expressed fear that if projects are not sustainable beyond ACS funding, they may hurt credibility with partners and opportunities for further work.

Outcomes Evaluation

Q3: To what extent have ACS' efforts increased selected communities' health equity knowledge, Attitudes, Beliefs, and skills?

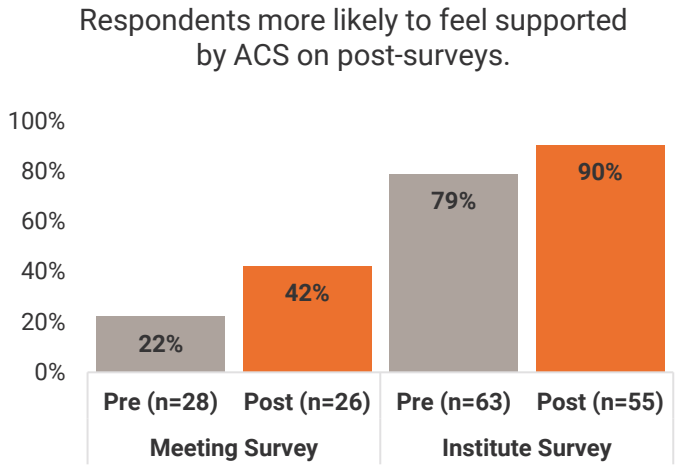
Knowledge: Pilot Community Projects participants showed high levels of knowledge about terms related to health equity.

Across respondents from both cohorts who took the Meeting and Institute surveys, knowledge of health equity terms was high, with more than 83 percent of respondents correctly identifying the terms "Health Disparity," "Health Equity," "Implicit Bias," and "Social Determinants of Health" in pre- and post-surveys. There were no significant differences between pre- and post-survey results.

Attitudes and Beliefs: Pilot Community Projects participants reported strong pro-health equity attitudes and beliefs overall, and Co-Chairs Meeting and Institute participation increased their sense of support from ACS.

Respondents to the Co-Chairs Meeting and Institute pre- and post-surveys reported strong agreement with statements about the importance of health equity. More than 95 percent of respondents to both surveys agreed that the social determinants of health impact cancer and that health equity is essential to accomplishing ACS's mission of a world without cancer. Community Projects survey respondents uniformly agreed they "have the support I need from my direct supervisors and team members to promote health equity in [their] community" (greater than 93 percent agreement on pre- and post-surveys for Co-Chairs Meeting and Institute). Fewer respondents reported that they had the support they need from ACS, especially among Co-Chairs Meeting survey respondents, with only 22 percent reporting agreement on the pre-survey and under half (42 percent) reporting this on the post-survey. However, there was a statistically significant increase in average agreement with this statement from the pre-survey to the post-survey among Institute respondents (see Exhibit 27). Since the Co-Chairs Meeting surveys occurred earlier in the project timeline than the Institute, the increases in agreement across all surveys could mean that more direct engagements with the initiative (through the Co-Chairs Meetings and Institutes) led to increased feelings of support.

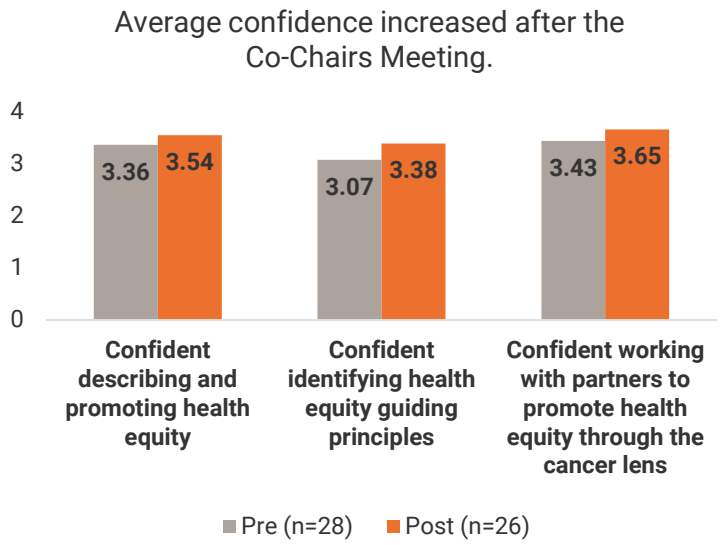
Exhibit 27. Support from ACS from Co-Chairs Meeting and Institute Pre- and Post-Surveys



Skills: Co-Chairs Meeting and Institute participation improved confidence in explaining and using health equity concepts.

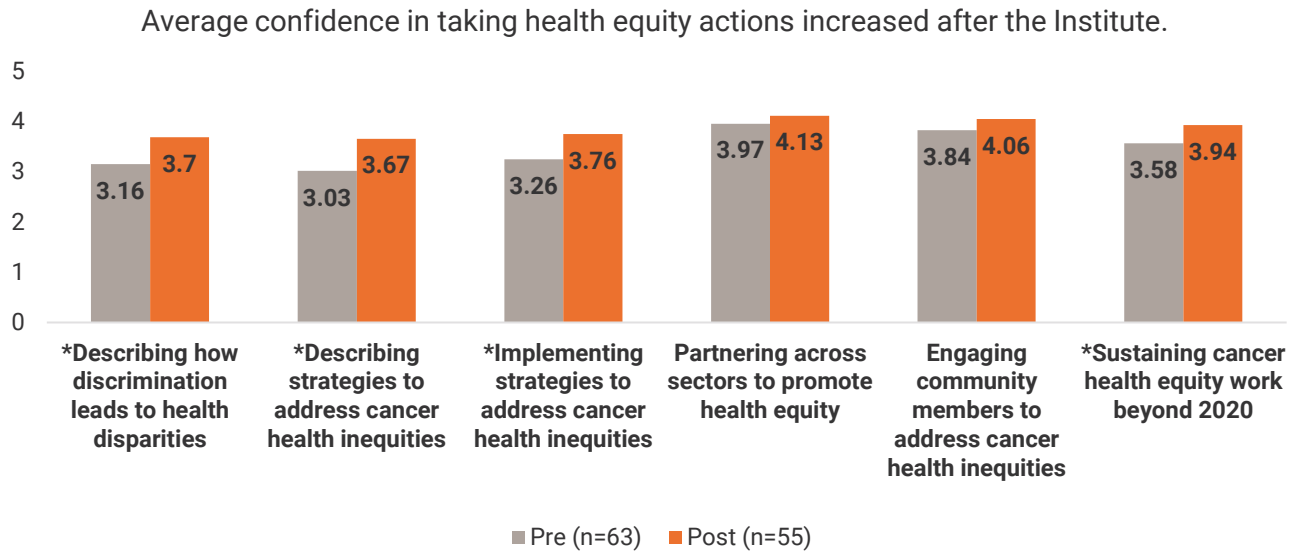
There were increases in average agreement with the statements related to confidence, including respondents' ability to describe and promote health equity, identify health equity guiding principles, and work with partners. Co-Chairs Meeting survey respondents were asked about their level of agreement with statements related to confidence in their ability to take different actions to advance health equity. Average scores were calculated on a scale of 1 (Strongly disagree) to 4 (Strongly agree). Average agreement increased from pre- to post-surveys across all items (see Exhibit 28).

Exhibit 28. Average Confidence in Each Item among Co-Chairs Meeting Survey Respondents



CLT members' confidence for taking different actions to promote health equity in their communities increased from pre- to post-Institute (see Exhibit 29). Average confidence was calculated on a scale of 1 (Not at all confident) to 5 (Completely confident). Pre-survey respondents were most confident about their ability to "partner with multi-sector partners to promote health equity in your community" (3.97) and least confident that they could "describe effective strategies to address cancer health inequities to a stakeholder or potential funder in your community" (3.03). The average confidence across all statements on the pre-survey was a 3.5, which increased to an average of 3.9 on the post-survey. Increases in average confidence from pre- to post-surveys were statistically significant ($p<.05$) for all but two of the statements ("partnering with multi-sector partners to promote health equity in your community" and "engaging community members in the planning and implementation of effective strategies to address cancer health inequities in your community"). However, respondents' confidence in their ability to partner with multi-sector partners was the highest out of all of the actions on the post-survey (4.13), followed closely by engaging community members in the planning and implementation of effective strategies to address cancer health inequities (4.06), indicating very high confidence for taking these actions among Institute respondents. Further, on the pre-survey, an average of 51 percent of Institute participants reported confidence in taking any action to advance health equity, which increased to 69 percent on the post-survey ($p=.005$).

Exhibit 29. Average Confidence in Taking Health Equity Actions among Institute Survey Respondents



*Indicates statistically significant increase from pre- to post-Institute

Q4: To what extent did Pilot community projects increase action in advancing health equity and addressing SDOH in communities?

Community Actions: Pilot Community Projects raised awareness about health equity and garnered buy-in from communities to engage in health equity work, while also developing resources and promoting use of these resources in the community and in health care settings.

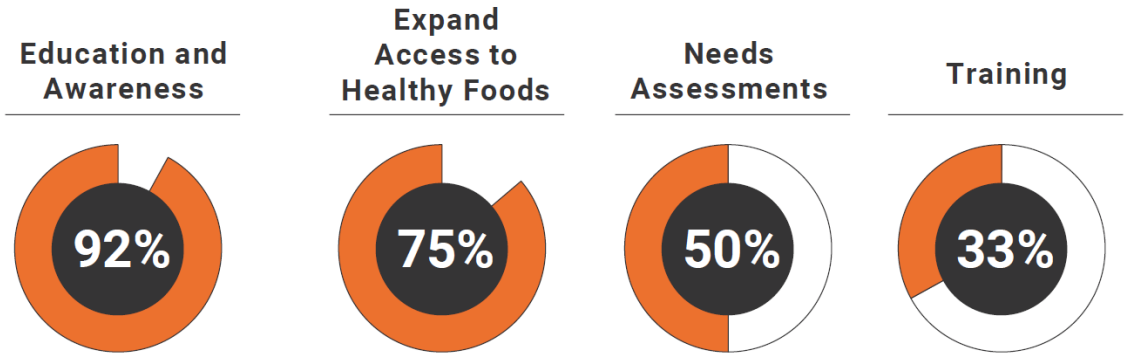
Pilot Community Projects teams reported increased community awareness, excitement, and buy-in around health equity work, a crucial first step for advancing health equity actions in communities. In progress reports, Pilot Community Projects teams described how their work increased community awareness of health equity, particularly the inequities surrounding food insecurity and its connection to cancer. They also described elevated community awareness and discussions around health disparities. These conversations and activities contributed to growing excitement for health equity work, with some teams describing how the projects re-energized existing stakeholders working on food insecurity efforts. This work also contributed to increased buy-in from community partners around health equity. KII participants reported that project-related activities resulted in not just addressing food insecurity needs, but also in establishing community hubs that served as opportunities to develop community relationships and provide access to other resources. For example, community gardens not only served as convening spaces for community members but also increased interest for other projects to revitalize and beautify the area surrounding the gardens. Other community hubs provided opportunities to develop relationships with other stakeholders like police. In other communities, mobile food distribution units served as opportunities not just to distribute foods, but also to provide information

about other community resources like COVID-19 testing and vaccination information, and eligibility for SNAP benefits.

Pilot Community Projects teams developed tools and resources that serve to advance health equity actions both during the course of the community projects and beyond the life of the funding. Across projects, community action plan activities reported in progress reports and KIIs included (see Exhibit 30):

- **Education and awareness:** Pilot Community Project teams described developing health education resources and materials, including healthy eating and nutrition demonstrations and pamphlets. They also described developing outreach templates and toolkits.
- **Expansion of access to healthy foods via food distribution efforts:** Pilot Community Projects described using ACS funds to provide sub-grants to community partners to establish food pantries/banks and provide food pantry supplies (e.g., shelving, food, fridge, freezer); construct community gardens; repair and revitalize farmers' markets; upgrade providers' electronic health record capabilities to support food insecurity assessment, tracking, and reporting; and purchase new nutrition telehealth software. When hospitals and clinics were open, community project teams also described conducting "screen-and-refer" programs to provide food boxes and nutritional education to patients with cancer who were experiencing food insecurity. These efforts resulted in identification and implementation of new approaches and processes, including screening and referral processes, voucher incentives, and virtual engagement options.
- **Needs assessments to understand communities' food insecurity needs:** Pilot Community Projects described developing data collection tools (e.g., survey instruments) and websites compiling resources and programs available in the community. They also described training members in data collection and health equity issues.
- **Training:** Pilot Community Projects reported training community members in data collection methods for needs assessments, on establishing organizational processes, or on health equity-related topics.

Exhibit 30: Activities of the 12 Pilot Community Projects, as Reported in Progress Reports



Integration into Social Norms and Core Functions: Leveraging health equity actions that build community capacity laid the foundation for sustainable, replicable change at ACS and in the communities beyond the current funding cycle.

ACS established new internal policies and programs to better accommodate the needs of communities. For example, some community partners had limited financial means for attending workshops and meetings due to limited access to credit cards, lack of geographic accessibility, and other factors. As a result, in December 2019 ACS updated its internal administrative processes and policies to offer cash advances for transportation, travel expenses, and funding project activities, rather than a reimbursement system. In addition, as requested by the Pilot Community Projects, ACS allowed funding to be used to provide sub-grants to other community organizations; this facilitated administrative purchases of supplies and allowed communities to better plan for implementing their projects given the timeline of the projects. Interview participants noted that these administrative changes increased community trust and demonstrated ACS' increased understanding of the needs of and socio-economic barriers faced by their communities.

Pilot Community Projects activities resulted in expanded community infrastructure and capacity to conduct health equity work beyond project funding. Interview participants described how the health equity activities and actions described above established or expanded community organizations' infrastructure and capacity to serve their communities. For example, new community gardens or fridges for pantries can be used by community organizations' capacity for the project and beyond to serve their community needs. In addition, some communities engaged in training efforts around data collection, providing communities with access to data on community needs and gaps, which can inform development of other projects beyond those funded by ACS. Others undertook education and training of community partners to help them establish organizational processes (e.g., developing a governance board, finding volunteers) or garner new skills to ensure that community organizations have capacity to continue health equity and other efforts beyond the life of the project. KII participants also described how the enhanced community partnerships and networks established through the program can be leveraged for other efforts outside of the Pilot Community Projects.

> "[Our members] realize that they do have leadership roles and qualities. I feel like [the project has] really given a lot of our team members confidence that they can do something like this and make a big difference. I keep telling our team members that if we never do another community project again, [these skills are] something that we are leaving behind that it can help our people especially during this pandemic."
>
> **- Community Member**

Most interview participants reported that Pilot Community Projects were doing work with sustainability and replicability in mind, for the potential to serve as models in other areas. Interview participants described sustainability as a key element of their work, recounting how the activities described above that build systems and infrastructure were intentional to promote sustainability. In addition, interview participants described how projects intentionally ensured that the community

remained the focus of their work and that community members, organizations, and coalitions were integrated into the work to ensure that it would continue beyond ACS funding. For example, they tied projects to specific community organizations so that efforts could continue beyond ACS funding. Most participants, across stakeholder type, noted they hoped to continue their health equity work after ACS funding ends. Some communities had already started conversations with other organizations and foundations to secure or have already secured additional funding to continue their efforts. ACS and ACS CAN staff that co-chaired Pilot Community Projects reported having thought about what their role with communities looks like after the end of grant.

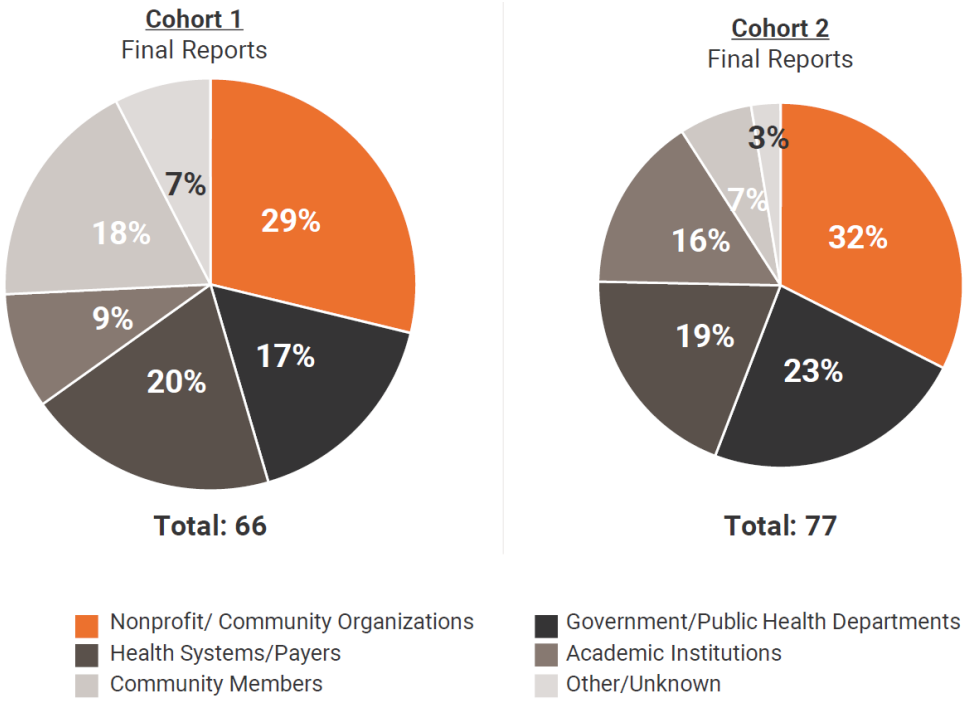
However, some ACS and ACS CAN staff expressed concerns about the sustainability of the projects once ACS funding ends. They noted that ACS and ACS CAN staff functioned in a project management capacity, coordinating efforts for teams, and worried about the momentum of the projects once ACS and ACS staff members were no longer in this role. ACS and ACS CAN staff also worried about the sustainability of the trust they built with communities if they no longer had resources and funding to continue to support communities in their efforts in the long term.

Q5: To what extent have selected communities increased collaboration across sectors and teams?

Partnerships: Pilot Community Projects enabled ACS to strengthen existing partnerships and diversify their networks to include new partners and sectors.

Pilot Community Projects included a broad range of partners and sectors as part of CLTs (see Exhibit 31). Outside of the ACS and ACS CAN Co-Chair staff, nonprofit and community organizations (e.g., food pantries, food banks, faith-based organizations) made up 29 to 32 percent of the CLTs in both cohorts. Based on progress reports, overall makeup of partners in CLTs remained relatively stable over time. Represented sectors include government and public health department representatives, health systems and payers, academic institutions, community members not tied to a community organization, and other (e.g., a construction company, foundations/grant makers) or unknown organizations. Cohort 1 had a larger share of CLT members that were community members (18 percent vs. 7 percent), likely reflecting KII participant feedback that engaging community members virtually without having had a chance to ever meet in person due to the COVID-19 pandemic was a challenge. In KIIs, most Co-Chairs reported identifying potential partners by researching organizations in their communities doing work related to the selected SDOH and/or tapping into existing ACS, ACS CAN, and community members' partnerships or networks. In progress reports, community projects described leveraging relationships and circles of influence of volunteers to garner buy-in and support. In KIIs, interview participants noted that corporations, payers, and individual community members not tied to community organizations were sectors often not sufficiently represented in CLTs. Some community projects also noted a need for increased diversity in the racial/ethnic makeup of CLTs to be more representative of the communities in which they are working. Based on final reports, 41 ACS and ACS CAN staff participated as part of the community projects' CLTs at some point during the program. Of these, 76 percent were ACS members, and 24 percent were ACS CAN staff.

Exhibit 31: Partnership Makeup of Community Leadership Teams Based on Final Reports



Pilot Community Project efforts resulted in building new partnerships and strengthening existing partnerships, seen as a value-add for both ACS and ACS CAN staff and leadership and communities. Interview participants described how ACS projects helped both ACS and community partners build new partnerships, diversifying networks of partners by working with communities and sectors they had not worked with before. They also reported strengthening existing relationships, including viewing prior ACS volunteers as partners. Interview participants noted that these partnerships are a value-add for ACS by broadening the scope of ACS' reach, including filling sector, topic area (e.g., food insecurity, survey development), or knowledge gaps and diversifying ACS staff perspectives. In addition, these partnerships helped communities overcome existing silos and promote synergies between organizations doing similar or overlapping work. In progress reports, Pilot Community Projects described how efforts helped bring together a strong group of leaders, with organizations that may not otherwise have known each other or worked together in the past now having new relationships. They noted the Pilot Community Projects served as a platform for collaboration and bridging relationships.

> "The doors we have opened, the partners brought to the table and conversations, those have been major impacts… Broadening our reach with greater need populations. When you look at our area board and local board, we are not as diverse as we need to be and are not touching the populations we need to be… so this is an opportunity for us to connect with a new population and help impact a new population that we haven't been able to engage with previously. This is filling those gaps."
>
> **- ACS Leadership**

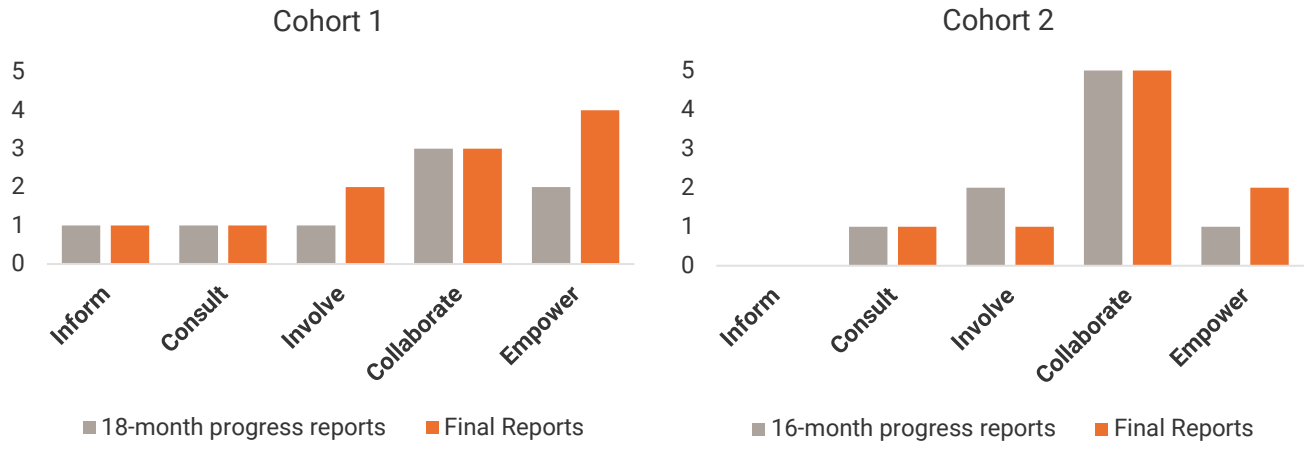
Institute, Co-Chair calls, and CLT calls were the main avenues for co-sharing and peer learning among Pilot Community Projects; some Pilot Community Projects participants desire additional avenues for peer-to-peer learning. In progress reports, many of the Cohort 1 communities reported that the Co-Chair and CLT calls are

the main avenues for sharing best practices, learning about other communities' progress and activities, and troubleshooting challenges. Most Cohort 2 communities reported limited engagement with other community projects outside of Institute. Across cohorts, a few communities reported a few examples of communicating with Co-Chairs or other ACS and ACS CAN staff around project progress and activities and brainstorming ideas for volunteer recruitment, retention, and engagement. In KIIs, participants noted a desire for increased co-sharing and peer-to-peer learning opportunities across projects and across cohorts.

Community Engagement: While most Pilot Community Projects reported that their programs are collaborative, there is a range of engagement levels in each community; regional ACS and ACS CAN staff members continue to serve a key role as drivers of the work, though communities remain at the center of the work.

Most Pilot Community Projects noted their programs are collaborative, where communities are involved in each aspect of decision-making (see Exhibit 32). Based on IAP2's Spectrum of Public Participation, level of public engagement ranges from inform (provide information) to consult (obtain public feedback) to involve (work with public throughout process) to collaborate (partner with the public in decision-making) to empower (place final decision-making in the hands of the public). In Cohort 1, the number of communities reporting that their level of engagement with community members was at the empower end of the IAP2 Spectrum increased between 18 months and final reports. Most Cohort 2 communities noted collaborative relationships with community members in both 16-month and final reports.

Exhibit 32: Level of Engagement Based on the IAP2 Spectrum, as Reported in Progress Reports



Some communities reported multiple levels of community engagement and so results are not mutually exclusive.
*Only four communities reported level of engagement in the 18-month progress reports.

Community members are at the center of the work, but regional ACS and ACS CAN staff members serve in a "project management" role and are driving projects forward. Interview participants described engaging with community members for health equity efforts, but the level of engagement varied by site. Some ACS and ACS CAN staff and leadership noted that community members are identifying needs, providing input on decisions and direction, and are a critical part of CLTs or subcommittees. Some are driving portions of the work, including leading subcommittees, planning events, and engaging community members. However, given competing interests, Regional ACS and ACS CAN staff members are driving project logistics forward (e.g., keeping track of administrative items, managing budget, driving meetings) and serving as project managers. For Cohort 2 projects that launched and took place almost entirely during the COVID-19 pandemic, interacting only virtually led to limited engagement with some CLT and community members. The inability to bring CLTs together in person to strengthen relationships or to visit community sites where work was taking place led to reduced engagement with projects as well. Some interview participants described losing CLT members due to competing interests as they navigated responding to COVID-19 within their own organizations and personal lives.

> "Because it's driven by our tribe, people are more invested in it; we had the flexibility to be like 'Oh, here's an idea,' and we'd go with that. That really fostered engagement and creativity. We weren't being so rigid, and that really helped our program."
>
> **- Community Member**

In a few communities, interview participants reported that community members are driving projects. They noted that the Co-Chairs and CLT format was a helpful leadership structure for keeping projects on track, especially in promoting inclusion of community partners. In addition, some KII participants reported that while ACS and ACS CAN staff members were driving more of the implementation of the projects at the start, over time community members and organizations took more ownership of the projects and implementation, and ACS and ACS CAN mainly served in a facilitating function.

Q6: To what extent did ACS' efforts in selected communities increase its relevancy?

External Relevancy: ACS gained visibility as an engaged partner interested in promoting community-based prevention and addressing health equity.

In KIIs and progress reports, individuals across stakeholder types noted ACS and ACS CAN have various important roles to play in the health equity space, including as a(n):

- **Convener:** Bringing together diverse partners to focus on a common goal. ACS and ACS CAN can bring organizations "to the table" together and facilitate discussions and efforts around a specific topic or goal.
- **Educator and advocate:** Operating at the provider and national level. This includes educating legislators and advocating for policies and funding at the local, state, and national level that advance

health equity. ACS and ACS CAN can also work closely with providers to better address health equity within their own health systems, with ACS and ACS CAN serving as the bridge to raise awareness within the provider community.

- **Expert leader:** Providing guidance on quality improvement to assess and enhance current processes and systems, and access to national experts in health equity, disparities, and SDOH.
- **Capacity builder:** Providing financial resources to fund community activities and supporting efforts to expand community infrastructure. They noted that, in this capacity, ACS and ACS CAN can help communities identify local solutions and enhance the capacity of communities for long-term change.

> "ACS has a lot of connections; I think it's incredibly important that there's intention nationally to push this conversation, so that it's not just one community… We can't do this alone or in silos. All the people experiencing these disproportionate impacts can't solve the problem all alone… there have to be honest and deliberate actions of those who are in power to help make the change happen; what happens at the top filters down to communities."
>
> **- Community Member**

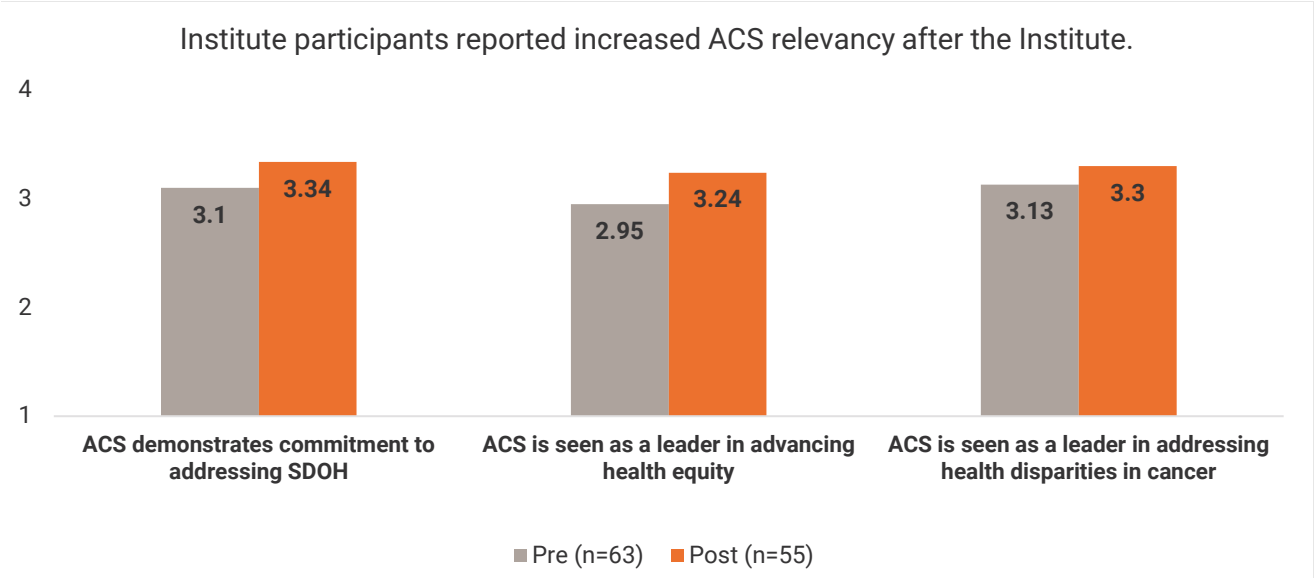
ACS can play a role in ensuring that the cancer lens is represented in health equity and SDOH. Interview participants described ACS' role as addressing anything that impacts health, including access to and the quality of health care. Health equity and SDOH are critical parts of the life cycle and of factors that affect cancer incidence and mortality and further contribute to cancer disparities. By focusing efforts on solutions for advancing health equity, ACS can transfer efforts into early cancer prevention, detection, treatment, and survivorship, ultimately reducing the impact of cancer on individuals' and communities' lives. In addition, participants noted that ACS should represent all people impacted by cancer, which requires advocating for increasing the diversity of the population being served; health equity is a big part of that. ACS can work with communities to understand perceptions of, challenges for, and barriers to cancer prevention within the context of SDOH and health equity.

The Pilot Community Projects program increased ACS' visibility in communities, providing a role for ACS outside of fundraising and cancer control. In KIIs and progress reports, community projects described that the grant gave ACS an opportunity to develop community relationships, strengthen community engagement, and work with new communities and populations at the local level. As a result, communities had increased awareness and understanding of ACS as a concerned organization willing to work with and value communities, and as relevant in the health equity and food insecurity space. By being more visible and engaging with communities, ACS helped dispel myths and increase awareness and understanding of what ACS does, making ACS a relevant and valuable resource for communities. Community members described seeing ACS as valuing community-based relationships, rather than only the health system/provider relationship.

Among Institute participants, average agreement with the statements "ACS, as an organization, is seen as a leader in advancing health equity" and "ACS is seen as a leader in addressing health disparities in cancer" increased from pre- to post-Institute. Agreement across all questions related to ACS' relevancy, including the commitment to and leadership on health equity and addressing health

disparities, increased slightly for both Institute participants (see Exhibit 33) and Meeting participants (see Appendix D, Section B).

Exhibit 33. Average Agreement with ACS Relevancy Statements among Institute Survey Respondents



KII participants noted that although ACS has a role to play in health equity, it needs to establish a clear and consistent strategy that is practically aligned with mission priorities. As ACS and ACS CAN resources changed in terms of funding and staff capacity due to the COVID-19 pandemic, perceptions of community-based health equity work also shifted. Both Cohort 1 and Cohort 2 KII participants agreed that the organization can and should work to address broad SDOH like food insecurity. However, as the pandemic caused resource constraints within the organization, staff supporting Cohort 2 expressed some reservations about the relative priority of work addressing broad, upstream social determinants of health compared to more cancer-specific work, such as access to care, prevention/early detection, and health systems' process improvement. They noted that a focus on community-based health equity work requires allocating sufficient resources and funding, *"put[ting] our stake in the ground,"* and bringing back community-based ACS programs that address health equity, reach priority populations, and establish *"boots on the ground"* staff that focus on building relationships, like the Community Health Advisory Program. Nevertheless, across both cohorts, KII participants agreed that health equity is an important and pressing issue, and the SDOH have a great effect on patients experiencing cancer.

Discussion

Through its efforts under the RWJF grant, ACS and ACS CAN advanced health equity by training over 2,000 staff members and volunteers, convening over 450 stakeholders including leadership, conducting public opinion research and an organizational assessment, and integrating health equity into strategic priorities and organizational policies, practices, and research. In addition, ACS and ACS CAN funded 12 Pilot Community Projects across two cohorts, providing resources, training, and technical assistance to address SDOH within their communities.

Health equity trainings and collaborative work sessions significantly increased participants' knowledge, attitudes, and beliefs. Staff and volunteers who were trained were significantly more knowledgeable about health equity and expressed significantly stronger health equity beliefs than staff members who were not trained. In Pilot Community Projects, the participation of CLT members in the Health Equity Institute resulted in significantly increased confidence to take action and feelings of support from ACS as compared to those who did not participate in Institute.

ACS and ACS CAN also integrated health equity into their organizational culture by embedding health equity as a value in their strategic plans and in organizational policies and practices. The GHQ Health Equity Team worked with ACS leadership to influence the inclusion of health equity in the organizational strategic plan, and team members directly influenced the inclusion of key health equity concepts in other important organizational work (e.g., the National Colorectal Cancer Roundtable's strategic plan, extramural research). Within the organization, trained staff and volunteers reported significantly more active involvement in work related to health equity and SDOH. They also perceived significantly more organizational commitment to health equity and leadership support to address health equity in their work than those that were not trained.

ACS' increase in internal marketing and communications related to health equity enhanced the presence of health equity information on various organizational platforms to expand its reach internally while also expanding its presence in the health equity space through external channels. Through the ACS Health Equity Team's efforts, ACS and ACS CAN have taken a more robust approach to promoting health equity in internal communications, resulting in increased reach of health equity-related communications to internal staff and volunteers in 2020. ACS/ACS CAN senior leadership identified increased discussion and staff education around health equity, staff incorporation of health equity into their work, funding, and raising health equity as a strategic priority in the organization as critical in increasing ACS' internal relevancy. In addition, ACS integrated health equity into external communications, including webpages, campaigns, social media posts, and digital advertising, which had broad reach with external audiences. ACS and ACS CAN leadership also conducted press statements, advocacy leadership statements, blogs, speaking engagements, and presentations.

For ACS, the Pilot Community Projects strengthened partnerships, increased ACS' visibility in communities, and provided ACS and ACS CAN with a better understanding of socio-economic barriers faced by communities, community engagement strategies, and approaches to building trust with communities. Despite some delays in implementation due to COVID-19 and ACS and ACS CAN staff

reorganization, ACS and ACS CAN staff, leadership, and community members had a positive opinion of the pilot project efforts overall. ACS and ACS CAN provided a flexible program structure that can be adapted to meet community needs and leverage community resources. In addition, regional and GHQ staff members were generally viewed as supportive, approachable, and accessible. The ACS brand enhanced community projects' credibility and gravitas, leveraging its role as an external and neutral organization and convener to keep projects moving forward.

For communities, the Pilot Community Projects resulted in expansion of community infrastructure and capacity to conduct health equity work, strengthened partnerships, increased community awareness and excitement around health equity work, promoted development of new tools and resources, and increased technical and leadership skills of CLT members. Most Pilot Community Projects addressed food insecurity, working to increase access to healthy foods in their communities. Communities experienced various challenges due to COVID-19 and ACS and ACS CAN staff reorganization, including adapting efforts to address urgent food insecurity needs in their communities, facing delays in implementation, and navigating virtual engagement approaches to community engagement and data collection. Nevertheless, leveraging existing efforts and capacity; establishing strong, action-oriented CLTs; including a diversity of sectors in partnerships; and setting tangible goals while tracking incremental progress helped communities "move the needle" on health equity efforts in their communities.

Recommendations for Future Efforts

Using the lessons learned from these efforts, ACS and ACS CAN have various opportunities to further integrate health equity into their organizational culture and communities.

National conversations about racial justice and equity helped ACS and ACS CAN make concrete movements toward integrating health equity into the organizations' strategic plans, policies, and programs/discussions by connecting these efforts to current conversations.

The social justice movements of 2020 and disproportionate impact of COVID-19 on Black, Latinx, American Indian and Alaska Native, and other racial/ethnic groups reignited national discourse around health equity and racial justice. This broader movement served as a spark for refocusing ACS and ACS CAN staff's and leadership's attention to equity and keeping health equity at the forefront of discussions, organizational efforts, and work. ACS and ACS CAN leveraged the groundwork laid by the GHQ Health Equity Team's efforts using RWJF funding to train staff and volunteers; establish common definitions and principles around health equity and enhance the narratives used to highlight ACS' and ACS CAN's health equity work; and refine and build upon health equity action. In addition, internal advocates, including the GHQ Health Equity Team and Health Equity Champions, also were key factors in

Recommendation

As ACS' and ACS CAN's efforts around health equity progress, continue highlighting the way this work is relevant and appropriate to current events and the national discourse.

increasing staff's and leadership's commitment to health equity. As ACS and ACS CAN continue to progress in their health equity efforts at the organizational and community levels, it will be critical to continue to highlight to staff, volunteers, and partners how their work is relevant to broader context and national discourse.

Increasing the reach and impact of training may be an important way to further integrate health equity into the core functions and social norms at ACS and ACS CAN.

Survey findings support that knowledge of health equity concepts is high among ACS and ACS CAN staff and volunteers; however, there is less certainty about SDOH and diversity among staff and volunteers who did not participate in trainings led or co-led by ACS' Health Equity Team. Changes over time indicate that there are many fewer staff and volunteers at ACS and ACS CAN who have never heard of health equity. Post-surveys for trainings and webinars suggest that attendees are learning how health equity relates to their work in these sessions and that their confidence and skills to address health equity are improved by the material and resources that they are exposed to in these areas. This applies to community partners, as well as CLT members participating in Institute, as they reported increases in their confidence around their ability to take actions to advance health equity in their communities. However, one potential consideration is whether people who participated in trainings self-selected into trainings because they were more interested in the topic, and possibly more motivated to engage with this work, than others who did not participate.

Recommendation

Trainings and webinars were shown to be effective mechanisms for increasing staff and volunteer knowledge around health equity concepts and should be expanded to have broader reach across ACS and ACS CAN staff and volunteers.

In addition, results also revealed that beliefs about feeling supported by ACS and ACS CAN to address health equity are low, with about half of all staff in Year 3 (regardless of training participation) and even fewer respondents who did not participate in trainings or health equity activities expressing this (36 percent). Given that those who did participate in these activities felt more supported by the organization to address health equity in their role (68 percent), engaging additional ACS and ACS CAN staff and volunteers (especially those who have not been previously exposed to them) in health equity activities provides an opportunity to increase feelings of support across staff and volunteers in the organization. This could further integrate health equity into core functions and social norms at ACS and ACS CAN as staff and volunteers feel both knowledgeable about these concepts and empowered to address them in their daily work.

Staff and volunteer knowledge about health equity concepts is high, but more work is needed to support the application of this knowledge to further integrate health equity into organizational activities.

Awareness of health equity concepts is a foundational step, but applying knowledge to practice is needed to assist ACS and ACS CAN staff and volunteers to actively integrate health equity concepts into their day-to-day work. Connections between terms may need to be emphasized so that ACS and ACS CAN staff and volunteers have a clearer understanding of not just the definition of health equity, but also how these terms and concepts relate to other concepts, like diversity and implicit bias. Staff and volunteers expressed a need to better understand how health equity is related to cancer disparities broadly, and how these concepts can be carried out in their own work and goals. Enterprise survey results revealed that there is interest in resources and trainings explaining how to improve health inequities in their role and how to use evidence of health inequities to improve programs and services (see Appendix D, Section A), indicating a desire for actionable steps that staff can take to integrate health equity into their day-to-day work.

An opportunity remains for ACS and ACS CAN to increase the active involvement and integration of health equity and SDOH among staff in their current roles. Most ACS and ACS CAN staff and volunteers can identify terms or feel "motivated" to act as a result of engaging with health equity trainings or webinars hosted by ACS and ACS CAN; but trainings or resources targeted toward tangible actions or goals to advance health equity are needed. Existing theories of planned behavior and organizational change frameworks[6] can provide ACS and ACS CAN with guidance for moving trainings forward toward translation of knowledge into practice through, for example, role modeling, identifying change drivers, and coaching to demonstrate leadership alignment. Engaging Health Equity Champions developed under the train-the-trainer model to become mentors or coaches to ACS and ACS CAN staff interested in applying health equity into their role could be one way to leverage the investment in staff that has already been made to further drive organizational capacity to address health equity.

Recommendation

Future trainings should be expanded to move from knowledge to practice. For example, trainings that engage Health Equity Champions to not only teach what health equity is but also to serve as mentors and partners to ACS staff interested in further integration of health equity into their work may be helpful.

Expanding engagement of and work with external partners and volunteers may increase ACS' and ACS CAN's reach and relevancy.

The Pilot Community Projects were effective mechanisms for strengthening existing, and building new, partnerships with a broad range of sectors. In addition, volunteers and community partners may be a particularly important group to target for inclusion in future health equity activities as they have access to other networks through work or communities in which they could "spread the message" of ACS and ACS CAN as Health Equity Champions and health equity as a priority. Volunteers also offer a unique perspective, as their interest and involvement with ACS and ACS CAN is driven by passion and desire for service to the broader cancer treatment and survivor community. However, volunteer involvement in

[6]Measuring and Analyzing Corporate Values during Major Transformations. Andrew Tipping, Aguirre, D., Van Lee, R., Jones, J., Schirra, W., Burger, C., Krings, J., and Staub, C. (2004). Report by Booz Allen Hamilton. (https://www.strategyand.pwc.com/media/uploads/MeasuringandAnalyzingCorporateValues.pdf)

organizational activities is somewhat low, as evidenced by their lower rates of participation in trainings and in the Enterprise Survey. Increasing participation of volunteers and community partners in organization-wide and community-level efforts could become a focus of future ACS and ACS CAN efforts.

Recommendation

Increase engagement of volunteers, community partners, and non-ACS actors to serve as health equity messengers and to increase ACS' relevance as a leader in the health equity space.

ACS and ACS CAN serve as conveners and capacity builders within local communities, but they should have an intentional focus on sustainability to increase impact over time.

The Pilot Community Projects resulted in increased excitement and buy-in around health equity work in the communities. In addition, community projects:

- Increased partnerships across a broad cross-section of actors, strengthening existing partnerships and building new partnerships;
- Provided communities with new tools, resources, and infrastructure for health equity-related work; and
- Expanded access to healthy foods in communities targeting food insecurity.

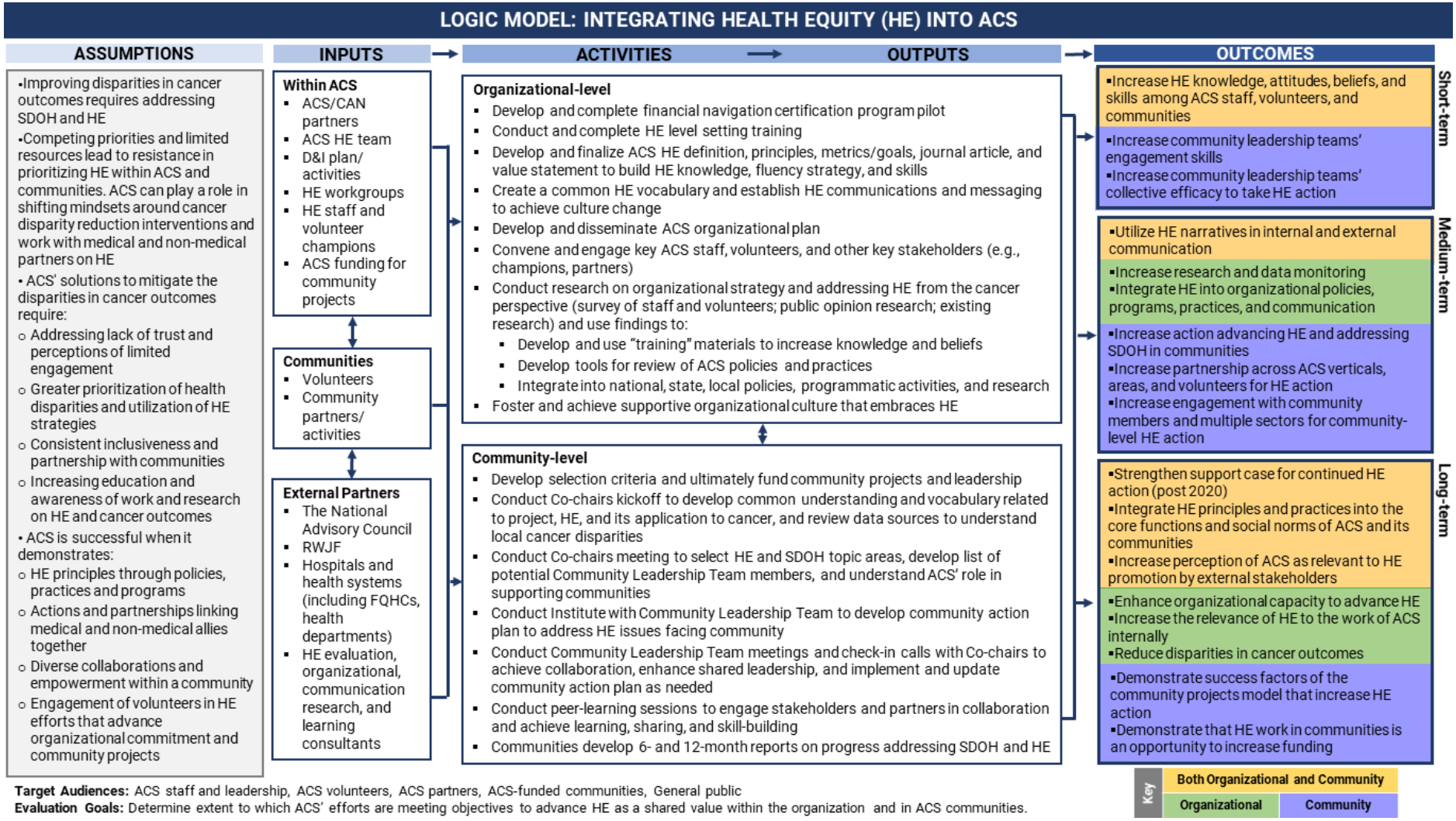
Furthermore, the projects led to ACS' increased visibility in communities, with the organization being seen as an actor in the health equity space. The program demonstrated its capacity as a scalable model for other community programs through key elements: leveraging communities' existing capacity rather than starting from scratch; understanding community context, culture, voices, and needs; developing strong leadership teams that drive projects while keeping communities at the center of the work; and allowing sufficient time for relationship building and communication to build trust. This model demonstrates ACS and ACS CAN should continue to serve a role in the health equity space, primarily around convening, education and advocacy in health systems and nationally, leadership and expertise on health equity and quality improvement, and building community capacity for health equity work. However, this role should include prioritizing strategies for sustainability to ensure continued strong partnerships and relevance of ACS and ACS CAN in communities.

Recommendation

ACS should continue to serve a key role in health equity, particularly convening multi-sector actors at the community level to work together toward a common goal and building capacity of community partners to more effectively conduct health equity work. However, these efforts should be intentional and focus on the sustainability of projects.

Appendices

Appendix A: Logic Model



Appendix B: Crosswalk of Evaluation Questions and Logic Model

Evaluation Question	Logic Model Element	Time Frame	Organizational Efforts	Community-level Efforts
PROCESS EVALUATION				
How did ACS and selected communities advance health equity actions?	• Logic model activities and outputs assessed based on: – Implementation – Reach – Fidelity – Context	N/A	X	X
What factors for success can be derived from the Health Equity Community Projects model?	• Demonstrated success factors of the community projects model that increase health equity action • Demonstrated that health equity work in communities is an opportunity to increase funding	N/A		X
OUTCOME EVALUATION				
To what extent have ACS' efforts increased staff, volunteers, and selected communities' health equity knowledge and skills?	• Increased health equity knowledge, attitudes, beliefs, and skills among ACS staff, volunteers, and communities • Increased community leadership teams' engagement skills • Increased community leadership teams' collective efficacy to take health equity action	Short-term	X	X
To what extent has ACS enhanced its organizational activities to advance health equity?	• Integrated health equity into organizational policies, programs, practices, and communication • Integrated health equity principles and practices into the core functions and social norms of ACS and its communities • Enhanced organizational capacity to advance health equity • Increased research and data monitoring	Medium-term	X	
To what extent did community projects increase action in	• Increased action advancing health equity and addressing SDOH in communities	Medium-term		X

Evaluation Question	Logic Model Element	Time Frame	Organizational Efforts	Community-level Efforts
advancing health equity and addressing SDOH in communities?	• Integrated health equity principles and practices into the core functions and social norms of communities			
To what extent have selected communities increased collaboration across sectors and teams?	• Increased partnership across ACS verticals, areas, and volunteers for health equity action • Increased engagement with community members and multiple sectors for community-level health equity action	Medium-term		X
To what extent did ACS' efforts increase its relevancy?	• Utilized health equity narratives in internal and external communication • Increased perception of ACS as relevant to health equity promotion by external stakeholders • Increased relevance of health equity to the work of ACS internally	Long-term	X	X
Not covered in this evaluation cycle	• Strengthen support case for continued health equity action (Post 2020) • Reduce disparities in cancer outcomes	Long-term	X	X

Appendix C: Full List of Document Review Materials

Document Type	Description
Cross-Cutting	
RWJF Annual Report	• 2019 Annual Report covering the 2018 reporting period • 2020 Annual Report covering the 2019 reporting period • 2021 Annual Report covering the 2020 reporting period
Organizational Efforts	
Meeting Notes and Materials	• National Advisory Council (NAC) meetings • Health Equity Research Events Talking Points and Run of Show • 2020 Meetings with a Health Equity Focus • Meetings Document • Webinar training slides
Resources and Other Materials	• Products on Brand Toolkit • Products with more equitable and inclusive language • Resources for Black Community • 2019 NCCRT Strategic Plan • Diversity and Inclusion Health Equity Resources • Health Equity Champion Tracker • South Region Tips and Tools • ACS Learning Log Spreadsheet • Core Team Wins • Health Equity Activities in the Field • Cancer Screening guidance during COVID-19 • Volunteer engagement data
Communications Materials	• Press releases • Health Equity Communications Data • Health Equity Communications Report • Log of Presentations and Webinars • Social Media Analytics • Brand Toolkit Analytics • ACS Health Equity (Donor, Federal, State Facing)
Research Materials	• ACS Health Equity Research Projects • PerryUndem Public Opinion Research Final Report • Research Priorities

Document Type	Description
Health Equity Community Projects	

Progress Reports	• Cohort 1 submitted progress reports at:
	  - Six months (February 2020) – one community was missing a progress report
	  - 18 months (February 2021)
	  - Final report (June 2021)
	• Cohort 2 submitted progress reports at:
	  - 16 months (March 2021)
	  - Final report (June 2021)

Community Projects Materials	• Health Equity Pilot Community Projects: Frequently Asked Questions (FAQs) • American Cancer Society Health Equity Community Projects: Social Determinants of Health through the Cancer Lens and Strategies to Address Them
	• Cohort 1 nominations
	• Cohort 2 nominations • Community Projects Jackson Story • Health Equity Community Projects Booklet • Health Equity Group Cash Advances

Appendix D: Survey Results

This appendix presents tables of the survey results referenced in the report for the Enterprise Survey (Section A) and the Community Projects Co-Chairs Meeting and Institutes Surveys (Section B). Table titles reflect the survey item for which results are presented. Statistical significance is noted where relevant under each table.

Section A. Enterprise Survey Results

Table 1. Number of Respondents

	Staff	Volunteers
Year 1	1,807	202
Year 2	1,044	52
Year 3	590	28

Training Items

Table 2. Have you ever received any training on health equity?

	Yes
Year 1	26%
Year 2	47%
Year 3	62%

P<.05 for changes over time

Table 3. Have you participated in any in-person training or webinars on health equity hosted by ACS in the past year?

	Yes
Year 2	44%
Year 3	40%

Table 4. How strongly do you agree with the following statement: As a result of my exposure to ACS'/ACS CAN's health equity resources and training over the past year, I feel more motivated to act to advance health equity.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
Year 2 (n=473)	6%	2%	20%	51%	21%
Year 3 (n=374)	0.40%	0.80%	10%	57%	32%

Note: Asked only to those respondents who indicated that they participated in any in-person training or webinars on health equity hosted by ACS in the past year.
P<.05 for changes in agreement with this statement over time.

Knowledge Items

Table 5. Proportion of Respondents Who Correctly Matched Terms and Definitions

	Health Equity	Health Disparity	Diversity	Social Determinants of Health
Year 1	95%	82%	94%	81%
Year 2	94%	86%	92%	81%
Year 3	99%*,**	88%	92%	81%

*P<.05 for differences from Year 1
**P<.05 for differences from Year 2

Table 6. Proportion of Respondents who Correctly Matched Terms and Definitions, by Participation in Training

	Participated in ACS Training	Did not participate
Health Equity	100%	98%
Health Disparity*	97%	75%
Diversity*	100%	82%
Social Determinants of Health*	97%	59%
Knowledge Summary Score*	98%	79%

Note: The Knowledge Summary Score is an average of the proportion of respondents who correctly identified all four terms.
*P<.05 for differences between groups

Attitudes and Beliefs Items

Table 7. Please indicate how strongly you agree with each statement: Personal Beliefs Statements.

Personal Beliefs Statements	Year 1 (n=1807)	Year 2 (n=1044)	Year 3 (n=590)
The health of our society, including the ability to prevent, detect, treat, and survive cancer is largely determined by a combination of social, economic and physical environment factors, such as access to affordable housing, healthy food, safe neighborhoods, and affordable healthcare. (Social Determinants)	96%	94%	99%*,**
It is part of ACS's responsibility to make sure that everyone has the same opportunity to prevent and survive cancer regardless of social, economic and physical environment factors, such as access to affordable housing, healthy food, transportation, safe neighborhoods and affordable healthcare. (ACS Responsibility)	87%	89%	84%
I believe my ACS/ACS CAN work can contribute to advancing health equity. (Personal Contribution)	84%	82%	78%
I believe addressing the social, economic and physical environment factors that impact cancer is important to my work at ACS. (Addressing Social Determinants)	90%	88%	94%*

Note: Results reflect proportion of respondents who reported "Agree" or "Strongly Agree."
*P<.05 for differences from Year 1
**P<.05 for differences from Year 2

Table 8. Please indicate how strongly you agree with each statement: Personal Beliefs Statements, by Participation in Training.

Personal Beliefs Statements	Participated in ACS Training (n=370)	Did not participate (n=240)
The health of our society, including the ability to prevent, detect, treat, and survive cancer is largely determined by a combination of social, economic and physical environment factors, such as access to affordable housing, healthy food, safe neighborhoods, and affordable healthcare. (Social Determinants)	99%	98%
It is part of ACS's responsibility to make sure that everyone has the same opportunity to prevent and survive cancer regardless of social, economic and physical environment factors, such as access to affordable housing, healthy food, transportation, safe neighborhoods and affordable healthcare. (ACS Responsibility)*	90%	76%
I believe my ACS/ACS CAN work can contribute to advancing health equity. (Personal Contribution)*	88%	66%
I believe addressing the social, economic and physical environment factors that impact cancer is important to my work at ACS. (Addressing Social Determinants)*	98%	91%
Personal beliefs score*	94%	82%

Note: Results reflect proportion of respondents who reported "Agree" or "Strongly Agree."
*P<.05 for differences between groups

Table 9. Please indicate how strongly you agree with each statement: Organizational Beliefs Statements.

Organizational Beliefs Statements	Year 1 (n=1807)	Year 2 (n=1044)	Year 3 (n=590)
I have the support that I need from leadership to focus on the social, economic, and physical environment factors that impact cancer through my work with ACS/ACS CAN. (Leadership Support)	45%	52%*	54%
I think ACS/ACS CAN, as an organization, considers health equity when making decisions on programs, policies, and services. (HE Consideration)	71%	75%*	58%**
I think ACS/ACS CAN, as an organization, demonstrates a commitment to addressing the social, economic, and physical environment factors that impact cancer. (HE Commitment)	72%	75%	66%

Note: Results reflect proportion of respondents who reported "Agree" or "Strongly Agree."
*P<.05 for differences from Year 1
**P<.05 for differences from Year 2

Table 10. Please indicate how strongly you agree with each statement: Organizational Beliefs Statements, by Participation in Training.

Organizational Beliefs Statements	Participated in ACS Training (n=373)	Did not participate (n=245)
I have the support that I need from leadership to focus on the social, economic, and physical environment factors that impact cancer through my work with ACS/ACS CAN. (Leadership Support)*	68%	36%
I think ACS/ACS CAN, as an organization, considers health equity when making decisions on programs, policies, and services. (HE Consideration)*	71%	44%
I think ACS/ACS CAN, as an organization, demonstrates a commitment to addressing the social, economic, and physical environment factors that impact cancer. (HE Commitment) *	77%	52%
Organizational beliefs score*	72%	44%

Note: Results reflect proportion of respondents who reported “Agree” or “Strongly Agree.”

Familiarity with Health Equity and Social Determinants of Health Items

Table 11. How familiar are you with the concept of health equity?

	Year 1 (n=1807)	Year 2 (n=1044)	Year 3 (n=590)
I have never heard of health equity	8%	3%*	0.01%*,**
I have heard of health equity but I am not sure I could define it	21%	16%*	7%*,**
I have heard of health equity and I am fairly clear on what it means	27%	27%	29%
I understand health equity but have not had the opportunity to incorporate it through my work at ACS/ACS CAN	17%	23%*	15%
I understand health equity and partner with others on health equity through my work with ACS/ACS CAN	20%	22%	21%
I am actively involved in advancing the ideas of health equity and would consider myself a health equity champion	8%	10%	27%*,**

*P<.05 for differences from Year 1
**P<.05 for differences from Year 2

Table 12. How familiar are you with the concept of health equity? By Participation in Training.

	Participated in ACS training (n=373)*	Did not participate (n=245)*
I have never heard of health equity	0.01%	0.03%
I have heard of health equity but I am not sure I could define it	4%	18%
I have heard of health equity and I am fairly clear on what it means	21%	42%
I understand health equity but have not had the opportunity to incorporate it through my work at ACS/ACS CAN	21%	6%
I understand health equity and partner with others on health equity through my work with ACS/ACS CAN	26%	14%
I am actively involved in advancing the ideas of health equity and would consider myself a health equity champion	30%	20%

P<.05 for differences between groups

Table 13. How familiar are you with the concept of social determinants of health?

	Year 1 (n=1807)	Year 2 (n=1044)	Year 3 (n=590)
I have never heard of social determinants of health	10%	6%*	5%*
I have heard of social determinants of health, but I am not sure I could define it	20%	17%*	11%*
I have heard of social determinants of health, and I am fairly clear on what it means	25%	24%	28%
I understand social determinants of health but have not had the opportunity to incorporate it through my work at ACS/ACS CAN	18%	26%*	16%
I understand social determinants of health and partner with others on health equity through my work with ACS/ACS CAN	20%	21%	23%
I am actively involved in advancing the ideas of health equity and would consider myself a social determinants of health expert	6%	6%	17%*,**

*P<.05 for differences from Year 1
**P<.05 for differences from Year 2

Table 14. How familiar are you with the concept of social determinants of health? By Participation in Training.

	Participated in ACS training (n=373)*	Did not participate (n=245)*
I have never heard of social determinants of health	0.5%	12%
I have heard of social determinants of health, but I am not sure I could define it	9%	12%
I have heard of social determinants of health, and I am fairly clear on what it means	15%	48%
I understand social determinants of health but have not had the opportunity to incorporate it through my work at ACS/ACS CAN	23%	4%
I understand social determinants of health and partner with others on health equity through my work with ACS/ACS CAN	29%	14%
I am actively involved in advancing the ideas of health equity and would consider myself a social determinants of health expert	23%	9%

P<.05 for differences between groups

Training Needs

Table 15. Please select 2 tools or resources that would help you include health equity your work.

	Year 1 (n=1807)	Year 2 (n=1044)	Year 3 (n=590)
An introductory training on health equity	36%	28%*	18%*
General tools and resources on health equity	40%	37%	18%*,**
How to make the case for health equity	17%	16%	7%*,**
How to improve health inequities in your role	39%	50%	47%
How to integrate health equity into policies or practices	26%	27%	23%
How to use evidence of health inequities to improve programs and services	33%	36%	39%

*P<.05 for differences from Year 1
**P<.05 for differences from Year 2

Table 15. Please select 2 tools or resources that would help you include health equity your work. By Participation in Training.

	Participated in ACS training (n=245)	Did not participate (n=373)
An introductory training on health equity*	3%	42%
General tools and resources on health equity	18%	21%
How to make the case for health equity*	11%	2%
How to improve health inequities in your role*	39%	55%
How to integrate health equity into policies or practices*	28%	17%
How to use evidence of health inequities to improve programs and services*	52%	16%

*P<.05 for differences between groups

Section B. Community Projects Co-Chairs meeting and institute Survey Results

Table 16. Number of Respondents

	Co-Chairs Meeting Survey		Institute Survey	
	Pre-Survey	Post-Survey	Pre-Survey	Post-Survey
Cohort 1	10	11	32	30
Cohort 2	18	15	31	26
Total	**29**	**26**	**63**	**56**

Co-Chairs Meeting Survey Results

Note that no significance was detected for Co-Chairs Meeting Survey results due to low Ns.

Table 17. Proportion of Respondents who Correctly Matched Terms and Definitions, by Participation in Training

	Pre (n=27)	Post (n=29)
Health Disparity	100%	100%
Health Equity	100%	92%
Implicit Bias	97%	96%
Social Determinants of Health	97%	93%

Table 18. Agreement with Beliefs Statements Pre- and Post-Meeting

	Pre (n=28)	Post (n=26)
The health of our communities, including the ability to prevent, detect, treat and survive cancer, is largely determined by a combination of social, economic, and physical environment factors, such as financial hardship, food insecurity/access to healthy foods and transportation/mobility barriers and has an impact across sectors (e.g. health care, business, philanthropy)	96%	96%
Health equity is essential to accomplishing ACS' mission of a world without cancer	100%	96%
I have the support I need from ACS to promote health equity in my community	22%	42%
I have the support I need from my direct supervisors and team members to promote health equity in my community	93%	96%
Collaborating to try to solve problems is common in my community	89%	96%

Table 19. Agreement with Confidence Statements Pre- and Post-Meeting

	Pre (n=28)	Post (n=26)
In general, I am confident in my ability to describe and promote health equity to my colleagues, partners, and community members	93%	96%
In general, I am confident in my ability to identify the health equity guiding principles that will help me promote health equity and check my health equity practice	86%	96%
I have the confidence to work with multi-sector partners to ensure that everyone has the opportunity to prevent, detect, treat, and survive cancer regardless of how much money they make, the color of their skin, their sexual orientation, or where they live	89%	100%
Average confidence score	89%	97%

Table 20. Agreement with ACS Relevancy Statements Pre- and Post-Meeting

	Pre (n=28)	Post (n=26)
ACS, as an organization, demonstrates a commitment to addressing the social, economic, and physical environment factors that impact cancer	89%	96%
ACS, as an organization, is seen as a leader in advancing health equity	63%	65%
ACS, as an organization, is seen as a leader in addressing health disparities in cancer	71%	77%

Table 21. How would you describe your level of comfort in explaining how discrimination and unconscious bias at interpersonal, organizational, community and social levels lead to health disparities?

	Post (n=26)	Pre (n=28)
I am uncomfortable with this.	4%	0%
I understand the concepts of discrimination and unconscious bias, but would not be able to describe this to others.	8%	29%
I understand the concepts, I am continuing to learn, and I am comfortable describing this to others.	88%	71%

Table 22. How would you describe your level of comfort in describing key components of effective policy, systems, and environmental approaches to address cancer health inequities to a stakeholder or potential funder?

	Post (n=26)	Pre (n=28)
I am completely uncomfortable with this.	4%	11%
I understand the components, but would not be able to describe it to others.	23%	25%
I understand the components, I am continuing to learn, and I am comfortable describing it to others.	73%	64%

Institute Survey Results

Table 23. Proportion of Respondents who Correctly Matched Terms and Definitions, by Participation in Training

	Pre (N=63)	Post (N=56)
Health Disparity	92%	92%
Health Equity	95%	91%
Implicit Bias	92%	89%
Social Determinants of Health	84%	86%

Table 24. Agreement with Beliefs Statements Pre- and Post-Institute

	Pre (n=63)	Post (n=55)
The health of our communities, including the ability to prevent, detect, treat and survive cancer, is largely determined by a combination of social, economic, and physical environment factors, such as financial hardship, food insecurity/access to healthy foods and transportation/mobility barriers and has an impact across sectors (e.g. health care, business, philanthropy).	95%	93%
Health equity is essential to accomplishing ACS' mission of a world without cancer.	97%	93%
In general, I am comfortable having discussions about inequities faced by different identity groups.	94%	95%
In general, I am comfortable describing and promoting health equity to my colleagues, partners, and community members.	94%	95%
In general, I am comfortable describing the relationships between cancer disparities, health equity and social determinants of health to my colleagues, partners, and community members.	89%	93%

	Pre (n=63)	Post (n=55)
I am comfortable identifying effective practices to promote health equity in cancer prevention, detection, treatment and/or survivorship.	89%	89%
I have the support I need from ACS to promote health equity in my community.*	79%	90%
I have the support I need from my direct supervisors and team members to promote health equity in my community.	95%	89%

P<.05 for differences between pre and post-surveys.

Table 20. Agreement with ACS Relevancy Items Pre- and Post-Institute

	Pre (n=63)	Post (n=55)
ACS, as an organization, demonstrates a commitment to addressing the social, economic, and physical environment factors that impact cancer.	81%	89%
ACS, as an organization, is a leader in advancing health equity.	74%	85%
ACS, as an organization, is a leader in addressing health disparities in cancer.	87%	81%

Table 21. How confident are you in each action (completely or very confident):

	Pre (n=63)	Post (n=55)
…describing how discrimination and unconscious bias at interpersonal, organizational, community and social levels lead to health disparities?*	34%	56%
…describing effective strategies to address cancer health inequities to a stakeholder or potential funder in your community?*	35%	57%
…implementing effective strategies to address cancer health inequities with stakeholders in your community?	45%	63%
…partnering with multi-sector partners to promote health equity in your community?	74%	85%
…engaging community members in the planning and implementation of effective strategies to address cancer health inequities in your community?*	65%	81%
…sustaining your work to address cancer health inequities in your community beyond 2020?*	53%	72%
Average confidence score*	51%	69%

*P<.05 for differences between pre- and post-surveys.

ABOUT NORC

NORC at the University of Chicago is an independent research organization headquartered in downtown Chicago with additional offices on the University of Chicago's campus, the DC Metro area, Atlanta, Boston, and San Francisco. NORC also supports a nationwide field staff, as well as international research operations. With clients throughout the world, NORC collaborates with government agencies, foundations, educational institutions, nonprofit organizations, and businesses to provide data and analysis that support informed decision-making in key areas, including health care, education, economics, crime, justice, and energy. NORC's decades of leadership and experience in data collection, analysis, and dissemination—coupled with deep subject matter expertise—provide the foundation for effective solutions.