Cancer Disparities Reduction Collaborative: Implementing a Community-based Screening Intervention in Appalachia

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Project Background

The Cancer Disparities Reduction Collaborative (**CHA Collaborative**) is an early detection and cancer screening intervention of the American Cancer Society (ACS) using Community Health Advisors (CHAs) and local community coalitions called Community Network Partnerships (CNPs) to help navigate underserved populations to cancer screenings. As cancer incidence and mortality rates are much greater in the Appalachian region than in other regions of the U.S. (Paskett et al., 2011), the CHA Collaborative included projects in West Virginia, Kentucky, and Western North Carolina. All other communities were African American and in the Southern U.S. Data from the pilot evaluation reveal that Appalachia communities had unique struggles with project implementation and increasing early detection efforts.

CHA Program Locations

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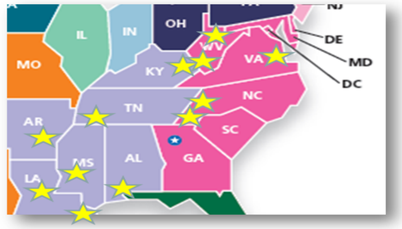

Mid-South

- AR – Little Rock/Pine Bluff
- AL – Mobile/Prichard
- KY –Eastern Kentucky (Appalachia)
- LA -New Orleans
- Central LA
- MS - Jackson
- TN – Memphis

South Atlantic

- WNC – Eastern Band of Cherokee Indians
- WNC – Jackson/Macon/Swain
- WNC – Madison/Mitchell/Yancy (Appalachia)
- VA – Portsmouth/Norfolk
- WV – Boone/Logan/Mingo (Appalachia)
- WV – Harrison, Lewis and Marion (Appalachia)

During the three-year pilot
Total Educated: 4859
Total Screened: 1000

Figure 2. Western NC CHA Event

Evaluation Methods

A mixed-method evaluation was conducted by the Center for Family and Community Engagement at NC State University and included qualitative data from field visits (representing a total of 13 counties in three Appalachian states), in-depth interviews with Appalachia program staff and focus groups with CNPs and CHAs (n=20), and a survey of CNP members (n=100/40 from Appalachia).

Key Issues in Appalachia

- Recruitment and retention of volunteers
- The "decentralized" nature of health and social services
- Inward nature of family and faith communities
- Individual-level factors
  - Culture of "privacy"
  - "Rugged individualism"
  - Low literacy and educational levels
  - Preference to speak with health providers around sensitive health issues versus lay health leaders

I thought I knew a lot about the rural counties, because my parents lived in Spruce Pine for 32 years. Well, Madison's totally different than Mitchell. I mean, you might not believe another universe is 30 minutes away. But it all has to do with how people are spread out, where your population centers are, and we are very decentralized here.

–Appalachian Community Partner

Community Network Partnership Survey Findings (N= 100)

- Appalachia partners rated key aspects of their leadership and involvement significantly lower than those in African American Communities
- The most significant differences involved changes in perceptions of ACS, participant benefits, and community impact.

Detailed Survey Findings (N= 100)

		Mean	Std. Deviation
Influence on Program	African American/Black	2.67	0.95
	Appalachia	2.61	0.65
Confidence in Skills and Experience	African American/Black	3.24	0.72
	Appalachia	3.01	0.64
Participation	African American/Black	3.05	1.06
	Appalachia	2.94	0.84
CNP Met Expectations+	African American/Black	4.12	0.92
	Appalachia	3.77	0.96
Commitment to CNP*	African American/Black	3.75	0.42
	Appalachia	3.55	0.54
Participation Benefits***	African American/Black	3.75	0.35
	Appalachia	3.41	0.55
Challenges to Participation	African American/Black	1.76	0.61
	Appalachia	1.90	0.55
Unity and Cohesion	African American/Black	3.45	0.53
	Appalachia	3.37	0.73
Impact on Community**	African American/Black	3.68	0.48
	Appalachia	3.31	0.70
Impact on Perceptions of ACS**	African American/Black	3.64	0.53
	Appalachia	3.29	0.72

+ p<.10, * p<.05, **p<.01, *** p<.001

Next Steps

The CHA program has provided an opportunity for ACS to work within communities in a way that is fundamentally different from previous efforts. As staff and volunteers reported, perceptions of ACS have changed to include a commitment to underserved communities. To continue this work in Appalachia some recommendations based on the qualitative evaluation include:

1. Deepen relationships with healthcare providers and health systems and work to embed community health workers (CHAs) within those environments.
2. Strengthen program relationships with faith communities.
3. Account for geographic challenges when setting expectations for volunteers and meeting planning.
4. Create applicable and relevant educational materials for this demographic.

Conclusions

While Community Health Worker interventions can play a significant part of addressing health disparities, community context must be fully understood for programs to be successfully implemented. The Appalachia region encompasses many distinct communities and program structures must be tailored to each community's specific cultural and geographical needs.

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