CPCRN
Cancer Prevention and Control Research Network
www.cpcrn.org

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June 25, 2021

Re: NCI Cancer Health Disparities Research RFI "Seeking Stakeholder Input on Enhancing Cancer Health Disparities Research" (NOT-CA-21-066)

Dear National Cancer Institute Equity and Inclusion Program,

Thank you for issuing this request for information (RFI) on enhancing cancer health disparities research. This response to this request for information is being submitted on behalf of the Rural Cancer Workgroup of the Cancer Prevention and Control Research Network (CPCRN). The CPCRN is a thematic network of academic institutions with Prevention Research Centers, other academic affiliates, public health, and community partners who have a goal of reducing the cancer burden in underserved communities. The primary objective of the Rural Cancer Workgroup is to leverage the resources, expertise, and relationships of the diverse CPCRN to conduct impactful and innovative rural cancer research to improve outcomes for rural residents and capacity for rural health care providers/organizations. As geographic location plays a role in cancer health disparities, we believe it is imperative for geography, particularly rural geography, to remain central to the discussion, funding, and conduct of cancer health disparities research.

We would like to commend the NCI for its increased commitment to rural cancer control over the past several years. In particular, we applaud the Division of Cancer Control and Population Sciences for maintaining an emphasis on rural cancer control as evidenced by multiple R01 grant opportunities and NCI-designated cancer center supplement grant opportunities. We appreciate that rural has remained central to many NCI conferences, including previously held rural cancer conferences in 2017 and 2018, the upcoming 2022 rural cancer conference, and the inclusion of a rural cancer control session at the May 2021 NCI Symposium on Cancer Health Disparities. We also appreciate the NCI's collaboration and consultation with other federal agencies such as HRSA to guide their rural-relevant work.

We wish to provide several recommendations primarily related to the "identify strategies to better prioritize and fund high-impact cancer health disparities research" section of the RFI. First, we support continued, rural-specific grant opportunities, including RFAs and NOSIs specific to rural cancer disparities research, cancer center supplement funding, and specific notation of rural populations in broader NCI RFAs and NOSIs. The RFI to which we are responding does not specifically note rural cancer health disparities, but further investment is needed to reduce the cancer disparities that exist in rural populations.

Second, we recommend that any such grant mechanisms consider the nuances of rural disparities research. We suggest flexibility in grant criteria for defining "rural". To be sure, there is strength in using federal definitions to ensure consistency, but this may not be reflective of "rural" locally. This is especially true as many federal definitions are currently based on 2010 Census counts. The changing population dynamics over the decade may not be accurately reflected in these measures. Additionally, the greatest cancer disparities often exist at the intersection of rurality and racial/ethnic minority composition, such as rural Black and rural American Indian/Alaska Native populations. However, while these populations experience notable disparities, they may be smaller in population size. Grant reviewers should receive guidance to appropriately score grants that may have smaller sample sizes, but for whom a study or intervention may provide a significant opportunity to reduce disparities. Such grant applications should not be penalized for having small sample sizes. To further

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consider nuances of rural disparities research, we also recommend that grant mechanisms specify asset-based assessments in rural and any other communities experiencing disparities. Studies that identify and enhance the strengths of rural communities may enable greater engagement of rural communities to address their cancer disparities.

Third, we recommend that grant submission processes reflect the time and resources needed to develop and submit application materials with rural and other community partners. Specifically, we suggest that additional time be provided between the release of a NOSI, RFA, or PA and the submission deadline. To be sure, NIH does provide "notices of intent to publish" announcements, but the details in these documents may not suffice to enable appropriate engagement of non-academic rural partners who may not have experience with academic research and related grant processes. Providing additional time between the release of NOSIs, RFAs, and PAs and the deadline would also be helpful for researchers at under-resourced institutions who may not have the same administrative support as researchers at well-resourced institutions. Further, cancer health disparities research is more likely to be conducted by Black and other persons of color and women, all of whom are more likely to have more unpaid labor obligations such as academic service and/or have caregiving responsibilities for children or other family members. Providing additional time would enable a more diverse and rich pool of cancer health disparities research proposals. In a similar vein, we recommend that traditional, 5-page NIH biosketches not be required of community partners in rural or other health disparities' communities who are participating as key personnel on a grant application. While it is important that the expertise of these partners is appropriately noted, the requirement of an NIH biosketch may provide an unnecessary burden on the community partner.

Finally, we recommend that population-based data resources better facilitate the conduct of rural cancer disparities research while protecting study participant privacy. For example, researchers are required to go to a research data center (RDC) to access the Medical Expenditure Panel Survey (MEPS) which includes a cancer survivorship supplement for any analysis that examines differences between metropolitan statistical areas (MSAs) and non-MSAs as well as to link contextual variables. The travel and other costs associated with accessing an RDC may be prohibitive for students and other early-career researchers. During the COVID-19 pandemic, researchers have been able to remotely access some data sources usually only available at an RDC. This provides proof of principle for future processes to access important data sources for cancer disparities research.

Again, we are grateful for the opportunity to respond to this RFI and look forward to seeing how the NCI uses the information from respondents to continue to enhance cancer health disparities research. Thank you for your commitment to improving the cancer disparities throughout the United States and the world.

Sincerely,

The CPCRN Rural Cancer Workgroup

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