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

Coordinating Center | University of North Carolina at Chapel Hill | CB#7424 | Chapel Hill, North Carolina 27599 | ph (919) 966-2812

To: The National Cancer Institute

From: Dr. Stephanie Wheeler, PhD MPH, on behalf of the Cancer Prevention and Control Research Network (CPCRN); stephanie_wheeler@unc.edu
Name of Organization: Cancer Prevention and Control Research Network (CPCRN)

On behalf of the Cancer Prevention and Control Research Network (CPCRN), we are pleased to respond to the NIH's request to comment on efforts to advance and strengthen racial equity, diversity and inclusion in the biomedical research workforce and advance health disparities and health equity research. CPCRN is a national network of academic, public health, and community partners across multiple sites who work together to reduce the burden of cancer, especially among those disproportionately affected. Its members work with the Centers for Disease Control and Prevention and the National Cancer Institute to conduct community-based participatory cancer research across its eight collaborating centers and more than 20 affiliate sites, crossing academic affiliations and geographic boundaries. The CPCRN is a thematic research network of the Prevention Research Centers (PRCs) program, which is CDC's flagship program for preventing and controlling chronic diseases.

Please find below our responses to each topic, in turn.

A. Address scientific gaps, innovative designs, or approaches to enhance cancer health disparities research

- Include representatives from Black, Indigenous, People of Color (BIPOC) communities on the decision making and scientific review committees at NCI and NIH at large
- Increase the diversity within the NCI workforce (at all levels and within leadership roles) to improve the reputation of NCI in the extramural community as an organization committed to diversifying its own workforce and leadership structure.
- Prioritize training and reputation building of diverse faculty in the NIH grant review process through preferred selection as peer grant reviewers. Appropriately recognize the time and energy required of peer reviewers by increasing the NIH peer review honorarium, as this may be a barrier to peer review participation, particularly among BIPOC scholars.
- Prioritize NCI funding to racial/ethnic minority PIs for health equity-oriented research by expanding "diversity"-focused grant opportunities, including but not limited to, more diversity supplements, K awards, R03s, R21s, R01s and more.
- Expand eligibility and timeframe criteria for diversity supplement applications through existing R01 projects. Specifically, allow for flexible supplement requests ranging from 1-3 years (not just 2 years), which may be particularly helpful for advanced predoctoral and postdoctoral scholars who only need 1 year of support. This will also increase the pool of R01s that are eligible.
- Create safe spaces within NCI for investigators from diverse backgrounds to voice concerns around diversity, equity, and inclusion
- Promote community engagement within NCI funding efforts, including prioritizing protected time to devote towards community-engaged research partnerships; reducing unnecessary bureaucratic, administrative, fiscal and regulatory hurdles that create barriers to community-engaged research, particularly for community organizations that serve BIPOC populations; and funding community-focused research.

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- Engage more diverse investigators in NIH-sponsored training, research and outreach events as speakers, panelists, moderators, facilitators and leaders.
- Reviewers of grant applications need to be advised by NIH to consider race/equity and rurality of populations, as well as employ an intersectional and equity lens in evaluating the significance and rigor of research addressing smaller size populations.
- Offer more response time between the release and the due date of NIH applications, particularly "one-off" and unique opportunities, as rapid-turn-around funding opportunities advantage those investigators and institutions already well-positioned to respond quickly and disadvantage others, including minority serving institutions.
- Expand the definition of diversity for supplement funding (i.e. Include Asian Americans for diversity supplements as well as gender-identity, sexual orientation, etc.)

B. Identify strategies to harness big data, advance methods and measurements to improve research, and technology development on cancer health disparities

- Future funding should be directed towards generating practice-based evidence in collaboration with community and clinical partners.
- Contribute to NIH guidance that builds in metrics for health equity work and team science contributions (as opposed to individual faculty merits) and input from community partners. Incentivize academic institutions to recognize efforts of developing strong community partnerships as a vital part of both research and service missions of the university and advancing health equity.
- Leverage existing structures like the COE offices at NCI-designated Comprehensive Cancer Centers and CTSAs to reduce the burden on community and clinical partners to participate in research projects.
- Revisit ALL categories for identity in research to reflect a comprehensive list of self-identities and possibly capture country of origin. Include Arab Americans in the definitions for racial and ethnic minority
- Consider requiring metrics in grant applications such as: community partner co-authorships, documenting/reporting how projects stem from community-defined needs, integrating mixed-methods approaches to evaluate partnerships, and leveraging measures summarized by Luger et al in the June 2020 issue of The Milbank Quarterly.
- Have national surveillance systems to collect disaggregated data on specific medically underserved groups/subgroups; Recommend researchers collect these disaggregated data and use a data equity lens to inform analysis and reporting of data to avoid perpetuating stereotypes or omission/erasure of racial and ethnic (particularly Native American/American Indian), rural, and Sexual Orientation and Gender Identity (SOGI) groups/subgroups. Review and make recommendations for more robust measurement of racial/ethnic, rural, and SOGI identification to avoid misclassification.
- Invest in efforts to better understand how to measure and address the health concerns of SOGI populations, particularly those from BIPOC backgrounds.
- Promote cross-institutional mentoring, with sufficient funding to support mentors, to increase diversity and enhance access to novel research approaches for diverse trainees. This could be easily implemented and show rapid effectiveness across existing research networks, e.g., CPCRN.
- Prioritize funding directed towards studies that consider the impact of more than one social/structural determinant on health outcomes. Further, sample size requirements should be adjusted for studies involving participants with intersecting identities, given that these populations are often disproportionately burdened by cancer and other diseases and thus need more study and/or intervention.

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- Develop targeted RFAs to increase funding to analyze the intersections of race, immigrant status, rurality, poverty, religion, sexual orientation/gender identity, and ability/disability. Support mixed methods research to understand and assess mechanisms, magnitude and nature of disparities using an intersectionality lens of research.
- These initiatives require ongoing funded support and infrastructure, above and beyond ongoing institutional U54 and P50 mechanisms, and they require NCI-wide commitment and leadership (not relegated to CRCHD). As a related point, within NCI and NIH, it would help tremendously to reduce the redundancy and administrative and communications confusion that exists around "disparities-focused" funding efforts and oversight.
- Require that community outreach and engagement efforts for all NIH Institutes/Centers infrastructure awards are funded appropriately to cover faculty and staffing effort, with sufficient stipends/incentives for community partners to engage in research.

C. Identify strategies to better prioritize and fund high-impact cancer health disparities research

- Provide coordination and opportunities to support large, team science center grants focused on cancer health disparities research.
- More opportunities are needed for HBCU investigators to affiliate with research-intensive institutions. Financial and administrative support is needed for investigators from non-research-intensive institutions to engage in research.
- Develop longer-term training support for trainees and mentors from pre-doctoral through post-doctoral at the same institution with some shift in mentoring over time, but also some degree of continuity in the mentoring process. Invest in programs that allow "distance education". Subsidize or reimburse trainees and investigators for required infrastructure for such programs that rely on remote mentoring and educational training, including hardware, software, and broadband and cellular connectivity (most of which is currently disallowed spending).
- Leverage existing networks such as the CPCRN, specifically the CPCRN Scholars workgroup, to promote the identification, training and career development of a diverse workforce in cancer health disparities and implementation science with a health equity focus.
- Leverage existing networks such as CPCRN to support long-term community-academic-clinical partnerships for meaningful and impactful health equity research.
- NCI should review the administrative, regulatory, fiscal and logistical processes required of grant-supported sub-contractual partners to reduce the burden as much as possible for non-academic partners. Increase community partner capacity to incorporate administrative and service delivery costs when participating in research projects (e.g., minimum of 15% indirect when no DHHS agreements are in place). Often community organizations lack capacity to procedurally complete these requirements to set indirect cost rates yet are the organizations that most need the additional overhead support.

D. Identify strategies to connect cancer health disparities research initiatives domestically and globally

- Develop large research grant mechanisms (U01s, P50s, etc.) to catalyze cancer health disparities research initiatives partnering across domestic and global settings
- Expand funding opportunities, for pilot resources and research feasibility studies, to early-stage investigators, across the training continuum, especially from under-represented communities, to learn from and train under mentors who are engaged in community-academic partnerships.

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- Expand individual and institutional training awards that would incentivize collaborative cancer health disparities research between domestic and global scholars.
- Increase levels of NIH stipends to reduce the opportunity cost of leaving the workforce to advance one's education.
- Expand funding opportunities to support protected time of mid-level and senior investigators, particularly those from underrepresented communities, to provide mentorship for under-represented and health equity-focused investigators.
- Leverage and expand the CPCRN Scholars Program to support the development of early-stage investigators (predoctoral through early-career faculty) in community-engaged health equity and cancer-focused implementation research in global settings.
- Develop non-US citizen specific training and funding opportunities to ensure equitable access to NIH funding and future tenure.

Other:

- Continue to engage the broad scientific and research community in gathering input on how best to make progress on health equity research.
- Continue the dialogue from the national leadership perspectives, regarding the examination of racism in medicine (i.e. Racism in Science Report)
- Continue to dedicate funding opportunities to examine and address racism as a structural determinant of health and supported these on a regular, ongoing basis (as opposed to a limited or one-time RFA).
- Revisit the use of "minority" when describing diversity given the potentially negative implications; consider "underrepresented groups" or "underrepresented populations"

We have outlined the specific action items in this request, for more details on each point please refer to our submission towards the NIH RFI (NOT-OD-21-066). We applaud the NCI for asking for input from the scientific and broader community through this RFI. However, we believe that that such RFIs could serve as continued learning opportunities for the NIH and the broader scientific community. Initiatives such as the Implementation Science Consortium in Cancer are additional valuable examples for engaging the scientific communities to think beyond what a single researcher, research project, or a research institution can contribute to move the health equity research agenda. We thank the NCI for engaging the scientific community in this important endeavor, and we support and affirm the commitment to addressing structural racism in the biomedical sciences. We stand ready to work together to dismantle the structural and social barriers and prejudices that hold us back as a society and as scientists.

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On behalf of the CPCRN Steering Committee

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