Opportunities to Improve Quality & Advance Equity Along the Cancer Care Continuum

2021

Eli Lilly Racial Justice Initiative

Eli Lilly has joined the national discourse on race, inequity, and our economic future by increasing our participation and amplifying our voice in our communities. Eli Lilly's Racial Justice Initiative focuses on people development, jobs, healthcare access, social impact, and diversity partners. Lilly became one of the first major companies in Central Indiana to pledge monetary and people resources to drive change beyond our own walls. The Lilly Foundation committed $25M over 5 years and the company pledged 25,000 volunteer hours over 5 years to combat racial injustice and inequity.

Introduction

Eli Lilly and the National Minority Quality Forum (NMQF) are working together to build a broad coalition to reimagine cancer care. The healthcare system must evolve to ensure high quality care and innovative treatments are accessible for all patients. Often, proposed solutions prioritize cost over health outcomes and patients' quality of life. Further, by taking a cost-centric rather than a patient-centric approach, the healthcare system reinforces the systemic inequities racial and ethnic minorities face when seeking and receiving care.

The goal of our healthcare system is to optimize care for each patient by maximizing the capability of medical science to manage health outcomes. Creating a patient-centric risk model is predicated on designing a health system that operates to reduce patients' risk of an acute event while improving quality of life. No cancer patient should be at a higher risk for hospitalizations, emergency room visits, disabilities, and mortality because of who they are or where they live.

Together, NMQF and Eli Lilly fundamentally believe that a multi-sector collaborative network can speed equity and care quality across the cancer care continuum. This can be done from screening and early detection through diagnosis, treatment affordability and access, clinical trial participation, survivorship, and end-of-life care.[1] Through such a network, stakeholders can build the capacity and alignment for a reimagined system of equitable cancer care with the purpose of mitigating risks to patient health, particularly in communities of color, improving equity and care quality for patients. This paper lays out building blocks of this shared vision and offers related policy priorities.

> "Lilly Oncology has dedicated more than half a century to developing transformative medicines that help people with cancer live longer, healthier, better lives. We are committed to reimagining equitable care for all people living with cancer regardless of race, ethnicity or background, and are looking forward to addressing this deep-rooted problem with leaders across the cancer care community."

Eric Dozier
Vice President, Lilly Oncology

> "True, equitable health care means mitigating patient risk while improving quality of life. Eli Lilly and NMQF ask all stakeholders to join us in reimagining cancer care so that "value" means treatment decisions prioritize lowering patient risk for hospitalization, emergency room visits, disabilities, and mortality ahead of limiting financial costs through rationing."

Gary A. Puckrein, PhD
President & CEO, NMQF

Lilly

NATIONAL
Minority Quality Forum

Background

Despite rapid scientific advances in treatment, patients still experience challenges when seeking a timely diagnosis for their cancer and struggle to access the proper care at the right time. Like many other diseases, communities of color are subject to higher incidence, prevalence, morbidity, and mortality rates among almost all cancer types. Income-based disparities also significantly affect cancer care, including the likelihood of a patient receiving a timely diagnosis, accessing treatment, and affording high-quality care.

Collaboration

To meaningfully address disparities among the cancer community, there is a need for greater stakeholder engagement, commitment, and collaboration to consider the wider environment beyond the healthcare system and the impact that social risk factors can have on outcomes. Collaborative approaches to address disparities are critical for identifying patients in need, ensuring they have access to care and services to improve their outcomes, and continuously using data to evaluate whether inequities are being reduced.

While systemic inequities will not be eliminated overnight, recent activities at the local and federal level support the long-term commitment to acknowledge the focus on addressing disparities and ultimately advance health equity.

In January 2021, the Centers for Medicare and Medicaid Services (CMS) released a roadmap for states to address SDoH; simultaneously, the House Ways & Means Committee announced a framework for achieving health equity.[9,10] As policymakers consider reforms, manufacturers, patient advocacy organizations, health plans, providers, and other stakeholders must collaborate to identify and implement changes to advance equity in cancer care.

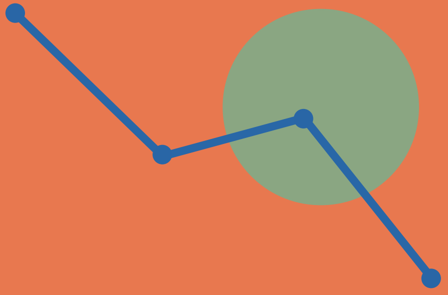
Social Determinants of Health in Oncology Care Impact Inequities in Care

Defined as "the conditions in which people are born, grow, live, work, and age," social determinants of health (SDoH) can have significant effects on meaningful access to care and are clear drivers widening disparities within the US.

90%

A recent survey of oncologists found over 90% of respondents believe SDoH factors, including financial security, access to food, and social isolation, have an impact on patients' long-term health outcomes.[2]

Communities of Color Face Disproportionate Barriers to Oncology Care and Worse Health Outcomes



70K+

In 2017, more than 70,000 Black Americans died of cancer in the US.[3] Black Americans have the highest death rates and shortest survival periods than any racial and ethnic group in the US for most cancers.[4]

While Hispanic Americans have a lower incidence rate of cancer than non-Hispanic white Americans, significant disparities in diagnosis and outcomes persist for certain cancer types, including prostate, breast, liver, stomach, and cervical cancer.[5] Compared to non-Hispanic white women, Hispanic women are 30% more likely to be diagnosed with breast cancer and 20% more likely to die of cervical cancer.[6]

Compared to non-Hispanic white Americans, American Indian/Alaska Natives are less likely to undergo diagnostic cancer screenings.[7] In addition, American Indian/Alaska Native women are more than twice as likely than non-Hispanic white women to die from liver and Intrahepatic Bile Duct (IBD) cancer, while American Indian/Alaska Native men are nearly twice as likely to die from liver and IBD cancer than non-Hispanic white men.[8]

Increase Racial and Ethnic Minority Representation in Clinical Trials

Clinical trials in oncology are crucial for developing new treatments and giving cancer patients the opportunity to benefit from early access to lifesaving therapies. Studies show nearly 75% of cancer patients will not have the option to enroll in a local clinical trial given their socioeconomic status, which disproportionately affects minority communities.[12]

Historically, under-enrollment of racial and ethnic minorities in clinical trials has been an issue and a clear contributor to preventable disparities in outcomes and survival.[13] Increased participation of ethnic and racial minorities in research and clinical trials for cancer and other diseases is imperative. Adequately representing the diversity of the US population in clinical trials can help ensure that medicines developed for and administered to patients demonstrate their intended benefit for patients.[14]

Representation

African American patients comprise just 5% of patients enrolled in clinical trials that support FDA approval of new drugs but represent 13.3% of the general US population.[11]

Recent Policymaker Action to Increase Representation in Clinical Trials

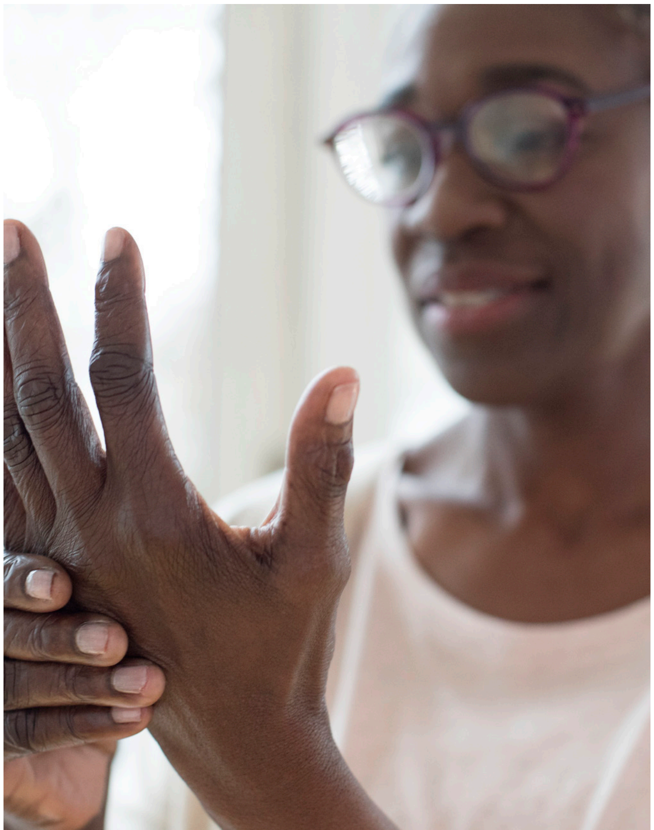
The U.S. Food and Drug Administration (FDA) released guidance in 2020 to enhance diversity in clinical trials and encourage inclusivity in medical product development.[15]

H.R. 133, the Consolidated Appropriations Act, 2021, requires state Medicaid plans to cover routine patient costs of items and services furnished in connection with a Medicaid beneficiary's participation in a qualifying clinical trials effective January 1, 2022.[16]

Agencies and organizations, including the FDA, have released guidance to promote best practices in increasing diversity in clinical trials via operational practices among medicines developers, contract research organizations, and investigator sites while policymakers are pursuing reforms. In addition to federal guidance, NMQF and other research and education organizations have published work showcasing strategies for increasing inclusion of racial and ethnic minorities in clinical trials. NMQF's Diverse Cancer Communities Working Group published manuscripts that outline best practices used by clinical trial sites to gain representative participation of racial and ethnic minority groups (REMGs) in cancer clinical trials. The 5 broad areas of focus encompassed commitment and center leadership, investigator training and mentoring, community engagement, patient engagement, and operational practices.[17]

Outside of federal efforts, healthcare organizations are taking steps to advance equity by focusing on patient engagement training and tools co-created with patient representatives, industry, academic researchers, clinicians, and other stakeholders. An example is the work of the Multi-Regional Clinical Trials Center (MRCT) of Brigham and Women's Hospital and Harvard, which focuses on solutions for the "global clinical trial enterprise," especially in emerging economies. MRCT resources include the free toolkit "Achieving Diversity, Inclusion, and Equity in Clinical Research" and other tools related to Plain Language Summaries, Health Literacy, and community resources. In November 2020, PhRMA announced its first industry-wide set of principles to increase clinical trial diversity. Specific to cancer, the American Society for Clinical Oncology (ASCO) and the Friends of Cancer Research (FOCR) introduced guidelines for expanding the inclusion/exclusion criteria in clinical research protocols to improve access and enhance the generalizability of research results.[18] These principles provide guidance to manufacturers to include real-world populations within clinical trials to support more representative data on the safety and efficacy of investigative therapies for diverse patient populations.[19] Eli Lilly has integrated these efforts to increase underrepresented populations in clinical trials consistent with US demographics.

Among other initiatives, Eli Lilly participated in the TransCelerate Biopharma, Inc clinical trial diversification solutions workstream.[20] This initiative that includes other pharmaceutical companies has produced initial tools and guidance focused on diversity awareness, patient engagement, cultural competency, and community engagement. These tools and guidance are publicly available for use and implementation across clinical trial stakeholders, including trial sites and clinical research organizations. Currently, TransCelerate, in collaboration with Eli Lilly, is creating a Diversity of Participants in Clinical Trials Workstream, which will tackle cross-industry collaboration in this space. Eli Lilly is also a sponsor participating in NMQF's Diverse Cancer Communities Working Group, a multi-stakeholder group of industry, advocacy, and clinicians to convene and develop actionable recommendations for equity in cancer care.



Solutions to Increase Representation in Clinical Trials

1. Expand Inclusion Criteria

Stakeholders must diversify clinical trial recruitment by modifying inclusion/exclusion criteria to be more inclusive of underserved populations. For example, current practices may result in individuals being systematically excluded because of comorbidities more common among certain populations. Due to step therapy requirements, patients may be ineligible to participate in clinical trials unless they have "failed" on a specific first-line treatment. Therefore, if a person could not access that initial first-line treatment, they will also be excluded from a clinical trial.

2. Provide Additional Support for Patients

Although explicit costs for participating in research or clinical trials are rare, the implicit costs (e.g., transportation, childcare, parking, loss of income from missing work) can be overwhelming to patients who lack economic resources.[21] Allowing more flexibility with patient reimbursement for clinical trial participation could help defray the costs of participating that may present a barrier to participating in trials for communities of color. In tandem, flexibility for clinical trial procedures, such as utilizing telehealth, home health services, or expanding clinic hours, would lend itself to addressing key access and participation barriers.

3. Engage Providers in Recruitment and Retention

While new legislation will support increased access to clinical trial participation, stakeholders must undertake targeted initiatives to recruit more heterogenous populations into trials. This may include having diverse principal investigators (PI) and/or diverse lead researchers who can attract more diverse patient populations. Manufacturers, patient advocacy groups, community-based organizations, and other key stakeholders should prioritize building trust among patient communities. Additionally, consider identifying community cancer centers not participating in clinical trials and engaging them in a referral network and/or investigator training program. Universal adoption of the evidence-based best operational practices related to recruiting and retaining diverse participants would promote the successful accrual of racial and ethnic minorities in clinical trials.[22]

As exhibited by the National Cancer Institute's Walking Forward program, rebuilding trust requires a holistic approach.[23] Stakeholders will need to develop education and decision support materials for patients to be more inclusive and considerate of the needs of disparate populations. Healthcare providers and manufacturers should train operations teams and agencies to identify essential information to support patient decision-making regarding participation in cancer clinical trials. To support these efforts, manufacturers should work with patient advocacy groups and community partners to identify gaps in clinical trial sites and promote community integration. Establishing clinical trial sites within marginalized communities will help expand access to new populations and allow manufacturers to be more active community partners.

Enable Earlier Detection of Cancer

In recent years, reductions in cancer death rates and improvements in survival across different forms of the disease have demonstrated the significant improvements in cancer care outcomes. Unfortunately, minority communities continue to bear a disproportionate cancer burden despite incremental improvements in cancer health outcomes.[24] Across the cancer disease states, studies show ethnic and racial minorities are more likely to be diagnosed with cancer at a later stage, resulting in higher mortality rates as compared to non-Hispanic white people.

Early cancer detection across all cancer disease states improves long-term health outcomes. However, many cancers do not have screening tools. According to the American Cancer Society (ACS), only five cancer types (breast, colorectal, lung, and prostate cancer) have early detection tests and associated screening recommendations.[25] Extending early detection to other cancers may improve long-term health outcomes for ethnic and racial minorities who often receive late-stage diagnoses for cancers without screening tools. Improving cancer health outcomes in ethnic and racial minorities will require equitable access to new screening technologies, as well as pre- and post-screening follow-up.

Solutions to Enable Earlier Detection of Cancer

1. **Improve Guidelines to Better Account for the Needs of Communities of Color**

   Among ethnic and racial minority communities, studies show barriers to care have an effect on when patients seek treatment and often delay receipt of cancer-related services.[26] To improve long-term health outcomes, stakeholders should develop guidelines and recommendations for early cancer detection and screening that keep pace with rapid technological advancements and reflect the unique needs of minority and disadvantaged populations.

2. **Increase Access to Screening for Underserved Populations**

   Racial and ethnic minorities continue to face disparities when considering stage of cancer diagnosis. For example, despite existing recommendations for lung cancer screenings for high-risk individuals, the proportion of Black Americans diagnosed at a distant stage is more than 53% higher compared to NHWs.[27] To address these disparities, stakeholders should ensure coverage of and access to early detection and screening technologies in both private and public insurance plans covering underserved communities. Ensuring coverage and access may take form through the creation of incentives that drive continued innovation in early detection and screening technologies.

3. **Modify Quality Measurement to Increase Incentives to Detect Cancer Early**

   The benefits of early detection have significant impacts on life expectancy and are consistent across the cancer spectrum. Early detection, in most cases, results in better treatment options and increases the chances of successful intervention. Healthcare stakeholders should develop better measures and standards for assessing the impact of early detection and screening in minority communities, including the cancer detection rate and the effectiveness and impact of policy changes.

Mitigate Barriers to Access to Oncology Care

Patients with cancer must have timely access across the cancer continuum of care, from early detection and screening through to survivorship and end-of-life care. This requires access to specialists, centers of excellence, patient navigators, and other support services that ensure coordinated care transitions. Barriers to access can result in delayed diagnoses, suboptimal treatment, and poor outcomes. Low-income patient populations with long travel distances to screening sites, or who lack health insurance or transportation to a medical facility, are less likely to have recommended cancer screening tests and be treated according to guidelines than those who do not encounter these obstacles.

NMQF's Diverse Cancer Communities Working group published an actionable framework to address cancer disparities based on recommendations from an expert roundtable.[29] The framework is an opportunity to integrate strategies and actionable approaches within the cancer care continuum to facilitate optimum care for medically underserved populations. The working group identified strategies across and within the cancer continuum of care in the following categories: community engagement, patient navigation, health equity, data collection, funding support, education and training, and clinical trials.

Stakeholders should undertake a range of activities to promote widespread, equitable access at all stages of a patient's journey.

Screening

Compared to non-Hispanic white people, American Indian/Alaska Natives are less likely to undergo diagnostic cancer screenings.

Referrals

Alaska Native Americans on average experience 13 referrals before getting into cancer care.[28]

Solutions to Enhance Access

1. **Promote Transparency**

   Patient knowledge and access to meaningful information are essential to positive long-term health outcomes. A patient's long-term success is jeopardized by the inability of the healthcare system to provide the full spectrum of services to meet all their needs. This includes understanding a patient's ability to access care, benefits, insurance status, and the type(s) of individualized support services needed. Legislative changes that would enable systemic change could take form through federal insurance regulation to require transparency into plan benefits and available patient support options. This includes expanding on recent legislative activities like the Hospital Price Transparency Requirements and the Medicare Advantage regulations requiring plans to adopt tools that provide clinicians with information to discuss out-of-pocket drug costs with patients.

2. **Provide Additional Services to Address Social Needs**

   Promote integration of medical and non-medical services, including transportation and housing, by ensuring systems allow for and incentivize collaboration between care delivery organizations, community-based organizations, and service providers. This will require ensuring adequate reimbursement, appropriate incentives, and building a data infrastructure to facilitate coordination and communication.

3. **Increase Access in Rural Areas**

   Increase cancer screening rates in rural areas and minority communities where the screening rates are significantly lower. Programs such as the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides a framework for establishing new screening programs and serve as a resource for improving access to care in rural communities.[30] In conjunction with increasing screening rates, patient care plans need to be established to encompass treatment options, post-screening navigation/patient support, care coordination, and insurance counseling.

4. **Promote Access to Telehealth Services**

   Policymakers should build upon existing efforts by the federal government in the wake of the COVID-19 pandemic to expand access to telehealth services, particularly in rural areas where lack of providers and/or transportation needs exist. By increasing provider reimbursement for telehealth services focused on screening and detection, policymakers can make important strides in reaching patients who require greater access to the healthcare system. Evidence has shown that public health measures to address the pandemic have led to a steep drop in cancer screenings and preventative care appointments, significantly increasing the risk of undetected cancer diagnoses and worsening clinical outcomes. As the US emerges from the pandemic, telehealth visits should be an enduring tool of the US reimbursement system to improve access to care.

Increase Affordability of High-Quality Care

Medical and non-medical costs are a significant financial burden for cancer patients, even for those with insurance. High out-of-pocket costs can result in patients forgoing or delaying necessary care and avoiding filling prescriptions in a timely fashion, thus having a negative impact on outcomes. Further, affordability challenges have a disparate impact on minority communities due to underlying disparities in income.

Manufacturers, plans, and other entities should consider opportunities to work closely with patient advocates and community-based organizations to ensure patients have the resources they need to gain holistic access to treatments and services. However, current federal policies may discourage certain types of collaboration between health plans, providers, and manufacturers to directly address patient needs, which can reduce these stakeholders' ability to provide additional support to patients to mitigate affordability barriers patients face.

Americans living in rural and/or low-income geographies are more likely to die from cancer than those living in urban areas.[31]

A 2017 cross-sectional study found "cancer death rates varied significantly in counties of different income levels, with a mean cancer death rate per 100,000 person years of 185.9 in high-income counties, 204.9 in medium-income counties, and 229.7 in low-income counties."[32]

Solutions to Help Address Affordability Barriers in Oncology Care

1. **Modify Policies to Remove Barriers to Collaboration**

   Federal statutes may inhibit manufactures from collaborating with health plans and providers in a holistic, patient-centered care approach. Policymakers should consider whether the anti-kickback statute (AKS) could be adapted to allow for manufacturers to engage with patients in a more meaningful way. This could include allowing engagement related to transportation, post-screening care plans, etc., that could mitigate future financial barriers to care that plague minority communities seeking support for oncology care.

2. **Promote Adherence Programs**

   Strengthen adherence programs and increase the speed with which patients who are struggling to afford treatment are appropriately connected to the resources they need. Organizations may consider linking adherence programs to patient support programs, so patients are able to receive the support they need through one vehicle of communication.

3. **Pursue Reforms that Limit Patient Out-of-Pocket Costs**

   Any reforms targeted at reducing healthcare costs must result in lower out-of-pocket costs for patients. Policymakers should identify opportunities to limit the coinsurance and copays that patients must pay for their medications. Of equal importance, policymakers should pursue an annual out-of-pocket cap for Medicare patients, like that which exists in the commercial market, to prevent patients from being forced to choose between access to necessary and potentially life-saving treatments and financial solvency. In addition, within the commercial market, policymakers should consider reforms to address high out-of-pocket caps, which, while offering patients some protection, may still limit access.

4. **Support Policies that Limit Aggressive Plan Utilization Management**

   Step therapy and “fail first” policies are increasingly used by health plans to limit access to prescribed treatments. While certain plan management techniques may be appropriate, policymakers should seek to limit utilization management controls that deviate from existing standards of care and clinical guidelines. Pharmaceutical value-based agreements (VBAs) have the potential to improve patient access to novel therapies while improving long-term patient outcomes. VBAs allow for risk mitigation through shared risk between the manufacturer and payer, which may lead to decreased step therapy or prior authorization barriers patients often face for novel treatment. Further, VBAs could serve as a mechanism for determining patient-centric clinical and economic value measures that reflect patient outcomes and real-world evidence, creating a virtuous cycle of data generation and value assessment that supports addressing SDoH throughout the care continuum.

Leverage Data to Catalyze Change

Manufacturers, payers, and other stakeholders are increasingly collecting, analyzing, and visualizing data about cancer prevalence and health care utilization in relation to data about race, income, and other patient and community-level SDoH, making it possible to understand how social risk factors affect access to quality of care and health outcomes. Despite tremendous advances in health record collection, there is a lack of visibility across providers in non-clinical needs, such as a patient's built environment.

Understanding where a cancer patient lives, works, learns, and plays is important to meeting an individual's goals and needs related to their long-term treatment plan. As stakeholders seek to combat disparities, data advancements can inform decision-making and make it timelier and possible to identify where and how to successfully intervene to address unmet needs. In addition to the patient-level SDoH, manufacturers also play a role in determining the circumstances and environments we live in, thus contributing to the SDoH that impact health equity in the communities where they operate.

Bold Goal Initiative

One such example is the innovative partnerships within Humana's Bold Goal initiative, a population-based initiative aimed at improving the health of communities.[33] Through the Bold Goal initiative, Humana has embedded SDoH into benefit plans which enables Humana's At Home programs to screen members for food insecurity, social isolation, and loneliness.

Solutions to Use Data to Address Health Equity

1. Increase Transparency and Make Data Publicly Available

Researchers, policymakers, and other stakeholders must be able to access representative data on race, ethnicity, gender, the access to services that patients have, etc., across healthcare markets to identify needs and barriers to care. To do so, stakeholders should engage partners to advance existing data-sharing or data-integration efforts; share data across sectors; and build relationships among community and state partners to support joint goals for improved health, well-being, and equity.

2. Target Interventions Using Data

Data can be used to transform existing approaches to increase access to screening and medications for minority communities. Through multi-stakeholder collaborative partnerships, industry leaders should develop new models that optimize how data can be integrated into each level of patient care to drive patient-centered decision-making.

3. Continue and Expand Ongoing Data Collection and Monitoring Efforts

The Centers for Disease Control and Prevention (CDC) is the primary agency responsible for monitoring the impacts disparities have on mortality and morbidity rates. Stakeholders may consider working with the CDC to identify new methods to expand monitoring of health outcomes by socioeconomic status and social risk factors in addition to race/ethnicity.

4. Expand Digital Health Solutions for the Treatment of Chronic Conditions

Policymakers should explore new opportunities to promote access to digital solutions such as connected drug/device delivery systems and medical mobile applications that can promote adherence to prescribed treatments for chronic conditions. Reimbursement of such digital health can be fragmented and inadequate, especially within government insurance markets. Policymakers should improve the reimbursement system that can promote access to mobile health technologies designed to increase patient engagement and improve treatment adherence.

Path Forward

The Robert Wood Johnson Foundation defines health equity as when "everyone has a fair and just opportunity to be as healthy as possible." The widening gap in disparities for cancer patients is yet another reminder of how far we are from this goal and the reality that exists today in the US. As noted in this paper, the disparities in race and ethnicity are shown through mortality and morbidity data and access to social determinants like affordable healthy food, a safe home, education, and health care. These are all directly correlated to a patient's health. To address inequities in cancer care, NMQF and Eli Lilly support collaboration to mitigate the dominating effect of social risk factors on communities of color.

AACR Cancer Disparities 2020 Report shows approximately 34% of cancer deaths among U.S. adults between the ages of 25 and 74 ages could have been prevented if socioeconomic disparities were eliminated.[34] Addressing cancer health disparities will require a multi-faceted stakeholder engagement commitment. Cancer disparities affect the entire healthcare system. Research illustrates eliminating health disparities for racial and ethnic minorities could reduce direct cancer care medical costs by more than $157B.[35]

CEO Action for Racial Equity is a coalition of stakeholders from the healthcare, finance, consumer, education, and business community. Their growing issue agenda mobilizes Corporate America to confront barriers in access to healthcare, technology, public safety, and the polls. Their collaborative efforts allow them to bring different types of thinking to solve for large scale health equity challenges across sectors.

1. Ensure Accountability

In April 2020, a set of Senators introduced the Health Equity Accountability Act.[36] The comprehensive legislation would expand access to immigrant and rural communities, improve care to the underserved through enhanced language access services, provide provider training on cultural competency and investments in diversifying the workforce. Part of this legislation intends to dismantle patient assistance funding barriers and fund programs to support mental, maternal, and reproductive health for underserved populations. The legislation also increases federal resources to address diseases that disproportionally impact minority communities and fund strategies to address social determinants of health. This type of accountability at the federal level is precisely what is needed to impact ways in which health systems, states, and community-based organizations are held accountable for providing equitable care across disparate populations. Creating learning systems of change and implementation can also support health system accountability and transparency to address disparities.

2. Build Trust

Minority communities may lack trust in the health care system for many reasons, among them a history of discrimination and the failure of health care institutions to provide culturally sensitive care. Interacting directly with the community is the key to success in understanding the communities being served. Going into the community to encourage cancer screenings is important, but given that most of the services (like clinical trials) only occur at cancer centers, having people that represent the minority communities on site is crucial to building comfort for communities of color. Building relationships with minority-owned businesses is one vehicle to increasing trust among minority communities. Lilly collaborated with National Center for Bioethics in Research and Health Care at Tuskegee University with the goal of understanding and publishing perspectives on how to build trust among the African American Community.[37]

The Integrated Model of Trust, the only model that builds trust into the clinical development process, frames trust development through integrated clinical and business perspectives. By focusing on the process rather than outcomes of trust-building diverse trial participants, clinical trials teams, participants, and cancer centers may be able to better understand, measure, and manage their trust relationships in real time. Ultimately, this may foster increased recruitment and retention of diverse populations to clinical trials.

3. Collaborate

Discussions on how to address affordability, access, and wide-ranging health disparities have repeatedly come back to this same point: none of these issues can be solved by one sector alone. Recognizing the weight that social determinants play on society and that the environments in which we work and live are largely responsible for the health of a community, a “raise all boats” approach is needed to combat health and health equity. Throughout this white paper, we have highlighted the need for cross-sector collaboration, where public health, healthcare, and social services work together with communities. An example of a cross-sector collaboration could include a health plan, provider, and community-based organization working together to address chronic health conditions (e.g., diabetes) through nutrition and social support interventions. These types of interventions, where we go beyond the medical care a patient needs, are the key to advancing health equity and reducing disparities in care.

Reimagining equitable high-quality cancer care is achievable through multi-sector, patient-centric collaborative networks. Effective policies, operational strategies, and practice interventions will reflect the intersection of data science, patient engagement, and racial justice disciplines. Lilly and NMQF are committed, through our joint and individual endeavors, to bringing key stakeholders and thought-leaders together to develop an equity-focused health and health policy roadmap to guide us towards our common goal.

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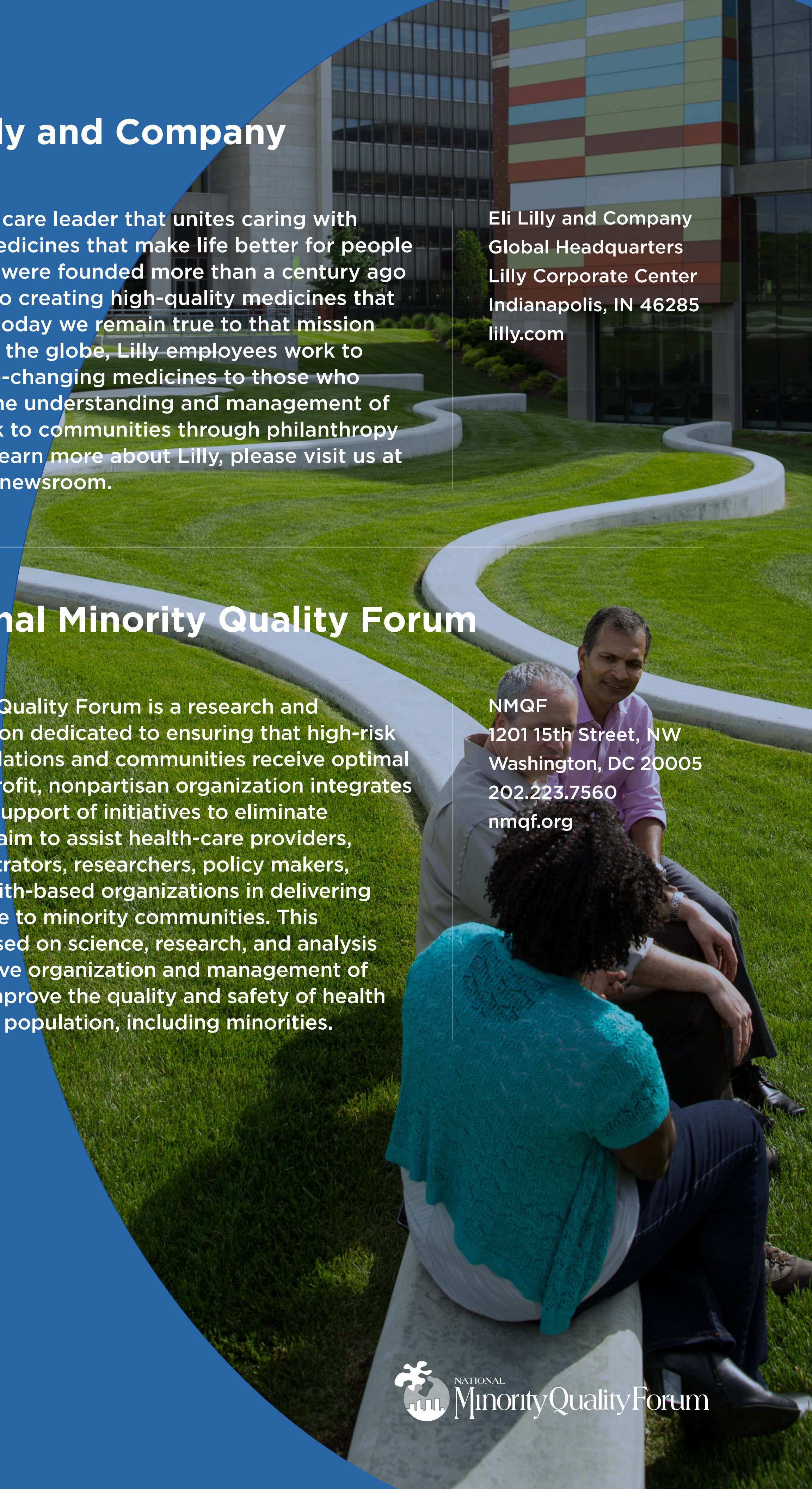

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Eli Lilly and Company
Global Headquarters
Lilly Corporate Center
Indianapolis, IN 46285
lilly.com

About National Minority Quality Forum

The National Minority Quality Forum is a research and educational organization dedicated to ensuring that high-risk racial and ethnic populations and communities receive optimal health care. This nonprofit, nonpartisan organization integrates data and expertise in support of initiatives to eliminate health disparities. We aim to assist health-care providers, professionals, administrators, researchers, policy makers, and community and faith-based organizations in delivering appropriate health care to minority communities. This assistance must be based on science, research, and analysis that lead to the effective organization and management of system resources to improve the quality and safety of health care for the entire U.S. population, including minorities.

NMQF
1201 15th Street, NW
Washington, DC 20005
202.223.7560
nmqf.org