**Administrative Supplements for the P30 Cancer Center Support Grants to advance research in persistent poverty areas**

**Background**

Despite advances in cancer prevention, diagnosis, treatment, and survival, disparities in cancer outcomes continue to persist, with increased mortality among people living in poverty. Populations living in poverty in the United States —in particular those in persistent poverty, face higher rates of morbidity and mortality. To shed light on this aspect of poverty, the US Department of Agriculture’s Economic Research Service (ERS) has defined counties as being persistently poor if 20% or more of their populations were living in poverty based on the 1980, 1990, and 2000 decennial censuses and the 2007-11 American Community Survey 5-year estimates. Using this definition, there are 353 persistently poor counties in the U.S. (comprising 11.2% of all U.S. counties). The large majority (301, or 85.3%) of the persistent poverty counties are nonmetro, accounting for 15.2% of all nonmetro counties. Persistent poverty also demonstrates a strong regional pattern, with nearly 84% of persistent poverty counties located in the South, comprising more than 20% of all counties located in the region (<https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/>).

An important dimension of poverty is its persistence over time. An area that has a high level of poverty this year, but not next year, is likely better off than an area that has a high level of poverty for a longer time period. Persistent poverty areas are at an increased risk of cancer due to multiple factors, including greater carcinogen exposure, lower educational attainment, lack of adequate housing, food insecurity, and the lack of access to care. All these factors result in increased cancer incidence and delayed cancer diagnosis, treatment, and subsequently, lower rates of survival. In particular, people living in poverty have higher rates of cancers caused by occupational, recreational, or lifestyle exposures (e.g., colorectal, laryngeal, liver, lung) and by human papillomavirus infection (e.g., anal, cervical, oral).

**Purpose**

The National Cancer Institute (NCI), Division of Cancer Control and Population Sciences (DCCPS), announces the opportunity for recipients of NCI-funded P30 Cancer Center Support Grants to submit requests for administrative supplements to enhance research capacity in persistent poverty areas. These projects should be designed to conduct studies in collaboration with key health care clinics and/or safety net providers serving low-income and/or underserved populations in persistent poverty areas.

The purpose of this opportunity is to provide resources to support the time and effort of multidisciplinary teams at NCI-Designated Cancer Centers, in collaboration with clinics that serve underserved populations living in persistent poverty areas, to plan, implement, and sustain a cancer control research program that focuses on low-income and/or underserved populations. As such, awardees will be expected to address challenges and opportunities related to working in partnership with these clinics, and enhance delivery of cancer control and prevention strategies to improve overall health and lessen the burden of cancer in these areas. The long-term goal of this supplement is to build the capacity for health care clinics and/or safety net providers to build cancer prevention and control research for the implementation of evidence-based programs and practices focused on low-income and/or underserved populations in persistent poverty areas.

There are several areas where NCI can play a significant role in advancing cancer prevention and control research in persistent poverty areas. These supplements are a part of a larger NCI research initiative to inform, test, and strengthen cancer control programs that are sustainable in these communities across the United States.

**Goals of This Supplement**

The primary aims of this one-year supplement opportunity are 1) the successful development of a collaboration with communities and clinics in persistent poverty areas (defined above) to conduct studies in cancer prevention and control; 2) data compilation, analyses, and/or integration; 3) collection of preliminary data for research proposals and/or for pilot projects in cancer control; and 4) to enhance and study implementation of programs for research in cancer prevention and control.

Many safety net providers are focused on delivery of primary care, and as such, may have limited research infrastructure or previous experience participating in cancer prevention and control research. Cancer centers are encouraged to work with these clinics to build and implement a cancer prevention (primary and secondary) and control research agenda. These areas may also face the added burden of being designated Health Professional Shortage Areas. DCCPS has developed a list of counties and zip codes of geographically underserved areas, which can be found at <https://cancercontrol.cancer.gov/research-emphasis/health-disparities/underserved-areas>.

Projects may focus on one or more of the cancer control continuum areas, including survivorship. Partnerships with community-affiliated clinics or hospitals; state offices of health; area health education centers; state health associations; primary care networks or associations; departments of health, education, or human services; and other community organizations are strongly encouraged. Engagement of clinic partners, community advisors, and other relevant stakeholders are encouraged.

By supporting more preliminary work and pilot projects, NCI hopes to ultimately increase the funded grant portfolio focused on persistent poverty populations that will lead to developing strategies that can be implemented in these communities.

These supplements are not intended to be focused on community outreach or building community awareness for cancer control programs.

**Eligibility and Budget**

* This opportunity is open to all currently funded P30 Cancer Center Support Grants.
* Only one supplement request per center will be considered.
* Cancer centers are encouraged to form research partnerships to work with communities/universities who have affiliations with persistent poverty counties that have previously not been affiliated with cancer centers.
* Preference will be given to these applications that focus on rural persistent poverty areas. Applicants are requested to define the rural population for the proposed study based on the non-metropolitan 2013 Rural-Urban Continuum Codes ([RUCC;](https://www.ers.usda.gov/data-products/rural-urban-continuum-codes/) see <https://www.ers.usda.gov/data-products/rural-urban-continuum-codes.aspx>) or the 2010 Rural-Urban Commuting Area ([RUCA;](https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/) see <https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/>) codes. Applicants are required to justify how their grant application addresses a persistent poverty population that is low income and/or underserved.
* Supplement requests may not exceed $200,000 total costs for one year.
	+ Budget should include funds to support the travel of two project team members to attend at least one annual meeting to discuss lessons learned from the program.
* Cancer centers whose P30 Cancer Center Support Grant will be in an extension at the time the award is made in FY21 are not eligible for this supplement.
* Awards will be based on responsiveness to this announcement, the range of applications representing different regions of the United States, and the availability of funds. It is anticipated that awards for this supplement opportunity will be made in September 2021.

**Application Submission Format**

Applications must be submitted electronically via eRA Commons to the parent award (P30) using PA-20-272 “Administrative Supplements to Existing Grants and Cooperative Agreements (Parent Admin Supplement)” on or before **May 21, 2021**. Your submission should follow the instructions in the funding opportunity announcement including the following:

* A detailed Budget and Budget Justification (using the SF424 forms)
* NIH Biographical Sketches for new key personnel proposed in the supplement
* Research Plan, not to exceed 5 pages (see below; no attachments or appendix are allowed)
* Letters of Support: Cancer centers proposing to work with AI/AN tribes/communities/clinics are required to submit letters of support and, if funded, obtain tribal resolutions/IRB before beginning data collection

**Research Plan** (5 pages) **should:**

* Provide a one-page justification that defines and explains the persistent poverty areas’ need for a cancer control program, particularly of low-income and underserved populations, and what research gap this would address
* Provide a justification for the research partnership and their role.
* Provide a background statement on any relevant existing services or resources offered in the cancer center, and any staff expertise for the expansion or incorporation into a new program for this effort.
* Describe the process that the lead staff member(s) will use to identify the appropriate framework and to incorporate strategies to elicit input from and address cancer control needs of the clinics and the communities they serve in persistent poverty areas. This should include how the program will address potential patient/clinic(s) barriers to developing a cancer control strategy and research program (such as how this program will fit into existing provider and/or administrative workflows, how staff will be engaging patients in the program), and how follow-up with community/patients will be conducted. It should account for the fact that many clinics are not designed to conduct research, and may not have the necessary preexisting infrastructure. It also should account for how their goals are to be incorporated into the cancer center’s research agenda.
* Outline a work plan that provides a timeline for development and implementation of the research (such as staff involved, staff training and hiring plans, IT integration). It should include milestones for tracking the progress of the work.
* Outline preliminary plans for sustaining the program beyond the funding period. The sustainability plan must include proposed methods to address barriers to implementation in health clinics and workforce, such as complexity of cancer care, licensing or proprietary tools, patient barriers (e.g., fatalistic beliefs about cancer, awareness/education, time, transportation, and monetary access barriers), cancer center staff time, ongoing costs, and insurance challenges.
* Provide an evaluation plan for the program. Please note that NCI may have its own metrics for conducting an evaluation of the supplement initiative, in which all the funded centers will participate.
* Include a statement of the qualifications for the identified lead(s) of the program.

For tracking purposes, please notify Stacey Vandor (Stacey.vandor@nih.gov) when you submit the application (but please do not send the application itself).

**Scientific Requirements**

Proposals will be reviewed by NCI staff experts for quality and for responsiveness to application criteria outlined above.

NCI will consider requests for supplements that include the following (but are not limited to):

* Data compilation, analyses, and/or integration to better understand cancer prevention and control challenges and to inform the development of interventions; and/or
* Collection of preliminary data for research proposals and/or for pilot projects in cancer control; and/or
* Implementation science study of programs for research in cancer prevention and control.

Applications may also include the following:

* Support for members of a multidisciplinary team to build and maintain the program, including an identified lead staff member (who may be either a health care provider or administrator).
* Inclusion of training of medical or non-medical personnel to build a cancer prevention and control research program in clinic settings.
* Implementation and utilization of telehealth systems and capacity to support and sustain cancer control research programs in clinics (including primary care clinics). Programs that purely use a telehealth program without on-the-ground partnership development will not be considered as responsive to this initiative.
* Where feasible, applicants are encouraged to consider a systems-based approach, i.e., one that integrates with electronic health care record systems and can be generalizable to additional centers or other parts of their health care system; extend cancer control services to family members of cancer patients and/or other persons within their health care system; and include written commitment to the program from leadership at the cancer center, clinic, and/or hospital and/or health care system(s) level (if relevant).

**Reporting Requirements**

As part of the progress report for the parent cancer center grant, information must be included on what has been accomplished via the administrative supplement (program details such as conceptual framework; tactics implemented; workflow incorporation; sustainability actions; progress on timeline tasks; and results from standardized evaluation measures on screening, reach, uptake, and other noted measures), as well as progress on the cancer center’s work and sustainability plans. Project leaders and their and partners (at least two from each cancer center) should plan to attend twice-annual meetings, where they will be expected to present their findings to other awardees of these supplements.

**Questions**

For technical inquiries, please contact your cancer center support grant program director. For inquiries about the scientific objectives and goals of this supplement, please contact Dr. Shobha Srinivasan (ss688k@nih.gov).