



CCADMW Webinar: COVID-19 and the Social Determinants of Health Disparities in Older Adults

Marvella E. Ford, Ph.D.

Professor, Department of Public Health Sciences

Associate Director, Population Sciences and Cancer Disparities, Hollings Cancer Center, Medical University of South Carolina

SmartState Endowed Chair, South Carolina State University



Hollings Cancer Center

An NCI-Designated Cancer Center

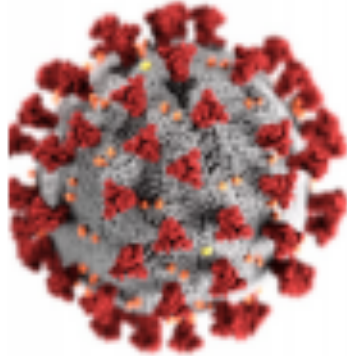
Definition of Health Disparities

"Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States." National Institutes of Health

Definition of Healthcare Disparities

Healthcare disparities refer to differences in access to or availability of facilities and services. **Health status disparities** refer to the variation in rates of disease occurrence and disabilities between socioeconomic and/or geographically **defined** population groups.

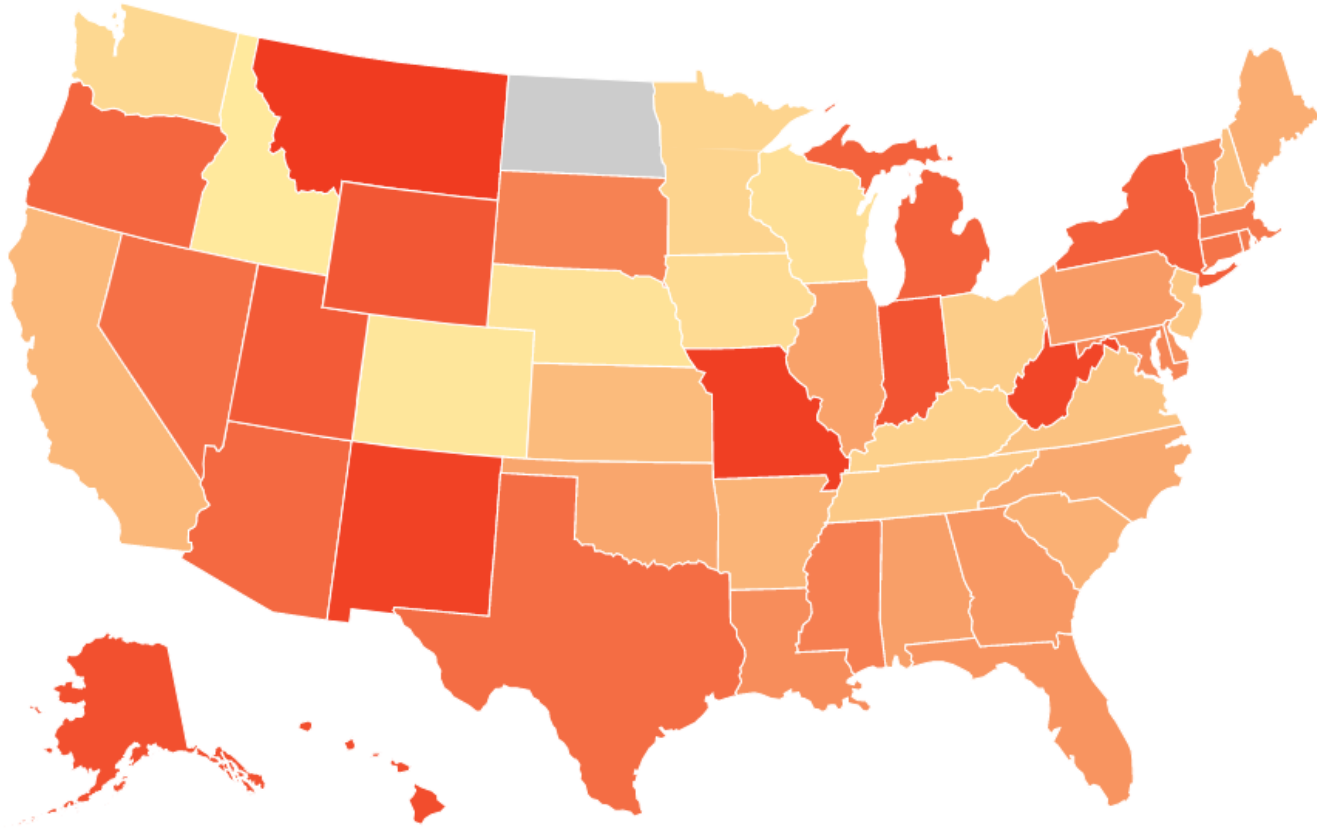
What Is COVID-19?



Know about COVID-19

- Coronavirus (COVID-19) is an illness caused by a virus that can spread from person to person.
- The virus that causes COVID-19 is a new coronavirus that has spread throughout the world.
- COVID-19 symptoms can range from mild (or no symptoms) to severe illness.

Racial Disparities in COVID-19 Cases, As of November 22, 2020

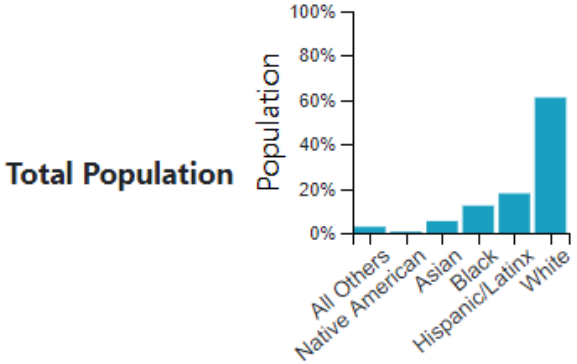


The redder the state, the greater the COVID-19 racial disparity. Source: <https://belonging.berkeley.edu/covid-19-race>

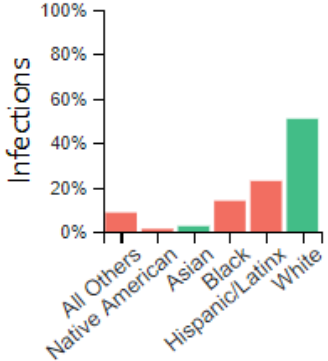
- Predominantly Black U.S. communities carry the burden of the country's COVID-19 cases and deaths.

Source: <https://www.esri.com/arcgis-blog/products/arcgis-living-atlas/health/new-data-collection-available-covid-19-health-racial-and-economic-equity/>

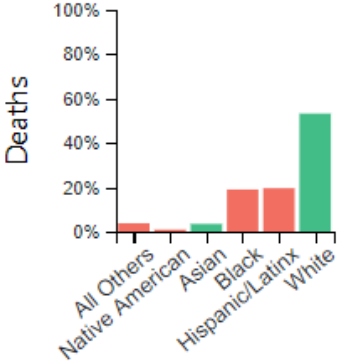
US Data As of November 22, 2020



COVID-19 Infections by race



Deaths from COVID-19 by race



COVID by Race/Ethnicity

| Rate ratios compared to White, Non-Hispanic Persons | American Indian or Alaska Native, Non-Hispanic persons | Asian, Non-Hispanic persons | Black or African American, Non-Hispanic persons | Hispanic or Latino persons |
|---|--|-----------------------------|---|----------------------------|
| CASES ¹ | 2.8x higher | 1.1x higher | 2.6x higher | 2.8x higher |
| HOSPITALIZATION ² | 5.3x higher | 1.3x higher | 4.7x higher | 4.6x higher |
| DEATH ³ | 1.4x higher | No Increase | 2.1x higher | 1.1x higher |

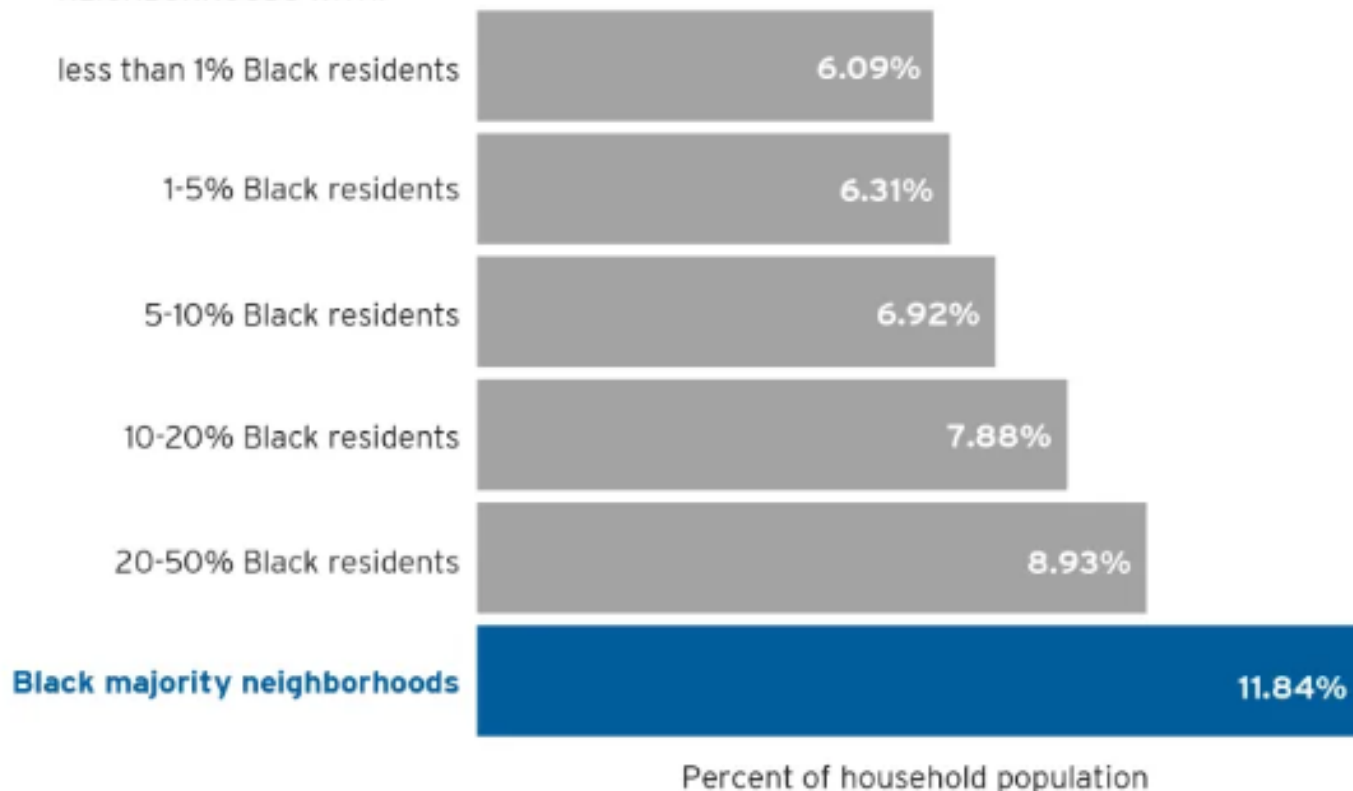
Race and ethnicity are risk markers for other underlying conditions that impact health — including socioeconomic status, access to health care, and increased exposure to the virus due to occupation (e.g., frontline, essential, and critical infrastructure workers).

cdc.gov/coronavirus — as of 10/30/20

Black majority neighborhoods have higher rates of multigenerational family cohabitation

Percent of household population that are extended family by neighborhood type

NEIGHBORHOODS WITH:

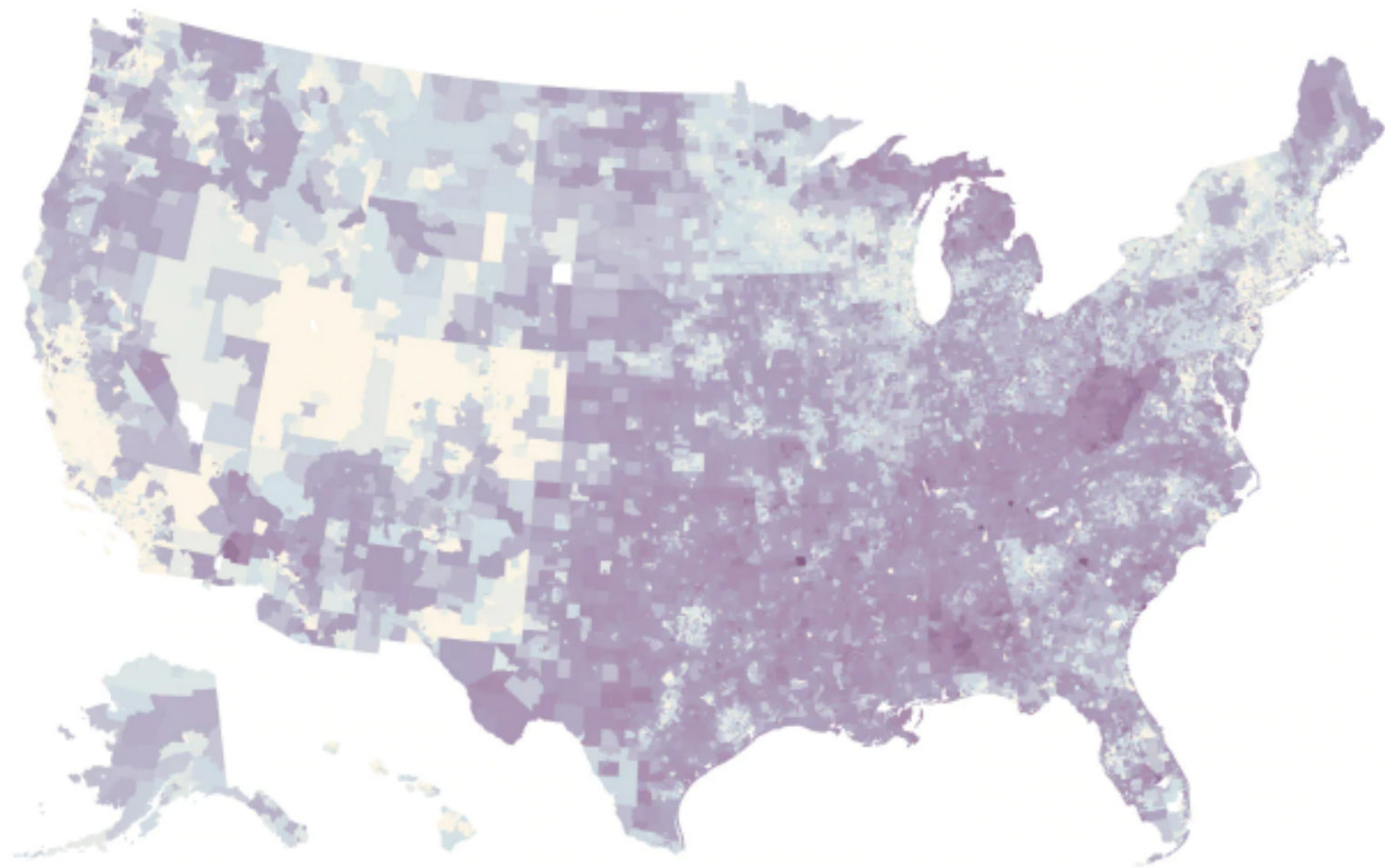


Source: Brookings analysis of 2014-2018 ACS 5-year estimate

B Metropolitan Policy Program
at BROOKINGS

High-risk health conditions above national rates

◀ Less risk  More risk ▶



South Carolina: FAST FACTS

COMMUNITY OUTREACH AND ENGAGEMENT

Population (SC / US)

2019 Population 5,148,714 / 328,239,523

Gender (SC / US)

Male 48.5% / 49.2%

Female 51.5% / 50.8%

Rural (SC / US)

33.7% / 19.3%

75% of SC counties include rural areas
(SC has 46 counties)

Race (SC / US)

White 68.5% / 76.5%

Black 27.1% / 13.4%

Asian 1.8% / 5.9%

Am.Ind./Al.Nat. 0.5% / 1.3%

Other 1.9% / 2.7%

(Nat. Haw./Oth./Pac. Isl./Two or More Races)

Ethnicity (SC / US)

Hispanic/Latino 5.8% / 18.3%

Education (SC / US)

High School or > 87.1% (US = 87.7%)

Bachelor's or > 27.4% (US = 31.5%)

Income (SC / US)

Per Capita \$27,986 / \$32,621

Median HH \$51,015 / \$60,293

SC

Median HH White \$54,000

Median HH Black \$31,000

Median HH Hispanic \$38,000

Below Poverty Level (SC / US)

Individuals 15.3% / 11.8%

Rural Coastal South Carolina Has Unique Needs and Opportunities



Rural Residents

Potential barriers to care:

- Transportation issues
- Distance to specialty care sites
- Access to cancer clinical trials

Unique Sea Island population:

- Primarily descendants of enslaved Africans from Sierra Leone
- Genetically and culturally distinct due to previous geographic isolation and low rates of genetic admixture

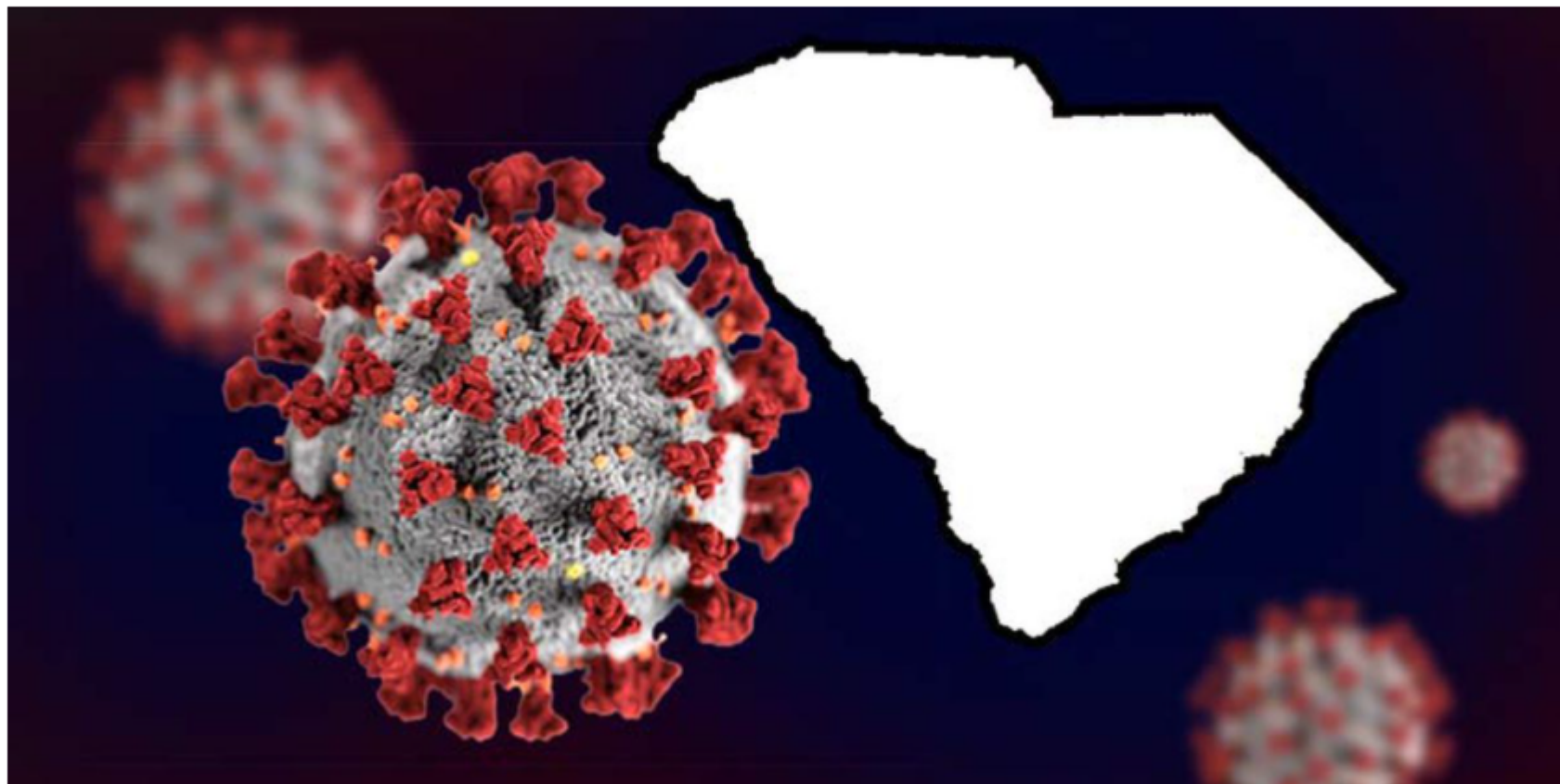
Bea, Cunningham, Ford et al.. 2018, Frontiers in Oncology-Cancer Epidemiology and Prevention.

Ford et al. 2020, Advances in Cancer Research.



January 6, 2021


South Carolina reports more than 4,000 new COVID-19 cases, percent-positive above 30%



The South Carolina Department of Health and Environmental Control reported 4,037 new cases of COVID-19 Wednesday along with 101 new probable cases. (Source: AP)

Reported Thursday, January 07, 2021 1:06 p.m.

Data as of Tuesday, January 05, 2021 11:59 p.m.

 New Confirmed Cases

3,935

Total Confirmed Cases


310,246

New Probable Cases

69

Total Probable Cases

27,866

 New Confirmed Deaths

51

Total Confirmed Deaths

5,189

New Probable Deaths

29

Total Probable Deaths

472

Individual Test Results

11,500

new individual test results reported
statewide (not including antibody
tests)

Percent Positive

34.2%

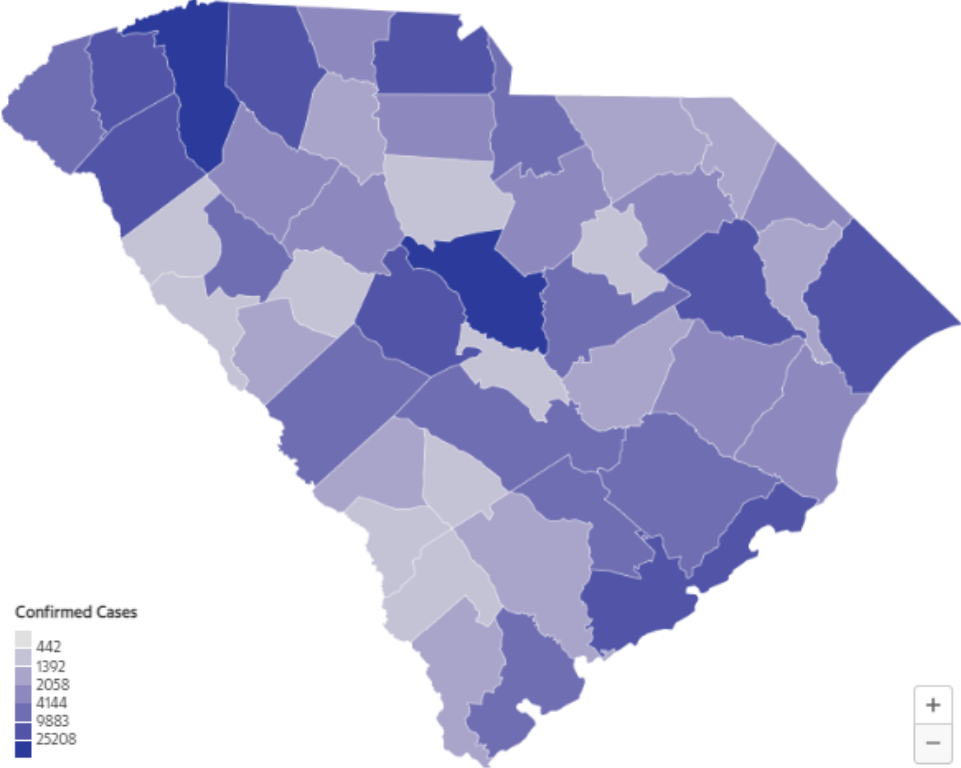
Total Tests

3,895,919

COVID-19 Cases in South Carolina, by County, as of January 6, 2021

SOUTH CAROLINA CASES OF COVID-19

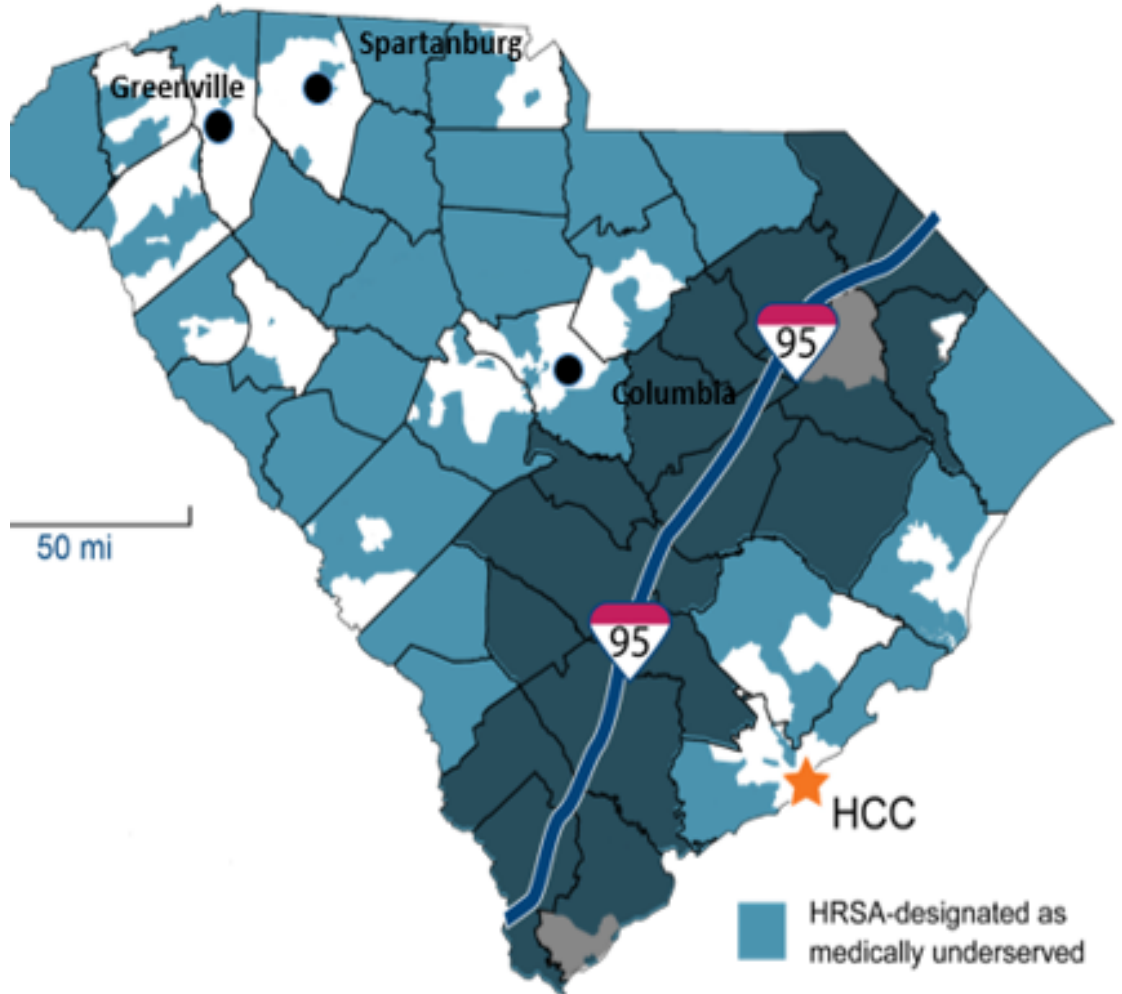
This map, created with data from the S.C. Department of Health and Environmental Control, displays the counties where COVID-19 has been reported and deaths confirmed.

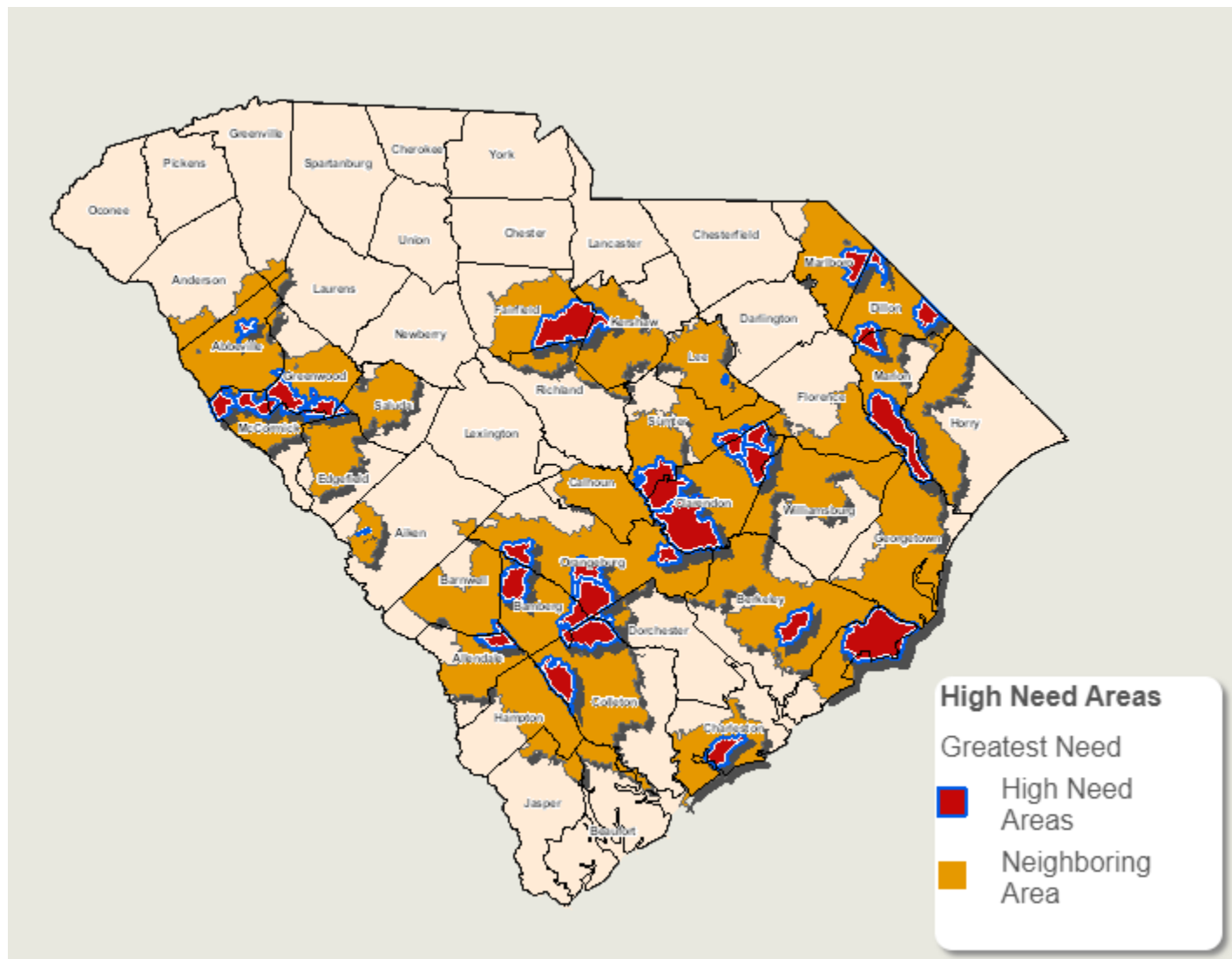


Tap a county to see the number of confirmed cases and deceased residents.

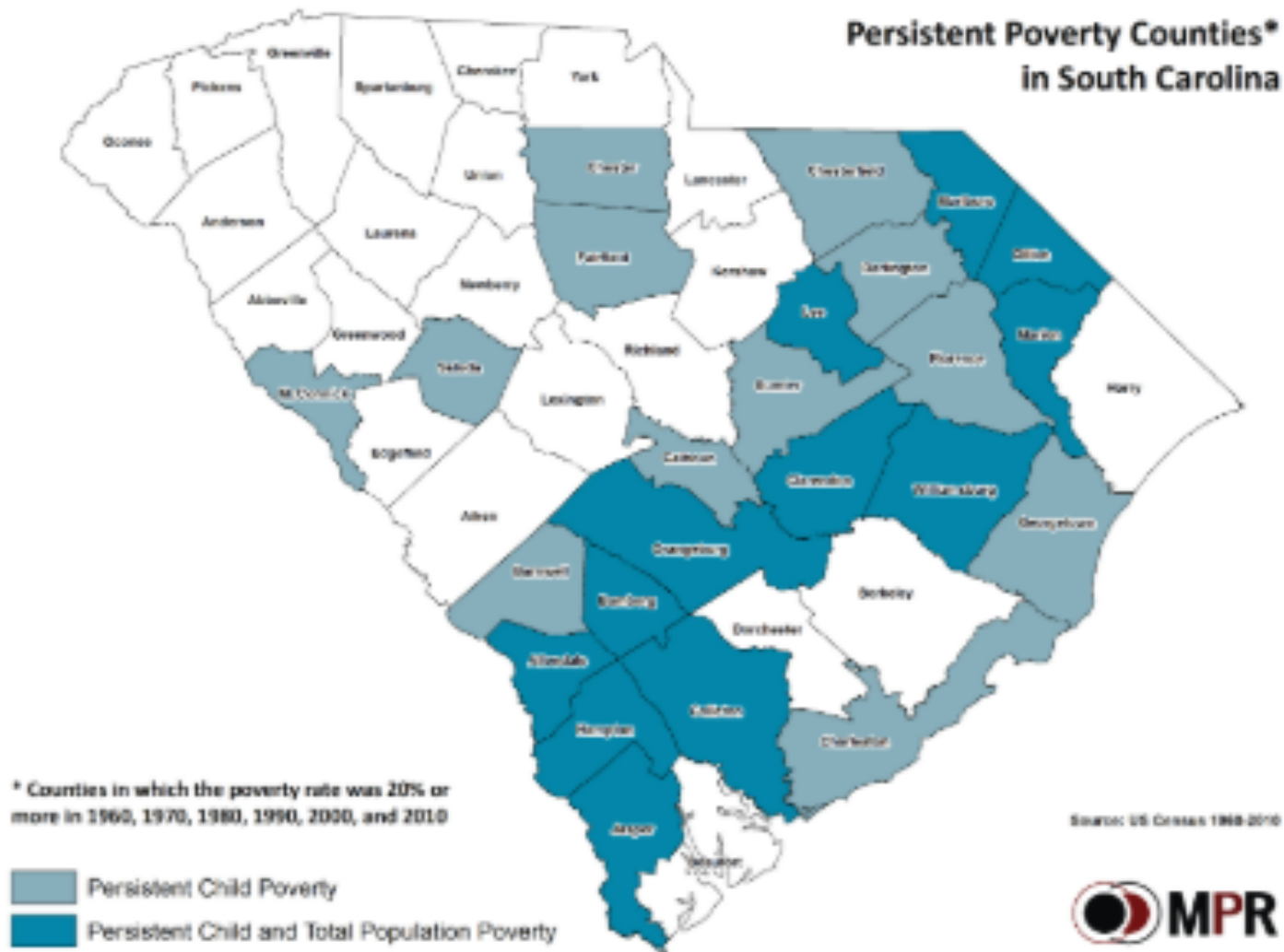
Map: Ben Connors and Emily Bohatch • Source: S.C. Department of Health and Environmental Control • [Get the data](#)

I-95 “Corridor of Economic Disadvantage”

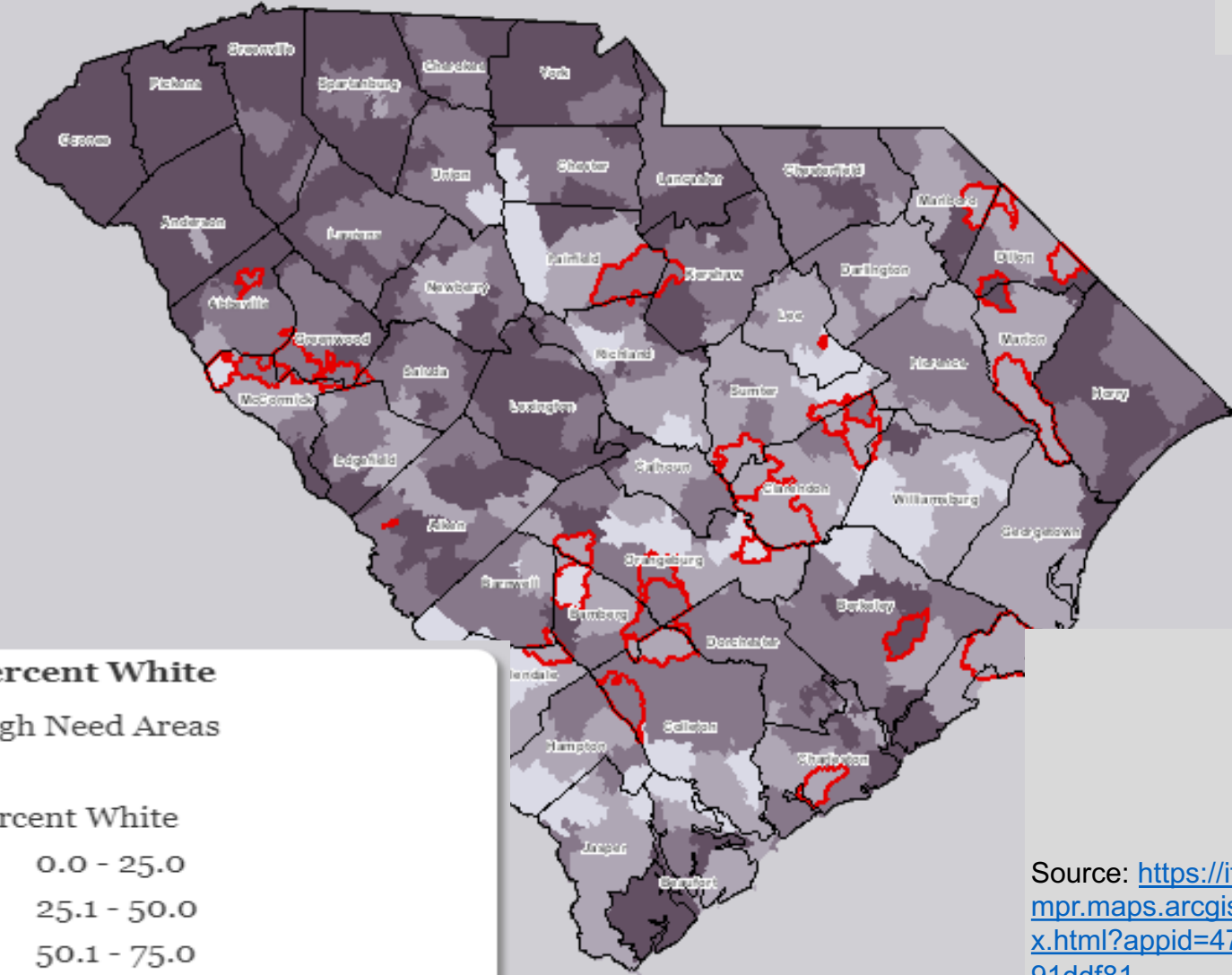




Persistent Poverty Counties* in South Carolina



Percent White



Percent White

High Need Areas

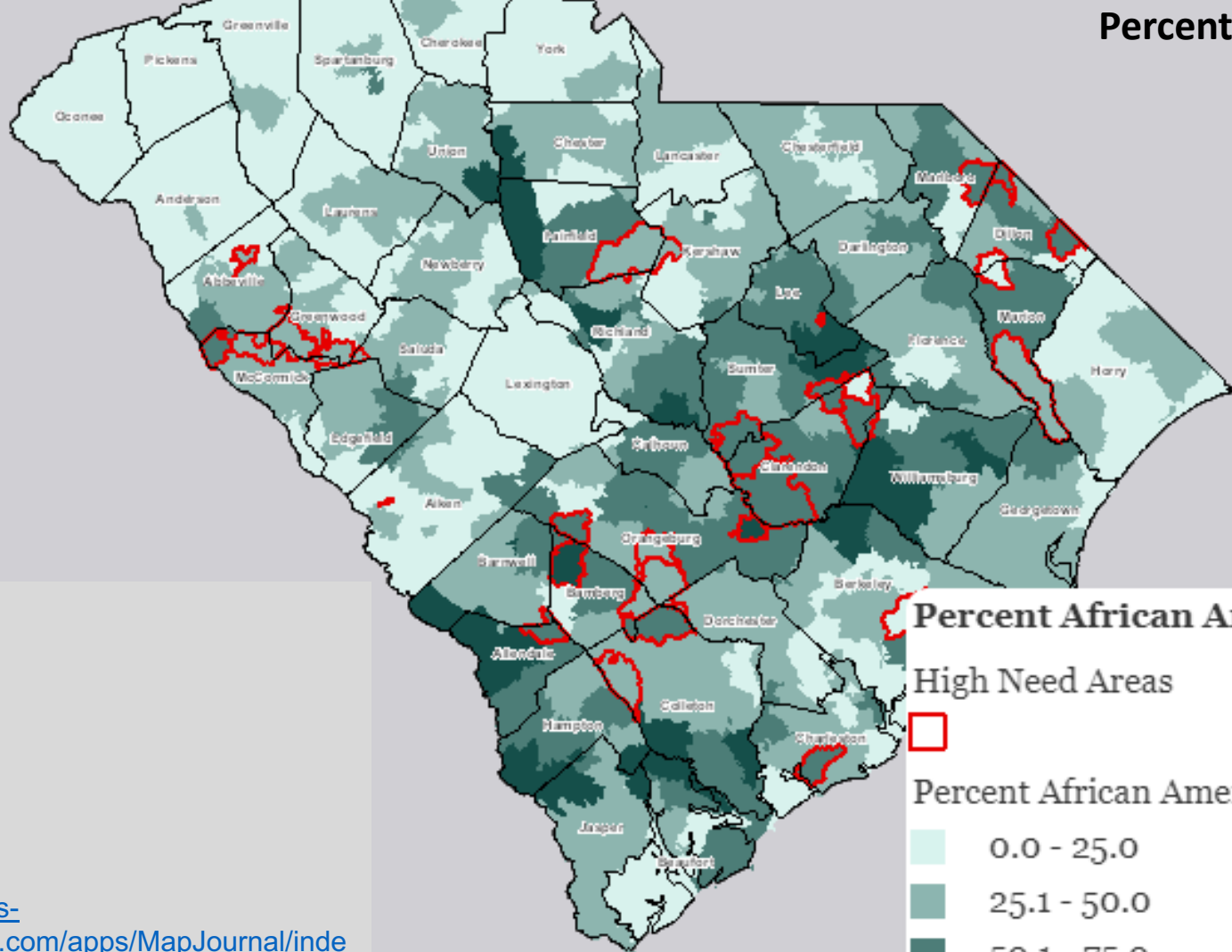


Percent White

- 0.0 - 25.0
- 25.1 - 50.0
- 50.1 - 75.0
- 75.1 - 100.0

Source: <https://ifs-mpr.maps.arcgis.com/apps/MapJournal/index.html?appid=47c9824a5b9e41219bc3f542191ddf81>

Percent Black



Percent African American

High Need Areas

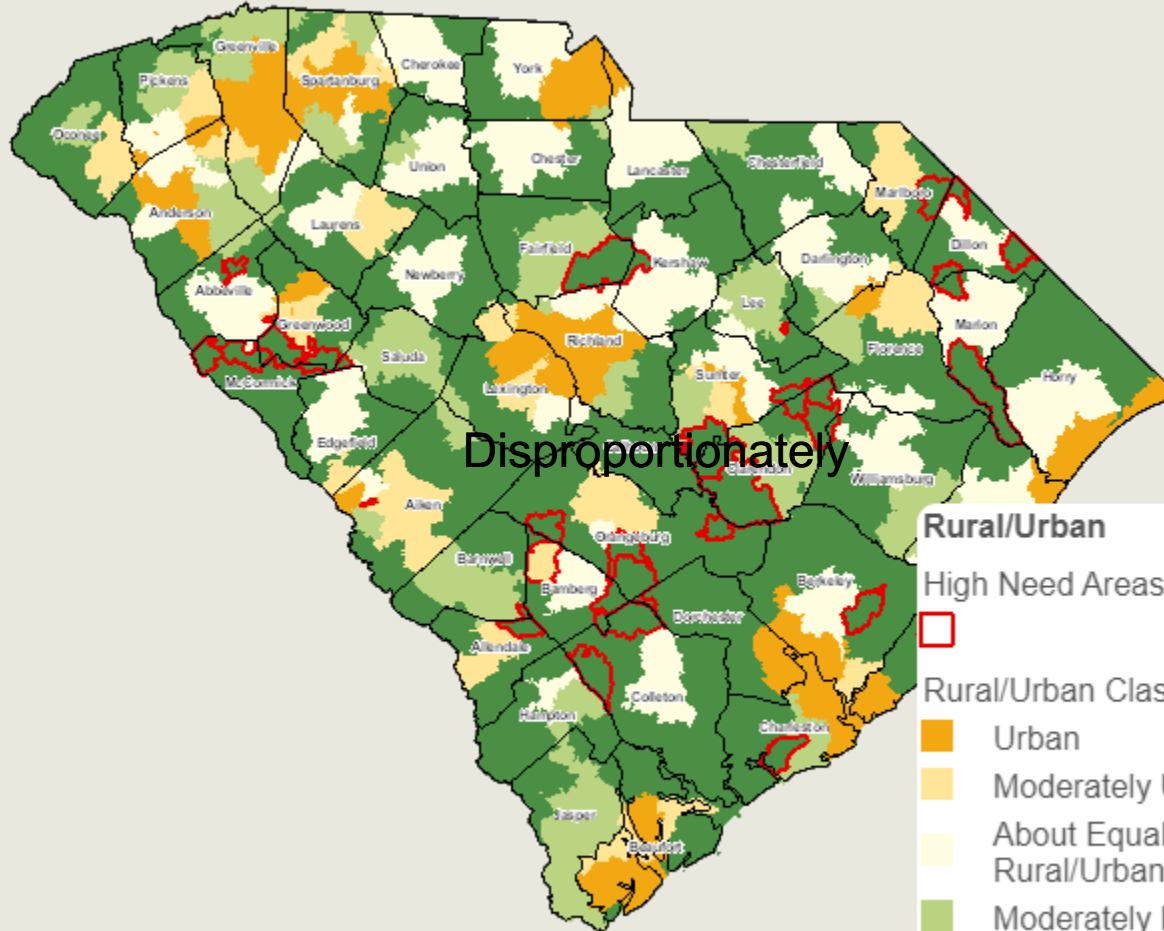


Percent African American

- 0.0 - 25.0
- 25.1 - 50.0
- 50.1 - 75.0
- 75.1 - 100.0


Source: <https://ifs-mpr.maps.arcgis.com/apps/MapJournal/index.html?appid=47c9824a5b9e41219bc3f542191ddf81>

Percent Rural








Disproportionately

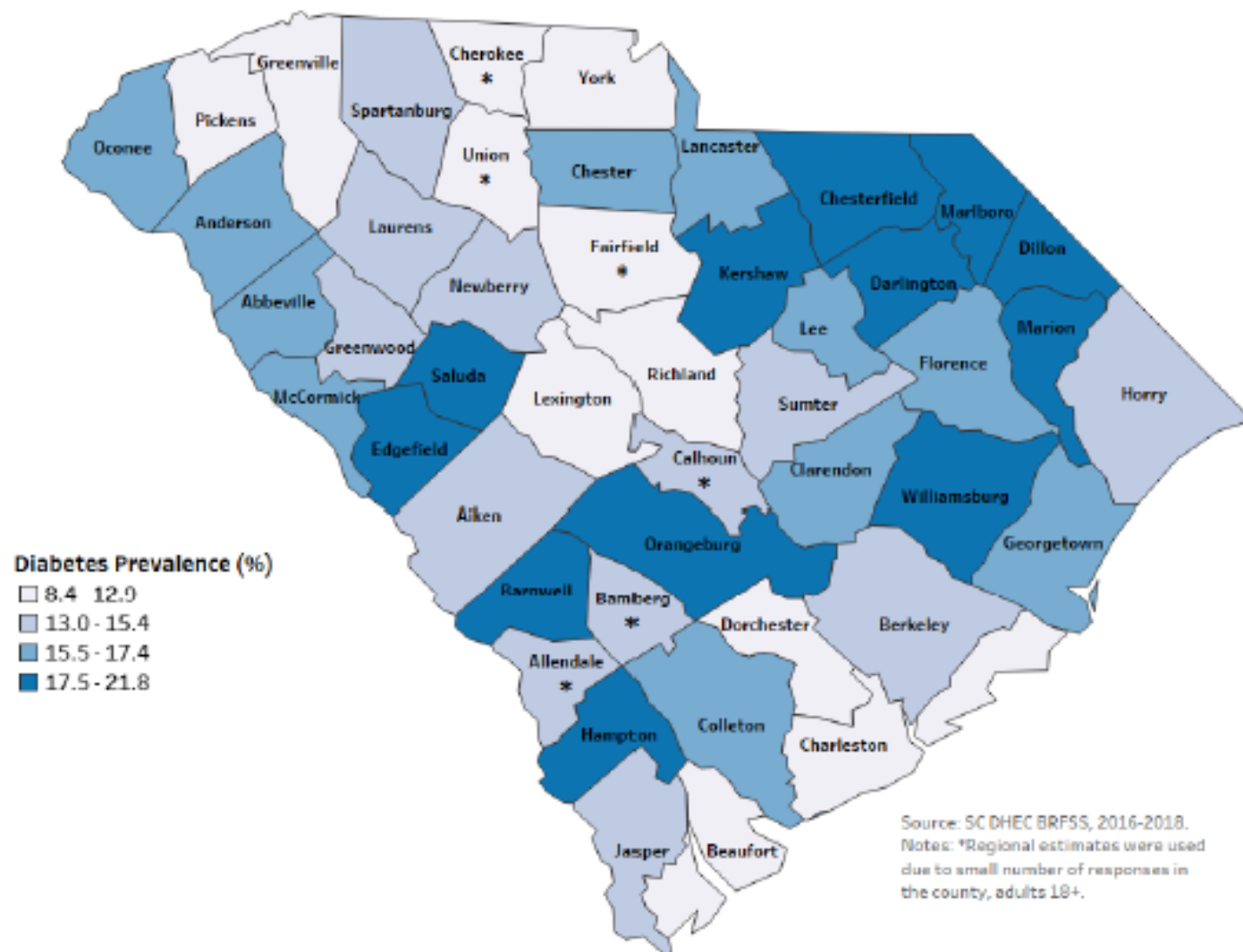
Rural/Urban
High Need Areas

 High Need Areas

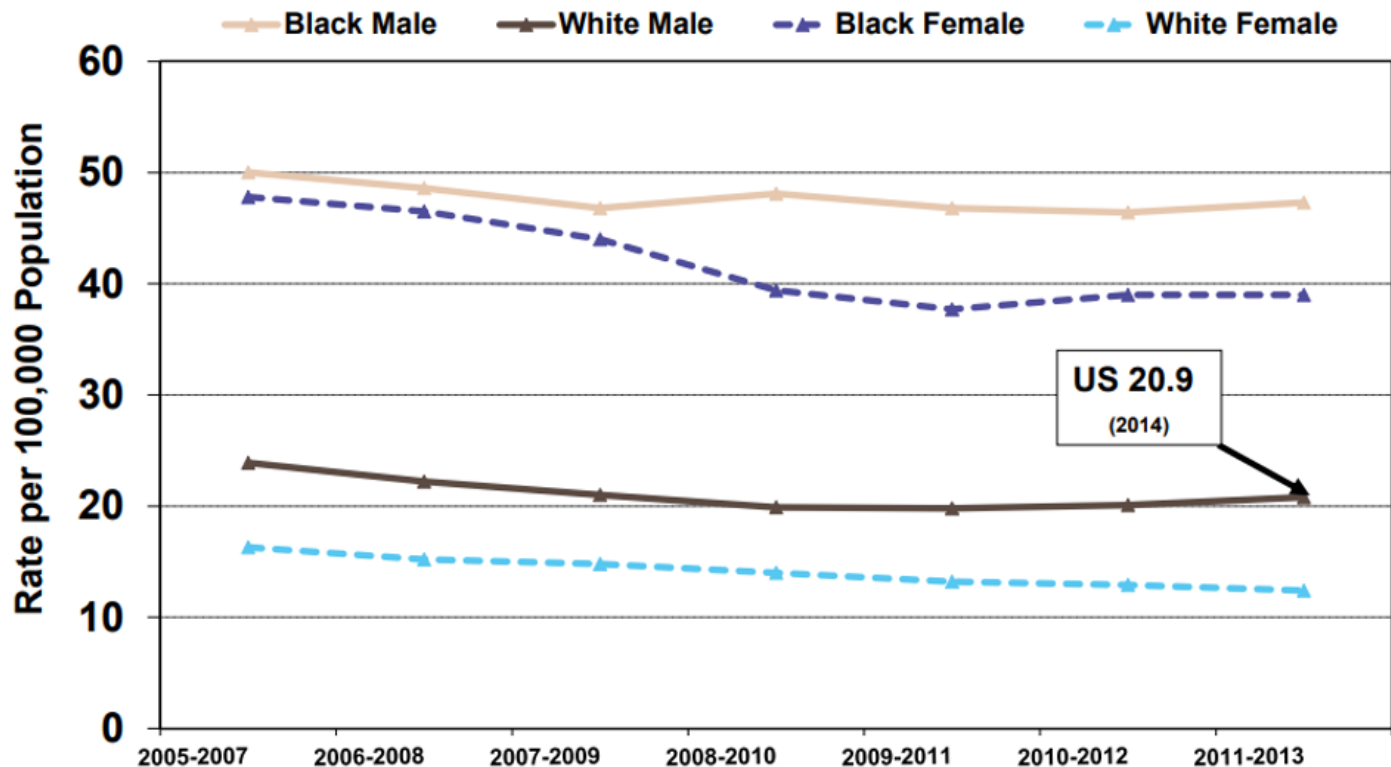
Rural/Urban Classification

-  Urban
-  Moderately Urban
-  About Equal Rural/Urban
-  Moderately Rural
-  Rural

Diabetes Prevalence Among Adults, 2016-2018



South Carolina Health Disparities: Mean Age-adjusted Diabetes Death Rates*

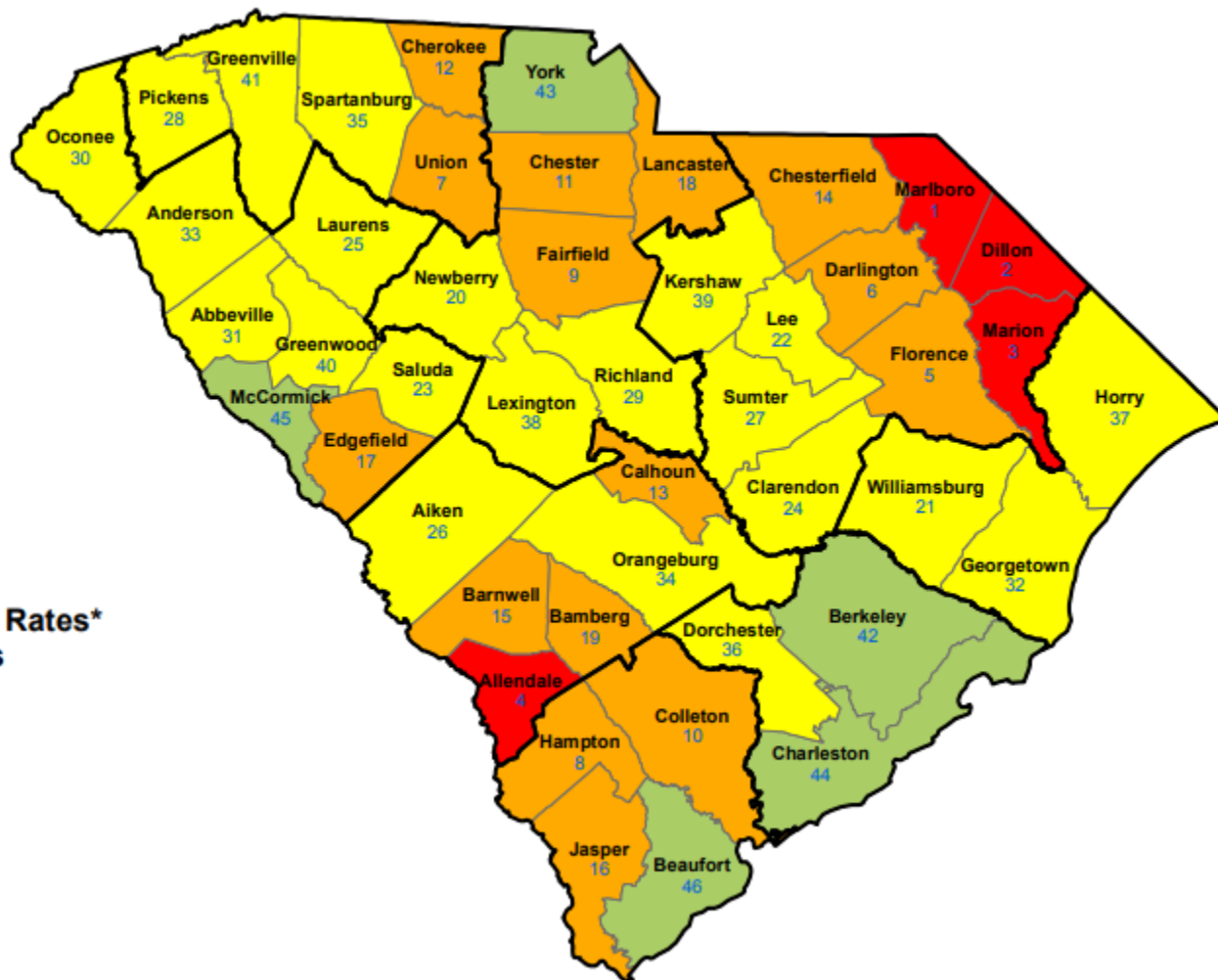


*Age Adjustment Uses 2000 Standard Population
Source: SC DHEC Vital Statistics, US CDC WONDER

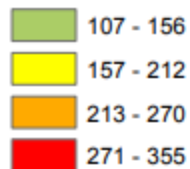
Generated by Division of Chronic Disease Epidemiology,
December 2015



Age-Adjusted Average Mortality Rates and Ranks for Heart Disease Among All Races in SC, 2010

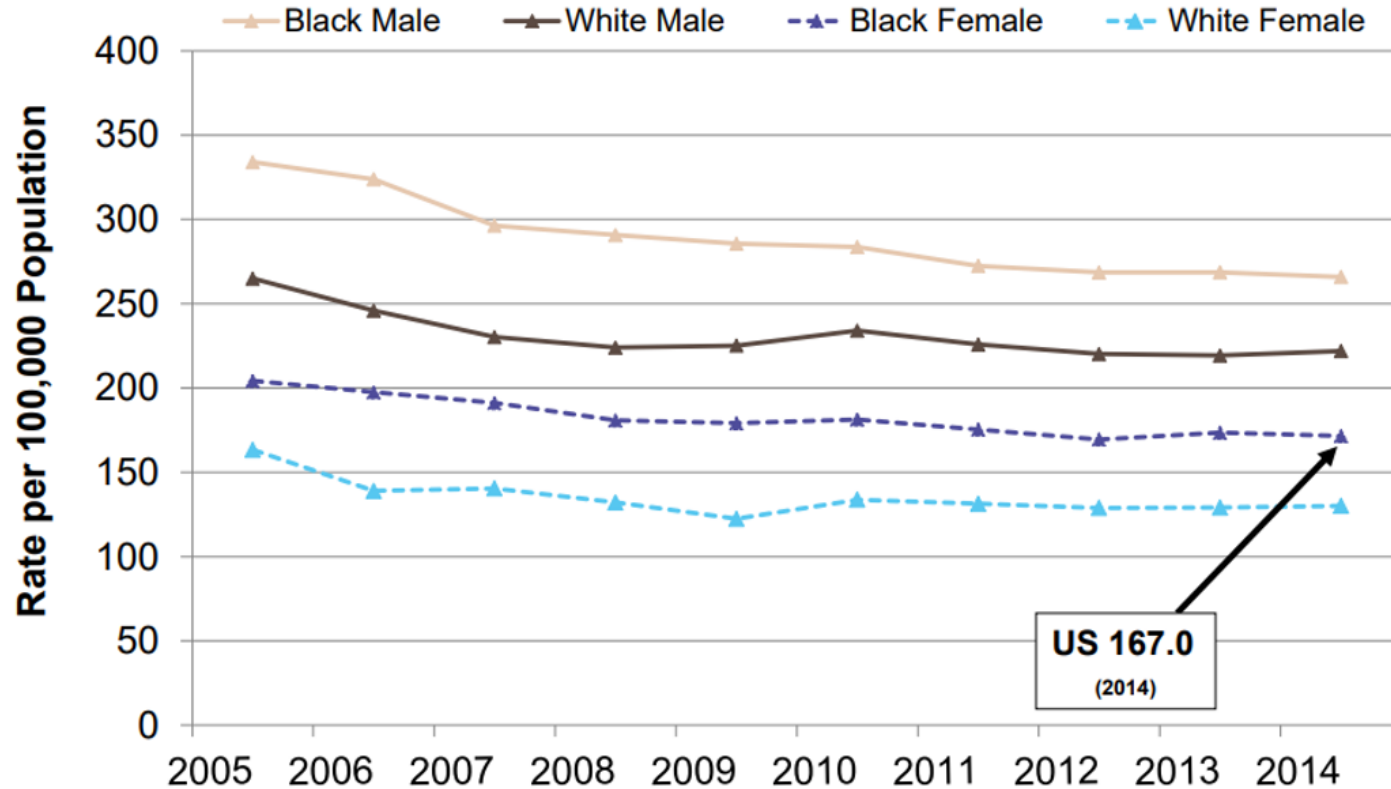


Heart Disease Mortality Rates* Among All Races



*Rates are per 100,000 people, age adjusted mortality to year 2000 Population.

South Carolina Health Disparities: Age-adjusted Heart Disease Death Rates*

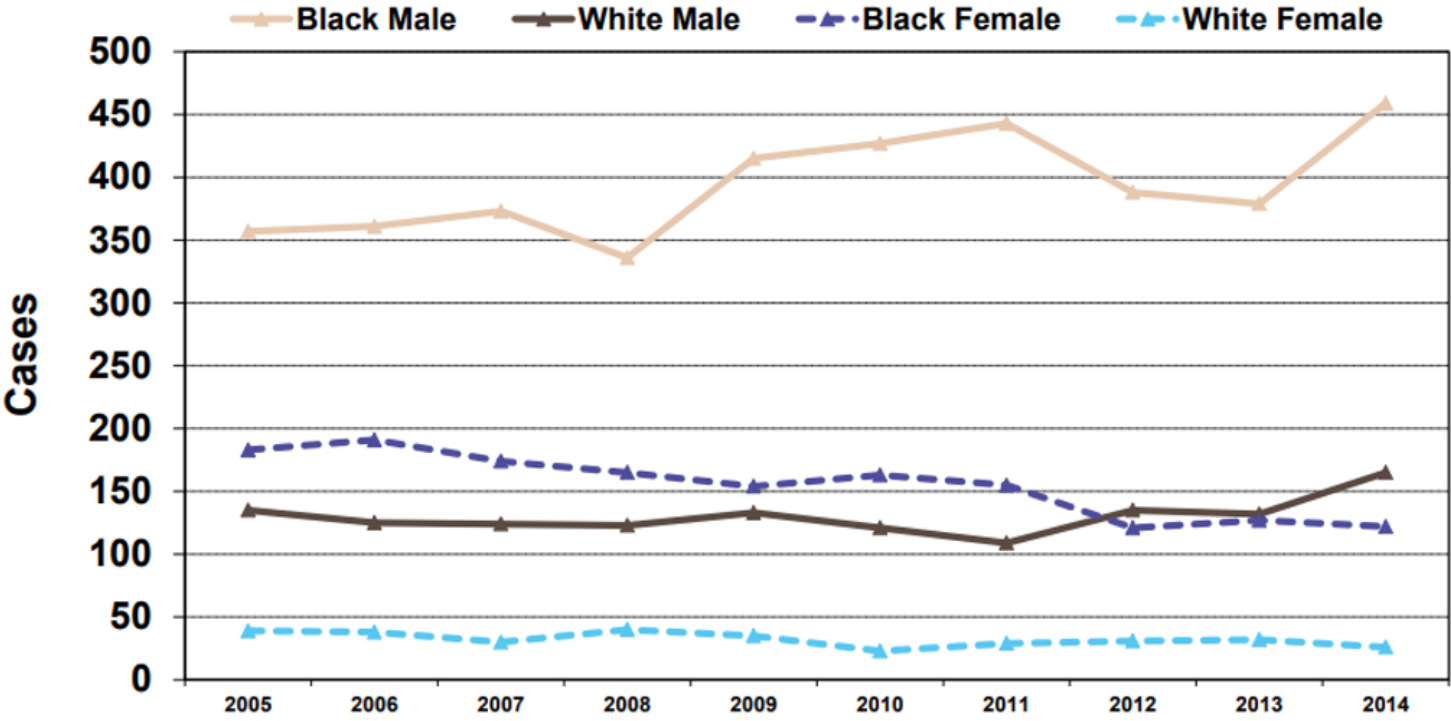


*Age Adjustment Uses 2000 Standard Population
Source: SC DHEC Vital Statistics, US CDC WONDER

Generated by Division of Chronic Disease Epidemiology,
December 2015



South Carolina Health Disparities: Reported Cases of HIV*



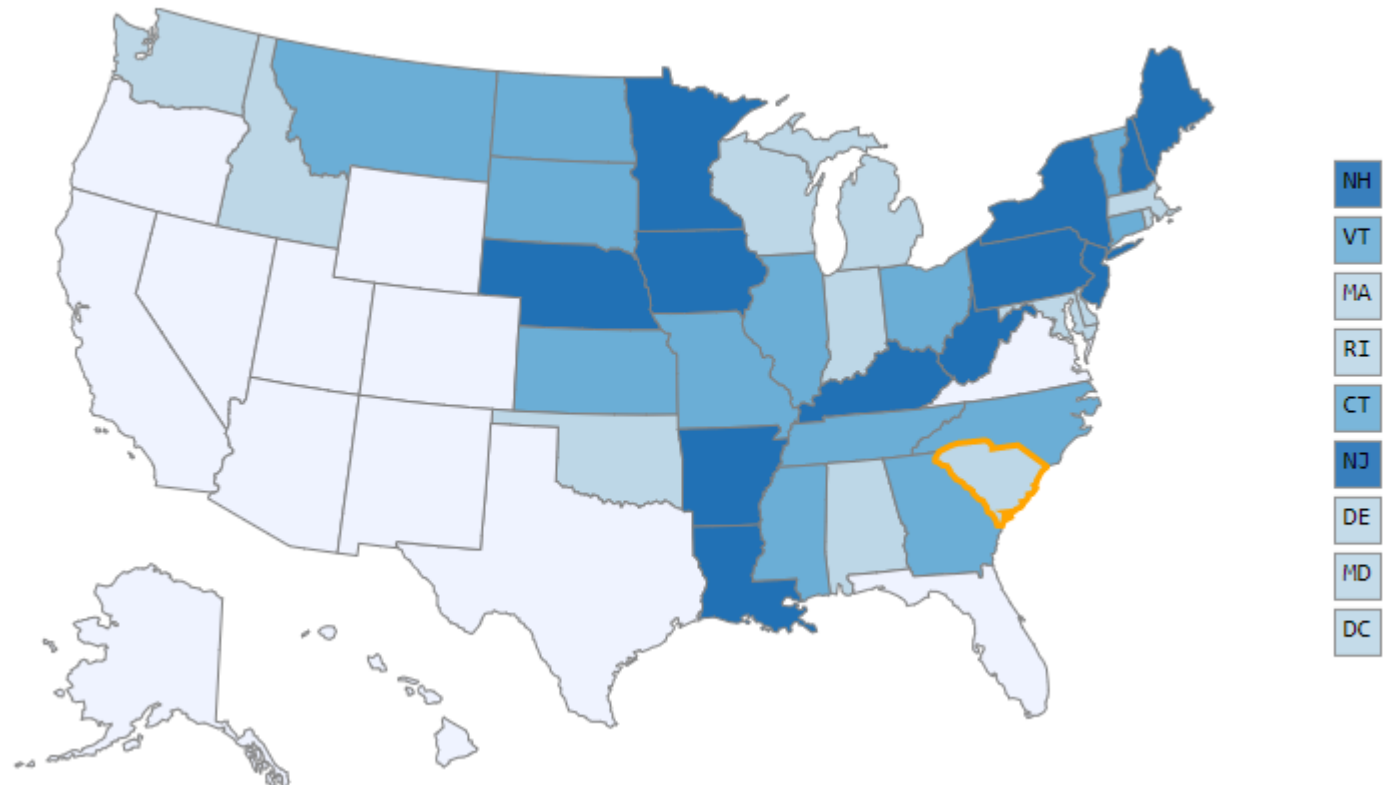
*AIDS cases are included in counts of HIV cases.
Source: SCDHEC HIV/AIDS Surveillance Data, Surveillance Report 2014

Generated by Division of Chronic Disease Epidemiology,
December 2015



Rate of New Cancers in the US, All Types of Cancer, All Ages, All Races/Ethnicities, Male and Female

Rate per 100,000 people



Rate per 100,000 people



Source: <https://gis.cdc.gov/Cancer/USCS/DataViz.html>



**CANCER IN
AFRICAN AMERICAN MEN
IN SOUTH CAROLINA**



A Message from Dr. Rick Toomey, SC Department of Health and Environmental Control

I am pleased to introduce this important report, *Cancer in African American Men in South Carolina*. The need to formally address cancer incidence and deaths occurring in African American men became evident from the 20-Year Cancer Trend Report from DHEC's South Carolina Central Cancer Registry (SCCCR), released in October 2018. Key findings indicated that while cancer trends have declined over the past two decades for most cancer types in our state, the differences between African Americans and Caucasians persist, especially among men. Clearly, African American men bear a disproportionate share of the cancer burden.

Through a collaboration among the SCCCR, DHEC's Division of Cancer Prevention and Control, and the SC Cancer Alliance this report was developed to address the complex factors that contribute to the disparities revealed in the data. A multidisciplinary workgroup came together to provide their expertise to document information that will increase knowledge and understanding of these complexities in order to prevent some of these cancers, diagnose cases earlier, and improve the outcomes of patients who are suffering from cancer.

Thanks to our statewide partners, including our healthcare network of hospitals, labs, and physicians who are dedicated to providing their cancer cases to the SCCCR, and then utilize the information provided in reports such as this one to guide their activities that are put into action daily throughout South Carolina. Thanks also to our national partner, the Centers for Disease Control and Prevention for their funding, guidance,

and encouragement to utilize our rich data resources to collect, interpret, and disseminate meaningful information that will ultimately improve the population health of the citizens of South Carolina.

Our goal is health equity for all South Carolinians! Through our collaborative work, we can continue to increase awareness so that proper steps can be taken to reduce the burden that cancer places on African American men as well as other groups within our state.



Richard K. Toomey
DHA, FACHE, Director

A Message from Marvella Ford, Medical University of South Carolina

Dear South Carolina Residents:

We are delighted to share this report with you! It highlights the cancer-related health of African American men in South Carolina. We chose to focus on this population for a number of reasons. First, the prostate cancer death rate is almost three times higher among African American men than among white men in our state. Second, few health reports focus specifically on African American men. Third, African American men play a very important and significant role in their families and communities, and too many are dying prematurely and unnecessarily.

South Carolina is making significant strides in combating cancer in our state. It is our desire for these benefits to reach African American men as well. The purpose of this report is to show areas where disparities still exist, and to make some recommendations to develop strategies to reduce, and eventually eliminate, these disparities.

We are pleased to present this collaborative report. The South Carolina Cancer Alliance worked with state, regional, and local academic, community, and governmental partners to develop the report.

We hope this report will serve as a living document for many years into the future, guiding the development and implementation of cancer prevention, control, treatment, and survivorship strategies focused specifically on African American men.



Marvella E. Ford, Ph.D.

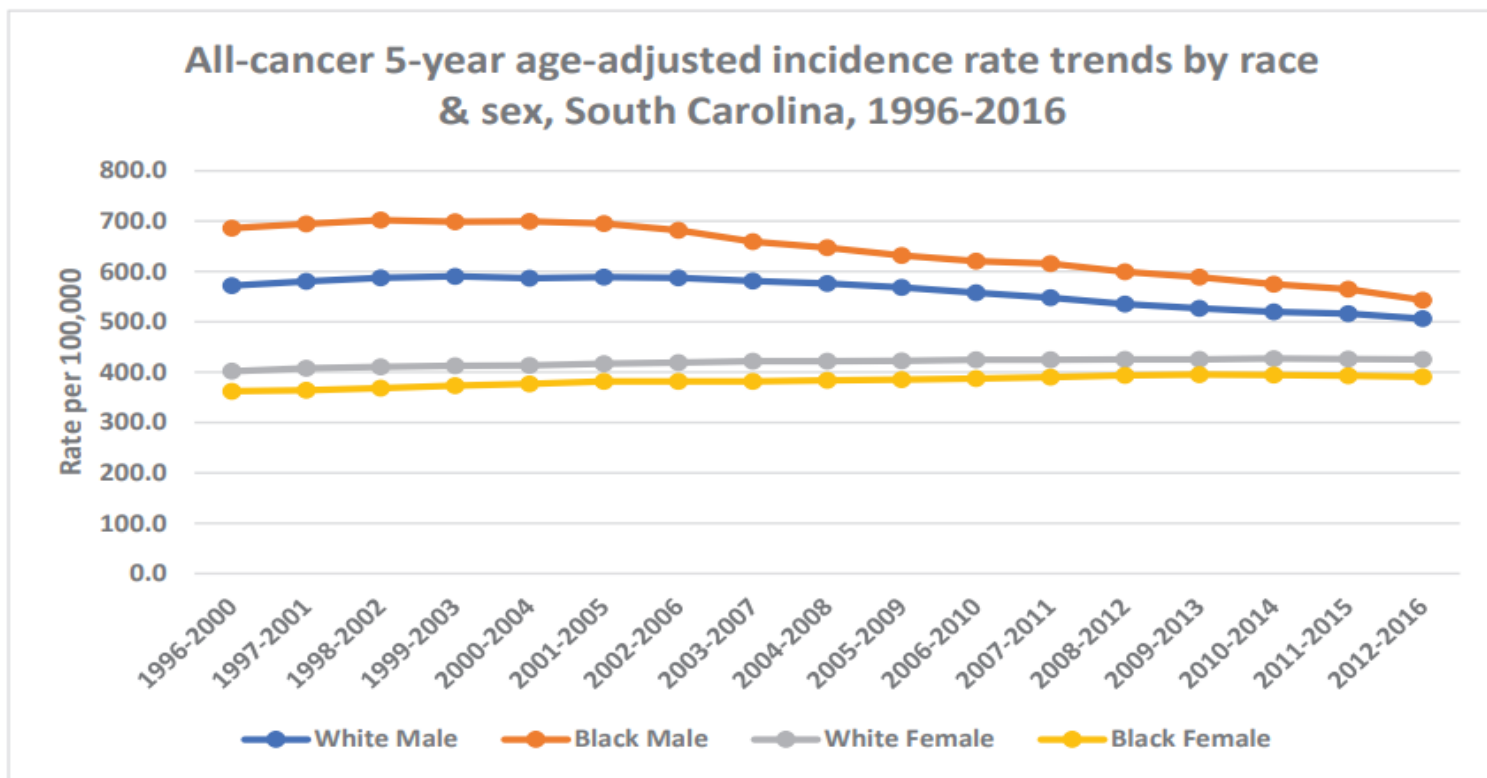
Professor, Department of Public Health Sciences

Associate Director, Population Sciences and Cancer Disparities, Hollings Cancer Center

Director, Office of Community Outreach and Engagement, Hollings Cancer Center

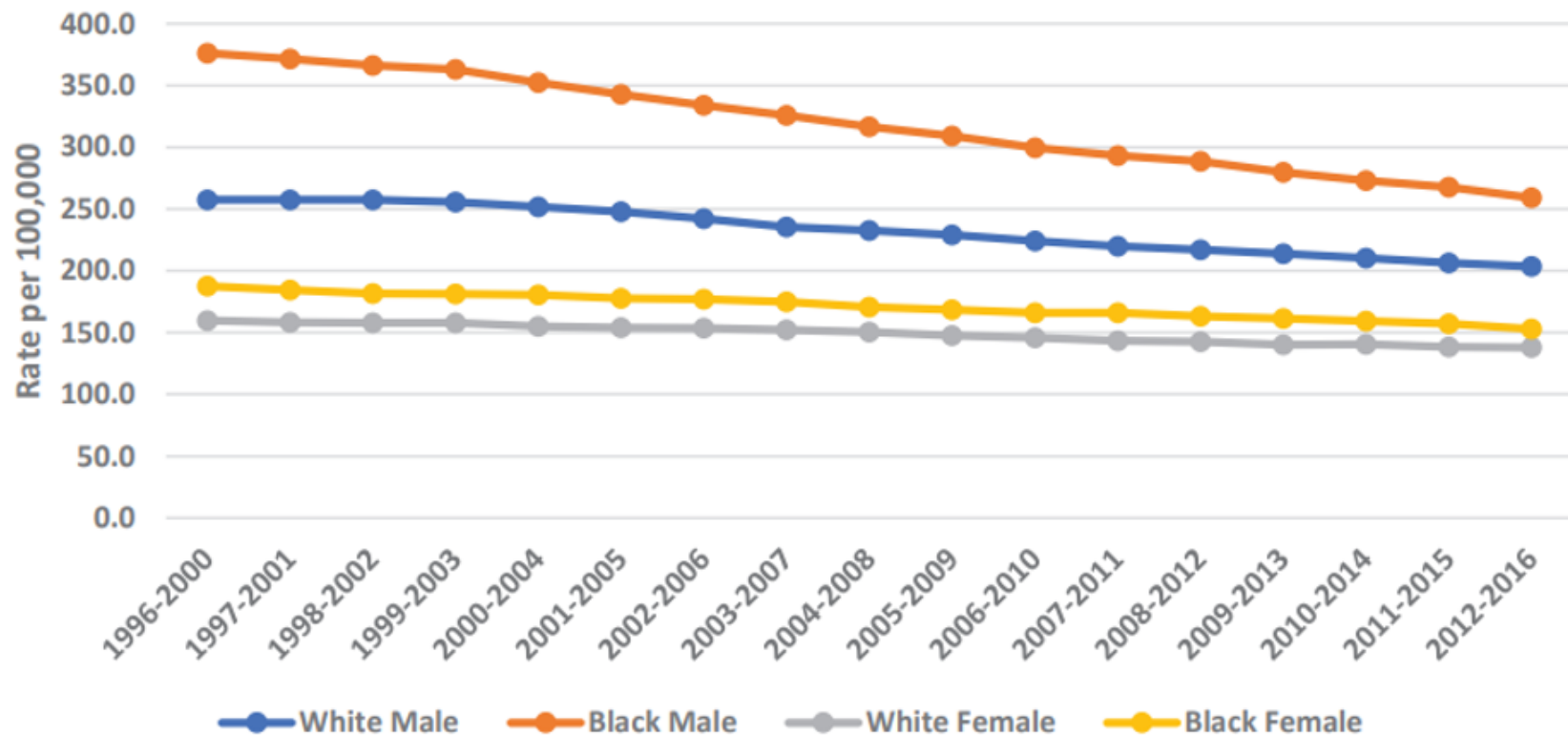
Medical University of South Carolina Hollings Cancer Center

Figure 1: Incidence Rates of All Cancers by Race and Sex, 1996 to 2016 (Age-adjusted to the 2000 US Std Population)



Mortality Rates of All Cancers by Race and Sex, 1996 to 2016 (Age-adjusted to the 2000 US Std Population)

All-cancer 5-year age-adjusted mortality rate trends by race & sex, South Carolina, 1996-2016



South Carolina COVID-19 Cases and Deaths for Blacks and Hispanics/Latinos

Statewide Racial Breakdown of Cases and Deaths

Black or African American

27% of population



28% of cases



34% of deaths

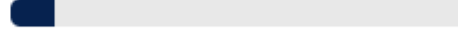


Hispanic or Latino

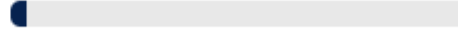
6% of population



10% of cases



4% of deaths



Data Source: COVID Tracking Project Racial Data Tracker. Data shown is only for cases and deaths where racial data is reported.

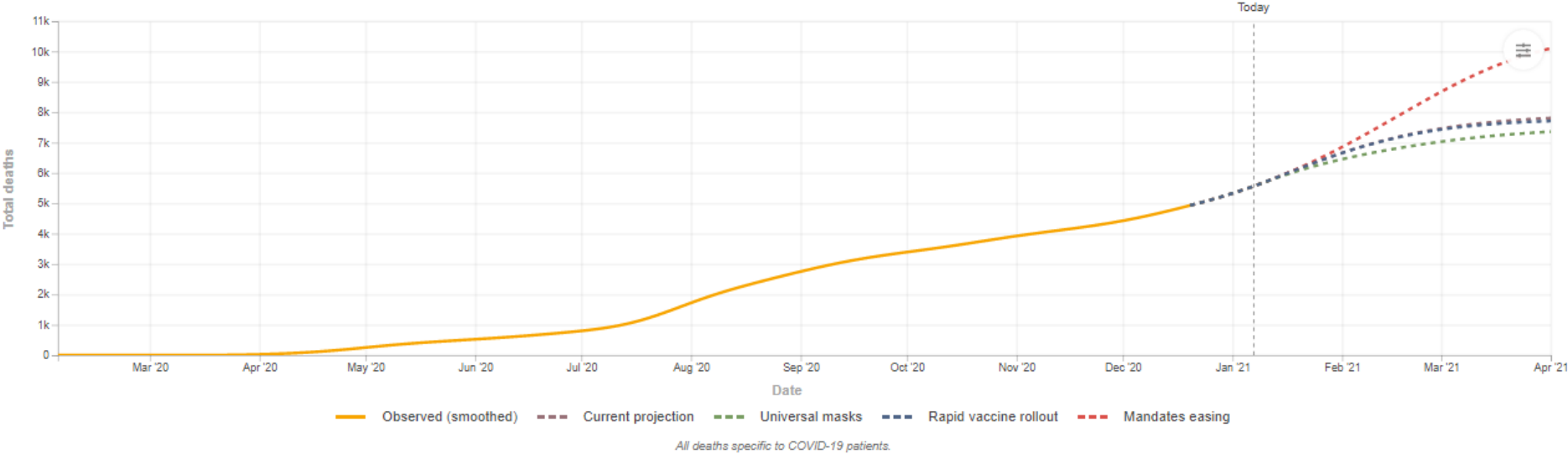
Source: <https://coronavirus.jhu.edu/region/us/south-carolina>

SC Data as of January 6, 2021

7,808 COVID-19 deaths

based on Current projection scenario by April 1, 2021

Scenario

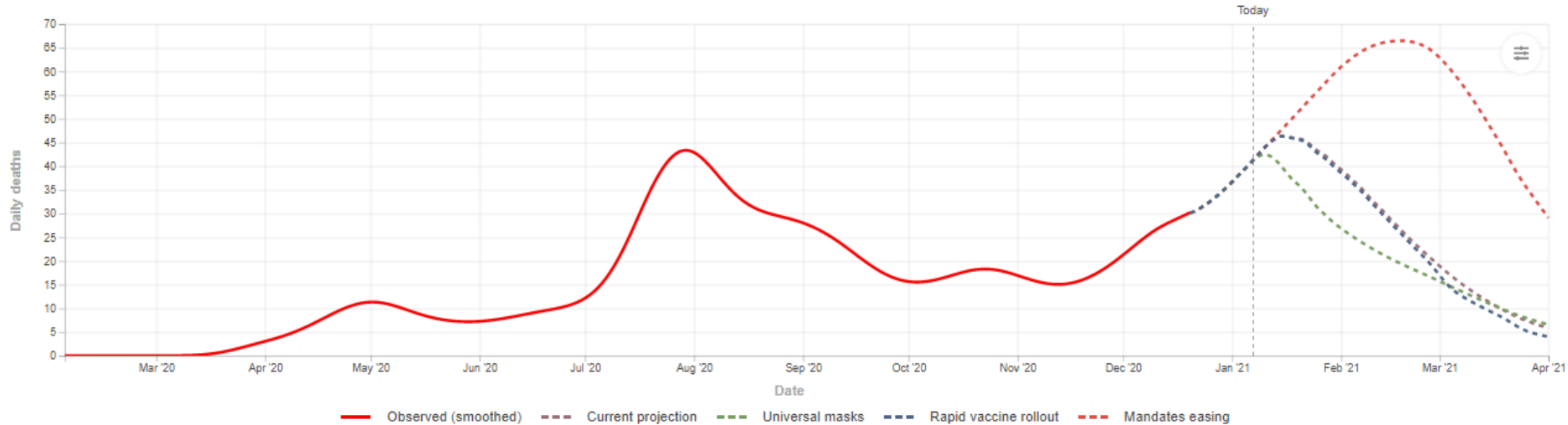


SC Data as of October 29, 2020

Daily deaths [↗](#)

[↗ Trend](#)[↗ Compare](#)[📍 Map](#)

Daily deaths is the best indicator of the progression of the pandemic, although there is generally a 17-21 day lag between infection and deaths.

Scenario Projection Masks Rapid rollout Easing 

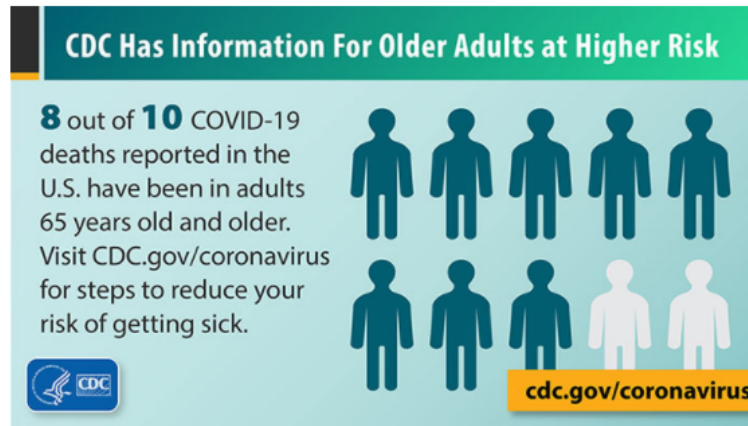
— Observed (smoothed) - - - Current projection - - - Universal masks - - - Rapid vaccine rollout - - - Mandates easing

All deaths specific to COVID-19 patients.

Source: <https://covid19.healthdata.org/united-states-of-america/south-carolina?view=total-deaths&tab=trend>

Relationship Between Aging and COVID-19

- **Older adults are at greater risk of requiring hospitalization or dying** if they are diagnosed with COVID-19.
- Risk for severe illness with COVID-19 increases with age, with older adults at highest risk.
- For example, people in their 50s are at higher risk for severe illness than people in their 40s. Similarly, people in their 60s or 70s are, in general, at higher risk for severe illness than people in their 50s. The greatest risk for severe illness from COVID-19 is among those aged 85 or older.



Relationship between Aging and COVID-19

Compared to younger adults, older adults are more likely to require hospitalization if they get COVID-19

| | Hospitalization ¹ | Death ² |
|-------------|------------------------------|--------------------|
| 18-29 years | Comparison Group | Comparison Group |
| 30-39 years | 2x higher | 4x higher |
| 40-49 years | 3x higher | 10x higher |
| 50-64 years | 4x higher | 30x higher |
| 65-74 years | 5x higher | 90x higher |
| 75-84 years | 8x higher | 220x higher |
| 85+ years | 13x higher | 630x higher |

Relationship between Aging and COVID-19

Certain Medical Conditions Can Increase Risk

- Other factors can also increase risk of severe illness, such as having [certain underlying medical conditions](#).

Relationship between Aging and COVID-19

Many of the diseases that increase risk for COVID-19 occur more commonly among adults ages 50 years and older:

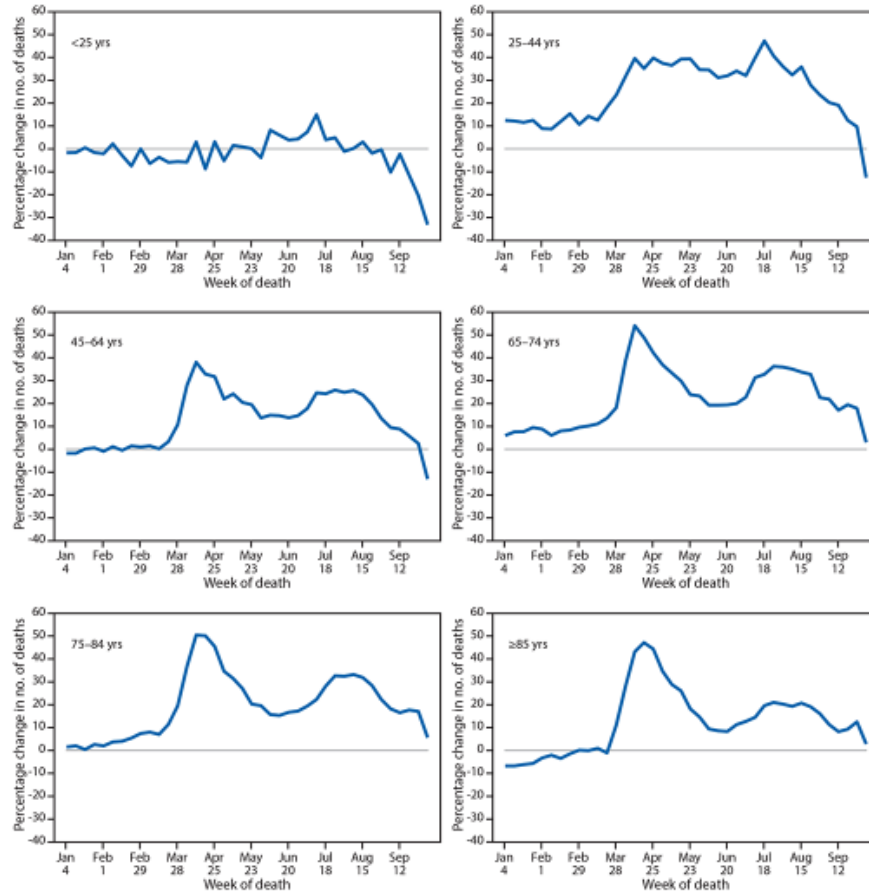
- Cancer
- Chronic kidney disease
- COPD (chronic obstructive pulmonary disease)
- Heart conditions such as heart failure, coronary artery disease or cardiomyopathies
- Immunocompromised state (weakened immune system) from solid organ transplant
- Obesity (body mass index (BMI) of 30 kg/m² or higher but < 40 kg/m²)
- Severe obesity (BMI > = 40 kg/m²)
- Pregnancy
- Sickle cell disease
- Smoking
- Type 2 diabetes mellitus

Relationship between Aging and COVID-19

Many of the diseases that **MIGHT** increase risk for COVID-19 occur more commonly among adults ages 50 years and older:

- Asthma (moderate-to-severe)
- Cerebrovascular disease (affects blood vessels and blood supply to the brain)
- Cystic fibrosis
- Hypertension or high blood pressure
- Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV or use of corticosteroids, or use of other immune weakening medicines
- Neurologic conditions such as dementia
- Liver disease
- Overweight (BMI > 25 kg/m² but < 30 kg/m²)
- Pulmonary fibrosis (having damaged or scarred lung tissues - idiopathic pulmonary fibrosis mainly affects persons aged **50 years** or older.)
- Thalassemia (a type of blood disorder)
- Type 1 diabetes mellitus

Percentage change in the weekly number of deaths in 2020 relative to average in the same weeks during 2015–2019, by age group — United States, 2015–2019 and 2020



Excess deaths are defined as the number of persons who have died from all causes, in excess of the expected number of deaths for a given place and time.

Excess Deaths Associated with COVID-19, by Age and Race and Ethnicity — United States, January 26–October 3, 2020

Weekly / October 23, 2020 / 69(42):1522-1527

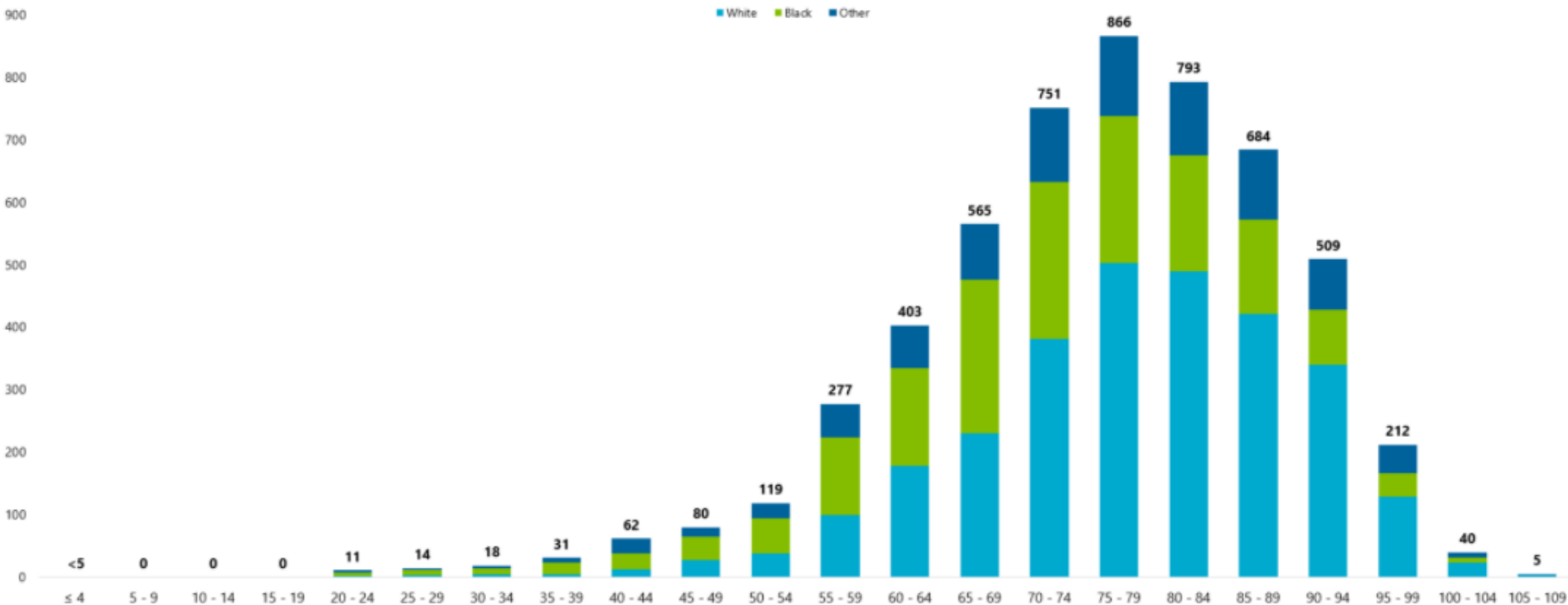
On October 20, 2020, this report was posted online as an MMWR Early Release.

Lauren M. Rossen, PhD¹; Amy M. Branum, PhD¹; Farida B. Ahmad, MPH¹; Paul Sutton, PhD¹; Robert N. Anderson, PhD¹ ([View author affiliations](#))

Age of COVID-19 Reported Deaths, by Race (n=5,444)

As of 11:59 PM on 1/3/2021

White Black Other



Note: A value of 0 means that no death has occurred. Values between 1-4 are suppressed and displayed as (<5)

| Reported Monday, January 04, 2021 | | | |
|--|-----------------------|------------------------------------|-------------|
| Data as of Saturday, January 02, 2021 11:59 p.m. | | | |
| <p>A delay in the reporting of an individual's death during this pandemic is often attributed to ensuring the death is accurately classified based on the most up-to-date federal guidance for determining a COVID-19-related death. Visit the COVID-19 Deaths in South Carolina chart on the SC Testing and Projections webpage for all deaths by date of occurrence.</p> | | | |
| Date of death | Confirmed or Probable | County | Age |
| 1/1/2021 | Confirmed | Aiken | Middle-Aged |
| 1/1/2021 | Confirmed | Barnwell | Young Adult |
| 12/29/2020 | Confirmed | Beaufort | Elderly |
| 12/31/2020 | Confirmed | Beaufort | Elderly |
| 12/31/2020 | Confirmed | Beaufort | Elderly |
| 12/30/2020 | Confirmed | Chesterfield | Elderly |
| 12/31/2020 | Probable | Georgetown | Elderly |
| 12/29/2020 | Confirmed | Greenville | Elderly |
| 1/1/2021 | Confirmed | Greenville | Elderly |
| 1/1/2021 | Confirmed | Lancaster | Elderly |
| 1/1/2021 | Confirmed | Lancaster | Elderly |
| 1/1/2021 | Confirmed | Lexington | Elderly |
| 1/1/2021 | Confirmed | Lexington | Elderly |
| 1/1/2021 | Confirmed | Lexington | Middle-Aged |
| 12/30/2020 | Confirmed | Orangeburg | Middle-Aged |
| 12/30/2020 | Confirmed | Spartanburg | Elderly |
| | | | |
| | | <i>Elderly: 65 & older</i> | |
| | | <i>Middle-aged: 35-64</i> | |
| | | <i>Young adult: 18-34</i> | |
| | | <i>Pediatric: 17 & younger</i> | |

What Are the Social Determinants of Health and How Do They Contribute to COVID-19 Disparities in Older Adults?

Definition of Social Determinants of Health

- [Healthy People 2020](#) defines **social determinants of health** as conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
- Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as “place.”
- In addition to the more material attributes of “place,” the patterns of social engagement and sense of security and well-being are also affected by where people live.

Social Determinants of Health

- Living in densely populated areas.
- Experiencing residential segregation. Racial **residential segregation** is linked with a variety of adverse health outcomes and underlying health conditions. These underlying conditions can also increase the likelihood of severe illness from COVID-19.
- Many members of racial and ethnic minorities live in neighborhoods that are **further from grocery stores and medical facilities**.
- **Multi-generational households**, which may be more common among some racial and ethnic minority families, may find it difficult to take precautions to protect older family members or isolate those who are sick.
- Racial and ethnic minority groups are **over-represented in jails, prisons, and detention centers**, which have specific risks due to congregate living, shared food service, and more.

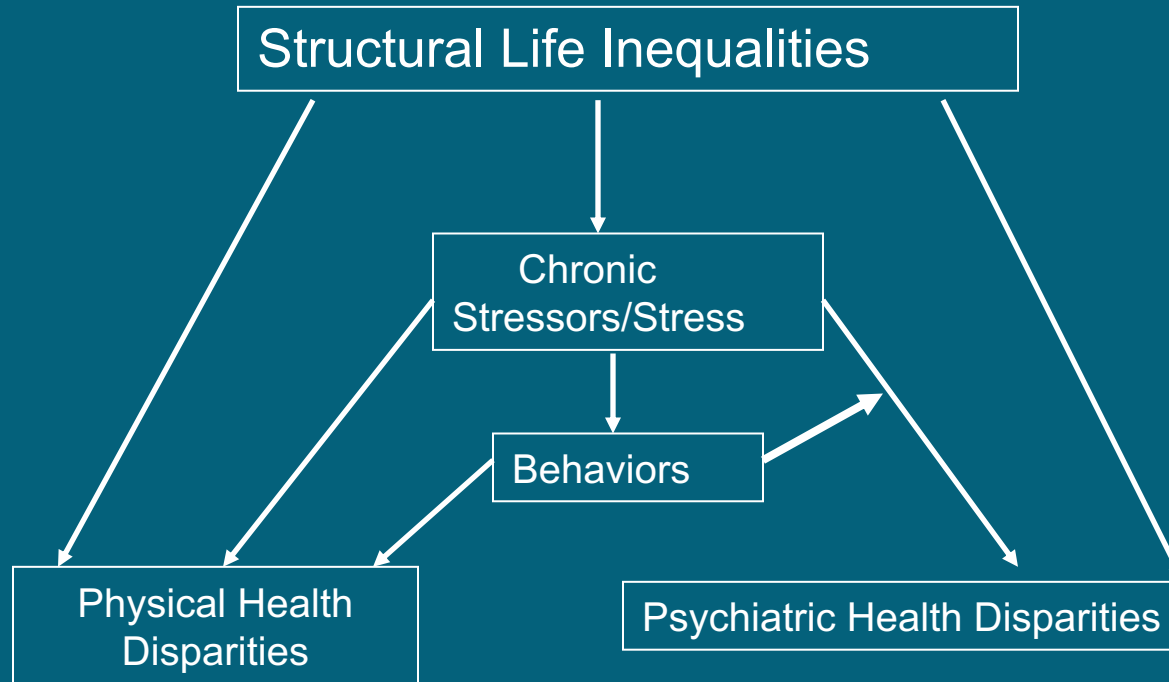
A Simple Model of the Social Determinants of Health Disparities

- Phenotypic genetic expressions of race affect social interactions and health outcomes



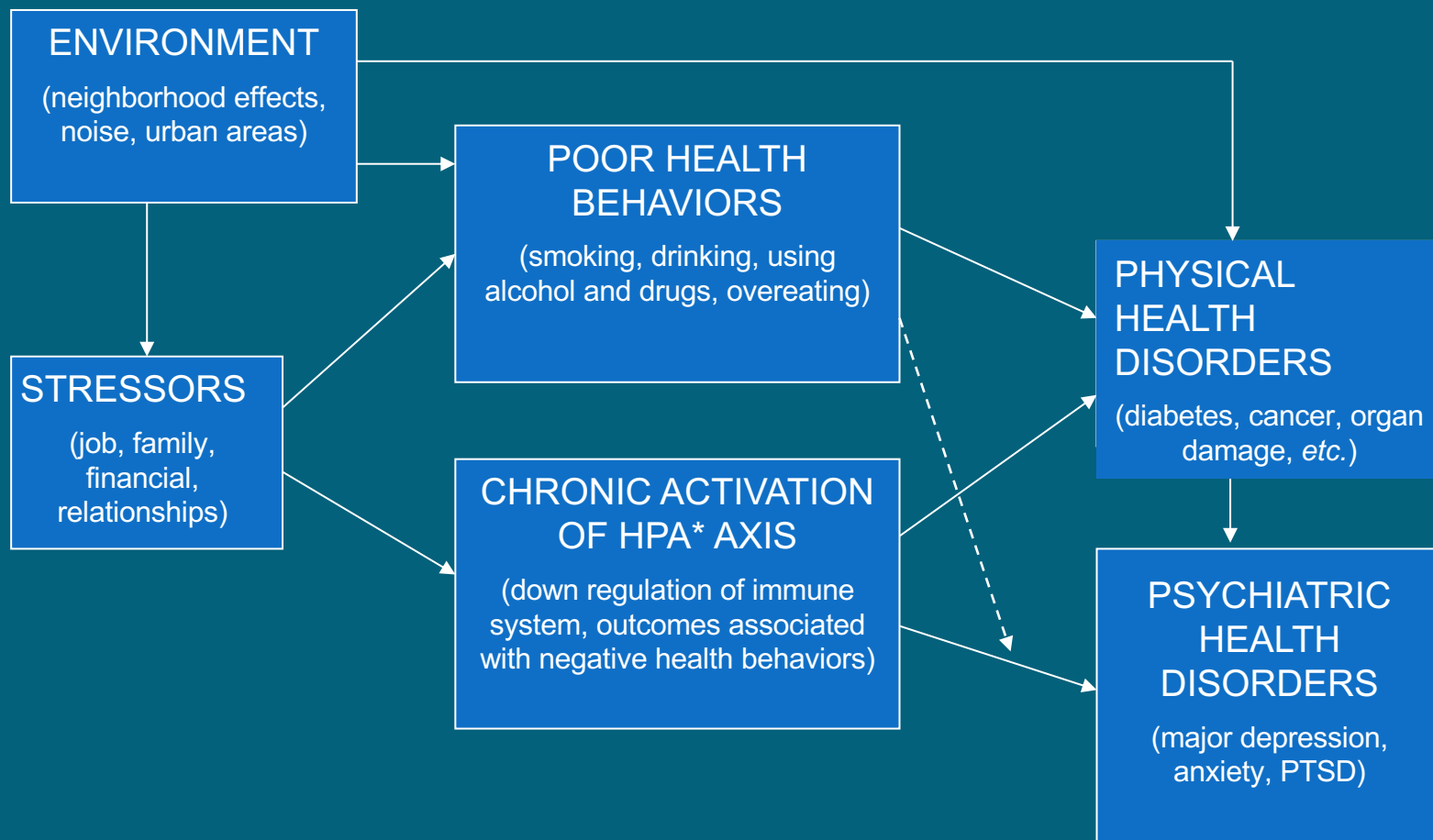
Whitfield, Ford, and Edwards. What Does Knowing about Genetics Contribute to Understanding the Health of Minority Elders? In Keith E. Whitfield and Tamara A. Baker (Eds.), Handbook of Minority Aging, New York, NY: Springer, 2014.

Relationships among Structural Life Inequalities, Chronic Stress, Negative Behaviors, and Physical and Psychiatric Health Disparities



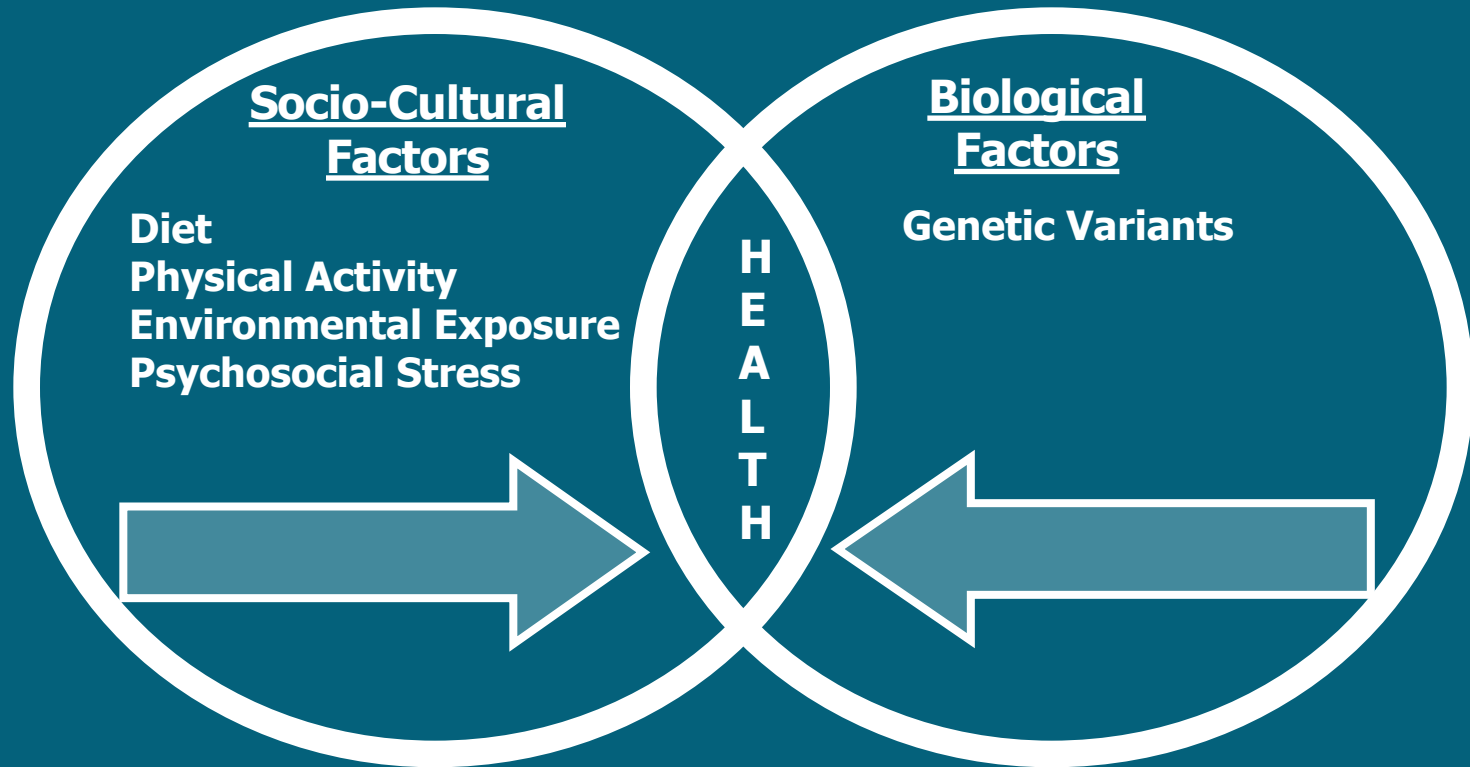
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Possible Interrelationships Among Environment, Stressors, Negative Health Behaviors and Physical and Mental Health Disorders



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Racial Differences in Health Outcomes as a Combination of Socio-Cultural and Genetic Factors



COVID-19 VACCINE FLOW IN SC

This graphic shows the progression of the vaccine from the federal government to the state and the steps along the way from providers to vaccine recipients.¹



Suppliers started shipping Dec. 13, 2020 (ships weekly)

| PROVIDERS | VACCINE ARRIVAL |
|-----------------------------------|-----------------|
| Acute Care Hospitals | Dec. 14, 2020 |
| CVS/Walgreens (LTCF) ³ | Dec. 28, 2020 |
| Non-Acute Care Hospitals | Jan. 4, 2021 |
| Limited Pharmacies | Jan. 18, 2021 |
| Limited Private Physicians | Jan. 11, 2021 |
| Limited Urgent Care | Jan. 11, 2021 |
| Limited DHEC Sites | Jan. 11, 2021 |

PHASE 1 IN SC STARTS

Vaccine first received Dec. 14, 2020

PHASE 1A (CURRENTLY ONGOING):

- Healthcare workers
- LTCF residents and staff
- Home health and hospice workers
- Dentists and dental hygienists/assistants
- Pharmacists

See more detailed listing of Phase 1a at scdhec.gov/vaxfacts

PHASE 1B (LATE WINTER 2021):²

- 75+ with or without underlying health conditions
- Frontline essential workers

See more detailed listing of Phase 1b at scdhec.gov/vaxfacts

PHASE 1C (EARLY SPRING 2021):²

- Essential workers continued
- 65–74 with or without underlying health conditions
- 16–64 with underlying health conditions

PHASE 2

PHASE 2 (LATE SPRING – FALL 2021):²

- All people who wish to be vaccinated
- Widespread availability



Wear a mask. Save lives.

Wear a face cover

Wash your hands

Keep a safe distance

Source:

https://www.google.com/search?rlz=1C1AJZK_enUS844US852&ei=DFn3X5DKEJCo5gK62aHIBw&q=how+to+prevent+covid+19&oq=how+to+prevent+covid+19&gs_lcp=CgZwc3ktYWIQAzIFCAAQyQMMyAggAMgIIADICCAAyAggAMgIIADICCAAyAggAMgIIADICCAA6BAgAEEc6CQgAEMkDEBYQHjoFCCEQoAFQ_RFYIzBguDJoAXACeACAAAd8BiAHeA5IBBTluMS4xmAEAoAEBqgEHZ3dzLXdpesgBA8ABAQ&scient=psy-ab&ved=0ahUKEwiQgl7Uv4ruAhUQIFkKHbpsCHkQ4dUDCA0&uact=5



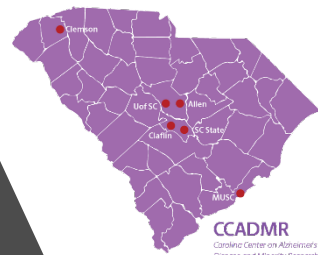
Hollings Cancer Center

An NCI-Designated Cancer Center



TODAY'S SPEAKER

Marvella Ford, PhD is a tenured Professor in the department of Public Health Sciences at the Medical University of South Carolina. She is also the Associate Director of Population Sciences and Cancer Disparities at the Hollings Cancer Center. She is the co-director of the South Carolina Cancer Disparities Research Center where they aim to create a future generation of cancer researchers.



Carolina Center on Alzheimer's Disease and Minority Research (CCADMR)

CCADMR Request for Pilot Research Proposals

Application Receipt Date: February 15, 2021

Award Period: Summer/Early Fall 2021—June 30, 2022

For more information, please contact:

Lucy A. Ingram, PhD (UofSC) | Lannang@sc.edu | 803 777-4389

Marvella E. Ford, PhD (MUSC) | Fordmar@musc.edu | 843 876-2433

Submit completed application to: Quentin McCollum, MPH | mccolluq@email.sc.edu

To find out more about the CCADMR, please visit our website:

https://www.sc.edu/study/colleges_schools/socialwork/research/ccadmr/index.php



**Arnold School
Public Health**

Thank you for participating!

Please give us your feedback about the session by answering a brief survey.

To access the survey:

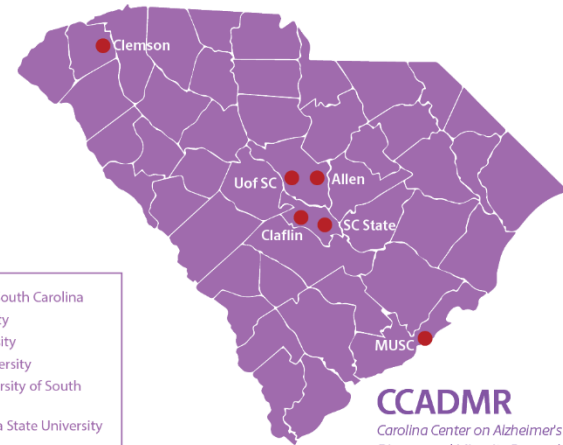
- Scan the QR code here *or*
- Complete the survey once you are emailed a link at the conclusion of the seminar

The QR code appears here or it can be accessed via the [Survey Link](#).



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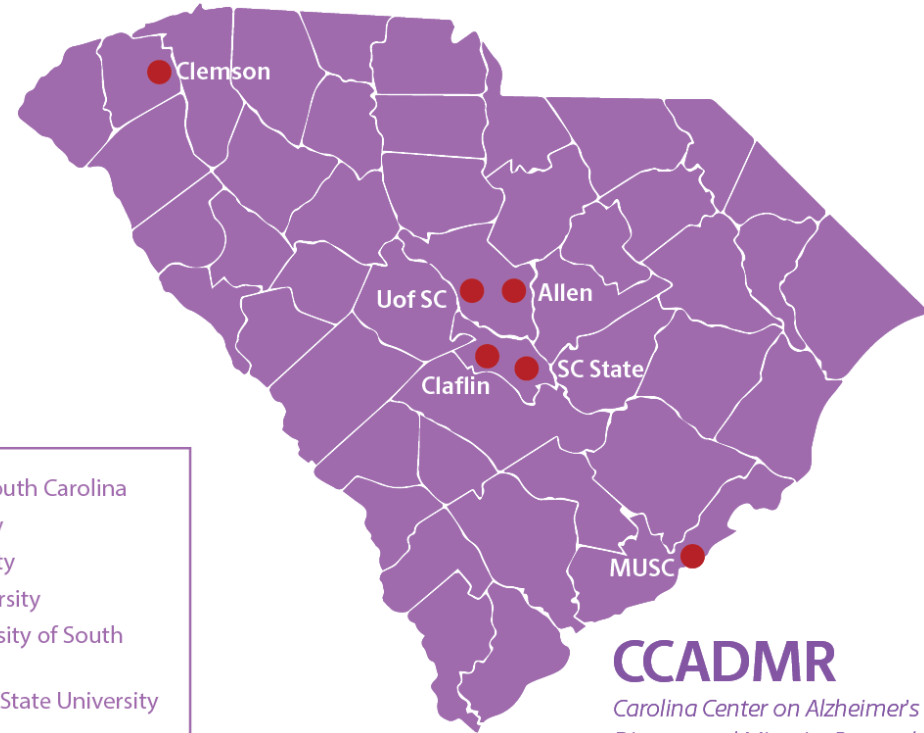
CCADMR
Carolina Center on Alzheimer's
Disease and Minority Research

Thank you!

If you have any questions,
please contact Quentin
McCollum
mccolluq@email.sc.edu or
Brianna Ashford- Carroll,
ashfordb@email.sc.edu.

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