

ASSOCIATION OF COMMUNITY  
CANCER CENTERS

OVERCOMING  
PROSTATE CANCER  
DISPARITIES IN CARE



Association of Community Cancer Centers



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## INTRODUCTION

In 2021, the American Cancer Society projects that the number of diagnosed prostate cancer cases will increase 30 percent, and deaths from prostate cancer will increase 2.4 percent.<sup>1</sup> This means that nearly 250,000 people will be diagnosed with prostate cancer this year, and more than 34,100 people will die from the disease. Experts expect 2022 numbers to be even higher.<sup>2</sup>

It is well documented that some populations have worse prostate cancer outcomes than others.<sup>1</sup> Addressing these disparities in a clinical practice setting requires the ability to recognize that inequities in care exist and to commit to proven efforts to provide equitable care to all patients. This is not an easy undertaking, but it is an essential one for any healthcare organization.

Data and insights from the members of the Association of Community Cancer Centers (ACCC) indicate a strong interest in learning and deploying models of care to level the playing field for their patients.<sup>3</sup> To address this need, ACCC identified four cancer programs that have developed or are developing strategies to overcome disparities in prostate cancer care. Results from this initiative demonstrate a broad range of approaches to creating change and improving prostate cancer detection and treatment.

## DISPARITIES IN CARE

How early cancer is detected, what type of treatment a patient receives, and the success of that treatment vary depending on several factors, including race or ethnicity, geography, and socioeconomic status. A study of Surveillance, Epidemiology, and End Results (SEER) data on individuals diagnosed with prostate cancer between 2007-2010 showed that White patients are more likely to be insured than non-White patients, while Black Americans have higher incidence and mortality rates from prostate cancer compared to other racial groups.<sup>4</sup>

Immigrants to the U.S. also experience barriers to quality care due to language differences and different cultural norms in accessing healthcare and receiving treatment. Access to early detection and treatment for prostate cancer can be influenced by one's community and financial situation. For example, patients who live in rural areas often experience barriers to transportation, making screening and treatment difficult to access. These differences can have a significant impact on outcomes. Patients from lower socioeconomic levels are more likely to receive

surgical androgen deprivation therapy (ADT) if they are covered by Medicaid or live in rural areas (as opposed to medical ADT, which is more expensive and has fewer long-term negative side effects).<sup>5</sup>

Cancer programs can implement policies and practices to improve outcomes in disadvantaged populations. Appropriately tailored outreach to targeted populations and their primary care providers (PCPs) can increase knowledge and awareness of screening, treatment options, and clinical trials. Some successful outreach programs and other proactive initiatives are profiled below.

The use of multidisciplinary clinics for prostate cancer has also been found to improve communication and provide opportunities for more effective shared decision-making, resulting in care decisions more consistent with guidelines and expected outcomes.<sup>6,7</sup> Building robust patient navigation programs using nurse navigators, social workers, and financial navigators can help identify potential barriers to care and address them before they interfere with detection and treatment.<sup>8,9</sup> And increasing the use of tailored, appropriate education and peer support can help empower disadvantaged populations. All of these are proven strategies that cancer centers can implement.

## PSA TESTING

A current challenge to the early detection of prostate cancer is continued confusion and inconsistent guidelines regarding the use of prostate-specific antigen (PSA) testing. The US Food and Drug Administration (FDA) approved serum PSA tests in 1986, and the use of these tests for prostate cancer screening began to expand. Initially, when high PSA levels led to a confirmation of prostate cancer, all patients were treated—often aggressively—for their cancer, including patients with low-risk, slow-growing cancers. As a result of the overtreatment of slow-growing prostate cancers, the US Preventive Services Task Force (USPSTF) stated in 2008 that there was “good evidence that PSA screening can detect early-stage prostate cancer but found mixed and inconclusive evidence that screening and early detection improve health outcomes.”<sup>10</sup>

Current recommendations for PSA testing vary regarding age of initiation and termination, as seen in Table 1. In addition, all the major guidelines stress the importance of shared decision-making (SDM) between the individual and their healthcare provider to determine whether prostate cancer screening is the right choice, and they discourage population-based PSA testing for all eligible individuals.

Based on evidence regarding disparities in the diagnosis and treatment of prostate cancer, several organizations recommend initiating conversations about PSA screening with younger individuals who are considered at higher risk of diagnosis and mortality due to race, family history, or associated germline mutations. During the time since the

USPSTF first issued their prostate cancer screening recommendations, researchers and clinicians have refined approaches to minimize the harms of unnecessary treatment. Today, “active surveillance” is part of regular clinical practice, decreasing the risk of overtreatment and its associated hazards.<sup>11</sup>

**Table 1. Recommendations for Prostate Cancer Screening**

Organization	Recommended Candidates
USPSTF and the American Academy of Family Physicians	<ul style="list-style-type: none"> <li>• Age 55-69</li> <li>• Not recommended for age 70 and older</li> <li>• No separate age ranges based on risk factors</li> </ul>
National Comprehensive Cancer Network®	<ul style="list-style-type: none"> <li>• Age 45-75 for average-risk patients</li> <li>• Age 40-75 for Black individuals, those with germline mutations that increase risk, or a family history of specific types of cancer</li> <li>• Age 75 and older only for very healthy individuals</li> </ul>
American Cancer Society	<ul style="list-style-type: none"> <li>• Age 50 and older for individuals with average risk of prostate cancer and who are expected to live at least 10 more years.</li> <li>• Age 45 and older for individuals at high risk of developing prostate cancer, including Black individuals and those who have a first-degree relative (father or brother) diagnosed with prostate cancer at an early age (younger than age 65)</li> <li>• Age 40 and older for individuals at even higher risk, including those with more than one first-degree relative who had prostate cancer at an early age</li> </ul>
American Urological Association	<ul style="list-style-type: none"> <li>• Age 55-69 for individuals with average risk</li> <li>• Age 40-69 for those at higher risk, including Black individuals, those with a family history of specific types of cancer that developed at a younger age</li> <li>• Age 70 and older only for very healthy individuals</li> </ul>

*Data adapted from the US Preventive Services Task Force,<sup>12</sup> American Academy of Family Physicians,<sup>13</sup> the National Comprehensive Cancer Network,<sup>14</sup> the American Cancer Society,<sup>15</sup> and the American Urological Association.<sup>16</sup>*

## PRACTICE PROFILES

To better understand how multidisciplinary cancer care teams can help overcome disparities in prostate cancer care, ACCC conducted a series of focus groups and interviews with four cancer programs that are part of the ACCC member network. This revealed

practical strategies for providing equitable care that can be incorporated into other cancer programs to help them improve early detection and care for vulnerable patients.



# ChristianaCare's Helen F. Graham Cancer Center & Research Institute

## WILMINGTON, DE



The Helen F. Graham Cancer Center & Research Institute within the ChristianaCare Health System is located in New Castle County, Delaware, just outside of Wilmington. Wilmington has a sizable Black community, which accounted for 58 percent of the city's population in 2019.<sup>17</sup> While the Graham Cancer Center treats patients from across the state, much of its outreach and education work is focused on New Castle County.

### Warriors Against Prostate Cancer

The Graham Cancer Center's Community Health Outreach and Education Program has the broad goal of decreasing cancer incidence and mortality across Delaware. The program focuses on the New Castle County population and uses cancer screening as its primary strategy in fighting the disease. Key to the program's success has been accurately identifying appropriate "messengers" who can identify with and reach vulnerable populations. ChristianaCare's program has found success by empowering members of the Black community to engage their peers in conversations about cancer screening. The program has also successfully deployed bilingual community outreach workers to talk to their communities about cancer prevention.

When the FDA approved PSA screening for prostate cancer in 1994, the Community Health Outreach and Education Program hosted free prostate cancer screening events at Wilmington Hospital. Part of the educational messaging was that Black Americans—a key demographic for the health system, particularly in this urban area—were at higher risk of death from prostate cancer. In 1998, a small group of Black community members decided they wanted to do more to increase the knowledge and uptake of PSA screening in their community. With the help of ChristianaCare's screening nurse navigator, they went through formal volunteer training and began meeting monthly to develop communications and outreach strategies to encourage members of Wilmington's Black community to be screened for prostate cancer. They called themselves Warriors Against Prostate Cancer.

Members of the group were recognized for the value they brought to outreach efforts. In addition to being formally trained as volunteers, they received identification badges that provided greater access to hospital facilities so when they arrived after work they could host meetings. The volunteers brought their message about screening to events and locations frequented by the Black community,

including music festivals, barber shops, and church health fairs. As members of the community, these volunteers had a vested interest in their messaging. They became a highly respected volunteer group and participated in focus groups for other types of cancer screening efforts. Several members also participated in a clinical trial on prostate cancer prevention. The volunteers received the Governor's Recognition Award to mark their contributions to their community.

The group was active through 2018 and was a big outreach success. Unfortunately, the most active members became less able to commit to the work over time due to age, illness, and death, and the outreach program couldn't bring in younger members to replace them due to time or work constraints. Because free, community-based prostate cancer screening was the cornerstone of the group's early outreach efforts, when organizations started discouraging population-based screening, the program had to evolve.

The Graham Cancer Center's outreach program revised its educational messages, and instead of carrying out PSA testing in the community, volunteers went into the community and brought the names and phone numbers of those they had spoken with to nurse navigators. Those nurse navigators, in turn, reach out to community members to educate them about risks and benefits and connect them to services. Prostate cancer education efforts have shifted to target all men with bundled messaging about prostate and colon cancer screening, as necessary.

## Diversifying Staff

In addition to identifying community volunteers to effectively target vulnerable populations, diversifying its staff has also enabled the Graham Cancer Center to access previously unreached communities. Health service delivery to the local Asian community was once considered fragmented, and a needs assessment indicated a gap in community engagement to deliver health services. This is particularly critical given that cancer is the leading cause of death for Asian American men and women, and Asian Americans have lower rates of cancer screening compared to most other American groups.<sup>18</sup> Many members of the Chinese community did not have insurance or primary care doctors, and they often sought solutions to health issues by visiting clinics run by Chinese providers in New York's Chinatown, where they pay discounted prices.

In 2011, a Mandarin Chinese-speaking outreach worker was hired to join the Outreach and Education Program. This employee has built productive relationships between the Asian community and the health system, an important prerequisite to increasing prostate cancer screening. The outreach worker builds trust with the Chinese community so they accept her as a credible resource. She teaches the importance of cancer screening, connects people to resources to enroll in insurance plans, explains how to navigate insurance issues, and ensures language is not a barrier to access.

These outreach efforts began at the Chinese Community Center and then spread to Chinese restaurants and the state-level Chinese Medical Association. In time, more and more members of the Asian community started referring their friends and family to the outreach worker, often using a social media platform specific to the Asian community: WeChat. WeChat has enabled targeted health messaging about cancer screening and other health services to the Asian community, and it has allowed the outreach worker to connect one-on-one with individual members of the Asian community who may have specific questions.

Community Health Outreach and Education Program staff have learned that a culturally appropriate and credible messenger can make all the difference when it comes to reaching underserved communities.

## Patient Navigation

Patient navigation has been found to reduce delays in getting patients into cancer treatment, particularly for underserved populations.<sup>19</sup> Through the Genitourinary Multidisciplinary Clinic, the Graham Cancer Center gives patients who have different treatment options to consider the opportunity to meet with multiple physicians to evaluate these options. Patients seen through the clinic account for approximately 25 percent of all patients with prostate cancer at this cancer center (ACCC focus groups with Susan Truitt, MSW, LBSW, CCM, and Ginny Pugh, MSN, RN, OCN, CCN, July 2021). During the clinic meeting, a surgeon, medical oncologist, radiation oncologist, nurse navigator, and social worker all meet with the patient to discuss the options and the patient's goals and preferences. The multidisciplinary care team sees patients who are considered medically high risk, because their cancer requires multiple modalities of care. During the appointment, if social issues become apparent, the social worker helps the patient and the family address these factors

and provides community resources. These factors may include Medicaid coverage, lack of a support system, homelessness, mental illness, addiction issues, and diminished executive functioning. Because all patients have different needs, the nurse navigator and social worker work together as a team to alleviate the role of disparities in patient care.

“When a nurse and social worker work together, each brings different expertise to the table for every patient and increases the quality of care provided to those patients,” says Ginny Pugh, MSN, RN, OCN, CCM, an oncology nurse navigator at the Graham Cancer Center. “Having these two disciplines work together with the patient ensures that the patient is treated more multi-dimensionally, not just medically but as an entire person.”

Multidisciplinary clinics have been found to improve standardization of care and potentially decrease disparities in care. One feature of many of these clinics is nurse navigation services, which can help ensure that patients maintain their treatment and monitoring schedules. During the multidisciplinary office visit, nurse navigators identify patient needs that may require follow up. After the clinic visit, navigators meet with patients to ensure they understand the information discussed and address any remaining concerns the patient may still have, whether those concerns are related to treatment, financial issues, or logistical concerns.

In response to these issues, some cancer centers offer additional services to enable smooth care delivery. For example, ChristianaCare provides a local campus shuttle and offers assistance arranging transportation for clinic visits for patients who live in New Castle County. For patients who live downstate in Kent and Sussex counties, social workers may be able to arrange a transportation plan that minimizes the travel burden. When patients require daily radiation, nurse navigators may be able to arrange care in another hospital system closer to a patient’s home. The social worker may be brought in if patients voice concerns about financial, housing, or other issues that may create barriers to optimal care.

In general, when patients are struggling to follow through with the steps required for their care—regardless of why—the nurse navigator and social worker work closely with those patients. At ChristianaCare, even patients with prostate cancer who are seen in physician practices but not through the multidisciplinary clinic are referred to the social worker and nurse navigator when additional needs are identified. In addition to connecting these patients with relevant resources, often the nurse navigator or social worker will check in with patients throughout their course of treatment to ensure that everything is going smoothly. It is this hands-on approach that helps all patients access the care they need.



# Spencer Cancer Center of East Alabama Health

OPELIKA, AL



East Alabama Health (EAH) opened Spencer Cancer Center in 2019 to meet the needs of its growing population in the local urban and suburban areas surrounding Opelika and Auburn and in the rural areas of Lee County and surrounding counties. The patients served by the Spencer Cancer Center are an even split between urban/suburban and rural, with rural patients tending to experience higher levels of poverty compared to their urban/suburban counterparts. According to the 2020 census, 16 percent of the residents of Lee County live in poverty, and surrounding counties have higher levels of poverty.<sup>20</sup> Staff at the Spencer Cancer Center estimate that about one in four patients seen at the cancer center in recent years was experiencing poverty.

The counties in the EAH catchment area are racially diverse, and clinicians estimate that about fifty percent of their patients are Black. Prostate cancer care is coordinated by the Urology Associates of East Alabama. While there is no designated multidisciplinary prostate cancer clinic, the urology and radiation oncology practices coordinate closely. Radiation oncologists see patients referred by the Urology Associates of East Alabama an average of six days after their urology consultation, so treatment

can begin in a timely manner. Patients with metastatic disease are also managed by the urology clinic. If a patient develops symptoms from a metastatic lesion, urology will enlist radiation oncology to treat the symptomatic area. If a patient's cancer stops responding to androgen deprivation therapy, the patient is referred to medical oncology for further treatment options.

## Removing Financial Barriers to Care

Serving a community with high levels of poverty makes social work support critical to maintaining care access. If someone is diagnosed with cancer, Spencer Cancer Center refers patients to the East Alabama Medical Center (EAMC) Foundation to provide financial support and ensure that no one is turned away due to lack of ability to pay for care. Foundation grants can support costs including consultation fees, travel, and medications. Uninsured patients can get financial assistance for an initial consultation, and if additional care is needed, a financial navigator or a certified Affordable Care Act counselor can help identify appropriate benefits and financial assistance.

Transportation tends to be a significant barrier to care at Spencer Cancer Center. Social workers will

first identify whether the need for transportation is due to a lack of funds to pay for gas or lack of a vehicle. If gas money is a barrier, the foundation can provide financial support for that. If access to a vehicle is the barrier, social workers will reach out to community resources to identify volunteers who can provide transportation. Cultivating relationships in the community allows social workers to find resources for their patients in many diverse places. "I don't think we've ever had anybody that we've not been able to get to treatment," says Chelsea Kroll, LMSW, OSW-C, an oncology social worker at Spencer Cancer Center. "We may have had to jump through a few hoops and search, but I think we've been able to network and partner and collaborate and coordinate to where we've been able to get our patients here."

The message that financial and logistical support for treatment is available is critical because fear of not being able to afford treatment if diagnosed can be a big barrier to screening. The message from Spencer Cancer Center is, "If you go through screening and you're diagnosed, we will treat you." Once members of the community are no longer worried about the financial implications of prostate cancer, the cancer center team works to overcome the logistical barriers to screening. Screening is offered for free, and the cancer center meets patients where they are. It holds screenings at Federally Qualified Health Centers (FQHCs), churches, through civic groups, and in a McDonald's parking lot. Screenings are held on weekends when people are available. Often these outreach events are the first time people are being screened for prostate cancer.

Once the financial and logistical issues regarding screening are addressed, there remains the issue of trust. That's where creating meaningful relationships in the community helps. One program that has successfully connected communities to prostate cancer screening in East Alabama is the Faith Community Nurse Program.

## Building Trust through Faith Communities

The EAH Faith Community Nurse Program was launched in 2001 to create opportunities for registered nurses employed by EAH to bring healthcare to their neighbors through their church congregations and faith communities. According to EAH, faith community nurses are active in more than 20 congregations across three Alabama counties, and they serve about 6,000 people annually through their programs. Because most of the nurses are active members of their faith communities, they already have a trusted relationship with their neighbors, which positions them to effectively deliver health education and screening.

Hosting annual health fairs through churches has proven to be an effective way to facilitate wellness screenings and services by providing blood pressure and blood sugar checks, giving flu shots, and holding nutrition demonstrations. Breast cancer navigators provide models to illustrate how to do a breast self-check for community members. These health fairs are a perfect opportunity to provide prostate cancer screening and engage community members in conversations about possible symptoms of prostate cancer. The consistency of an annual health fair also helps elevate awareness about prostate cancer screening, and community members have come back at recommended intervals for repeat testing. In cases in which a person's PSA is found to be elevated, the faith community nurse can facilitate quick care with the urology clinic.

"In the community I serve as a Faith Community Nurse, the majority of residents are underserved and underinsured," says Sutricia Johnson, BSN, eMBA, director of case management at East Alabama Health. Johnson also serves as a Faith Community Nurse for her church. "We are an African American church, and I am an African American healthcare professional. Just having people come through that look like you, talk like you, and can relate to you, speaks volumes, and lays the groundwork for building trusting relationships, which I believe makes them more comfortable."

# The Ohio State University Comprehensive Cancer Center (OSUCCC) Arthur G. James Cancer Hospital and Richard J. Solove Research Institute COLUMBUS, OH



The OSUCCC Arthur G. James Cancer Hospital and Richard J. Solove Research Institute (“The James”) is based in Columbus, Ohio. Although it is in an urban setting, The James also serves patients who must travel several hours for treatment. Clinicians in The James’ urology department recently launched a three-year project to decrease disparities in care for patients covered by Medicaid. This project includes a focus on outreach to primary care providers (PCPs) and establishes a referral process for prompt patient evaluation.

## Tapping PCPs to Address Disparities

When the members of the U.S. Preventive Services Task Force (USPSTF) revised their prostate cancer screening recommendations in 2012, they emphasized the importance of shared decision-making between patients and their clinicians. The James subsequently encouraged PCPs to become key partners in encouraging PSA testing and appropriate follow-up.

To address the importance of the patient/PCP relationship in eliminating cancer care disparities, clinician researchers at The James identify PCPs in disparity “hotspots.” These providers serve communities that have historically been disproportionately affected by prostate cancer, particularly Black people and those covered by Medicaid. After the PCPs are identified, urologists at The James reach out and set up meetings to discuss current screening guidelines and treatment recommendations, making sure PCPs know the urology clinic is there to respond to any positive screens. They also encourage the PCPs to talk to their patients about the importance of prostate cancer screening.

The James also has family medicine residents do rounds with the urology cancer clinic to help increase their knowledge and understanding of current best practices in prostate cancer screening and care. It’s a natural fit for family medicine rounds since urology issues—both prostate cancer related and others—are common.



According to the American Urological Association, only 38 percent of all counties in the U.S. have a practicing urologist.<sup>21</sup> For The James, the wait to get evaluated after a positive PSA test can be several months. Patients who already face barriers to care are the ones most likely to face delays in care as a result. With the growth of telehealth, clinics could explore using initial consultations between urologists and PCPs to discuss test findings and then triage patients for care. That triage system could include factoring in information such as patient race, absolute PSA level, and family history. Having previous PSA test results could also assist in triaging.

“Many actions, like an initial intake for a minor issue or a follow up of a repeat test, can all be done via telehealth,” says Shawn Dason, MD, a urologic oncologist at The James. “This really does not lose the essence of the visit. This can also be a lot more convenient for patients, reducing some of the barriers to access that we see in certain groups that are higher risk.”

**Table 2. Barriers to Care and Solutions for Financially Disadvantaged Patients**

Barriers	Solutions
<ul style="list-style-type: none"> <li>• Limited language access services (e.g., no bilingual staff, interpreters, or translations of vital documents)</li> <li>• Limited provider office hours and availability for working patients</li> <li>• Inconvenience of or unfamiliarity/discomfort with practice location (The practice may be located far from a patient’s home or work.)</li> <li>• Lack of transportation; cost of parking/gas</li> </ul>	<ul style="list-style-type: none"> <li>• Patient navigation</li> <li>• Multilingual providers</li> <li>• Telehealth visits</li> <li>• Transferring treatment to local facilities</li> <li>• Parking/gas/public transportation reimbursement</li> </ul>

# UCSF Helen Diller Family Comprehensive Cancer Center

## SAN FRANCISCO, CA



UCSF Health's Helen Diller Family Comprehensive Cancer Center (HDFCCC) has affiliated hospitals and clinics across the San Francisco Bay area, where it serves a racially and ethnically diverse community. Tackling cancer disparities is a major research and service priority for the cancer center, which has deep roots in the community through collaborations such as its Community Advisory Board's Abundant Life Health Ministries Program (established 2007) and the partnerships that make up the San Francisco Cancer Initiative.<sup>22,23</sup>

### Building Multi-Level Multi-Institutional Partnerships

Serving as the backbone institution in a collective impact collaboration, HDFCCC reached across San Francisco in 2015 to establish the San Francisco Cancer Initiative (SFCAN). Partners in SFCAN include UCSF, the San Francisco Department of Public Health, major health systems such as Kaiser Permanente, and multiple community coalitions. There are five task forces in SFCAN that address different aspects of cancer care. One of the five is the Prostate Cancer Action Network (PCAN), which seeks to eliminate the morbidity and mortality disparities that afflict Black men.<sup>24</sup>

This ambitious goal requires both intensive community action and substantial institutional change. To accomplish that, the task force members of PCAN built on HDFCCC's Abundant Life Program, an academic/faith community partnership to reduce health disparities. The task force convened local faith leaders, who gave the Prostate Cancer Action Network its name. PCAN seeks to raise awareness, educate, and increase access to prostate cancer screening and follow-up. PCAN's "wellness warriors" are trained community members armed with educational tools that teach local men about what prostate cancer is, how it is detected, and the importance of being tested. PCAN's comprehensive approach includes deploying individual and group education efforts and connecting with community gatherings, where PSA testing can be offered.

After conducting screening, PCAN leaders follow up with the men who have abnormal results and stay in touch with them until any necessary care is obtained. The patient navigation provided by the task force is tailored to each man's health literacy level and emphasizes pre-biopsy counseling on possible outcomes. This counseling is intended to prepare patients for the possibility of having a cancer that will

not require invasive treatment—a concept that is more difficult to convey after an actual cancer diagnosis.

To help meet the full spectrum of community needs, SFCAN/PCAN established a support group for Black men dealing with prostate cancer that is modeled after one the UCSF Cancer Center created in Oakland, California in 2014. Restrictions imposed in response to the COVID-19 pandemic resulted in the Oakland and San Francisco groups merging and becoming virtual. Thus far, nearly 100 men have participated in the group. Key to the group's success is the fact that it has been community-driven from the beginning, with participants determining the format, meeting dates and times, facilitators, and more.

The goal of the group is for men to learn from one another's experiences. "There's a myth out there that African American men don't talk to each other, or don't relate, or aren't vulnerable enough to have these kinds of conversations, and that's just a false statement," says Nynikka Palmer, DrPH, MPH, a co-leader of the SFCAN Prostate Task Force. "We've had men come in and say, 'I saw my urologist and I went ahead and scheduled surgery,'" says Dr. Palmer, "and the other group members are like, 'Hold up, wait a minute, have you talked to the radiation oncologist?' The other men are saying this—I don't even have to."

The support group has been especially important in educating group participants about active surveillance/watchful waiting, which can be a contentious issue in Black communities. Some men have compared it to the Tuskegee Syphilis Study, in which Black men were not treated for their disease. The support group helps to address such fears by talking about the hesitations that patients may have about their care.

## Smarter Screening, Smarter Treatment (S3T)

To tackle the widespread inconsistencies in care experienced by patients, primary care and urology leaders from UCSF, Kaiser Permanente, and the San Francisco Department of Health came together with the goal of ensuring that wherever a person goes for prostate cancer care in San Francisco, they will receive high-quality screening, counseling, and treatment options.

This effort began when Matthew Cooperberg, MD, a urologist at UCSF, taught continuing education courses at Kaiser Permanente and the San Francisco Department of Health, in which he presented data

that support broad implementation of the protocol Smarter Screening, Smarter Treatment (S3T). The protocol is a synthesis of rigorous research that shows the impact of risk-based PSA testing and diagnosis and risk-stratified treatment, including active surveillance, which together can improve outcomes while reducing both under- and over-treatment of prostate cancer. (A manuscript on S3T is in development.)

Central to the overall approach of S3T is that cancer diagnoses can be categorized by levels of risk that are associated with treatment recommendations. For patients at low risk for the spread of prostate cancer outside the prostate, active surveillance is offered, since nearly 70 percent of patients with low-risk prostate cancer will never experience disease progression.<sup>25</sup> Patients with higher-risk cancers will be offered surgery, radiation, or combination therapy.

To support the adoption of S3T, an intensive vetting process was conducted by UCSF Internal Medicine leaders that culminated in the protocol's addition to that division's Electronic Health Record Health Maintenance Banner. More time is required for this development in the other institutions.

## Increasing Participation in Clinical Trials

Due to the extreme disparities in outcomes for Black individuals diagnosed with prostate cancer, increasing their participation in clinical trials is especially important to improving long-term outcomes.

Programs can measure inequity in clinical trials by looking at the demographic characteristics of incident cases in their catchment area, the characteristics of patients coming into the cancer center, and the characteristics of patients enrolling in clinical trials. By looking at these characteristics, programs can draw conclusions about the degree of inequity in care and what's driving it. The chosen intervention should be tailored appropriately, based on where the disparity exists.

"Improving representation in clinical trials does not occur passively," says Hala Borno, MD, the co-medical director of the Genitourinary Medical Oncology Clinic at HDFCCC. "There has to be active intent around addressing inequities and access to clinical trials. The only way you can address those inequities is to examine the degree to which they are occurring within your own context."



How should programs go about improving recruitment to clinical trials? At a basic level, it starts with tailoring recruitment materials to the patient population you are trying to recruit. Information must be culturally appropriate, tailored, and accessible. UCSF Health is developing technology solutions to empower patients as well as providers to understand and consider clinical trial options. Researchers have created patient-facing prostate cancer clinical trial-matching software called the Trial Library. This software helps patients navigate potential clinical trial options using plain language summaries and information that explains the key components and design of individual studies.




Beyond improvements in communication, it is critical to look at financial barriers to clinical trial participation. HDFCCC looked at the indirect costs of patient participation in clinical trials, such

as travel, lodging, financial concerns, and work disruption. Researchers then studied the impact of the convenient availability of a patient navigator and the provision of a financial reimbursement program on cancer clinical trial accrual. They saw improved patient accrual to clinical trials, with a bigger impact on late-phase studies.<sup>26</sup> By addressing disparities in this way, cancer programs are more likely to find success in meeting health equity goals.

## SUMMARY

Prostate cancer disparities do not arise from any single factor, so addressing them requires a multilayered approach. The strategies to overcome prostate cancer disparities being implemented by these highlighted programs address these different layers, often in similar ways.

**Table 3. Strategies to Overcome Disparities**

 <p>Early detection in targeted populations</p>	<ul style="list-style-type: none"> <li>▶ Outreach to PCPs to educate patients about screening and PSA results management</li> <li>▶ Outreach to vulnerable populations through community leaders and other trusted messengers</li> </ul>
 <p>Access to care</p>	<ul style="list-style-type: none"> <li>▶ Navigation of high-risk PSA results and high-risk patients</li> <li>▶ Minimize financial barriers</li> <li>▶ Utilize multi-disciplinary clinics</li> <li>▶ Integrate standardized protocols into EHR</li> </ul>
 <p>Tailored, culturally appropriate support</p>	<ul style="list-style-type: none"> <li>▶ Hire culturally appropriate support staff</li> <li>▶ Work with the target community to define what they want and need, as opposed to making assumptions</li> </ul>

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