

Effective Practices in Bladder Cancer Care: MITIGATING DISPARITIES WITH GUIDELINE-BASED CARE

Despite the expansion of therapeutic options for patients with bladder cancer (see Box 1), disparities persist in the United States (U.S.). Receipt of guideline-concordant treatment is suboptimal across the bladder cancer spectrum, especially for Black patients, women, older patients, and patients living in rural areas. Large studies using the National Cancer Database (NCDB) report that Black, female, uninsured, or Medicaid patients with any stage of bladder cancer are less likely than other patient populations to receive cancer-directed therapies.^{1,2}

The causes of disparities in bladder cancer care are multifactorial, and include patient-, provider-, and institutional-related factors. Referral delays, insurance authorization delays, patient preference, socioeconomic status, and limited access to high-volume treatment centers contribute to these disparities.^{3,4} Implicit racial/ethnic bias, or discriminatory treatment that occurs without clinicians' awareness, is a major factor in disparities in receipt of guideline-based treatment.⁵ Providers need to be aware of these barriers to guideline-concordant care.

BOX 1. Guideline-Based Treatment

75 percent of patients present with non-muscle invasive bladder cancer (NMIBC), which is predominantly treated with transurethral resection of bladder tumor (TURBT) and surveillance cystoscopy. Standard-of-care treatment for patients with muscle invasive bladder cancer (MIBC) includes platinum-based neoadjuvant chemotherapy (NAC), radical cystectomy, multimodal therapy (TURBT, chemotherapy, and radiation therapy), or palliation.⁶ Preferred options for metastatic disease in the first-line include platinum-based chemotherapy, pembrolizumab for patients who are ineligible for platinum-containing chemotherapy, followed by avelumab as maintenance therapy.⁷ The National Comprehensive Cancer Network's NCCN Guidelines for Patients(R): Bladder Cancer has systemic immunotherapies as an option after chemotherapy treatment for patients with metastatic bladder cancer (mBC). Tyrosine kinase inhibitor erdafitinib, targeted gene-therapy enfortumab vedotin-ejfv and antibody-drug conjugate sacituzumab govitecan are included as therapies for patients whose metastatic disease progresses after treatment with checkpoint inhibitors.⁷

Improving Guideline-Based Treatment with Quality Improvement

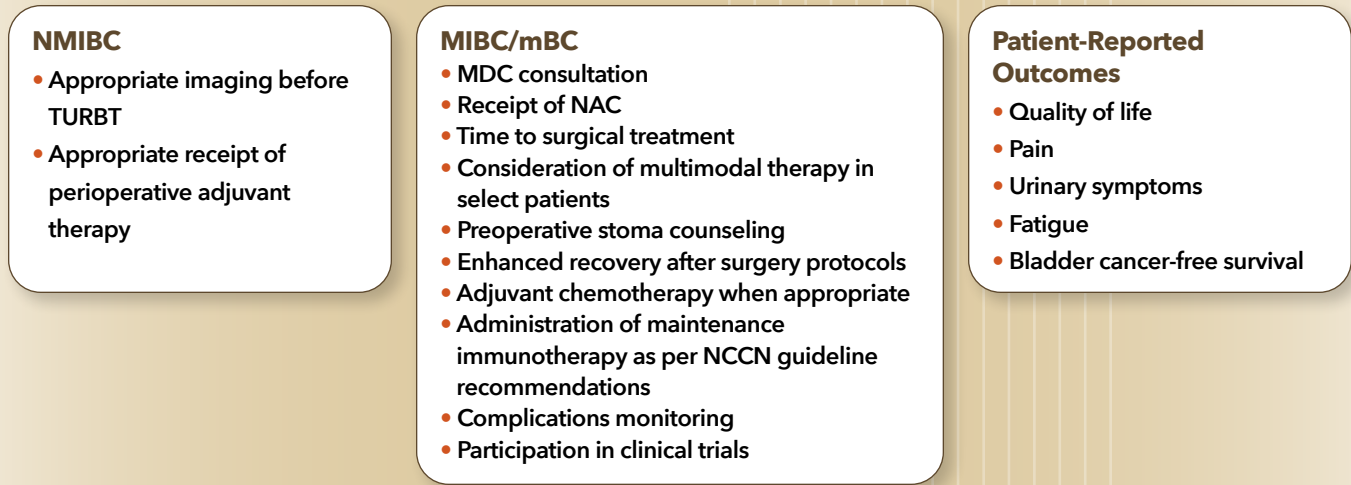
Neither urologists nor oncologists are necessarily aware of all the barriers that prevent patients who are diagnosed with bladder cancer from receiving appropriate care. Samuel L. Washington III, MD, Assistant Professor of Urology and Goldberg-Endowed Professorship in Cancer Biology from the University of California, San Francisco, observes that providers may make assumptions about their patients' education, literacy, insurance, transportation, or anxieties about treatment-related complications. These assumptions can perpetuate implicit bias against patients who already face multiple systemic barriers to care and may impact decision-making conversations between patients and providers.

Dr. Washington highlights that community cancer centers are well-positioned to explore internal practice patterns to determine which patients with bladder cancer could benefit from a formal QI assessment and intervention. Consider reviewing chart data and other internal metrics to tease out practice patterns and identify areas for improvement in specialist referral, care coordination, receipt of guideline-based treatment, and shared decision-making. Current evidence-based practices point to several candidate quality metrics for improving bladder cancer care (Figure 1).

Dr. Washington notes that the first step for community programs should be to identify and understand what is occurring within your institution. That is, examine the specific individual and organizational factors that negatively impact your patients. Only then are you able to tailor an action plan to address barriers.

Cancer programs and practices can also explore QI initiatives that address barriers to accessing care and reaching vulnerable populations. A few examples to further explain Dr. Washington's point include a recent study on parking fees for patients, and access to clinical trials. Lee et al., identified parking fees as a barrier to cancer care.¹¹ This cross-sectional study reviewed parking fees at National Cancer Institute (NCI)-designated cancer treatment centers and assessed parking costs for the treatment duration of certain cancers. A similar study undertaken at

FIGURE 1. Candidate Metrics for QI in Bladder Cancer⁷⁻¹⁰



the University of California San Francisco’s Helen Diller Family Comprehensive Cancer Center looked at improving access to cancer clinical trials.¹² The IMPACT study is a 3-year pilot that aims to improve patient enrollment, retention, minority participation and equitable access in oncology trials. These studies provide a framework of first identifying and understanding the barriers your patient population faces in accessing quality care and addressing them through quality initiatives.

Conclusion

Community cancer programs can implement quality improvement steps to optimize the delivery of guideline-based treatment for vulnerable patients with bladder cancer and, in doing so, prevent disparities in treatment delivery and outcomes.

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