AD_____

Award Number: W81XWH-11-1-0540

TITLE: Racial Disparities in the Quality of Prostate Cancer Care

PRINCIPAL INVESTIGATOR: Nina Bickell

CONTRACTING ORGANIZATION: Icahn School of Medicine at Mount Sinai
New York, NY 10029

REPORT DATE: September 2014

TYPE OF REPORT: Annual

PREPARED FOR: U.S. Army Medical Research and Materiel Command
Fort Detrick, Maryland 21702-5012

DISTRIBUTION STATEMENT:
Approved for public release; distribution unlimited

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1. REPORT DATE	2. REPORT TYPE	3. DATES COVERED
September 2014	Annual	01-SEP-2013 to 31-AUG-2014

4. TITLE AND SUBTITLE

Racial Disparities in the Quality of Prostate Cancer Care

5a. CONTRACT NUMBER

5b. GRANT NUMBER
W81XWH-11-1-0540

5c. PROGRAM ELEMENT NUMBER

6. AUTHOR(S)

Nina Bickell, MD, MPH

E-Mail: nina.bickell@mssm.edu

5d. PROJECT NUMBER

5e. TASK NUMBER

5f. WORK UNIT NUMBER

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)

Icahn School of Medicine at Mount Sinai
New York, NY 10029

8. PERFORMING ORGANIZATION REPORT NUMBER

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)
U.S. Army Medical Research and Materiel Command
Fort Detrick, Maryland 21702-5012

10. SPONSOR/MONITOR'S ACRONYM(S)

11. SPONSOR/MONITOR'S REPORT NUMBER(S)

12. DISTRIBUTION / AVAILABILITY STATEMENT
Approved for Public Release; Distribution Unlimited

13. SUPPLEMENTARY NOTES

14. ABSTRACT

We have completed the retrospective chart abstraction of men with localized prostate cancer at Mount Sinai. We are in the process of completing the abstraction at Harlem Hospital. Physician interviews have begun and focus groups are in the process of being scheduled.

15. SUBJECT TERMS
Quality indicators, locally advanced prostate cancer

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			USAMRMC
U	U	U	UU	4	19b. TELEPHONE NUMBER *(include area code)*

Table of Contents

Introduction:

For younger men (<65 years of age) with high risk locally advanced (>stage 2C), active treatment with surgery or radiotherapy appears to improve disease-free and overall survival as compared to active surveillance (no active treatment). Minority men are less likely to receive active treatment but the reasons for this haven't been evaluated in younger men. Since black men with prostate cancer are younger at diagnosis, more likely to have poorly differentiated tumors, less likely to receive active treatment and more likely than white men to die of prostate cancer, it is possible that the quality of prostate cancer care delivered may be contributing to the racial disparity in mortality. While it is clear that physician recommendation and physician specialty affects the type of prostate cancer treatment recommended and ultimately received, little is known about racial differences in which treatments are offered to minority vs nonminority men and why. Nor are there data explaining younger minority men's lower rates of active treatment in circumstances when active surveillance does not achieve the same benefits of active treatment. This proposal seeks to determine whether the quality of care received by minority men with locally advanced prostate cancer differs from the care received by white men controlling for comorbidity, age and insurance. We will look at reasons for the treatment choices minority men make including their experiences, their physicians' recommendations, beliefs about the prostate cancer, its treatment and consequences and assess racial differences in beliefs and potential causes of poorer quality care; and, explore urologists perceptions of their decision-making and referrals among men who do not receive active treatment (surgery, EBRT or brachytherapy), and those receiving poor quality of care.

Body:

During this third year of funding of the "Racial Disparities in the Quality of Prostate Cancer Care" project, we have accomplished several important milestones. The goals of this third year as per our statement of work are: 1) completing abstraction of medical records; 2) data entry and analysis of chart abstraction data; 3) recruitment, conduct and analysis of focus groups, 4) conduct and analysis of physician interviews.

Chart abstraction:
We encountered some unexpected challenges with chart abstraction at Mount Sinai as we found key critical elements missing from one particular surgeon's charts whose paper charts were not available on EMR. In August, the paper charts became available and a re-review of 300 charts was done in order to obtain the missing data. We have now completed the chart abstraction at Mount Sinai and data cleaning of the sample.
We have conducted data analysis based on quality measures identified through our literature review and expert Steering Committee review. Of the 676 abstracted charts, 581 are eligible for inclusion: 50 have prior h/o cancer; 39 have metastatic cancer; 6 have poor prognosis. Our results show that 92% of our population consists of intermediate risk cancers (Gleason 7). 28% of black men have a comorbid condition as compared to 11% of whites. Of note, 84% of the no treatment group are men with intermediate cancers.

We have encountered numerous obstacles in getting the study started at Harlem Hospital. IRB approval was obtained from the IRB of record however HHC approval (internal organizational approval) had internal signoff delays and was finally approved in April. Despite initial buy-in by the Principal Investigator and IRB & organizational approval, there has been a delay with allowing study chart abstractors review the medical records. The final process of getting clearance for the abstractors for chart abstraction was not obtained until August. Despite these challenges, we have made significant strides forward. We met with Pathology, IT and the tumor registry to identify white, and black men with a Gleason score $\geq$7 applying the same criteria used with the Mount Sinai sample. The Pathology Department does not have a searchable electronic system which allows patient identification; therefore, we worked with IT and the Tumor Registry to be able to identify the sample. Chart abstractors have been trained on the electronic medical record used at the site. Radiation therapy is given at another hospital and we are working with the sites to see how this information may be obtained for Harlem patients. We are now in the process of cleaning the chart abstraction data and obtaining missing information.

Physician Interviews & Patient Focus Groups

We have begun our physician interviews and have completed 11 physician interviews at Mount Sinai and are scheduling the one remaining interview. The physician interviews will serve to explore reasons for treatments given to specific patients. We are in the process of transcribing the interviews. We have worked with our data analyst to be able identify a potential sample of patients for focus groups. We took a random sample of patients who received treatment for their prostate cancer and matched them based on race, gleason, and age. We have reached out to the identified patients and are working on scheduling the focus groups. In addition, we have begun cleaning the Harlem chart abstraction data and physicians interviews. We are working on identifying the patients for focus groups.

Key Research Accomplishments:

- Completed chart abstraction at Mount Sinai site
- Identified retrospective sample for Harlem Hospital and completed 80% of abstraction
- Cleaned and analyzed Mount Sinai chart abstraction
- Began cleaning of Harlem Hospital chart abstraction data
- Began physician interviews at Mount Sinai
- Identified focus group participants and working on scheduling focus groups

Reportable Outcomes:

None at this time.

Conclusion:

We have completed the majority of the chart abstraction and have found that a little over 80% of patients have surgery to treat prostate cancer at Mount Sinai but a small number go on to receive RT or ADT.

References:

None.

Supporting Data:

None.