

COMPREHENSIVE CANCER CONTROL PLAN



TIP SHEET

PROSTATE CANCER SCREENING

The Comprehensive Cancer Control National Partnership (CCCNP) is a 20+ year collaboration of diverse national organizations working together to build and strengthen Comprehensive Cancer Control (CCC) efforts across the nation.

This Tip Sheet is part of a series offered through the CCCNP to assist CCC programs charged with developing, implementing, and evaluating cancer control plans tailored to their state/tribe/territory/jurisdiction. CCC Plans focus coalition efforts on evidence-based interventions (EBIs) that impact cancer prevention and control across the cancer continuum.





How to Use This Tip Sheet

Use When Updating Your CCC Plans

Tip Sheets can be used to help CCC program staff, coalition staff, and volunteers update CCC plans. Each tip sheet focuses on a specific topic (e.g., colorectal cancer screening, tobacco control, risk factors for cancer survivors). Follow the steps throughout the Tip Sheet to help guide your process in updating your cancer plan for that specific topic area. Some ideas:

- Incorporate the Tip Sheet into your plan update process – share it with your coalition workgroups and use it to help guide your decisions.
- Identify a lead person to ensure that the Tip Sheet is used by the workgroup or team assigned to update the plan section that addresses each Tip Sheet topic.
- Use the Tip Sheet to check that the topic is appropriately addressed in your plan and that the elements outlined on the next page are covered (objective, data, strategies).
- Use the **worksheet** at the end of this document with your partners to ask and answer critical questions related to the topic as you update your plan.

Use When Implementing Your CCC Plan

Tip Sheets can be used while you are implementing the priorities in your plan. The partners and resources listed in each sheet can help ensure your coalition work stays on track and is of high quality. Some ideas:

- Use with coalition leadership and workgroups as they implement the plan, to find resources, data, and to think about partners that could be engaged in implementing specific strategies from the plan.
- Engage coalition members and reactivate workgroups that have been inactive or need a renewed sense of direction.
- Orient new CCC program staff and coalition members or leaders, to help them better understand the importance of the Tip Sheet topics to CCC efforts, and to provide access to relevant information and resources
- Use the Tip Sheets to help with decision making when identifying priorities from the CCC plan.
- Help a priority workgroup who is just forming to help find an area to focus in on, especially by using the questions at the end of the Tip Sheets.
- Use as a tool to check progress in implementing the plan's priorities, especially focusing on data being collected, EBI's being used and the engagement of key implementation partners.
- Share them with partners (community organizations, FQHCs, Primary Care Associations, etc.) as a resource about a specific topic including sources of information, data, and evidence-based interventions.

Definitions

- **SMART Objective** – is an objective in the cancer plan that is Specific, Measurable, Achievable, Relevant, and Time-bound.
- **Evidence-Based Strategy** – is a specific activity that is designed to achieve the objective and is based on evidence that the strategy is expected to work in your situation, i.e., it has been evaluated and shown to work.
- **Crude vs. Age-adjusted Rates** – Crude rates are influenced by the age distribution of the state's population. Even if two states have the same age-adjusted rates, the state with the relatively older population will generally have higher crude rates because incidence or death rates for most cancers increase with age. Age-adjusting the rates ensures that differences in incidence or deaths from one year to another, or between one geographic area and another, are not due to differences in the age distribution of the populations being compared. Find out more [here](#).
- **Populations of Focus** – are those groups experiencing the greatest cancer disparities in your region. Disparities might include higher cancer incidence or mortality; greater challenges accessing cancer screening, treatment, and/or survivorship care services; or populations experiencing bias in society and the healthcare system.
- **Health Equity** – occurs when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.
- **Health Disparity** – is a type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systemically experienced greater social or economic obstacles to health. These obstacles stem from discrimination or exclusion that is historically linked to characteristics such as race or ethnicity, socioeconomic status, disability, sexual orientation, and many other factors.¹
- **Social Determinants of Health (SDoH)** – are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.²

¹ U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020 [Internet]. Section IV: Advisory Committee findings and recommendations [cited 2010 January 6]. Available from: http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf.

² Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 12/04/2020, from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>.



Tips for Updating Your CCC Plan

- **Use your current cancer plan as a starting point:** Think of this process as updating the current plan instead of starting a new plan from scratch.
- **Be systematic:** Assign workgroups to review and update certain sections of the plan. Create a process that is common across all workgroups tasked with updating the plan, which should include a standard set of criteria for the inclusion of plan goals, objectives, and strategies.
- **Focus workgroups on assessing and updating the core aspects of the plan:** the goals, objectives, and strategies.
- **Identify someone to take the lead** on writing the introduction, connecting text, and putting the document together for publication.
- **Use data to determine the focus of the plan:** Which cancers are most prevalent in the population? What subpopulations experience the most disparities?
- **View through a health equity lens:** Be intentional and proactive in keeping health equity issues at the forefront in every step of the cancer plan process – when engaging partners, collecting data, and setting goals. Include representatives from your population of focus in the writing of your cancer plan.

Use these resources to explore more cancer control planning tips and examples:

- **Nine Habits of Successful CCC Coalitions**
- **CCC Implementation Building Blocks** (see page 7 of the Appendices for more tips on updating your plan)

Additional resources you can use:

- Search other CCC plans to get ideas – **CDC's CCC Plan Map and Search Tool**
- **CDC Cancer Plan Self-Assessment Tool**
- **GW State Cancer Plans Priority Alignment Resource Guide and Tool**
- **A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease**

Checklist for Updating Your CCC Plan

- ☐ **Ensure that your workgroup is familiar with your current cancer plan.**
- ☐ **Create a systematic process for the workgroup to follow that is intentional about addressing health equity.**
- ☐ **Use data to focus on the populations with the highest cancer burdens.**
- ☐ **Focus workgroups on assessing and updating goals, objectives, and strategies.**
- ☐ **Identify someone to write the introduction and assemble the final document.**

COMPREHENSIVE CANCER CONTROL PLAN UPDATE TIP SHEET

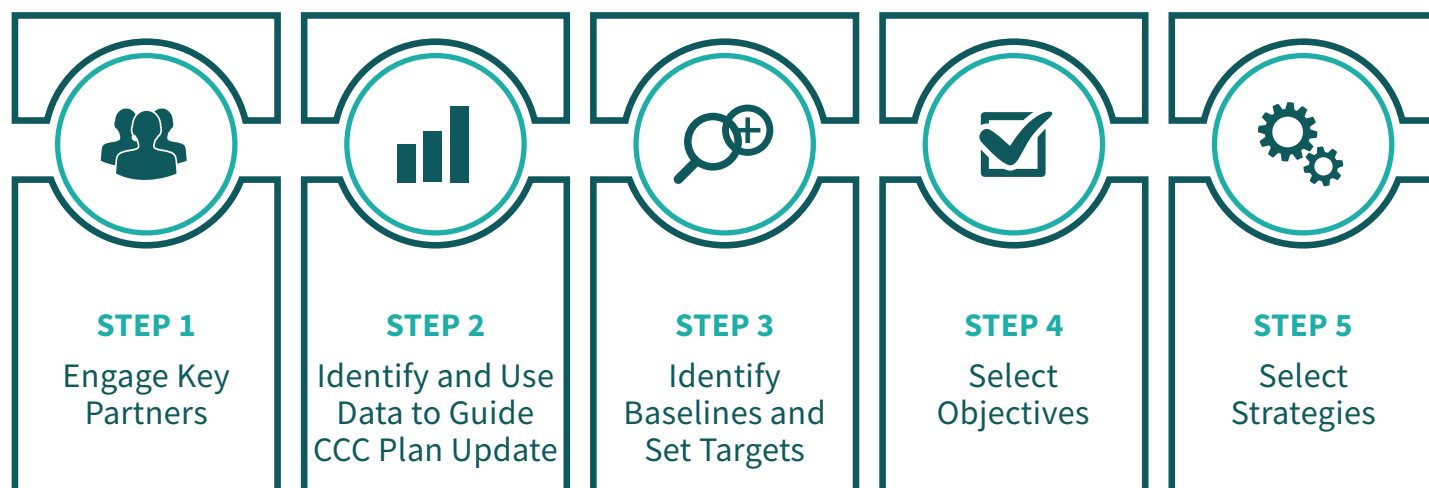
Prostate Cancer Screening

Why Prostate Cancer Screening is an Important Part of Your CCC Plan

- Other than skin cancer, prostate cancer is the most common cancer in men who live in the United States.
- About 1 man in 8 will be diagnosed with prostate cancer during his lifetime.
- Prostate cancer is more likely to develop in older men and in non-Hispanic Black men. About 6 cases in 10 are diagnosed in men who are 65 or older, and it is rare in men under 40. The average age of men at diagnosis is about 66.
- Prostate cancer can be a serious disease, but most men diagnosed with prostate cancer do not die from it. In fact, more than 3.1 million men in the United States who have been diagnosed with prostate cancer at some point are still alive today.

For prostate cancer screening, ensure that your objectives and strategies are supportive of nationally recognized prostate cancer screening guidelines, such as the **US Preventive Services Task Force recommendations** and **American Cancer Society recommended screening guidelines**.

Screening recommendations for prostate cancer screening focus on shared decision-making with a healthcare provider. Therefore, CCC plans should have objectives and evidence-based strategies that remove barriers, increase opportunities, and support those conversations with men aged 55 to 69 years and their healthcare providers. In addition, prostate cancer survivors and their families should be included in the population that is served in the survivorship objectives and strategies in your CCC plan.





STEP 1 Engage Key Partners

Engage experts in prostate cancer screening. Organizations and agencies who have access to the data you need and partners who will be critical to implementing your cervical cancer screening strategies are:

- **ACS Cancer Action Network (ASC-CAN)**
- **American Cancer Society**
- **American Academy of Family Physicians**
- **National Medical Association**
- **American Medical Association**
- **American Urology Association**
- Organizations that can reach large numbers of men
- Cancer centers and academic partners that are interested in prostate cancer-related research
- Current coalition workgroup or advisory group members focused on prostate cancer screening
- Health plans, insurance providers
- Local medical associations that include the following practice areas: primary care, nurses, and navigators
- Organizations and individuals that represent communities experiencing disparities in prostate cancer
- Provider champions
- State Medicaid and Medicare offices
- Your central cancer registry [**National Program of Cancer Registries (NPCR)**] and **Surveillance, Epidemiology, and End Results (SEER)**





STEP 2

Identify and Use Data to Guide CCC Plan Update

Data is essential to your cancer plan in several ways, including:

- Identifying populations that have higher incidence and mortality rates of prostate cancer and lower rates of men who follow the recommendations to discuss prostate cancer screenings (if available). At a minimum, it would be helpful to examine this by race/ethnicity, health insurance status, and geographic area.
- Identifying data that support strategies, baselines, and targets that focus on increasing the number of providers that are having shared decision-making conversations with their patients.
- Identifying adherence to prostate cancer screening recommendations and trends over time to identify specific areas for focus.
- Identifying the availability and type of providers, cancer services, and ancillary supports (survivor programs, etc.) in different geographic areas and population groups to inform objectives and strategies in this topic area. Comparing local data with national data to highlight key areas of need or lagging progress.
- Identifying organizations and settings that provide access and opportunities to encourage large numbers of age-appropriate men to request these discussions with their providers.
- Laying a foundation to measure progress over the life of the plan (e.g., baselines and targets).

- CCC coalitions can:
 - Provide data in easy-to-understand formats to communicate the importance and benefits of recommendations to discuss prostate cancer screening.
 - Collect and share information with health providers to have a discussion regarding prostate cancer screening in your state, tribe, or territory.
 - Analyze healthcare provider survey data on knowledge, attitudes, and practices about prostate cancer screening.

It is best to use data from your own state, tribe, or territory, but national data can help you set targets, letting you compare your data with other locations and the nation.

Local data sources include:

- Your central cancer registry **National Program of Cancer Registries (NPCR)** and **Surveillance, Epidemiology, and End Results (SEER)**
- In addition, some states' **Behavioral Risk Factor Surveillance System (BRFSS)** programs collect prostate cancer screening recommendation data

National data sources for national and state-level estimates include:

- **American Cancer Society Facts and Figures**
- **American Society of Clinical Oncology (ASCO)**
- **Health Information National Trends Survey (HINTS)**
- **National Cancer Institute (NCI) Cancer Trends Progress Report**
- **State Cancer Profiles**
- **US Cancer Statistics**



STEP 3

Identify Baselines and Set Targets

The questions in the worksheet below can guide you in thinking through data collection, decision-making and priority-setting processes. Think about the following topics as you work through the questions:

- Set targets for increases in providers that follow the prostate cancer screening recommendations based on data, stakeholder input, and local/national targets.
- Identify if there are priority areas based on data.
- Consult **Healthy People** 2030 goals, your health department's chronic disease plan to see what baselines and targets are already being used by your partners; remember to cite your data sources.





STEP 4 Select Objectives

It is helpful to show how your CCC plan goals contribute to national goals. Create a **primary objective** that mirrors national priorities, such as those in Healthy People 2030, and identify 1-2 other **complementary health equity objectives** that support specific needs within your communities, including a special focus on subpopulations that experience health disparities.

There is no Healthy People 2030 target specifically directed at the prostate cancer screening recommendation. There is a target goal to increase the proportion of adults who get recommended evidence-based preventive health care — AHS-08.

EXAMPLES OF PRIMARY OBJECTIVES



Increase the percentage of men from X% to X% by 2030 who have discussed the advantages and disadvantages of screening for prostate cancer with their health care provider (BRFSS – check with your state).



Reduce mortality from prostate cancer from X deaths per 100,000 to Y deaths per 100,000 (state cancer registry).



Increase the number of healthcare systems or clinics using client reminders to increase the number of men requesting shared decision-making discussions.

EXAMPLE OF A COMPLEMENTARY HEALTH EQUITY OBJECTIVE



Increase the percentage of Black men from X% to X% who have discussed the advantages and disadvantages of screening for prostate cancer with their health care provider from X% to X% by 2030 (BRFSS).

EXAMPLE OF A COMPLEMENTARY POLICY OBJECTIVE



Increase the number of (e.g., health systems, clinics, medical schools, physician associations) from X# to X# that train providers on prostate recommendations by 2030.



STEP 5 Select Strategies

When choosing strategies that can help address the needs you have identified, think about existing networks, programs, and services you can leverage, enhance, or expand. Also, consider if the strategy is realistic and feasible given current support for addressing this issue, as well as available resources to implement the strategy.

For prostate cancer screening, ensure that your strategies are supportive of nationally recognized prostate cancer screening guidelines, such as the **US Preventive Services Task Force recommendations** and **American Cancer Society recommended screening guidelines**.

Although the Community Preventive Services Task Force (CPSTF) states in the Community Guide, Informed decision making (IDM) interventions help educate clients about cancer screening and make decisions with respect to their preferences. The aims of IDM interventions are to increase client participation in decision-making at a level desired by the client and to promote decisions consistent with client values. These interventions can be delivered in many ways, such as group education or the mass media, and can include the use of decision aids.

The following strategies are examples of evidence-based strategies found in CCC plans:

Strategies to Educate and Train Health Care Providers

- Work with healthcare provider networks to encourage providers to obtain and act on the most recent data and tools that support how to best communicate with African American patients about their increased risk of prostate cancer, all risks, and benefits of PSA testing. One online resource that supports shared decision making is CDC's "**Talk to Nathan**."

Strategies to Increase Community Access

- Work with organizations that have access to large numbers of African American men and integrate prostate awareness and education about the high risk of prostate cancer for African Americans into their existing meetings, events, and activities. In addition, assist those who are unaffiliated to establish a medical home. For others who have primary care providers, reconnect for ongoing preventive care.
- Use interpreter services or bilingual providers to promote health equity.

Strategies for Health System Changes

- Work with health insurance providers to examine their claims data and identify populations to educate regarding the USPSTF prostate cancer screening recommendations.
- Promote the use of client reminders to increase the number of men requesting shared decision-making discussions.

Often, using a combination of these strategies is more effective than implementing a single strategy.

For health systems changes, establishing a relationship and shared outcomes with the system is important to consider upfront. It's also helpful to have a clinical champion who can energize clinic staff and keep everyone focused on ensuring adherence to prostate cancer screening recommendations and that discussions happen. Periodically monitoring clinic-level goals for these prostate cancer discussions is an important activity when implementing health system interventions, so approaches can be adjusted as needed.

Where to Find EBIs

- Your own program evaluations
- Your partners' evidence-informed evaluations
- **The Community Guide (prostate)**
- **NCI's Evidence-Based Cancer Control Programs**
- **Cochrane Reviews**

For information and tools on adapting strategies to fit your location, start at **The Cancer Prevention and Control Research Network (CPCRN) site** and include the training, **Putting Public Health Evidence Into Practice**.



Worksheet: Questions to Ask and Answer

Use this worksheet to help you and your coalition partners focused on cervical cancer to identify best practices, gaps, opportunities, and challenges that should be reflected in your CCC plan objectives and strategies. Record your answers and use the information to help inform your selection of objectives and strategies for your updated plan.

1. Overall, how are we doing in prostate cancer deaths and incidence compared to the national rates, our neighboring states, and our own rates in previous years?

- What primary objectives do we want to set, given our analysis of this data?

2. In what specific populations or communities are prostate cancer high? Do we know why? If we do not know why, how do we find out?

- What complementary health disparity objectives do we want to set, given our analysis of this data?

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3. What partners can we engage to help implement policy and system changes to support adherence to prostate cancer recommendations? Do we have existing connections with them? How can we engage these partners? Why will they want to be involved? What is the value proposition for them?

- What strategies should we select, given the answers to the questions?

4. Are healthcare providers who can discuss prostate cancer screening recommendations, and if needed, diagnostic services easily accessible to all populations? Is there a geographic area or subpopulation with less convenient access or greater barriers to accessing services?

- What strategies should we select, given the answers to the questions?

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5. What existing services, networks, or programs could we leverage to increase the number of men who have prostate cancer screening discussions with their healthcare providers?

- What strategies should we select, given the answer to this question?

6. Are there prostate cancer screening policies that we want to advocate for or promote?

- What strategies should we select, given the answers to this question?

7. What gets measured is what gets done: How can we best track prostate cancer screening recommendation outcomes? How do we know we are making progress along the way?

- Are there strategies we should select related to the answers to these questions?

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8. What and how do we communicate these results to the public and policymakers, along with a “one voice” recommendation?

- Are there strategies we should select related to the answers to this question?

9. How will the strategies we selected optimize health outcomes for those who have historically experienced health outcome disparities (or populations of focus)?