CANCER IN AFRICAN AMERICAN MEN IN SOUTH CAROLINA

Provider recommendations for engagement and re-engagement of cancer screening and prevention

A 2019 joint report issued by the South Carolina Cancer Alliance and South Carolina's Department of Health and Environmental Control highlighted the disproportionately high cancer incidence and mortality in South Carolina among African American men (1). Most hypotheses for why African American men continue to have poorer cancer outcomes than non-African American men center on disparities in health insurance coverage and utilization of care, (2-4) but data collected in South Carolina Behavior Risk Factor Surveillance System (BRFSS) suggests these may not be the direct causes. Most African American men in South Carolina have health insurance and see their doctor based on self-reported data; this suggests providers are missing opportunities to connect their African American male patients to screening and care. Provided in the table below are misconceptions in healthcare around African American men and data to address these mistaken beliefs.

MISCONCEPTION	FACT
African American men are un-insured.	While it's true that 8.5% fewer African American men surveyed through BRFSS reported having insurance than White men, most (79.0%) stated that they do have insurance; holding age, education, and income the same, there is no difference in the odds of having health insurance between African American and white men (OR:1.27, 95% CI: 0.87-1.86).
African American men are not going to doctor's appointments routinely.	According to BRFSS data, African American men are actually more likely to have had a checkup in the last 12 months than white men (OR:1.36, 95% CI:1.01-1.82); the likelihood increases to 78% more when the men are matched on age and health insurance status.
African American men are not able to see a doctor because of cost.	The proportion (20.1%) of African American men reporting an inability to see a doctor because of cost is higher than in white men (11.4%), but when matched on age, health insurance, and income, there is no association between race and ability to pay for services (OR:1.26, 95% CI:0.89-1.79).

BLUE GRANITE DAY

In December of 2019, the South Carolina Cancer Alliance hosted 'Blue Granite Day', an event meant to engage community stakeholders in finding ways to reduce the cancer disparities observed in African American men across South Carolina. The attendees created a list of over 80 ideas to reduce cancer incidence and mortality in South Carolina African American men, seven of which focused on provider education (see Figure 1). Using these suggestions as a starting point, three major themes for provider-driven evidence-based interventions to promote cancer screening and prevention among AA men emerged:

Figure 1: Translation of Blue Granite Day suggestions to evidence-based interventions

Blue Granite Day Suggestions

- Present cancer rates at state & other conferences; promote adherence to screening guidelines
- Educate PCP to recognize & refer patients with family history/risk factors for earlier screenings
- Develop simple, standard screening education modalities for PCP
- Create/administer SCMA health disparities education curriculum
- Preventive Health Service Model for AA Men
- Oncology Medical Associates: prevention, earlier referrals, educate staff
- Increase access to programs that provide free cancer screenings to uninsured/under insured patients

THEME 1 Reduce structural barriers to men accessing screening services

- Have designated days only for male patients with longer appointment slots [2-4]
- Allow husband-and-wife appointments [5]
- Coordinate with local employers to conduct cancer health screenings on-site [6]
- Coordinate cancer screenings at churches [7]
- Match patient with AA providers, nurses, and staff [8-9]
- Provide AA men with proposed questions as discussion starters
- Deploy community outreach staff to educate patients [10]
- Use patient navigation staff to monitor and assist with outreach, access, and follow through with AA men [11]
- Reduce out-of-pocket costs for cancer screening services [12]

THEME 2

Utilize eHR to provide provider and patient reminders.

- Use eHR data to determine number of AA men in the practice and provide outreach to those not seen in 12+ month [13-15]
- Adjust the referral of AA men for cancer screenings based on family history, genetics, and other known risk factors [3,13]
- Create standing orders for cancer screening services for AA men[13-15]

THEME 3

Educate, assess, and provide feedback to providers.

- Have providers complete a cultural competency course, focusing on the specific disparities and needs of AA men [16]
- Use a combination of clinic records, eHR, and patient surveys to periodically (e.g., quarterly) give providers feedback on screening rates among AA men [17-18]
- Implement a welcoming clinical environment and discuss screening/medical options in a manner that will build trusting relationship between AA male patients and providers [19]

**For the purposes of this report, African American or black refers to the ethnic group of Americans with total or partial ancestry from any of the black racial groups of Africa. Most African Americans are descendants of enslaved peoples within the boundaries of the present United States (US). On average, African Americans are of West/Central African and European descent, and some also have Native American ancestry. South Carolina also includes a unique population of African Americans with Sea Island or Gullah ancestry. They are the most genetically homogeneous group of blacks in the US. According to US Census Bureau data, African immigrants generally do not self-identify as African American. The overwhelming majority of African immigrants identify instead with their own respective ethnicities. Immigrants from some Caribbean, Central American and South American nations and their descendants may or may not also identify as African American.*

THEME 1 Reduce structural barriers to men accessing screening services

Have block days specifically for men; Schedule longer appointment time for African American men to allow additional 1-on-1 education

African American men have cited poor communication with their provider (e.g., lack of recommendation, unaddressed concerns and motivations) as reasons they don't participate in cancer screening (5-7). Having days that providers see only men would allow for greater face-to-face time between provider and patient to address concerns and adequately evaluate screening outcomes.

Allow husband and wife appointments

Studies have shown that the female loved ones of men have a large impact on their health and healthcare choices (8). Allowing wives, or other female family members, to accompany men to their appointments could make them feel more comfortable in the clinical environment, lessen the burden of questioning the provider, and allow immediate discourse with loved ones on screening pros and cons.

Coordinate with local employers to conduct cancer health screenings on-site

Mobile mammography has effectively brought breast cancer screenings to underserved women for years; while patient retention and follow up of care with mobile mammography is difficult, bringing the screening to the patients has improved uptake (9). Workplace screening captures the accessibility of mobile screening, but could improve patient retention and care follow up because the patient is easily contacted at the workplace.

Coordinating cancer screening at churches

There is a large body of evidence that church-based health promotion interventions, particularly among African American populations, have significantly impacted a variety of health behaviors (10). Offering cancer screenings to African American men at their sites of worship places health in a spiritual and cultural context that could improve acceptance of screening practices.

Match patient with African American providers, nurses and ancillary staff

A study that recruited African American men for free preventative services randomized African American and non-African American male doctors for appointments. They found that patients who saw African American doctors were more likely to agree to invasive procedures, had longer interactions with the provider, and discussed more personal issues than men seeing the non-African American providers (11); a review of race concordance on healthcare utilization and patient satisfaction supports these findings (12). Putting African American men in a clinical environment with other African American staff, particularly African American male providers, would overcome several barriers to care.

Provide African American men with proposed questions as discussion starters with physician at the time when an appointment is made; Have Q&A document for African American men in office

Providing question prompts to patients may normalize the discomfort associated with sensitive health topics, offer a starting point of discussion with the provider, and inspire further questions concerning the patient's health.

Deploy community outreach staff to educate patients

African American men often don't know that they are at higher risk for many cancers, even when they have family histories of cancer or other common risk factors independent of race (13). Using community outreach as an opportunity to educate African American men on their increased risk of certain cancers could stimulate them to seek screenings through their health care providers.

Use patient navigation staff to monitor and assist with outreach, access and follow through with African American men

Patient navigation is a proven strategy to connect patients to care, retain patients in care, and reduce healthcare costs (14); several studies have shown patient navigation is particularly beneficial in increasing colorectal cancer screenings among African Americans (15).

Reduce out-of-pocket cost for cancer screening services

The Community Guide recommends offering full or partial coverage of cancer screenings to reduce racial disparities in cancer outcomes (16); since one out of five African American men in South Carolina report not seeing a doctor because of cost, providing free or reduced cost screenings would be an effective tool to get these men screened and linked to care.

Offer various options for screening modalities as appropriate based on patient cultural and religious preference.

African American men have expressed reserve about certain cancer screening procedures because of sexual connotations of the procedure, perceived accuracy of the procedure, or general distrust of medical procedures and/or anesthesia (17). Offering multiple screening options would allow African American men to choose the procedure that makes them feel comfortable with and in control of their health care management.

THEME 2 Utilize eHR to provide provider and patient reminders

Use electronic health record data to determine number of African American men in the practice and provide outreach to those not seen in 12+ months

A simple pop-up message or flag in a patient's electronic health record indicating that they are eligible or in need of screening/follow up is effective at initiating provider outreach to patients (18-20). These notifications can often be programmed to automatically alert the provider when certain criteria are met, reducing the burden on providers and staff.

Create standing orders for cancer screening services for African American men (population-based approach)

Institutional changes in screening, including standard orders for screening panels for patients that meet certain criteria, have proven effective at increasing screening uptake among African American men (18-20).

Use best judgement for cancer screening recommendations for African American men based on family history, genetics, and other pertinent factors

Current cancer screening recommendations often don't differentiate by race, even though there is evidence that multiple cancers have risks that differ by race/ethnicity (3,13). A combination of provider education and automated electronic health record reminders could encourage providers to offer screening to high risk men, despite falling outside normal screening guidelines; example: colonoscopy standard screening age is 50 years of age, but patients with certain risk factors could benefit from being screened at 40 years of age.

Coordinating cancer screening at churches

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Additional Recommendation: Small Media

Although not addressed in the Blue Granite work group, the Community Preventive Services Task Force recommends the use of small media (brochures, pamphlets, flyers, posters, short videos, newsletters, letters) for both general and targeted audiences to motivate and educate patients on health topics (25). Providers could print posters, pamphlets, flyers, and/or brochures for presentation in waiting rooms and exam rooms for patients to review during wait times. Short videos that outline cancer risk factors in African American men, list offered screening procedures, and address common questions could be played in provider waiting areas (if TV available).

THEME 3 Educate, assess, and provide feedback to providers on screening

Have providers complete a cultural competency course, focusing on the specific disparities and needs of African American men

Having providers complete a cultural competency course improves provider knowledge of cultural barriers, improves provider attitudes and skills, and positively impacts patient satisfaction (21). Having providers complete a cultural competency course, or developing one specifically for African American men, could improve screening among African American male patients.

Use a combination of clinic records, electronic health records, and patient surveys to periodically (quarterly or biannually) obtain feedback on screening rates among African American men.

One randomized controlled trial study looked at the effect of an initial education session followed by regular quality improvement workshops for providers on veteran patient colorectal cancer screening rates and found a positive effect (22); a separate study found that quarterly reports on physician/clinic screening raised screening rates over time (23). Regular feedback to providers appears to help them adjust recommendations based on need.

Implement a welcoming clinical environment and discuss screening/medical options in a manner that will build trusting relationships between the patient and the provider.

There is a persisting distrust of the medical community among African American patients, which has been linked to lower colorectal cancer screening rates (24). Providing guidance to clinic managers on how to create a welcoming clinic environment and educating providers on effective communication techniques with African American male patients (e.g., ask-tell-ask, conveying empathy through key phrases) would begin to build trust between African American men and the medical community.

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