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COMMENTARY

Consensus-built recommendations to improve prostate cancer outcomes: A summary of the American Cancer Society Prostate Cancer Collaborative

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Abstract

The incidence of prostate cancer in the United States has steadily risen since 2014, which has reversed decades of progress toward lowering the burden of prostate cancer. Mortality rates have plateaued, despite reliable screening methodology in the form of prostate-specific antigen testing, and despite a recent surge in the number of approved therapeutics for the management of primary and metastatic prostate cancer. If these trends are not addressed quickly and decisively via a multidisciplinary approach, loss of life and economic strain due to prostate cancer could precipitously increase in the coming years. To this end, the American Cancer Society (ACS) convened a collaborative of experts across the prostate cancer continuum to identify barriers to progress and generate opportunities for innovation. Through a series of consensus-building exercises and progressive refinement of themes into actionable priority areas, the collaborative identified three strategic priorities. These priorities form the backbone of an action plan to improve risk assessment and screening uptake, optimize therapeutic intervention for localized prostate cancer, and leverage the emerging arsenal of tools to more effectively manage advanced prostate cancer in the clinic. To advance this work, the ACS has launched the ACS National Prostate Cancer Roundtable to nucleate and coordinate partners from across the prostate cancer continuum to activate around these strategic priorities, and to build momentum toward improving prostate cancer outcomes for all.

KEYWORDS
cancer screening, health disparities, implementation science, prostate cancer, public health

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BACKGROUND

After decades of decline, the number and rate of prostate cancer diagnoses have been increasing in the United States.[1,2] Problematically, this increase is driven by the diagnosis of advanced-stage and de novo metastatic disease, when a cure is no longer possible. Since 2014, the incidence rate for prostate cancer has increased by 3% per year overall, and by approximately 5% per year for the incidence of de novo metastatic prostate cancer.[3,4] Mortality rates have plateaued in recent years after years of decline, and the increased incidence of advanced cancers may be a harbinger of higher death rates to come. These worrisome trends particularly affect Black patients, who experience the worst outcomes among all racial and ethnic groups, with a 70% higher incidence and 210% higher mortality rate than White patients.[3] Both socioeconomic and biologic factors have been shown to contribute to this disparity[5] but the exact drivers of excess prostate cancer incidence in Black patients are not fully understood. The longer term impact of metastatic prostate cancer diagnoses will likely exacerbate racial disparities in mortality in years to come. An estimated 313,780 new cases of prostate cancer will be diagnosed in 2025, and 35,770 deaths from prostate cancer are predicted.[4]

Prostate cancer is heterogeneous and complex, with specific challenges inherent to each phase of the cancer continuum across screening, diagnosis, treatment, and survivorship. Discrepancies in prostate-specific antigen (PSA) screening guidelines have further compounded the confusion as to who should be screened, at what age, and how frequently screening should occur.[6,7] Moreover, misperceptions among the public related to the use of PSA screening versus digital rectal examination further complicate these issues and reduce screening uptake.[8] The clear disparities in outcomes underscore the need for alignment around concordant guidelines for screening, treatment, and supportive care. It is therefore critical to build consensus between partnering organizations to resolve conflicting guidelines and recommendations, and thereby diminish confusion among patients, clinicians, and the community.

To tackle these challenges, in January 2023 the American Cancer Society (ACS) launched its IMPACT initiative, Improving Mortality From Prostate Cancer Together. This cross-institution effort leverages its resources across advocacy, research, and patient support, with the goal of ultimately improving prostate cancer outcomes for all while also reversing cancer health disparities among all groups, and with a particular emphasis on Black men, by 2035. In addition, with the relaunch of the Cancer Moonshot and the release of the President's Cancer Panel report, Closing Gaps in Cancer Screening,[9] the recommendation was made to expand and strengthen the National Cancer Roundtables with a focus on cancer screening.

As a component of the ACS IMPACT initiative and in response to the President's Cancer Panel report, the ACS created a strategic plan to convene a group of diverse thought leaders and experts in prostate cancer to discuss current trends, activate around shared priorities addressing common clinical challenges and evidence-based practice changes, and ultimately renew the nation's collaborative energy to shift our current prostate cancer paradigm.

To this end, the ACS National Roundtables and Coalitions team actively engaged public and private multisectored organizations, as well as volunteer clinicians, professionals, advocates, and people with lived experience, to convene a collaborative on the state of prostate cancer screening and care. These ACS Prostate Cancer Collaborative partners were engaged across multiple touchpoints to build consensus around a common agenda and catalyze action to reduce disparities and improve outcomes. This commentary describes for the first time the ACS National Roundtables and Coalitions consensus-building model, which provides structured interactions among partners from diverse backgrounds to drive collaborative action. This framework was applied to the ACS Prostate Cancer Collaborative, which resulted in a consensus set of three broad strategic priority areas and 14 potential implementation strategies geared toward lowering prostate cancer mortality and narrowing prostate cancer health disparities in the United States.

METHODOLOGY AND PROCESS

Surveying and design thinking model

In August 2023, the ACS launched the Prostate Cancer Collaborative to convene thought leaders across the prostate cancer continuum and develop consensus around actionable issues. The collaborative was composed of prostate cancer experts in research, academia, patient advocacy groups, government, and industry, as well as clinicians and people with lived experience. Three meetings were held along with other touchpoints throughout, including pre- and post-meeting surveys and one-on-one conversations (Figure 1). Forty partners participated to discuss current trends in prostate cancer incidence, diagnosis, treatment, survivorship, and supportive care; identify unmet needs and shared priorities in addressing challenges; and ultimately establish a roadmap to implement the resulting strategic priorities (Figure 2).

Identifying priority areas of focus

To identify matters of concern and barriers to progress, partners completed an exploratory needs assessment survey to (1) determine actionable opportunities to advance outcomes, and (2) weigh in on where they feel the most collaboration is needed to achieve the desired outcomes. Responses were presented at the first meeting, where they were evaluated and merged into overarching themes via group discussion.

In a second survey, partners chose their top two "challenge" and "opportunity" theme areas. The top two challenges identified were

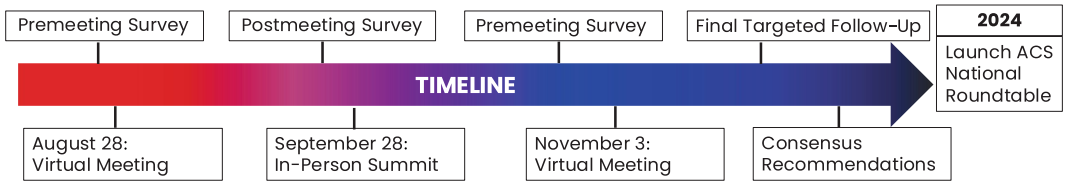

FIGURE 1 Project timeline. The ACS Prostate Cancer Collaborative took place across 5 months in 2023, and was structured as two virtual meetings and one in-person summit. Pre- and post-meeting surveys were distributed between the meetings to refine priority statements and overarching goals. ACS indicates American Cancer Society.

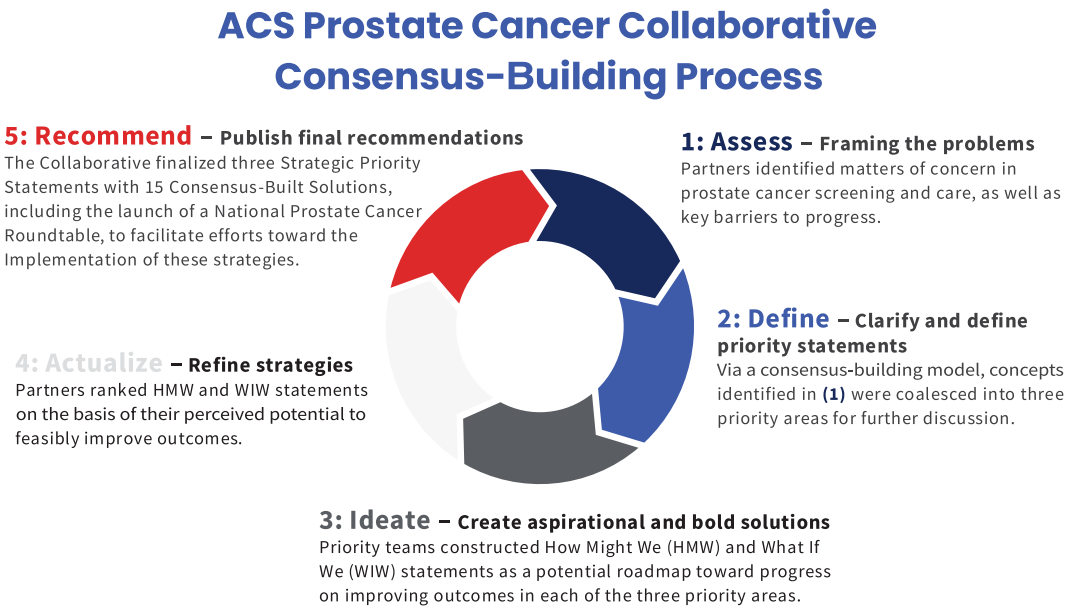

FIGURE 2 Consensus-building model. Partners were engaged at multiple touchpoints to identify obstacles, strategize potential solutions, and iteratively refine themes into cohesive, actionable priority statements. The consensus-building strategy used in this collaborative was derived from the design thinking model.[10] ACS indicates American Cancer Society.

(1) equitable access to information, screening, and treatment, and (2) general patient understanding, motivations, and behaviors. Respondents also identified the top opportunities for collaborative action to be (1) messaging coordination, consensus in screening discussion, and the quality of provider recommendations and treatment options, and (2) patient education and advocacy. From these conversations, the pre- and post-meeting surveys, and consultation with ACS subject matter experts, three priority areas spanning the prostate cancer continuum were established for continued discussion:

- Priority area 1: Risk assessment and screening
- Priority area 2: Initial treatment strategies and treatment around localized prostate cancer
- Priority area 3: Addressing advanced prostate cancer with appropriate imaging, therapies, and supports

These three priority areas were then used to guide and segment solution-oriented conversations at an in-person summit.

Clarifying challenges and opportunities; creating solutions

At the in-person summit, partners were divided into discussion groups. Each group evaluated their respective priority area topic and drafted a cognate priority statement. The groups then reconvened and suggested refinements to all three priority areas and accompanying statements (see the Results section).

Partners then discussed challenges to overcome and areas for innovative opportunity specific to their priority area. Using an ideation process with "how might we" and then "what if we" statements, participants identified areas where there is a critical need or challenge to be addressed. Similar topics were then grouped together until a consensus was reached on three finalized "how might we" statements. Next, partners generated "what if we" statements as solutions to each of the three "how might we" statements. These "what if we" statements were then refined via discussion into the top four to six solutions (Table 1). Finally, partners voted on their top "how might we" and "what if we" statements for each priority area.

TABLE 1 "How might we" problem statements and "what if we" potential implementation strategies.

Topic area	Impact, 1–5	Feasibility, 1–5
Topic area 1: Risk assessment and screening		
HMW1: Identify and communicate with high-risk groups without labeling or vilifying them?		
WIW1: Surveyed and reviewed currently available risk assessment tools to identify an optimal strategy, and then educated clinical and community members on the importance of screening and preventive/healthy practices?	3.7	4.1
HMW2: Increase primary care understanding and screening of high-risk individuals?		
WIW1: Developed and disseminated (in partnership with professional societies) a targeted PCP campaign to educate on the current state of the science of prostate cancer screening and the populations at highest risk?	4.2	4.2
HMW3: Increase prostate cancer screening among Black men without creating racial or other unacceptable problems and stigma?		
WIW1: Invited/partnered with Black organizations and communities, including family and women, to amplify and expand successful community engagement initiatives to increase prostate cancer screening?	4.6	4.4
Topic area 2: Initial treatment strategies and treatment of localized prostate cancer		
HMW1: Improve clinical decision support for men newly diagnosed with prostate cancer via existing tools and guidelines?		
WIW1: Empowered navigators to review materials with patients that guide and inform from diagnosis through treatment?	3.9	3.6
WIW2: Used multidisciplinary teams to ensure clinical risk stratification to produce personalized treatment recommendations?	4.3	3.1
HMW2: Leverage technology for telehealth to improve access to care when providers are limited?		
WIW1: Identified successful telehealth in rural settings, documented case studies, and learned from them by sharing best practices?	4.1	3.7
WIW2: Developed clinical care nodes and virtual prostate cancer tumor boards to translate multidisciplinary strategies to rural areas?	4.1	3.5
WIW3: Encouraged patients at diagnosis to enroll in a prostate cancer care app?	3.5	3.5
HMW3: Ensure that patients navigate the system without delay by better coordinating communication between them and multidisciplinary teams?		
WIW1: Educated health care providers on the importance of providing support to patients as they navigate a complex multidisciplinary treatment plan, and provided resources to patients that helped them understand their treatment options?	4.1	3.9
Topic area 3: Addressing advanced prostate cancer with appropriate imaging, therapies, and supports		
HMW1: Aggregate diverse data sources to understand the treatment patterns and sequences associated with improved outcomes for patients with metastatic prostate cancer?		
WIW1: Partnered with organizations including the Commission on Cancer to focus a project on mining treatment patterns among patients with metastatic prostate cancer?	3.6	3.6
WIW2: Were able to get high-quality structured data from electronic medical records to understand metastatic disease outcomes?	3.8	3.2
HMW2: Increase concordance with evidence-based treatment for metastatic prostate cancer, including precision-based approaches such as genomics, imaging, and biomarkers?		
WIW1: Offered germline and somatic genetic testing to every patient with metastatic prostate cancer?	4.5	3.5
WIW2: Incentivized the use of tailored, interactive, culturally relevant, and plain-language educational tools for patients and clinicians?	4.3	4.1
HMW3: Improve supportive care to address the social, emotional, and financial needs of patients with metastatic disease?		
WIW1: Collaborated with the ACS National Navigation Roundtable to address metastatic prostate cancer?	3.7	4.0

Abbreviations: ACS, American Cancer Society; HMW, how might we; PCP, primary care provider; WIW, what if we.

RESULTS

Establishing consensus-built solutions

Working together via this facilitated process, partners established consensus-built recommendations that are potential solutions to known barriers and challenges to the improvement of prostate cancer outcomes. These priority areas and accompanying priority statements provide a structure to guide work going forward focusing on prostate cancer across the continuum.

Priority area 1: Risk assessment and screening

Improving access to and awareness of recommended prostate cancer screening, risk assessment, and follow-up via community and professional education, with a focus on high-risk populations, including Black Americans, will decrease cancers diagnosed at advanced stages and improve outcomes.

Priority area 2: Initial treatment strategies and treatment around localized prostate cancer

Improving access to early and equitable multidisciplinary treatment strategies will increase the likelihood of patients receiving an appropriate standard of care and improving outcomes for high-risk patients, while also reducing overtreatment and optimizing quality of life.

Priority area 3: Addressing advanced prostate cancer with appropriate imaging, therapies, and supports

Improving timely and equitable implementation of evidence-based and emerging strategies will produce better survival rates, quality of life, and supportive care for patients with metastatic prostate cancer.

Prioritizing solutions for feasibility and impact

A final survey was sent out after the summit in which partners rated each "how might we" and "what if we" statement on a scale of 1–5 in terms of feasibility to implement and impact if implemented, with 1 indicating low impact/feasibility and 5 indicating high impact/feasibility. The results of this survey are included in Table 1. A final meeting was held to discuss the results of the final survey, consolidate recommendations and guidance, and finalize solutions.

DISCUSSION AND CONCLUSIONS

The ACS Prostate Cancer Collaborative highlighted the interest in—and urgent need for—the prostate cancer community to work together and work differently to effect positive change and improve outcomes. Prostate cancer outcomes are worsening, and notable disparities exist across multiple demographic groups. Cohesive guidelines around screening, treatment, and supportive care must be established and widely adopted before progress can be made.

One of the key issues raised by the collaborative partners was the need for broader education on the utility of PSA testing as a method of screening for prostate cancer, given the disparate recommendations and guidelines around this topic. Because this field seeks to harmonize messaging to health care providers, the collaborative agreed that more resources should be devoted to helping practitioners identify at-risk patients and engage them in informed decision-making (Table 1, topic area 1). The known health disparities in Black patients in particular should be communicated more strongly to health care providers in an effort to close the gap in mortality among these patients. For example, although many guidelines recommend that prostate cancer screening should be offered to patients starting at age 50 years, more recent analyses of trends among Black patients suggest that this threshold should be lowered to age 40–45 years depending on family history and other health metrics.[11]

This collaborative further outlined three general areas of strategic priority that are critical to the ultimate goal of reducing prostate cancer mortality. All three of these priorities specify that equitable access to next-generation screening, imaging, and therapies is crucial to the pursuit of this goal. This speaks to a broader systemic challenge to improving cancer health outcomes: namely, how can we truly achieve equitable care when some patients live prohibitively far away from key resources such as next-generation imaging? This is a limitation of this report because a full implementation plan was not within the scope of the collaborative's objectives. However, it is worth noting that the collaborative's recommendations tended to center on a need for better communication between health care providers and patients. With this in mind, perhaps facilitating patients' understanding of their options at each stage of the care continuum, and providing them with resources to navigate screening and treatment decisions in an informed way, are the most impactful things that could be done to improve the state of prostate cancer care in the United States.

Ultimately, these issues cannot be tackled by just one organization, and as such the ACS National Prostate Cancer Roundtable (ACS NPCRT) launched in September 2024. The ACS NPCRT's near-term goals include recruitment of member organizations whose mission and activities are in alignment with those of the roundtable to activate around the recommendations produced by this collaborative. In particular, the priority statements outlined above have been adopted as the strategic priorities of the ACS NPCRT, with plans to engage

partner organizations in developing and implementing projects centered around the "how might we" and "what if we" statements outlined in Table 1. Part of this work will involve standardizing strategies for clinical management of prostate cancer at different disease stages via the establishment of consensus recommendations, and then identifying barriers to implementing those recommendations. Where this is not feasible, it will likely be necessary to recommend alternative approaches when the optimal standard of care is not available.

In the longer term, the ACS NPCRT will formulate and release a national strategic plan toward the implementation of key recommendations put forth by this collaborative. The "what if we" statements outlined in Table 1 will eventually form the basis for working groups within the three strategic priority areas outlined here. The ACS National Roundtable development timeline includes release of a formal strategic roadmap within the first 2 years of launch, with the plan itself laying out a 3-year plan for development and implementation of intervention strategies. Plans are also underway to provide online toolkits, data resources, and educational initiatives in the interim until the strategic plan is finalized and implemented.

The impact of these initiatives will be measured via tracking attendance at training sessions, attendance and downloads of educational webinars, downloads of informational resources and educational modules, recruitment of health systems to implement interventions designed by roundtable working groups, and so forth. Additionally, the ACS Patient Support Pillar—of which the ACS National Roundtables are a part—tracks the number of lives touched via partner engagement and access to educational/informational content, which is summarized annually in an impact report (http://www.cancer.org/impact2024). Ultimately, the true metrics of success for these initiatives will be the increased uptake of prostate cancer screening and, eventually, reduced mortality from prostate cancer—although these metrics will, by necessity, be measured on a longer timescale.

The ACS has doubled down on efforts supporting the ACS National Roundtable model (https://www.cancer.org/about-us/our-partners/american-cancer-society-roundtables.html) to bring many organizations with a cancer focus together for collaborative acceleration to improve cancer outcomes. The ACS NPCRT joins the suite of already-established ACS National Roundtables, which focus in the disease areas of colorectal, breast, lung, and cervical cancers, as well as human papillomavirus vaccination and patient navigation. The ACS National Roundtables provide essential support around building sustained partnerships, developing patient and provider education opportunities, driving research priorities, and coordinating advocacy around priority policy issues across the cancer continuum. The newly established ACS NPCRT will provide an opportunity to build and sustain collaborative relationships and momentum to improve prostate cancer outcomes for all.

AUTHOR CONTRIBUTIONS

Jessie Sanders: Conceptualization; methodology; data curation; investigation; visualization; writing—original draft; project administration; formal analysis; and writing—review and editing. **Caleb Levell:** Conceptualization; methodology; data curation; investigation; formal analysis; visualization; project administration; and writing—review and editing. **Lucas J. Brand:** Investigation; formal analysis; visualization; writing—original draft; and writing—review and editing. **William L. Dahut:** Supervision; funding acquisition; conceptualization; and writing—review and editing. **Yaw K. Nyame:** Supervision and writing—review and editing. **Lorelei Mucci:** Conceptualization; writing—review and editing; and supervision. **William K. Oh:** Conceptualization; supervision; and writing—review and editing.

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CONFLICT OF INTEREST STATEMENT

Lorelei Mucci reports consulting for Bayer HealthCare Pharmaceuticals, receiving grants from AstraZeneca, and holding stock with Convergent Therapeutics. William K. Oh reports consulting for GlaxoSmithKline, NTx Bio, Analysis Group, Pfizer, Novartis, Sumitomo Dainippon Pharma, VieCure, and AstraZeneca, and holding stock with GeneDx. The other authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author on reasonable request.

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