intervals. Disability status was defined according to Davidoff and colleagues using inpatient, outpatient and durable medical equipment claims files, and assessed monthly, beginning 1 month after cancer diagnosis (or index date), continuing until disability, death, end of Medicare continuous enrollment, or end of study. Results: Factors that were significantly associated with disability status in the cancer cohort were age (HR = 3.50 for >80 years old), female gender (HR = 1.50), race/ethnicity (HR = 1.34 for Hispanic and 1.21 for Black), stage (HR = 2.26 for distant stage), comorbidity (HR = 2.18 for >1), and radiation (HR = 1.21). When compared to the non-cancer cohort, having a cancer diagnosis (HR = 1.07) and comorbidity (HR = 2.09 for >1) were associated with developing disability. Conclusions: Colorectal diagnosis is an independent risk for disability status. Beyond well-known risk factors "age and mortality" subsets of survivors (Hispanic and Black survivors and those with comorbidity) are found to be at higher risk for developing disability. This warrants further investigation and may indicate targeted intervention to prevent future disability.

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PSA Testing and Prostate Cancer Incidence Following the 2012 Update to the U.S. Preventive Services Task Force Prostate Cancer Screening Recommendation: Implications for Racial/Ethnic Disparities

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The 2012 U.S. Preventive Services Task Force (USPSTF) recommendation against prostate specific antigen (PSA) testing led to a decrease in prostate cancer screening, but its impact on prostate cancer racial/ethnic disparities remains unclear. Methods: The proportion of men ages 40–74 years who received a routine PSA test in the past year was estimated over time in the Behavioral Risk Factor Surveillance System (BRFSS; 2012–2018) and the National Health Interview Survey (NHIS; 2005–2018). Screening trends by race/ethnicity were evaluated using logistic regression models to estimate odds ratios (ORs) of screening adjusting for socioeconomic and healthcare-related factors. Prostate cancer incidence rates and rate ratios (IRRs) by race/ethnicity were estimated in the Surveillance, Epidemiology and End Results (SEER) registry data over time (2004–2016). Results: In the 2012 BRFSS, PSA testing rates were highest among non-Hispanic white (NHW) men (32.3%), followed by non-Hispanic black (NHB; 30.3%), Hispanic (21.8%), and Asian/Pacific Islander men (17.7%). The absolute screening frequency declined by 9.5% overall from 2012 to 2018, with a greater decline among NHB (11.6%) than NHW men (9.3%). Adjusting for socioeconomic and healthcare-related factors, the relative decline was greater among NHB (OR per year = 0.86, 95% CI 0.84–0.88) than NHW men (OR = 0.89, 95% CI 0.89–0.90; p-het. = 0.005), driven by a steeper drop among NHB men ages 40–54. In the NHIS, the 2012 update was associated with a 35% decrease in the odds of screening (OR = 0.65, 95% CI 0.51–0.82), though there was no annual change since 2012 (OR = 1.00, 95% CI 0.98–1.03). Trends in the NHIS did not differ by race/ethnicity. The NHB:NHW IRR for total prostate cancer increased from 1.73 in 2011 to 1.87 in 2012 and has remained elevated, driven by differences in the incidence of localized tumors. Disparity IRRs have been consistent since 2012 for other racial/ethnic populations. Conclusions: Although the frequency of prostate cancer screening varies by race/ethnicity, the impact of the 2012 USPSTF recommendation against PSA testing on screening trends did not robustly differ by race/ethnicity. Following 2012, there was a modest increase in the disparity for localized prostate cancer incidence between NHB and NHW men.

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Reducing Cancer-related Financial Toxicity through Financial Navigation: Results from a Pilot Intervention

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Our purpose was to pilot a novel patient-centered financial navigation (FN) intervention to decrease the burden of financial toxicity (FT) among uninsured and underinsured patients with cancer treated at the North Carolina Cancer Hospital (NCCH). Methods: Participants were recruited by cancer clinic nurses and social workers at the NCCH. Eligible patients scored less than 22 points (indicating significant FT) on the COmprehensive Score for financial Toxicity (COST) instrument. Fifty patients were enrolled in the intervention, which included an intake assessment of financial needs and vulnerability, initial one-on-one consultation with a trained financial navigator (i.e., financial counselor or social worker), triage to financial support services matching patients' needs, and multiple follow-up appointments. Navigator recommendations were based upon a detailed review of patients' financial status, billing information, insurance, and other indicators used to refer patients to appropriate financial and social services resources offered by the hospital, government, nonprofits and private corporations. Following the initial appointment, patients were given a checklist of resources they were eligible for and the required paperwork to complete applications. During follow-up appointments, application status was reviewed, and practical assistance was provided. Patients were re-contacted at 2-week intervals to assess progress toward financial assistance goals. Outcome data collection included pre/post-intervention COST scores, patient satisfaction with the intervention, and intervention fidelity and retention. Results: The first fifty patients approached all screened positive for FT (COST < 22). Baseline COST scores ranged from 0–19. Results indicated a significant improvement in COST scores following the FN intervention (average increase = 6.86, 95% CI = 4.30–9.42), $P < 0.0001$). Post-intervention questionnaires indicated excellent patient satisfaction and retention with the FN intervention, and navigator logs indicated high fidelity to the intervention protocol. Conclusions: A novel FN intervention was feasible, acceptable, and effective in reducing FT among uninsured and underinsured oncology patients.

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