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Meet the Experts: Wanda Wilt, RN, BSN, and Gordon A. Brown, DO, FACOS

Neal D. Shore, MD, FACS

Carolina Urologic Research Center, Myrtle Beach, South Carolina

Neal D. Shore, MD, FACS, Moderator

Wanda Wilt, RN, BSN

Gordon A. Brown, DO, FACOS

Meet the Experts

Well, hi, everyone, and thank you so much for joining us today for our first Meet the Expert of the year with our very special guests, Dr Gordon Brown of New Jersey Urology and Wanda Wilt from Specialty Networks. Dr Brown is associate professor at Thomas Jefferson University School of Medicine in Pennsylvania. He is also the medical director for the New Jersey Urology Center for Advanced Therapeutics. And Wanda Wilt is the executive vice president of provider solutions for Specialty Networks, a Cardinal Health Company. I'm Neal Shore. I'm the medical director of Carolina Urologic Research Center, practicing with AUC Urology Specialists in Myrtle Beach, South Carolina. So this is really a great opportunity, and we're privileged to speak with you today. Just published last month in *Urology*, what is oftentimes called the Gold Journal, February 2025 edition, the 3 of us, along with our colleagues Ben Lowentritt, Lorraine O'Donnell, Sabree Burbage, Ibrahim Khilfeh, and Franklin Gaylis.

The following interview has been edited for clarity and length. The full conversation can be accessed by scanning the QR code provided.

Interview

Neal Shore, MD, FACS: We were all co-authors on, I think, a really very enjoyable and instrumental paper titled "Evaluating the Importance of Practice-Level Factors on Adherence to Prostate Cancer Treatment

Guidelines in Urology" (https://www.goldjournal.net/article/S0090-4295(24)00950-6/fulltext). So we just published it last month, and so we want to just have a nice conversation today discussing the findings that suggest there exists a wide range of performance indicators. We call these PIs, not to be confused with "physician investigators," but PIs, "performance indicators," in the adherence rates for urologists in the delivery of community urology care in the United States and how that compares to clinical guideline recommendations. I think this is a really good paper. I encourage so many of my colleagues to read this. It's certainly not totally definitive, but it really will tweak your interest in understanding how well you and your colleagues are monitoring and following PIs. So these are some of my overall thoughts on this article. We didn't copy everything under the sun in order to address everything under the sun, but before we get into the full discussion, I'm really happy to have co-authors Gordon Brown and Wanda Wilt. Let me first begin with you, Wanda. This study was conducted using what we very affectionately call, over almost 10 years now, PPS [Precision Point Specialty] data. What is PPS Analytics, and what is your role?

Wanda Wilt, RN, BSN: Great. Thanks, Dr Shore. And actually, I just want to start by saying, "Thank you." It's very much a privilege to be on here today and be a co-author with this. You guys are physicians I have looked up to for a long time because of your dedication and your care for patients. It's been passionate for me, and I have loved being in this space with you, so thank you. So "PPS Analytics" stands for Precision Point Specialty, and that is software that we use and we connect with practices. It hooks up to the practice management as well as the EMR [electronic medical record] and allows us to pull all the data from a patient but bring it into a single field so we can see what's going on with the patient. And it originally started, as you said, a long time ago, and it was originally to just identify patients early on in prostate cancer when we just had that metastatic CRPC [castration-resistant prostate cancer] space. But it's had the privilege of growing up and staying with the times and being able now to be a full population-tion management tool for every patient in that space

as well as other urologic spaces. And the idea behind it is that we want to make sure that every patient has the opportunity for the right test, the right treatment, at the right time and to support practices with their economic and operational values for their clinic and the patient.

Dr Shore: Yeah, that's a really great, concise review: right patient, right treatment, right time, especially now, I think, in 2025, where we certainly want to optimize clinical care that's always been our North Star. But when you're in community practice and certainly even an academic practice, large health care system, solo practice, a large group, etc, the economic optimization is key, isn't it? And understanding the data analytics that PPS affords us is super important for all of the colleagues who've been involved with it. So kudos to you and your colleagues, but we started this analysis, and I want to turn it over to some questions to Gordon here. So Gordon, feel free to help our audience understand why the study was conducted, what the rationale for the design was, and then I think we could get into the implications of what this means and some other thoughts too. So thanks for addressing that, Gordon.

Gordon A. Brown, DO, FACOS: Sure. Again, I want to echo Wanda's sentiments. Thanks for having me. It's really a pleasure to be here with everybody, and I appreciate the invitation to talk about this paper, which is near and dear to me and also, I think, speaks

to how we may improve outcomes in our large group practices for patients with prostate cancer along the care continuum. A little bit of a background, Neal—and I know obviously you're intimately familiar with this, but for the audience's sake—that obviously urologists have been the key not only gatekeepers of patients with prostate cancer but have really been more intimately involved in their care than any other specialists throughout the disease continuum. That role of the urologist has increased certainly in advanced disease within the last year with more widely available therapies, which are dispensed within our practices, and more of a multispecialty kind of feel to a lot of our larger groups.

However, within that framework, historically there's been some data out there to suggest that adherence to guidelines, and specifically among test ordering in neurologists, has been less than ideal. And so the concept here was to try to develop some key PIs which were easily measurable, which were able to be obtained easily from the EMR database, PPS, and which could be open to potential modification based on any gaps in care which were identified. And we know that historically the adherence to guideline-based care drives not only optimal patient outcome but tends to decrease costs. And conversely, the lack of guideline adherence does just the opposite. Unfortunately, it has a tendency to impact that adverse patient outcome and make the cost of care much higher when we see wide variances in care not only among individual practices but across the disease spectrum more broadly. So the goal here was to assess a key group of PIs and a couple of different disease realms along the continuum of prostate cancer, from diagnosis to advanced disease, and to see what factors specifically on a patient and practice level might impact the adherence to those PIs. Really a true measure-to-manage approach here so we can ask some of the hard questions of ourselves to see how we're performing.

Dr Shore: Yeah, that's really good. And I think everybody would say this is really important, and it's not a goal but a necessary goal for us to practice in

2025. So maybe you can comment a little bit on, we looked at over 100 000 patients over a 3-year period. It was a retrospective study, but I think it might be really important for the viewers to briefly mention the 5 key PIs that we chose, mostly based on NCCN [National Comprehensive Cancer Network] guideline recommendations. One of them came from the RADAR [Radiographic Assessments for Detection of Advanced Recurrence] paper, but can you review those just briefly, Gordon? I certainly hope our readers will go to the article, but [explain] these 5 key PIs and maybe why we wanted to look at those.

Dr Brown: Yes, of course. Again, the goal of choosing these 5 out of all the possible PIs that could have been chosen was a couple, obviously. One, we wanted to make sure we had the data available within our PPS platform. Two, we wanted to make sure there was some clinical relevance based on the published NCCN and RADAR guidelines that you alluded to, Neal. And lastly, we wanted to make sure that they were actionable within our practices to be able to be modified, should we find gaps in care. I think actually, not to pat ourselves in the back, but I think that these are very reflective of being able to attain those goals. And we looked at 5 PIs across 3 distinct states within prostate cancer. The first one, first state of prostate cancer that we chose to look at, was screening and diagnosis.

So really 3 realms. The first realm being screening and diagnosis, the PI in that setting was patients obtaining a DEXA [dual-energy x-ray absorptiometry] scan, probably within the 6 months of initiation of ADT [androgen-deprivation therapy]. The second realm was prostate cancer treatment, and in this realm we looked at 2 PIs. One is the use of concomitant ADT in intermediate- and high-risk patients. I should say probably unfavorable-, intermediate high-risk, and high-risk patients undergoing external beam radiation therapy [EBRT] for prostate cancer as well as the use of an NCCN category 1 preferred option in combination with ADT for patients with diagnosed hormone-sensitive metastatic disease. And the third realm that we looked at was monitoring patients and following them with prostate cancer. And we looked

at 2 key PIs here. One was the checking of a serum testosterone biannually in patients who were on continuous ADT.

And lastly, looking at a scan evaluation within 12 months. And somebody on a continuous ADT, as you alluded to, we looked at over 100 000 patients with a PPS dataset, and these patients had to have at least 1 claim within the prior 12 months to be considered eligible. So I think that both the realms of the disease state capture the entirety of the disease continuum, and the PIs I think are actionable and translatable to real-world practice and help us get some insight into the quality of care that we're delivering to our patients with prostate cancer.

Dr Shore: Yeah, spot on. What I really like in the formatting in our paper is we put together some very terse, pithy, concise tables looking at practice-level, patient-level metrics that would lead toward improvement and adhering to the guidelines and improving the likelihood of successfully managing these PIs there in table form. And I think it'd really behoove our listeners to take a look at that. But what I wanted to ask you, when we looked at these PIs, which you really nicely articulated, Gordon, we didn't find 100% adherence with these PIs. Could we comment on where our percentages ranged among the 5 PIs?

Dr Brown: Yeah, unfortunately, we didn't perform as well as we had anticipated, which I think is why we're asking the question, right? It goes back to that measure-to-manage concept that Wanda speaks to oftentimes, that if we don't ask the hard questions, we can't make good changes in the best interest of our patients. With that being said, when we looked at the 5 PIs, we had a fairly wide variation in adherence to these PIs across the disease continuum, with the lowest adherence being obtaining a DEXA scan within 6 months of initiation of ADT. The adherence there was 13.6% up through 72.3% compliance with the use of concomitant EBRT and ADT for unfavorable-, intermediate-, and high-risk patients undergoing radiation therapy. I think the one thing that sticks out to me and is a little bit concerning is the undertreatment of patients with hormone-sensitive metastatic disease.

When we look at this, I think our PI adherence was only about 44%, and this is despite several large phase 3 randomized trials demonstrating significant improvements in outcomes in this group of folks, and with most of our practice having somewhat robust prostate cancer clinics. So certainly it suggests that there's room for improvement, but it also suggests that we as practices have to turn the light on ourselves a little bit and ask these questions and not assume that we're doing as good a job as we would've anticipated and get some hard data internally to address any gaps in care to maximize patient outcomes.

Dr Shore: Yeah, to me that's one of the most important aspects of this study. We looked at these 5 PIs, and of the 5, only using EBRT concurrently with ADT for grade groups 3 and higher, we had a 70% plus adherence. We were under 50%, way under 50%, in using DEXA scans, systemic therapy for metastatic disease imaging monitoring, and testosterone measurement. So to your point, Gordon, where there's incredible opportunity for improvement, I like the way you said it: We have to turn the spotlight on ourselves, and we have in the paper what are some of the practice characteristics and patient characteristics that can help improve your adherence to these guidelines. So Wanda, let me ask you, you did a really nice job of explaining why so many practices over the last decade find incredible clinical utility, economic utility, the value proposition for using PPS.

So the outcomes of this study I alluded to, it showed where there were patient and practice performance benefits when appropriately navigated. So anyone who's listening to this program right now, embedded within it is how PPS works. But there's also mention about clinical analyst services (CAS is the acronym); how does this fit into the patient care and practice optimization? That's one of the biggest take-homes. I think we're trying to get folks to understand in this article, not to just say, "Oh, look, you're not doing as well as you think you may be, but how can you be forward thinking and improve?"

Ms Wilt: Yeah, so this is probably the most exciting thing for me in this whole project. And that may

sound self-serving, but those of you who know me, I've pretty much put a stake in the ground for my career to be a patient advocate for navigation. And so for years and years, we've called them many things—coordinators, navigators, things like that—but allowing someone else to help a patient or truly navigate this complicated health care system started out that way. And that was the simple terminology, but when you add data to it, it makes even more the opportunity to identify any care gap. I often describe it as, we want to have a pathway. And I've talked many times about personalized pathways for practices. Know what your guardrails are so your staff can help be your eyes and ears. And as navigators, do that.

And this is a huge shout-out to navigators. I don't think they get near the praise that they should. They are between them. And then my team, as clinical analysts, I think they're the heroes behind the physicians, and they really are looking at every opportunity to make sure a patient gets offered every test, every treatment, and be able to do as well as they possibly can. And in this case, in the prostate cancer journey, CAS came about because we realized that there's so many patients falling through the care gaps, not because practices plan on that; it's just so busy. So how can we support the navigators and the providers and the practices? And so, as we looked at that, managing the data and knowing exactly where every patient is, being able to input data that maybe came from a provider's office, that's a family doctor that doesn't come right in from your EMR system.

Making that whole picture of the patient very solid allows you to know exactly where the patient is in the journey, and then we should be watching for any changes to know what they're going to need to be offered next. And so CAS is a group of highly trained individuals that manage practices' data, and they're not just inputting data. Somebody said, "Oh, they just fill in data." I'm like, "No. They know the disease backwards and forwards. They know exactly where every patient is." The tech-enabled tools that our team has built allow us to stage every patient, know exactly what's coming. And then we've created this system within CAS to know when patients are making

even a slight change, to be able to put our eyes on them and watch and make sure we're not missing anything. And just being that second set of eyes and ears for the practice.

And then we do all the reporting for the practice, so they're busy running their practice. And if we can deliver the data to them and say, "Hey, these are your opportunities, here's your percentages." So if you think about this article, these percentages all came from the data that we've been measuring, and we deliver that to the practices to help them continue to improve on any area that they choose as far as PIs for themselves. And so it's the right hand of the navigator and the practice and the physicians taking care of these patients.

Dr Shore: Yeah, I really appreciate what you just said. The complexity and the constant evolution of therapeutics and diagnostics is somewhat overwhelming for many. And I think if you're not measuring what you're doing and you're solely relying on, well, my empiric experience, it's no longer acceptable. Frankly, it hasn't been acceptable for over a decade now. And having tools to quantify so that you can see your utilization, you can see your quality performance, and the navigators who help along with it, I think is embedded within CAS, embedded within PPS, other analytic tools. And now as part of the clinic practice, we always typically have these wheels of the multidisciplinary team. And to your point, Wanda, the navigator is absolutely essential, and even getting as delineated as a prostate cancer navigator, a bladder cancer navigator, etc, depending upon your disease state. So now let me just close by asking each of you for your take-homes on this paper. What was from this study—again, just published in February 2025 in *Urology*—what are the highlights of the information, and where do you think we're going to move forward for future studies? Let me start with you, Gordon, and then Wanda, please.

Dr Brown: Yeah, so I think this paper certainly not only demonstrates some gaps in care but also should be hypothesis-generating on some level. And what I mean by that is that this should cause us to take a little bit of a step back, look more globally at the care

of our prostate cancer patients along their continuum and, frankly, probably among other disease states within our practices, as well. And we should look as a specialty, developing key PIs—certainly in prostate cancer would be a great place to start but also in other disease states—to effectively and thoughtfully manage these patients more robustly and more accurately along their disease continuums to maximize outcomes and to minimize costs from a systems perspective. I think when we look at this, the data in this paper is compelling and supports that role, and aligning with folks like Wanda and with CAS and PPS certainly can help us deliver on those goals in our busy community practices where we're delivering, for the most part, high-level care on a day-to-day basis.

Dr Shore: Thanks, Gordon. Wanda, final thoughts?

Ms Wilt: I agree with everything Gordon said. We're not doing as well as we thought, we as a medical community, and the opportunity is highlighted here. Some of these we think are simple, right? Testosterone levels, DEXA is hard to get approved, but these are necessary things. So maybe we have an opportunity to use this to educate some of our insurance companies. But I think the opportunity here highlights that we can use the data, as Gordon said, create those KPIs [key performance indicators]. And I hope we'll continue to do this as PPS. I know we will, right? Deliver it and help practices know what those are so they can improve. And then overall, it seems odd for those of us on this program that we would need to continue to justify navigation, but my hope is that for those practices who aren't sure they need a navigator, this really does make a difference. And this is just a small sample. We could do so many more PIs. And overall, I think this has been a great work to justify the fact that our patients deserve this and the fact that we can continue to do it better, and it doesn't take a lot of effort. And so my hope is that we'll be able to continue to work together to do better for our patients.

Dr Shore: Well, that was wonderful. Wanda and Gordon, thank you so much for your time today. Thanks for being part of this 2025 Meet the Expert program. Of course, a shout out to all of the coauthors on our paper. I'm really proud of it. And so we encourage everyone to, if they have some time, read through it, as well as thank you for attending this podcast and for our readership. If you want to listen to this full interview or other similar interviews, please visit the website (reviewsinurology.com), or you can download the *Reviews in Urology* app, which is also available in Apple Store and Google Play. So thanks, everybody. Thank you again, Gordon and Wanda, and thanks everyone, and we look forward to future presentations and publications.

Article Information