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Social risk factors screening preferences among breast and prostate cancer survivors: A qualitative study

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Abstract

Objectives: This project aimed to understand the experiences and preferences for social risk factor screening among racially, ethnically, and linguistically diverse cancer survivors in the Washington, DC, region.

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Disclosure statement

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Methods: Semi-structured interviews were conducted with English, Spanish, and Amharic-speaking breast and prostate cancer survivors. Data were inductively coded to identify themes, and differences by race and preferred language were evaluated.

Findings: Twenty-two interviews in English ($n = 14$), Spanish ($n = 7$), and Amharic ($n = 1$) among participants who identified as Black ($n = 8$), White ($n = 5$), Asian ($n = 1$), Other ($n = 6$), and multiracial ($n = 2$) were completed. Participants reported unresolved needs during treatment including transportation, healthful food, mental health care, financial help, and employment assistance. COVID-19 exacerbated many needs. Most participants did not recall discussing needs with oncology teams, but all participants were open to having these conversations.

Conclusion(s): This research reveals that cancer survivors might benefit from culturally appropriate strategies that address social needs.

Keywords

cancer survivorship; social risk screening; health-related social needs; Hispanic

Introduction

Cancer survivors are a growing population in the United States, estimated at 18 million in 2022, with 90% surviving five or more years.¹ In the general population medical care is estimated to account for 10%–20% of health outcomes, while other factors, including social determinants of health (SDOH), are responsible for as much as 80%–90%.^{2–4} In addition to having ongoing medical needs, cancer survivors are likely to face unmet social needs, such as emotional and mental health concerns, difficulty with medical transportation, financial challenges, and food insecurity, among others.^{5–10} Cancer survivors also face physical, mental, and social challenges including long-term effects from their therapies (e.g. fatigue, sexual dysfunction, depression, pain, etc.), financial toxicity related to medical bills, inability to work and/or job loss, and psychosocial challenges in adapting to life after being diagnosed with cancer.^{11–16}

Intersectionality theory posits that individuals have multiple identities (i.e. race, ethnicity, sex, sexuality, education, etc.) that intersect and reinforce one another in a way that shapes social experiences.¹⁷ Intersectionality provides a unique way of understanding health inequities, especially in cancer care. Historically marginalized populations, including racial and ethnic minorities, experience worse cancer outcomes regardless of socio-economic status,¹⁸ and also experience a higher prevalence of social risk factors due to structural inequities resulting from discrimination (e.g. redlining affecting geographic residence). People with cancer who also endure additional and interrelated disadvantages, such as lower income, racial stigma, and challenges with insurance, ultimately face greater stress and worse health outcomes.¹⁹

In a Detroit-based study of nearly 2,000 African American breast, colorectal, lung, and prostate cancer survivors, 36% reported unmet social needs including food insecurity, transportation challenges, housing instability, and utility shutoffs.¹⁰ Hispanic cancer survivors have also reported greater levels of unmet needs than non-Hispanic White patients,

and Hispanic breast cancer survivors have reported greater unmet needs than Hispanic prostate cancer survivors.²⁰ Even when patients are referred to social resources, some of the most common barriers to accessing these resources include lack of sufficient information to access the resource, competing priorities, distrust or prior negative experiences with resources, immigration concerns, and language barriers.²¹ Thus, strategies are needed to better identify and address patients' social needs and referral practices accounting for the needs of people from various racial, ethnic, and linguistic backgrounds and lived experiences.

While the impact of unmet social needs on cancer health outcomes is clear, few studies report on patient preferences for social care.^{22–24} Furthermore, screening for and addressing social needs is at the discretion of the individual healthcare system or clinic as it is not a required standard of cancer care. The distress thermometer asks about some social needs, but its administration is highly variable across clinical settings and social needs are not asked if no distress is identified.²⁵ Furthermore, previous studies on social risk factor screening preferences among adults have largely focused on White individuals and English speakers.²⁶ Those that have included Spanish speakers in other populations (e.g. pediatrics) have observed some distinct preferences related to both culture and language.²⁷ As part of a larger study to address racism and bias in cancer care, we conducted these interviews to inform the delivery of social risk factor screening and community health worker support. For the parent study, we focused on breast and prostate cancer as they are the most common cancers with entrenched racial disparities in health outcomes.^{28,29} We thus conducted this qualitative study oversampling racial and ethnic minority breast and prostate cancer patients to inform an intervention aimed to assess and address social risk factors among racially, ethnically, and linguistically diverse cancer survivors.

Methods

The study protocol was approved by the Institutional Review Board from the Georgetown-Howard University Center for Clinical and Translational Science (IRB #4397). Verbal consent was obtained from all participants prior to starting interviews to limit recording unnecessary identifiable patient information. The parent study was pre-registered at [clinicaltrials.gov NCT05301114](https://clinicaltrials.gov/NCT05301114).

Selection and description of participants

The research team reached out to oncology MDs, Nurse Practitioners, and Clinical Social Workers from large, Mid-Atlantic cancer centers to request names of adults 18+ diagnosed with cancer since 2020 with distribution across the following characteristics to ensure heterogeneity of demographic and medical characteristics: race (Black, White, other), preferred language (English vs non-English speaking), cancer site (breast, prostate), and cancer stage at diagnosis (stage I vs II-III). The research team then called potential participants by phone to explain the purpose of the interviews and to provide informed consent. No information was collected regarding immigration status or country of origin. We recruited participants between February 2022 and October 2023.

Data collection and measurements

The research team refined the interview guide with feedback from clinicians. We conducted semi-structured, <60-minute virtual interviews in English, Spanish, and Amharic between February 2022 and October 2023. We opted to oversample individuals who identified as Hispanic/Latinx and Black/African American and those with non-English language preferences of Spanish and Amharic due to documented racial/ethnic inequities stemming from social determinants of health,¹⁸ as well as to reflect the demographics and languages common in the Washington DC region: In 2012–2016, 42% of all African immigrants in DC were born in Ethiopia, and Amharic was spoken at home by four in ten African immigrants in the DC metro region.³⁰ Similarly, it was estimated by Washington DC 2023 census data that Hispanic or Latinx residents made up 12% of all racial/ethnic groups, and among those who reported using a language other than English at home, 8.9% reported speaking Spanish.^{31,32}

Interviews were recorded after obtaining verbal consent. Interviews were conducted by female masters- or doctoral-level team members trained in qualitative methods (RL, LS, JRR). Interview guides were developed in English by the study team, translated into Spanish and Amharic, and then back translated by a professional translation company to ensure accurate capture of the interview language and intent. Interviews in Spanish were conducted by a native language speaker with doctoral-level training in qualitative methods and previous experience conducting qualitative interviews (JRR). In two instances (including the single Amharic interview) interviews were conducted by clinical research coordinators due to language preference or scheduling conflicts; research coordinators had listened to previous interviews and were trained by the study team. Interviewers did not have a prior relationship with participants.

The larger project is guided by the Exploration, Preparation, Implementation, Sustainment (EPIS) framework. These interviews were part of the preparation phase to integrate patient perspectives in a culturally sensitive intervention design.³³ Interviews focused on discussions with care teams (described to participants as “doctors, nurses, social workers, or others”) about social needs, comfort in these questions being asked in a medical setting, social risk screening delivery modalities, and preferences for who should conduct social risk screening and when to screen (Table 1). English and Spanish interviews were transcribed *via* Microsoft Teams’ live transcription service, then reviewed for quality control by the original interviewer and by a second team member during coding. The Amharic interview was not recorded per the participant’s preference, so the interviewer took notes in English and met with the research team for a report out of the discussion. These notes were then used for coding, but no direct quotes were used where there was no transcription. Participants were compensated \$50.

Analysis

To develop an initial codebook, a member of the research team (LS) reviewed all transcripts in detail and an inductive approach was used to identify common themes in participant responses.³⁴ The codebook was reviewed and discussed with the full team for appropriateness and clarity before analyzing data. Qualitative analysis of English language

transcripts was completed by three researchers (LS and JA for English interviews, and JRR for Spanish and Amharic interviews) in Dedoose, an online mixed methods software;³⁵ Excel was used for Spanish transcripts and the Amharic interview was analyzed based on interviewer notes. The same codebook was applied to all transcripts. First, researchers (LS and JA) coded two English patient interviews concurrently but independently (blinded to codes applied by the other). Unmasked results were subsequently discussed with a senior researcher (HA) to resolve conflicting applications of codes. Differences in coding and interpretation were discussed until >80% consensus was reached. Remaining interviews were then split between researchers for coding. Given the single Amharic-speaking respondent, to assess differences by language preference, Amharic- and Spanish-speaking participants were combined into one non-English-speaking category. Differences in response by race/ethnicity and linguistic preference were evaluated.

Results

We interviewed 22 individuals with an average age of 64.5 years. Approximately 64% ($n = 14$, 63.6%) identified as female breast cancer survivors and 36.4% ($n = 8$) identified as male prostate cancer survivors (Table 2). While all participants were identified from the medical record by clinical staff as stage I–III at diagnosis, $n = 8$ (36.4%) did not know their stage at diagnosis. Eight participants (36.4%) self-reported their racial group as Black, one (4.5%) as Asian, two (9.1%) as “Two or more races,” five (22.7%) as White, and six (27.3%) as “Other.” Eight (36.4%) participants identified as Hispanic/Latinx ethnicity. For interview language, $n = 14$ (63.6%) preferred English, $n = 7$ (31.8%) Spanish, and $n = 1$ (4.5%) Amharic. English-speaking participants were diagnosed between March 2020 and July 2021, while Spanish speaking participants were largely diagnosed between January 2021 and April 2023. One Spanish speaking participant was first diagnosed in 2016 but had prostate cancer surgery in 2023 and the Amharic speaking participant was diagnosed in 2019.

Experiences with social risk screening

Most participants did not recall oncology teams asking about social needs (described to patients as non-medical needs and “experiences that get in the way of [a patient’s] health such as trouble getting to or from appointments, paying for food, housing, utility bills, or medical prescriptions”) in a systematic way (Table 3). However, many participants, regardless of race, reported ad hoc discussions of transportation to medical appointments with care teams in conversation. After the identification of needs such as transportation, participants shared that caseworkers or social workers provided resources to address these needs. Other patients talked about the need for mental health services. One English-speaking Black participant recounted that her care team attempted to connect her to a mental health provider, but it ultimately “fell through the cracks” as she never received follow up.

Of the non-English speaking participants who reported having conversations about social needs, discussions were varied. Four non-English speaking participants mentioned that there were instances where support was offered by the healthcare team but there was no follow-through, and one non-English speaking participant reported that while it made her feel good

that her oncologist frequently asked her if she needed anything, she did not disclose any needs because she was embarrassed about being unable to work due to treatment.

Social risk screening preferences

All participants welcomed the idea of social risk factor screening in oncology. However, there was variability in preference for screening modality, frequency, and whom from the care team should be involved. There were no clear patterns observed by race. Most English-speaking participants reported no preference for who conducts social risk screenings or how, while a few preferred having these conversations in person. In contrast, some non-English speaking participants suggested that self-administered questionnaires would increase their comfort level, lead to better understanding of the questions, and create a record of their responses in their medical records. Other non-English speaking participants preferred to be asked by phone so they could answer the questions in the privacy of their home if a caller could be identified as a member of the oncology team to ensure trust. Similarly, some non-English speaking participants wanted privacy to avoid pity or embarrassment from the family members or friends who care for them, while others wanted an adult child present to help. Finally, some non-English speaking participants preferred completing social risk screening in their native language. Participants in our sample generally did not want a patient portal-delivered questionnaire.

Most participants, regardless of race or language, did not have a preference with whom to have the conversation, as long as they were familiar with what patients in oncology go through. There was a consensus that nurses and physicians should receive the social risk screening results. Non-English speaking participants additionally indicated that the person who asks the questions should also provide resources to address the disclosed needs. Some non-English speaking participants noted that they would feel more comfortable disclosing their needs if the provider identifies the resources that they can provide prior to asking about social needs. Multiple respondents suggested that social risk screening should occur at the initial visit with follow-up as needed, with no noted difference in preference by race. Many non-English speaking participants recommended ongoing social risk screening because their needs could change over time.

Social needs during survivorship

Most participants regardless of race or preferred language reported experiencing social needs including reliable transportation for treatment appointments, financial strain, and dietary needs. Participants also cited needs pertaining to housing, support groups and/or mental health support, physical therapy, timely medication refill, and access to wigs. Some of the reported needs depended on the severity of their illness, underscoring how cancer treatment changes the needs that individuals have.

Few participants received referrals from their medical teams, but many described challenges and ended up seeking their own resources. Two participants received a referral but could not connect with the organization; one English speaking participant spoke of challenges in learning what resources their hospital provided and hearing differing information from different sources. Some non-English speaking participants reported difficulties connecting

with the provided supports due to language barriers (the automated phone system was only in English), when they called no one answered, or the team members did not follow-up with them. Notably, multiple English-speaking participants located and accessed their own resources through books, friends, the internet, churches, and other survivors. Similarly, some non-English speaking participants reported benefiting from resources available in their community.

Barriers for cancer care and social needs

COVID-19 was cited as a barrier to receiving cancer care and social support across all participants, regardless of race. COVID-19 created challenges to accessing community resources due to public transportation inaccessibility and community organizations closing or being under-resourced. Participants also noted the impacts that the COVID-19 pandemic had on their treatment experiences including provider turnover, challenges in accessing transportation to or from treatment visits, being unable to bring loved ones to appointments, and canceled or postponed visits. Non-English-speaking participants also cited challenges navigating the healthcare system (e.g. identifying providers and scheduling appointments), lack of available interpreters and non-English-speaking schedulers, and perception of limited information shared by provider due to a language barrier or the time constraints of having an interpreter.

Participants, regardless of race, also discussed challenges with their insurance, resource availability, and provider variation over the course of their cancer treatment. Both Black and White English speaking participants discussed challenges in identifying in-network providers and accessing mental health care. A few non-English speaking participants also expressed concerns about exceeding limits on their insurance coverage and preferred not using their insurance to cover non-medical needs like transportation due to a fear they could receive unexpected bills.

Facilitators for cancer care and social needs

Participants, regardless of race, also discussed how social support, familial or otherwise, was necessary during their treatment and recovery. Eight participants, seven of whom were Black/African American, discussed the support they received from their providers and care teams as being a critical part of their comfort with and understanding of their care. Two participants of Black and “Other” race relied on other survivors for support and guidance. Non-English speaking participants emphasized the role of family members for instrumental (e.g. transportation, housing, and food) and informational support (e.g. communicating with providers and helping them answer medical questions), but family members had their own responsibilities which made it difficult to rely on them too often.

Perceptions of health

When participants were asked what “health” means to them to better understand what supportive services would resonate, most, regardless of race, cited the importance of nutrition, rest, and exercise to live a healthy lifestyle. Some non-English speaking participants also noted the importance of health to be with their loved ones and be able to work.

Discussion

We found that health-related social needs, preferences for screening discussions, and barriers/facilitators to social risk factor screening and cancer care differed by language among English speaking and non-English speaking breast and prostate cancer patients in our sample; we did not observe notable differences in responses by race. Actionable take-aways include suggestions to 1) accommodate patient preferences to speak to a member of the oncology team or be offered an option to respond to a trusted team member by phone; 2) provide examples of types of resources available to patients prior to or in tandem with social risk screening; and 3) inform patients who would be notified and who would address identified social needs. There was some consensus around a screening time point at initiation of treatment but differences in opinion on how often to reassess risk factors, suggesting that patients may prefer a choice to opt out of continued screening.

The literature surrounding social risk screening in patients is variable: Some work has previously suggested that patients may be averse to reporting social needs, citing concerns about data privacy.^{22,23} This is contrary to other published findings, including our own work, in which both English speaking and non-English speaking patients were open to sharing social needs with clinical teams.^{36,37} There was also no consensus on the ideal frequency of social risk screening among our sample, and we found that patient preferences on the frequency for screening varied significantly, suggesting that patients may prefer an option to opt out of repeat social risk screening. Challenges with identifying an “ideal” frequency of screening have been discussed in other work, suggesting a need for cancer care teams to balance changes in needs and survey fatigue among patients.³⁸

The English-speaking participants in our sample indicated a preference for having face-to-face conversations with care teams about social risk. This is consistent with other studies, and it is possible that holding these conversations face-to-face could serve to strengthen the relationship and trust between patient and provider.^{23,39} Conversely, the non-English speaking participants in our work expressed an interest in survey or phone-delivered social risk screening in their native language so that conversations could remain private. However, if conducted by phone, participants indicated the caller should identify themselves as part of the healthcare team. To our knowledge, this has not previously been reported in relation to social risk factor screening. However, previous work has found associations between individuals who have experienced bias and discrimination and a desire for confidential social risk screening,⁴⁰ suggesting that patients’ preferences may therefore relate to their identities and lived experiences with discrimination and bias in the healthcare setting. Previous work on patient centered care and communication examining characteristics such as age, sex, race/ethnicity, and diagnosis suggests that there are racial and ethnic differences in how communication is perceived;⁴¹ however, racial differences did not come through explicitly in our work. Some previous work on patient portal-based screening suggests that portal use and perception may vary based on demographics, health literacy, and usability; this option was not preferred by participants in this study, though portal delivered screening has been successfully implemented in other settings.^{42,43}

Non-English speaking participants also expressed a preference for screening in their native language, and discussed challenges with interpreter services. This has been previously documented, with improved patient experiences and care when patients have language concordant healthcare workers.^{44–47} Similarly, existing literature suggests that patients may be more willing to engage with healthcare practices and providers who are culturally concordant, who actively listen, and who can anticipate cultural needs and priorities in screening (e.g. *familismo*).²⁷ Our contradictory finding of family providing support but also being a source of stigma that could impede asking for help with social needs among Hispanic/Latinx patients has also been previously reported.^{48–50} Together, these findings suggest the importance of linguistically concordant and culturally appropriate social risk screening practices, while recognizing that there may not be a one-size-fits-all approach. It is important to note that the survey and phone preference in our non-English speaking sample noted above could also be due to lack of language concordance with their oncology team members.

Our findings also support the importance of universal social risk screening to better capture and address the burden of social risk factors.^{51–54} In our study, several English-speaking participants received referrals or resource information from their care teams only after they asked for help. Some non-English speaking participants also described feeling more comfortable disclosing needs if they knew their care team could provide relevant resources. Previous qualitative work among Latinx patients described how patients feel frustrated when they disclose social needs information without follow-up or complete a social needs screening without discussing results with their care team.²⁷ This sentiment was echoed in participants in this study. Furthermore, most participants interviewed in the present study experienced social needs at some point in their cancer experience, many of which were not discussed with care teams. The high prevalence of unmet social needs among cancer survivors is not unique to our study,^{55–58} nor is social risk screening for social needs a standard part of cancer care for all cancer care settings despite a recognition of its importance.⁵⁹ The finding that most participants experienced a need during the cancer experience provides evidence to suggest that health-related social risk factor screening should be completed through a standardized, scheduled format⁶⁰ rather than waiting to see if social needs emerge through patient-provider conversations.

It is also important to note that many participants attempted to seek out support for their social needs but faced challenges in finding appropriate resources and/or did not receive helpful responses. Research exploring care delivery models for addressing unmet social needs suggested improved outcomes through direct, as opposed to indirect, referrals.⁶¹ At least some of the participants in the present study relied on indirect referrals, which may explain the challenges they faced in addressing needs. This further suggests that healthcare systems should consider referral pathways carefully when implementing social needs screening.

Finally, in this study we asked participants to define what “health” means to them with the intention of understanding participant values pertaining to their health and to inform culturally appropriate interventions. Previous research has theorized that motivations for enhancing and sustaining healthy behaviors can be fostered through trusted connections

with health professionals, suggesting a role for non-medical healthcare workers (e.g. CHWs) in helping cancer survivors reach health goals.^{62–64} The range in responses among cancer survivors in our study, from actionable behaviors (e.g. nutrition) to social relationships (e.g. family), is consistent with other work regarding health-related goals in cancer survivorship.⁶⁵

Our study has limitations. First, participants were recruited primarily from two cancer sites, and fewer prostate cancer survivors agreed to participate than breast cancer survivors. Those participants who were recruited *via* referral may have had unique experiences, either good or bad, that motivated participation. Second, this work was conducted primarily with English and Spanish-speaking individuals. The first round of interviews in 2022 was with English speakers, the second round in 2023 was with Spanish and Amharic speakers. There may have been secular changes over that time. Still, the strengths of our study include the racial, ethnic, and language diversity of the sample and the attention to understanding patient perspectives as part of formative work for an intervention. Next steps include delivering social risk factor screening and referrals for survivors of cancer and conducting subsequent rounds of interviews to understand patient experiences with social risk factor screening and referrals, and its impact on quality of life.

Conclusions

Findings suggest the breast and prostate cancer survivors in this study were open to social risk factor screening during treatment, and that language preference emerged as the primary distinguishing factor in screening experiences and preferences for screening delivery. This work highlights a need for culturally and linguistically appropriate tailoring for interventions, particularly for Hispanic/Latinx patients who prefer Spanish to identify and address patients' social risk. Future research may focus on additional culturally diverse populations, exploring social needs screening implementation, and its impact on health outcomes.

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Data availability statement

The full data underlying this article cannot be shared for the privacy of individuals that participated in the study, but deidentified transcripts can be shared upon reasonable request to the authors.

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Table 1.
Key interview guide topics and example questions.

Domains	Example questions
Experiences with screening	1. Have you ever had conversations with your care team(s) about [social needs]? Can you tell me about them? a. (If yes) How often did you have these conversations? b. How did being asked these questions make you feel? c. Can you tell me about the last time you were asked these questions? i. Prompt: Who asked you these questions? ii. Prompt: When during your visit were you asked? iii. Prompt: What did your doctor/nurse do with this information? iv. Prompt: How did you feel about this experience? 2. Sometimes a health care team will ask about things like transportation or food availability in your household because they may be able to connect you with organizations that provide these services. Has anyone outside of your regular care team(s) asked you these types of questions?
Screening preferences	1. How would you feel if your health care team asked you [about social needs]? 2. Who do you think is the best member of your clinical team (e.g. doctor, nurses, front desk, etc.) to ask these kinds of questions? 3. There are a few different ways to answer these questions too. For example, you could answer these questions by filling out a form in the waiting room, using a patient portal, or answering them in-person during your appointment. How would you prefer to answer? 4. How often do you think your care team should ask these kinds of questions? 5. Is there another place/organization in your life where you would rather have these kinds of conversations (e.g. not the healthcare system)
Social needs during survivorship	1. Has your doctor’s office ever connected you to you to a social worker or outside organizations to address any needs like social support, paying your bills, transportation, or accessing healthful food? a. (If yes) What challenges did they help you with? b. (If no) Would you want your doctor’s office to help you with any of these issues if you ever needed help? 2. Do you have family or friends who might have experienced practical, social, or emotional needs support? 3. Cancer survivors especially have experiences that can be hard for others to understand. What kind of support do you think would be helpful for patients who are finishing treatment?
Patient perceptions of health	1. What does health mean to you? 2. What are the most important ways a community health worker could support you in achieving your health-related goals?

Table 2.Demographics of participants ($n=22$).

	n	%
Sex		
Female	14	63.6
Male	8	36.4
Cancer type		
Breast	14	63.6
Prostate	8	36.4
Self-reported stage at diagnosis ^a		
I	4	18.2
II	6	27.3
III	4	18.2
Unknown	8	36.4
Race		
African American/Black	8	36.4
Asian	1	4.5
White	5	22.7
Two or more races	2	9.1
Other	6	27.3
Ethnicity		
Hispanic/Latinx	8	36.4
Language the interview was conducted in		
English	14	63.6
Spanish	7	31.8
Amharic	1	4.5
Age (range, median), years	34–84, 64.5	

^a All participants were identified by oncology teams or the cancer registry as stage I-III, but we asked participants for self-report of stage as we did not otherwise need to access the medical record.

Table 3.

Representative quotes on preferences for social risk factor screening processes.

Quote(s) related to...	
Experience with screening	"I guess [I had discussions about] food when I was going through my first bout of cancer... The doctor told me, you know, some things to eat that would help if I had nausea or whatever problem or it was good for you... but as far as having any real conversations [about social needs] with anybody, I really haven't." – Female, age 81, ES, White [The social worker] ... actually reached out to some of them. I didn't get any response from any of the organizations that I reached out to or she reached out to, but she was able to help. She was able to connect me with transportation, which was an amazing help. [I talked with her] on a regular basis, not every time I went there, but maybe every other week or every two weeks." – Female, age 70, ES, Black "You know, they give you this huge, ginormous packet... It's like, congratulations you have breast cancer. Here you go. Do all this reading. And maybe something was in there. They might have asked [about social needs] at the beginning ... They might have said, do you need anything? And it's like, no? Good. Here's my parking ticket. Please stamp it." – Female, age 63, ES, White "They called me when I just started going here and asked me if I needed help and I said yes, because since I'm retired now, I no longer have a salary. Then she gave me some phone numbers where they could help me. But it seems that those numbers that she gave me are out of service because they never answered, and I stopped calling... I called her back too, but the problem is that to reach them I need to go through the language barrier... I was never able to communicate with her again." – Male, age 66, NES, Hispanic/Latinx "No, I don't know, because they did ask me questions once, but that was it. They just asked me, I answered. They said they were going to help me and so far nothing." – Female, age 84, NES, Hispanic/Latinx
Preferences for screening	"I would talk... I'm not that good at filling out stuff." – Male, age 70, ES, Black "I think a conversation would, would be nice cause you get surveys and it's like, okay, is anybody really gonna look at this or get back to me on this? So I think just a simple conversation would be nice." – Female, age 61, ES, Black "I think I would have felt more sincere responding to a form that was there... Sometimes, we don't understand it if it's in English... So, it has to be in Spanish too.... I think that every time the patient goes to the clinic it is good to ask because the needs change, perhaps from one day to the next." – Female, age 41, NES, Hispanic/Latinx "It should be in private. Because well, in my case I always go to my appointments alone, but my sister also has that way of thinking. When you ask for help is like you give pity." – Male, age 61, NES, Hispanic/Latinx
Social needs during treatment	"I was so deep in debt. I was like, oh my God, I just can't lose my house... I wasn't working. My husband was the only one [financially supporting us] and I wasn't able to make a contribution. That weighs heavily on you. I mean, we're still trying to dig ourselves out of debt. It's a long, slow process." – Female, age 61, ES, Black "I got the [therapy referrals] from [my social worker], and I reached out. I don't remember the names of them and it wasn't a lot, but the few that I did reach out to, I didn't hear anything back and I just didn't follow up anymore." – Female, age 70, ES, Black "I asked [my care team] to find a therapist 'cause I thought maybe they would have a list... [but there was] an absence of access to either a psychologist or psychiatrist or therapist or even having a list of folks who... take insurance [and are] accessible." – Female, age 54, ES, White "I was telling the other patients that had the same problem [with transportation as I did]... So I passed [referral information] around to the people I met in the chemotherapy" – Female, age 60, ES, Black "I had a personal friend that just went through this [who shared] information, and I got on my computer and I pulled a little information up to educate myself... It made me mentally more relaxed." – Male, age 64, ES, Black "I think my health would be much better if I had the means to buy certain things like food, mainly vegetables. I don't really eat vegetables as I should, or fruits, because ... I have no income and my sister already does a lot for me and economically she is not that solvent. I have access to food, but not a complete diet, including fruits and vegetables." – Male, age 61, NES, Hispanic/Latinx "I'm a little worried because what do I do without transportation to return home?... my son is going to drop me off, but because he works and I'm done at 2:30pm, he is not able to pick me up. Could you help me, please? Sometimes my son asks an Uber for me, that way them, my daughter, they order transportation for me..." – Male, age 72, NES, Hispanic/Latinx
Barriers for cancer care and social needs	"I was losing my doctors. My oncologist, she left just before my last cancer chemo treatment... There was a transition of another doctor stepping in, but because of the pandemic doctors were leaving. I think they were just burned out... I saw [my new oncologist] once, then she left. Now there's a new oncologist... You'd know these people, they know you. And then they're leaving." – Female, age 70, ES, Black "Everything was super shut down 'cause [COVID-19] was spiking again. Taxis weren't on the street. Ubers weren't on the street. And I didn't have anyone I felt like I could ask to take me to radiation every day for six weeks." – Female, age 54, ES, White "It was a challenge. It was not easy to find [a therapist]... I had to go online and look for one through my health insurance. I went online and I called different ones. And eventually this one place actually got back to me and... I started working with them." – Female, age 61, ES, Black "I don't know if it is with everyone, and I understand that I have a language problem. Can't they just tell me what I really need to know? 'I'm going to waste time, I have this and he doesn't understand me, I need someone that is translating?'" – Male, age 66, NES, Hispanic/Latinx
Facilitators for cancer care and social needs	"I started to research people who went through the same process, and I was able to get in touch with one survivor. She was diagnosed with [the same] cancer, pretty much the same age, a lot of similarities... [Also] I had my whole family... So all of them were supporting me in a way that you can't imagine. And that helped me a lot... I was able to find sources who went through the same process and I learned a lot about them." – Female, age 34, ES, Hispanic/Latinx "My head was spinning when I was going through [treatment]. [Then my social worker] came in and spoke to me during my first treatment... I don't know if I was hearing everything that she was saying. But she was just reassuring me that she's here

Quote(s) related to...	
	<i>to help...</i> – Female, age 70, ES, Black <i>"They called me from the clinic and told me that on that day they were going to be there, distributing food. "Look, I can write you down and you arrive." I would say, "Of course" ... I didn't have insurance at first and [case manager] helped me to go get the exam that I had to do on the chest. So, that's how she met me. She helps with the referrals... with her I have the confidence that if I can't make a referral or something, I can call her and tell her."</i> – Female, age 41, NES, Hispanic/Latinx
Patient perceptions of health	<i>"...Even after having the biopsy, I never thought that this could happen to me. I never thought that it was even possible... because of my age... [and] there weren't even any records from my family having breast cancer, so it was never a possibility. And whenever they told me what was happening to me, I was like, oh my goodness, I really have to pay attention to my body. I really have to pay attention to my health, to the way I'm feeling."</i> – Female, age 34, ES, Hispanic/Latinx <i>"You see, health gives you the opportunity to be with the people you love most and work. Even if you work hard, if you are healthy, you don't feel it."</i> – Male, age 65, NES, Hispanic/Latinx <i>"Well, what has helped me is faith, I am a man of great faith and I always put everything in the hands of God. I don't believe in religions, but I do believe in God."</i> – Male, age 61, NES, Hispanic/Latinx

ES: English speaking; NES: Non-English speaking.