# Welcome!

***Before we begin…***

**Today's session will be recorded**

**Please add your name and health system in the chat**

March 19, 2024, | 4:30 PM ET • 3:30 PM CT • 2:30 PM MT • 1:30 PM PT

# Prostate Cancer Screening IMPACT ECHO

**Session 2:** Informed Decision Making, Effective Shared Decision-Making Conversations and Decision Aids

Welcome to Session 2 of the

# Prostate Cancer Screening IMPACT ECHO

Each ECHO session will be recorded and ***will*** be posted to a publicly-facing website. Chat content, attendance, and poll responses are also recorded

Please update your Zoom Participant Name to First Last, Org (Molly Black, ACS).

Type your full name, the full name of your organization, and e-mail in the chat box.

You will be muted with your video turned off when you join the call. Use the buttons in the black menu bar to unmute your line and to turn on your video.

Today's materials will be made available on our ACS ECHO website.

All ECHO sessions take place on the iECHO & Zoom platforms. iECHO Terms of Use & Zoom Privacy Policy.

Questions about Zoom during the call? Find **@Beth Graham** in the chat.

# This project is being funded by

American Cancer Society | Project ECHO


**Have a question?** Don't wait to ask! Feel free to enter in the **Chat** at any time.

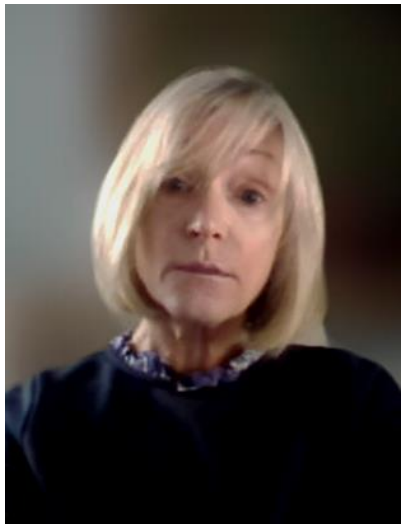
# Today's Agenda

1. Welcome, Housekeeping & Data | *7 minutes*
2. Didactic Presentation & Discussion: Informed Decision Making, Effective Shared Decision-Making Conversations and Decision Aids | *25 minutes*
   Presented by: Quoc-Dien Trinh, MD, MBA
3. Participant Site Introduction: Central Florida Health Care | *3 minutes*
4. Case Presentation & Recommendations | *20 minutes*
   Presented by: Geoff Hall, APRN, FNP-C | Central Florida Health Care
5. Survey, Schedule, Reminders, & Wrap-Up | *5 minutes*

# Your ACS ECHO Team

**Molly Black**
Director, Screening
American Cancer Society
**ACS ECHO Program Lead & ECHO Facilitator**

**Mindi Odom**
Director, Project ECHO
Your ECHO Co-Lead



**Beth Graham, MPH, CHES**
Program Mgr., Project ECHO
Your Program Support

**Jennifer McBride, PhD**
Senior Data & Evaluation Manager

# Introductions

## Meet Our Prostate Cancer Screening IMPACT ECHO HUB – Subject Matter Experts (SMEs)

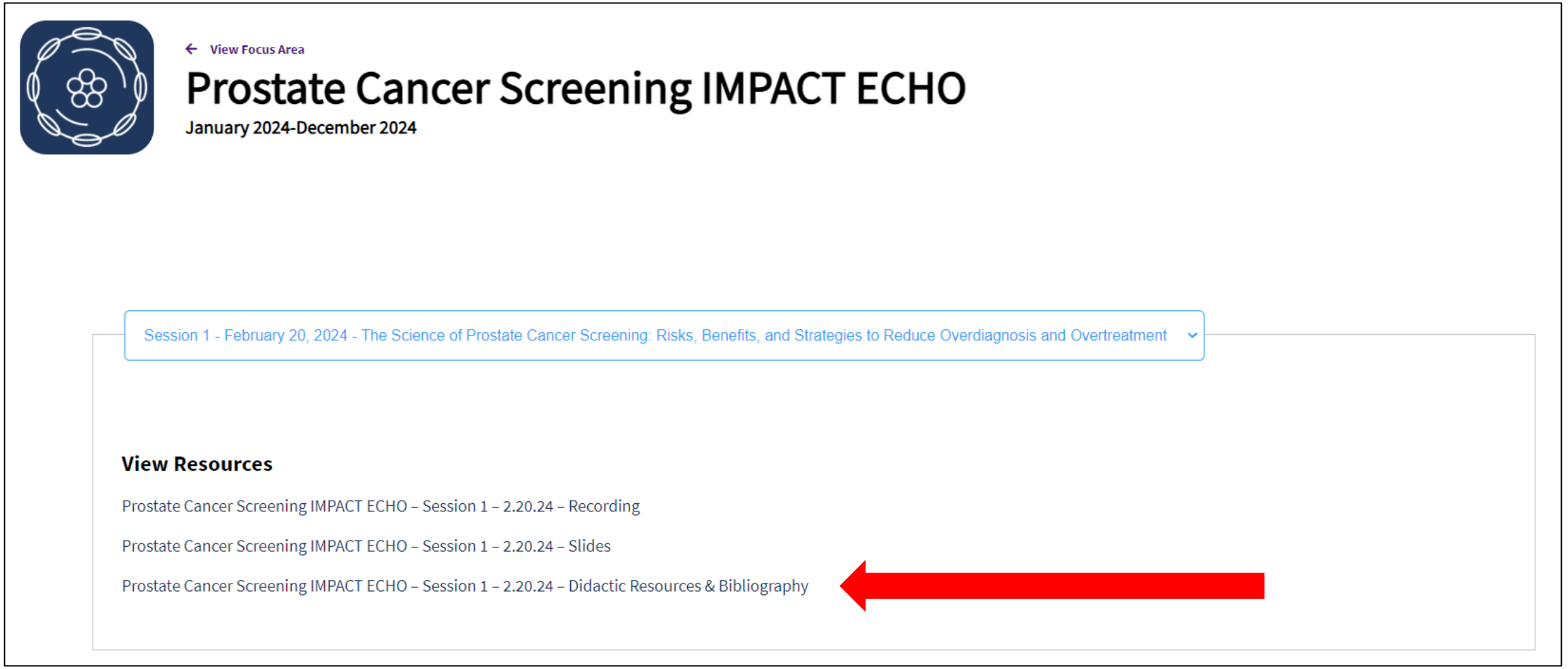
**Andrew M.D. Wolf, MD, MACP**
Professor, Internal Medicine
**University of Virginia, School of Medicine**

**Quoc-Dien Trinh, MD, MBA**
Chief of Urology
**Brigham and Women's Faulkner Hospital**

**William H. Boykin, Jr, MD**
Urology Specialist
**UK King's Daughters Medical Center**

**Yaw A. Nyame, MD, MS, MBA**
Assistant Professor,
Director of Urology
**Fred Hutch at University of Washington**

# We use your survey feedback!



# EHR Systems

| Primary Care Participant Site | EHR system: |
|---|---|
| Central Florida Health Care, Inc. | Athena |
| CareSouth Medical and Dental | Athena |
| Agape Family Health | Athena |
| BMS Family Health Center | Athena |
| North Hudson Community Action Corporation | eClinicalWorks |
| Greater Baden Medical Services, Inc | eClinicalWorks |
| Albany Area Primary Health Care, Inc. | eClinicalWorks |
| Nashville General Hospital | eClinicalWorks |
| Cornell Scott-Hill Health Corporation | Epic |
| Family Circle of Care | Epic |
| Southside Community Health Services | OCHIN Epic |
| Roots Community Health Center | Advanced md |

## C-SASI: Do you use a shared decision-making tool now?

Only two – both report using clinical decision alerts within Athena

## C-SASI: Number of Male Patients 45-70 (with at least one medical visit* in 2023) with a documented Shared Decision-Making encounter related to PSA screening: What is your capacity?

Only one system with Athena is able to provide and trust.

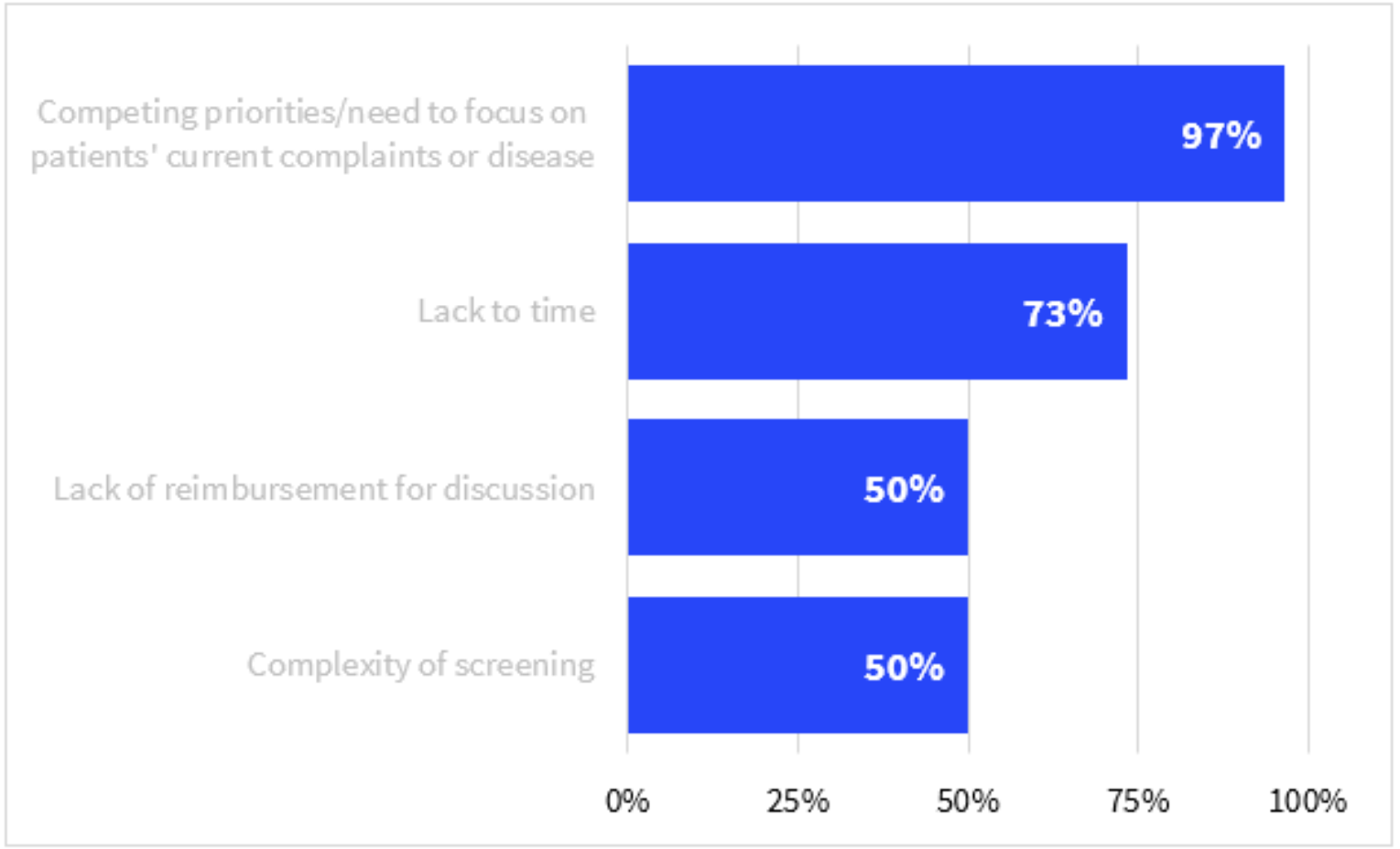
**Quoc-Dien Trinh, MD, MBA**
Chief of Urology
Brigham and Women's Faulkner Hospital

# Informed Decision Making, Effective Shared Decision-Making Conversations and Decision Aids

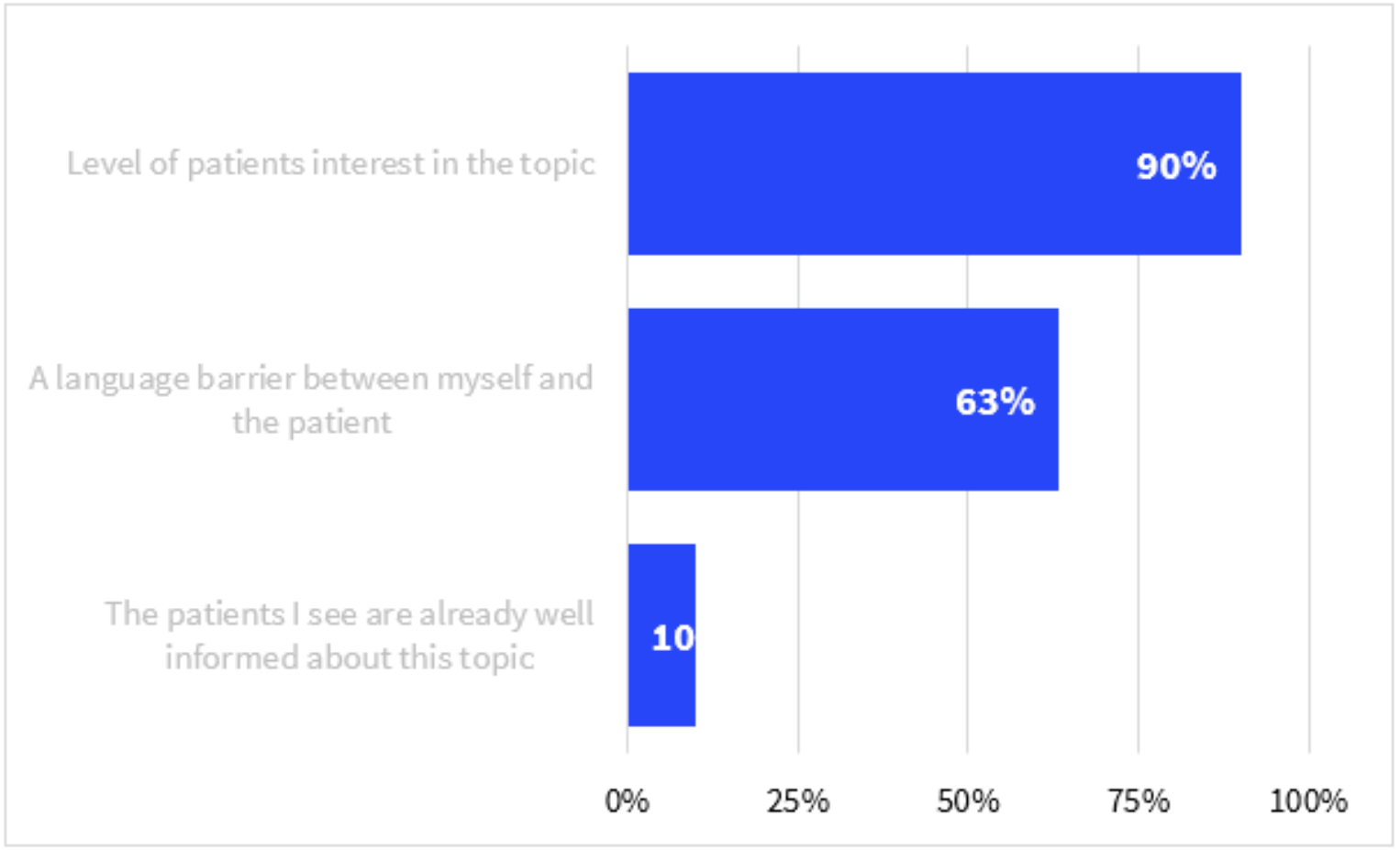
# Disclosures

- **Consulting**: Astellas, Bayer, Intuitive Surgical, Janssen, Novartis, Pfizer
- **Funding**: American Cancer Society - Pfizer Global Medical Grants (Prostate Cancer Disparities #63354905), Health Disparity Research Award from the Department of Defense Congressionally Directed Medical Research Program (#PC220551).

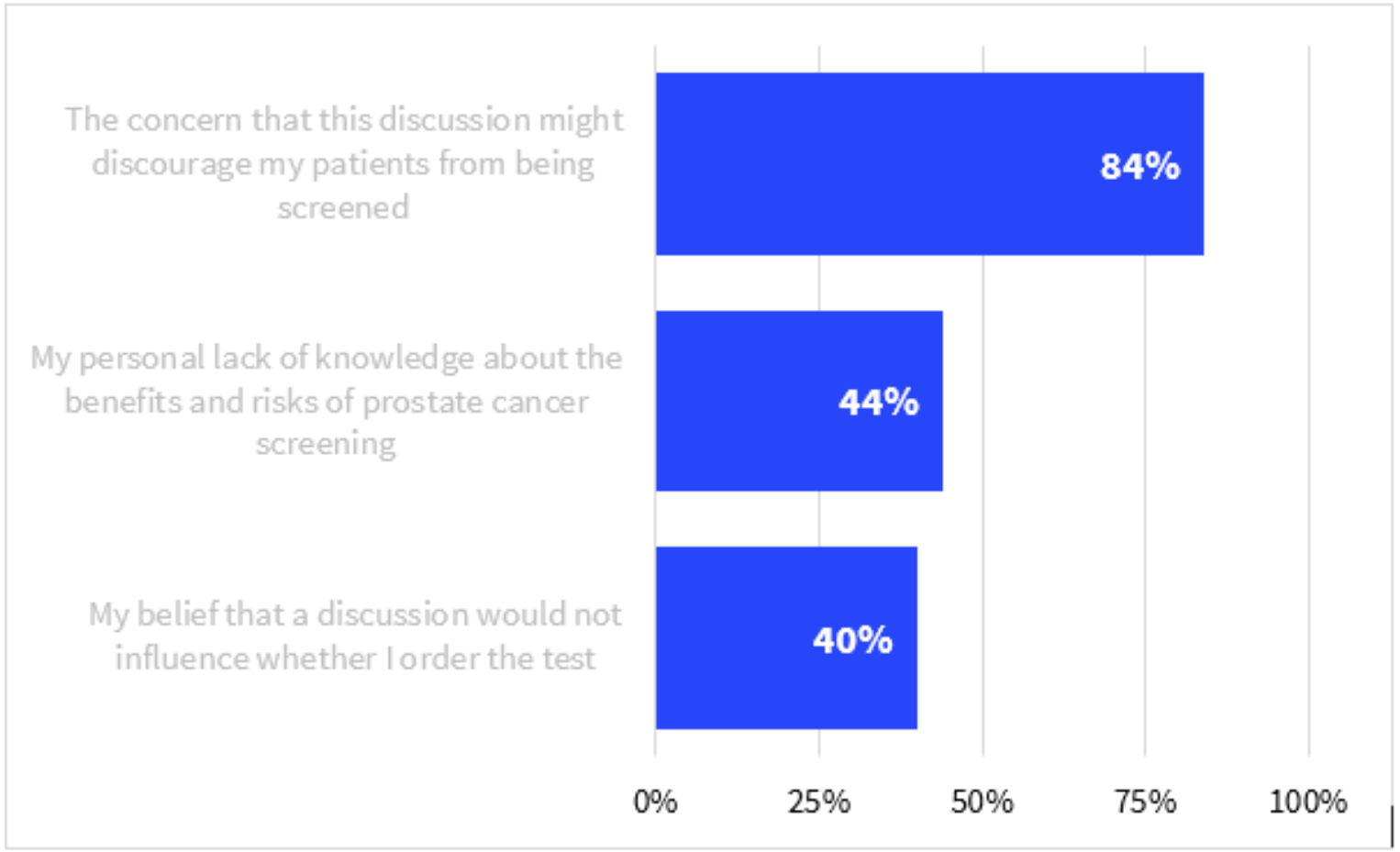
# Pre-ECHO assessment: Systemic factors that influence shared decision-making discussion



# Pre-ECHO assessment: Patient factors that influence shared decision-making discussions



# Pre-ECHO assessment: Physician factors that influence shared decision-making discussions



# What is shared decision-making and when is it useful?

# Definition of shared decision-making

- At least two participants—physician and patient be involved
- Both parties share information (decision aid)
- Both parties take steps to build a consensus about the preferred treatment
- An agreement is reached on the treatment to implement

Charles et al, Soc Sci Med. 1997 Mar;44(5):681-92. doi: 10.1016/s0277-9536(96)00221-3.

# Preference Sensitive Care

- Care for conditions where treatment options exist
- Where the treatment options involve significant tradeoffs in the patient's quality or length of life
- **The choice of treatment should be decided upon by the fully informed patient in partnership with their physician (shared decision-making)**

Wennberg et al, Preference-Sensitive Care: A Dartmouth Atlas Project Topic Brief

# Examples of Preference Sensitive Care

- Herniated disc (meds, PT, surgery)
- Osteoarthritis (meds, surgery)
- Coronary artery disease (meds, angioplasty/stenting, CABG)
- Prostate cancer (active surveillance, radiation, surgery)
- Early-stage breast cancer treatment (lumpectomy/radiation, mastectomy +/- reconstruction)
- Benign uterine conditions (meds, D&C, ablation, hysterectomy)
- Obesity (behavior change, meds, bariatric surgery)
- End of life care (‘curative/futile’, palliative, hospice, etc)
- Depression (meds, psychotherapy, watchful waiting)

Wennberg et al, Preference-Sensitive Care: A Dartmouth Atlas Project Topic Brief

# There is variation in the perceived value…

# … among providers.

**Table 1** The US, UK and Australian recommendations for prostate-specific antigen (PSA) testing of asymptomatic men for prostate cancer

| | Professional body | Advice for health practitioners (see original documents for exact phrasing) |
|---|---|---|
| Population | US Preventive Services Task Force (USPSTF)[3] | ▶ Discuss PSA screening thoroughly with men who raise the issue or if the man's individual circumstances warrant consideration of PSA testing. Do not feel obligated to offer PSA testing if a patient does not raise the issue or request the test<br>▶ The decision to start or continue PSA screening should reflect the patient's understanding of the possible benefits and expected harms and should respect his preferences |
| | National Health and Medical Research Council (NHMRC)[11] | ▶ Before ordering a PSA test, health practitioners should talk to men about the potential benefits and harms of PSA testing |
| | National Health Service (NHS)[12] | ▶ Screening not recommended. An informed choice programme, Prostate Cancer Risk Management aims to provide high-quality information about the risks and benefits to men who ask about screening in order to enable them to decide whether to have the test |
| National | American Cancer Society (ACS)[10] | ▶ Provide men the opportunity to make an informed decision; for men who are unable to decide, the screening decision can be left to the discretion of the healthcare provider<br>▶ Men at average risk and expected to live at least 10 more years should receive this information beginning at age 50 years. Men in higher risk groups should receive this information at age 40–45 years |
| | Cancer Council Australia (CCA) and Australian Health Ministers' Advisory Council (AHMAC), 2010*[13] | ▶ Speak to men about the benefits and harms of testing and treatment so that they can make an informed choice |
| Specialist | American Urological Association (AUA)[8] | ▶ Shared decision-making for men aged 55–69 years based on a man's values and preferences<br>▶ Routine screening is not recommended in men aged 40–54 years at average risk, or in men over 70 years or with less than a 10–15-year life expectancy; decisions should be individualised for men younger than 55 years at higher risk |
| | Urological Society of Australia and New Zealand (USANZ)[14] | ▶ PSA and digital rectal examination (DRE) should be offered to men 55–69 years, after providing information about the risks and benefits of such testing<br>▶ Interested men in younger age groups (under 55 years) could have a single PSA test and DRE performed at or beyond age 40 to provide an estimate of their prostate cancer risk over the next 10–20 years, with the intensity of subsequent monitoring being individualised accordingly |
| Primary Care | American College of Physicians (ACP)[15] | ▶ Inform men 50–69 years about the limited potential benefits and substantial harms of screening for prostate cancer<br>▶ Base the decision on the man's risk for prostate cancer, a discussion of the benefits and harms of screening, the patient's general health and life expectancy and patient preferences<br>▶ Advised not to screen patients who do not express a clear preference for screening<br>▶ Advised not to screen average-risk men under 50 years, over 69 years, or with a life expectancy of less than 10 to 15 years |
| | Royal Australian College of General Practitioners (RACGP)[6] | ▶ Not recommended unless the man specifically asks for it, and he is fully counselled on the pros and cons<br>▶ General practitioners need not raise this issue, but if men ask about prostate screening they need to be fully informed of the potential benefits, risks and uncertainties of prostate cancer testing<br>▶ When a patient chooses screening, both PSA and DRE should be performed<br>▶ Responding to the patient's concerns and fulfilling medicolegal responsibilities are considerations in discussion with patients |

BMJ Open

# Doctors' approaches to PSA testing and overdiagnosis in primary healthcare: a qualitative study

Kristen Pickles,[1] Stacy M Carter,[1] Lucie Rychetnik[1,2]

Four broad patterns ('heuristics') were employed.

1. Some GPs preferred to offer PSA testing to avoid underdiagnosis.
2. Some GPs were strongly oriented to avoiding over-diagnosis, and so tried to test as little as possible.
3. Some GPs made case-by-case individualised decisions.
4. Some GPs did not think about underdiagnosis or overdiagnosis at all.

Pickles et al, BMJ Open. 2015; 5(3): e006367.

# Shared Decision Making and Use of Decision Aids for Localized Prostate Cancer

## Perceptions From Radiation Oncologists and Urologists

Table 3. Perceptions of Possible Barriers Toward Using Decision Aids of the 641 Survey Respondents

| | Agree, % | | Disagree, % | | |
|---|---|---|---|---|---|
| Variable | Strongly | Moderately | Moderately | Strongly | *P* Value |
| **Decision Aids Are Applicable to My Patients** | | | | | |
| Use decision aids | 23.8 | 62.6 | 13.2 | 0.4 | |
| Urologists | 20.6 | 56.0 | 20.3 | 3.1 | .008 |
| Overall | 22.2 | 59.2 | 16.8 | 1.8 | |
| **Decision Aids Lead Patients to Choose Less Effective Treatment Options** | | | | | |
| Radiation oncologists | 0.7 | 8.6 | 62.7 | 28.8 | |
| Urologists | 1.4 | 13.3 | 61.8 | 23.5 | .21 |
| Overall | 1.1 | 11.0 | 62.2 | 23.5 | |
| **The Average Patient in My Clinic Could Not Process Information From a Decision Aid** | | | | | |
| Radiation oncologists | 4.8 | 28.9 | 54.4 | 11.8 | |
| Urologists | 8.3 | 33.6 | 42.5 | 15.6 | .03 |
| Overall | 6.6 | 31.3 | 48.3 | 13.8 | |
| **My Estimation of My Patient's Risk of Recurrence Is More Accurate Than What the Currently Available Decisions Aids Would Predict** | | | | | |
| Radiation oncologists | 3.0 | 24.6 | 55.6 | 16.8 | |
| Urologists | 5.9 | 35.0 | 46.2 | 12.9 | .01 |
| Overall | 4.5 | 30.0 | 50.7 | 12.9 | |

# There is variation in role preferences…

# … between patients and providers.

# Physician's decision-making role preferences

| Preferences | Number of Providers (n=1050) |
|---|---|
| **Preferred to share decision-making with their patients** | 780 (75%) |
| Preferred paternalism | 142 (14%) |
| Preferred consumerism | 118 (11%) |
| Perceived themselves as practicing their preferred style | 87% |

Murray et al, BMC Fam Pract. 2007 Mar 15:8:10. doi: 10.1186/1471-2296-8-10.

# Patient's decision-making role preferences

| Preferences | Number of Patients (n=914) |
|---|---|
| "I prefer to leave all the decisions regarding my treatment to my doctor." | 102 (11.1%) |
| "I prefer that my doctor make the final decision about which treatment will be used, but seriously consider my opinion." | 225 (24.6%) |
| **"I prefer that my doctor and I share responsibility for deciding which treatment is best for me."** | 400 (43.7%) |
| "I prefer to make the final selection of my treatments after seriously considering my doctor's opinion." | 167 (18.2%) |
| "I prefer to make the final decision about the treatment I will receive." | 20 (2.1%) |

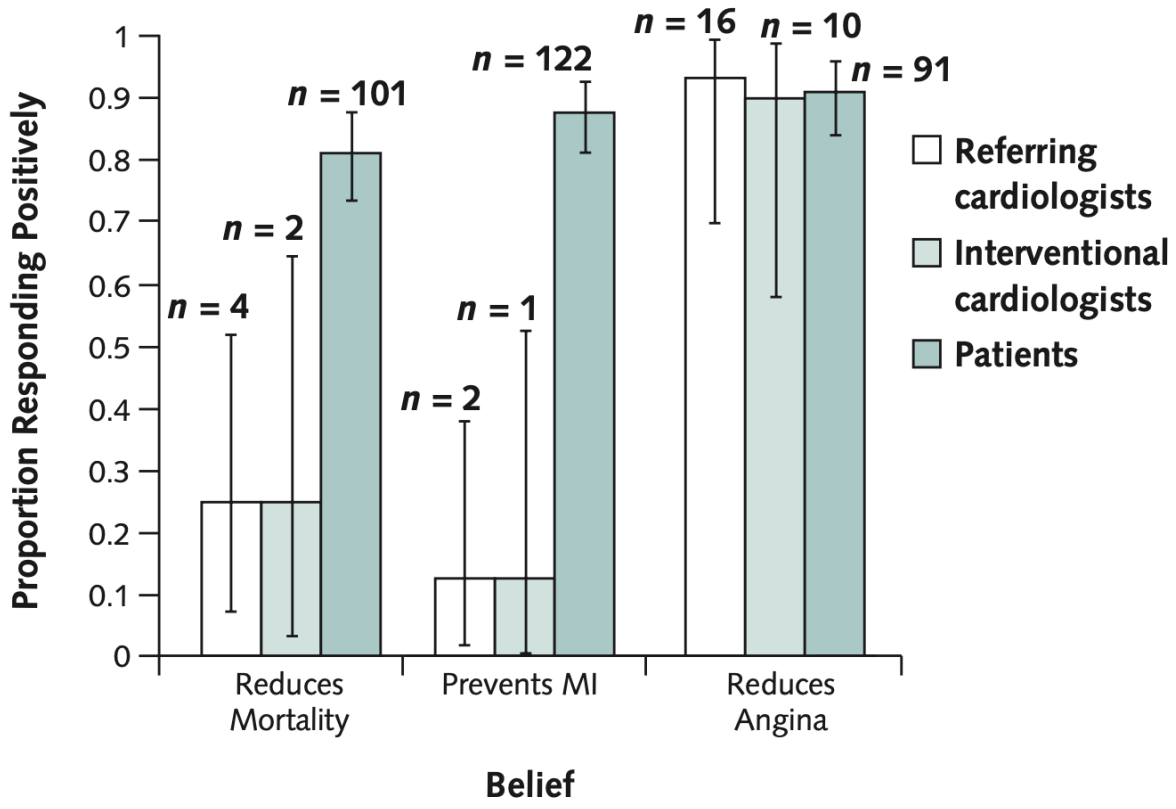
Shields et al, Support Cancer Ther. 2004 Jan 1;1(2):119-26. doi: 10.3816/SCT.2004.n.005.

# There is variation in the perceived value…

# … between patients and providers.

# Patients' and Cardiologists' Perceptions of the Benefits of Percutaneous Coronary Intervention for Stable Coronary Disease

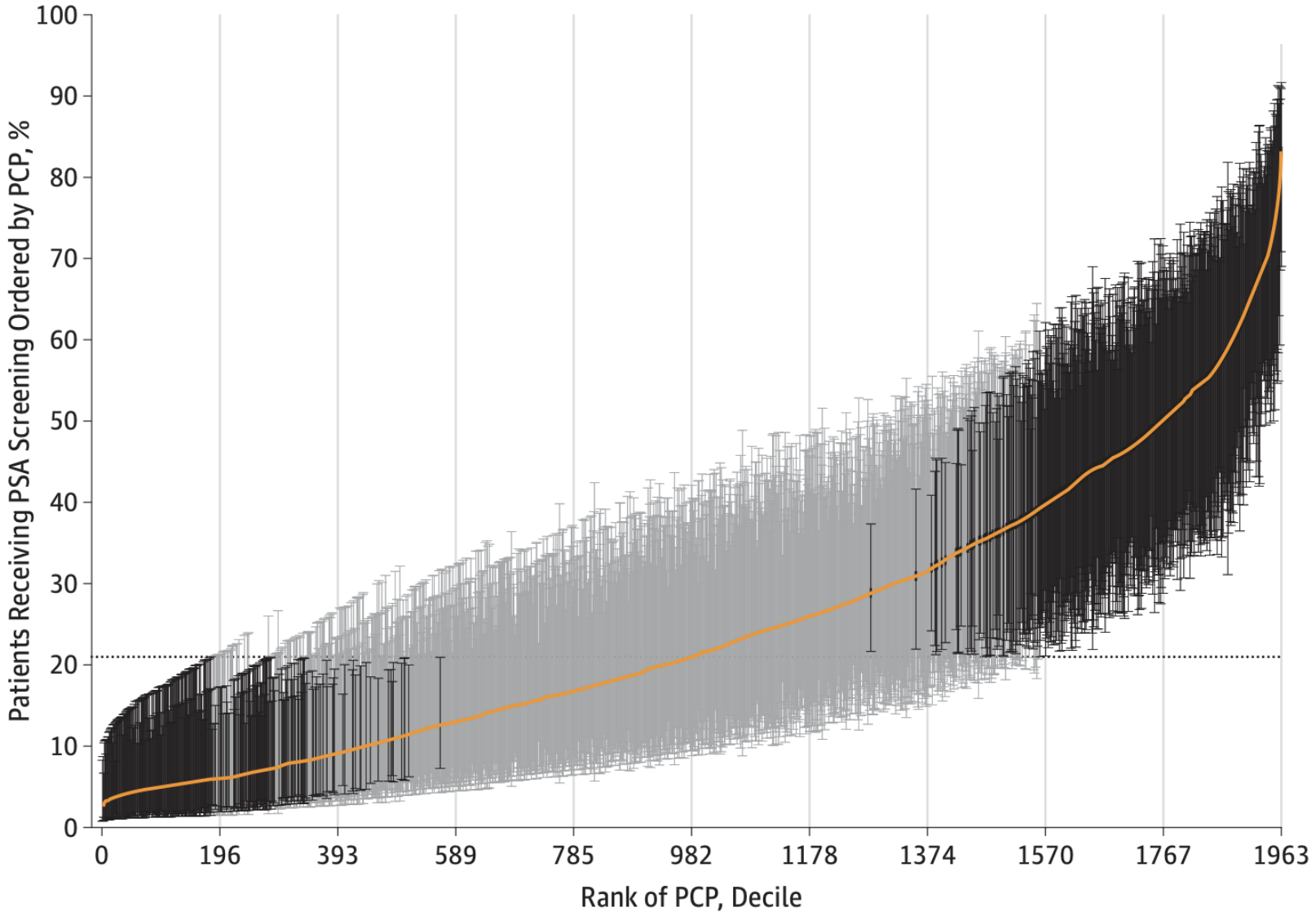
Michael B. Rothberg, MD, MPH; Senthil K. Sivalingam, MD; Javed Ashraf, MD, MPH; Paul Visintainer, PhD; John Joelson, MD; Reva Kleppel, MSW, MPH; Neelima Vallurupalli, MD; and Marc J. Schweiger, MD

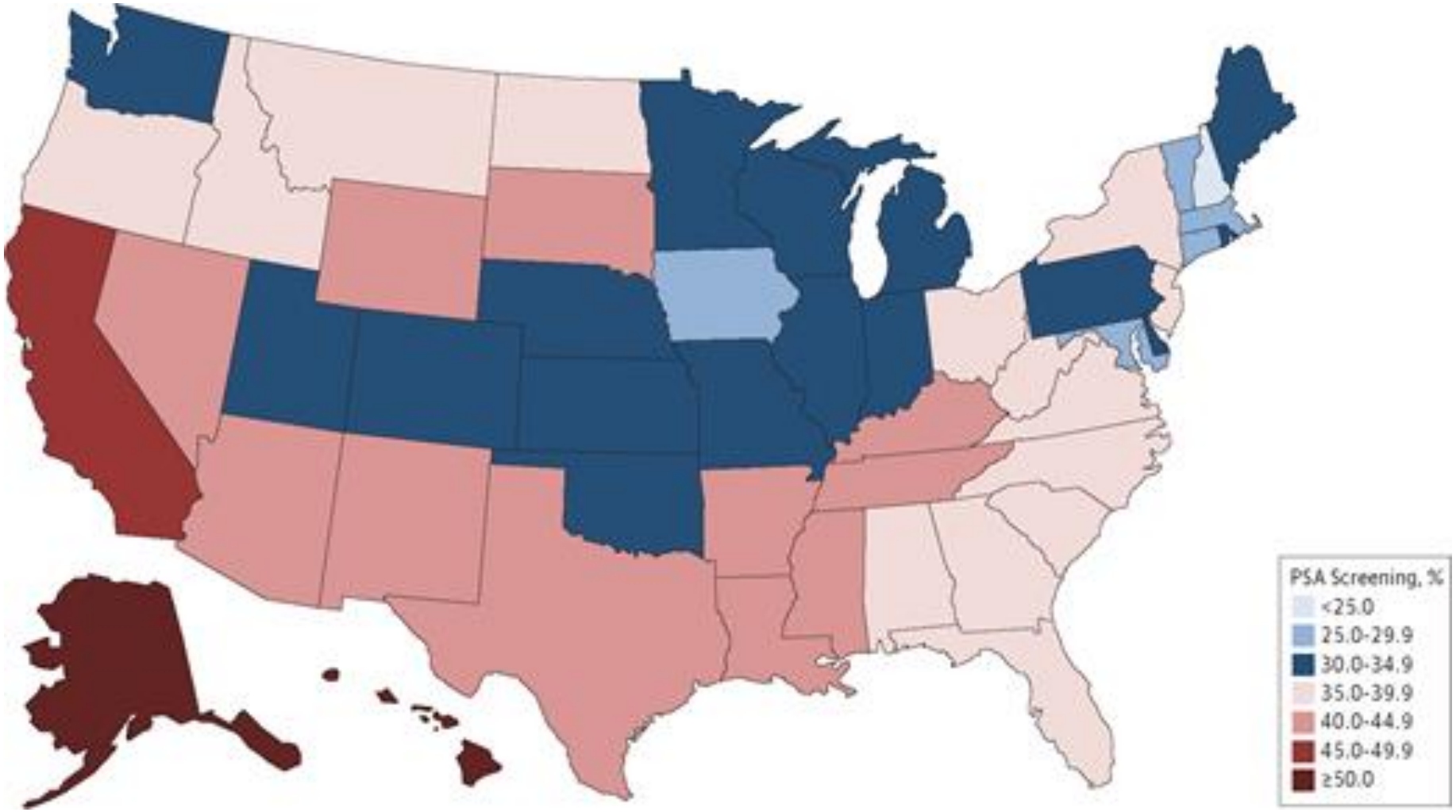



Cardiologists' beliefs about PCI reflect trial results, but patients' beliefs do not.

# … which leads to variation in prostate cancer screening practices.

Cumulative Distribution of 1963 Texas Primary Care Physicians (PCPs) by the Adjusted Percentage of Their Male Patients 75 Years or Older Who Underwent Prostate-Specific Antigen (PSA) Screening Ordered by Their PCP in 2010






Sammon, et al JAMA Intern Med. 2014 Nov;174(11):1839-41. doi: 10.1001/jamainternmed.2014.4117.

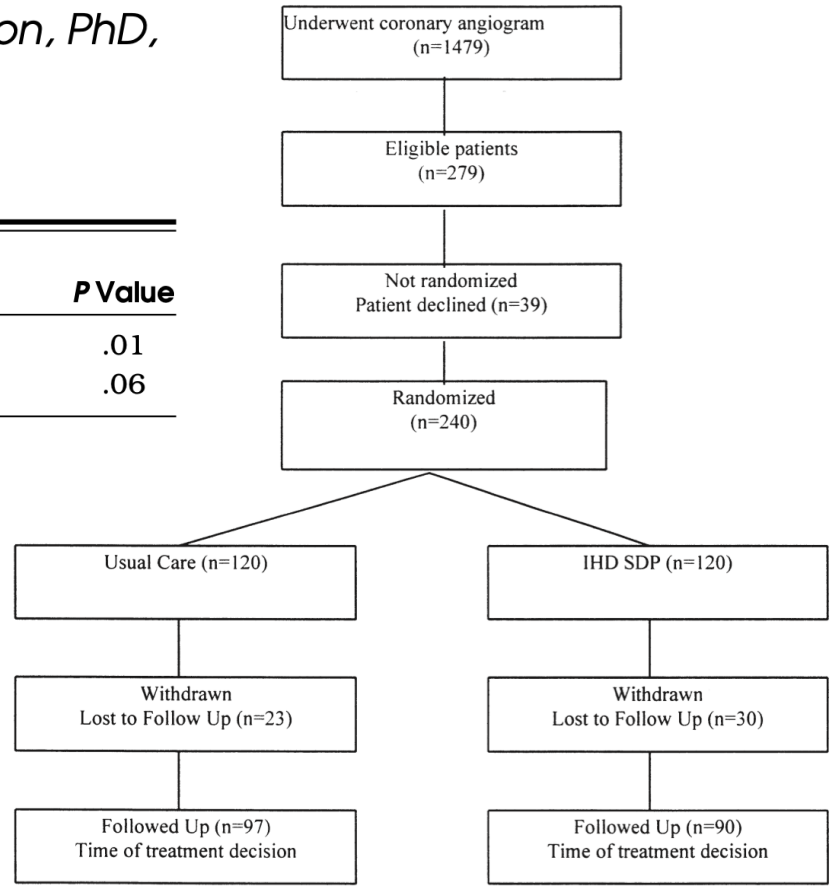
# Fully informed patients may choose another option.

# Randomized, Controlled Trial of an Interactive Videodisc Decision Aid for Patients with Ischemic Heart Disease

*Matthew W. Morgan, MD, MSc, Raisa B. Deber, PhD, Hilary A. Llewellyn-Thomas, PhD, Peter Gladstone, MD, R.J. Cusimano, MD, Keith O'Rourke, MBA, George Tomlinson, PhD, Allan S. Detsky, MD, PhD*

**Table 3. Initial Patient Treatment Decision and Actual Treatment at 6 Months**

| Outcome | Control Group | SDP Group | Delta | 95% Confidence Interval Around Delta | *P* Value |
|---|---|---|---|---|---|
| Revascularization initial decision | 75% ($n$ = 97) | 58% ($n$ = 90) | 17% | (4%, 31%) | .01 |
| Actually performed by 6 months | 66% ($n$ = 95) | 52% ($n$ = 86) | 14% | (0%, 28%) | .06 |




Morgan et al, J Gen Intern Med. 2000 Oct;15(10):685-93. doi: 10.1046/j.1525-1497.2000.91139.x.

# Unfortunately, there is heterogeneity in the use of decision aids and shared decision-making.

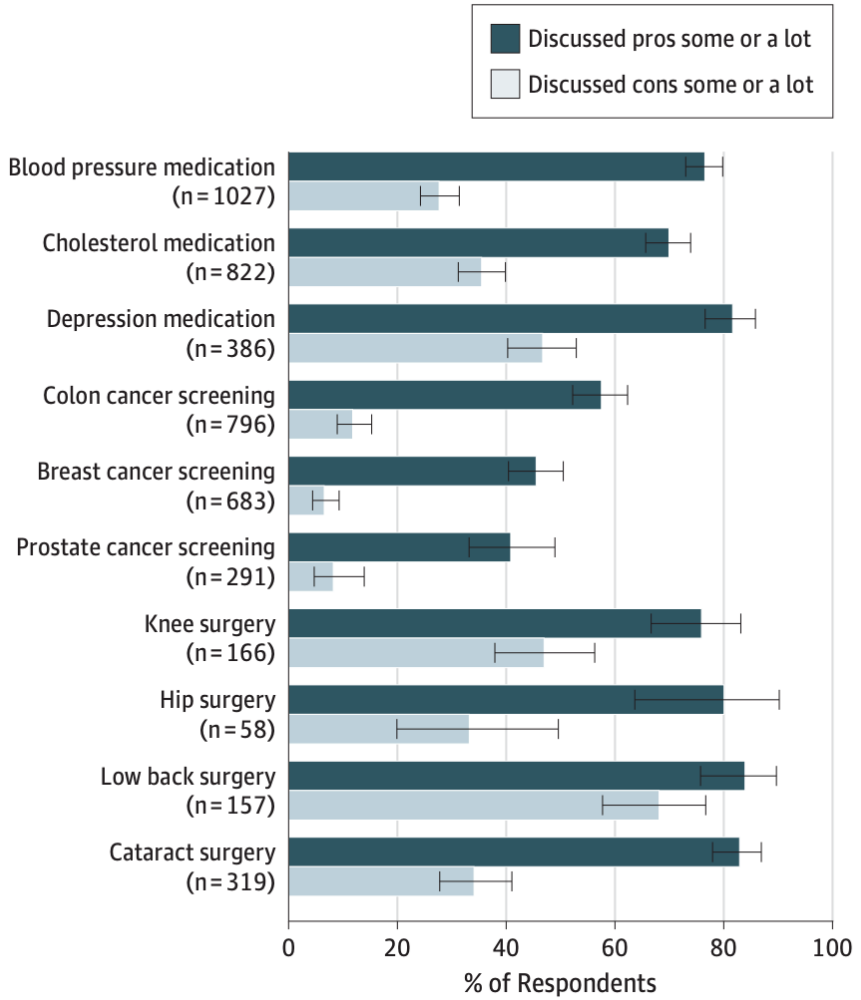
# Shared Decision Making and Use of Decision Aids for Localized Prostate Cancer

## Perceptions From Radiation Oncologists and Urologists

Table 2. Use and Perceptions of Usefulness and Degree of Confidence for Decision Aids for Localized Prostate Cancer by Physician Specialty of the 641 Survey Respondents

| Variable | Radiation Oncologists, % (n = 711) | Urologists, % (n = 711) | Overall | *P* Value |
|---|---|---|---|---|
| Currently use a decision aid in clinic | 37.4 | 33.7 | 35.5 | .36 |
| Familiarity with decision aids | | | | |
| Very familiar | 21.3 | 21.7 | 21.5 | .36 |
| Somewhat familiar | 56.4 | 60.5 | 58.5 | |
| Not familiar | 22.3 | 17.7 | 20.0 | |
| Usefulness of decision aids | | | | |
| Very useful | 16.7 | 16.4 | 16.5 | .13 |
| Somewhat useful | 70.7 | 65.2 | 67.9 | |
| Somewhat not useful | 11.1 | 14.0 | 12.6 | |
| Not useful at all | 1.5 | 1.4 | 3.0 | |
| Confident that decision aids improve treatment decisions | | | | |
| Very confident | 10.3 | 8.2 | 9.2 | .01 |
| Moderately confident | 63.8 | 54.8 | 59.2 | |
| Moderately not confident | 21.8 | 27.4 | 24.7 | |
| Not confident at all | 4.1 | 9.6 | 6.9 | |

# Discussions About Common Tests, Medications, and Procedures as Reported by Patients

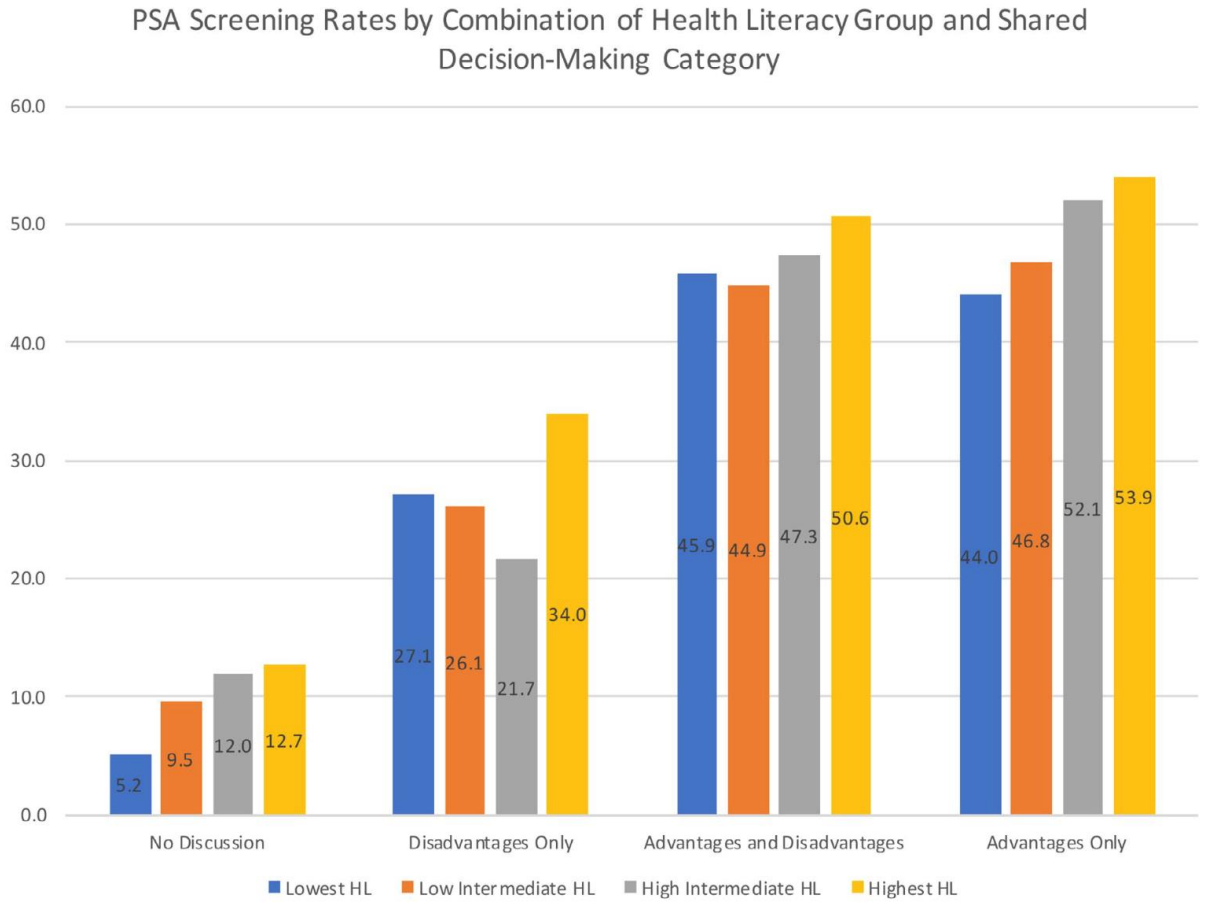



Fowler et al, JAMA Intern Med. 2013 Jul 8;173(13):1215-21. doi: 10.1001/jamainternmed.2013.6172.

# Impact of Health Literacy on Shared Decision Making for Prostate-Specific Antigen Screening in the United States

David-Dan Nguyen, MPH [1,2]; Quoc-Dien Trinh, MD[1]; Alexander P. Cole, MD [1]; Kerry L. Kilbridge, MD [3]; Brandon A. Mahal, MD [4]; Matt Hayn, MD[5,6]; Moritz Hansen, MD[5,6,7]; Paul K. J. Han, MD[5,7]; and Jesse D. Sammon, DO [5,6,7]

- Men who reported higher levels of health literacy were found to have higher levels of screening
- Increased health literacy may reduce the screening-promoting effect of shared decision-making




Nguyen et al, Cancer. 2021 Jan 15;127(2):249-256. doi: 10.1002/cncr.33239. Epub 2020 Nov 9.

# What is the impact of decision aids on patient care?

JAMA Internal Medicine | Original Investigation

# Decision Aids for Prostate Cancer Screening Choice
## A Systematic Review and Meta-analysis

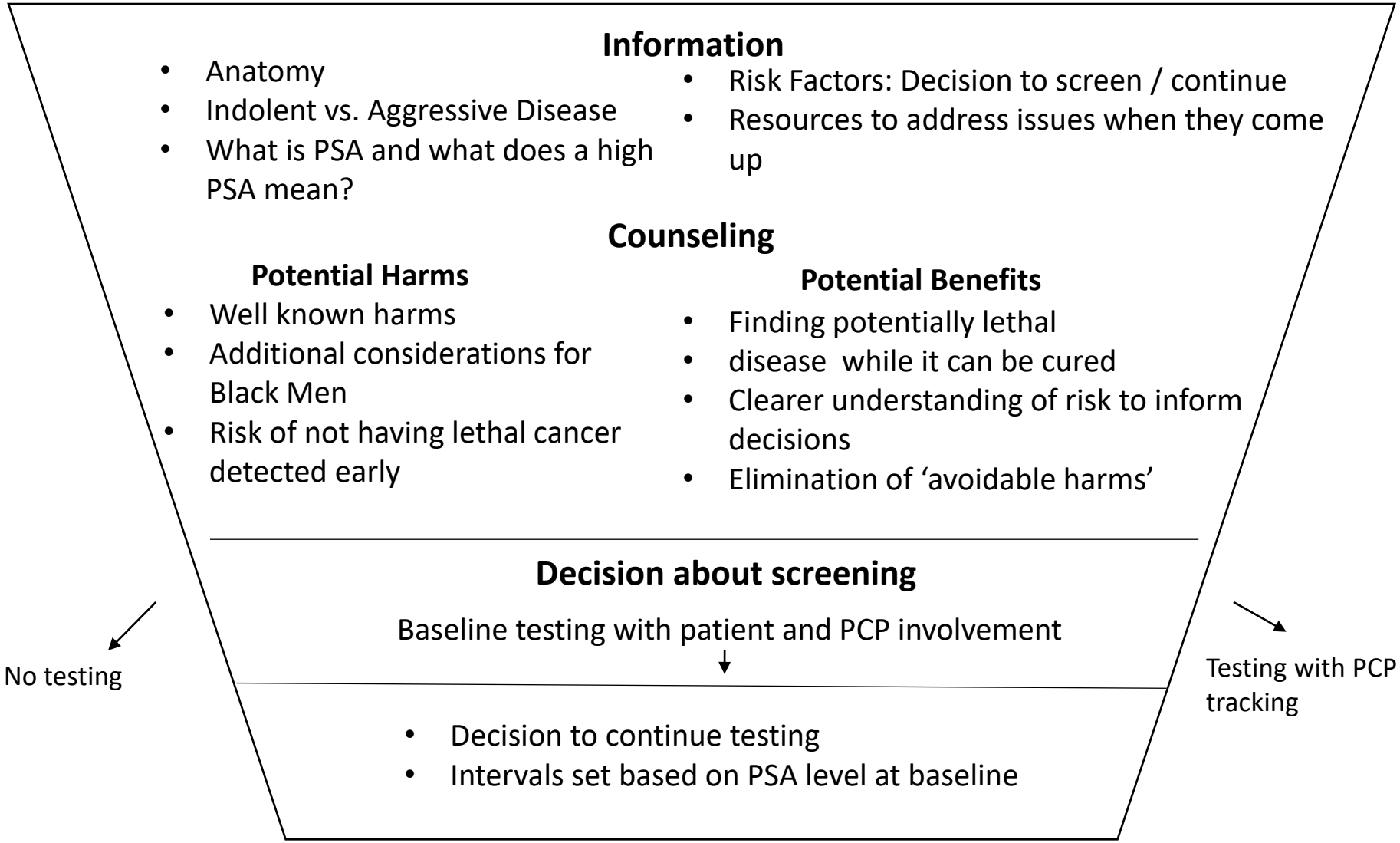
Jarno M. Riikonen, MD, PhD; Gordon H. Guyatt, MD; Tuomas P. Kilpeläinen, MD, PhD; Samantha Craigie, MSc; Arnav Agarwal, MD; Thomas Agoritsas, MD, PhD; Rachel Couban, MA, MISt; Philipp Dahm, MD, MHSc; Petrus Järvinen, MD, PhD; Victor Montori, MD, MSc; Nicholas Power, MD; Patrick O. Richard, MD, MSc; Jarno Rutanen, MD, PhD; Henrikki Santti, MD, PhD; Thomas Tailly, MD, MSc; Philippe D. Violette, MD, CM, MSc; Qi Zhou, PhD; Kari A. O. Tikkinen, MD, PhD

- Moderate-quality evidence that decision aids compared with usual care are associated with a small **decrease in decisional conflict**
- Low-quality evidence that decision aids are associated with an **increase in knowledge** but not with whether physicians and patients discussed prostate cancer screening or with screening choice
- **Further progress in facilitating effective shared decision-making may require decision aids that not only provide education to patients but are specifically targeted to promote shared decision-making**

Riikonen et al, JAMA Intern Med. 2019 Aug 1;179(8):1072-1082. doi: 10.1001/jamainternmed.2019.0763.

# Case studies

# Education-Driven SDM Process for Prostate Cancer Screening African-American Men



MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

IN-OFFICE DECISION AID

# Should you get the PSA test?


New research is changing how providers use the PSA (prostate-specific antigen) test. It's not a regular test that you'll get automatically at your checkup — now, you have to decide if you want it. **Talk it over with your provider during your appointment.**

### What's the PSA test?

It's a blood test. It checks for levels of protein (prostate-specific antigen) made by a man's prostate. Sometimes a high level may indicate an increased risk of prostate cancer.

### What's the Problem?

If you have a high PSA level, the next steps might be biopsy and treatment for

### What do I do?

Talk about the test with your doctor. Learn about the possible benefits and harms, and about your individual risk for prostate cancer. Then decide if the test is right for you.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

PROSTATE CANCER SCREENING FACT SHEET

# **Be smart.** Get the latest facts about the PSA test.

Then talk about it — with your provider, partner, family and friends.

Providers don't all agree that getting the PSA test to look for prostate cancer is a good idea. The test may lead to more harm than benefit for many men.

### Should you get the PSA test?

Things have changed: Getting the PSA test is no longer automatic during a man's check-ups as he gets older. It's not like getting your blood pressure checked. **Now, the smart move is to talk with your doctor and decide together about getting the test—even if you've had it before.**

### Here's what the medical experts are saying:

New research has shown that the PSA test doesn't work very well as a regular screening test for prostate cancer. It could help some men avoid dying from prostate cancer. But for many men, the test may lead to serious harms without providing any benefit.

### How to decide if the PSA test is right for you:

There's no right or wrong answer. But think about:

- Your individual risk. If you are at high risk for prostate cancer, you may feel the possible benefit is greater than any harm that may come from the test.
- What feels right to you. Are you the sort of person who wants to get all the tests to be sure? Or do you take things as they come and are not likely to request tests unless your provider recommends them?

### What increases your risk of prostate cancer?

Race. African-American and black men have a 50% higher risk.

Family history. Having a close relative who had prostate cancer raises your risk 2 to 3 times.

Age. The risk of prostate cancer goes up as you get older — especially after age 50.

## About the PSA Test

### What is it?

The PSA is a blood test. It checks levels of a protein (prostate-specific antigen) made by a man's prostate.

### What does the PSA test do?

It won't give you a yes or no answer about prostate cancer. A high PSA level can be a sign of cancer, but usually it's not. You would need a biopsy to know for sure.

### What are the benefits?

The PSA test may help catch a harmful type of cancer early. Treatment tends to work better the earlier you catch this type of cancer.

### What are the risks?

The PSA test can lead to more tests, stress, and overtreatment. Some men wind up getting operations and radiation (maybe with serious side effects) that might not have been necessary.

### Have more questions about the PSA test?

**Talk to your provider**

CA1382

# **Men:** You have a choice to make about your prostate health.

The PSA blood test *may* help find prostate cancer, but it's not a test every man should get. Find out why.

**Get the facts to help you talk with your doctor and make the right choice for you.**

**Your Prostate Health**

**PSA Test Pros & Cons**

**Facts & Numbers**

**Make Your Decision**

**Questions to Consider**

https://www.cancer.org/cancer/types/prostate-cancer/prostate-cancer-videos.html

https://www.mass.gov/info-details/prostate-cancer-screening-for-providers

# Physician Considerations for Shared Decision-making in a Clinical Workflow

- Unbundle the content from the counseling
  - Patient Navigator
  - Community Health Worker
- Organized vs Opportunistic screening
  - Patient comes in for shared decision-making only
  - Baseline testing

# Take home messages

- Shared decision-making about PSA screening should be a collaborative between patients and physicians
- The use of shared decision-making for prostate cancer screening is suggested by guideline groups, but shared decision-making remains underutilized
- Facilitators to shared decision-making include a consistent clinician–provider relationship, trust in the clinician, having a partner, and high education level
- Barriers to shared decision-making include limited appointment times, insufficient knowledge, poor health literacy, any barrier to communication, and physician beliefs about screening

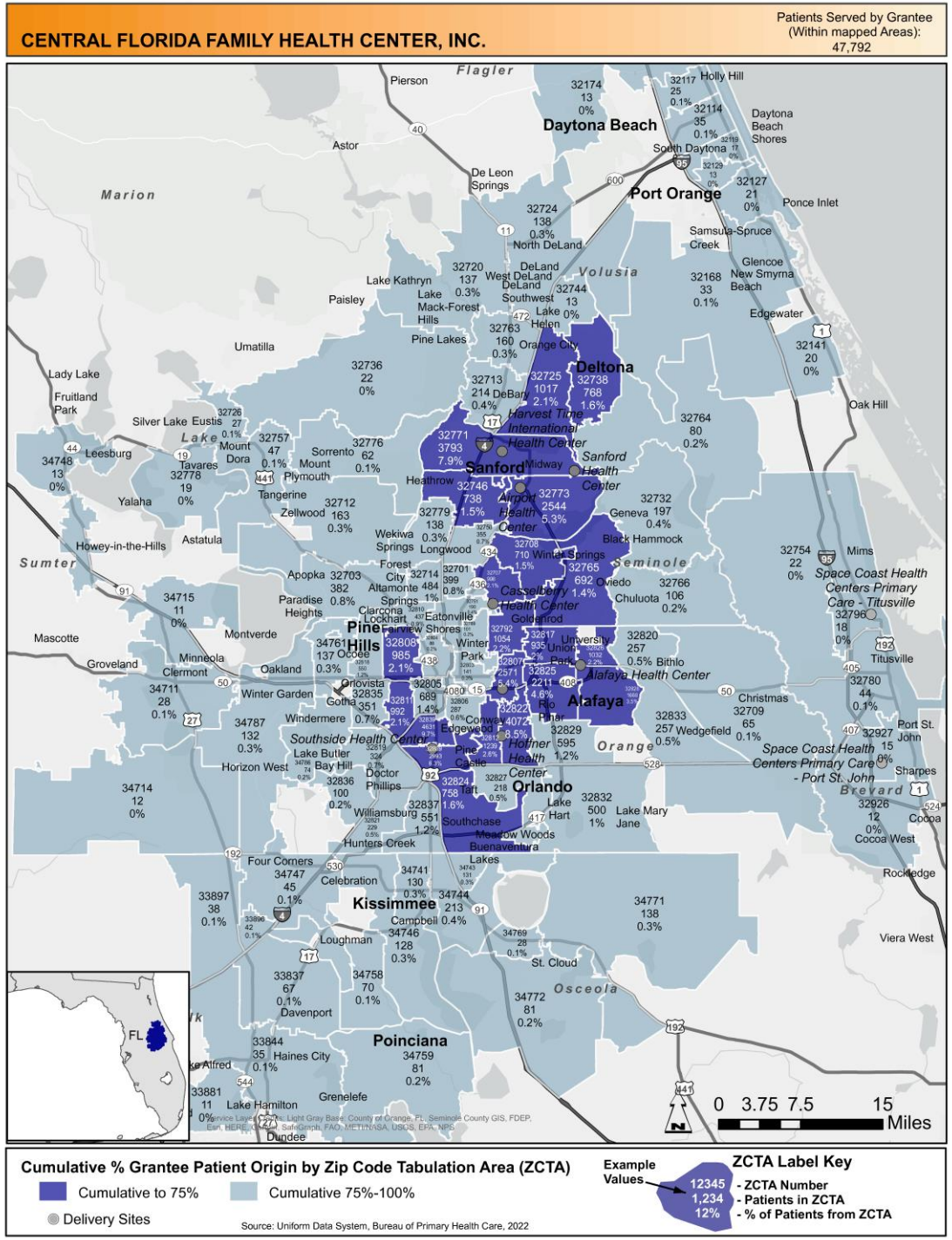
Pekala et al, Nat Rev Urol. 2024 Jan 2. doi: 10.1038/s41585-023-00840-0.

# Open Discussion: Questions & Answers

# Welcome **Central Florida Health Care, Inc.**

Winter Haven, FL

Central Florida Health Care



**Geoff Hall, APRN, FNP-C**
Family Nurse Practitioner
Central Florida Health Care

# Session 2
# Patient-related Case Presentation

# Patient Case Presentation

**Presented By:** Geoff Hall, APRN, FNP-C | Central Florida Health Care

## Patient-related Case Presentation

| Patient Hx | Current Strategies |
|---|---|
| 60-year-old, non-Hispanic or Latino, white male<br>**Past Medical/Surgical History**<br>Hypertension, Mixed Hyperlipidemia, and seasonal allergies. Vasectomy around 2005. Tonsillectomy in childhood.<br>**Past Cancer Screening History**<br>Never a smoker - No LDCT done. CRC screening in 2022 - found colonic polyps, benign, to be repeated in 2028. Free and Total PSA done in 2023 - PSA Total 2.6ng/ml, PSA Free 0.6ng/ml, PSA % Free 23%<br>**Medications**<br>Amlodipine 5mg, Atorvastatin 40mg, Losartan 10mg, Fluticasone 50mcg/actuation nasal spray<br>**Family History**<br>Doesn't know a lot of Family Hx.<br>Father - Heart dx (deceased). Mother - Breast CA (deceased). | **What strategies or actions have you tried so far?**<br>Repeat labs. Counseled on lab results, and what it means. Pros and cons vs with additional testing. Patient open to further testing, but he is long haul truck driver, and doesn't know when he will have the time to follow up with specialist. |

# Patient Case Presentation

**Presented By:** Geoff Hall, APRN, FNP-C | Central Florida Health Care

**Question:**

Patient denies any current symptoms associated with his prostate. No weak stream, no straining, no nocturia, and no incomplete voiding. Current ACS guidelines state that a low percent-free PSA means that your chance of having prostate cancer is higher and you should probably have a biopsy. At 23% he falls into the category of "maybe" needs additional testing. **With him being asymptomatic, and at his current level what are his risk associated with additional testing? Can he wait, and if so, how long can he wait? Or should I encourage him to try and see a specialist sooner rather than later?**

# Open Discussion: Questions & Answers

# Survey Time!

## Participant Site Team Members Only

Post-Session 2 Survey

### How to Use a QR Code

1. **Turn on** your phone camera
2. **Aim** the camera at the code
3. A link will show up
4. **Tap** the link to go to the survey

# Reminders

**Session 2 Slides, Recordings, & Resources** will be made available within one week on the [ACS ECHO Website.]


GREATER BADEN MEDICAL SERVICES
Primary and Preventive Health Care

Is **Session 3** in your calendar?

**Tuesday, April 16, 2024**

4:30 PM ET • 3:30 PM CT • 2:30 PM MT • 1:30 PM PT

**Topic:** Addressing Implicit Bias within Primary Care to Increase Efficacy of Patient & Health Care Team Engagement

**Case Presentation:** Greater Baden Medical Services, Inc.

# Thank You!

Post-Session 2 Survey

See you again

Tuesday, April 16th at
4:30 PM ET • 3:30 PM CT • 2:30 PM MT • 1:30 PM PT
in iECHO Zoom