



Informed Decision Making in Men's Health

LEARNING COLLABORATIVE

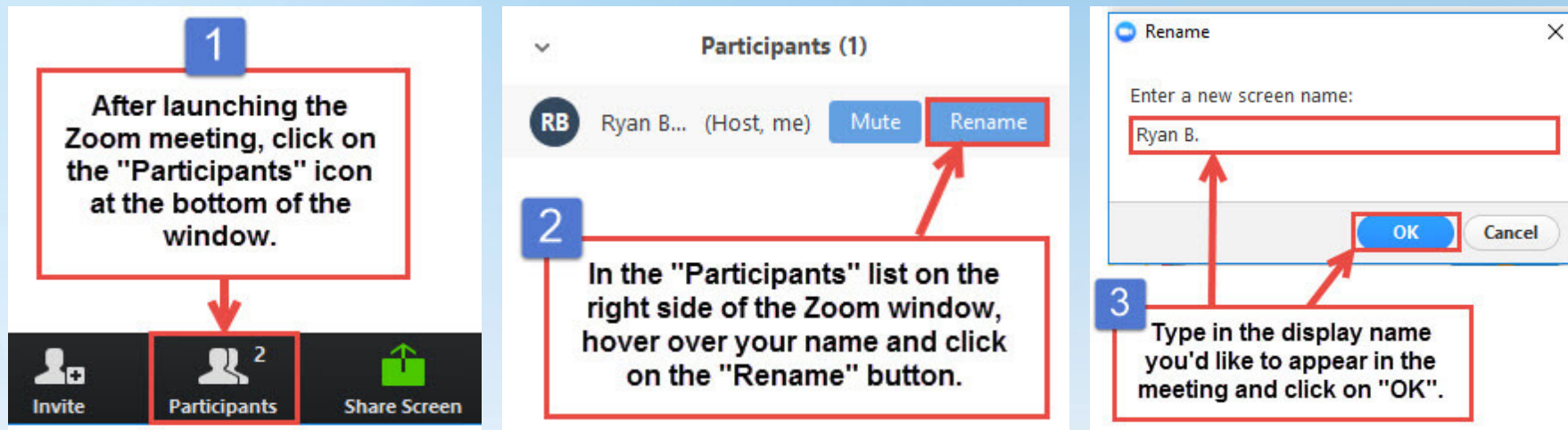
Learning Session 1

Welcome, Introductions, & Overview

Thursday, September 17, 2026

Get the Most Out of Your Zoom Experience

- Please keep yourself on MUTE to avoid background/distracting sounds
- Use the CHAT function or UNMUTE to ask questions or make comments
- Please change your participant name to your full name and organization:
“Meaghan Angers CHCI”



The image contains three panels illustrating the steps to change a Zoom name:

- Panel 1:** A screenshot of the Zoom bottom toolbar. A red box labeled '1' contains the text: "After launching the Zoom meeting, click on the 'Participants' icon at the bottom of the window." An arrow points from this box to the 'Participants' icon in the toolbar.
- Panel 2:** A screenshot of the 'Participants (1)' list. A red box labeled '2' contains the text: "In the 'Participants' list on the right side of the Zoom window, hover over your name and click on the 'Rename' button." An arrow points from this box to the 'Rename' button next to the user 'Ryan B...'.
- Panel 3:** A screenshot of the 'Rename' dialog box. A red box labeled '3' contains the text: "Type in the display name you'd like to appear in the meeting and click on 'OK'." An arrow points from this box to the 'OK' button. Another arrow points from the text input field (which contains 'Ryan B.') back to the 'Rename' button in Panel 2.

Continuing Education Credits

In support of improving patient care, Moses/Weitzman Health System is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

This series is intended for physicians, nurse practitioners, physician associates/assistants, nurses, and other members of the care team.

Please complete the survey and claim your post-session certificate on the Weitzman Education Platform after today's session.

You will be able to claim a comprehensive certificate on the WeP at the end of the series, April 2027.



Disclosures

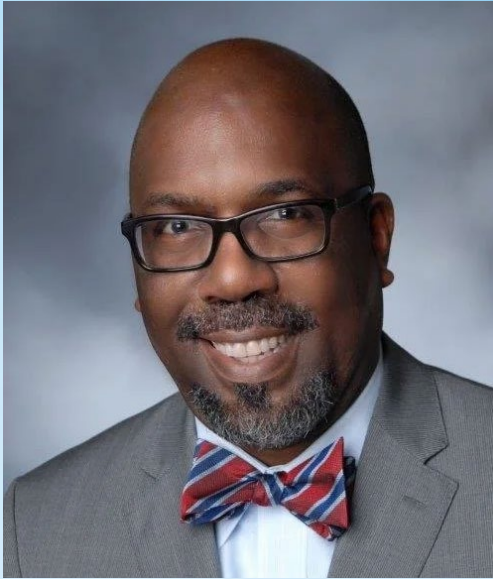
- With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship between the faculty listed above or other activity planners and any ineligible company in the past 24 months which would be considered a relevant financial relationship.
- The views expressed in this presentation are those of the faculty and may not reflect official policy of Moses Weitzman Health System.
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- This activity is supported by a grant from Novartis.

Session 1 Agenda

- **2:30-2:40pm** Welcome and Introductions
- **2:40-2:45pm** Foundations of the Learning Collaborative
- **2:45-3:05pm** Men's Health Overview: Cancer Screening, Sexual Health, Urinary Issues
- **3:05-3:25pm** Informed Decision Making and Patient-Centered Care in Men's Health
- **3:25-3:30pm** Q/A and Wrap-Up

Welcome and Introductions

Faculty Introductions



**Dr. Reginald
Tucker-Seeley**



Lisa Leary



Dr. Mark Splaine

Learning Collaborative Cohort

Los Angeles

Clínica Monseñor
Oscar A. Romero
Family Health Care
Centers of Greater
Los Angeles, Inc.
(FHCCGLA)
Southern California
Medical Center
Valley Community
Healthcare

Detroit

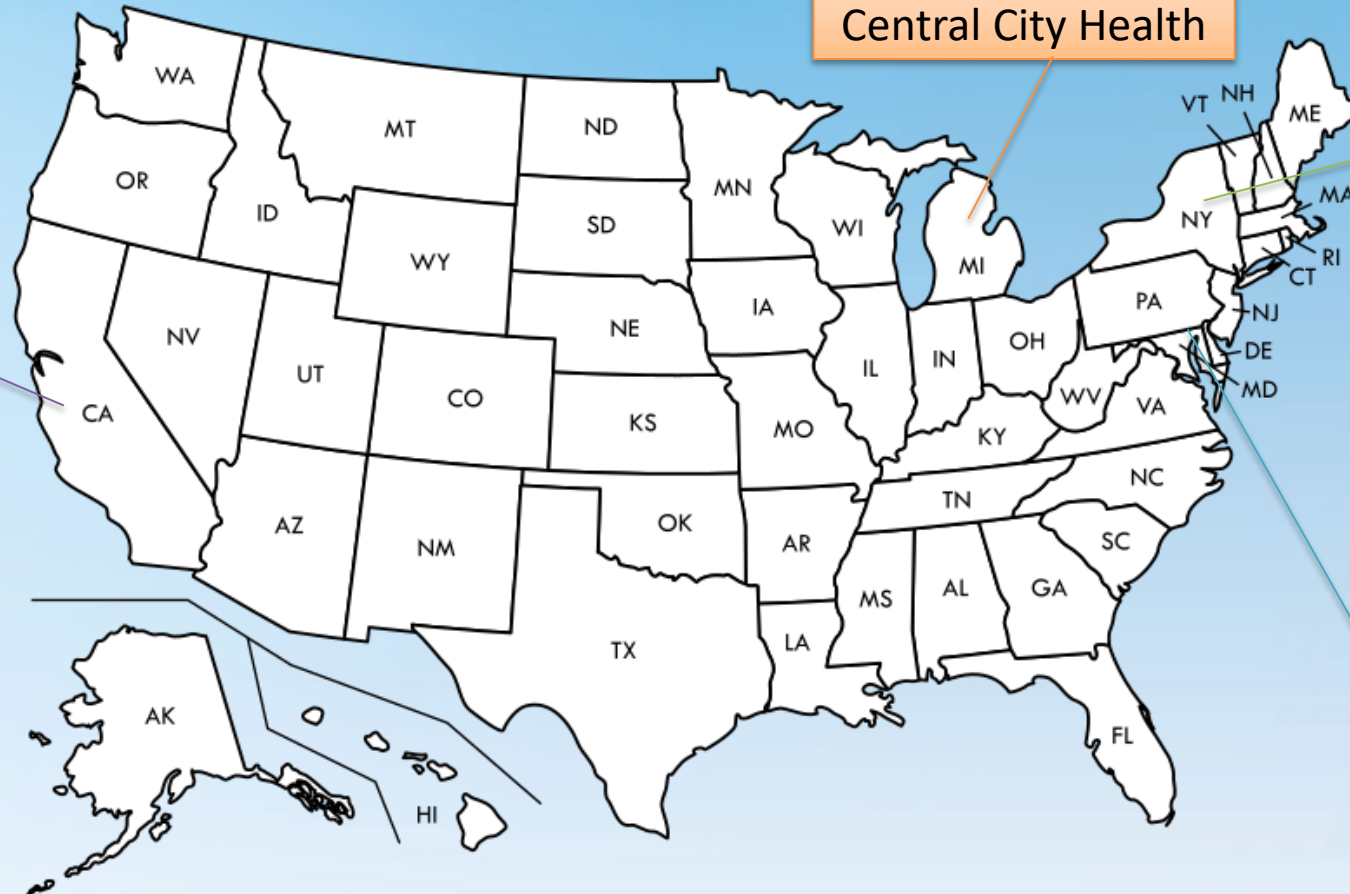
Central City Health

New York City

BMS Family Health
and Wellness
Centers
Morris Heights
Health Center, Inc.
Urban Health Plan,
Inc.

Baltimore

The Levi Watkins Jr.
Outpatient Center
at Johns Hopkins



Foundations of the Learning Collaborative

Chat Question

**What do you hope to accomplish
through your participation in
the Learning Collaborative?**

Welcome!

- **Overview:** Supported by Novartis, the Weitzman Institute's free Learning Collaborative will bring together health center organizations for an eight-month learning experience from September 2026 to April 2027.
- **Focus:** Strengthen how health centers support men and their families in making informed decisions about prostate and sexual health, using practical tools and resources.
- **Target communities:** Health centers serving Baltimore, Detroit, Houston, Los Angeles, and New York City, with an emphasis on engaging patients and families as active partners in care.

Learning Collaborative Objectives

Upon completion of this learning collaborative, participants should be able to do the following:

- 1) Assess strengths and areas for improvement in education and decision support for men related to sexual health and prostate conditions.
- 2) Design site-specific interventions to improve education and decision support related to men's health areas of focus.
- 3) Use quality improvement tools and skills to implement selected interventions for improving education and decision support.
- 4) Evaluate patient-level and system-level barriers and develop strategies to improve education and decision support for men and their families.

Learning Collaborative Structure

- Eight monthly 60-minute sessions via Zoom occurring on the 3rd Thursday of each month
- Four quality improvement sessions
- Weekly internal health center team working meetings
- Weitzman Education Platform (WEP) for CME credit or participation hours
- Complete deliverables and upload drafted/complete deliverables to the [Google Drive folder](#)

Learning Session Dates	
Learning Session 1	Thursday September 17 th
Learning Session 2	Thursday October 15 th
Learning Session 3	Thursday November 19 th
Learning Session 4	Thursday December 17 th
Learning Session 5	Thursday January 21 st
Learning Session 6	Thursday February 18 th
Learning Session 7	Thursday March 18 th
Learning Session 8	Thursday April 15 th

Elements of Success

- **Attendance** at monthly learning sessions and quality improvement sessions.
- **Engagement** in deliverables between learning sessions that included protected time to meet as a team, trust, and respect.
- **Commitment** of the team to improve their quality improvement skills and achieve results.
- **Support** of health center leadership for time, resources, spread, and sustainability.

Men's Health Overview: Cancer Screening, Sexual Health, Urinary Issues

Stanley Frencher, MD MPH | UCLA Urology

Three complaints. One health signal.

The urologic symptom is often the visible part of a broader cardiometabolic, oncologic, or functional story.



PSA / screening

Risk + preference



Erectile dysfunction

Vascular health



LUTS / nocturia

Function + comorbidity

PCP opportunity: normalize the question → risk-stratify → start first-line care → know the red flags

Prostate screening: start with risk, not a reflex PSA

AUA/SUO emphasizes shared decision-making and a risk-adapted starting age.

Age 40–45

Offer earlier screening for increased risk:

- Black ancestry
- Germline mutations
- Strong family history

Age 45–50

A baseline PSA is reasonable for average-risk men; use it to individualize the next interval.

Age 50–69

Regular screening has the clearest evidence. AUA: typically every 2–4 years, individualized by PSA + risk.

After ~70 or limited life expectancy: screening benefit falls; individualize rather than continue automatically.

An elevated PSA is a decision point—not a cancer diagnosis

Before referral or biopsy, make sure the number is real and interpretable.

1

Repeat

Newly elevated PSA → repeat before biomarkers, imaging, or biopsy.

2

Context

UTI/prostatitis, instrumentation, retention, ejaculation, prostate size, 5-ARI use.

3

Risk

Age, ancestry, family history, PSA trend/density; consider a validated risk calculator.

4

Escalate

Persistent elevation or abnormal DRE → urology; MRI/biomarkers can refine biopsy decisions.

Finasteride / dutasteride: PSA is typically suppressed ~50% after ~6 months — interpret accordingly.

What should PCPs screen for? Mostly: symptoms + risk

There is no population screening test for testicular, bladder, or kidney cancer in asymptomatic average-risk adults.

Testicular cancer

No routine population screening.

Evaluate promptly:

- New painless mass
- Firmness / asymmetry
- Persistent swelling

Ultrasound first; urgent urology if intratesticular mass.

Bladder cancer

Do not “screen” with UA/cytology in asymptomatic average-risk adults.

Visible hematuria = evaluation.

Microscopic hematuria = risk-stratify by age, smoking, degree/persistence, and other risk factors.

Kidney cancer

No routine population imaging.

Incidental renal mass → characterize appropriately.

Gross hematuria, unexplained flank mass/pain, or concerning imaging → refer.

Ask about erections before the patient has to

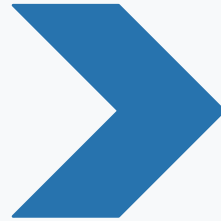
ED is common, undertreated, and often a vascular/metabolic signal—not just a quality-of-life complaint.

A 60-second PCP screen

“Any change in erections or sexual function?”

Then ask:

- Onset + rigidity + morning erections
- Libido / orgasm / ejaculation
- Partner/context + distress
- Medications/substances
- Diabetes, BP, lipids, smoking, sleep, mood



ED = a cardiovascular risk marker

Use the visit to check the whole patient:

BP • A1c/glucose • lipids • weight
exercise • tobacco • sleep apnea risk
medication contributors • depression

First-line ED care belongs comfortably in primary care

Treat the risk factors and the erection at the same time.

1 • Optimize

Exercise, weight, tobacco cessation, diabetes/BP/lipid control. Review culprit meds when feasible. Address relationship, anxiety, depression, sleep.

2 • PDE5 inhibitor

Sildenafil or tadalafil are reasonable first-line options. Teach timing, stimulation, dose titration, food effect (sildenafil), and several attempts before declaring failure.

3 • Refer when needed

Failure despite correct use; penile deformity/Peyronie; complex neurologic/endocrine disease; fertility concerns; patient wants injections, devices, or surgery.

Never combine PDE5 inhibitors with nitrates. Use caution with unstable cardiovascular disease and hypotension.

Low T: diagnose the syndrome, not the number

Symptoms + consistently low morning testosterone are both required.

Symptoms

Low libido, fewer morning erections, fatigue, low bone/muscle mass; ED alone is nonspecific.

Confirm

Two separate early-morning total testosterone levels; evaluate reversible contributors.

Explain

Obesity, sleep disorders, opioids, acute illness, pituitary/testicular disease can contribute.

Before Rx

Discuss fertility: exogenous testosterone suppresses spermatogenesis. Check contraindications and monitoring needs.

LUTS is a symptom complex—not synonymous with BPH

Storage, voiding, and post-micturition symptoms often overlap.

STORAGE

Frequency
Urgency
Nocturia
Urge incontinence

VOIDING

Weak stream
Hesitancy
Intermittency
Straining

POST-MICTURITION

Incomplete emptying
Terminal dribble
Post-void dribble

Nocturia? Think beyond the prostate: evening fluids • diuretics • edema • diabetes • sleep apnea • insomnia

A practical PCP work-up

The goal is to identify bother, complications, and alternative diagnoses.

History

Bother + trajectory • meds • fluids/caffeine/alcohol • constipation • neuro symptoms • sexual function

Exam

Abdomen/genitals as indicated • DRE when it will change management • edema / neurologic clues

Basic tests

Urinalysis. PSA when screening is appropriate or when prostate size/progression risk will affect management.

Selective tests

PVR if retention/emptying concern; creatinine if renal risk; bladder diary for nocturia/frequency.

Red flags: gross hematuria • recurrent UTI • stones • renal dysfunction/hydronephrosis • recurrent retention • abnormal prostate exam

Match treatment to the dominant problem

Start simple; reassess symptom response and adverse effects.

Lifestyle / behavior

Reduce evening fluid; time diuretics; moderate caffeine/alcohol; treat constipation; address edema and sleep apnea.

α -blocker

Fast symptom relief. Watch dizziness/orthostasis and ejaculatory effects. Does not prevent progression.

5-ARI

Best when prostate is enlarged / progression risk is higher. Slow onset; reduces retention/surgery risk over time.

Tadalafil 5 mg daily

Option when LUTS + ED coexist. Review nitrate contraindication and hemodynamics.

Know the “don’t miss” urinary presentations

Two common reasons a routine urinary complaint becomes urgent.

Hematuria

GROSS hematuria

→ generally warrants urologic evaluation, especially with smoking/age risk.

MICROhematuria

→ confirm microscopy; treat obvious benign cause when appropriate, then risk-stratify if persistent.

Do not dismiss hematuria because the patient takes anticoagulants.

Retention

Painful inability to void

→ bladder decompression + identify precipitant.

Urgent escalation if:

- Sepsis / infected obstruction
- AKI / bilateral obstruction
- Neurologic red flags
- Difficult/traumatic catheterization
- Persistent gross hematuria/clots

The 5-minute men's health add-on

A few normalized questions can uncover high-value preventive and functional care.

1

SCREEN

“Have you ever discussed prostate cancer screening—and does your family history change your risk?”

2

SEX

“Any change in erections, libido, ejaculation, or sexual function?”

3

VOID

“Any weak stream, urgency, getting up at night, blood in urine, or trouble emptying?”

4

CONNECT

Use the answer to check cardiometabolic risk, medications, sleep, mood, and health behaviors.

Normalize → identify risk → start first-line care → refer for complexity, red flags, or failed treatment

Three things to do Monday morning

1

Make PSA screening risk-adapted

Earlier conversation for high-risk men; repeat a newly elevated PSA before escalating.

2

Treat ED as a health signal

Ask first. Address vascular risk + sexual function together.

3

Stop calling every LUTS complaint “BPH”

Identify storage vs voiding symptoms, systemic contributors, and red flags.

Questions / cases

Selected guidelines for PCP follow-up

- AUA/SUO Guideline: Early Detection of Prostate Cancer (2023; current amendments as applicable).
- USPSTF. Prostate Cancer: Screening (2018 recommendation statement).
- AUA Guideline: Management of Benign Prostatic Hyperplasia / Male LUTS (current version).
- AUA Guideline: Erectile Dysfunction (2018; current updates as applicable).
- AUA/SUFU Guideline: Microhematuria (2020; amended 2025).
- Endocrine Society. Testosterone Therapy in Men With Hypogonadism: Clinical Practice Guideline (2018).

Clinical decisions should reflect the current guideline version, local pathways, patient comorbidity, life expectancy, and preferences.

Informed Decision Making and Patient-Centered Care in Men's Health

Aisha Langford, PhD, MPH

Informed Decision Making and Patient-Centered Care in Men's Health

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WAYNE STATE
School of Medicine



Engaging Men in Health: Start by Listening

PREVENTING CHRONIC DISEASE

PUBLIC HEALTH RESEARCH, PRACTICE, AND POLICY

Volume 11, E164

SEPTEMBER 2014

COMMUNITY CASE STUDY

A Cancer Center's Approach to Engaging African American Men About Cancer: The Men's Fellowship Breakfast, Southeastern Michigan, 2008–2014

Aisha T. Langford, PhD, MPH; Derek M. Griffith, PhD; Derrick D. Beasley, MPH;
Effat Id-Deen Braxton, MSW

- See the whole person
- Create safe, nonjudgmental opportunities for discussion
- Connect people with information and expertise
- Men's engagement can begin long before a clinical decision occurs and outside of a doctor's office

Informed Decision Making (IDM) Overview

With *informed decision making*, the patient recognizes there is a decision to be made and has adequate, accurate, balanced, understandable information needed to make an informed choice.

Components to consider:

- Options
- Benefits and harms of each option
- Uncertainty
- Values and preferences

Patient-Centered Care (PCC) Overview

Patient-centered care puts the individual patient's needs, goals, values, and circumstances at the center of care and health care decisions.

Key elements:

- Whole person
- Partnership
- Preferences and values
- Information and involvement

“Preference-Sensitive” Decisions Overview

- More than one reasonable option
- The "best" option depends in part on how an individual weighs potential harms, benefits, and tradeoffs

Examples:

- Colorectal cancer screening tests
- Prostate cancer treatment
- Hypertension treatment decisions

FDA. List of Patient Preference-Sensitive Priority Areas. <https://www.fda.gov/about-fda/division-patient-centered-development/list-patient-preference-sensitive-priority-areas>. Accessed 9/15/2026.

Stiggelbout AM, Pieterse AH, De Haes JC. Shared decision making: Concepts, evidence, and practice. Patient Educ Couns. 2015 Oct;98(10):1172-9. doi: 10.1016/j.pec.2015.06.022. Epub 2015 Jul 15. PMID: 26215573.

What Matters Most to the Patient?

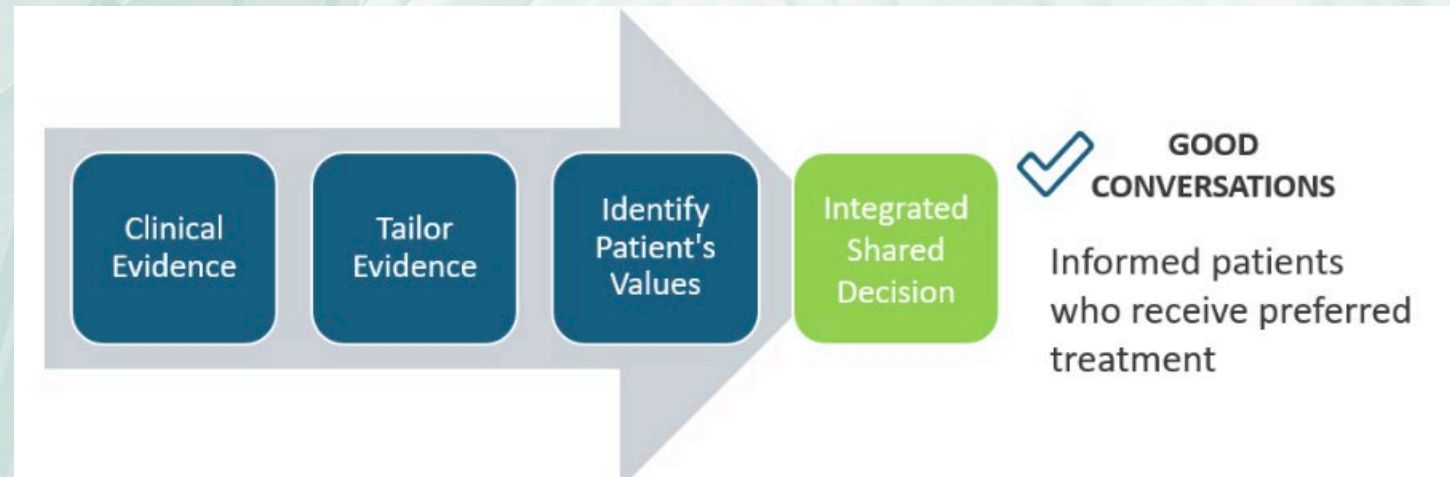
Values clarification is the process of sorting out what matters most to an individual relevant to a given health decision.

What matters may include:

- Preferences
- Concerns
- Contextual factors that affect a person's ability to carry out a decision
 - e.g., how well a treatment plan fits with work schedules, caregiving duties, mobility limitations, or daily routines

Shared Decision Making (SDM) Overview

“Shared decision making (SDM) is a communication process by which patients and clinicians work together to make optimal health care decisions that align with what matters most to patients.”



3 Components of SDM

- Clear, accurate, and unbiased medical evidence about reasonable options and the risks, benefits, and burdens of each alternative, including no intervention
- Clinician expertise in communication and in tailoring evidence to the individual patient
- Patient goals, informed preferences, and concerns, including treatment burden and context of daily life

What is Shared Decision Making? <https://mghdecisionsciences.org/about-us-home/shared-decision-making/>. Accessed 9/15/2026.

One SDM Model Example

The Agency for Healthcare Research and Quality's (AHRQ) SHARE Approach is a five-step SDM model designed to support meaningful dialogue with patients about the benefits, harms, and risks of options and what matters most to them.

The SHARE Approach

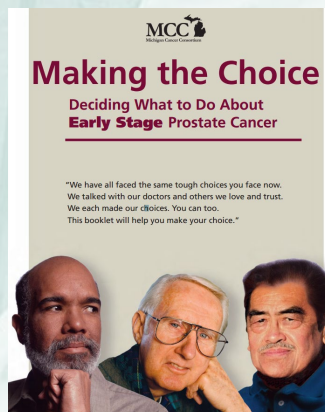


Team-Based Care and Shared Decision Making

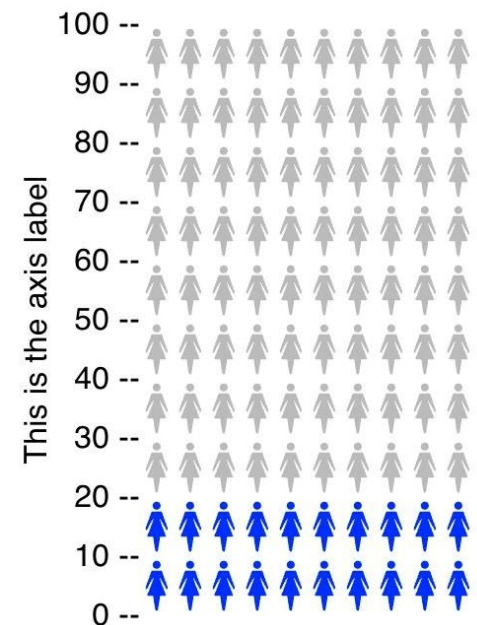
- Shared decision making is often depicted as something that happens between one patient and one physician.
- But decision support can involve multiple members of the care team and interactions that occur before, during, and after the clinical encounter.

Tools and Strategies to Support IDM and SDM

- Patient decision aids
- Option grids
- Question prompt lists
- Visual aids (e.g., icon arrays)
- Skills training
- Approaches like SHARE
- Decision coaching



Example Icon Array

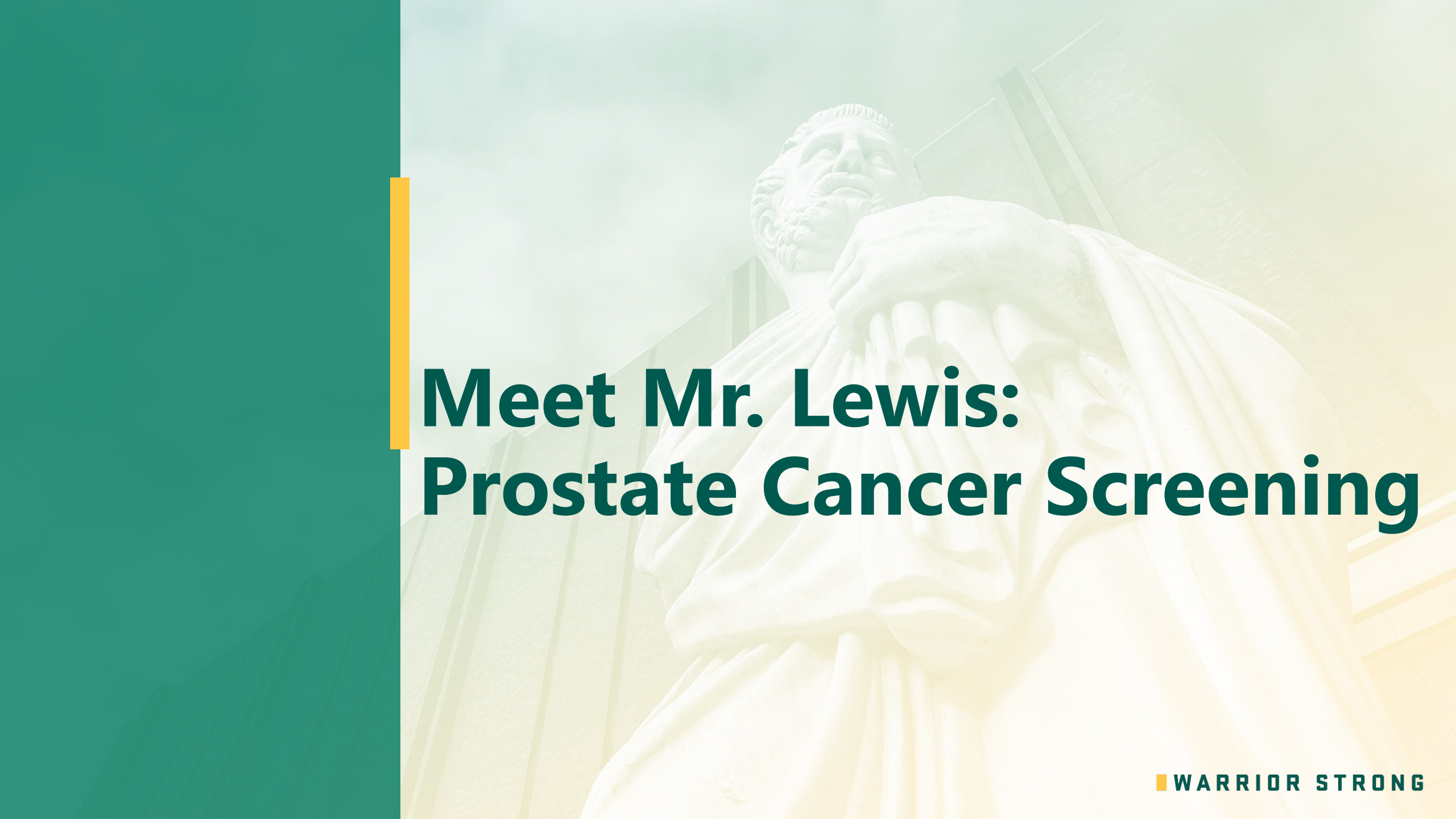


 20 out of 100 people like you will develop X

 80 out of 100 people like you will NOT develop X

Informed Decision Making vs. Shared Decision Making

Informed	Shared
Patient has sufficient information to make an informed decision	Patient and clinician/team deliberate together
Includes reasonable options, benefits, harms and uncertainty	Combines clinical evidence/expertise with patient values and preferences
Can occur independently (i.e., patient can do it alone)	Involves interpersonal interaction
Can be supported by patient decision aids, decision support tools, and strategies	Can be supported by patient decision aids, decision support tools, and strategies

A background image featuring a statue of George Washington, the first President of the United States, in a light yellow-green hue. The statue is shown from the waist up, holding a scroll. The background is a soft-focus view of the Washington Monument and other structures in Washington, D.C. A solid teal vertical bar is on the left side of the image, with a thin yellow vertical line separating it from the main content area.

Meet Mr. Lewis: Prostate Cancer Screening

Patient Profile

Name: Mr. Robert Lewis

Age: 58

Sex: Male

Job: High school teacher

History: Healthy, no chronic medical conditions.
No family history of prostate cancer.

Meds: None. Takes OTC multivitamin

Lifestyle: Nonsmoker, some exercise, overweight

Visit: Routine annual physical with primary
care physician

Patient Profile, cont.



- Mr. Lewis loves football and says he has seen the NFL's "Crucial Catch" commercials.
- He asks if he should get screened for prostate cancer.
- His sister, a nurse at a cancer center, strongly encourages him to get a PSA test.
- He worries about wasting money on unnecessary doctor visits and tests:

"I'm healthy and feel fine."

What Should Happen Next? Zoom Poll

- A. Recommend Mr. Lewis get a PSA test now.
- B. Give Mr. Lewis information and let him decide.
- C. Discuss the options, benefits and harms, explore what matters to him, and deliberate together about how to proceed.
- D. Defer the decision until later and schedule a time to revisit it.

What Would High-Quality Decision Support Look Like for Mr. Lewis?

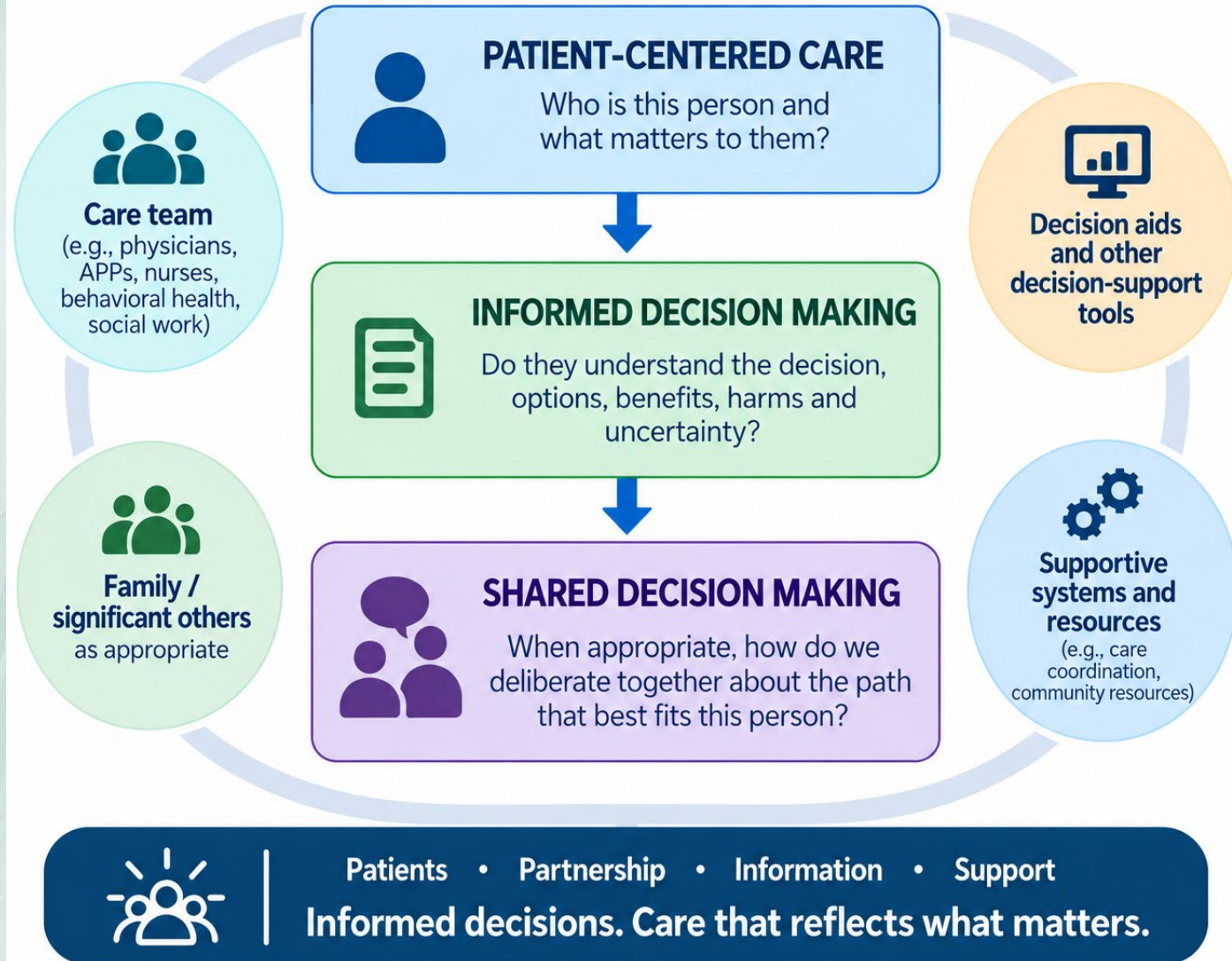
- Understand what matters most to him and his context:
 - patient-centered care
- Information, options, benefits, and harms:
 - informed decision making
- Active listening and deliberation:
 - shared decision making
- Different professionals providing decision support:
 - team-based care

A low-angle photograph of the George Washington Monument in Washington, D.C. The statue of George Washington is the central focus, shown from the waist up. He is wearing a white powdered wig and a white military-style coat with a high collar. His right hand is raised to his chin in a contemplative pose. The background shows the top of the monument's column and a clear blue sky. The image has a light green and yellow color overlay. On the left side, there is a solid green vertical bar with a thin yellow horizontal line intersecting it.

Bringing it together.

A Patient-Centered Approach to Decision Making

Key Concepts and Supports

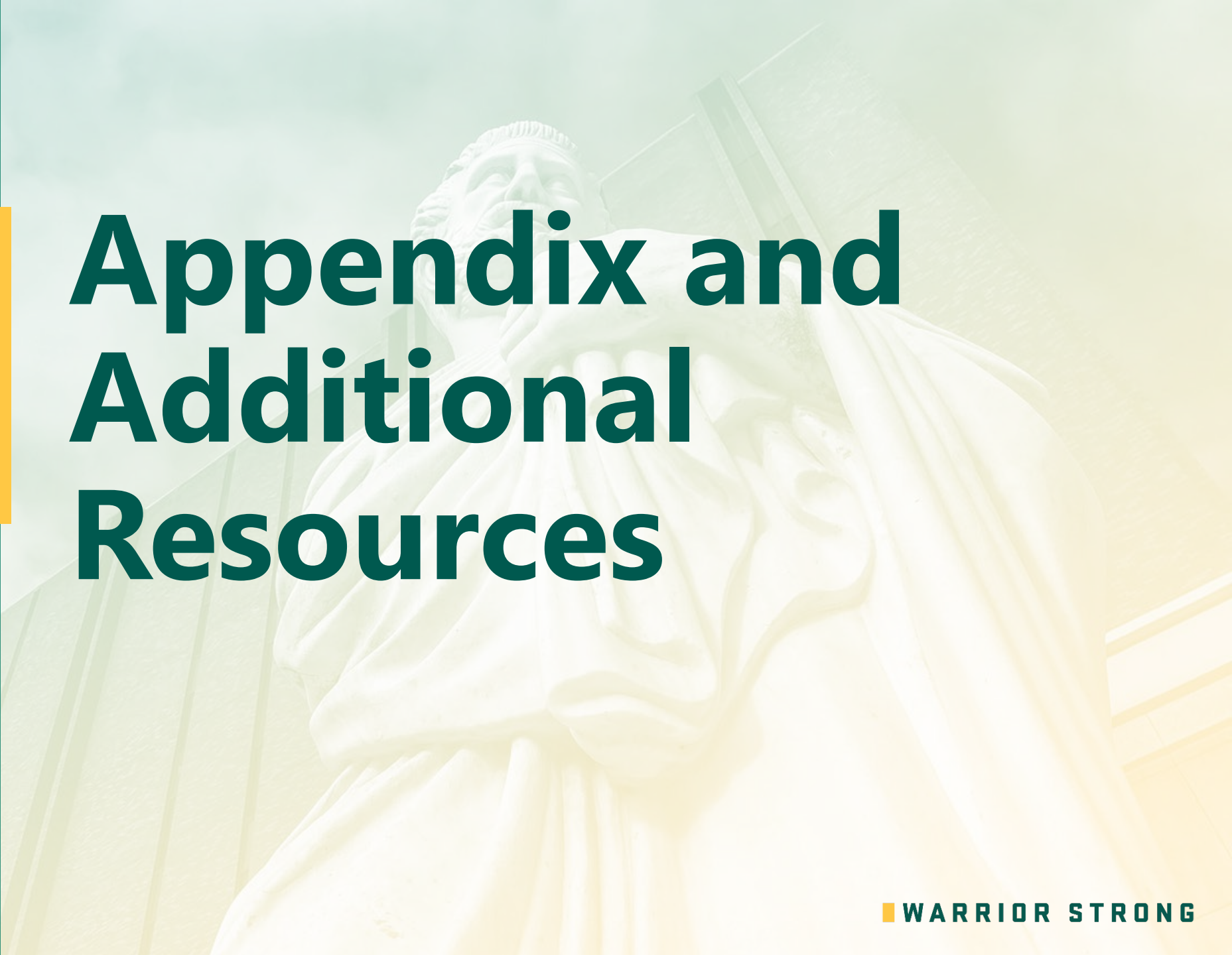


Key Take-Home Points

1. Patient-centered care starts with understanding the patient's needs, circumstances, values, and preferences.
2. Informed decision making and shared decision making are related but are not synonymous.
3. High-quality decisions can be supported by care team members, family and significant others when appropriate and desired, and well-designed decision-support tools.

Thank You and Group Discussion

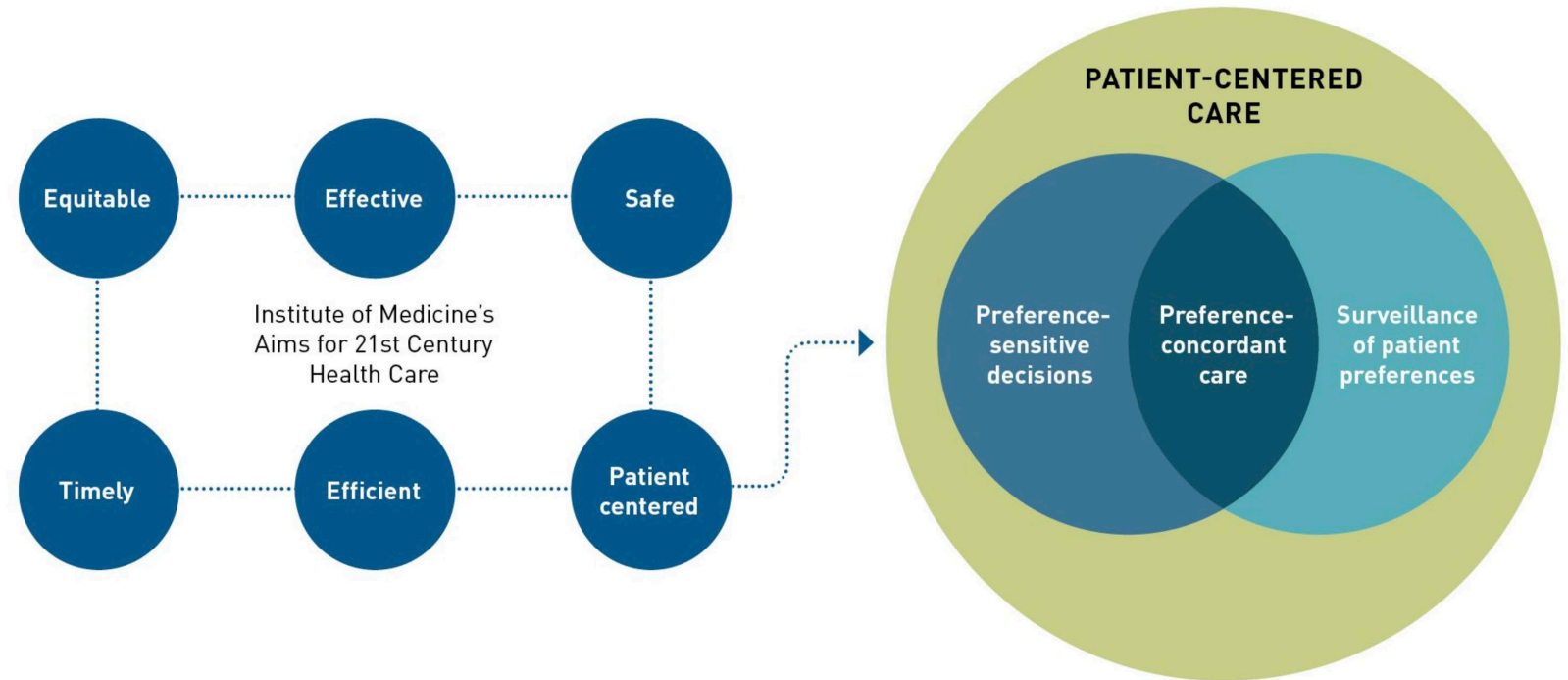


A background image of a statue, likely the Statue of Liberty, with a person in a white robe. The image is faded and has a yellowish tint. A dark teal vertical bar is on the left side of the slide.

Appendix and Additional Resources

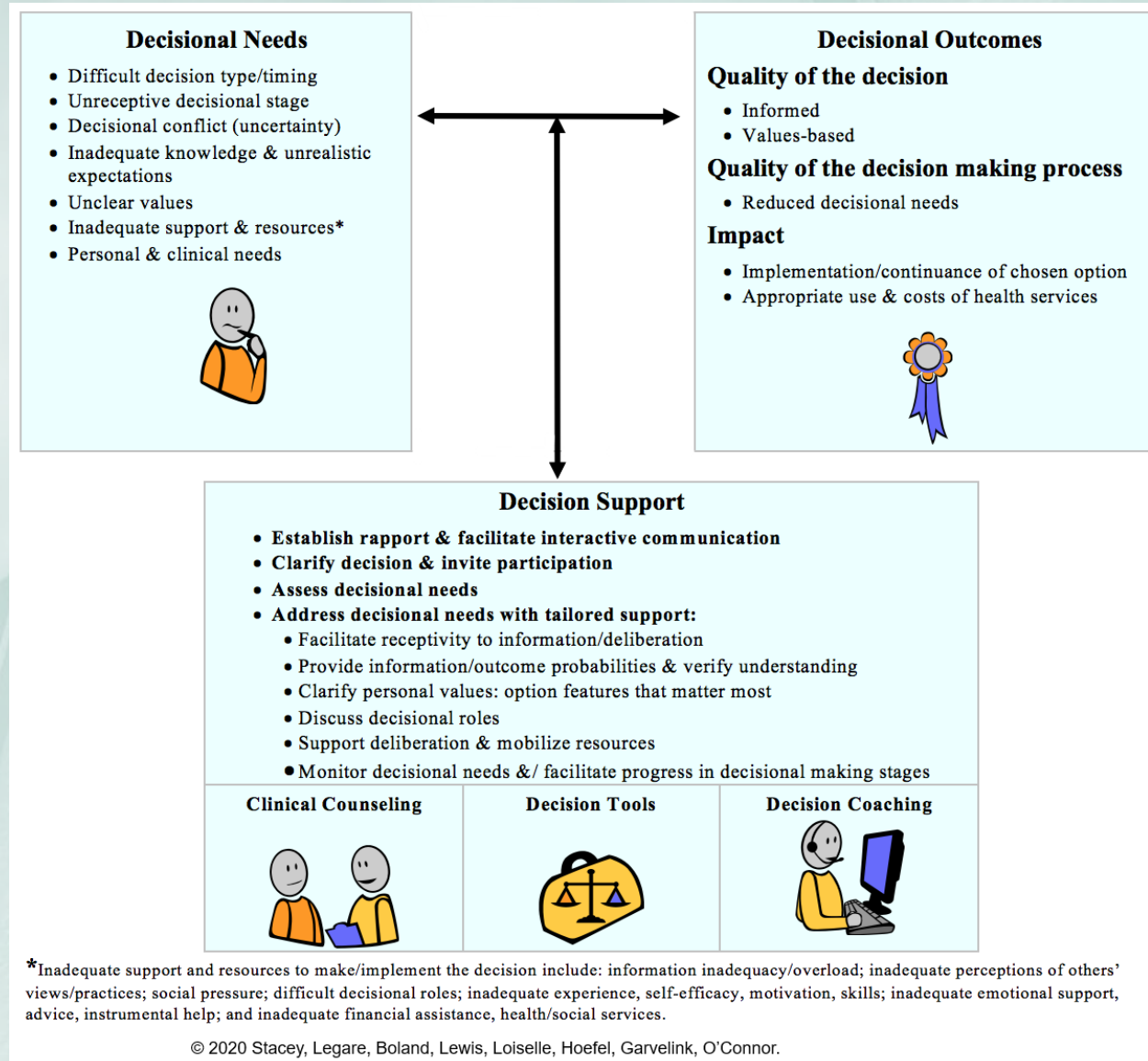
One way to think about PCC

FIGURE. Conceptualization of Patient-Centered Care



Langford AT, Kang SK, Braithwaite RS. When does nonadherence indicate a deviation from patient-centered care? *Am J Manag Care*. 2021 May 1;27(5):e141-e144. doi: 10.37765/ajmc.2021.88635.

The Ottawa Decision Support Framework



Ottawa Personal Decision Guide

Ottawa Personal Decision Guide

For People Making Health or Social Decisions



1 Clarify your decision.

What decision do you face?

What are your reasons for making this decision?

When do you need to make a choice?

How far along are you with making a choice?

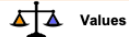
☐ Not thought about it ☐ Close to choosing
☐ Thinking about it ☐ Made a choice

2 Explore your decision.



Knowledge

List the options and benefits and risks you know.



Values

Rate each benefit and risk using stars (★) to show how much each one matters to you.



Certainty

Choose the option with the benefits that matter most to you. Avoid the options with the risks that matter most to you.

	Reasons to Choose this Option Benefits / Advantages / Pros	How much it matters to you: 0 ★ not at all 5 ★ a great deal	Reasons to Avoid this Option Risks / Disadvantages / Cons	How much it matters to you: 0 ★ not at all 5 ★ a great deal
Option #1				
Option #2				
Option #3				

Which option do you prefer? ☐ Option #1 ☐ Option #2 ☐ Option #3 ☐ Unsure



Support

Who else is involved?

Which option do they prefer?

Is this person pressuring you? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

How can they support you?

What role do you prefer in making the choice?

☐ Share the decision with...
☐ Decide myself after hearing views of...
☐ Someone else decides...

3 Identify your decision making needs.

Adapted from The SURE Test © 2008 O'Connor & Légaré.



Knowledge

Do you know the benefits and risks of each option?

☐ Yes ☐ No



Values

Are you clear about which benefits and risks matter most to you?

☐ Yes ☐ No



Support

Do you have enough support and advice to make a choice?

☐ Yes ☐ No



Certainty

Do you feel sure about the best choice for you?

☐ Yes ☐ No

If you answer 'no' to any question, you can work through steps two and four, focusing on your needs. People who answer 'No' to one or more of these questions are more likely to delay their decision, change their mind, feel regret about their choice or blame others for bad outcomes.

4 Plan the next steps based on your needs.

Decision making needs

Things you could try



Knowledge

If you feel you do NOT have enough facts

- ☐ Find out more about the options and the chances of the benefits and risks.
- ☐ List your questions.
- ☐ List where to find the answers (e.g. library, health professionals, counsellors):



Values

If you are NOT sure which benefits and risks matter most to you

- ☐ Review the stars in step two to see what matters most to you.
- ☐ Find people who know what it is like to experience the benefits and risks.
- ☐ Talk to others who have made the decision.
- ☐ Read stories of what mattered most to others.
- ☐ Discuss with others what matters most to you.



Support

If you feel you do NOT have enough support

- ☐ Discuss your options with a trusted person (e.g. health professional, counsellor, family, friends).
- ☐ Find help to support your choice (e.g. funds, transport, child care).

If you feel PRESSURE from others to make a specific choice

- ☐ Focus on the views of others who matter most.
- ☐ Share your guide with others.
- ☐ Ask others to fill in this guide. (See where you agree. If you disagree on facts, get more information. If you disagree on what matters most, consider the other person's views. Take turns to listen to what the other person says matters most to them.)
- ☐ Find a person to help you and others involved.



Certainty

If you feel UNSURE about the best choice for you

- ☐ Work through steps two and four, focusing on your needs.

Other factors making the decision DIFFICULT

List anything else you could try:



Welcome

Patient Decision Aids

A to Z Inventory

Decision Guides

Developed in Ottawa

Other Inventories

Cancer Symptom Tools

Decision Coaching

Conceptual Frameworks

Development Toolkit

International Standards

Systematic Review

Decision Aid Library Inventory

Evaluation Measures

Implementation Toolkit

A to Z Inventory of Patient Decision Aids

To find a patient decision aid you may search using keywords about the health condition, body part(s) or treatment(s), or browse a list from A to Z. To be included on this list, the patient decision aids must meet a [minimal set of criteria](#).

Search all patient decision aids:

Go

OR

[Browse](#) an alphabetical listing of patient decision aids by health topic.

Looking for patient decision aids that focus on the connection between the heart and the brain? You can find them in our A–Z inventory. Just search for “brain-heart” to access the decision aids that are publicly available. They are also listed in [Decision Aids Addressing Combined Brain-Heart Conditions](#)

Notes:

1. The A to Z inventory was revised in 2025 to apply the [IPDAS 5.0 criteria](#). For 2 new essential criteria to minimize a biased decision, some patient decision aids indicate no response. This data was not collected when that patient decision aid was registered in the inventory. We are indicating a response to these items as patient decision aid developers provide updates.
2. [Addition of other patient decision aids to the A to Z inventory is an ongoing process.](#)
3. Healthwise provided access, free of charge, to their patient decision aids for educational purposes for over 15 years. Healthwise was purchased by WebMD Ignite in 2024 and WebMD Ignite did not renew our access to the patient decision aids in 2025.

<https://decisionaid.ohri.ca/AZinvent.php>. Accessed 9/15/2026.

Research Methods & Reporting

Updated International Patient Decision Aid Standards (IPDAS version 5.0): modified Delphi, evidence informed consensus process

BMJ 2026 ; 393 doi: <https://doi.org/10.1136/bmj-2025-088116> (Published 12 June 2026)

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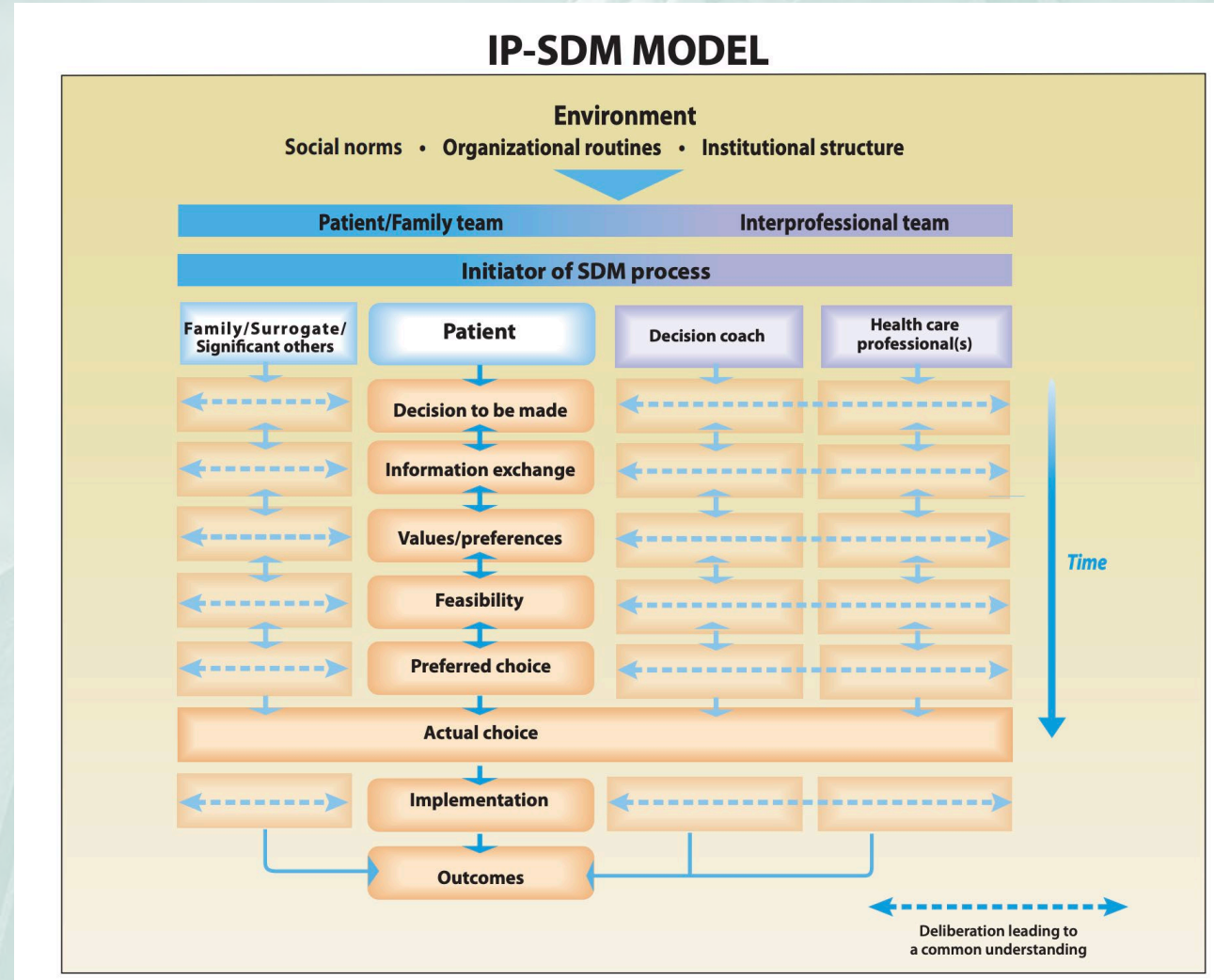
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Accepted 10 April 2026

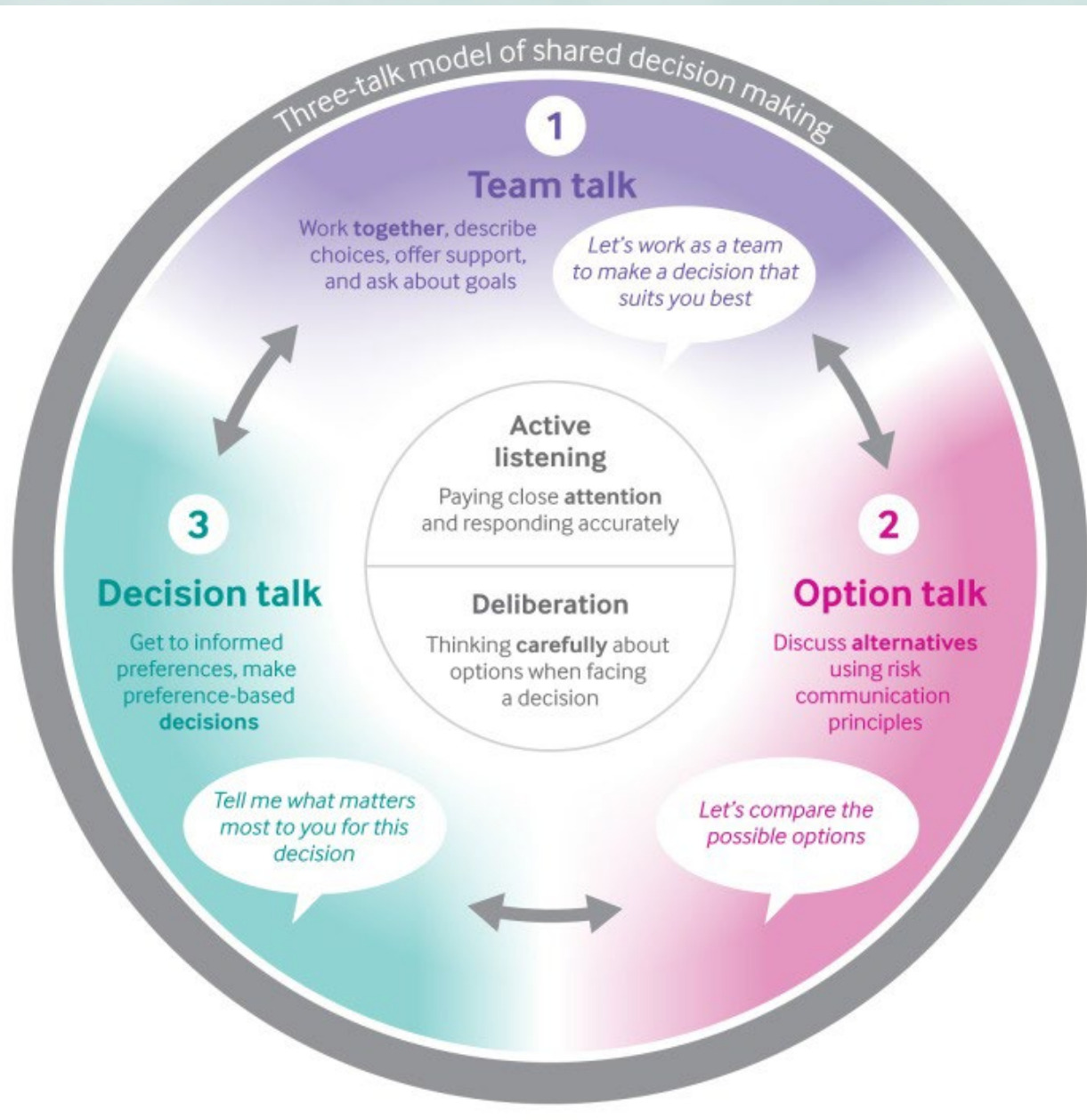
Potential Roles in Team-Based Care and SDM

Team member	Example decision-support contribution
Patient	Goals, preferences, priorities
Physician/Advanced Practice Provider	Clinical options, evidence, recommendations
Nurse	Education, understanding, follow-up
Pharmacist	Medication tradeoffs, costs, adverse effects
Medical assistant	Identify information needs, reinforce resources
Community health worker	Access, logistics, navigation
Social worker	Social/practical barriers

Interprofessional Shared Decision Making (IP-SDM) Model



<https://decisionaid.ohri.ca/ip-sdm.html>. Accessed 9/15/2026.



Elwyn G et al. A three-talk model for shared decision making: multistage consultation process. BMJ. 2017 Nov 6;359:j4891. doi: 10.1136/bmj.j4891.

Ways to Start Incorporating SDM

- Invite patients into decisions early
- Present options neutrally
- Use plain language
- Use visuals (icon array, infographics)
- Ask: “What matters most as you think about these options?”
- Check understanding (e.g., teach-back)
- Document 1–2 SDM steps in the clinical note

Guideline Snapshot for Prostate Cancer Screening

Group	Recommendation	Informed and Shared Decision-Making References
USPSTF (2018)	For men 55–69, the decision to undergo prostate cancer screening should be an individual one.	Men should have an opportunity to discuss the potential benefits and harms of screening with their clinician and incorporate their values and preferences in the decision.
AUA (2023)	Offer regular prostate cancer screening for men 55–69 every 2 to 4 years. Start earlier for men at higher risk.	Prostate-specific antigen (PSA)-based prostate cancer screening in combination with shared decision-making is recommended.
ACS (2023)	Offer PSA screening after discussion starting at age 50 (average risk). Start earlier for men at higher risk.	Men should have a chance to make an informed decision with their health care provider about whether to be screened for prostate cancer.

Prostate Cancer Screening Resources

USPSTF Final Recommendation Statement Prostate Cancer: Screening (2018). *Currently in the process of being updated.
uspreventiveservicestaskforce.org/uspstf/recommendation/prostate-cancer-screening

Early Detection of Prostate Cancer: AUA/SUO Guideline Part I: Prostate Cancer Screening (2023)
auajournals.org/doi/10.1097/JU.00000000000003491

American Cancer Society Recommendations for Prostate Cancer Early Detection (2023)
cancer.org/cancer/types/prostate-cancer/detection-diagnosis-staging/acs-recommendations.html

Other General Resources

Society for Medical Decision Making
smdm.org

International Shared Decision Making (ISDM) Society
isdmsociety.org

A to Z Inventory of Patient Decision Aids: Ottawa
Hospital Research Institute
decisionaid.ohri.ca/azinvent.php

MGH Health Decision Sciences Center
mghdecisionsciences.org/about-us-home/shared-decision-making

Icon Arrays
iconarray.com

Questions?

Wrap-Up

Deliverables

- Each team member, please complete the [Organizational Readiness to Implement Change \(ORIC\) Self-Assessment](#)

Discussion Questions

- What additional factors (e.g. language, cultural) are important to be aware of in your community?
- What is your approach to men's health at your health center?
Does your health center have any resources for specialists related to men's health?

Thank You!

Questions?

Email Meaghan Angers, angersm@mwhs1.com

**Learning Session 2 –
Exploring Men's Health: Medical Uncertainty & Health Disparities
October 15th, 2026
2:30-3:30pm Eastern / 11:30am-12:30pm Pacific**