



Informed Decision Making in Men's Health

LEARNING COLLABORATIVE

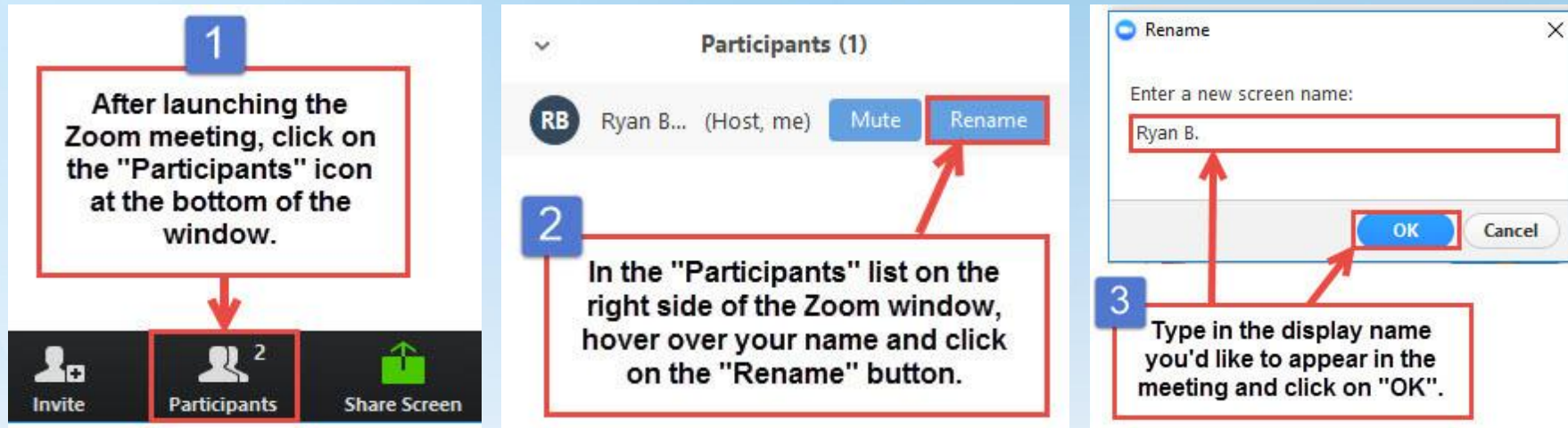
Learning Session 2

Exploring Men's Health: Medical Uncertainty and Health Disparities

Thursday, October 15, 2026

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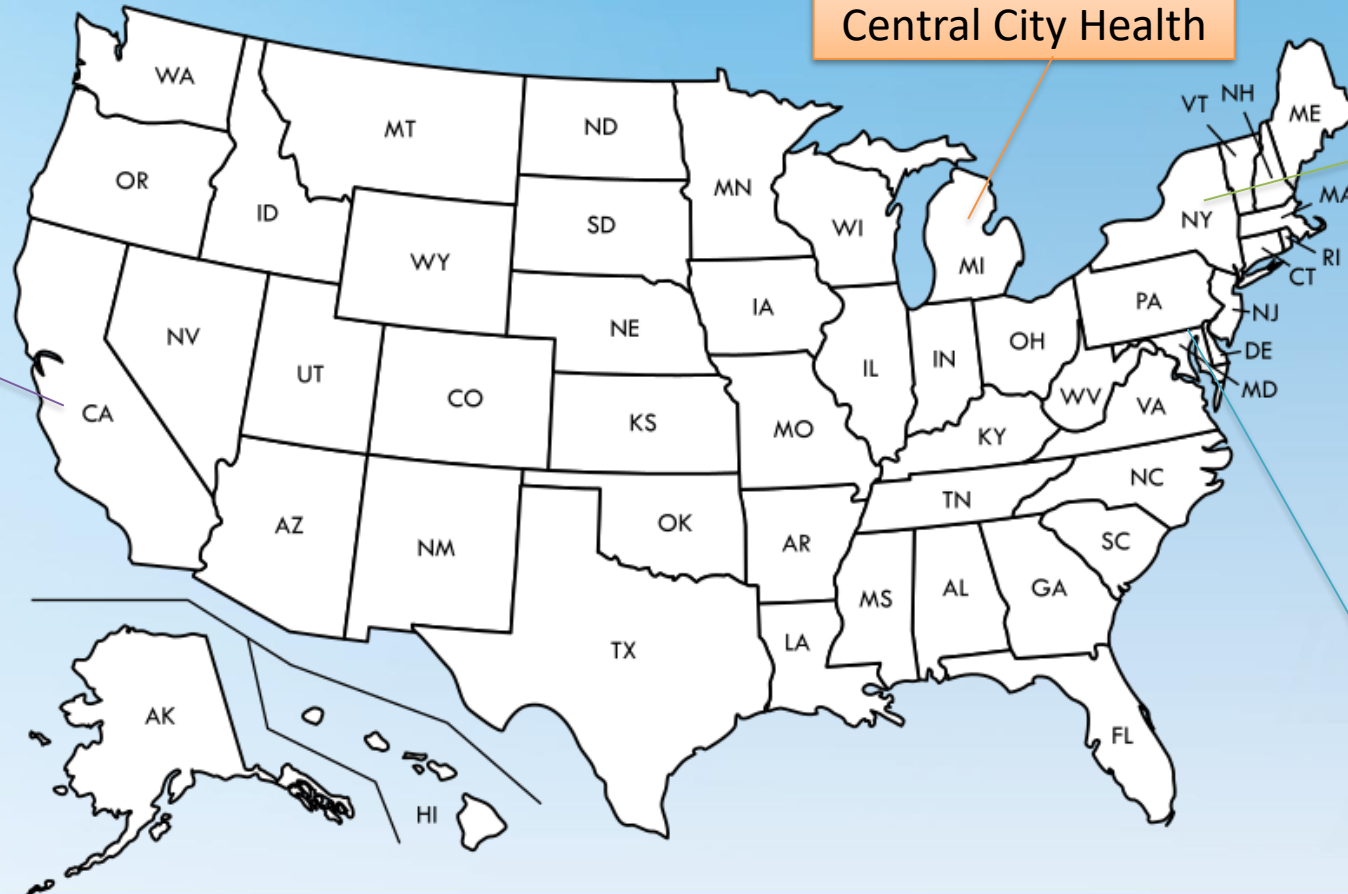
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Session 2 Agenda

- **2:30-2:35pm** Welcome
- **2:35-3:00pm** Medical Uncertainty in Men's Health
- **3:00-3:15pm** Social Drivers of Health and Their Impact on Men's Health Outcomes
- **3:15-3:25pm** Breakout Group Discussion & Report Out
- **3:25-3:30pm** Q/A and Wrap-Up

MEDICAL UNCERTAINTY

Medical Uncertainty in Men's Sexual & Reproductive Health

A 20-minute primary care playbook

?



Stanley Frencher, MD | Urology

One patient. Five plausible explanations.

38-year-old man

Fatigue • lower libido • inconsistent erections

Total testosterone: 287 ng/dL
BMI 34 • snores • SSRI

He and his partner are trying to conceive.

What might be true?

Hypogonadism?
Sleep / metabolic disease?
Medication effect?
Relationship / performance factors?
Male-factor infertility?

The dangerous shortcut

“Low T” → testosterone prescription

That may improve a number while suppressing spermatogenesis and missing the real driver.

Uncertainty is not indecision.

“Good medicine is not certainty. It is calibrated action.”

The question: How certain do I need to be before I act?

1 VERIFY

Is the finding
reproducible?

2 CONTEXTUALIZE

Symptoms, goals,
meds, comorbidity

3 RISK-STRATIFY

What can't I miss?

4 SAFETY-NET

Treat, repeat, or refer

Sexual symptoms are often systems symptoms.

ED is a symptom

Vascular
Neurogenic
Hormonal
Medication-related
Psychogenic / relational
Mixed — often the answer

PCP first pass

Onset + rigidity + morning erections
Libido and ejaculation
Medication/substance review
BP, BMI, diabetes/lipids
Genital exam when indicated

Uncertainty move

Do not wait for a perfect etiology
before addressing modifiable risk,
medication contributors, and first-line
ED treatment when appropriate.

A testosterone of 287 is a question—not a diagnosis.

VERIFY

Symptoms matter.

Repeat an early-morning total testosterone on a separate day.

Avoid diagnosing from a single low or borderline value.

CONTEXTUALIZE

Sleep deprivation / OSA
Obesity / acute illness
Opioids and other medications
Caloric deficit / overtraining
SHBG-altering states

THEN LOCALIZE

If repeatedly low: LH $\pm$ prolactin and targeted evaluation help distinguish primary from secondary hypogonadism.

Biologically plausible ≠ clinically proven.

COMMONLY MARKETING

CoQ10
L-carnitine
Zinc / selenium
Vitamins C / E / D
Ashwagandha
“Testosterone boosters”

WHAT WE KNOW

Correct a true deficiency.
Support a sustainable healthy dietary pattern.

But AUA/ASRM: supplement / antioxidant benefits for male infertility are of questionable clinical utility.

PCP COUNSELING

Ask what is actually in the product.
Check dose + interactions.
Avoid delaying proven evaluation or treatment.
Separate “may help a biomarker” from “improves live birth.”

The optimization marketplace moves faster than the evidence.

PEPTIDES

BPC-157, ipamorelin, CJC-1295 and other “recovery” peptides are increasingly encountered.

For several compounded peptides, FDA identifies limited human safety data, impurity / immunogenicity concerns, or other safety signals.

PRP

For erectile dysfunction, AUA classifies platelet-rich plasma as experimental.

“Autologous” does not mean proven effective.

STEM CELLS

AUA classifies intracavernosal stem-cell therapy for ED as investigational.

Mechanistic promise ≠ established clinical benefit.

SHOCKWAVE

Low-intensity extracorporeal shockwave therapy for ED remains investigational in AUA guidance.

Ask what device, protocol and evidence are actually being offered.

PCP move: identify the product → indication → human evidence → regulatory status → safety / fertility implications.

Before testosterone, ask one question.

“Do you want children now—or might you want them later?”

That answer changes the treatment pathway.

If NO reproductive goal

TRT may be considered after diagnosis, counseling, contraindication review and monitoring.

If YES / UNSURE

Avoid reflex exogenous testosterone.
Evaluate fertility and consider fertility-preserving pathways with men's health / reproductive urology.

Male infertility starts with both partners—not with blame.

WHEN TO EVALUATE

Usually after 12 months of unprotected intercourse; earlier when female partner age or known risk factors justify it.

Evaluate both partners in parallel.

PCP HISTORY

Prior paternity
Cryptorchidism / torsion / infection
Cancer therapy
Pelvic/inguinal surgery
Heat / toxins / cannabis
TRT / anabolic steroids

FIRST TEST

Semen analysis is foundational—but one abnormal sample is not a verdict. Biological variability and collection factors matter.

The semen analysis is a map—not a fertility score.

READ THE WHOLE PATTERN

Volume
Concentration / total count
Motility
Morphology
Azoospermia vs oligospermia
Collection quality

WHY REPEAT?

Semen parameters vary.

Illness, fever, abstinence interval,
collection loss and lab factors can
change the result.

Repeat testing often clarifies a
borderline result.

REFER EARLY WHEN

Azoospermia
Severe oligospermia
Testicular atrophy / mass
Endocrine abnormality
Genetic concern
Time-sensitive couple

Azoospermia is a branch point, not an endpoint.

PRE-TESTICULAR

Endocrine suppression
Exogenous testosterone /
anabolic steroids
Pituitary disease

TESTICULAR

Primary spermatogenic failure
Genetic causes
Prior chemo/radiation
Severe testicular injury

POST-TESTICULAR

Obstruction
Congenital absence of vas
Prior vasectomy / surgery
Ejaculatory duct pathology

PCP move: confirm → stop gonadotoxic exposures when appropriate → endocrine exam/labs → refer.

ED ≠ ejaculation ≠ orgasm.

ERECTION

Difficulty achieving or maintaining rigidity sufficient for sexual activity.

EJACULATION

Premature, delayed, absent, painful, or retrograde ejaculation.

ORGASM

Pleasure/sensation can be impaired even when erection and ejaculation occur.

LIBIDO

Desire is distinct from performance—and is influenced by hormones, mood, sleep, medications and relationship context.

Peyronie disease: time changes the treatment conversation.

ACTIVE / EVOLVING

Pain and/or changing curvature

Document onset, functional impact and trajectory.

Reassure about cancer fears; avoid promising spontaneous correction.

STABLE / FUNCTION-LIMITING

Stable deformity with difficulty with intercourse is where definitive options become more relevant.

Refer when curvature, pain, ED or distress affects function.

Fertility preservation is a “before,” not an “after.”

CANCER THERAPY

Before chemotherapy, pelvic radiation or gonadotoxic treatment: discuss sperm cryopreservation when feasible.

EXOGENOUS ANDROGENS

Before TRT or anabolic steroid exposure: clarify future reproductive goals and counsel on spermatogenesis suppression.

PROCEDURES / LIFE PLANS

Vasectomy counseling and other reproductive decisions should include future goals, reversibility limits and alternatives.

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

THE CASE

52-year-old man
PSA 4.6 ng/mL
Prior PSA 2.8
No symptoms
“Do I have cancer?”

VERIFY + CONTEXT

Repeat newly elevated PSA
before biomarkers, MRI or
biopsy.
Consider family history,
ancestry, DRE, prior PSA
and transient contributors.

SHARED DECISION

Balance clinically significant
cancer detection against
false positives and
overdiagnosis.
Use risk assessment to
guide referral.

A negative MRI lowers risk; it does not erase risk.

THE TENSION

Biopsy can find important cancer—but also indolent disease.
MRI and biomarkers refine probability, not certainty.

RISK STRATIFY

Integrate PSA density, DRE, family history, risk calculators and MRI.
Biopsy may still be appropriate despite negative MRI.

PCP TAKEAWAY

Refer persistent elevation or high-risk features.
Active surveillance is often appropriate for low-risk disease.

Treat now—or safely watch?

THE CASE

62-year-old, PSA 5.8
Biopsy: Grade Group 1
Low-volume disease

“I want the cancer out. Is surveillance really safe?”

ACTIVE SURVEILLANCE

Often preferred for low-risk localized disease.

Not “do nothing”: serial PSA, periodic MRI and repeat biopsy per risk and protocol.

Some men progress and need treatment.

TREATMENT TRADE-OFFS

Surgery or radiation may reduce uncertainty about leaving cancer untreated—but carry urinary, sexual and bowel trade-offs.

Risk group, life expectancy, priorities and follow-up reliability matter.

Return to the 38-year-old. What changes now?

VERIFY

Repeat early-AM
testosterone
Confirm symptom pattern
Consider SHBG/free T
when useful
Semen analysis

CONTEXTUALIZE

Fertility goal
SSRI
Sleep/OSA
Weight/metabolic health
Relationship/performance
context

RISK-STRATIFY

CV risk
Endocrine red flags
Severe semen
abnormality
Testicular findings

SAFETY-NET

Treat reversible drivers
ED therapy if appropriate
Avoid reflex TRT
Refer reproductive urology
if indicated

What can primary care own?

OWN

- Clarify the sexual phenotype
- Cardiometabolic risk
- Medication review
- Repeat borderline testosterone
- Initial semen analysis
- Fertility-goal conversation

AVOID

- Diagnosing hypogonadism from one value
- TRT before fertility discussion
- Treating every sexual complaint as ED
- Calling one semen analysis “infertile”

REFER

- Azoospermia / severe oligospermia
- Testicular mass/atrophy
- Complex endocrine findings
- Peyronie with functional impact
- Refractory ED / fertility-preserving therapy

Three phrases that improve the visit.

“This result is borderline; repeating it will tell us whether it is persistent.”

“There are several possible contributors, and more than one may be true.”

“Before we treat the number, I want to know your goals—especially around fertility.”

Take-home: uncertainty should change the next step.

VERIFY

Repeat what is variable.
Define the symptom
precisely.

CONTEXTUALIZE

Ask about goals, meds,
sleep, metabolic health
and relationship context.

RISK-STRATIFY

Know the findings that
need faster evaluation or
specialist care.

SAFETY-NET

Treat what is safe to treat;
set a clear follow-up or
referral threshold.

Men's sexual & reproductive health rewards curiosity before certainty.

Selected guidance

- AUA / ASRM. Diagnosis and Treatment of Infertility in Men (amended 2024).
- AUA. Erectile Dysfunction Guideline — regenerative therapies / shockwave statements.
- Endocrine Society. Testosterone Therapy guideline + 2026 TRT statement.
- FDA. Human Drug Compounding: risks of compounded drugs and peptide safety reviews.
- AUA. Peyronie's Disease Guideline.
- Princeton IV Consensus: ED and cardiovascular risk.

Clinical decisions should be individualized to symptoms, reproductive goals, comorbidities and current guideline updates.

Social Drivers of Health and Their Impact on Men's Health Outcomes

Reginald Tucker-Seeley, MA, ScM, ScD, FASCO

Principal/Owner, Health Equity Strategies and Solutions



Opening Question

- What can make it difficult for a man to get preventive care (e.g. cancer screening), even when he wants it?

Background

- There have been many calls for the healthcare delivery system to tackle the social determinants of health (SDOH) to reduce healthcare costs and to facilitate efficient health care utilization.
 - A focus on SDOH recognizes that health does not only happen in a doctor's office—it also happens in our homes, our schools, where we work, and across our communities.

Background

- ***Social determinants of health (SDOH):***
 - conditions in which we are born, live, learn, work, play, worship, and age that affect our health, functioning, and quality-of-life outcomes and risks for disease. (*Healthy People 2030*)
 - ...and “the fundamental drivers of these conditions” (*WHO*)
 - the interrelated social, economic, and environmental factors that shape health inequity in the United States, like income and wealth or employment (*National Academy of Medicine, Communities in Action Report*)
 - “Social determinants of health refer to both specific features of and pathways by which societal conditions affect health and that potentially can be altered by informed action” (Krieger, 2001)

Sources:

- https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1
- National Academies of Sciences, Engineering, and Medicine. (2017). Communities in action: Pathways to health equity;
- Krieger, N. (2001). A glossary for social epidemiology. *Journal of Epidemiology & Community Health*, 55(10), 693-700.

Background

- The World Health Organization (WHO) defines the SDOH as the “*conditions in which people are born, grow, live, work, and age*” and “*the fundamental drivers of these conditions.*”
 - Deprivation in these conditions produces *poor health care outcomes*
 - Differences in the distribution of this deprivation *produce health care–related disparities*

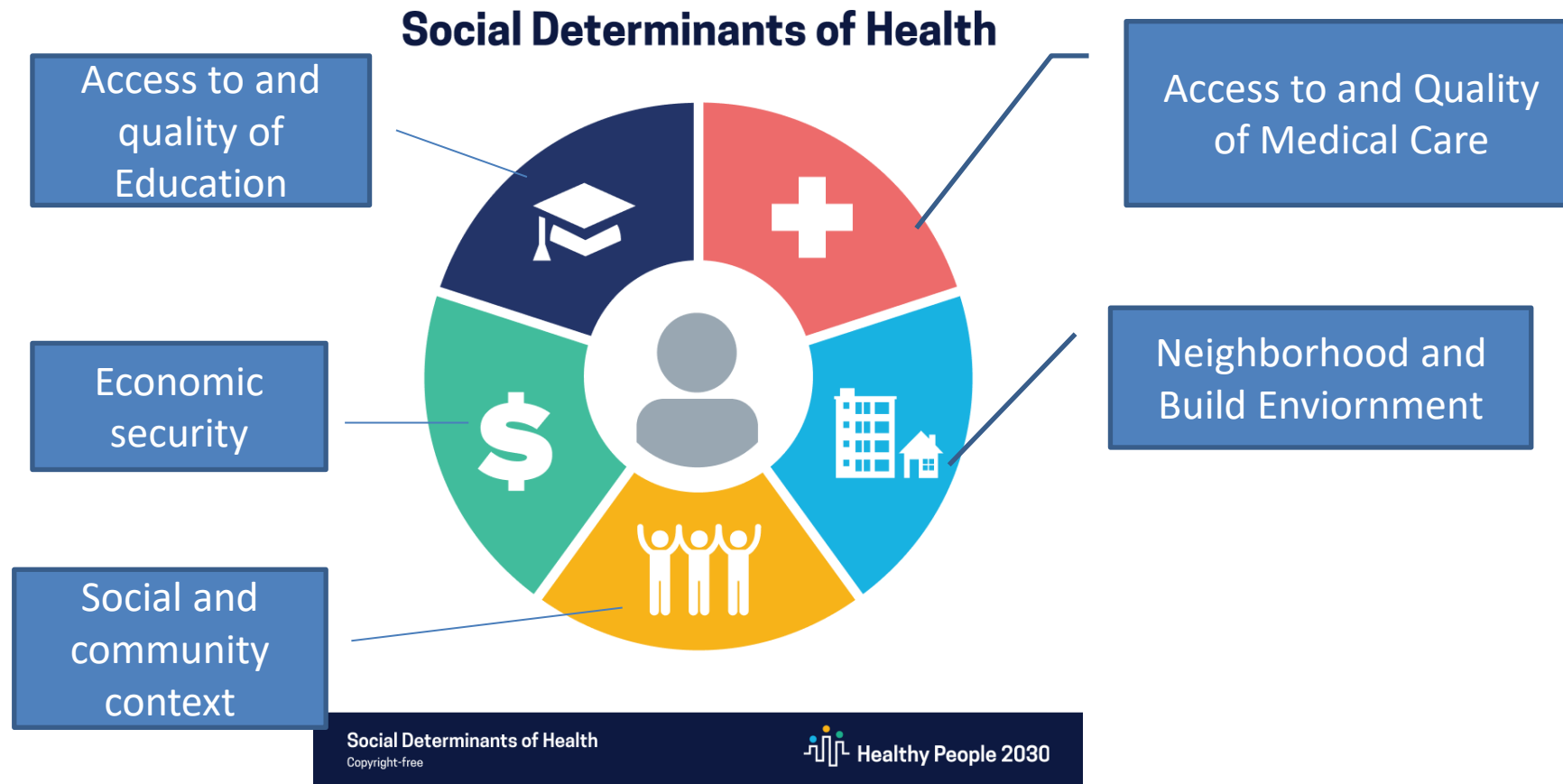
Social determinants vs. social drivers

- “**Social determinants of health** can indicate that people’s health has already been determined.”
- “**Social drivers of health**, on the other hand, better expresses the idea that change is possible.”
 - **Drivers of health**
 - Individual drivers of health
 - Community drivers of health

SDOH and social needs

- SDOH and social needs
 - “SDOH manifests as individual social needs, which can present in the clinical setting as financial hardship (financial toxicity), food insecurity, housing insecurity, and transportation needs.”
 - “...there are substantial differences in the environments in which individuals are born, grow, live, work, and age;” thus, without direct intervention on the deprivation that exists across those contexts it will be incredibly difficult to substantially reduce disparities and create health equity.

Healthy People Social Determinants of Health Framework



Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion.
[<https://health.gov/healthypeople/objectives-and-data/social-determinants-health>]

Social Determinants of Health operationalized as Patient Social Needs

TABLE 1. SDOH and Social Needs to Screen Based on Healthy People 2030

SDOH	Examples of Social Needs to Screen
Neighborhood and built environment	Crime and exposure to violence Access to food Transportation resources
Health and Health care	Usual source of care Access to primary care Health literacy
Social and community contexts	Experiences of discrimination Social isolation and loneliness Social support
Education	High school graduation Language and literacy
Economic stability	Financial hardship (financial toxicity) Food insecurity Housing instability

Abbreviation: SDOH, social determinants of health.

Social needs vs. SDOH

- “Words matter. Common definitions ensure that we understand each other. When health care leaders and public health officials use “social determinants of health” to mean different things, it becomes more difficult for us to engage meaningfully with community partners, who will struggle to differentiate between these complementary but different approaches.”
- “...health care navigators and similar enhancements to health care can’t actually change the availability of resources in the community. They can’t raise the minimum wage, increase the availability of paid sick leave, or improve the quality of our educational system. These are the systemic changes that are necessary to truly address the root causes of poor health.” (Castrucci & Auerbach, 2019)

Social Care Integration into Clinical Spaces

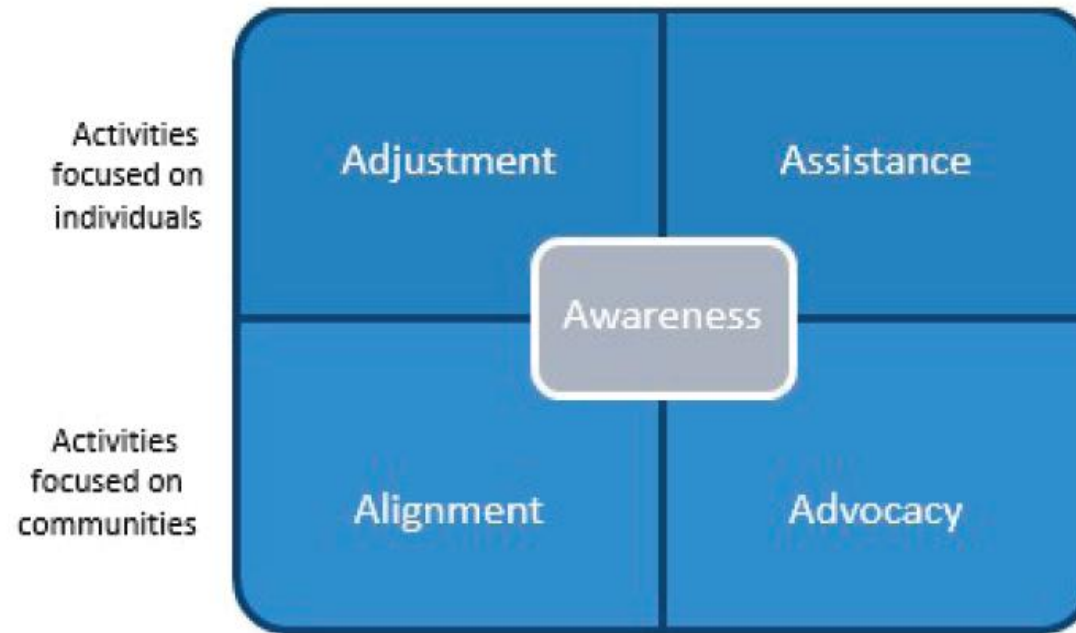


FIGURE S-1 Health care system activities that strengthen social care integration.

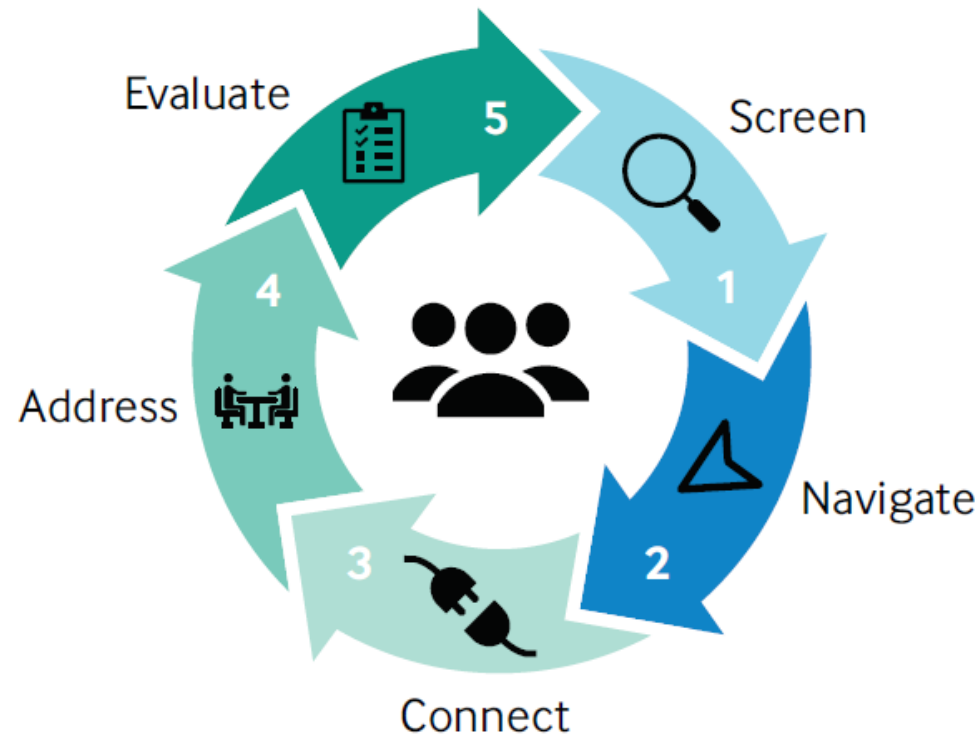
Social Care Integration into Clinical Spaces

TABLE S-1

Definitions of Health Care System Activities That Strengthen Social Care Integration

Activity	Definition	Transportation-Related Example
Awareness	Activities that identify the social risks and assets of defined patients and populations.	Ask people about their access to transportation.
Adjustment	Activities that focus on altering clinical care to accommodate identified social barriers.	Reduce the need for in-person health care appointments by using other options such as telehealth appointments.
Assistance	Activities that reduce social risk by providing assistance in connecting patients with relevant social care resources.	Provide transportation vouchers so that patients can travel to health care appointments. Vouchers can be used for ride-sharing services or public transit.
Alignment	Activities undertaken by health care systems to understand existing social care assets in the community, organize them to facilitate synergies, and invest in and deploy them to positively affect health outcomes.	Invest in community ride-sharing or time-bank programs.
Advocacy	Activities in which health care organizations work with partner social care organizations to promote policies that facilitate the creation and redeployment of assets or resources to address health and social needs.	Work to promote policies that fundamentally change the transportation infrastructure within the community.

Formative Evaluation of Social Care Integration in a large safety-net healthcare delivery system (PI: Dr. Breena Taira)



Source: [Taira, B.R., Yadav, K., Perez, Y., Aleman, A., Steinberg, L., Tchakalian, G. and Tucker-Seeley, R., 2023. A Formative Evaluation of Social Care Integration Across a Safety-Net Health System. *NEJM Catalyst Innovations in Care Delivery*, 4\(4\), pp.CAT-22.](#)

Formative Evaluation of Social Care Integration in a large safety-net healthcare delivery system

LA County SBDOH Project	<i>Screen</i>	<i>Navigate</i>	<i>Connect</i>	<i>Address</i>	<i>Evaluate</i>
What to measure?	Number of patients screened? Prevalence of food, housing, transportation issues?	Number of patients linked to "navigator"?	Number of patients referred to Community Based Organization (CBO)?	Prevalence of food, housing, transportation issues at site? Patients screened at follow-up appointment?	Number of patients lost to follow-up at screen, navigate, connect, or address stage of process?
When to measure?	Registration, nurse check-in, physician/NP	Initial referral; Connection with "navigator"	Referral organization (CBO) contacted; Following social service provision	Following social service provision; Follow-up appointment at healthcare facility	Does the timing of measurement influence navigation to or connection with CBO?
Who will measure?	Registration staff; Nursing staff; social work staff; or physician staff	Registration staff; Nursing staff; social work staff; or physician staff	Registration staff; Nursing staff; social work staff; physician staff; or CBO staff	Registration staff; Nursing staff; social work staff; physician staff; or CBO staff	Registration staff; Nursing staff; social work staff; physician staff; or CBO staff

Source: Taira, B.R., Yadav, K., Perez, Y., Aleman, A., Steinberg, L., Tchakalian, G. and Tucker-Seeley, R., 2023. A Formative Evaluation of Social Care Integration Across a Safety-Net Health System. *NEJM Catalyst Innovations in Care Delivery*, 4(4), pp.CAT-22.

Challenges to screening for social drivers of health

- Potential for patients feeling stigmatized
 - What is being asked and how its being asked matters
 - Acknowledge that some of these questions may be sensitive
 - Important to normalize the conversation
- Patients may not trust you enough to answer honestly
 - Do they trust you to discuss their needs outside the clinical setting?
 - Be honest about how their data will be used and who will be using it
 - Acknowledge research or QI uses
- Disappointment after not receiving help in the past can be a strong deterrent to being willing to disclose a need in the future
 - Follow-up is important

- Tips for addressing these challenges, according to the [Patient Insight Institute](#):

Tips for a Successful SDOH Screening Process



What are the implications for men visiting your clinic?



“Necessary but not sufficient”

- Screening for and understanding the social drivers of health are necessary but not sufficient for fully understanding the factors that influence men’s health, their health behaviors, and how they navigate healthcare
- Improving men’s health requires more than encouraging healthy choices:
 - it requires making prevention, informed decision-making, and follow-up care accessible
 - Social conditions (social drivers of health) such as employment, housing, transportation, experiences of discrimination, and health care access shape opportunities for men to make the best choices for themselves

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.

Reminder
from Dr.
Langford's
presentation
in Session #1

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

Factors in addition to SDOH that influence men's health

- Expectations about masculinity may influence willingness to discuss vulnerability or sexual concerns, but they should not be presumed to apply to every man.
- Historical and contemporary experiences of discrimination
 - Perceived racism and unfair treatment in medical settings
 - Perceived discrimination becomes more complex for men with multiple minoritized identities: men of color, LGBTQ+ men, and men from lower socioeconomic backgrounds
- Potential question prompts to capture SDOH and other psychosocial factors:
 - “What matters to you?”
 - “What concerns you?”
 - “What gets in the way?”
- While capturing SDOH is necessary in providing high-quality healthcare to men, it is not a prostate cancer screening-readiness or decision-making assessment and does not capture:
 - screening knowledge, trust, sexual-health concerns, informed preferences, and follow-up access

Summary

- **What can make it difficult for a man to get preventive care, even when he wants it?**
 - His social environment: men's health is shaped by the conditions in which they live and work, not only by their individual choices.
 - Masculinity: societal norms that men need to be tough, independent, and in control
- **What are social determinants of health/social drivers of health?**
 - The conditions in which people are born, grow, live, work, and age and the fundamental drivers of those conditions
- **What are the domains of social determinants of health from Healthy People generally discussed in the research literature and screened for in clinical care?**
 - Neighborhood and built environment
 - Health and health care
 - Social and community contexts
 - Education
 - Economic stability
- **What are some examples of patient social needs/health related social needs (HRSN)?**
 - Financial hardship
 - Food insecurity
 - Housing insecurity
 - Transportation needs

RESOURCES

AAFP's (American Academy of Family Physicians) Guide to Social Needs Screening

- This 15-question screening tool screens across the core health-related social needs including housing, food, transportation, personal safety, employment, education, childcare and financial strain.
 - Example questions:
 - Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?
 - Within the past 12 months, you worried that your food would run out before you got money to buy more.
 - How often does this describe you? I don't have enough money to pay my bills.
 - Do you put off or neglect going to the doctor because of distance or transportation?

Additional SDOH screening resources

- Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE®)
 - <https://www.nachc.org/resource/prapare/>
- The Accountable Health Communities Health-Related Social Needs Screening Tool
 - <https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf>
- The Health Leads Screening Toolkit
 - <https://healthleadsusa.org/news-resources/the-health-leads-screening-toolkit/>

Social Determinants of Health in Cancer Care

with American Society of Clinical Oncology (ASCO)

ASCO presents Social Determinants of Health in Cancer Care, a podcast series in which oncologists, patients, advocates, and other thought leaders in health equity, turn a spotlight on actionable methods to provide equitable access to cancer care.

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**SOCIAL DETERMINANTS
OF HEALTH IN
CANCER CARE**



- Source: <https://sites.libsyn.com/470343/socialdeterminantsofhealth>

Contact information

- Email: reggie@healthequitystrategies.org
- Website: <https://www.healthequitystrategies.org/>

Breakout Group Discussion & Report Out

Breakout Group Instructions

● **3:15-3:25pm Breakout Groups**

- Introduce Yourself: Name, Role, Organization
- Discussion Question #1: What factors (e.g. language, cultural) are important to be aware of in your community?
- Discussion Question #2: What is your strategy or approach to men's health at your health center? Does your health center have any resources for specialists related to men's health?

Questions?

Wrap-Up

Deliverables

Discussion Questions

- ⦿ What are your current strategies for facilitating conversations with male patients around sexual health? What are your organization's strengths and weaknesses?
- ⦿ How does your health center provide education for men in the following areas of focus:
 - ⦿ Sexual health (including erectile dysfunction)
 - ⦿ Urinary symptoms (including benign prostate hypertrophy)
 - ⦿ Prostate cancer screening and overall prostate health

Thank You!

Questions?

Email Meaghan Angers, angersm@mwhs1.com

**Learning Session 3 –
Assessing Men's Education and Decision Support for
Sexual Health and Prostate Conditions
November 19, 2026
2:30-3:30pm Eastern / 11:30am-12:30pm Pacific**