



2017 AAFP FMX Needs Assessment

Body System: Reproductive-Male			
Session Topic: Prostate Cancer			
Educational Format		Faculty Expertise Required	
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.	
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. <u>Please describe your interest and plan for teaching a PBL on your proposal form.</u>	
Professional Practice Gap		Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
<ul style="list-style-type: none"> • New grade group system for risk stratification of prostate cancer. • New guidelines for active surveillance for patients with low risk, localized prostate cancer. • Physicians are not knowledgeable or are not confident in their use of validated screening tools and guidelines to assess men's risk for and manage prostate cancer. • Prescreening discussions are under-utilized for prostate cancer due to perceived controversy over their usefulness in reducing mortality. • Patients diagnosed with localized prostate cancer frequently do not understand the risks and benefits of treatment options. • Physicians have knowledge gaps with regard to 		<ol style="list-style-type: none"> 1. Counsel patients, using shared decision making resources, regarding the risks and benefits of prostate cancer screening. 2. Assess the value and limitations of the new ISUP Grade Group Classification System for risk stratification of prostate cancer. 3. Develop collaborative care plans, taking into account the risks and benefits of current evidence-based recommendations of pharmacologic, surgical, CAM, or watchful waiting treatment strategy. 4. Establish a coordinated care process with other health providers (e.g. urologists and oncologists) for men requiring prostate cancer surveillance, and possibly treatment. 	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.



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<p>understanding and implement cancer survivorship guidelines, surveillance strategies, access to community and web-based resources, and strategies to improve communication and coordinate care with oncology, surgical, and other health care providers.</p> <ul style="list-style-type: none">• Family physicians may require additional education and training to increase their self-efficacy and confidence in testing for recurrence of cancer using recommended laboratory tests and ancillary procedures.• Most men with LPC underestimate their life expectancy without treatment and overestimate their potential gain in life expectancy with surgery or radiation.		
ACGME Core Competencies Addressed (select all that apply)		
X	Medical Knowledge	Patient Care
X	Interpersonal and Communication Skills	Practice-Based Learning and Improvement
	Professionalism	Systems-Based Practice
Faculty Instructional Goals		
<p>Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.</p> <ul style="list-style-type: none">• Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations• Facilitate learner engagement during the session• Address related practice barriers to foster optimal patient management• Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the <u>References</u> section below are a good place to start		



- Visit <http://www.aafp.org/journals> for additional resources
- Visit <http://familydoctor.org> for patient education and resources
- Provide an overview of relevant clinical guidelines for prostate cancer screening, treatment, and management, and provide recommendations for their practical application to practice
- Provide strategies and resources for counseling patients, using shared decision making resources, regarding the risks and benefits of prostate cancer screening.
- Provide strategies and resources for counseling patients with diagnosed localized prostate cancer about the risks and benefits of their treatments options, using a standardized clinical decision aid.
- Provide strategies and resources for collaborating with other health providers (e.g. urologists and oncologists) to construct a coordinated referral process for men requiring prostate cancer treatment.
- Provide strategies and resources on the appropriate and current resources to survivors on the psychosocial effects of cancer.
- Provide an overview and recommendations for current evidence for new treatment options.
- Provide recommendations regarding guidelines for Medicare reimbursement.
- Provide recommendations to maximize office efficiency and guideline adherence to the diagnosis and management of prostate cancer.
- Provide an overview of newly available treatments, including efficacy, safety, contraindications, and cost/benefit relative to existing treatments.
- Provide instructions regarding the incorporation and use of the PCMH/ACO/Primary Care Core Measure Set into practice.

Needs Assessment:

PSA Screening

The estimated number of new cases of prostate cancer in the United States in 2010 was 196,038, and the estimated number of deaths from prostate cancer was 28,560; which is anticipated to increase to about 233,000 new cases, and 29,480 deaths in 2014.^{1,2} Prostate cancer occurs mainly in older men, and is the second leading cause of cancer death in American men.^{1,2}

The 2008 National Ambulatory Medical Survey reveals that family physicians ordered nearly 5 million prostate specific antigen (PSA) tests.³ A meta-analysis of prostate cancer screening in a 2013 Cochrane Review of more than 340,000 men, indicates that there was no significant decrease in prostate cancer specific mortality, and that over diagnoses and overtreatment are common and associated with harm.⁴

A recent American Academy of Family Physicians (AAFP) Needs Assessment Survey indicates a statistically significant and meaningful difference between family physicians' medical knowledge about prostate cancer and their skill level at managing patients with prostate cancer.⁴ More specifically, CME outcomes data from 2012 and 2015 AAFP FMX (formerly Assembly): *Prostate Cancer* sessions suggest that physicians have knowledge and practice gaps with regard to appropriate PSA screening; educating patients on lifestyle modifications; follow up and



monitoring; appropriate use of DEXA for patients on androgen suppression therapy; and having shared decision making conversations with patients about the risks and benefits of PSA screening and results of screening.^{5,6}

Despite increasing survival rates since the advent of PSA testing, decisions regarding screening for prostate cancer are complicated. Much of the debate stems from a lack of evidence supporting a role for screening in reducing mortality and concerns about over-diagnosis and subsequent overtreatment of prostate cancer.⁷⁻⁹ Both the AAFP and the US Preventive Services Task Force (USPSTF) recommend against PSA testing or digital rectal exam testing for prostate cancer screening.^{10,11}

In April 2013, the American Urological Association (AUA) released a guideline on early detection of prostate cancer, namely to reduce prostate cancer mortality, summarized as follows:¹²

- The AUA *recommends against* PSA screening of men younger than 40 years
- The AUA *recommends against* PSA screening of men 40 to 54 years of age
- The AUA *strongly recommends* shared decision making in men 55 to 69 years of age who are considering PSA screening, with the decision being based on the patient's values and preferences.
- The AUA *does not recommend* routine PSA screening in men 70 years and older, or in men with a life expectancy less than 10 to 15 years.

The American Cancer Society's (ACS's) recently updated guideline for early detection of prostate cancer recommends that asymptomatic men with ≥ 10 -year life expectancy have the opportunity to make an "informed decision," together with their physician, about screening for prostate cancer, but only after they receive information about the uncertainties, risks, and potential benefits associated with screening. ACS guidelines state that prostate cancer screening be supported by an informed decision-making (IDM) process, and recommend that men at average or higher risk for prostate cancer receive this information beginning at or before age 50, respectively.¹³ In addition, the guidelines state that men should either receive this information directly from their healthcare providers, or be appropriately referred. Despite these recommendations, a recent studies of IDM practices (defined as "prescreening discussions") among primary care physicians showed that more than 20% did not routinely use such discussions and found variation in the routine use and role of the physician.^{14,15} For physicians in primary care and family practice, these developments signal a need for education that:

- Clarifies definitions of high and average prostate cancer risk
- Identifies which patients will benefit most from screening, and
- Provides guidance and patient decision aids that help implement IDM.

Physicians should also be familiar with a new grade group system for risk stratification of prostate cancer, which may provide more accurate risk stratification than the current composite Gleason score.¹⁶ The 2014 International Society of Urological Pathology Consensus Conference adopted an alternative grade grouping system based upon the Gleason grade, and this alternative grade group system has been adopted in the 2016 World Health Organization classification of genitourinary tumors.^{17,18}



Prostate Cancer Diagnosis

Diagnosis of prostate cancer is complicated by wide variations in symptoms and overlap with symptoms of other prostate diseases, such as difficulty passing urine, painful urination, and/or painful ejaculation. Diagnosis also requires ruling out non-prostate-related conditions, including bladder cancer, interstitial cystitis, and lower urinary tract infections.¹⁹⁻²¹ When PSA testing and/or DRE indicates prostate cancer, a biopsy of prostate tissue is needed for confirmation, and requires referral to an urologist. When cancer is confirmed, PSA test and DRE results, together with biopsy findings and other evaluations, are used to determine the stage of the cancer. Staging helps to determine patient prognosis and guides further work-up, with higher stages indicating the need for imaging studies to assess the presence and location of any metastatic disease.²² These steps are typically performed by an urologist, but close communication with the referring family physician is needed. An important role for the family physician in this process is to provide education and counseling that reassures patients with a diagnosis of prostate cancer and allays patient fears regarding prognosis, treatment, and treatment-related morbidity. Physicians can improve patient satisfaction with the referral process by using readily available strategies and tools such as, improving internal office communication, engaging patients in scheduling, facilitating the appointment, tracking referral results, analyzing data for improvement opportunities, and gathering patient feedback.^{23,24}

Prostate Cancer Treatment

Standard approaches for non-metastatic prostate cancer include radical prostatectomy, radiation therapy, active surveillance, and “watchful waiting”. For locally advanced prostate cancer, radiation therapy together with androgen-induced ablation may be recommended, with radical prostatectomy as an appropriate alternative to radiation therapy for some patients some cases. These procedures have the potential to cause impotence and urinary problems. More than 90% those diagnosed with prostate cancer, are diagnosed with localized prostate cancer (LPC), and between 70% to 90% of patients choose a treatment during their first visit to a urologist after a positive biopsy.²² However, more than half of these patients overestimate the survival benefit of treatment, and underestimate their potential gain in life expectancy with surgery or radiation; therefore, primary care physicians should use evidence-based National Comprehensive Cancer Network (NCCN), American Cancer Society (ACS), and AUA clinical guidelines, along with a clinical decision scale to assess patient misperceptions about treatment choices for LPC.^{22,25,26}

Physicians may want to consider the following evidence-based recommendation for treatment options for localized prostate cancer:^{9,22}

- Treatment for localized prostate cancer should be recommended for higher-risk patients. Risk can be estimated by using an index of cancer stage and grade, prostate-specific antigen level, and comorbidity-adjusted life expectancy.
- Patients can be counseled that surgery and external beam radiation therapy are almost equally effective in treating prostate cancer.
- Brachytherapy is an option for monotherapy in low-risk patients.
- Active surveillance is a reasonable option for low-risk and very low-risk patients.



Physicians may want to consider the following evidence-based recommendations for the primary care of the prostate cancer survivor:²⁷

- Digital rectal examination should be performed annually as follow-up after prostate cancer treatment.
- Prostate-specific antigen levels should be checked every six to 12 months for five years and then annually thereafter as follow-up after prostate cancer treatment.
- In patients treated with androgen deprivation therapy, baseline dual energy x-ray absorptiometry should be performed to measure bone mineral density.
- After prostate cancer treatment, health-related quality of life should be assessed annually using tools such as the Expanded Prostate Cancer Index Composite for Clinical Practice (EPIC-CP).

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Urologists and oncologists are primarily responsible for treatment of prostate cancer, however, for many patients, prostate cancer is a chronic disease that may be managed with ADT for years or even decades. Family physicians play important roles in follow-up and long-term care of cancer survivors, including monitoring for cancer recurrence and management of treatment-related morbidity. Thus, family physicians need basic knowledge of available treatment options and their benefits and risks in order to prevent or manage adverse effects of cancer treatment.²⁸

Physicians should also be kept up to date on new treatment therapies, changes to therapies, or warnings associated with existing therapies. Provide recommendations regarding new FDA approved medications for the treatment of prostate cancer; including safety, efficacy, tolerance, and cost considerations relative to currently available options. Current examples include, but are not limited to:²⁹

- Xofigo (radium Ra 223 dichloride); Bayer Healthcare Pharmaceuticals; For the treatment of prostate cancer with bone metastases, Approved May 2013
- Xtandi (enzalutamide); Medivation; For the treatment of metastatic castration-resistant prostate cancer, Approved August 2012
- Zytiga (abiraterone acetate); Centocor Ortho Biotech; For the treatment of prostate cancer, Approved May 2011
- Jevtana (cabazitaxel); sanofi aventis; For the treatment of prostate cancer, Approved June 2010
- Provenge (sipuleucel-T); Dendreon; For the treatment of hormone refractory prostate cancer, Approved May 2010
- Degarelix (degarelix for injection); Ferring Pharmaceuticals; For the treatment of prostate cancer, Approved December of 2008



- Plenaxis (abarelix for injectable suspension); Praecis Pharmaceuticals; For treatment of advanced prostate cancer, Approved December 2003

Data from a recent American Academy of Family Physicians (AAFP) CME Needs assessment survey indicate that family physicians have significant knowledge gaps regarding the care of cancer survivors.³⁰ More specifically, CME outcomes data from the 2013 AAFP Assembly: *Care of Cancer Survivors*, and 2014 AAFP Assembly: *Prostate Cancer and Prostate Specific Antigen (PSA) Screening* sessions indicate that family physicians require additional continuing medical education regarding PSA screening guidelines; how to counsel men regarding PSA screening, and treatment options, including risks and benefits; surveillance strategies; access to community and web-based resources; understand and implement cancer survivorship guidelines; and strategies to improve communication and coordinate care with oncology, surgical, and other health care providers.^{31,32}

Primary care providers are often overburdened by an aging population with multiple chronic conditions and may not be adequately prepared to care for these survivors due to perceived knowledge gaps about the individualized needs, risks, and surveillance plans for cancer survivors.³³⁻³⁶ Additionally, there is often a lack of inter-professional communication and clarity about responsibilities in the coordination of care between oncology professionals and primary care providers.^{34,35,37} In fact, patients are often unaware that a transition back to their primary care provider, from their oncology provider, is an option. Cancer survivors are at increased risk for recurrence of the original cancer and development of second primary malignancies as a result of cancer therapy and other risk factors.³⁸ Additionally, recent studies suggest that men with prostate cancer, who were receiving androgen deprivation therapy, are at increased risk of venous thromboembolic disease.³⁹

Family physicians are integral in the care of their patients with cancer, most involvement occurring at the time of diagnosis and with end-of-life care.⁴⁰ One challenge is to integrate family physicians into the continuum of providing care for cancer survivors.⁴¹ The Patient-Centered Medical Home is one approach of supporting patients and their families by providing a patient-centered orientation and coordinated care between medical specialties.^{42,43} In data from a recent survey of a sample group of active AAFP physician members, 76.8% of respondents indicated they were currently treating patients with cancer. Of these respondents, only 32% indicated that they were either moderately comfortable or comfortable in managing the care of patients with cancer. In addition, 51% of these respondents voiced they would be moderately likely or extremely likely to engage in CME on this topic. These data demonstrate a self-identified need by family physicians for CME on the management of patients with cancer.⁴⁴

The American Academy of Family Physicians Academy has participated in the Core Measures Collaborative (the Collaborative) convened by America's Health Insurance Plans (AHIP) since August 2014. The Collaborative is a multi-stakeholder effort working to define core measure sets of various specialties promoting alignment and harmonization of measure use and collection across both public and private payers.

Participants in the Collaborative included Centers for Medicare and Medicaid Services (CMS), the National Quality Forum (NQF), private payers, provider organizations, employers, and



patient and consumer groups. This effort exists to decrease physician burden by reducing variability in measure selection, specifications and implementation– making quality measurement more useful and meaningful for consumers, employers, as well as public and private clinicians.

With significant AAFP input, a PCMH/ACO/Primary Care Core Measure Set has been developed for primary care. The goal of this set is to decrease burden and allow for more congruence between payer reporting programs.⁴⁵

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- (AAFP) Prostate Cancer. Clinical Preventive Service Recommendation¹⁰
- AUA Guideline: Early detection of prostate cancer¹²
- American Cancer Society guideline for the early detection of prostate cancer¹³
- Diagnosis and management of benign prostatic hyperplasia²¹
- Treatment options for localized prostate cancer²²
- Primary Care of the Prostate Cancer Survivor²⁷
- Prostate cancer screening: the continuing controversy⁹
- Care of cancer survivors³⁸
- Simple tools to increase patient satisfaction with the referral process²³
- FamilyDoctor.org. Prostate Cancer | Overview (patient education)⁴⁶
- Engaging Patients in Collaborative Care Plans⁴⁷
- The benefits of using care coordinators in primary care: a case study⁴⁸
- Managing difficult encounters: understanding physician, patient, and situational factors⁴⁹
- Adding health education specialists to your practice⁵⁰
- Thinking on paper: documenting decision making⁵¹
- Clinical decision support: using technology to identify patients' unmet needs⁵²
- Exam documentation: charting within the guidelines.⁵³

References

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