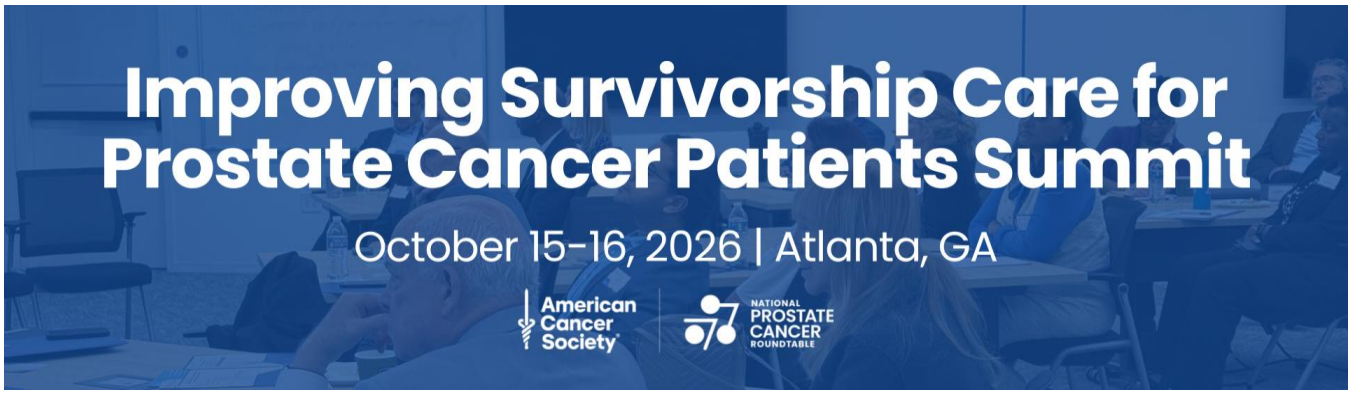


Participant Workbook

NAME

_____

MY DAY 2 QUESTION *(assigned at the close of Day 1 — check your name tent)*

_____

MY DAY 2 TABLE

_____

If found, please return to the registration desk.

1. How to use this workbook

This workbook is the connective tissue of the Summit. Day 1 takes you through four domains of prostate cancer survivorship, one at a time. By the end of Day 2 we need something different — a set of consensus statements general enough to hold across all four, written well enough for review by a wider expert panel.

The bridge between those two things is built here, by you, over the course of Day 1.

We are not relying on scribes to capture the discussion. Every participant records their own responses, and tomorrow you draft from your own pages.

Practical consequence: if you don't write it here, it is gone.

The two things that matter most

> **The grid at Section 7.** At the end of every domain discussion your facilitator will stop the conversation and give you a few minutes to fill in one column. By 5pm on Thursday you will be looking at a single page that runs across all four domains. That page is what you work from on Friday morning.
>
> **The disagreements box.** Under every question there is a box asking what you heard that you'd argue with. Please use it. Workbooks have one predictable failure mode, which is that everybody records what they already believed walking in and the genuine disagreement quietly evaporates. Knowing where this room splits is useful for drafting honest statements.

How the two days fit together

Thursday. Four domain presentations, four discussions. Capture responses and disagreements in Sections 3–6. Fill one grid column after each one. At the close of the day, you will be assigned ONE of the five framework questions and a table for Friday.

Thursday evening. Roughly twenty minutes of work. Using the template in Section 2, draft two or three consensus statements for your assigned question that hold across all four domains. Write them in Section 8. You will be copying them onto cards first thing Friday.

Friday morning. Five groups, one per question, pool and sharpen the statements down to a working consensus set. Then the whole room reads the wall, signals priority and flags anything ambiguous. Sections 8–10.

After the Summit. The statement set goes into a review and voting process with a panel wider than the people in this room. That is why wording discipline matters so much on Friday — the panel will only ever see the sentence, not the discussion behind it.

2. What makes a good consensus statement

Everything we produce on Friday needs to survive being read cold, out of context, by an expert who was not at this Summit, and be rateable on a simple agree/disagree scale. That is a narrow target, so here are some guardrails.

The template

> **[WHO]** should **[DO WHAT]** for **[WHICH SURVIVORS]** at **[WHAT TRIGGER OR INTERVAL]**, using **[WHAT METHOD]**.

Not every statement will use every slot, and research-gap statements take a different shape. But if you cannot name a WHO and a DO WHAT, you have written an observation, not a consensus statement.

Three worked examples

These are the three types we expect to produce. All three are legitimate outputs.

Practice statement

> "Primary care providers should provide annual screening for [X] to patients who receive radiation therapy as part of their prostate cancer treatment."

Names the population, the actor, the action and the window. A panellist can agree or disagree without asking a single clarifying question.

Research gap statement

> "More research is needed to identify the appropriate intervention to address [X]."

Where the evidence genuinely isn't there yet, say so rather than inventing a recommendation. Be specific about what the gap is.

System or policy statement

> "Health systems should form and maintain partnerships with [X] to streamline referrals for supportive care needs in prostate cancer patients."

Operates at the level of the organisation rather than the encounter. Often where the real barrier sits.

Four rules

- **One proposition per statement.** If a panellist could agree with the first half and disagree with the second, it is two statements.
- **No "and/or".** It is almost always two statements wearing a trench coat.
- **No unmeasurable qualifiers.** "Appropriate", "adequate", "timely", "regularly" — everyone agrees with these words and nobody agrees what they mean. Replace them with a number, a trigger, or nothing.
- **It must stand alone.** After the summit, a group wider than this room will review the draft consensus statements. If understanding the statement requires having been in the session, it will not work.

Sharpening in practice

Too vague to rate	Rateable
Survivors should have appropriate psychological support.	Every prostate cancer survivor should be screened for distress at the end of primary treatment using a validated tool, with a defined referral route for positive screens.
Sexual function is under-addressed and needs more attention.	The treating urologist should initiate a sexual function conversation before treatment begins, and document it in the survivorship care plan.
Care should be equitable across settings.	Health systems serving under-resourced populations should be able to deliver a defined minimum survivorship assessment without on-site specialist access.

Note what changes: an actor appears, the population narrows, and a trigger replaces an adverb.

3. Breakout 1: Physical Function

Cardiometabolic health, body composition, frailty and aging-related considerations.

Write as you go. Tomorrow you draft consensus statements from these pages, so anything you don't capture here is gone.

1. Monitoring Parameters

What parameters should we be monitoring? Does this differ by treatment modality (surgery, radiation, ADT)?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

2. Intervention Thresholds

At what point does a finding warrant clinical action relative to normal performance status?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

3. Provider Ownership

Who owns the physical function evaluation — oncologist, urologist, navigator, primary care? Where are the accountability gaps?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

4. Assessment Interval

How often should physical function be assessed, and how does shared decision-making shape that interval?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

5. Ideal Pathway

What does an ideal care pathway look like — and how does it differ in well-resourced vs. under-resourced settings?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

PLENARY SHARE

What is ONE insight from your small group that you want everyone else to know?

4. Breakout 2: Psychological Function

Fear of recurrence, anxiety, depression, shame and stigma.

Write as you go. Tomorrow you draft consensus statements from these pages, so anything you don't capture here is gone.

1. Monitoring Parameters

What psychological markers — fear of recurrence, anxiety, depression, shame, cognitive impairment — should be routinely screened for? Does the pattern differ by treatment type?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

2. Intervention Thresholds

At what point does a screening result warrant active clinical intervention?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

3. Provider Ownership

Who currently owns psychological screening in survivorship care — and who should? Where is the handoff between oncology, primary care and mental health breaking down?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

4. Assessment Interval

How often should psychological wellbeing be assessed? How should survivors' own preferences shape that interval?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

5. Ideal Pathway

What does an ideal psychological care pathway look like — from screening to referral to support? How does it differ in under-resourced settings?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

PLENARY SHARE

What is ONE insight from your small group that you want everyone else to know?

5. Breakout 3: Social Function — World Café

Behavioural factors, social isolation, support networks, and the role of the built environment.

This session runs differently. You will rotate through three stations, roughly ten minutes each, building on what the previous group left behind. This section is laid out by station rather than by the five questions — the stations cover the same ground, grouped differently.

Station A — Monitoring & Thresholds

What social function parameters should be routinely assessed? At what point does a finding warrant action?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES

Station B — Provider Ownership & Intervals

Who in the care team owns social function assessment — and who should? How often, and through what shared decision-making process?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES

Station C — Pathways & Equity

What does an ideal social function pathway look like? How does built environment and access change the picture in under-resourced settings?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES

> **BEFORE THE HOSTS REPORT BACK**
>
> Fill in the Social Function column of the grid at Section 7 — one line per question. Station A covers questions 1 and 2, Station B covers 3 and 4, Station C covers 5.

6. Breakout 4: Sexual Function

Erectile dysfunction, anorgasmia, libido and physical intimacy.

Write as you go. Tomorrow you draft consensus statements from these pages, so anything you don't capture here is gone.

1. Monitoring Parameters

What aspects of sexual function — ED, anorgasmia, libido, physical intimacy — should be routinely assessed? Does this differ by treatment modality?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

2. Intervention Thresholds

At what point does a finding warrant clinical intervention — who defines the threshold, and how do patient priorities factor in?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

3. Provider Ownership

Who owns the sexual function conversation — oncologist, urologist, sex therapist, primary care? Where is the handoff failing?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

4. Assessment Interval

How often should sexual function be assessed? How should shared decision-making shape that frequency?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

5. Ideal Pathway

What does an ideal sexual function pathway look like — from screening to treatment? How does access to specialists change the model?

KEY RESPONSES

DISAGREEMENTS / UNCERTAINTIES — what did you hear that you'd argue with?

PLENARY SHARE

What is ONE insight from your small group that you want everyone else to know?

7. The Synthesis Grid

Fill in one column after each domain discussion. One line per cell — this is a summary page, not a notes page, and its usefulness comes from being readable at a glance. **By Friday morning this is the page you work from.**

Read down a column and you have a domain. Read across a row and you have the beginnings of a consensus statement.

	Physical	Psychological	Social	Sexual
1. Monitoring Parameters What should be routinely assessed?				
2. Intervention Thresholds When does a finding warrant action?				
3. Provider Ownership Who owns it? Where is the handoff failing?				
4. Assessment Interval How often, and shaped by what?				
5. Ideal Pathway & Equity What does good look like, well- vs under-resourced?				

Blank cells are a signal, not a failure — a row that is empty in one domain and full in three is often the most interesting finding in the room.

8. Day 2: Your question

MY ASSIGNED QUESTION:

Thursday evening — about twenty minutes

Using the template in Section 2 p3, draft two or three consensus statements for your assigned question that hold across all four domains. Work from the grid at Section 7, reading ACROSS your row rather than down any one column.

Twenty minutes, not an hour. These are drafts, and they will be pooled with four other people's drafts in the morning. Rough and specific beats polished and vague.

Where a statement holds for three domains but not the fourth, write it anyway and note the exception. Those exceptions are useful — do not let them stop you generalising.

Draft statement 1

Holds for: ☐ Physical ☐ Psychological ☐ Social ☐ Sexual

EXCEPTION — where does it not hold, and why?

Draft statement 2

Holds for: ☐ Physical ☐ Psychological ☐ Social ☐ Sexual

EXCEPTION — where does it not hold, and why?

Draft statement 3

Holds for: ☐ Physical ☐ Psychological ☐ Social ☐ Sexual

EXCEPTION — where does it not hold, and why?

Friday morning — how the session runs

Your group works through four stages. The first two are deliberately constrained, which feels odd for about five minutes and then works.

- **Silent generation (10 min).** Copy your statements onto cards, one per card, in marker. No talking.
- **Round-robin (15 min).** Each card is read aloud and posted, one person at a time. No debate, no evaluation — including approving noises. The point is to get every statement onto the wall before any of them get argued about.
- **Clarify and cluster (15 min).** Clarifying questions only. Move near-duplicates together.
- **Redraft (25 min).** Cut, merge and sharpen to four to six statements, rewritten in final wording on fresh cards.

9. Day 2: Gallery walk

You have two red dots and two blue dots.

- **RED — highest priority.** The statement you most want to see implemented.
- **BLUE — the wording will not survive.** Ambiguous, two ideas in one, or unintelligible to someone who was not in this room.

Read the whole wall before you start placing dots. You may dot your own group's statements. Keep it silent — the moment it becomes a conversation it becomes a lobbying exercise.

Statements I want to remember

What is MISSING from the wall?

Write these on a sticky note as well — they get picked up in the plenary read-out.

10. Day 2: Moving to action

Where is the best chance of making a difference, and what would it take?

The session will brainstorm and discuss how we move toward implementation and action. Efforts will feed into the ACS Implementation Science team's work after the Summit, including a competitive grant process for pilot implementation projects. The goals for this conversation are:

- Compile short list of high-priority promising/evidence-informed interventions for PC survivorship care
- Recommendations on ideal implementation settings, grantee types, or sub-populations of interest
- Prioritization of prostate cancer survivorship domains for implementation
- Input on multi-domain efforts versus a single domain focus

You will use a separate worksheet in person so we can collect and compile generated ideas.

Feel free to make any notes here ahead of or during Friday's session:

Appendix A: The five framework questions

These anchor every discussion across both days. On Day 1 you answer them four times, once per domain. On Day 2 you answer one of them across all four.

1. Monitoring Parameters

What should be routinely assessed?

2. Intervention Thresholds

When does a finding warrant action?

3. Provider Ownership

Who owns it? Where is the handoff failing?

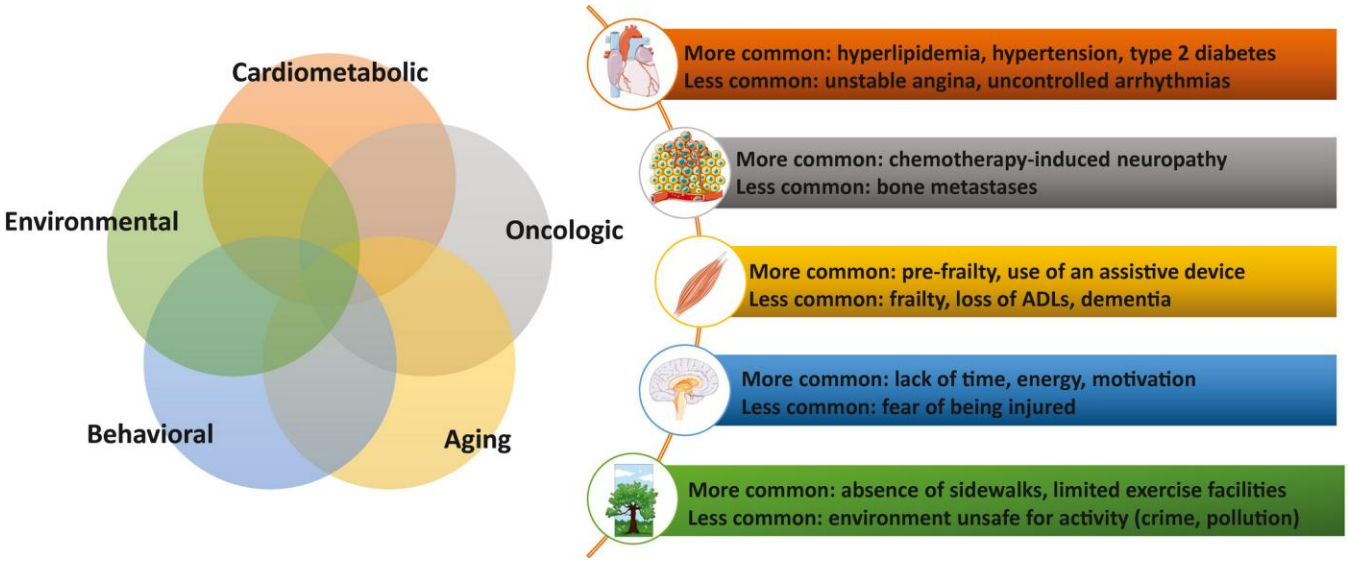
4. Assessment Interval

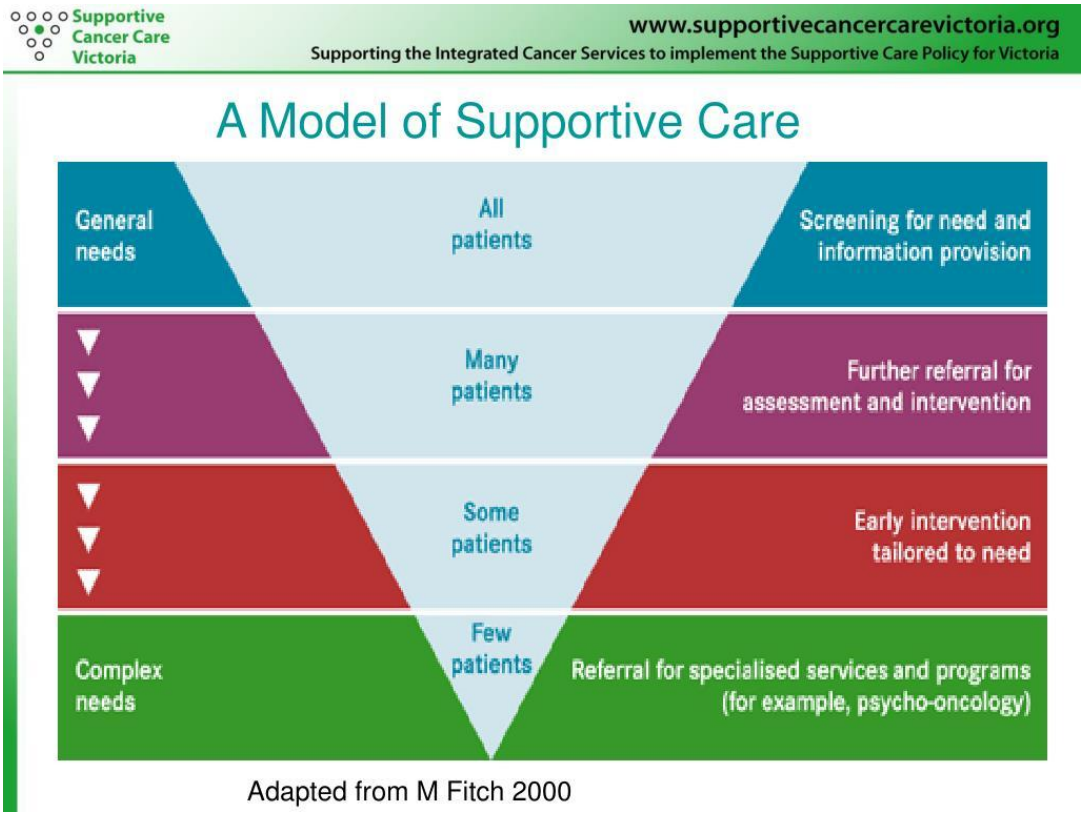
How often, and shaped by what?

5. Ideal Pathway & Equity

What does good look like, well- vs under-resourced?

Appendix B: Reference documents





A Prospective Surveillance Model for Physical Rehabilitation for Women with Breast Cancer

