

Integration of PSA Screening Pathways to Improve High-Risk Screening Rates and Reduce Low-Value Diagnostic Evaluation

Project Lead/Key Contact
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Why are you interested in the Improvement Scholars Program?
<p>As a Urologic Oncology fellow at UNC, I have taken a leadership role in developing a Rapid Access program designed to streamline the evaluation and management of patients referred with an elevated Prostate-specific antigen (PSA). This initiative has involved a comprehensive redesign of our clinic workflow, including the integration of an initial telehealth intake visit to improve accessibility and reduce delays in care. Additionally, I have worked to establish standardized clinical pathways for PSA diagnostic evaluation, refine criteria for biopsy, and implement protocols for pre-biopsy preparation. These efforts have been successful in enhancing efficiency, reducing variability in practice, and improving the patient experience.</p> <p>Despite my strong interest in quality improvement, my work in this domain has been largely self-directed, as I have not had the benefit of formal training. This gap has motivated me to seek structured opportunities to deepen my understanding of quality improvement methodologies and apply them more effectively in clinical settings. The IHQI Improvement Scholars Program represents an ideal opportunity to gain this essential training while receiving mentorship from experts. Through this program, I hope to build a strong foundation in quality improvement principles that will enable me to approach future initiatives with greater rigor and impact.</p> <p>As I transition into my role as an Assistant Professor in the Department of Urology at UNC, I am committed to embedding quality improvement into my clinical and academic work. I aspire to develop and lead future QI initiatives that not only enhance patient care within our institution but also contribute to broader efforts in advancing healthcare delivery in urologic oncology. I believe that participation in this program will equip me with the skills, knowledge, and collaborative network necessary to drive meaningful, sustainable change in patient care.</p>
Problem Statement: What is the problem you are looking to solve?
<p>Prostate-specific antigen (PSA) screening has been demonstrated to reduce mortality from prostate cancer.¹ However, PSA screening is also associated with morbidity related to overdiagnosis and overtreatment.² At UNC, nearly 75,000 PSA tests were ordered in 2024. The problem we intend to solve is the application of a one-size-fits-all threshold for elevated PSA referral, where a PSA level of >4.0 is universally flagged as "abnormal," often leading to referral. This approach does not account for age-specific PSA thresholds, or for early screening and referral of high-risk patients (based on American Urological Association guidelines i.e. Black ancestry, strong family history/genetic risk of prostate cancer, etc).</p> <p>Due to the current PSA threshold, men aged 70 and older with PSA <6.5 are frequently referred for further evaluation despite having PSA values that are likely within the normal range for their age group. Once referred, these patients may undergo additional diagnostic testing, including MRI and prostate biopsy. While MRI is costly, prostate biopsy is invasive and carries risks such as infection, bleeding, and urinary complications. Meanwhile, patients at high-risk of harboring prostate cancer with metastatic and/or lethal potential, where benefits of screening are maximized, may not be appropriately referred based on a PSA <4 despite age-specific references suggesting further diagnostic evaluation.</p> <p>Since launching our Elevated PSA Rapid Access Program in February 2024, we have seen more than 400 men with an elevated PSA, 25% of whom have been 70 years of age or older. Among these patients, more than half are referred with a PSA <6.5. For men with a PSA <6.5, 40% ultimately undergo no additional testing, suggesting an unnecessary visit which is often associated with anxiety and costs incurred by the patient. Amongst men that do proceed to further diagnostic testing, 60% undergo MRI and 35% have proceeded to prostate biopsy. However, only a small fraction (<10%) were diagnosed with prostate cancer that ultimately required treatment. This highlights the inefficiency and potential harm associated with the current schema.</p>

Importance Statement: Why is this project important?

The development of clinical pathways to guide primary care providers in determining which patients should be referred for additional testing is critical to optimizing prostate cancer screening. **The proposed project aims to improve the selection of patients at risk for clinically significant prostate cancer that may require intervention while minimizing unnecessary diagnostic procedures, including MRI and biopsy.** By embedding support tools in the electronic health record (EHR), an evidence-based clinical pathway for managing elevated PSA can be accessed easily by primary care providers during a patient visit.³ By integrating an evidence-based clinical pathway, incorporating age-specific PSA referral thresholds and guidance regarding the identification and approach to high-risk patients, this project will reduce the number of unnecessary procedures performed on older men with PSA <6.5. Furthermore, optimizing referral criteria will improve access to urologic care by prioritizing patients at higher risk for clinically significant prostate cancer.

The primary concern in raising the PSA threshold for referral in older men is the potential to miss a small number of prostate cancers that may require treatment. However, this risk may be mitigated by the long lead time associated with prostate cancer progression, allowing for later diagnostic workup if PSA levels continue to rise. There is strong evidence supporting the use of age-specific PSA thresholds to improve prostate cancer screening and referral practices.⁴ A comparative effectiveness analysis demonstrated that increasing the PSA threshold for referral among older men maintained similar prostate cancer mortality risk reduction while significantly reducing overdiagnosis.⁵ **The American Urological Association (AUA) guidelines endorse a PSA threshold of >6.5 for additional diagnostic evaluation in men aged 70 and older, and suggest lower PSA thresholds for younger men, including those at high-risk, reinforcing the validity of this approach.**⁶ Implementing this aligns with best practices in prostate cancer screening and risk stratification.

This project aligns with key organizational priorities, including reducing unnecessary procedures, optimizing resource utilization, and improving access to care for high-risk patients. By providing clinical pathways embedded in the electronic health record that clarify referral criteria, we can decrease the number of low-value interventions while ensuring that patients at the highest risk receive timely and appropriate evaluation. **This approach supports broader organizational goals of enhancing healthcare equity while reducing unnecessary procedures and overall healthcare costs.**

A similar initiative was implemented at Duke Health, where a clinical decision support tool was embedded within the electronic health record to guide appropriate PSA screening. This intervention improved guideline-concordant screening, leading to higher screening rates among high-risk populations while reducing unnecessary PSA testing in low-risk groups.⁷ The success of this model suggests that a structured clinical pathway, integrated within the healthcare system, can effectively optimize prostate cancer screening practices and improve patient outcomes. This effort is supported by the UNC Department of Urology, including mentors Dr. Matthew Nielsen and Dr. Hung-Jui Tan, as well as physician leaders in Primary Care including Dr. Tamara Godfrey and Dr. Anisha Ganguly. Further, this project also aligns with UNC's Forward Together 2030 initiative, which aims to support the integration of clinical pathways into the EHR.

Project Scope

Prostate cancer is a significant health concern in the United States, with notable disparities affecting Black men. Approximately 1 in 8 men will be diagnosed with prostate cancer during their lifetime, equating to a lifetime risk of about 12.8%.⁸ This risk is elevated in Black men, with estimates indicating that 1 in 6 will develop the disease, highlighting a substantial disparity.⁹

In North Carolina, the impact of prostate cancer is pronounced, particularly among Black men. **North Carolina reports an average of 124 new prostate cancer cases and 20 deaths per 100,000 men annually,** based on data from 2016 to 2020 (**FIGURE 1**). North Carolina ranks 11th nationwide for new prostate cancer cases and 20th for prostate cancer-related deaths, making it the second leading cause of cancer death among men in the state, following lung cancer. Black men in North Carolina are disproportionately affected, being 1.7 times more likely to be diagnosed with prostate cancer and 2.3 times more likely to die from the disease compared to their white counterparts.¹⁰

This project will focus on male patients aged 40 years and older who are considered to be at risk for prostate cancer. This includes both average-risk individuals and those with identified risk factors (e.g., family history, race/ethnicity, genetic predispositions) presenting to primary care clinics within the health system. There were 75,000 PSA laboratory tests ordered at UNC Health in 2024, while there were nearly 20,500 outpatient visits wherein an elevated PSA was listed as the primary problem. At present, the Department of Urology at UNC Medical Center receives nearly 800 new referrals for elevated PSA annually.

The project will be implemented across the outpatient primary care clinics within the health system. These clinics serve as the primary entry point for prostate cancer screening and longitudinal management of preventive care in adult men. The decision to refer a patient for additional diagnostic testing occurs in this setting. A clinical decision support pathway can be integrated for use across the UNC Health system.

Measures: (Process, Balancing, Structure)

Measure Name	Measure Type	Measure Calculation	Measure Exclusion	Data Source	Baseline	Goal	Collection Frequency
% of PSA referrals meeting age/risk-adjusted thresholds	Outcome	% of urology referrals for elevated PSA that meet age- and risk-specific thresholds	None	EHR-derived dataset from Elevated PSA Rapid Access Program	87% (13% inappropriately referred)	Increase to >95% appropriate referrals	Weekly
% of biopsied patients with clinically significant prostate cancer	Outcome (Secondary)	% of referred patients with biopsy showing Gleason Grade Group ≥ 2	Patients not undergoing biopsy	Manual EHR extraction	40%	Maintain or increase >40%	Weekly
Utilization rate of the decision support tool	Process	% of PSA test results for which the tool was accessed	None	EHR logs / audit trails	Not currently available	>75% utilization	Monthly
Rate of appropriate referral with tool use	Process	% of referrals deemed appropriate when tool was used	None	EHR logs + referral data	TBD (post-implementation)	Improvement over baseline	Monthly
% of men <55 with negative biopsy post-referral	Balancing	% of younger men (<55) undergoing biopsy with negative (benign) pathologic findings.	Patients ≥ 55	Manual chart review / biopsy data	13%	Maintain or reduce <13%	Weekly

***Pre-implementation data has been collected for 14 months (>500 patients) at the time of this application

Root Cause Analysis

The current approach to prostate-specific antigen (PSA) screening in primary care is multifactorial. Contributors likely include the one-size-fits-all model that defines a PSA value >4.0 ng/mL as abnormal, changes in the United States Preventive Services Task Force (USPSTF) screening recommendations, and systemic factors.

The universal flagging of PSA values >4.0 ng/mL as abnormal creates pressure on providers to refer all such patients for urologic evaluation. This is particularly problematic for older men (age >70), where evidence suggests that a higher threshold (>6.5 ng/mL) is more appropriate due to increased baseline PSA levels and the lower likelihood that screening will impact survival. Conversely, in younger men (age <50), especially those at higher risk (e.g., Black men or those with a family history of prostate cancer), a lower PSA threshold (e.g., >2.5 ng/mL) may warrant earlier evaluation, yet these patients are often missed because their values fall below the standard lab threshold. This mismatch between evidence-based stratification and laboratory flagging contributes to both over-referral and under-referral patterns.

The attitude toward PSA screening has shifted significantly over the past decade, largely influenced by changes in the USPSTF recommendations. In 2012, the USPSTF issued a Grade D recommendation, advising against routine PSA screening due to concerns about overdiagnosis and overtreatment.¹¹ This led to a reduction in screening rates and a reflexive increase in the number of men presenting with metastatic disease.¹² In 2018, the recommendation was revised to a Grade C for men aged 55–69,

encouraging individualized decision-making and shared conversations between patients and providers.¹³ This fluctuation has led to inconsistent screening practices and uncertainty among primary care providers about when and how to screen appropriately.¹⁴

Primary care providers are often burdened with a wide range of clinical responsibilities. As a result, they may have limited time to engage in nuanced conversations about prostate cancer risk, PSA interpretation, and the benefits and harms of screening.¹⁵ Clinical decision support pathways represent an opportunity to provide evidence-based management strategies at the point of care, facilitating consistent, optimal management.

Ideas for Improvement

The central idea for improvement is the development and integration of an evidence-based clinical decision support pathway into the EHR to guide primary care providers in triaging patients with elevated PSA levels (**FIGURE 2**). This tool will incorporate age-specific PSA thresholds, such as suggesting a higher PSA threshold (>6.5 ng/mL) to trigger referral to urology for men over 70. This will help providers identify younger men (<50) with an age-specific elevated PSA, as well as high-risk individuals, for referral. By embedding this clinical pathway within the EHR, **providers will receive real-time, patient-specific guidance at the point of care, reducing variability in PSA interpretation and minimizing both over-referral of low-risk patients and under-referral of high-risk patients.**

Notably, AgileMD, an EHR-integrated clinical decision support platform, has already been utilized to draft a pathway for the evaluation of elevated PSA, incorporating evidence-based, age-specific referral thresholds and high-risk patient identification criteria. This pathway is currently in the midst of institutional review and approval for formal integration into the electronic health record, significantly enhancing the feasibility of this quality improvement project. With the foundational infrastructure already in place and nearing deployment, the project is well-positioned to leverage this platform to guide provider decision-making in real time. The anticipated go-live timeline aligns well with the proposed one-year project period, allowing sufficient time for implementation, provider engagement, and data collection to assess the impact of the pathway on prostate cancer screening and referral practices.

In addition to a clinical decision support pathway, a future project could aim to assess the impact of changing the laboratory referent value, providing age-specific abnormal flags, on the appropriateness of referral to urology for additional diagnostic evaluation.

Risks and Opportunities

Several key factors are expected to foster improvement. The use of age-specific PSA thresholds and risk-stratified referral criteria is well-supported by current clinical guidelines, including those from the American Urological Association.⁶ Similar efforts, such as the PSA decision support tool implemented at Duke Health, have demonstrated success in improving guideline-concordant care.⁷ These models provide both a proof of concept and valuable implementation insights. This strong foundation in evidence-based practice increases provider confidence in the changes and supports adoption. In addition, embedding the clinical algorithm directly into the electronic health record ensures that guidance is accessible at the point of care. This seamless integration into existing workflows reduces reliance on memory or external resources and encourages consistent use. Furthermore, the project is supported by leadership in both urology and primary care, including faculty mentors and departmental champions. This collaboration fosters shared ownership, enhances implementation across specialties, and increases provider buy-in. Similarly, the project aligns with broader organizational priorities, such as reducing low-value care, optimizing resource utilization, and improving health equity, as outlined in UNC's *Forward Together 2030*. Alignment with institutional goals facilitates support and resource allocation. Lastly, ongoing provider education and performance feedback will help reinforce adoption and continuous improvement, allowing for iterative refinement of the tool and processes based on real-world use.

A critical challenge will be ensuring that primary care providers are both aware of and comfortable using the new tool. Given their limited time during patient visits, it will be important to emphasize the efficiency and value of the tool in guiding PSA triage without adding burden. Additionally, the tool must be integrated smoothly into their workflows, acknowledging that the traditional PSA >4 flag will continue to appear in the EHR. Therefore, fostering buy-in from providers and supporting them through training and ongoing feedback will be essential to encourage consistent and effective usage. We anticipate that engagement from project stakeholders in primary care, Dr. Godfrey and Dr. Ganguly, will impact uptake.

Stakeholders and Project Team Members

We believe that one of the key strengths of our proposal lies in the strong multidisciplinary support and engagement from leadership within the Departments of Urology and Internal Medicine.

Dr. Zachary Feuer, MD, a current Urologic Oncology fellow, who will transition into the role of Assistant Professor in the Department of Urology in July 2025, will serve as Project Lead. Dr. Feuer led the development and implementation of the Elevated PSA Rapid Access Program at UNC to improve the timeliness of prostate cancer diagnosis. In this capacity, he has overseen the standardization of the prostate cancer diagnostic pathway, improving diagnostic yield, reducing unnecessary procedures, and streamlining processes to increase procedural efficiency. He drafted the initial AgileMD clinical decision support pathway for PSA Screening. **Dr. Hung-Jui Tan, MSHPM**, Director of Urologic Oncology at UNC, brings deep expertise in prostate cancer care and quality improvement, having played a central role in the development and implementation of the GU Rapid Access pathway for elevated PSA. He has significant experience in quality improvement as he serves on the Advisory Committee for the Prostate MR Image Quality Improvement Collaborative and has been instrumental in expanding the Michigan Urologic Surgery Improvement Collaborative (MUSIC) to UNC, marking it as the first external affiliate site. He will serve as the project Sponsor. **Dr. Matthew Nielsen, MD**, Chair of the Department of Urology, brings a wealth of experience in quality improvement initiatives across various institutions and has previously held the role of associate director at the UNC Institute for Healthcare Quality and Improvement (IHQI). He serves as Chair of the American Urological Association Science and Quality Council. He has been intimately involved in the development of the AgileMD clinical decision support pathway. He will serve as a subject matter expert in the design and implementation of this project.

On the primary care side, **Dr. Tamara Godfrey, MD**, Assistant Professor in the Department of Medicine, Division of General Medicine and Clinical Epidemiology, with a particular focus on equitable access to care, has been the physician champion in the development of the clinical decision support pathway to ensure smooth integration into primary care practice. She will remain involved in the implementation of dissemination of the support tool across the UNC Health system and will serve as a co-sponsor. **Dr. Anisha Ganguly, MD, MPH**, an Assistant Professor in the Department of Medicine, is an advocate for evidence-based prostate cancer screening and health equity, and will serve as an additional stakeholder in the successful implementation of this initiative.

Finally, **Joseph Vionito, MBA**, a senior analyst has supported data infrastructure for the GU Rapid Access clinic and will be available to support data collection and performance tracking throughout the project. He will serve as the Data Lead for the proposed project. The collaboration and commitment from these leaders across specialties significantly enhances the feasibility, scope, and sustainability of the proposed quality improvement initiative.

Impact on the Quintuple Aim

This quality improvement initiative directly supports the Quintuple Aim by optimizing prostate cancer screening through the integration of an evidence-based clinical pathway into the EHR. By refining PSA referral thresholds based on age and risk factors, the project will **improve patient health outcomes** by facilitating earlier identification and evaluation of high-risk individuals while minimizing overdiagnosis and overtreatment in those unlikely to benefit. The **reduction of unnecessary procedures** such as MRIs and biopsies **enhances the patient experience** by decreasing harm, anxiety, and inconvenience associated with low-value testing.

For clinicians and staff, the embedded decision support tool **streamlines workflow** and alleviates the cognitive and time burden of interpreting PSA results during busy primary care visits, leading to a **more satisfying and efficient practice environment**. The project also **promotes health equity** by ensuring that high-risk populations, such as Black men and those with a family history of prostate cancer, are more reliably identified and referred for appropriate care. Finally, by avoiding unnecessary diagnostic testing and prioritizing referrals for those most likely to benefit, the **intervention supports cost reduction across the system**, aligning with broader institutional goals of value-based care and optimal resource utilization.

Sustainment Plan

Sustainability is a critical consideration of this project, and several key factors will support ongoing improvement beyond the project's initial implementation. Most importantly, the clinical decision support pathway will remain embedded within the EHR, ensuring that the age- and risk-specific PSA referral guidance continues to be available to primary care providers at the point of care. Because the tool is integrated into the routine workflow, it does not rely on external resources or temporary interventions, making it inherently sustainable.

In addition, this project aligns directly with the *Forward Together 2030* initiative, which prioritizes the development and integration of clinical pathways and decision support tools across the institution. This alignment ensures continued institutional investment in maintaining and refining the tool over time. As the EHR evolves, the decision support infrastructure will be preserved

and updated as needed, supported by ongoing collaboration between clinical leaders, IT teams, and quality improvement stakeholders. Collectively, these efforts will help embed improved PSA screening practices into the fabric of routine primary care, leading to durable improvements in patient outcomes and resource utilization.

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FIGURE 1: New Prostate Cancer Diagnoses and Deaths from Prostate Cancer in North Carolina

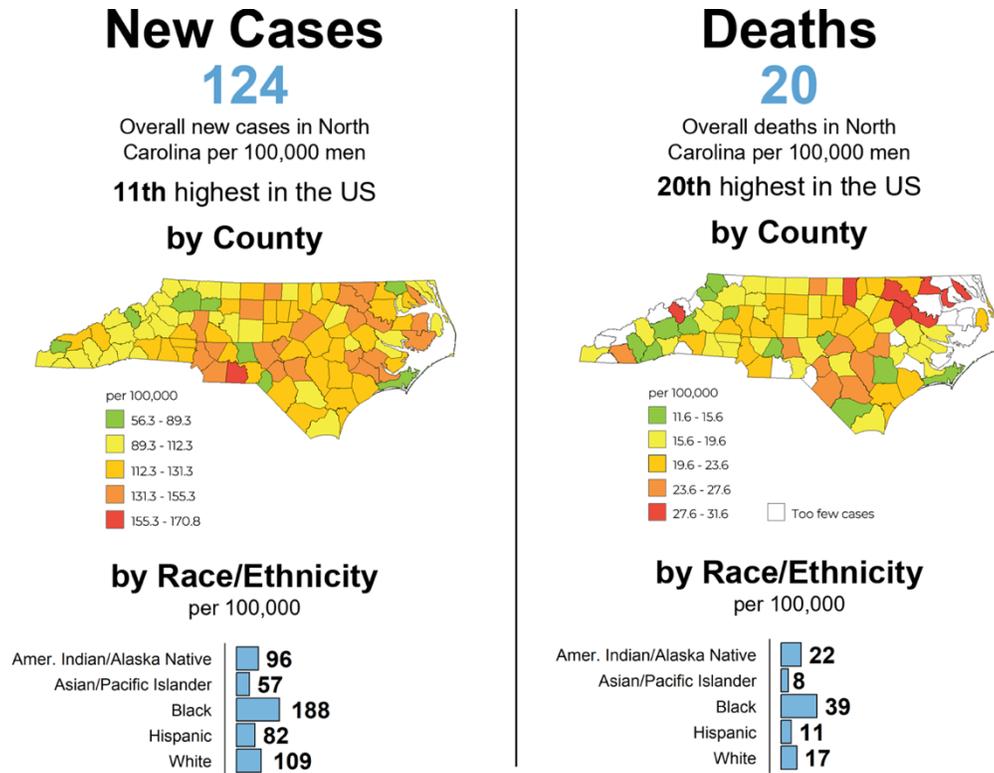
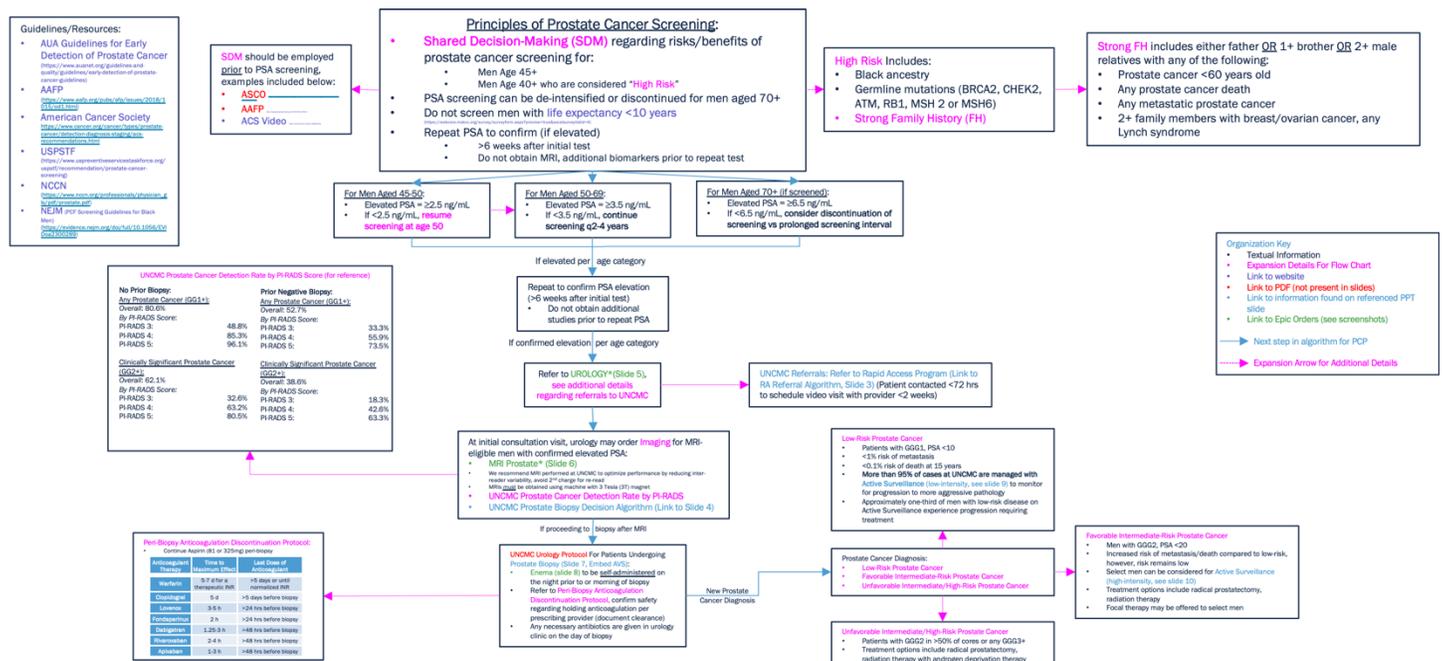


FIGURE 2: Proposed EHR-Integrated Clinical Decision Support Pathway for PSA Screening



Hung-Jui Tan, MD, MSHPM
Associate Professor of Urology
Director of Urologic Oncology

April 11, 2025

Re: IHQI Scholars Program

Dear Review Committee,

I write today to enthusiastically support Dr. Zachary Feuer's application for the UNC Institute for Healthcare Quality and Improvement (IHQI) Scholars Program. As outlined in his application, Dr. Feuer is a thoughtful and dedicated urologist with a clear commitment to advancing quality improvement in prostate cancer care. He brings valuable clinical insight and institutional engagement to this effort despite the fact that his training in quality improvement has been mostly self-taught. Participation in the IHQI Scholars Program would provide him with the mentorship, tools, and structure to build on his clinical expertise and lead sustainable, system-wide improvements.

Dr. Feuer has led the development and implementation of the Elevated PSA Rapid Access Program. This project stemmed from a recognized need to streamline the diagnostic pathway for patients with elevated PSA levels, which previously lasted as long as 6 months from referral to diagnosis. His proposed IHQI project addresses a critical gap in the current prostate cancer screening paradigm—the reliance on a uniform PSA threshold of >4 ng/mL for referral—which fails to account for age-specific and risk-based variation in prostate cancer risk. This has led to both over-referral of older men unlikely to benefit from further workup and under-referral of high-risk younger men, particularly African American men and those with a family history. Dr. Feuer proposes an evidence-based solution through the implementation of a clinical decision support algorithm embedded within the electronic health record (EHR), guiding primary care physicians on age-specific PSA thresholds and referral criteria.

Importantly, this project builds on existing infrastructure and quality improvement efforts. In addition to the Rapid Access Program, we have created a clinical pathway for PSA screening for PCPs as part of UNC's AgileMD initiative, which would be an EPIC-integrated platform for decision support. This along with ongoing engagement work through UNC Health and Lineberger Comprehensive Cancer Center make this project highly feasible within the scope of the IHQI program. With the support of mentors from both urology and primary care, Dr. Feuer is well-positioned to implement, evaluate, and refine this intervention to ensure it is both clinically impactful and scalable.

Dr. Feuer's work aligns strongly with institutional priorities, including reducing unnecessary procedures, improving access for high-risk populations, and advancing health equity. I am committed to his success and will ensure that he has protected time to pursue this important work, including full participation in IHQI meetings and just-in-time training sessions. I hope you will give this outstanding proposal your highest consideration, as I believe it holds real potential to improve patient care, enhance provider decision-making, and serve as a model for future clinical pathway implementation across the health system.

Sincerely,



Hung-Jui Tan, MD, MSHPM

