The U.S. Preventive Services Task Force and Improving Prevention in Primary Care

Ann Kurth, PhD, CNM
USPSTF member 2014-2018
Dean, Yale School of Nursing

NaRCAD Conference, Boston
November 14, 2016

U.S. Preventive Services TASK FORCE

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U.S. Preventive Services TASK FORCE

Disclaimer

I am making this presentation on behalf of the U.S. Preventive Services Task Force (USPSTF). Some views I express, however, may not reflect the process and recommendations of the USPSTF. For the current findings and recommendations of the USPSTF, please see: www.uspreventiveservicestaskforce.org.

USPSTF Recommendation Use: Manual Vote

- How many of you use USPSTF recommendations regularly in your setting?
  - Primarily?
  - As one of many sources?
- Throughout talk please think about challenges & opportunities for guideline D & I
  - Will do final wrap-up Q+A of about 5 minutes that focuses on the 'how to' issues

Overview

The U.S. Preventive Services Task Force…

- Makes recommendations on clinical preventive services to primary care clinicians
  - The USPSTF scope for clinical preventive services include:
    - screening tests
    - counseling
    - preventive medications
  - Recommendations address only services offered in the primary care setting or services referred by a primary care clinician.
  - Recommendations apply to adults & children with no signs or symptoms (or unrecognized signs and symptoms)

Overview, cont'd.

The U.S. Preventive Services Task Force…

- Makes recommendations based on rigorous review of existing peer-reviewed evidence
  - Does not conduct the research studies, but reviews & assesses the research
  - Evaluates benefits & harms of each service based on factors such as age & sex
- Is an independent panel of non-Federal experts in prevention & evidenced-based medicine
- Does not address issues covered by ACIP and Community Task Force

USPSTF Members

- The 16 volunteer members represent disciplines of primary care including family medicine, internal medicine, nursing, obstetrics/gynecology, pediatrics, and behavioral medicine
- Led by a Chair & Vice Chairs
- Serve 4-year terms
- Appointed by AHRQ Director with guidance from Chair & Vice Chairs
- Undergo a rigorous review of potential conflicts of interest
- Current members include deans, medical directors, practicing clinicians, and professors
    - http://www.uspreventiveservicestaskforce.org/members.htm

AHRQ's Support of the Task Force

- AHRQ's Mission: to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within U.S. Department of Health and Human Services and other partners to make sure evidence is understood and used
- AHRQ provides administrative, scientific, technical, and dissemination support to the USPSTF
- While AHRQ provides support to the USPSTF, it is important to note that the USPSTF is an independent entity

USPSTF Recommendation Development Process

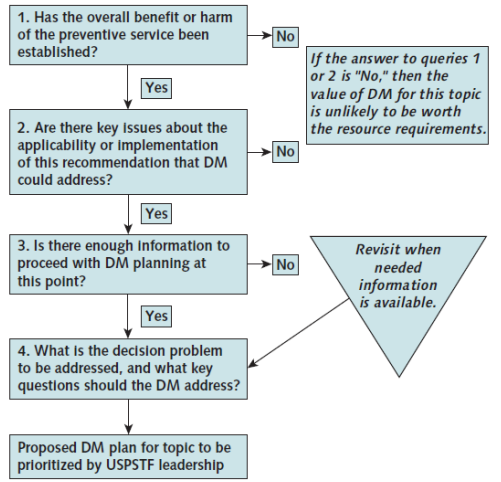
- Rigorous 4-stage recommendation development process:
  - Topic nomination
  - Draft and final research plans
  - Draft evidence review and recommendation statement
  - Final evidence review and recommendation statement
- 4-week public comment period on all draft materials
- Consult with subject matter experts
- Procedure Manual available under Methods and Processes at: http://www.uspreventiveservicestaskforce.org

Engaging the Public

- Since 2009, the Task Force has focused on making its work more transparent so that stakeholders and the public better understand and have more confidence in the approach of the Task Force.
- Ensures that its work is open, credible, independent, and unbiased, and is recognized as such.
- By expanding opportunities for the public and stakeholders to engage in the process, the Task Force believes that its recommendations will be more accurate and relevant.
- Currently the public can:
  - nominate new members for the Director to AHRQ's consideration
  - suggest new topics for consideration by the Task Force
  - provide comments on draft research plans and draft evidence reviews and draft recommendation statements.
  - All comments received concerning draft documents are reviewed by the Task Force and used to revise the final documents.

Use of Modeling by the USPSTF

- Task Force uses modeling only when there is evidence of benefit of a preventive service on health outcomes
- Models may integrate sufficient evidence across an analytic framework (AF)
- Not used to bridge a gap in the AF where evidence is insufficient by using assumptions or unreliable data
- Determine when to start, how long to continue, how frequently to repeat the service, and appropriate choices among different screening options
- Past or current topics with modeling:
  - Cervical cancer screening
  - Colorectal cancer screening
  - Lung cancer screening
  - Breast cancer screening
  - Aspirin for CVD and cancer prevention



Wolf, AHRQ '16

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Framework for determining whether modeling will be added to topics

1. Has benefit for this clinical preventive service been established?
2. Are the primary reasons for adding decision modeling important to address for this clinical preventive service?
3. Is the information gained from modeling or reviewing existing models likely to be worth the opportunity cost of modeling?
4. Can the desired modeling approach be clearly outlined, or is it contingent on additional information not known at the outset of the systematic review?
5. What is the decision problem/objective to be addressed through decision modeling?
6. What is the most expedient approach for needed decision modeling?

Wolf, AHRQ '16

Use of Modeling by the USPSTF

Previous Recommendation			Purpose of Using Model-Based Analyses	Most Recent Recommendation			Incorporation of Modeling Results in Recommendation
Topic	Year	Grade		Year	Grade	Reference	
Colorectal cancer	2008	A recommendation	Assess screening method (e.g., colonoscopy, fecal occult blood test, and sigmoidoscopy) Assess ages at which to begin and end screening Assess screening interval	2016	A recommendation (C for ages 76–85 y)	1	Modeling identified sigmoidoscopy alone as the strategy with the least benefits. Caution added to recommendations.
Breast cancer	2009	B recommendation	Assess ages at which to begin and end screening Assess screening interval Assess potential benefits	2016	B recommendation (C for ages 40–49 y)	2	Modeling was useful in understanding benefits and harms of different screening intervals and starting ages.
Cervical cancer	2003	A recommendation	Assess screening interval Assess ages at which to begin and end screening Assess screening method (human papillomavirus testing, human papillomavirus and cytology testing, and liquid-based vs. conventional cytology)	2012	A recommendation (D for ages <21 y and >65 y)	3	Modeling was useful in comparing alternative screening strategies; it helped to identify cotesting with the human papillomavirus test every 5 y as an effective option.
Lung cancer	2004	I statement	Assess ages at which to begin and end screening Assess screening interval (1, 2, or 3 y) Assess eligibility for screening (pack-years of smoking history or years since quitting) Assess eligibility to stop screening (years since quitting)	2013	B recommendation for adults aged 55–80 y with a 30-pack-year smoking history and who currently smoke or have quit within the past 15 y	4	Modeling informed choice of criteria for screening (starting and stopping ages, years of smoking, and years since last smoked).
Aspirin use for the primary prevention of cardiovascular disease and colorectal cancer*	–	–	Integrate varying benefits and harms for subpopulations on the basis of risk prediction for cardiovascular disease Assess ages at which to begin aspirin use Integrate evidence on cardiovascular disease and prevention of colorectal cancer	2016	B recommendation for adults aged 50–59 y with a 10-y risk for cardiovascular disease ≥10% (C for ages 60–69 y)	5	Modeling was useful in estimating net benefit by age and sex; it informed age stratification and corresponding grades.

Owens et al. ‘16

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Subpopulations

- Developing a framework for USPSTF **approach** to subpopulation recommendations
  - Heterogeneity (different sources and dimensions)
  - How to approach subpopulations in entire USPSTF process of evaluating evidence;
  - When to call out subpopulations in USPSTF recommendations (within the current USPSTF framework for evaluating certainty and magnitude of net benefit).
- Subgroups defined by risk
- Refinement of processes for USPSTF recommendations on pregnant women

Wolf, AHRQ '16

Institute of Medicine Standards for Guideline Development

Standards for Developing Trustworthy Clinical Practice Guideline (CPG)	USPSTF Compliance with Standard
Establishing transparency	Meets All Standards
Management of conflicts of interest	Meets All Standards
Guideline development group composition	Substantially Meets Standards
CPG and systematic review intersection	Meets All Standards
Establishing evidence foundations for and rating strength of recommendations	Meets All Standards
Articulation of recommendation	Meets All Standards
External review	Meets All Standards
Updating	Meets All Standards

Gillman '16

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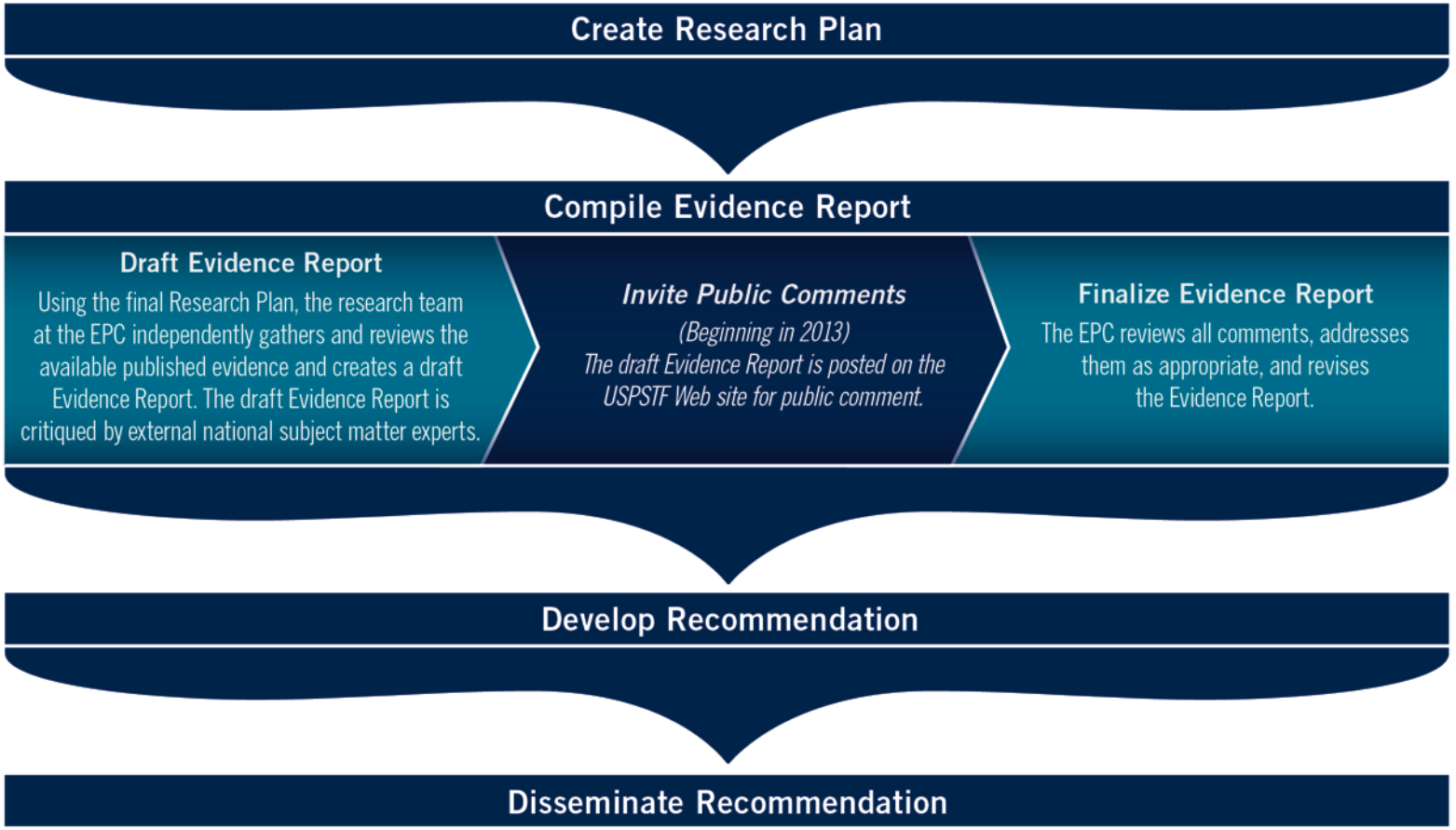
Steps the USPSTF Takes to Solicit Public Input and Make a Recommendation

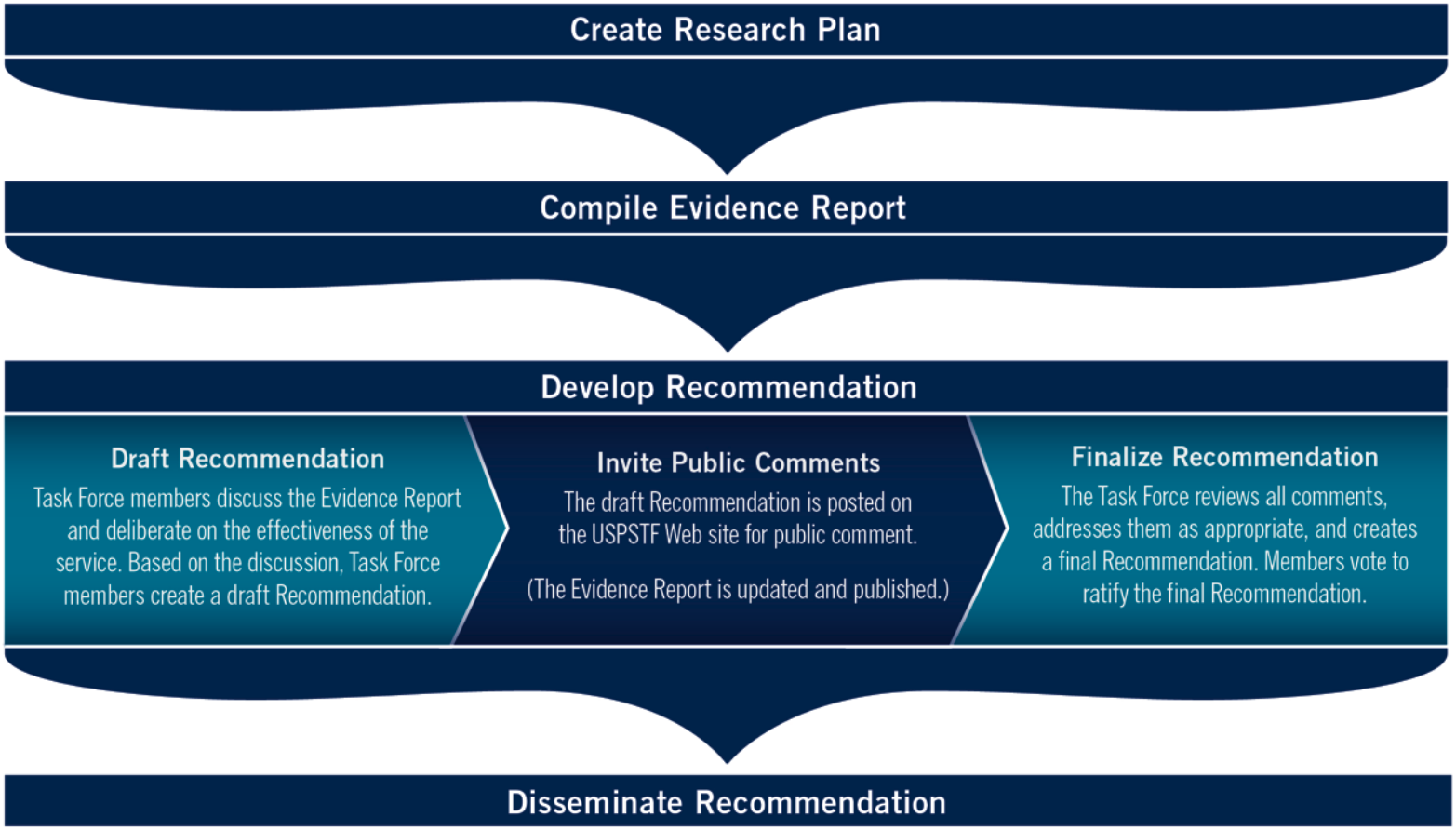
- Anyone can nominate a topic for the USPSTF to consider via its website http://www.uspreventiveservicestaskforce.org/tftopicnon.htm

Steps the USPSTF Takes to Solicit Public Input and Make a Recommendation: Step 1

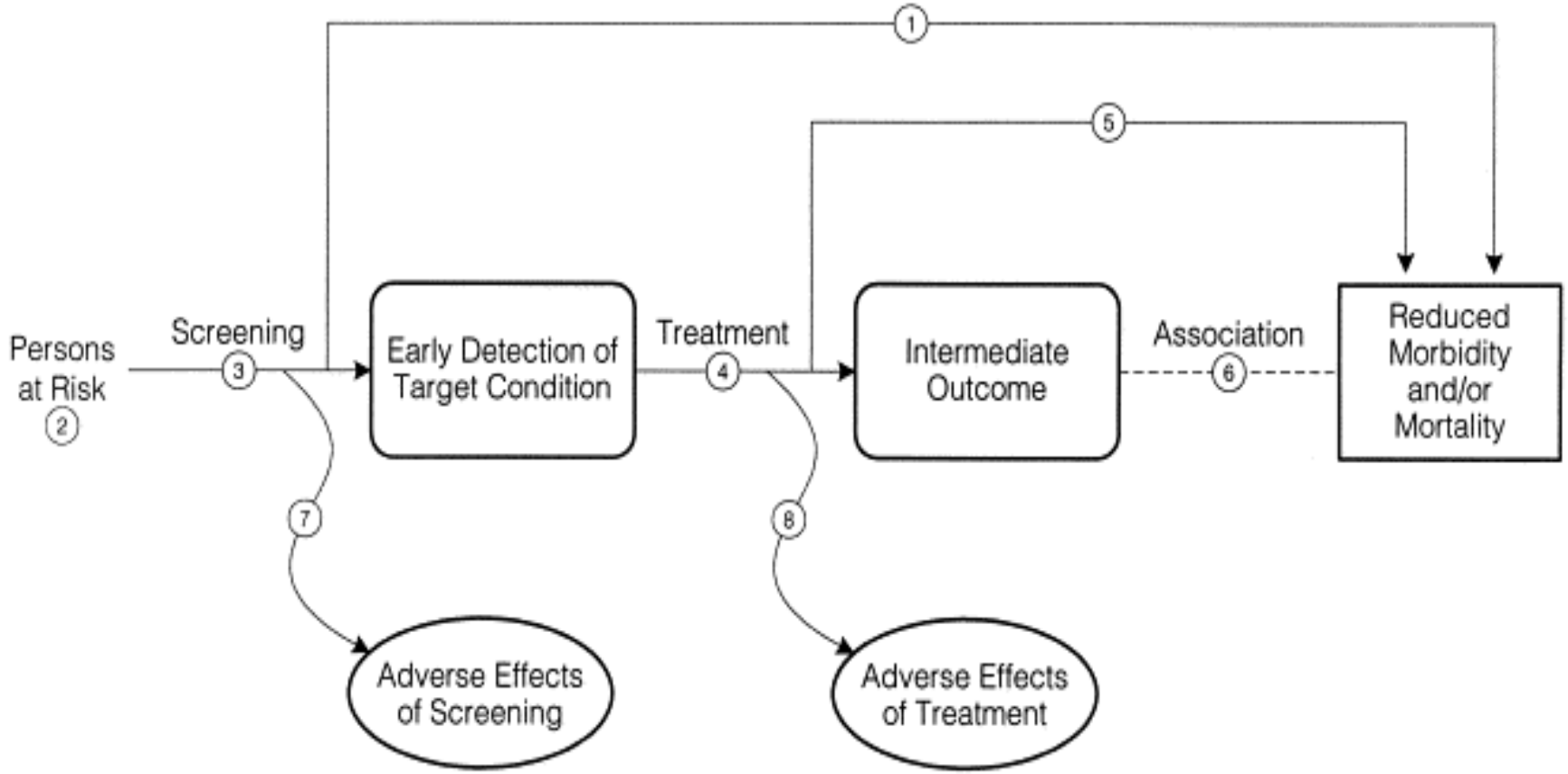
Steps the USPSTF Takes to Solicit Public Input and Make a Recommendation: Step 2



Steps the USPSTF Takes to Solicit Public Input and Make a Recommendation: Step 3



Analytic Framework on Screening for a Disease: What Evidence Do We Seek?



The USPSTF Steps: Brief and Generic

- Assess the evidence across the analytic framework, synthesizing the assessment of each key question:
  - Judge the ***certainty*** of the estimate of benefits and harms
  - Judge the ***magnitude*** of both benefits and harms
  - Determine and judge the *balance* of benefits and harms: the ***magnitude of net benefit***
- When evidence is not sufficient (low certainty), the USPSTF does not use “expert opinion”

Recommendation Grades

Certainty of net benefit	Magnitude of net benefit			
	Substantial	Moderate	Small	Zero/Negative
High	A	B	C	D
Moderate	B	B	C	D
Low	I – Insufficient Evidence			

Recommendation Grades

Letter grades are assigned to each recommendation statement. These grades are based on the strength of the evidence on the harms and benefits of a specific preventive service. http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm

Grade	Definition
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

Recommendation Grades

U.S. Preventive Services Task Force (USPSTF) Grade Definitions and Examples of Services in Each Category.

Grade	Definition	Examples
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Screening for HIV infection in adolescents and adults 15–65 yr of age Screening for high blood pressure in adults ≥18 yr of age
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Annual screening for lung cancer with low-dose computed tomography in adults 55–80 yr of age with a 30 pack-yr smoking history who currently smoke or have quit within the past 15 yr Behavioral counseling to promote a healthful diet and physical activity for prevention of cardiovascular disease (CVD) in adults who are overweight or obese and have additional CVD risk factors
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Behavioral counseling to promote a healthful diet and physical activity for prevention of CVD in the general adult population without a known diagnosis of hypertension, diabetes, hyperlipidemia, or CVD* Low-dose aspirin use for the primary prevention of CVD and colorectal cancer in adults 60–69 yr of age who have a 10% or greater 10-yr risk for CVD
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Prostate-specific-antigen–based screening for prostate cancer in men* Routine screening of asymptomatic adolescents for idiopathic scoliosis*
I statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Screening for autism spectrum disorder (ASD) in children 18–30 mo of age for whom no concerns of ASD have been raised by their parents or a clinician Screening for lipid disorders in children and adolescents ≤20 yr of age

* This topic is in the process of being updated.

Johns & Bayer ‘16

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Evidence-Based Clinical Prevention in the Era of the Patient Protection and Affordable Care Act

- The passage of the ACA has not influenced the methods or evidence thresholds USPSTF uses to assign an A, B, or any letter grade, nor does USPSTF consider coverage implications when making recommendations.
- USPSTF maintains that the science on effectiveness of preventive services should help to inform coverage decisions
- Also maintains that the linkage between USPSTF recommendations and the ACA coverage mandate sets a minimum standard for coverage of preventive services.
  - A and B recommended services are a floor, rather than a ceiling, on coverage of preventive services

Evidence-Based Clinical Prevention in the Era of the Patient Protection and Affordable Care Act

- Services graded other than A or B, the ACA does not prohibit full or partial insurance coverage
    - The law states that "nothing in this subsection shall be construed to prohibit a plan or issuer from providing coverage for services in addition to those recommended by USPSTF or to deny coverage for services that are not recommended by the Task Force." Thus, payers can offer full or partial coverage for preventive services graded other than A or B. Patients and their clinicians may choose preventive services they deem appropriate, even those without A and B grades
- Some have misinterpreted USPSTF grades of C or I as recommendations against screening or even against coverage. This is not the intent of USPSTF
- A C grade is still a positive recommendation that recognizes small net benefit, and the USPSTF recommends that clinicians offer C-rated services to patients after considering the presence of patient risk factors, patient preferences, local disease prevalence, and availability of services

Topic Updates

- In accordance with the Affordable Care Act, the Task Force aims to update topics every 5 years in order to keep its recommendations current. Current topics that are approaching 5 years since the last recommendation and newly nominated topics are prioritized for review. Topics are prioritized based on:
  - Public health importance (burden of suffering and potential of preventive service to reduce the burden);
  - Potential change to a prior recommendation (for example, because new evidence has become available); and,
  - Potential for Task Force impact (practice not reflective of evidence, timeliness).

In Progress

https://www.uspreventiveservicestaskforce.org/Page/Name/topics-in-progress

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USPSTF Recommendations

https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

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Dissemination & Implementation (D&I)

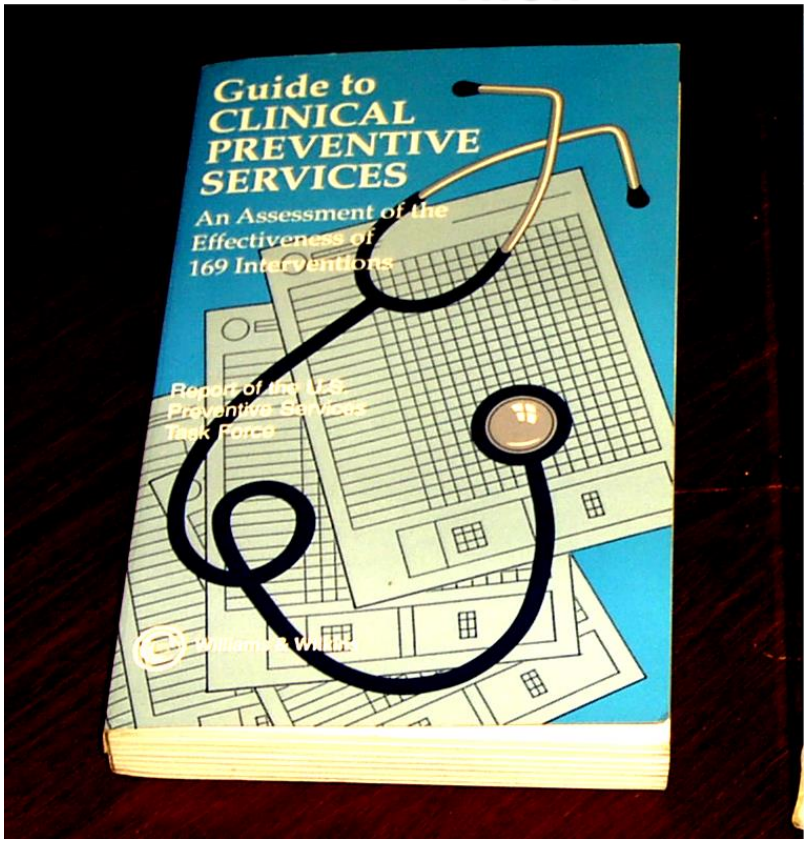
- USPSTF Partners provide input on recommendations and facilitate dissemination and implementation. Partners represent:
  - Primary care clinicians, consumers, and other stakeholders
  - Federal agencies
- Examples of D&I resources:
  - USPSTF Web site (www.uspreventiveservicestaskforce.org)
  - Electronic Preventive Services Selector (ePSS) (http://epss.ahrq.gov)
  - http://healthfinder.gov

TF Website

- **View** all current USPSTF recommendations and supporting materials
- **Learn more** about the Task Force's methods and processes
- **Nominate** a new USPSTF member or a topic for consideration by the Task Force
- **Provide input** on specific draft materials during public comment periods
- **Sign up** for the USPSTF Listserv to receive USPSTF updates
- **Access the Electronic Preventive Services Selector (ePSS)**, designed to help primary care clinicians and health care teams identify, prioritize, and offer preventive services appropriate for their patients; on the Web or mobile phone or PDA app
- **Access MyHealthFinder**, personalized recommendations for preventive services based on USPSTF; Bright Futures Guidelines; and Advisory Committee on Immunization Practices (ACIP)

Increasing Scope and Size of Audience

Then



- Landmark book in 1989
- Audience = primary care physicians and public health professionals

Now

- www.uspreventiveservciestaskforce.org
- Audience = professionals and general public audience
- 500,000 web page views in 2015

Krist '16

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How USPSTF Recommendations May Get Used to Potentially Influence Practice

- In UPSTF scope:
  - Communication to primary care clinicians and health systems
  - Stimulate research, scientific debate, and public discourse
  - Education of the public
- OUTSIDE of USPSTF scope
  - Clinical decision support
  - Quality measures (use by the National Quality Forum)
  - Insurance Coverage

Communication Framework for TF D&I

Audience	Main Message	Task Force Product
Clinicians	• What are the recommendations • What clinicians should recommend to their patients • How to use USPSTF recommendations • How to implement recommendations • Tools for patient communication • How to provide input/feedback on recommendations • How to suggest new topics • What are the Task Force's methods	Slides • USPSTF 101 Electronic • EPSS • Website • Videos (select topics) Writing/journals • Guide to Clinical Preventive Services • Annals/JAMA • AFP PPIPS (some topics) • Clinician Fact Sheet (some topics) • Individual articles (over-diagnosis/screening/treatment)

Communication Framework for TF D&I

Audience	Main Message	Task Force Product
Patients/ Consumers	• What preventive services should they be receiving • Why certain services are recommended or not (harms and benefits of services) • How to provide input/feedback on recommendations • How to suggest new topics • What are the Task Force's methods	Electronic • EPSS/http://healthfinder.gov • Videos • Website Writing • Consumer Fact Sheet (all topics) • North American Precis Syndicate (NAPS) articles • "Stay Healthy" Brochures

Communication Framework for TF D&I

Audience	Main Message	Task Force Product
Media	• What's "new" or "newsworthy" (new/updated recommendations, recommendation of other groups that coincide or conflict, changes to recommendations, new research, new products/services) • Marketing and outreach of tools • What are the Task Force's methods	Electronic • Website Writing • News Bulletins • NAPS articles Speaking • Interviews with UPSTF members

Communication Framework for TF D&I

Audience	Main Message	Task Force Product
Researchers /Scientific Community	• What are evidence gaps • What kind of research/studies are needed to fill evidence gaps and inform future recommendations • How to provide input/feedback on recommendations • How to suggest new topics • What are the Task Force's methods	Electronic • USPSTF and NIH/ODP website Writing • Report to Congress • Annals/JAMA materials • NAPS articles

Communication Framework for TF D&I

Audience	Main Message	Task Force Product
Other Stakeholders • Professional groups • Disease advocacy groups • Consumers • Federal partners • Insurance groups • Biotech/pharma industry	• How recommendations affect them (process, etc.) • How to implement recommendations • How to provide input/feedback on recommendations • How to suggest new topics • What are the Task Force's methods	Electronic • Website Writing • Report to Congress • Annals/JAMA • NAPS articles

Communication Framework for TF D&I

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Other Stakeholders • Professional groups • Disease advocacy groups • Consumers • Federal partners • Insurance groups • Biotech/pharma industry	• How recommendations affect them (process, etc) • How to implement recommendations • How to provide input/feedback on recommendations • How to suggest new topics • What are the Task Force's methods	Electronic • Website Writing • Report to Congress • Annals/JAMA • NAPS articles

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  - Federal agencies
- Examples of D&I resources:
  - USPSTF Web site (www.uspreventiveservicestaskforce.org)
  - Electronic Preventive Services Selector (ePSS) (http://epss.ahrq.gov)
  - http://healthfinder.gov

USPSTF Partners

Partners Who Support Primary Care Delivery

- American Academy of Family Physicians (AAFP)
- American Association of Nurse Practitioners (AANP)
- American Academy of Pediatrics (AAP)
- American Academy of Physician Assistants (AAPA)
- American College of Obstetricians and Gynecologists (ACOG)
- American College of Physicians (ACP)
- American College of Preventive Medicine (ACPM)
- American Medical Association (AMA)
- American Osteopathic Association (AOA)
- American Psychological Association (APA)
- National Association of Pediatric Nurse Practitioners (NAPNAP)

Partners Focused on Healthcare Utilization, Coverage, and Quality

- America's Health Insurance Plans (AHIP)
- AARP
- Consumers Union
- National Business Group on Health (NBGH)
- National Committee for Quality Assurance (NCQA)
- Patient-Centered Outcomes Research Institute (PCORI)

Federal Partners

- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Community Preventive Services Task Force (CPSTF)
- Department of Defense (DOD) Military Health System
- Department of Veterans Affairs (VA) Center for Health Promotion and Disease Prevention
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Cancer Institute (NCI)
- National Institutes of Health (NIH)
- Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion (ODPHP)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- U.S. Food and Drug Administration (FDA)

Partners Who Develop Recommendations on Prevention

- Canadian Task Force on Preventive Health Care (CTFPHC)
- Community Preventive Services Task Force (CPSTF)

Reports to Congress

- 2011: High-priority evidence gaps (n=11)

- 2012: High-priority evidence gaps (n=6)

- 2013: Older adults (n=5)

- 2014: Children and Adolescents (n=7)

- 2015: Women's health (n=5)

- 2016: 'I' statements (n=8)

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National Institutes of Health
Office of Disease Prevention

Resources for Researchers from NIH

Background

Resources for Researchers is a new section on the NIH Office of Disease Prevention website that aims to assist extramural investigators who are interested in prevention research. The section includes information about:

- Finding NIH Funded Research
- Applying for NIH Funding
- Prevention-Related Study Sections
- **Prevention Research Needs and Gaps**

Prevention Research Needs and Gaps

There are many gaps in prevention research. Identifying these gaps and providing the information necessary to guide future research could help improve the health of the population. Learn more about prevention research needs and gaps and NIH's efforts to address them.

U.S. Preventive Services Task Force I Statements

The USPSTF utilizes systematic reviews to make recommendations for primary care clinicians and health systems regarding a broad range of clinical preventive services. Often, the evidence base summarized in these systematic reviews is insufficient to enable the USPSTF to make a recommendation for or against a preventive service because the evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms for a clinical preventive service cannot be determined. When this occurs, the USPSTF issues an insufficient evidence, or I, statement, along with a description of research needs and gaps. The list below details 47 I statements, each with a brief summary of research needs and gaps.

Abdominal Aortic Aneurysm: Screening
The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for AAA in women ages 65 to 75 years who have ever smoked.

Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care
The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse in adolescents.

Aspirin for the Prevention of Cardiovascular Disease: Preventive Medication
The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of aspirin for cardiovascular disease prevention in men and women 80 years or older.

Abdominal Aortic Aneurysm: Screening
The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for AAA in women ages 65 to 75 years who have ever smoked.

Research Needs/Gaps Summary

A. Randomized controlled or modeling studies assessing the effectiveness of screening for AAA in women who smoke and in men and women with a family history of AAA.

B. Studies, especially those using genetic markers, to assess the validation of risk-scoring tools to identify patients most likely to benefit from screening for AAA.

C. Effectiveness of antibiotics, statins, or other pharmaceutical agents to reduce AAA growth.

D. Interventions that address modifiable risk factors and strategies for smoking cessation.

E. Appropriately powered studies that assess efficacy of treatments on health outcomes.

Read full statement

U.S. Preventive Services Task Force Annual Reports to Congress: Summary of High-Priority Research Gaps

The USPSTF also issues an annual report to Congress that identifies gaps in the evidence base and recommends priority areas that warrant further examination. Research gaps from the last three reports are listed below.

2015 Research Gaps (Improving the Health of Women)
In the Fifth Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services, the USPSTF has prioritized evidence gaps related to women's health. Research in these areas, which are listed below, would generate much-needed evidence for important new recommendations to improve the health and health care of women in the United States.

1. Screening for Intimate Partner Violence, Illicit Drug Use, and Mental Health Conditions
2. Screening for Thyroid Dysfunction
3. Screening for Vitamin D Deficiency, Vitamin D and Calcium Supplementation to Prevent Fractures, and Screening for Osteoporosis
4. Screening for Cancer
5. Implementing Clinical Preventive Services

Resources for Researchers can be found at:
prevention.nih.gov

For More Information Contact:
NIH Office of Disease Prevention
301-496-1508
prevention@mail.nih.gov

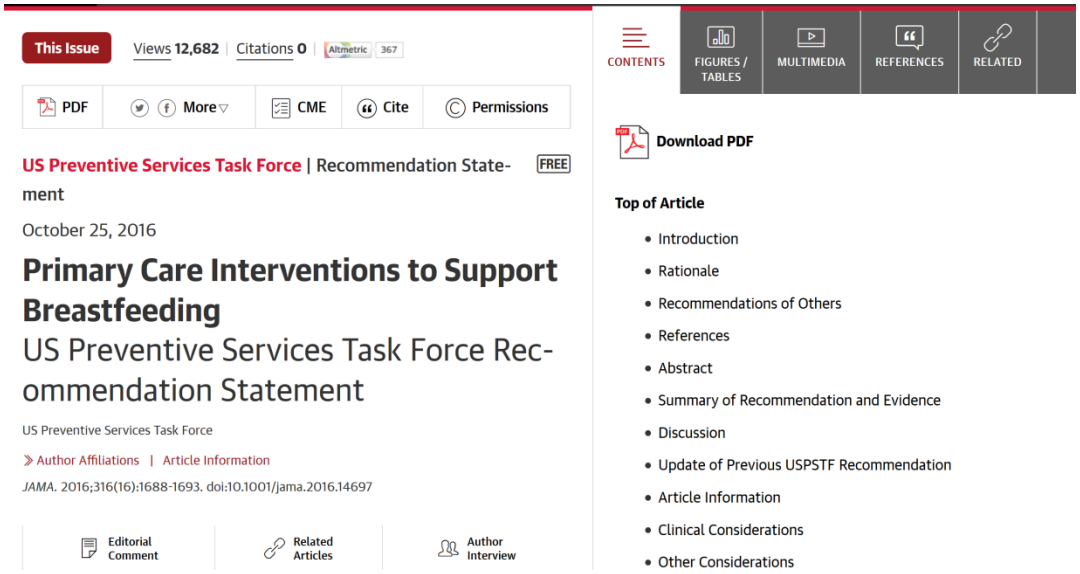
JAMA

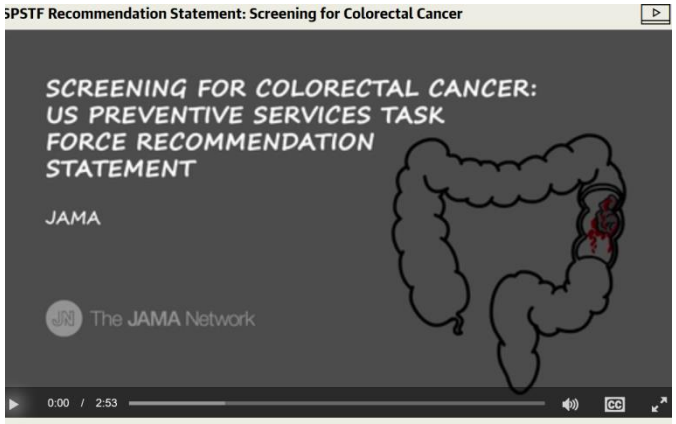
The Task Force's journal of record is *JAMA*

Materials include RS, related articles, editorials, podcasts, patient handouts, CME

The JAMA Report: U.S. Preventive Services Task Force Updates Recommendations for Depression Screening in Adults

Author Interview: Dr. Michael Pignone on the U.S. Preventive Services Task Force Recommendations for Depression Screening in Adults





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USPSTF May Be (mis)Interpreted By Others

Medscape Medical News > Oncology

Urology Groups Support Bill to Reform the USPSTF

Roxanne Nelson, RN
March 11, 2015

The three largest urology associations in the United States have issued a joint statement in support of legislation that aims to transform the way decisions are made at the US Preventive Services Task Force (USPSTF).

Changes Must Be Made to USPSTF Representation and Recommendation Process

WASHINGTON, Nov. 24 /PRNewswire-USNewswire/ -- Several sections of Senate health care reform legislation contain language stipulating that insurance entities such

CONGRESS.GOV

Legislation | Congressional Record | Committees | Members | Browse | About | Glossary | Resources

Current Legislation | Examples: hr5, sres9, "health care"

Home > Legislation > 114th Congress > H.R.1151 | Print | Subscribe

H.R.1151 - USPSTF Transparency and Accountability Act of 2015

114th Congress (2015-2016) | Get alerts

BILL | Hide Overview

Sponsor: Rep. Blackburn, Marsha [R-TN-7] (Introduced 02/27/2015)

Committees: House - Energy and Commerce; Ways and Means

Latest Action: 03/06/2015 Referred to the Subcommittee on Health.

Tracker:

Introduced | Passed House | Passed Senate | To President | Became Law

MYTH:

The Task Force does not recommend mammography screening.

FACT:

The Task Force recognizes that **mammography is an important tool** in reducing breast cancer deaths. The science shows that screening is **most beneficial for women ages 50 to 74**. The decision to start screening before age 50 should be an individual one, recognizing the potential benefits and potential harms.

Krist, '16

U.S. Preventive Services TASK FORCE

Misinterpretations of the USPSTF Processes: Example of Our Breast Cancer Screening Recommendations

- **Myth**: "The USPSTF "C" recommendation for women ages 40 to 49 years and its "I" statement for women ages 75 and older are recommendations *against* mammography screening"
- **Myth**: "The USPSTF is recommending against insurance coverage for screening mammograms for women in their 40s"
- **Myth**: "The USPSTF does not have the requisite expertise to make recommendations about breast cancer screening"
- **Myth**: "The USPSTF recommendation development process does not meet IOM standards for trustworthy guidelines

Gillman, '16

USPSTF Grades

- A
- B
- C

All three grades are recommendations in favor of screening

They differ by the level of certainty of the evidence and the magnitude of potential net benefit

- I

Not enough evidence to make a recommendation

NOT a recommendation against screening – rather it's a call for more research

Gillman, '16

USPSTF Role in Estimating Certainty of Net Benefit			
Grade	Definition	ACA Linkage	Role of Insurers
A	Recommends (high certainty of substantial net benefit)	ACA mandates coverage with no cost sharing	Establish coverage policy consistent with USPSTF grade and ACA[b]
B	Recommends (high certainty that net benefit is moderate or moderate certainty that net benefit is moderate to substantial)		
C	Recommends selectively offering or providing to individual patients based on professional judgment and patient preferences (at least moderate certainty of small net benefit)	ACA does not deny coverage and does not prohibit a plan from providing coverage[a]	Determine coverage policy based on effectiveness, consumer demand, community norms, and other considerations[b]
D	Recommends against the service (moderate or high certainty of no net benefit or that harms outweigh benefits)		
I	Concludes that current evidence is insufficient to assess balance of benefits and harms of the service; evidence is lacking, of poor quality, or conflicting, and balance of benefits and harms cannot be determined		

Gillman, '16

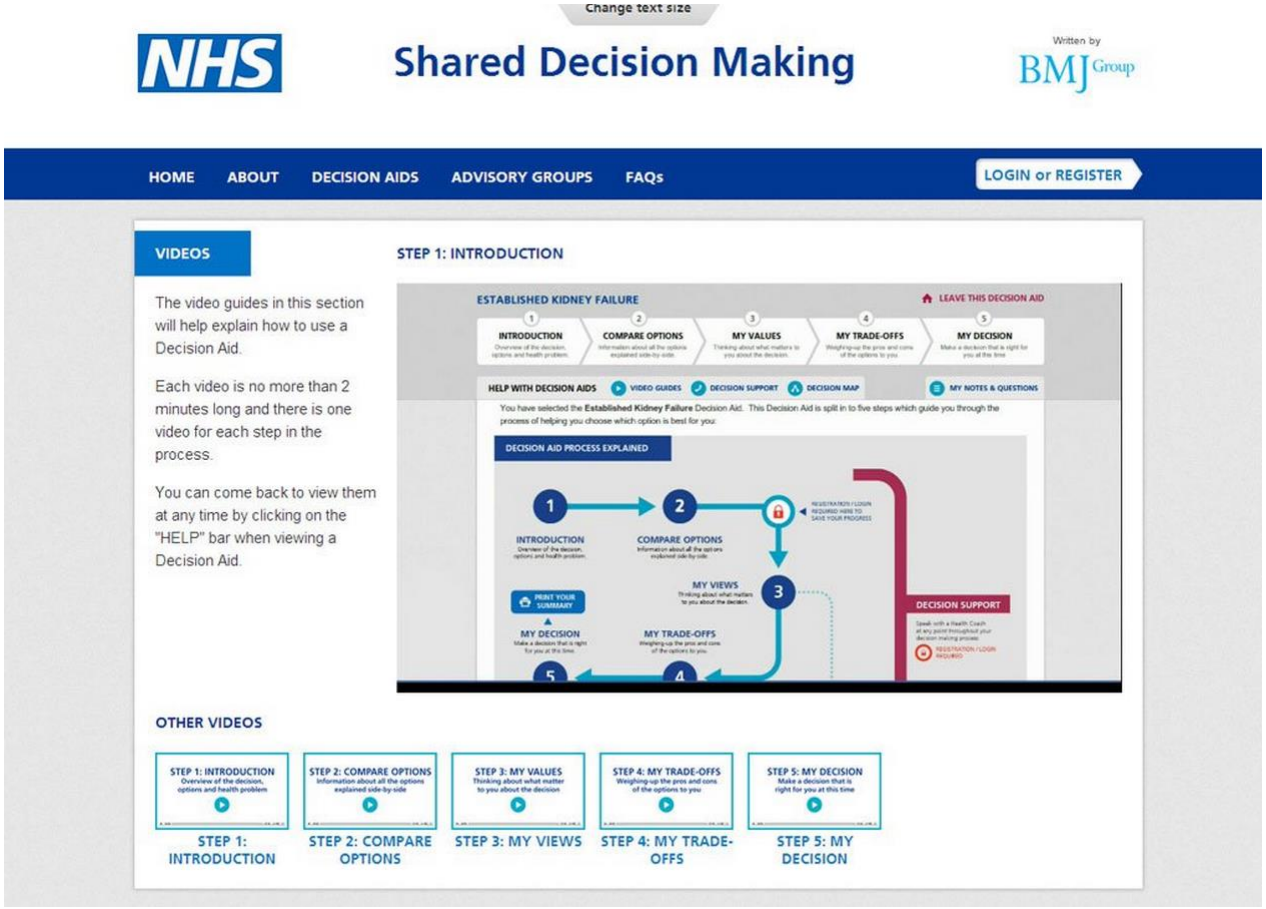
U.S. Preventive Services TASK FORCE

Use Shared Decision-Making to Ensure the Patient Understands the Service

1. Patient understands the risk or seriousness of the disease or condition to be prevented
2. Patient understands the preventive service, including the risks, benefits, alternatives, and uncertainties
3. Patient has weighed his or her values regarding the potential benefits and harms associated with the service
4. Patient has engaged in decision-making at a level which he or she desires and feels comfortable

Am J Prev Med 2004; 26(1): 56-66

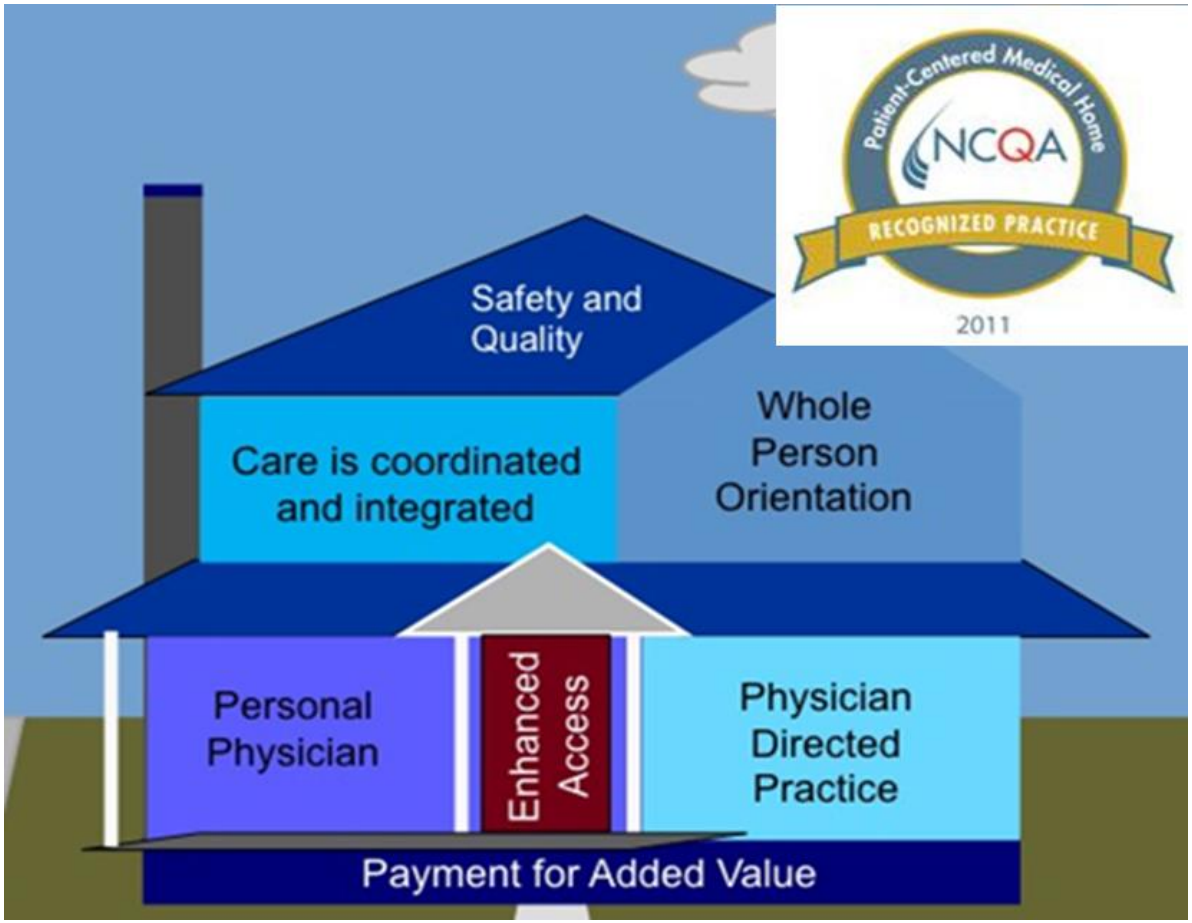
Decision Aids Can Help Clinicians and Patients Decide if Screening is Right



Krist, '16

U.S. Preventive Services TASK FORCE

Primary Care Should Lead and be the Home for Screening



Krist, '16

Health Systems TF D&I Study (preliminary, 2016)

- Internal study initiated by AHRQ (Ngo-Metzger & Mabry-Hernandez)
  - L&M Policy Research team
- Purpose
  - study exploring D&I of USPSTF recommendations by large health organizations (LHOs)
  - identify potential gaps in current understanding of these organizations' approaches to reviewing, adopting, adapting TF recommendations in primary care settings

Doherty '16; for AHRQ

Overview of D&I 2016 Study Methods

- Convened Technical Committee (TC)
- Developed discussion guides based on input from TC, literature scan, and prior experience working with LHOs
- Identified LHOs representatives, recruited interviewees, and conducted interviews
- Analyzed and synthesized findings
- Producing report on findings

Doherty ‘16; for AHRQ

Identification of LHO Participants

- Selected purposive and diverse sample of LHOs and key informants to interview and conducted semi-structured interviews between August and November 2015
  - 9 LHO organizations (9 interviews with 12 key informants)
- Discussions lasted 60 to 90 minutes depending on number of key informants on the calls

Doherty ‘16; for AHRQ

Analysis and Synthesis of Findings

- Imported interview notes into an Excel database arrayed according to key discussion categories for LHOs interviewees
- Synthesized findings across all key informant interviews
- Identified major themes for LHO interviewees
- Produced summary report
- Developing manuscript for publication

Doherty ‘16; for AHRQ

Study Limitations

- Small sample size (limited project scope)
- Varying perspectives within any given LHO
- Not all informants were able to provide same level of detail about their organization's approach
- Mostly interviewed clinical leaders and executives – perspective of front-line primary care clinicians may be different

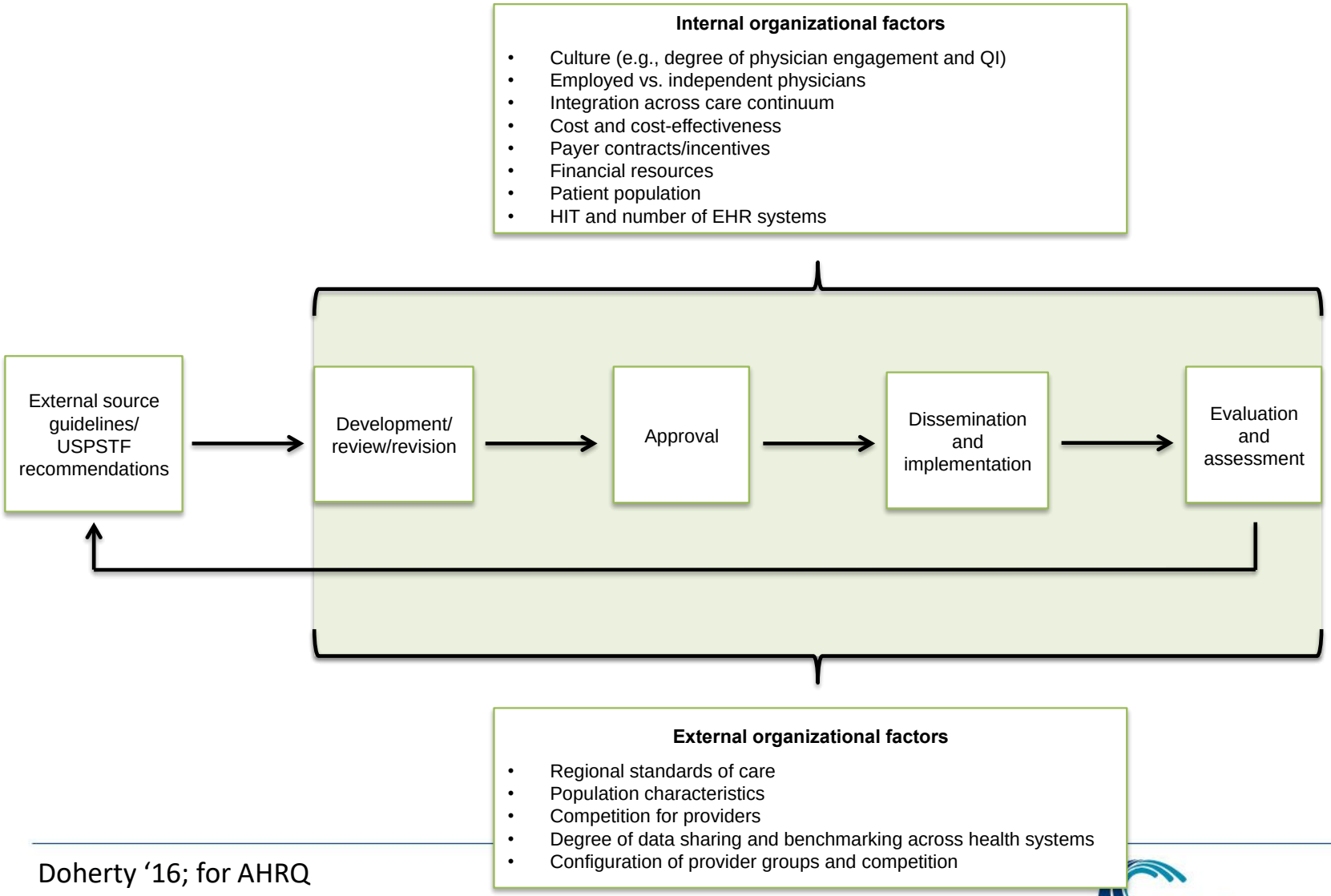
Doherty '16; for AHRQ

Overarching Findings – USPSTF "Trusted Source"

- LHO participants consider TF one of most reliable and trustworthy sources of evidence-based guidelines
- However, USPSTF recommendations are only one of many sets of recommendations LHOs have to be attentive to
  - LHO approaches to clinical guideline review and extent to which they adopt USPSTF recommendations varies, based on constellation of internal and external factors, more resources spent on determining which clinical guidelines to follow
- Despite variation, guideline implementation processes generally share common steps

Doherty '16; for AHRQ

Common Steps in Clinical Guideline Development & Implementation



Doherty '16; for AHRQ

Clinical Guidelines from other Sources Cited by LHO Interviewees

Organizations	
Agency for Healthcare Research and Quality (ePSS)	Centers for Medicare & Medicaid Services (star ratings, survey and certification requirements, etc.)
American Academy of Family Practice	Choosing Wisely®*
American Academy of Pediatrics	Integrated Health Association**
American Cancer Society	Internal Large Health System data and expertise
American College of Cardiology	The Joint Commission
American College of Physicians	National Committee for Quality Assurance (HEDIS)
American College of Gastroenterology	National Comprehensive Cancer Network
American College of Obstetrics and Gynecology	National Institute for Health and Care Excellence (NICE)
American College of Radiology	National Institutes of Health
American Diabetes Association	National Heart Lung and Blood Institute
American Heart Association	National Patient Safety Foundation
American Medical Association	Obesity Society
American Society for Colonoscopy and Cervical Pathology	Other specialty societies
American Thoracic Society	Insurers (quality and performance metrics in payer contracts)
Centers for Disease Control (ACIP, Travelers' Health)	Scottish Intercollegiate Guidance Network (SIGN)

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Multiple Factors Impact LHO Approach to Clinical Guideline Development

- Internal Factors
  - Organizational geographic presence – local, regional, national
  - Degree of integration of providers across organization
  - Number and range of product offerings
  - Organizational structure and financial/HIT resources
  - Decision-making process and degree of physician engagement
  - Organizational culture and values

- External Factors
  - Amount of performance-based contracting in market(s)
  - Degree of data sharing
  - Local and regional standards of care
  - Strength of area provider groups and networks
  - Population(s) served

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Considerations in LHO Guideline Development & Review

- Competing/overlapping federal, state and local government standards and requirements
- Multitude (hundreds) and sometimes conflicting different payer and performance requirements

NAM/IOM describes a *"multitude of uncoordinated, inconsistent, and often duplicative measurement and reporting initiatives"*

- Access to timely and complete utilization and cost data
- Influence of specialty societies and disagreements about approach among providers
- Degree of influence on provider behavior

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Common Features in Guideline Development & Review Process

- Timing (recurring review, often annual or biannual)
- Multiple levels and layers of review
- Focus on performance and quality metrics, frequently linked to provider and system-wide contracts
- Ongoing emphasis on provider engagement

"We can't limit ourselves to making recommendations only for those with high-quality bodies of evidence, because our doctors deal with things all of the time that don't have great evidence but they still have to come up with something to do for their patient."

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Key Factors Enhancing Guideline Dissemination and Adherence

1. Clinician engagement and support (beginning with guideline review process through D&I)
2. HIT resources and development of decision-support tools
3. Provider communication strategies (multiple communication means)
4. Monitoring and measuring performance

"The volume of the work for physicians, operationally and clinically, is a challenge. It is hard to get the shelf space, in their schedule and on their mind, so we have to build it into the workflow, into the care process. You can't just ask people to try hard and do more."

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Conclusions: Similarities Between LHOs

- Reliance on HIT, EHR systems, and clinical reminders
- Emphasis on system-level guidelines (for all but one LHO)
- Clinician-led committees to encourage buy-in and adherence
- Clinicians face significant time and attention constraints
- Primary care clinicians tend to put more weight on USPSTF recommendations than specialists
- Widespread use of performance feedback provided to individual clinicians
- Competing organizational resources and priorities
- Difficulty meeting and measuring adherence to USPSTF counseling recommendations (most do not do so)

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Conclusions: Differences between LHOs

- Organization structure and degree of centralization
- Populations served
- Degree of affiliation with academic medical centers
- Consistency in HIT resources and EHR systems
- Number of contracting entities and varying fee schedules and requirements

- STUDY PUBLICATION forthcoming

Doherty '16; for AHRQ

US Preventive Services Task Force…

- Provides recommendations for primary care screening, counseling, and preventive medications
  - Based on best evidence
  - Is aware of, but does not make, policy
- Is committed to improving methods, enhancing transparent processes, and soliciting input from public, generalists and subspecialists, other stakeholders at all stages
- Recognizes need to enhance dissemination and implementation of clinical preventive services
  - Need likely to increase as public demands greater accountability from health professions and as US system shifts to more of a population health and value-based care approach

USPSTF Recommendation Use: Audience Exercise

- 5 minutes:
  - Turn to people near you, discuss
    - NaRCAD, personal experience with USPSTF recommendations use
    - Overcoming barriers
    - Examples of best practices
- 5 minutes report out from your small group

Thank you for your interest

www.USPreventiveServicesTaskForce.org

To nominate a new member of the USPSTF, go to www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/nominate.html