DIALOGUE FOR ACTION™ ON CANCER SCREENING

prevent cancer FOUNDATION

2015 DIALOGUE FOR ACTION™:
Expanding Access Through Innovation
April 22-24, 2015 | Renaissance Baltimore Harborplace Hotel

Update on Cancer Screening Guidelines

Robert A. Smith, PhD
American Cancer Society
Atlanta, GA

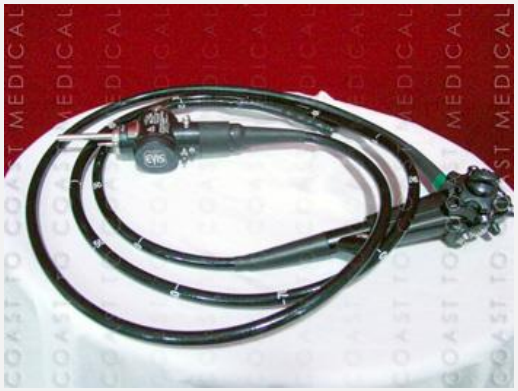
American Cancer Society®

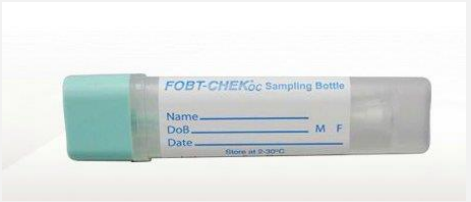
What's New?

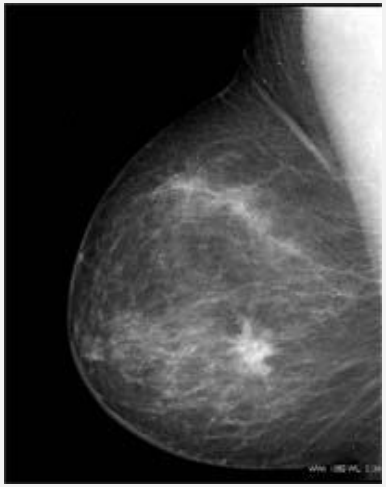
- ACS & USPSTF will update breast cancer screening guidelines in 2015
- ACS & USPSTF will update colorectal cancer screening guidelines within the next 12-24 months
- Cervix, Prostate, & Lung cancer screening guidelines updates due for updates within next few years

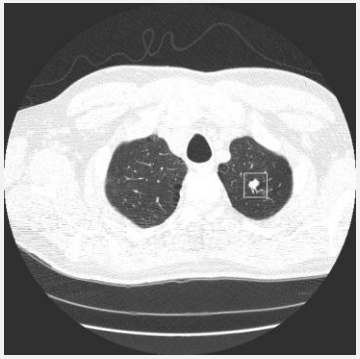
What else is new? QUALITY!

- ***Colorectal screening tests***
  - Measuring quality of colonoscopy
  - Increased scrutiny on performance and FDA approvals process of stool blood tests
- ***Mammography***
  - IOM Meeting in May, 2015 on improving mammography interpretation
  - New imaging technology to increase accuracy
- ***Lung CT***
  - ACS convening leading organizations to focus on quality in roll out of lung cancer screening





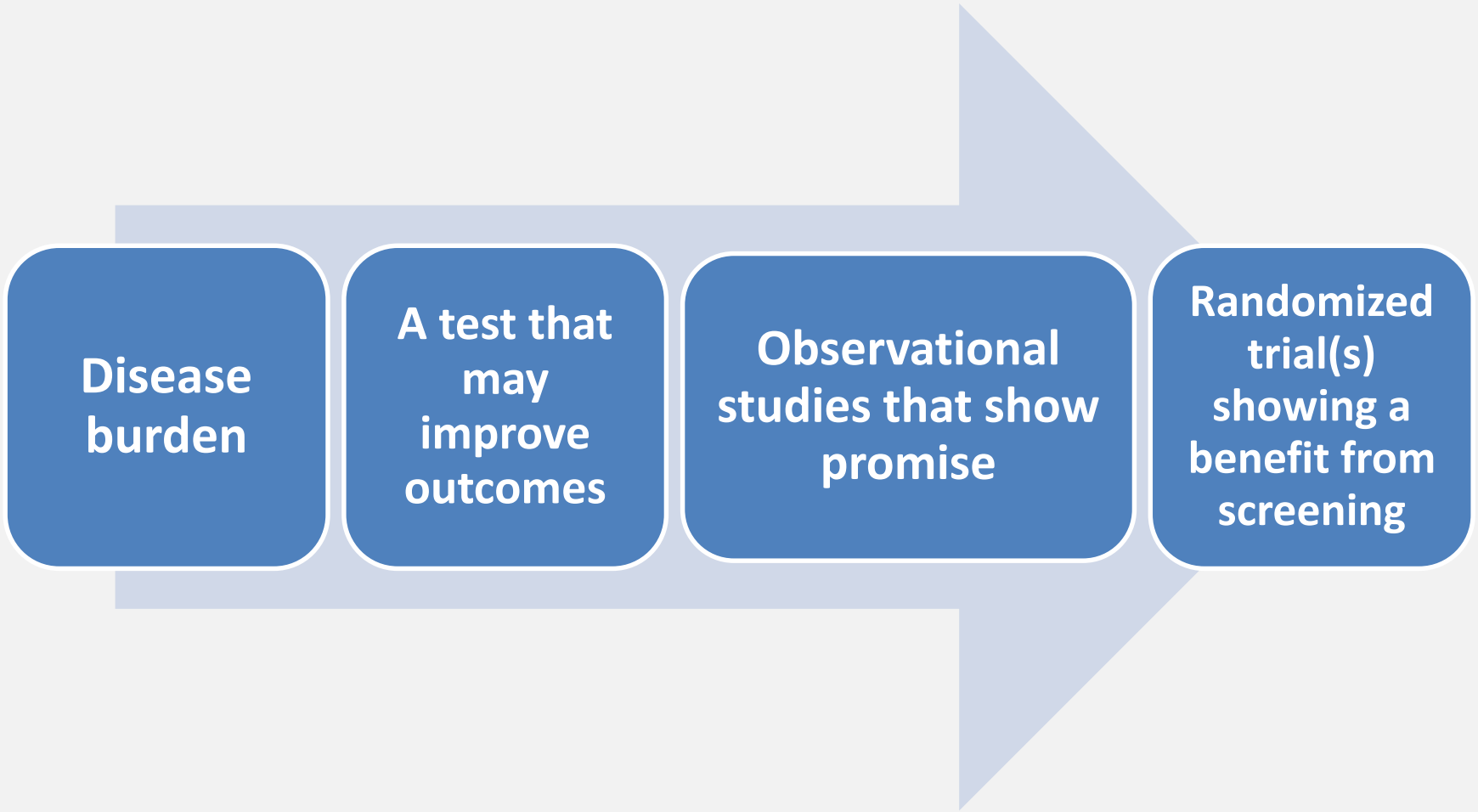




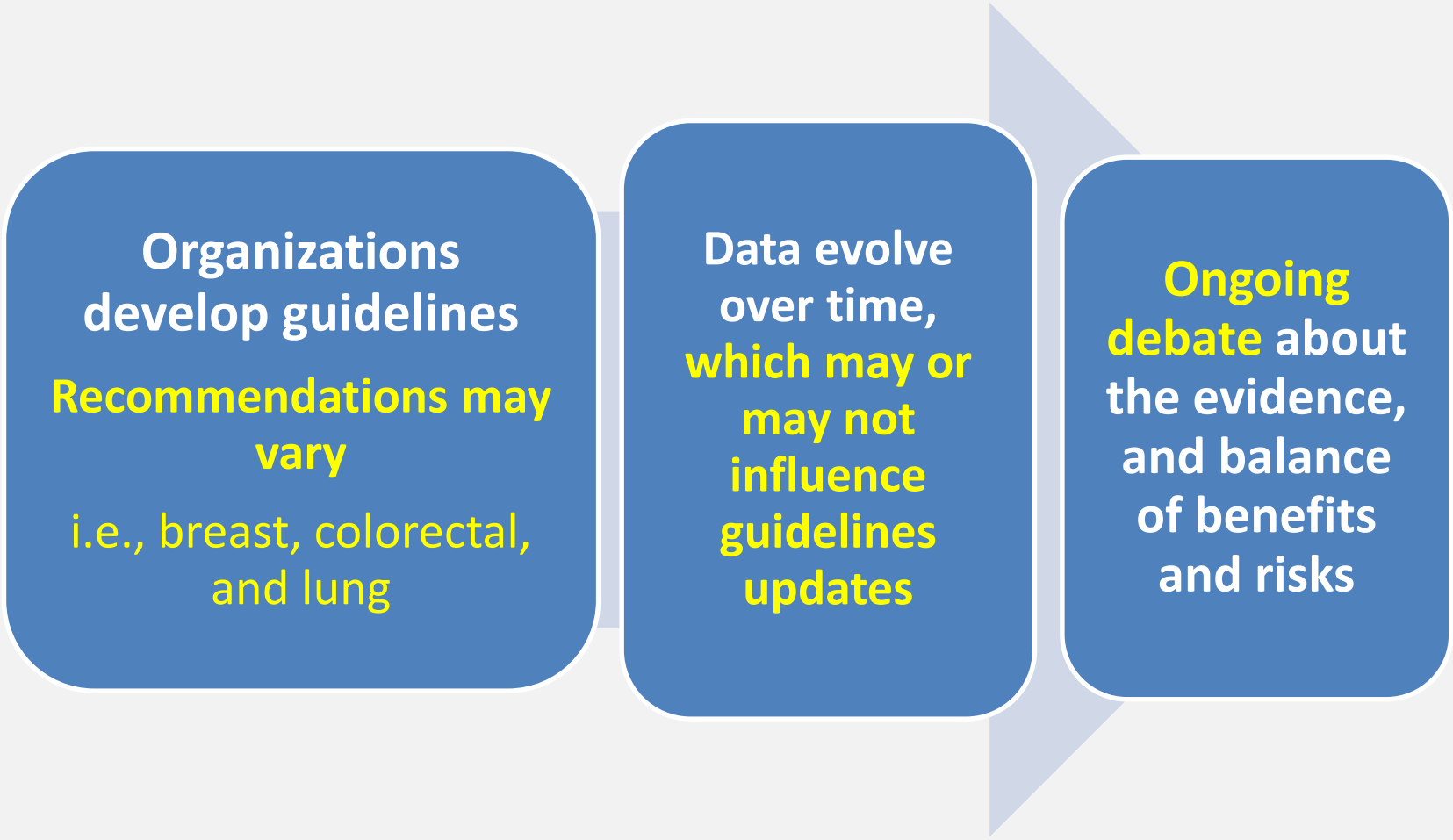
What else is new? Guideline development has entered a new era

- Guideline developers face increasingly strict:
  - Operational standards
  - Standards for grading evidence
  - Standards for grading recommendations
- These standards are conservative, ***but also imprecise***, allowing wide latitude for judgment about “trustworthiness”

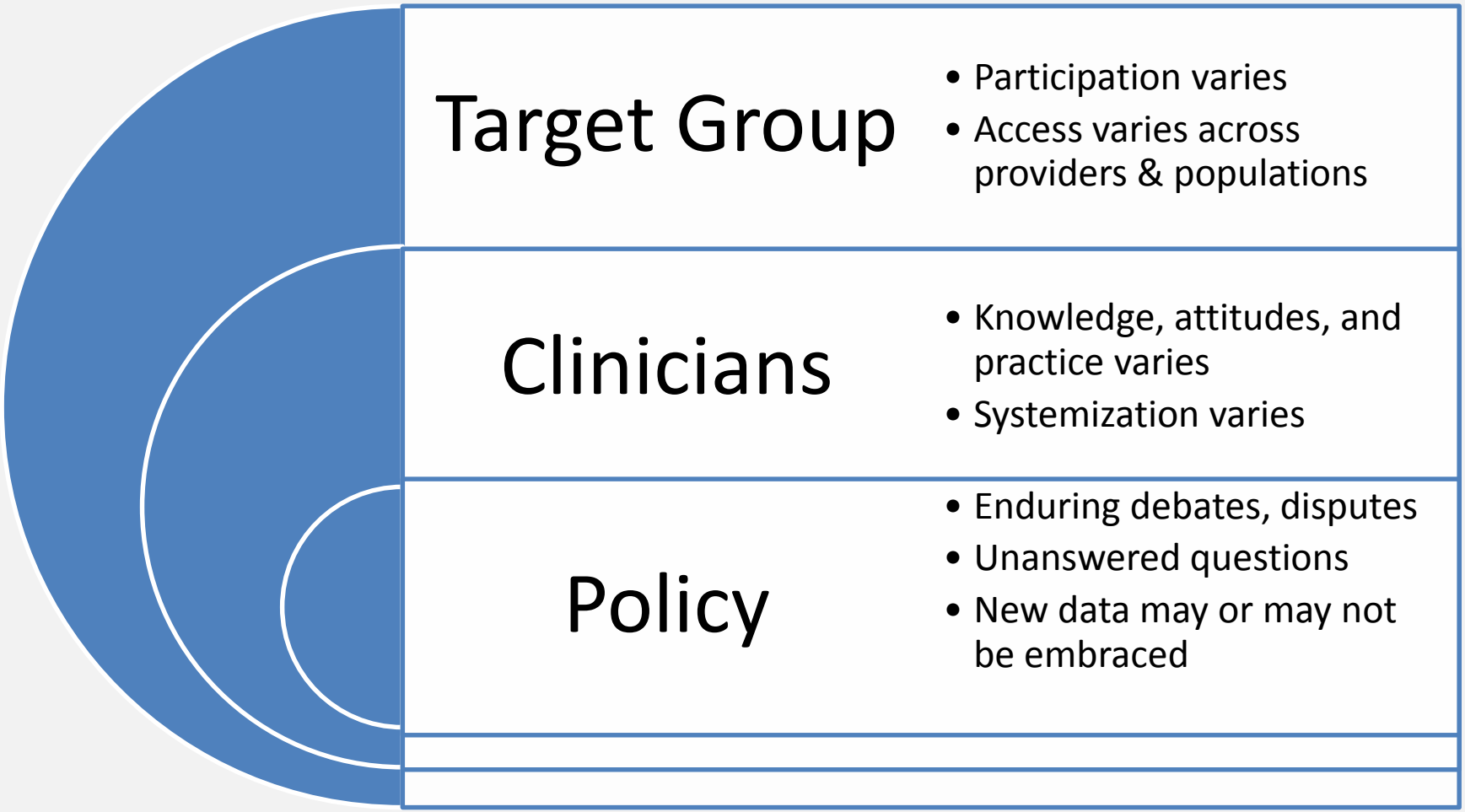
The long road to the *development* of a cancer screening guideline



The long road to the *development* of a cancer screening guideline (2)



The long road to *implementation* of a cancer screening guideline

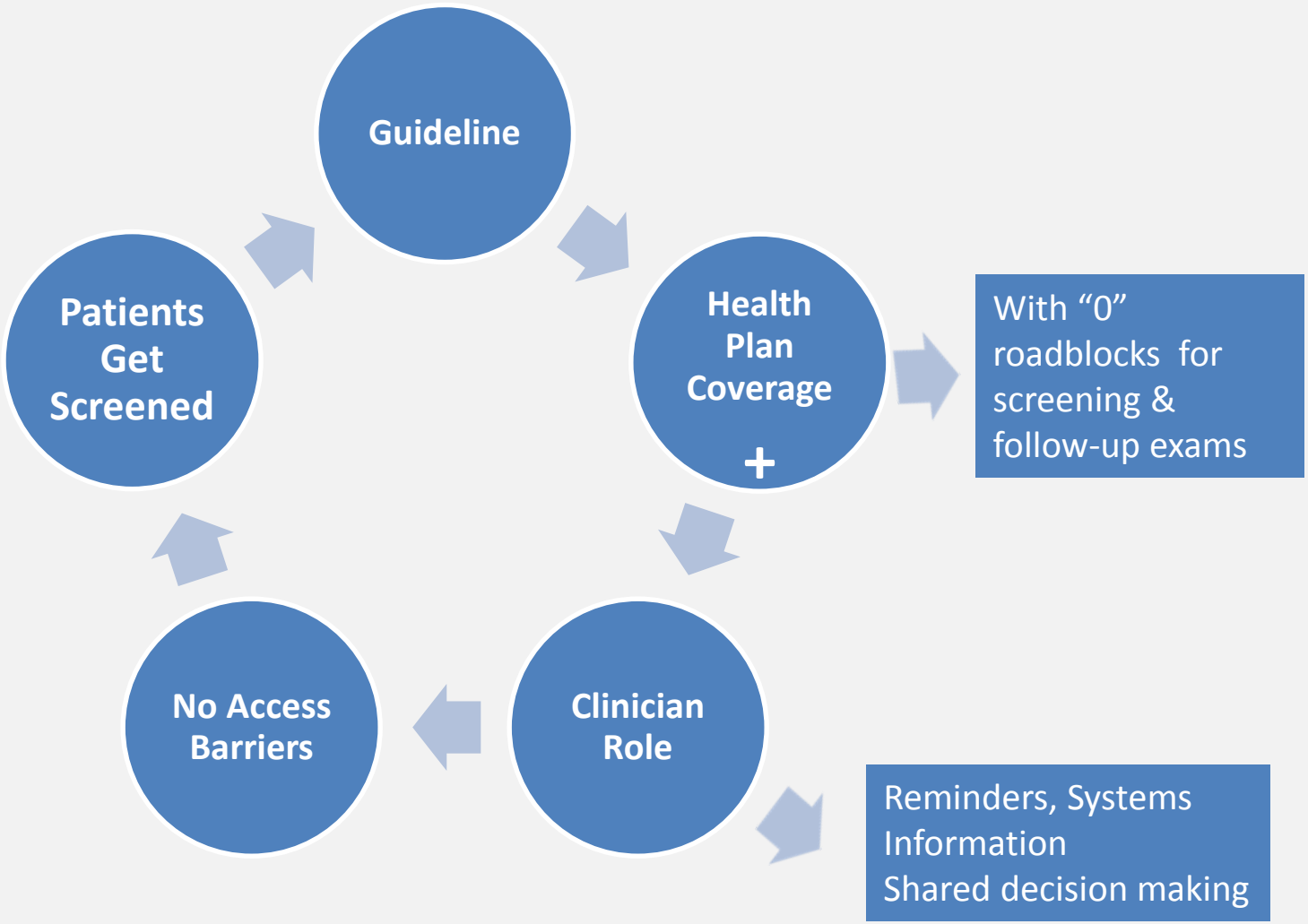


Cancer Screening—The Public Health Goal

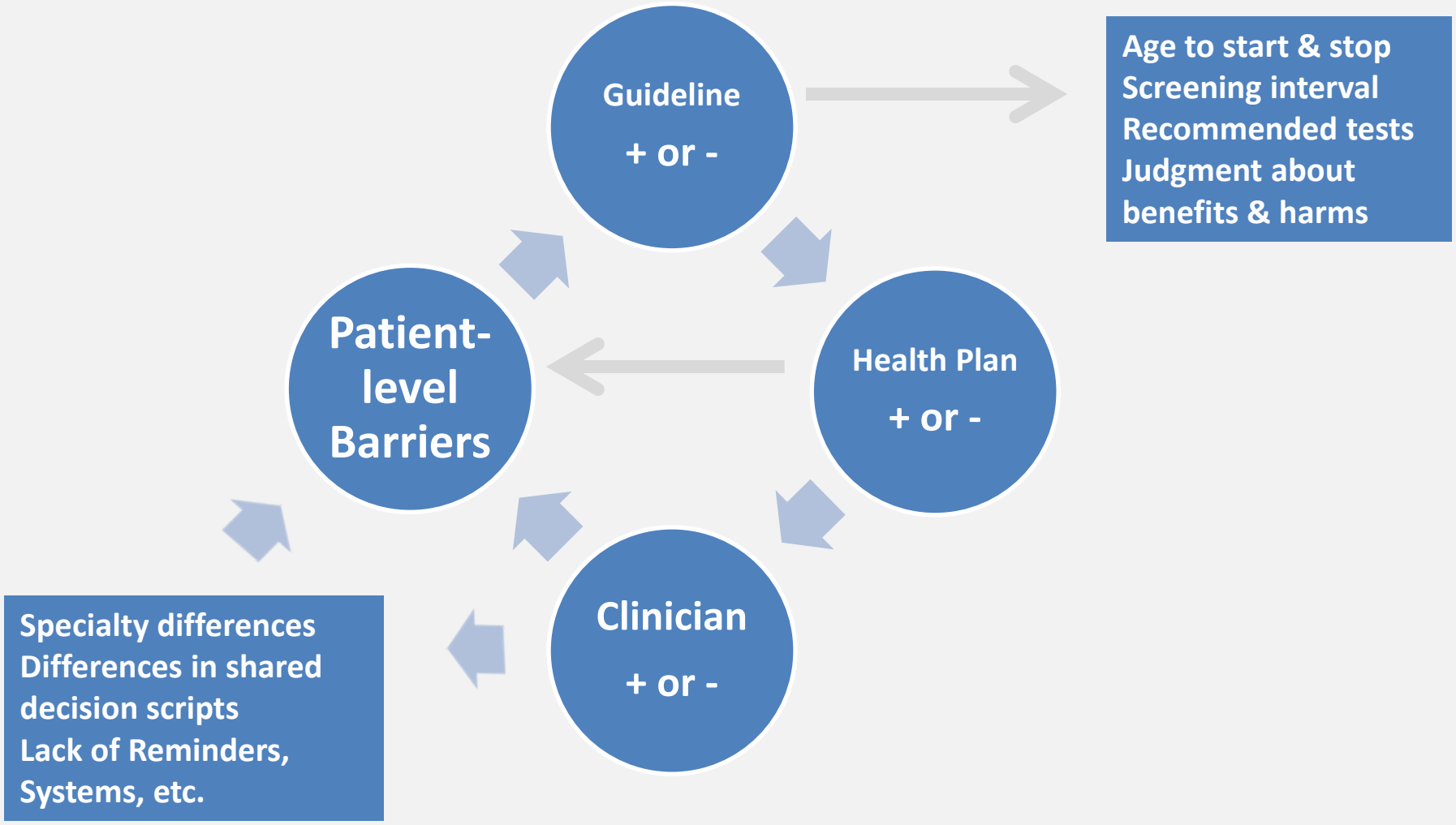
- **The Goal? High Rates of Cancer Screening**

- ***100% screening rates are not achievable***
  - Some adults will choose to "opt out"
  - Some adults will fail to respond to invitations to screening (procrastination, etc.)
  - Some adults are not candidates for cancer screening due to poor health, or limited longevity

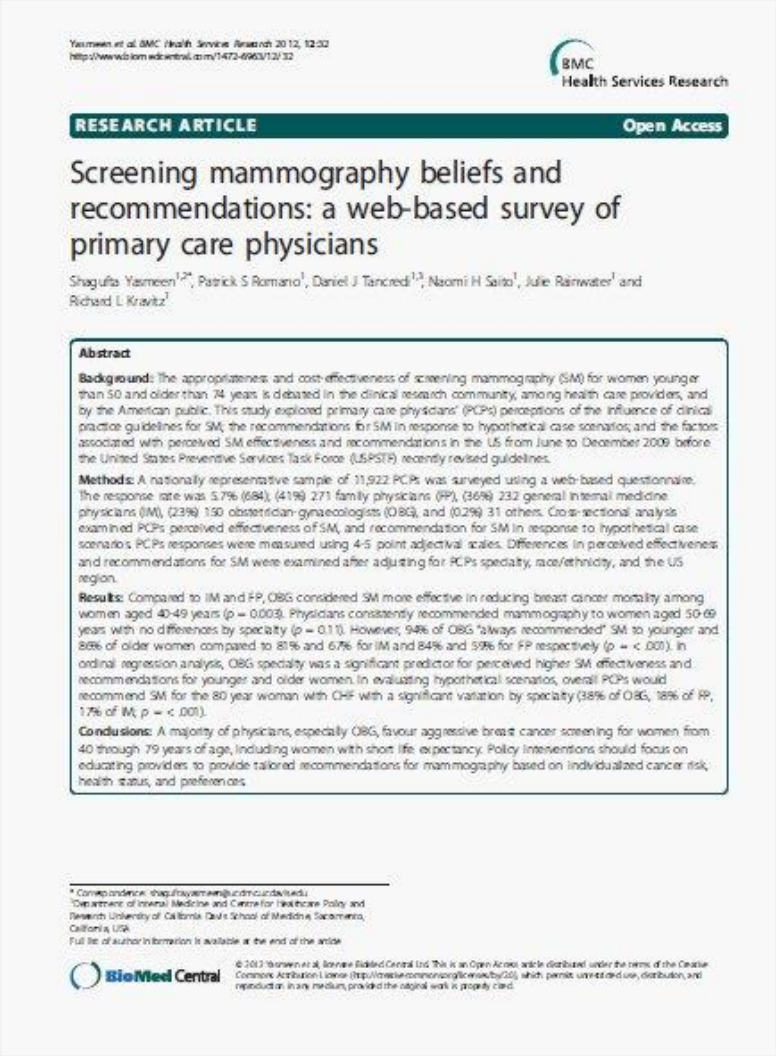
The *Ideal* Relationship between Guidelines, Health Plans, Clinicians, and Patients



The *Actual* Situation between Guidelines, Clinicians, Health Plans, Geography, Patient-level Barriers



Primary Care Physicians Beliefs and Recommendations about Mammography



Yasmeen et al. BMC Health Services Research 2012, 12:32
http://www.biomedcentral.com/1472-6963/12/32

BMC Health Services Research

RESEARCH ARTICLE Open Access

Screening mammography beliefs and recommendations: a web-based survey of primary care physicians

Shagufta Yasmeen[1,2*], Patrick S Romano[1], Daniel J Tancredi[1,3], Naomi H Saito[1], Julie Rainwater[1] and Richard L Kravitz[1]

Abstract

Background: The appropriateness and cost-effectiveness of screening mammography (SM) for women younger than 50 and older than 74 years is debated in the clinical research community, among health care providers, and by the American public. This study explored primary care physicians' (PCPs) perceptions of the influence of clinical practice guidelines for SM; the recommendations for SM in response to hypothetical case scenarios; and the factors associated with perceived SM effectiveness and recommendations in the US from June to December 2009 before the United States Preventive Services Task Force (USPSTF) recently revised guidelines.

Methods: A nationally representative sample of 11,922 PCPs was surveyed using a web-based questionnaire. The response rate was 5.7% (684), (41%) 271 family physicians (FP), (36%) 232 general internal medicine physicians (IM), (23%) 150 obstetrician-gynaecologists (OBG), and (0.2%) 31 others. Cross-sectional analysis examined PCPs perceived effectiveness of SM, and recommendation for SM in response to hypothetical case scenarios. PCPs responses were measured using 4-5 point adjectival scales. Differences in perceived effectiveness and recommendations for SM were examined after adjusting for PCPs specialty, race/ethnicity, and the US region.

Results: Compared to IM and FP, OBG considered SM more effective in reducing breast cancer mortality among women aged 40-49 years ($p = 0.003$). Physicians consistently recommended mammography to women aged 50-69 years with no differences by specialty ($p = 0.11$). However, 94% of OBG "always recommended" SM to younger and 86% of older women compared to 81% and 67% for IM and 84% and 59% for FP respectively ($p = < .001$). In ordinal regression analysis, OBG specialty was a significant predictor for perceived higher SM effectiveness and recommendations for younger and older women. In evaluating hypothetical scenarios, overall PCPs would recommend SM for the 80 year woman with CHF with a significant variation by specialty (38% of OBG, 18% of FP, 17% of IM; $p = < .001$).

Conclusions: A majority of physicians, especially OBG, favour aggressive breast cancer screening for women from 40 through 79 years of age, including women with short life expectancy. Policy interventions should focus on educating providers to provide tailored recommendations for mammography based on individualized cancer risk, health status, and preferences.

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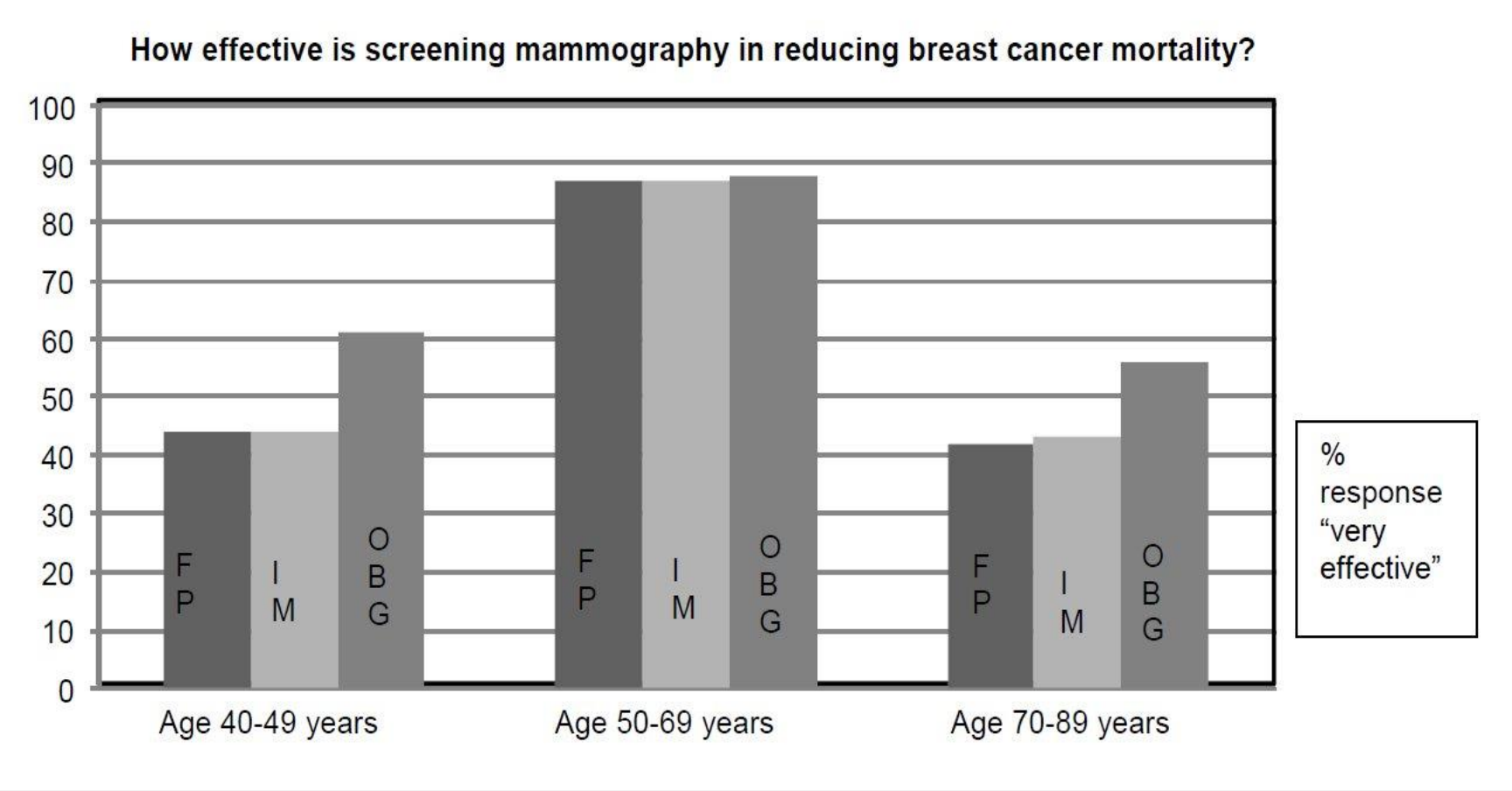
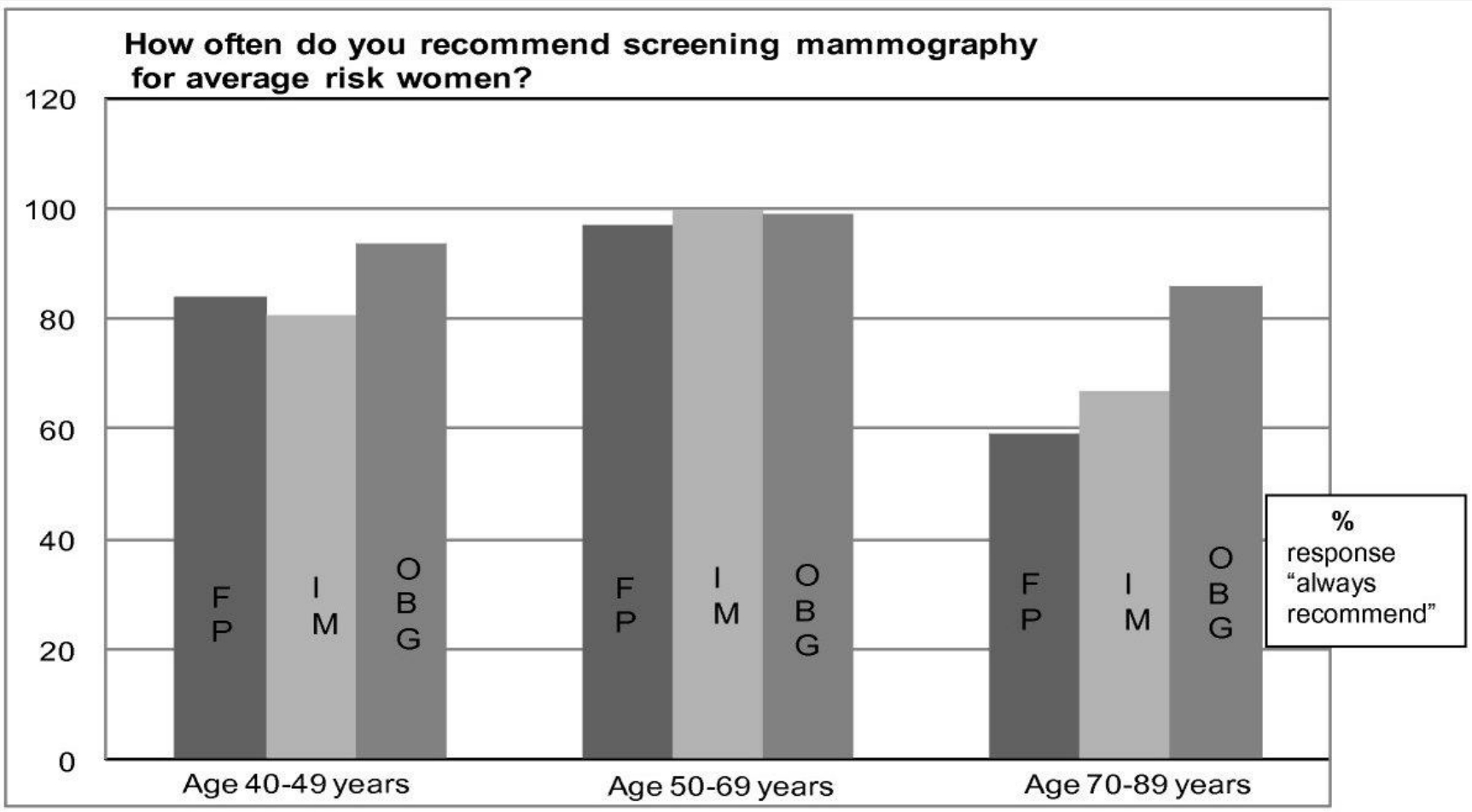
- A nationally representative sample of **11,922 PCPs** was surveyed using a web-based questionnaire.
- **The response rate was 5.7% (684);** (41%) 271 family physicians (FP), (36%) 232 general internal medicine physicians (IM), (23%) 150 obstetrician-gynecologists (OBG), and (0.2%) 31 others.

Primary care physicians' perceived effectiveness of screening mammography for average-risk women by age categories. How effective is screening mammography in reducing breast cancer mortality?



Yasmeen et al. BMC Health Services Research 2012 12:32

Primary care physicians' recommendations for screening mammography. How often do you recommend screening mammography for average-risk women?



Yasmeen et al. BMC Health Services Research 2012 12:32

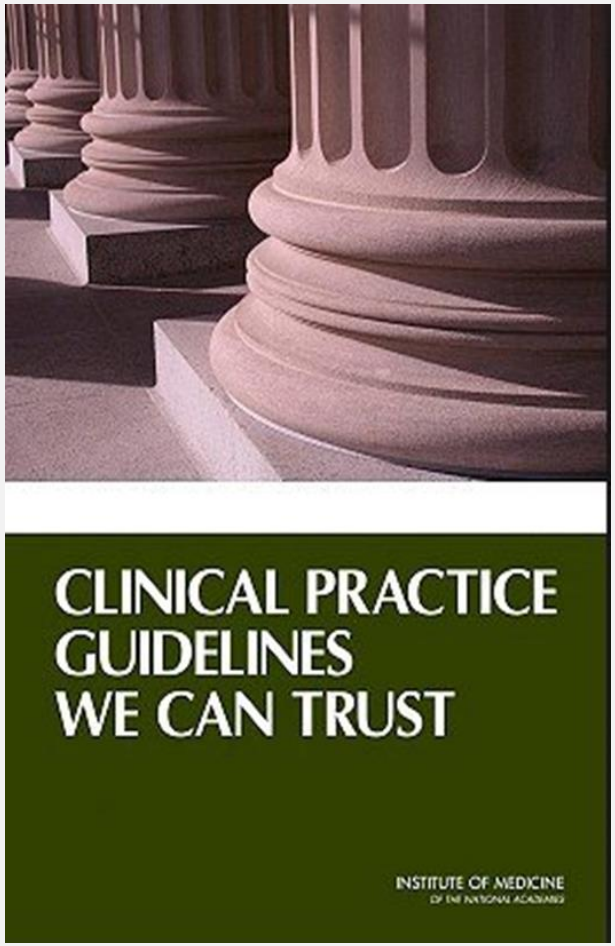
Primary care physicians' responses to clinical vignettes by primary care specialty

Primary care specialty	Family Physicians	General Internal Medicine	Obstetrics and gynaecology				
	FP	IM	OBG*	Over all	IM vs OBG	FP vs OBG	FP vs IM
Would order screening mammogram for following case scenarios.....	n (%)	n (%)	n (%)			*P- value*	
Healthy 70 year old woman	245 (90)	223 (96)	143 (95)	0.024	0.795	0.088	0.013
50-year-old with unresectable non-small cell lung cancer	102 (38)	61 (26)	81 (54)	< 0.001*	< 0.001*	0.001*	0.007
Healthy 55-year-old woman	264 (97)	224 (97)	148 (99)	0.466	0.327	0.501	0.608
80-year-old with ischemic cardiomyopathy who has dyspnoea with ordinary activity	44 (16)	39 (17)	56 (37)	< 0.001*	< 0.001*	< 0.001*	0.904

= Not Ideal = Good!

IOM Guideline Development Principles

Grading evidence and recommendations gets strong emphasis



1. Transparency
2. Conflicts of Interest
3. Group Composition
4. Systematic Review of Evidence
5. **Grading Strength of Recommendations**
6. Articulation of Recommendations
7. External Review
8. Regular updates of the recommendations

Under the ACA, only the USPSTF recommendations determine coverage for preventive services

- **The USPSTF is charged with evaluating evidence and issuing recommendations about clinical preventive services**
- **The USPSTF is *not* charged with making decisions about insurance coverage, or considering insurance coverage in their deliberations**
- **Health Plans may choose to cover services the USPSTF has graded "C" or "D"**

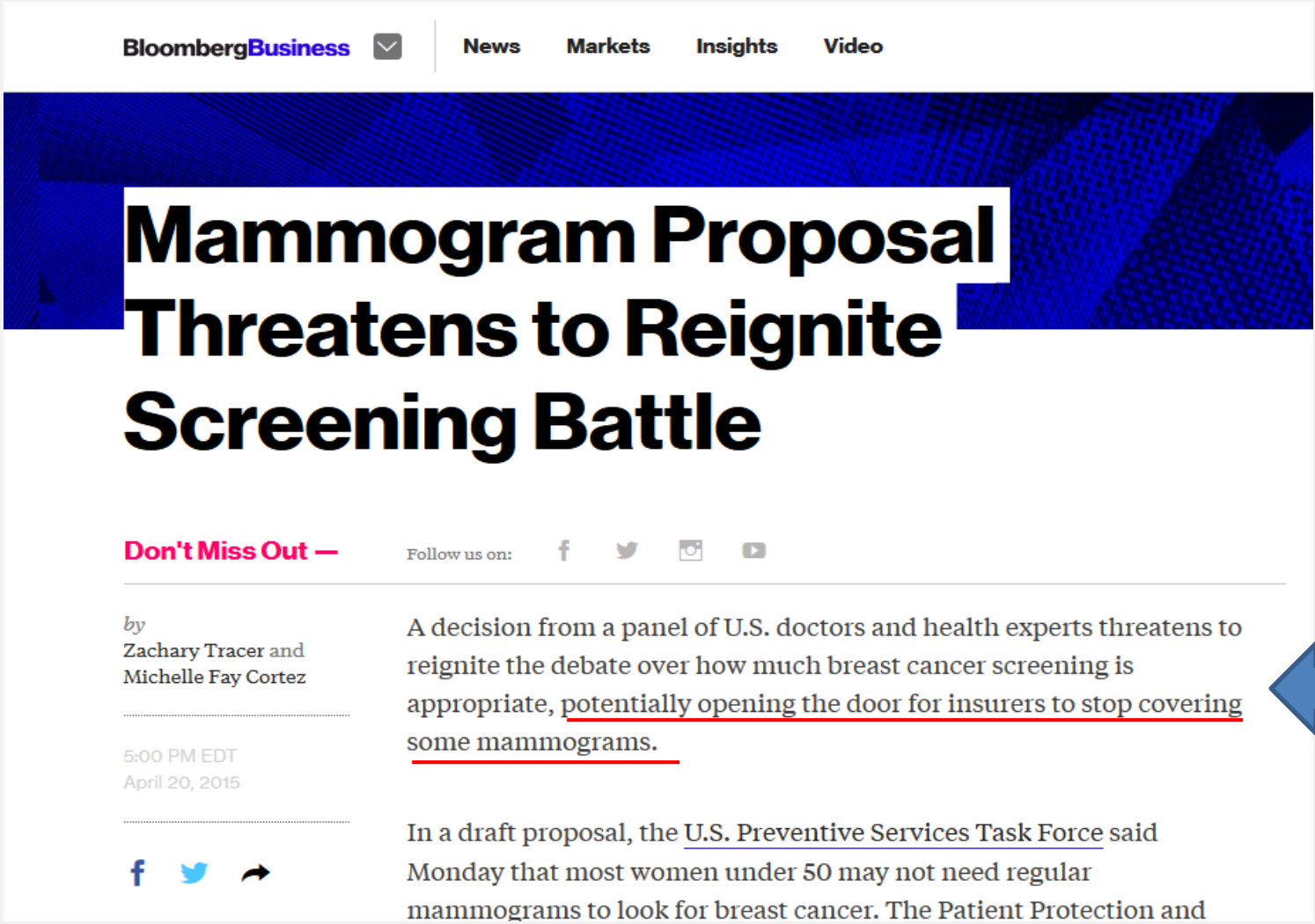
USPSTF Recommendation Grades

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
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.	Offer or provide this service.
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.	Offer or provide this service for selected patients depending on individual circumstances.
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.	Discourage the use of this service.
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.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

The meaning of the USPSTF "C" Recommendation has changed from 1998-2012

- The essence of the C recommendation has remained consistent: ***at the population level, the balance of benefits and harms is very close, and the magnitude of net benefit is small.***
  - **1998**: the USPSTF does not make a recommendation "for or against routinely" providing the service;
  - **2007**: the USPSTF recommends "against routinely" providing the service
  - **2012**: the USPSTF recommends "selectively" providing the service (2012).
- "Grade C recommendations are particularly sensitive to patient values and circumstances, and typically will require an informed conversation between the clinician and patient."

The USPSTF has released for draft review an update of the 2009 breast cancer screening guidelines



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Mammogram Proposal Threatens to Reignite Screening Battle

Don't Miss Out — Follow us on:

by
Zachary Tracer and
Michelle Fay Cortez

5:00 PM EDT
April 20, 2015

A decision from a panel of U.S. doctors and health experts threatens to reignite the debate over how much breast cancer screening is appropriate, potentially opening the door for insurers to stop covering some mammograms.

In a draft proposal, the U.S. Preventive Services Task Force said Monday that most women under 50 may not need regular mammograms to look for breast cancer. The Patient Protection and

Draft 2015 USPSTF Breast Cancer Screening Recommendations

The USPSTF recommends biennial screening mammography for women ages 50 to 74 years. (B recommendation)

The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years. (C recommendation)

Implementation of the C Recommendation

The "C" recommendation for screening mammography in women ages 40 to 49 years means that the USPSTF concluded that the benefit of screening mammography outweighs the harms in this age range, but only by a small amount.

“C” Ratings are unavoidable, but can be problematic

- **Problems with Evidence**
  1. Data on benefits and harms may be limited
  2. Benefits and harms are dissimilar metrics
  3. Measuring benefits and risks is a challenge
     - Which outcome?
     - When is it measured?
     - Relative vs. Absolute vs. Both
     - Benefits & harms vary by risk
  4. Not all adults experience harms the same way
- **Problems with Implementation**
  1. Is the recommendation to individuals, or based on the population?
  2. Who should judge the ***value*** of the benefit?
  3. Who makes the decision about the **impact and acceptability** of risks
  4. Is there a policy threshold for acceptable levels of benefit and risk, and can it be reached?

Conclusion (1)

- The goal of cancer screening is to reduce avoidable deaths and morbidity from cancer
- Guidelines have a useful role, ***but they are less influential than they should be due to:***
  - Lack of consensus on methodology
    - Leads to different estimates of benefits and harms
    - ***Leads to different content in shared decision making materials***
  - Lack of agreement on thresholds and goals
  - Lack of knowledge and awareness of the details
  - Lack of incentives to implement them in clinical practice
  - Variations in coverage for the continuum of cancer screening

OK, Let’s not end on a discouraging note

Conclusion (2)—So how do we move forward?

- **Improving Guidelines & Guidelines Utilization**
  - Lack of consensus on methodology—**Get engaged in influencing guidelines development methodology**
  - Different estimates of benefit and harm? **–This is a scientific advocacy issue….explain to (1) media, (2) clinicians, and (3) the target population *why* one interpretation and judgment about the evidence is preferable**
  - Lack of agreement on thresholds and goals—**Do research on what the target population wants**

Conclusion (3)—So how do we move forward?

- **Improving Guidelines & Guidelines Utilization**
  - Lack of knowledge and awareness of the details **- Develop strategies to educate clinicians and the public**
  - Lack of incentives to implement guidelines in clinical practice **–Advocate for payment reform and other incentives, AND system reform**
  - Variations in coverage for the continuum of cancer screening **– Educate plans, and create a consumer movement**

Thank you