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Preventive Care: Controversies, Challenges and Upcoming Changes in Guidelines

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Objectives

- Organizations who make guidelines
- Current guidelines for average-risk adults, with a focus on guidelines with differing recommendations and challenges to implementation/operational issues
- Preview of upcoming changes in guidelines
- Cases to illustrate some of the common questions that come up in delivering office-based preventive care
- Some disclaimers

Who Makes Recommendations?

- US Preventive Services Task Force
  - Considered the most "conservative" and evidence-based guidelines
  - Pt Protection and Affordable Care Act covers preventive services graded "A" or "B"
- Disease-focused organizations (ACS, ADA, NCEP, etc.)
- Centers for Disease Control (CDC)
- Medical subspecialty organizations (AAFP, ACOG, AAP, ACP, etc.)

US Preventive Services Task Force

- Created in 1984, First edition, 1989—guidelines now released in journals and on their website
- Independent organization, convened by the AHRQ: 16 Experts from Family Medicine, Pediatrics, Internal Medicine, OB/GYN, Geriatrics, Preventive Medicine, Public Health, Behavioral Medicine, and Nursing
- Supported by outside experts
- Evidence-based guidelines (graded recommendations)
- Does NOT incorporate cost-effectiveness
- App: Prevention TaskForce https://www.uspreventiveservicestaskforce.org/apps/

USPSTF RECOMMENDATIONS AND RATINGS

A. The USPSTF strongly recommends that clinicians routinely provide (the service) to eligible patients

B. The USPSTF recommends that clinicians routinely provide (the service) to eligible patients

C. The USPSTF makes no recommendation for or against routine provision of (the service)

D. The USPSTF recommends against routinely providing (the service) to asymptomatic patients

I. The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing (the service)

Breast Cancer Screening

(2016)

- The USPSTF recommends against routine screening mammography in women 40-49 years old. Decision should be individualized – **"C"**
- Biennial screening mammography for women 50-74 years old – **"B"**
- Women ≥ 75 years old – **"I"**
- Dense Breasts, other imaging – **"I"**

New Guideline in Process

- Currently in Draft Research Plan stage

(Draft Research Plan->Final research plan->Draft Recommendation/Draft Evidence Review->Final Recommendation/Evidence Summary

- Reviewing:
  - new modalities
  - Differences based on age, breast density, race/ethnicity, family history

ACS Guidelines (2015)

- Ages 40-44: Should have the choice to start annual breast cancer screening with mammograms if they wish to do so
- Ages 45-54: Annual mammograms
- Ages 55 and older: Mammograms every 2 years or can continue yearly screening
- Screening should continue as long as a woman is in good health and is expected to have at least 10 years of life expectancy

- Clinical breast examination is not recommended

Controversies and Challenges

- Somewhat confusing guidelines
- Stick to guidelines you feel most comfortable/agree with
- When do you start talking to your patients about starting mammograms?
- When do you start talking to your patients about stopping mammograms?
- Recognize that Jefferson Breast Imaging Center recalls all mammogram patients yearly, regardless of age
  - Medical Assistants will often pre-order annual mammograms prior to provider coming into the room

Colorectal Cancer Screening

(2016)

- The USPSTF recommends screening for CRC at ages 50-75 years old – "A"
  - gFOBT/FIT annual
  - sDNA-FIT every 3 years
  - Cx every 10 years
  - CT colonography every 5 years
  - Flex Sig every 5 years
  - Flex Sig with FIT: FS every 10 years plus FIT every year
- Decision to screen patient 76-85 years old should be individualized – "C"
- Recommends against screening in ages >85 years old – "D"

New Guideline in Progress

- Draft Recommendation Stage (10/2020):

- 50-75 yo: “A”
- 45-49 yo: “B” (New)
- 76-85 yo: “C”

Age to start

- US Multi-Society Task Force recommends starting at 45 yo in Black adults (weak recommendation)
- ACS issued a “qualified” recommendation to begin screening at age 45 yo in all adults; starting at 50 yo is a “strong” recommendation
  - Recommends that clinicians discourage individuals >85yo from continuing CRC screening (“qualified”)
- AAFP does not address screening before age 50 yo

ACS (2018)

- Recommends screening with either a high-sensitivity stool-based test or a structural exam, depending on patient preference and test availability

- Structural exams

  Flex sig q 5 years

  Colonoscopy q 10 years

  CT colonography q 5 years

- Stool-based tests

  Annual high-sensitivity FOBT or FIT

  Stool DNA test with high sensitivity for cancer, every 3 years

JFMA CRC Screening Policy

- Colonoscopy is preferred screening modality, with FIT as alternative
- Direct Access Referral to Colorectal Surgery (3-3941 or 5-5896)
- Direct Access Referral to GI (5-5112)

Controversies and Challenges

- Age of starting, and questions about insurance coverage when starting at 45 yo
  - Additional problem: insurance issues when patient is found to have a polyp on a screening exam (becomes diagnostic, and patient may incur a charge)
- Direct access scheduling has been successful
- FIT follow up and documentation has been suboptimal at JFMA
  - Insurance companies doing FIT separately

Prostate Cancer Screening

(2018)

- The USPSTF concludes that the decision to undergo PSA-based screening for prostate cancer should be an individual one in men 55-69yo - "C"
- Recommends against screening for prostate cancer in men ≥70 years old - "D"
- No mention of DRE in the guideline

ACS Guidelines (2010)

- Start conversations about screening at age 50yo and earlier in African American men and men with FDR of prostate cancer before age 65yo
  - Focus on shared decision making
    - Discuss pros and cons
    - Consider patient preferences
    - Individualize the decision
- If patient wants provider to make decision, patient's values and beliefs should be taken into consideration
- Annual PSA with or without DRE, if PSA is >2.5 ng/ml
- If PSA is <2.5 ng/ml, can retest in 2 years

Other recommendations

- AAFP recommends against screening
- ACP recommends discussing benefits and harms with men 50-69yo who have a life expectancy greater than 10-15 years
- American Urological Association recommends SDM with men 55-69yo, with a life expectancy more than 10-15 years

Controversies and Challenges

- How best to do SDM? Your experience?
- One example:
  - A man who chooses to be screened might place a higher value on finding cancer early, might be willing to be treated without definite expectation of benefit, and might be willing to risk injury to urinary, sexual, and/or bowel function
  - A man who chooses not to be screening might place a higher value on avoiding the potential harms of screening and treatment, such as anxiety or the risk of injury to urinary, sexual, or bowel function

Lung Cancer Screening (2013)

- Adults aged 55-80:
  - Screen with annual low-dose CT in adults with a 30 pack-year smoking hx and currently smoke or have quit within the past 15 years – "B"
  - Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery

New guideline in progress

- In the draft recommendation stage, no longer taking public comments
- LCS recommended in adults ages 50-80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years – "B"

Other recommendations

- ACS (2013): 55-74yo, with at least a 30 pack-year history
- American College of Chest Physicians/ASCO/American Thoracic Society: 55-74yo, 30 pack-year history

Controversies and Challenges

- Identifying eligible patients:
  - Determining pack-years takes time
- Jefferson's Lung Cancer Screening program (direct referral): Will determine eligibility, do SDM, schedule the CT, give results, and arrange follow up (whether if positive or negative result)
- Screening rates are less than 5-10% nationally
  - Research study starting in March at JFMA: using an external health educator-driven process (prior to their office visit) to identify and contact eligible patients, provide education/SDM around LCS, and make appointment at the Jefferson LCS program

Cervical Cancer Screening

(2018)

- The USPSTF strongly recommends screening for cervical cancer in women who have been active and have a cervix – **"A"**
  - Ages 21-29: every 3 years
  - Ages 30-65: every 3 years with co-testing or every 5 years with HPV testing alone or with co-testing

- The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal PAP smears and are not otherwise at high risk for cervical cancer – **"D"**

- The USPSTF recommends against routine PAP smear screening in women who have had a total hysterectomy for benign disease – **"D"**

Other recommendations

- ACS (2020):
  - Start at age 25 and undergo primary HPV testing every 5 years through age 65 (preferred)
  - If primary HPV testing is not available, then individuals between ages 25-65 years should be screened with contesting every 5 years or cytology alone every 3 years
- AAFP: in agreement with the USPSTF

Controversies and Challenges

- Bimanual exam: Any role?
- What is “adequate screening” in women over 65 yo?
- What if have a normal screen at 63yo?

Aspirin for Primary Prevention of Cardiovascular Events and Colorectal Cancer

(2016)

- The USPSTF recommends the use of low dose aspirin for persons age 50-59 years who have a 10% or greater 10-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years and are willing to take low-dose aspirin daily for at least 10 years– **"B"**

- The USPSTF recommends that the decision to use low dose aspirin for persons age 60-69 years who have a 10% or greater 10-year CVD risk should be individualized – **"C"**

- **For adults younger than 50yo or 70yo or older – "I"**

- **ACC/AHA risk calculator: http://tools.acc.org/ASCVD-Risk-Estimator/**
  - **Age, sex, race/ethnicity, TC, HDL, SBP, HTN Tx, DM, Smoking**

Other recommendations

- AHA/American Stroke Association: recommend low dose ASA in adults whose 10-year CVD risk is 6-10%
- ADA recommends low dose ASA in patients with Type 1 or Type 2 diabetes with an CVD risk >10%
- AAFP is similar to USPSTF

High Blood Pressure Screening

(2015)

- The USPSTF strongly recommends that clinicians screen adults aged 18 and older for high blood pressure - "A"

- The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment (ambulatory BP monitoring is preferred over home BP monitoring)

  - For ages 18-39yo, if normal BP (<130/<85) and no other RF, can check every 3-5 years
  - For ages 40yo and over, or if overweight/obese or African American, should check annually

Other recommendations

- JNC7 (JNC8 in 2014 does not address screening)
  - <120/<80 - recheck in two years
  - 120-139/80-89 - recheck in one year
- AHA
  - At least once every 2 years in adults with BP less than 120/80
- AAFP is similar to USPSTF

Lipid Disorders

USPSTF last addressed in 2013

Since replaced with guidelines for:

Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication (2016)

Other recommendations

- National Cholesterol Education Program (NCEP)/American Heart Association:
  - A fasting lipoprotein profile (total cholesterol, LDL-C, HDL-C, and TG) in all adults over the age of 20 once every 5 years
- The AAFP strongly recommends periodic cholesterol measurement in men aged 35 to 65 and in women aged 45 to 65
- The American College of Obstetricians and Gynecologists recommends screening women every 5 years beginning at age 45; screening is recommended for women aged 19-44 based on risk factors.

Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication

(2016)

- "B": The USPSTF recommends that adults without a h/o CVD use a low-to-moderate dose statin for the prevention of CVD and mortality when ALL of following criteria are met:
  - Ages 40-75
  - Have 1 or more CVD RF (dyslipidemia, DM, HTN, smoking)
  - Have a calculated 10-year risk of CVD of 10% or greater

  - If have all the above but CVD risk is 7.5-10%: "C"

New Guideline in Progress

- Final Research Plan stage (no longer taking public comment)

- USPSTF does recommend measurement of Total Cholesterol, LDL and HDL in persons at 40-75yo. The optimal interval is uncertain but every 5 years is thought to be appropriate

Other recommendations

- ACC/AHA: recommend statins in asymptomatic adults, 40-75yo, without a h/o CVD who have an LCL of 70-189 mg/dl if they also have DM or an estimated 10-year CVD risk of 7.5% or greater (fixed dose statin therapy)

Abnormal Blood Glucose and Type II Diabetes Mellitus

(2015)

- Ages 40-70: USPSTF recommends screening for abnormal blood glucose for persons who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity – "B"
  - A1c, FPG, oral GTT all acceptable
  - Rescreening every 3 years may be reasonable (evidence limited)
- Consider screening in persons with one or more Risk Factors: family h/o DM, h/o gestational DM, member of certain racial/ethnic groups

New guideline in progress

- In Final Research Plan stage

Other recommendations

- ADA: Screen adults ages 45 years or older and screen in persons with multiple risk factors regardless of age
- AAFP/American Association of Clinical Endocrinologists: recommend screening in persons with risk factors only

Controversies and Challenges

- What is intensive behavioral counseling?

"Behavioral interventions that have an effect on CVD risk and delay or avoid progression of glucose abnormalities to DM combine counseling on a healthful diet and physical activity and are intensive, with multiple contacts over extended periods"

"The evidence is insufficient to conclude that pharmacologic interventions have the same multifactorial benefits as behavioral interventions"

Interventions for Tobacco Smoking Cessation in Adults

(2021)

- The USPSTF recommends asking all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and FDA-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco - "A"
  - Assessment: 5 A's (ask, advise, assess willingness to quit, assist, arrange f/u) or Ask, advise, refer
  - Interventions: Best for combo behavioral counseling and pharmacotherapy but either alone have benefits

Other recommendations

- AAFP, ACP, ACOG all have a similar recommendation
- USPSTF states that the current evidence is insufficient to assess the balance of benefits and harms of e-cigarettes for tobacco cessation – "I"
- Other organizations are varied as to whether they recommend screening for e-cigarette use or whether to use e-cigarettes as a smoking cessation method

Chlamydial and Gonorrhea Infection

(2014)

- The USPSTF strongly recommends that clinicians routinely screen all sexually active women aged 24 years and younger, and in older women at increased risk for infection- "B"
  - Interval not addressed, based on sexual history/risk
- The USPSTF concludes that the evidence is insufficient to recommend for or against routinely screening asymptomatic - "I"

New guideline in progress

- In final research plan stage (public comments are closed)

Other recommendations

- CDC:
  - Annual screening for chlamydia and gonorrhea in all sexually active females, aged 25yo or younger and in older women with RF (new or multiple sex partners and those reporting that their sex partner may have a concurrent sex partner)
- AAFP: same as the USPSTF
- ACOG: screening for chlamydia and gonorrhea in sexually active females aged 25yo and younger

Osteoporosis Screening

(2018)

- The USPSTF recommends screening for women aged 65 and older and in younger women who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment- "B"
  - Several tools acceptable: FRAX tool, Osteoporosis Risk Assessment Instrument (ORAI), others
  - Unclear interval
- Insufficient evidence to assess balance of benefits and harms of screening in men - "I"

Other recommendations

- National Osteoporosis Foundation (2014): recommends screening in all women 65yo and older and all men 70yo and older; screening in postmenopausal women youger than 65yo and men, 50-69yo based on RF profile

- AAFP: Similar to USPSTF

Additional "A" or "B" Recommendations

- All women planning or capable of pregnancy take 400 – 800 µg of folic acid daily (2017) – **"A"**
- Screen for depression in adults (2016) – **"B"**
- One time screening for AAA by ultrasound in men aged 65-75 who have ever smoked (2019) – **"B"**
- BRCA counseling and testing for women at increased risk (2019) – **"B"**
- Screening and Behavioral counseling intervention to reduce alcohol misuse by adults (2018) – **"B"**

- Breast Cancer Medication use to reduce risk: women at increased risk for breast cancer, ages 35yo and older (2019) – **"B"**
- Screen adults 18yo and older for unhealthy drug use (2018) - **"B"**
- Syphilis testing for high risk adults (2016) – **"A"**
- Offer or refer adults with a BMI of 30 or higher to intensive, multicomponent behavioral interventions (2018) – **"B"**
- Falls Prevention in Community-Dwelling Older Adults 65yo and older (2018) – **"B"**
- Offer or refer adults with CVD disease RF to behavioral counseling interventions to promote a healthy diet and physical activity (2020) – **"B"**

- Screen for Hep B in adults at increased risk for infection (2020) – "B"
- Screen for Hep C in adults ages 18-79yo (2020) – "B"
- Screen for HIV in adults 15-65yo (2019) – "A"
- Screen for intimate partner violence in women of reproductive age and refer screen+ women for support services (2018) – "B"
- Screen for latent TB in populations at increased risk (2016) – "B"
- Offer PrEP to persons at high risk of HIV acquisition (2019) – "A"

Getting Preventive Care Done

- Physician recommendation is KEY, but team-based care is critical in optimal delivery
- JFMA strategies
  - Epic/BPAs, Epic/MyChart
  - Office Policy, including MA involvement
  - Outreach by office staff/medical students
  - Quality measures
    - Public view/reporting
    - Incentives, disincentives

Health Maintenance Exams vs. Opportunistic Preventive Care

- Evidence/Research is almost always directed at individual services, less available around scheduling regular health maintenance exams (HME)
- Some data that cancer screening rates are higher if a patient gets regular HME

Case #1

- 83yo female, asking if she should continue getting breast cancer screening
  - BMI of 28, generally in “good” health, nonsmoker
  - Mobile without difficulty, one hospitalization in last 12 months, able to do own ADLs and IADLs, lives independently
  - +DM
  - No lung disease, h/o cancer, CHF

How do you decide?

Calculating life expectancy: example of risk calculator

- Lee Schonberg Index
- https://eprognosis.ucsf.edu/leeschonberg-result.php

  - Includes risk of 5-year, 10-year and 14-year mortality as well as life expectancy
  - Includes physician's assessment of patient's 10-year mortality rate

  - This patient has a life expectancy of 12.6-14.3 years

Case #2

- 28 year old male, comes in for an office visit and states he wants a full physical and his “annual labs”
  - Has no chronic diseases, just wants a “check up”

How do you approach the visit?

- History-taking and counseling of most evidence-based benefit for this patient
  - PMH, FH
  - SH: Sexual history, Tobacco/Drug/ETOH history
  - Depression screening
- Physical Exam
  - Ht: 5’10”, Wt: 202 (BMI of 29), Blood pressure 118/76
    - Counsel on diet/exercise
  - Little guidance from the evidence of extent of PE
- Laboratory tests/Vaccines
  - Lipids? A1c? Hep B or C? HIV? Syphilis? Chlamydia/GC?