US Preventive Services Task Force: Who we are, What we do, and How we hope to work with you

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The U.S. Preventive Services Task Force (USPSTF)

- Independent panel of volunteer, non-federal experts (N=16)
- Makes recommendations on clinical preventive services offered in the primary care setting
  - Screening tests
  - Preventive medications,
  - Counseling
- Recommendations apply to asymptomatic patients – without signs of symptoms of disease.
The US Preventive Services Task Force (USPSTF)

Current Task Force Members

Kirsten E. Bibbins-Domingo  
UCSF

John W. Epling, Jr.  
(Member)

Francisco Garcia  
(Member)

Alex R. Kemper  
(Member)

Alex H. Krist  
(Member)

Ann E. Kurth  
(Member)

C. Seth Landefeld  
(Member)

Carol M. Mangione  
(Member)

William R. Phillips  
(Member)

Maureen G. Phipps  
(Member)

Michael P. Pignone  
(Member)

Please consider nominating yourself or a colleague

David Grossman  
Group Health

Sue Curry  
University of Iowa

U.S. Preventive Services Task Force
What is the Task Force and what does it do?
Increasing Scope and Size of Audience

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

**Now**
- www.uspstf.org
- Audience = professionals and general public audience
- 500,000 web page views in 2015
Steps the USPSTF Takes to Solicit Input & make a Recommendation

1. Topic Nomination
2. Create Research Plan
3. Compile Evidence Report
4. Develop Recommendation
5. Disseminate Recommendation

At each stage –
1. Solicit feedback from content experts, sub-specialists
2. Draft posted for public comment
3. Peer-review of evidence report prior to public posting
Basic USPSTF Methods for Developing Recommendations

• The USPSTF assesses the evidence across the analytic framework:

  • Assesses the **certainty** of the estimates of the potential benefits and harms
  
  • Assesses the **magnitude** of the potential benefits and harms
  
  • The ultimate goal is to assess the **balance** of the benefits and harms, or the **magnitude of the net benefit** of the preventive service
## Basic USPSTF Methods for Developing Recommendations: The Letter Grades

<table>
<thead>
<tr>
<th>Certainty of Net Benefit</th>
<th>Magnitude of Net Benefit</th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Substantial</td>
<td>Moderate</td>
<td>Small</td>
<td>Zero/Negative</td>
</tr>
<tr>
<td>High</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>Moderate</td>
<td>B</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>Low</td>
<td>I</td>
<td></td>
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Screening for Prostate Cancer
2012 Recommendation
Evaluating the balance of benefits and harms

• The Test

• The Treatments
Calling for more research: Annual Report to Congress

- More research on prostate cancer
- More research on African Americans and prostate cancer
Advice for patients and clinicians

- In the 2012 Recommendation - Clinical Considerations:

“Although the USPSTF discourages the use of screening tests for which the benefits do not outweigh the harms in the target population, it recognizes the common use of PSA screening in practice today and understands that some men will continue to request screening and some physicians will continue to offer it. The decision to initiate or continue PSA screening should reflect an explicit understanding of the possible benefits and harms and respect patients' preferences. Physicians should not offer or order PSA screening unless they are prepared to engage in shared decision making that enables an informed choice by patients. Similarly, patients requesting PSA screening should be provided with the opportunity to make informed choices to be screened that reflect their values about specific benefits and harms.”
USPSTF Grades and the Affordable Care Act

• **Private insurers** “…shall provide coverage for and shall not impose any cost sharing requirements for evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the USPSTF”

• **The law also states** “…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”
USPSTF Grades and the Affordable Care Act

• The ACA expands access to evidence-based preventive services, but is the “floor” and not the “ceiling” for coverage

• USPSTF evaluates science, but does not determine coverage - that role is left to insurers, regulators, and lawmakers

• As physicians, we value access for our patients, but as a Task Force, we cannot reinterpret the science to arrive at an A or B recommendation
Screening for Prostate Cancer - Update in Progress
Update in Progress

• Recommendation statements are updated approximately every 5 years, particularly in areas of active research.

• 2012 recommendation update began at the end of 2015

• Draft Research Plan
  • Included from the outset explicit consideration of groups with a greater risk of prostate cancer – particularly African American men
Update in Progress

Draft Research Plan posted for public comment

- Public comment period: 10/29/15 to 11/25/15
- Many comments received - Including from PHEN

- Final Research Plan posted 4/28/16
Example Changes Based on Public Comments

• Clarified that the review will examine:
  • Differences within patient subpopulations at higher risk of prostate cancer
  • Harms of diagnostic follow-up (e.g., biopsy)

• Added contextual questions to address:
  • Use of informed and shared decision-making tools to guide screening and treatment decisions
  • How the benefits and harms of PSA-based screening may vary under different clinical scenarios
Final Analytic Framework
Final Contextual Questions

4. What do model estimates suggest about:
   
   a. The possible mitigation of harms of PSA-based screening for prostate cancer by using different screening strategies (i.e., varying the age at which to start/stop screening, the screening interval, the threshold for biopsy, and treatments)?
   
   b. The net benefit for subpopulations at higher risk for prostate cancer, prostate cancer mortality, or both (e.g., African Americans, men with a family history of prostate cancer)?
   
   c. The magnitude of over diagnosis of prostate cancer with PSA-based screening?

5. Do model estimates of net benefit depend on patients’ values and/or preferences for various health states?
Conclusions

• The USPSTF is an independent entity that uses a structured systematic review of the scientific evidence, combined with expert judgment, to make recommendations about preventive services offered in primary care.

• We strive to make recommendations relevant and useful to all communities in the US and have increased our focus on methods and communication in this area.

• Please stay engaged with us in our process. We value and utilize input from individuals and organized stakeholders throughout our process.

• Please read our reports! Our rationale and other clinical considerations are outlined there – please read more than just the grade. We hope these are useful for clinical practice, research, policy, and advocacy.
Thank you for your interest
www.USPreventiveServicesTaskForce.org
Addressing diverse communities in USPSTF recommendations

• Increasing partnership with stakeholder organizations interested in particular communities

• Epidemiology and practice by age, sex, and race/ethnic populations in the US described in all reports
  • Increasing attention to implementation

• Developed methodology for evaluating evidence in systematic review process for information on sub-populations
  • 5 methods papers by the Evidence based practice centers currently under review

• Sub-populations workgroup on how to incorporate evidence for specific populations into recommendations
  • 2 papers in process
The tension

• How much more incremental evidence do we need to make a different recommendation for a particular community?

• How do we balance the desire for a specific recommendation for a particular community with the important goal of pushing for more studies in diverse populations?
How can you help us?

- Topic Nomination
- Create Research Plan
- Compile Evidence Report
- Develop Recommendation
- Disseminate Recommendation

- We need your comments and feedback!
- Organizations can become stakeholders, and we solicit feedback from organizations
- Earlier in the process is better
Diabetes
Abnormal blood glucose and Type 2 diabetes: Screening

Release Date: October 2015

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What's This?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults aged 40 to 70 years who are overweight or obese</td>
<td>The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years 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.</td>
<td>B</td>
</tr>
</tbody>
</table>
Abnormal blood glucose and Type 2 diabetes: Screening

Clinical Considerations

Patient Population Under Consideration
This recommendation applies to adults aged 40 to 70 years seen in primary care settings who do not have symptoms of diabetes and are overweight or obese. The target population includes persons who are most likely to have glucose abnormalities that are associated with...

Other Considerations

Research Needs and Gaps
The USPSTF found only 2 studies, both conducted in Europe,\(^8,\,\,^9\) that directly evaluated the mortality benefit of screening in asymptomatic adults. Neither study had follow-up beyond 10 years or measured nonfatal cardiovascular events. Screening studies that follow larger numbers of participants for 20 years or longer and measure both morbidity and mortality are needed. Further, screening studies in the U.S. population (in which the prevalence of undiagnosed diabetes is probably higher than that identified in European studies [3%]) are needed. More research is needed on the effects of screening among racial/ethnic minorities because they have a higher prevalence of diabetes than white persons. Clinical trials and additional modeling studies are needed to better elucidate the optimal frequency of screening and the age at which to start screening. More U.S. data are also needed on the benefits and harms of lifestyle interventions and medical treatments for screen-detected IFG, IGT, and diabetes over a longer follow-up period.
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