AN OUNCE OF PREVENTION: *A PRIMER ON PREVENTATIVE HEALTH CARE FOR FAMILY PHYSICIANS*

Tara Mertz-Hack, MD
11/12/2022
NDAFP Annual Meeting, Grand Forks, ND

1

CONFLICTS OF INTEREST

None.

2

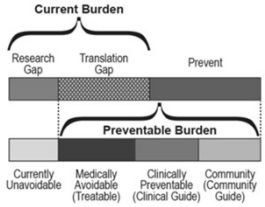
OBJECTIVES

- **Review**: Review the history and current state of preventative health care recommendations.
- **Identify**: Identify clinical tools to assist with patient decision making.
- **Assist**: Assist with developing an approach to implementing preventative health into clinical practice.

3

WHY DOES PREVENTION MATTER?

- Tobacco use, poor diet, and physical inactivity account for nearly 40% of premature deaths in the United States
- 7 out of 10 U.S. deaths are caused by chronic disease and half of the country has been diagnosed with a chronic illness considered preventable
- Chronic diseases are the most common, but also the most preventable



4

THE NEW YORKER

ANNALS OF MEDICINE JANUARY 23, 2017 ISSUE

THE HEROISM OF INCREMENTAL CARE

We devote vast resources to intensive, one-off procedures, while starving the kind of steady, intimate care that often helps people more.

By Atul Gawande

By 2010, Bill Haynes had spent almost four decades under attack from the inside of his skull. He was fifty-seven years old, and he suffered from severe migraines that felt as if a drill were working behind his eyes, across his forehead, and down the back of his head and neck. They left him nauseated, causing him to vomit every half hour for up to eighteen hours. He'd spend a day and a half in bed, and then another day stumbling through sentences. The pain would gradually subside, but often not entirely. And after a

5

MYTHS OF PREVENTATIVE HEALTH

- Preventative health recommendations change little over time
- The general health check is the best way to provide preventative health care
- Comprehensive physical examinations are important parts of preventative health care
- Preventative health care reduces health care costs
- Patient expectations of preventative healthcare are often evidence based

6

PREVENTATIVE HEALTH RECOMMENDATIONS

7

- United States Preventative Services Task Force (USPSTF)
- Specialty specific academies and colleges (AAFP, AAP, ACP, ACOG, ACG, etc.)
- Other medicine and health organizations (American Cancer Society, American Diabetes Association, etc.)
- Practice groups and health systems

8

USPSTF

Volunteer panel from fields of preventative medicine and primary care

A. Recommended (likely significant benefit)
B. Recommended (likely moderate benefit)
C. Do not use routinely (benefit is likely small)
D. Recommended against (likely harm or no benefit)
I. Insufficient evidence to recommend for or against

46 grade A and B recommendations

9

GRADE A & B RECOMMENDATIONS (FOR NONPREGNANT ADULTS) AT A GLANCE

- **Clinical data and questionnaires**: BP, BMI, tobacco use, alcohol use, depression screen, IPV screen, STI risk, fall risk, breast cancer risk
- **Laboratory screenings**: DMT2, chlamydia/gonorrhea, HIV, hepatitis C, hepatitis B, syphilis, tuberculosis
- **Imaging screenings**: osteoporosis, AAA
- **Cancer screenings**: cervical cancer, breast cancer, colorectal cancer, lung cancer
- **Medications**: folic acid, statins, PrEP
- Healthy lifestyle recommendations

10

FOCUS ON THE EVIDENCE

- Colorectal cancer screening
- Breast cancer screening
- Prostate cancer screening
- Asymptomatic pelvic examinations
- Aspirin use

11

FUTURE UPDATES

- Cervical cancer screening
- OSA screening

12

Testing methods
Testing frequency

COLORECTAL CANCER

13

WHICH OF THE FOLLOWING IS CORRECT REGARDING COLORECTAL CANCER SCREENING?

A. A healthy 81yo should not be screened

B. A 54yo may be screened with yearly FIT

C. Colonoscopy is the screening method of choice according to the USPSTF

D. A 63yo had a normal colonoscopy 5 years ago and is now offered yearly gFOBT or FIT

14

COLORECTAL CANCER

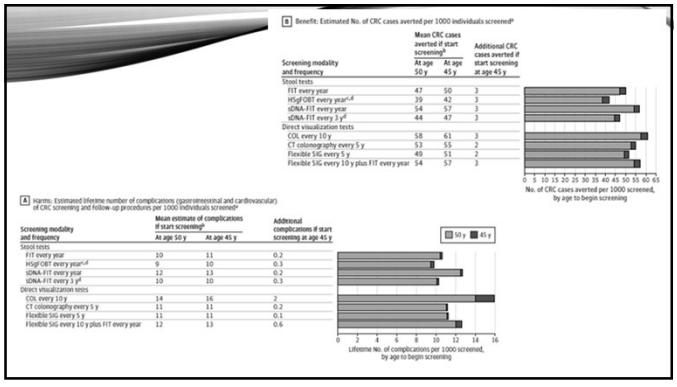
Adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer in all adults aged 50 to 75 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	A
Adults aged 45 to 49 years	The USPSTF recommends screening for colorectal cancer in adults aged 45 to 49 years. See the "Practice Considerations" section and Table 1 for details about screening strategies.	B
Adults aged 76 to 85 years	The USPSTF recommends that clinicians selectively offer screening for colorectal cancer in adults aged 76 to 85 years. Evidence indicates that the net benefit of screening all persons in this age group is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the patient's overall health, prior screening history, and preferences.	C

15

SCREENING METHODS

Screening Method	Frequency	Considerations
Colonoscopy	Every 10 years	Screening and diagnostic
Flexible sigmoidoscopy	Every 5 years	
CT colonography	Every 5 years	Insufficient evidence about harms of extracolonic findings
Flexible sigmoidoscopy + FIT	Every 10 years + yearly	
FIT	Yearly	Can be done with single specimen
FIT-DNA	Every 1 or 3 years	Specificity is lower than for FIT, but improved sensitivity

16



17

COMPARISON

- ACS, ACR, and gastroenterology groups
  - Non stool studies are preferred if available
- ACG and NCCN
  - Colonoscopy is the preferred screening strategy

18

Screening
BRCA testing

BREAST CANCER

19

BREAST CANCER

Women aged 50 to 74 years	The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.	B
Women aged 40 to 49 years	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

20

COMPARISON

	USPSTF	ACS	NCCN	ACOG	ACR
Age to start mammograms	50	45	40	40	40
Age to stop mammograms	74	Life expectancy <10 years	Not established	As long as in good health	Life expectancy <5-7 years
Interval	Every 2 years	Annual 45-54; every 1-2 years 55+	Annual	Annual	Annual

21

BRCA MUTATION RISK FACTORS

- Family history of breast cancer:
  - Bilateral
  - Diagnosed before age 50
  - Diagnosed in multiple family members
  - In 1 or more male family members
  - With a family history of ovarian cancer
  - Family member with 2 BRCA-related cancers

22

Screening

PROSTATE CANCER

23

PROSTATE CANCER

Men ages 55 to 69 years	The USPSTF recommends that clinicians inform men ages 55 to 69 years about the potential benefits and harms of prostate-specific antigen (PSA)–based screening for prostate cancer. The decision about whether to be screened for prostate cancer should be an individual one. Screening offers a small potential benefit of reducing the chance of dying of prostate cancer. However, many men will experience potential harms of screening, including false-positive results that require additional testing and possible prostate biopsy; overdiagnosis and overtreatment; and treatment complications, such as incontinence and impotence. The USPSTF recommends individualized decisionmaking about screening for prostate cancer after discussion with a clinician, so that each man has an opportunity to understand the potential benefits and harms of screening and to incorporate his values and preferences into his decision. Please refer to the Clinical Considerations sections on screening in African American men and men with a family history of prostate cancer for more information on these higher-risk populations.	C

24

COMPARISON

- ACP, 2013
  - 50-69yo discuss benefits and harms and only recommend to those with 10+ year life expectancy
- AUA, 2013
  - 55-69yo discuss benefits and harms
  - Screening interval should be 2 or more years
- ACS, 2016
  - Highlighted importance of shared decision making
  - Start discussing at 50yo with African American men or those with family member with prostate cancer before 65yo

25

RATIONALE

- Neither ERSPC or PLCO trial found an overall all cause mortality benefit from screening for prostate cancer
- Majority of studies examining radical prostatectomy and radiation found reductions in prostate cancer-specific mortality compared to watchful waiting
- Overdiagnosis of asymptomatic cancer that would never cause symptoms or contribute to death is the main rationale for the USPSTF recommendation

26

Draft: Table. Estimated Effects After 13 Years of Inviting U.S. Men Ages 55 to 69 Years to PSA-Based Screening for Prostate Cancer*

	Number of Men Affected
Men invited to screening	1,000
Men who receive at least 1 positive PSA test result	240
Men who have 1 or more transrectal prostate biopsies	220†
Men hospitalized for a biopsy complication	2
Men diagnosed with prostate cancer	100
Men who initially receive active treatment with radical prostatectomy or radiation therapy	65
Men who initially receive active surveillance	30
Men who initially receive active surveillance who go on to receive active treatment with radical prostatectomy or radiation therapy	15
Men with sexual dysfunction who received initial or deferred treatment	60
Men with urinary incontinence who received initial or deferred treatment	15
Men who avoid metastatic prostate cancer	3
Men who die of causes other than prostate cancer	200
Men who die of prostate cancer despite screening, diagnosis, and treatment	5
Men who avoid dying of prostate cancer	1 to 2

27

To do or not to do?

ASYMPTOMATIC PELVIC EXAMS

28

PELVIC EXAMS

Asymptomatic, nonpregnant adult women who are not at increased risk for any specific gynecologic condition	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of performing screening pelvic examinations in asymptomatic women for the early detection and treatment of a range of gynecologic conditions. This statement does not apply to specific disorders for which the USPSTF already recommends screening (ie, screening for cervical cancer with a Papanicolaou ["Pap"] smear, screening for gonorrhea and chlamydia). See the Table for more information.	I

29

COMPARISON

AAFP Recommends Against Pelvic Exams in Asymptomatic Women

Guidance Differs From USPSTF Final Recommendation

April 25, 2017 12:42 pm Chris Crawford – On March 7, the U.S. Preventive Services Task Force (USPSTF) published its final recommendation statement (www.uspreventiveservicestaskforce.org) and evidence review (www.uspreventiveservicestaskforce.org) on screening asymptomatic, nonpregnant adult women for gynecologic conditions using pelvic examination. The task force found that current evidence is insufficient to assess the balance of benefits and harms of performing screening pelvic exams in these women -- an "I" statement.

- AAFP and ACP
  - Recommend against
- ACOG
  - Recommends annually in all patients 21+*

30

For prevention of CV disease

ASPIRIN USE

31

ASPIRIN

Adults aged 40 to 59 years with a 10% or greater 10-year cardiovascular disease (CVD) risk	The decision to initiate low-dose aspirin use for the primary prevention of CVD in adults aged 40 to 59 years who have a 10% or greater 10-year CVD risk should be an individual one. Evidence indicates that the net benefit of aspirin use in this group is small. Persons who are not at increased risk for bleeding and are willing to take low-dose aspirin daily are more likely to benefit.	C
Adults 60 years or older	The USPSTF recommends against initiating low-dose aspirin use for the primary prevention of CVD in adults 60 years or older.	D

32

COMPARISON

- ACC/AHA
  - Select 40-70yo with high CVD risk who are not at increased bleeding risk
- ADA
  - Men >50yo and women >60yo with DMT1 or DMT2 with 10-year CVD risk of >10%

33

PATIENT TOOLS

34

PATIENT TOOLS

- Patients overwhelmingly say they want to learn about risks associated with various decisions, but less than half report that their provider asked about their goals or concerns
- Many important decisions in medicine, including those related to preventative health, involve options
- Shared decision making typically involves a significant amount of time
- Decision aids are interactive tools that help patients become involved in decision making, augment clinical discussions, and help patients become more informed about options

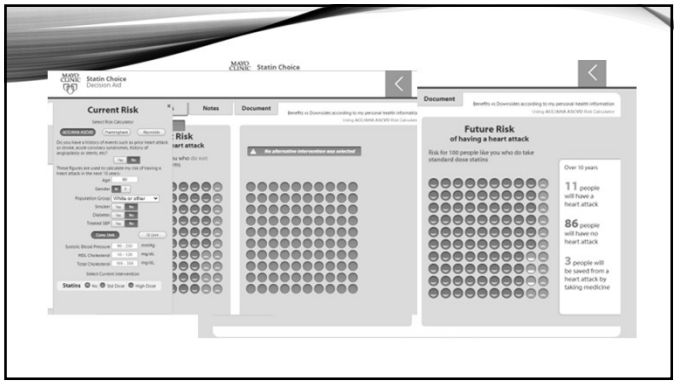
35

DECISION AID RESOURCES

- HealthWise
- St. Luke's Decision Points
- Mayo Clinic Decision Aids

Decision Points About Surgery
Decision Points About Surgery
Decision Points for Medicines
Decision Points for Medicines
Decision Points for Medical Tests
Decision Points for Medical Tests
Decision Points About Treatments and Other Health Issues
Decision Points About Treatments and Other Health Issues

36



37

CLINICAL IMPLEMENTATION

38

CLINICAL IMPLEMENTATION

- "The annual exam"
- Clinical tools
  - Prevention Task Force application
    Search for ePSS on Android, iPhone/iPod/iPad, Windows Apps
  - AAFP one-pager and other Family Practice Management resources *Family Practice Management Topic Collection: Preventative Care*
- Registry

39

"THE ANNUAL EXAM"

40

"THE ANNUAL EXAM"

- 45 million Americans have a general health check each year
- 66% of the public thinks having an annual general health check is necessary
- 2012 Cochrane review showed that general health checks did not decrease total, cardiovascular-related, or cancer-related mortality or morbidity
  - Most exams took place outside of primary care and included non-evidence based screening tests
- 2007 systematic review showed a beneficial effect on patients receiving recommended preventative services

41

"THE ANNUAL EXAM"

"I do physical exams and I do those procedures that lack an evidence base, often because patients will think they have not gotten their money's worth if there is no laying on of hands."

- Dr. Steven H. Woolf, USPSTF member and professor of family practice at VCU

"I still listen to everyone's heart. Why pick that fight? Why try to explain 10 years of evidence-based medicine so the patient will understand why I didn't do that test? The reason to listen to hearts is that it establishes our priestly majesty when you tell them about smoke alarms."

- Dr. Stewart Rogers, internist at Moses Cone Hospital in Greensboro, N.C.

42

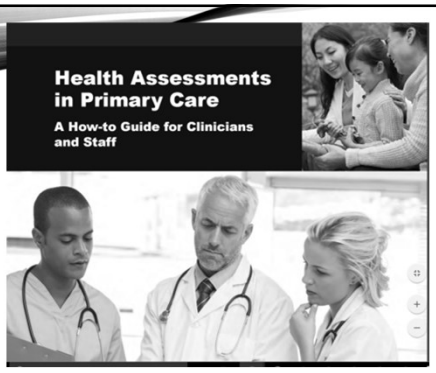
PREVENTION TASK FORCE APP

43

REGISTRIES

- Educate staff to effectively manage patient registries
- Consider tracking a different core preventative health measure each month or each quarter
- Use EMR and data analysis software to assist with registry management

44



45

TAKEAWAYS

46

TRUTHS OF PREVENTATIVE HEALTH

- Preventative health recommendations are frequently updated
- Every visit is an opportunity to provide preventative health care
- Risk stratification and counseling are important parts of preventative health care
- The most cost effective services are tobacco-use screening and brief intervention and immunizing children
- There are great resources available to assist clinicians in order to appropriately inform patients about preventative health

47

REFERENCES

48

REFERENCES

- Agoritsas T, Heen AF, Brandt L, et al. Decision aids that really promote shared decision making: the pace quickens. BMJ 2015;350:g7624.
- American Academy of Family Physicians. Summary of recommendations for clinical preventative services. 2017 Apr.
- Boulware LE, et al. Systematic review: the value of the periodic health evaluation. Ann Intern Med. 2007;146(4):289–300.
- Chosewood LC. Are your patients getting the preventative services they need? Fam Pract Manag. 1999 Jan;6(1):56-57.
- Cohen JT, Neumann PJ, Weinstein MC. Does preventative care save money? N Engl J Med 2008;358:661-663.
- Hostetter M, Klein S. Helping patients make better treatment choices with decision aids. Quality Matters. 2012 Oct.
- Kolata G. Annual physical checkup may be an empty ritual. The New York Times. 2003 Aug 12.
- Krogsbøll LT, Jørgensen KJ, Grønhøj Larsen C. General health checks in adults for reducing morbidity and mortality from disease. Cochrane Database Syst Rev. 2012;(10):CD009009.
- MacLean MV, Canfield AB, Edwards NM, Flottemesch TJ, Goodman MJ, Solberg LI. Priorities among effective clinical preventive services: results of a systematic review and analysis. Am J Prev Med 2006;31:52-61
- Mayo Foundation for Medical Education and Research. 2022. https://statindecisionaid.mayoclinic.org/
- McAndrews JA, McMullen S, Wilson SL. Four strategies for promoting healthy lifestyles in your practice. Fam Pract Manag. 2011 Mar-Apr;18(2):16-20.
- Makdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA 2004;291:1238-1245.
- Narasimhan K. General health checks for reducing morbidity and mortality. Am Fam Physician 2013 Oct 1; 88(7):432-433.
- National Center for Chronic Disease Prevention and Health Promotion. The power of prevention. 2009.
- Ockene JK, Edgerton EA, Teutsch SM, et al. Integrating Evidence-Based Clinical and Community Strategies to Improve Health. U.S. Preventative Services Task Force. 2016 Sept.
- Swenson PF, Ebell MH. Introducing a one-page adult preventative health care schedule: USPSTF recommendations at a glance. Am Fam Physician. 2016 May 1;93(9):738-740.
- Swift D. Is the annual physical exam past its prime…again? Medscape. 2015 Jan 15.
- U.S. Preventative Services Task Force. https://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations. 2022 Oct.
- Watson LW. Preventative medicine: giving patients the hard sell. Fam Pract Manag. 2008 Jan;15(1):22-24.

49

QUESTIONS

50