Assessing PPRNet-TRIP for Recently Updated Recommendations of the U.S. Preventive Services Task Force

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THE PPRNET FOUNDATION (TPF)

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Agenda

- To present an overview of recent (2016-18) A& B recommendations of the USPSTF and more details on some of the more recent

- To learn how your practices have implemented key factors from the PPRNet-TRIP model to optimize delivery of some of the most recent recommendations
The U.S. Preventive Services Task Force (USPSTF)

An independent panel of non-federal experts in prevention and evidence-based medicine and is composed of primary care providers (such as internists, pediatrcicians, family physicians, OB-GYN, nurses, and health behavior specialists).

http://www.uspreventiveservicestaskforce.org/uspstoptics.htm
<table>
<thead>
<tr>
<th>Grade</th>
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<tbody>
<tr>
<td>A</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial.</td>
</tr>
<tr>
<td>B</td>
<td>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.</td>
</tr>
<tr>
<td>C</td>
<td>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.</td>
</tr>
<tr>
<td>D</td>
<td>The USPSTF recommends <strong>against</strong> the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.</td>
</tr>
<tr>
<td>I</td>
<td>The USPSTF concludes that current evidence is insufficient to assess the balance of benefits &amp; harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</td>
</tr>
<tr>
<td>Date</td>
<td>Recommendation Details</td>
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<tr>
<td>April 2016*</td>
<td>Aspirin preventive medication: adults aged 50 to 59 years with a ≥10% 10-year cardiovascular risk. The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular 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.</td>
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<td>February 2016*</td>
<td>Depression screening: adolescents. The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.</td>
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<td>January 2016*</td>
<td>Depression screening: adults. The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.</td>
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<td>November</td>
<td>Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater. The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.</td>
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<td>October</td>
<td>Breastfeeding interventions The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.</td>
</tr>
<tr>
<td>September</td>
<td>Tuberculosis screening: adults The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.</td>
</tr>
<tr>
<td>June</td>
<td>Colorectal cancer screening The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.</td>
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<tr>
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<td>Syphilis screening: nonpregnant persons The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.</td>
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# USPSTF A&B Recommendation: 2017

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<tr>
<td>September 2017*</td>
<td>Vision screening: children</td>
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<td>The USPSTF recommends vision screening at least once in all children ages 3 to 5 years to detect amblyopia or its risk factors.</td>
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<td>June 2017*</td>
<td>Obesit_y screening: children and adolescents</td>
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<td></td>
<td>The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.</td>
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<td>April 2017</td>
<td>Preeclampsia screening</td>
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<td></td>
<td>The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.</td>
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<tr>
<td>January 2017*</td>
<td>Folic acid supplementation</td>
<td>A</td>
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<tr>
<td></td>
<td>The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.</td>
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# USPSTF A&B Recommendation: 2018

**August 2018**
- **Cervical cancer screening**
  - The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).

**June 2018**
- **Osteoporosis screening: postmenopausal women younger than 65 years at increased risk of osteoporosis**
  - The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.

- **Osteoporosis screening: women 65 years and older**
  - The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.

**April 2018**
- **Falls prevention: older adults**
  - The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.

**March 2018**
- **Skin cancer behavioral counseling**
  - The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.
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<th>Month</th>
<th>Specialties</th>
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<td>November 2018</td>
<td>Unhealthy alcohol use: adults</td>
<td>The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.</td>
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<tr>
<td>September 2018</td>
<td>Obesity screening and counseling: adults</td>
<td>The USPSTF recommends that clinicians offer or refer adults with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.</td>
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<td>September 2018</td>
<td>Syphilis screening: pregnant women</td>
<td>The USPSTF recommends early screening for syphilis infection in all pregnant women.</td>
</tr>
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Today’s Focus

- Obesity: children, adolescents, and adults
- Osteoporosis screening for women <65 y.o.
- Falls prevention: older adults
- Skin cancer behavioral counseling
Why These Preventive Services?

- They are not simple and may be challenging to implement
- We have not discussed them much before
- If the USPSTF is to recommend these services, it is interesting to know if exemplar PCPs are implementing them
Obesity Screening: Children, Adolescents, and Adults

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<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What’s This?)</th>
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<td>Children and adolescents 6 years and older</td>
<td>The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.</td>
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<tr>
<td>Adults</td>
<td>The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.</td>
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Rationale: Children and Adolescents

- 17% of US children 2-19yo are obese (>=95th percentile 2000 growth charts)
- 32% are overweight or obese (>=85%)
- Childhood obesity associated with asthma, OSA, orthopedic, CVD and MH problems
- Age and sex adjusted BMI percentile is accepted measure
- Screening and intensive behavioral interventions can improve weight status
- Harms minimal
Clinical Considerations: Children and Adolescents

- All children 6 & older though some at higher risk; interval uncertain
- Intensive behavioral interventions with >= 26 contact hours (>= 52 hours better) over 2 to 12 months resulted in weight loss
- Multicomponent strategies targeting both the parent and child; provided information about healthy eating, safe exercising, and reading food labels; encouraged stimulus control (e.g., limiting access to tempting foods and limiting screen time), goal setting, self-monitoring, contingent rewards, problem solving; and supervised physical activity
- >=52-hour programs rarely provided in primary care settings
Rationale: Adults

- > 35% of men and 40% of women in the U.S. are obese
- Obesity associated with CHD, T2DM, some cancers, gallstones, disability, and premature death
- Behavior-based interventions in obese adults can lead to clinically significant improvements in weight and reduced incidence of T2DM
- Harms of intensive, multicomponent behavioral interventions small to none
Clinical Considerations: Adults

- Weight loss of 5% is clinically important
- Most intensive behavioral weight loss interventions 1 to 2 years; majority had 12 or more sessions in year 1
- Heterogenous interventions
- PCP involvement: limited interactions with participants in interventions conducted by others to reinforcing intervention messages through brief counseling sessions; few interventions included a PCP as the primary interventionist
- Interventions combining pharmacotherapy with behavioral interventions reported > weight loss and weight loss maintenance compared with behavioral interventions alone, but participants required to meet highly selective inclusion criteria and trials had high attrition
| Postmenopausal women younger than 65 years at increased risk of osteoporosis | The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. | B |
Rationale

- By 2020, approximately 12.3 million in U.S. will have osteoporosis
- Osteoporotic fractures, particularly hip associated with ambulation limitation, chronic pain, disability, loss of independence, decreased QOL
- 21% to 30% of patients with hip fracture die within 1 year
- Dual-energy x-ray absorptiometry (DXA) of the hip and lumbar spine
- Postmenopausal women < 65 years who are at increased risk of osteoporosis, adequate evidence that screening can detect osteoporosis and that treatment provides a moderate benefit in preventing fractures
- Harms of screening and medical treatment <= small
Clinical Considerations

- Risk factors in postmenopausal women < 65 y.o.: smoking, parental hx of hip fracture, excess ETOH, low body weight; those with risk use clinical risk assessment tool:
  - Simple Calculated Osteoporosis Risk Estimation (SCORE; Merck)
  - Osteoporosis Risk Assessment Instrument (ORAI)
  - Osteoporosis Index of Risk (OSIRIS)
  - Osteoporosis Self-Assessment Tool (OST)
  - The FRAX tool (University of Sheffield)—assesses 10-year fracture risk
## Falls Prevention: Older Adults

<table>
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<tr>
<th>Adults 65 years or older</th>
<th>The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.</th>
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<td>Adults 65 years or older</td>
<td>The USPSTF recommends that clinicians selectively offer multifactorial interventions to prevent falls to community-dwelling adults 65 years or older who are at increased risk for falls. Existing evidence indicates that the overall net benefit of routinely offering multifactorial interventions to prevent falls is small. When determining whether this service is appropriate for an individual, patients and clinicians should consider the balance of benefits and harms based on the circumstances of prior falls, presence of comorbid medical conditions, and the patient’s values and preferences.</td>
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Rationale

- Falls leading cause of injury-related morbidity/mortality older U.S. adults
- Annually ~30% of community >=65 y.o. fall, causing ~33,000 deaths
- No good screening test, other than hx of falls
- Exercise interventions moderate benefit in preventing falls in older adults at increased risk, multifactorial interventions small benefit, Vit D no benefit
Clinical Considerations

- Pragmatic approach to identifying persons at high risk for falls--assess for a history of falls, problems in physical functioning and limited mobility

- Clinicians could also use assessments of gait and mobility, such as the Timed Up and Go test

- Effective exercise interventions include supervised individual and group classes and PT, most studies reviewed included group exercise

- Most common frequency/duration for exercise interventions was 3x per week/12 months
**Directions:** Patients wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters, or 10 feet away, on the floor.

1. **Instruct the patient:**

   **When I say “Go,” I want you to:**
   1. Stand up from the chair.
   2. Walk to the line on the floor at your normal pace.
   3. Turn.
   4. Walk back to the chair at your normal pace.
   5. Sit down again.

2. **On the word “Go,” begin timing.**
3. **Stop timing after patient sits back down.**
4. **Record time.**

**Time in Seconds:**

An older adult who takes ≥12 seconds to complete the TUG is at risk for falling.
## Skin Cancer: Behavioral Counseling

| Young adults, adolescents, children, and parents of young children | The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer. |
| Adults older than 24 years with fair skin types | The USPSTF recommends that clinicians selectively offer counseling to adults older than 24 years with fair skin types about minimizing their exposure to UV radiation to reduce risk of skin cancer. Existing evidence indicates that the net benefit of counseling all adults older than 24 years is small. In determining whether counseling is appropriate in individual cases, patients and clinicians should consider the presence of risk factors for skin cancer. |
Rationale

- 3.3 million new cases of nonmelanoma skin cancer in 2012
- >91K new cases of melanoma skin cancer in 2018
- Exposure to UV radiation in childhood/adolescence (esp. severe sunburns) ↑ skin cancer later in life
- Persons with fair skin types (ivory or pale skin, light hair and eye color, freckles, or those who sunburn easily) ↑ risk
- Behavioral counseling result in a moderate ↑ sun protection behaviors for persons aged 6 mths to 24 yrs
Clinical Considerations

- Most trials of skin CA counseling in persons with fair skin
- Children/adolescents studies focused on sun protection (sunscreen, avoiding midday sun, sun-protective clothing)
- Most interventions directed at parents; some provided child-specific materials or messages.
- Half of interventions included face-to-face counseling; all included print materials
- Delivered by PCPs and health educators
PPRNet TRIP Model for Preventive Services

SELECTED REFERENCES
A-TRIP
(CVD, Cancer, Immunizations, Mental Health)
C-TRIP  
(Colorectal Cancer screening)
Implementing and Evaluating Electronic Standing Orders in Primary Care Practice: A PPRNet Study

Lynne S. Nemeth, PhD, RN, Susan M. Ornstein, MD, Ruth G. Jenkins, PhD, Andrew M. Wessel, PharmD, and Paul J. Nieman, PhD

Background: A standing order (SO) authorizes nurses and other staff to carry out medical orders per practice-approved protocol without a clinician’s examination. This study implemented electronic SOs into the daily workflow of primary care practices: identified methods and strategies: determined barriers and facilitators: and measured changes in quality indicators resulting from electronic SOs.

Methods: Within 8 practices using the Practice Partner® electronic health record (EHR), a customized health maintenance template provided SOs for screening, immunization, and diabetes measures. EHR data extracts were used to calculate the presence and use of these measures on health maintenance templates and performance over 21 months. Qualitative observation/interviews at practice site visits, network meetings, and correspondence enabled synthesis of implementation issues.

Results: Improvements in template presence, use, and performance were found for 11 measures across all practitioners. Median improvements in screening ranged 6% to 10%; immunizations, 8% to 17%; and diabetes, 0% to 18%. Two practices achieved significant improvements on 4 of the 15 measures. All practices significantly improved on at least 3 of the measures.

Conclusions: A small sample of primary care practices implemented SOs for screening, immunizations and diabetes measures supported by PPRNet researchers. Technical competence and leadership to adapt EHR reminder tools helped staff adopt new roles and overcome barriers. (J Am Board Fam Med 2012;25:594–601.)

Keywords: Electronic Health Records, Practice-based Research, Practice-based Research Networks, Standing Orders
PPRNet TRIP Model for Preventive Services

Key Elements:
- Audit and Feedback
- Practice Facilitation
- Team Care
- Standing Orders
- EHR Reminders
- Registry Use and Outreach
Your Practice’s Implementation of These New USPSTF Recommendations
# Obesity Screening: Children, Adolescents, and Adults

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Poll

To what extent has your practice implemented this USPSTF recommendation?

1. Completely
2. A lot of it
3. A little of it
4. None of it
Which elements of the PPRNet-TRIP model for improving PS delivery have you used for this PS: Audit and Feedback, Practice Facilitation, Team Care, Standing Orders, EHR Reminders, Registry Use and Outreach?

What other strategies have you used to implement this recommendation?
Practices Answering 3 or 4

- Do U agree with this recommendation: if not, why not?
- Does the recommendation apply to your practice?
- If you agree with the recommendation and it is applicable to your practice, what facilitators/barriers have U faced implementing it?
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Practices Answering 1 or 2

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Do U agree with this recommendation: if not, why not?

Does the recommendation apply to your practice?

If you agree with the recommendation and it is applicable to your practice, what facilitators/barriers have U faced implementing it?
Questions and Comments