Past, present and future issues for the US Preventive Services Task Force

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USPSTF history

* USPSTF I: 1984 — 1989
  - Followed first report of the Canadian Task Force on the Periodic Health Examination
  - Established by the US Department of Health and Human Services
  - 20 members — MDs (14), other providers
  - Members did all reviews and wrote the recommendations
  - First *Guide* published in 1989 (169 services)

USPSTF history

* USPSTF II: 1990 — 1995
  - 10 members — 8 primary care MDs
  - Staffed by medical officers in the Office of Disease Prevention and Health Promotion
  - Members did reviews; staff wrote many of the recommendations
  - Second Guide published in 1996 (200 services)

USPSTF history

* USPSTF: 1998 — present
  - Codified by US Congressional action and charged to:
    - Review the scientific evidence for clinical preventive services and
    - Develop evidence-based recommendations for the health care community
  - Moved to the Agency for Health Research and Quality (AHRQ)

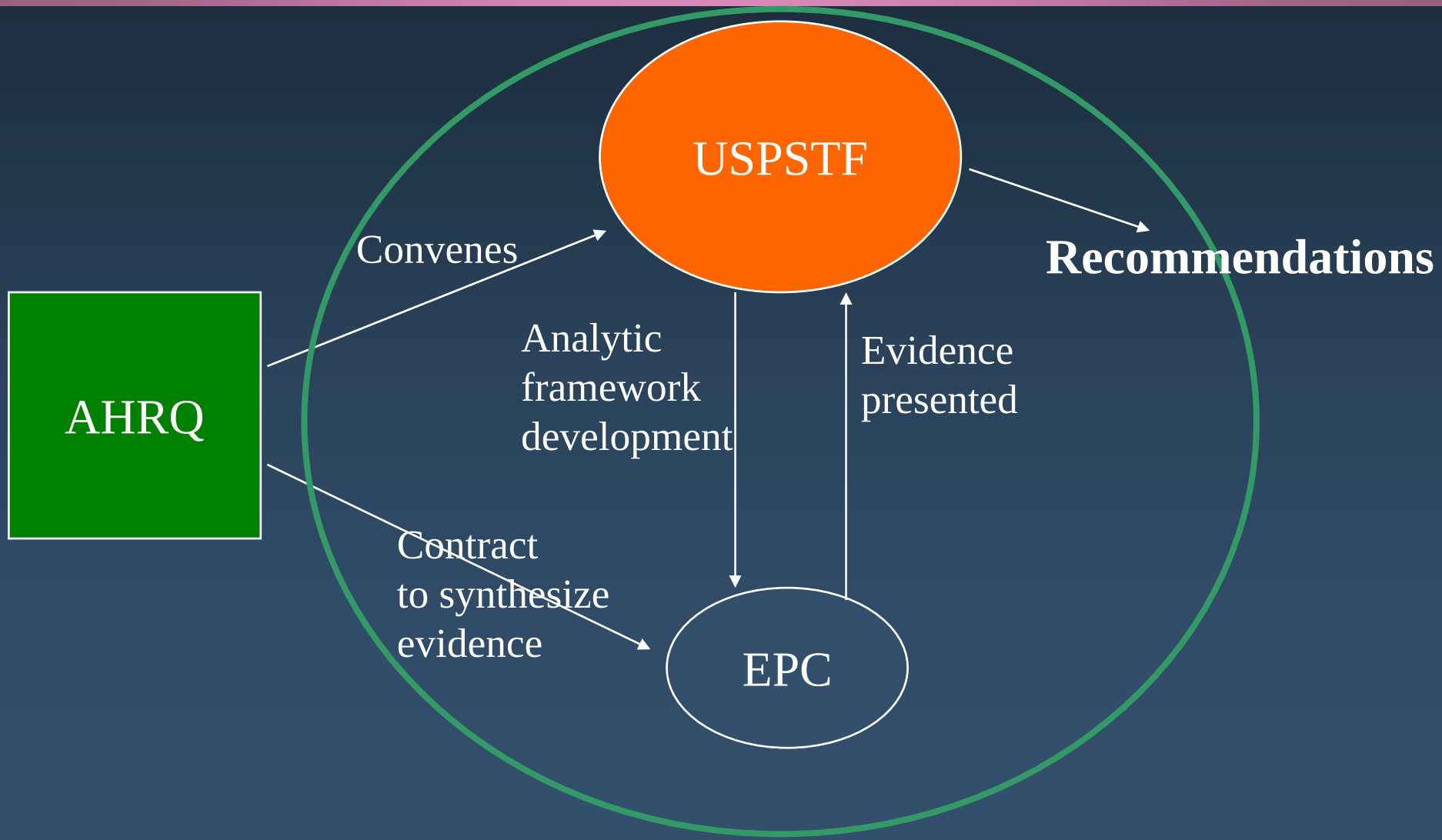
USPSTF today

* Independent panel of nationally recognized, non-federal researchers experienced in primary care, prevention, evidence-based medicine, and research methods
* 16 members constitute the Task Force, now with a revolving membership (4 year terms)
* Member disciplines: family medicine, internal medicine/geriatrics, preventive medicine, pediatrics/adolescent medicine, Ob/Gyn, nursing, counseling/behavioral medicine, public health, and health policy

USPSTF today

* Systematic Evidence Reviews (SERs) are contracted out to a separately funded and independent Evidence-based Practice Center (EPC) that works more or less exclusively for the Task Force
* EPC staff (primarily academic physicians) work closely with Task Force leads during the SER process
* The entire Task Force reviews the SER and works collaboratively to decide on and write the recommendation
* Task Force members also review and update the core methodology and publications/products

AHRQ Support of USPSTF



USPSTF today

* Liaisons with partner organizations:
  - Federal partners: the Centers for Disease Control and Prevention, Department of Defense, Centers for Medicare and Medicaid Services, Department of Veterans Affairs, Health Resources and Services Administration, National Institutes of Health, U.S. Army Center for Health Promotion and Preventive Medicine, and the U.S. Food and Drug Administration
  - Primary care partners: include the American Academy of Family Physicians, American Academy of Pediatrics, American Academy of Physician Assistants, American College of Obstetricians and Gynecologists, American College of Physicians, American College of Preventive Medicine, America's Health Insurance Plans, the Canadian Task Force on Preventive Health Care, the National Committee for Quality Assurance, and the Pan American Health Organization

USPSTF today

* Task Force products have changed:
  - Systematic Evidence Reviews and the resulting Recommendation and Rationale statement are co-published in a medical journal promptly on completion
  - All materials are posted on the internet
  - An annual summary of the recommendations are published
  - All recommendations are included in a free, down-loadable PDA program
  - Other support materials are aimed at providers and the public

Issues and challenges

* There is a significant paradigm shift from expert panels and consensus recommendations to evidence-based methods
* Experts with vested interests often review the same evidence and come to different conclusions (or make recommendations without supporting evidence)
* Evidence-based recommendations often conflict with the market and the drive for profit

Issues and challenges

* Maintenance of independence
  - » Congress has “lobbied” the Task Force on services for which advocates have approached them
  - » Some reviews have been prioritized later due to concerns regarding approval from the administration
  - » Some advocacy groups complain that the Task Force recommendations are used to limit what publicly-funded care pays for

Issues and challenges

- Limits of evidence
  - There is little scientific evidence regarding key areas of clinical recommendations:
    - Age at which to begin or stop providing a service
    - Periodicity at which to provide the service
    - Use of the service in special populations (specifically, different race or ethnic groups)

Issues and challenges

- Modeling
  - What should be the role of modeling to extrapolate from where there is evidence to where there is no available evidence?
  - What should be the role of decision-analysis?
  - Can we base recommendations on modeling the bounds of potential benefits and harms?
  - What should be the role of expert systems modeling such as David Eddy's Archimedes project?

Issues and challenges

* Cost and cost-effectiveness
  - What role should cost and cost-effectiveness play in making a decision about a recommendation?
* Prioritization
  - There are many recommended services to try to fit into practice
  - Services may be prioritized based on effectiveness, population benefit, gaps in utilization, and cost-effectiveness

Issues and challenges

- Maintenance of up-to-date recommendations
  - Target is to update a review and recommendation every 5 years (meets criteria for inclusion in the National Guideline Clearinghouse)
  - Updates compete for the same resources as new topics
  - The Task Force is pioneering update methods:
    - Brief updates, targeted reviews, reaffirmations

Issues and challenges

* Evidence-based medicine methods are evolving
  - » Concern about the relative exclusion of external validity of studies from review methods
  - » Concern about the other criteria currently used to judge study quality
  - » Questions about how most appropriately to include evidence from quasi-experiments and observational studies in evidence reviews

Issues and challenges

* The I statement
  - » Providers don’t like the insufficient evidence conclusion
  - » It’s difficult to address services with an I conclusion in practice, policy and payment
  - » The I statement is the most commonly used letter grade!
  - » The Task Force is working on methods to provide contextual guidance to providers for I-rated services, without creating a non-evidence based recommendation

Issues and challenges

* Genomics
  - There are over 900 genetic and proteomic tests being promoted for screening, risk assessment and other uses
  - The Task Force does not have the resources to address this volume of services
  - While heavily marketed directly to the public, almost none of these have evidence of analytic validity, clinical validity or clinical effectiveness

The Spanish initiative

* This appears to be a feasible and appropriate endeavor
* While the evidence base will be very much the same, there will be difference in recommendations based on:
  * Spanish national values that vary from the U.S.
  * Difference in disease prevalence
* National recommendations are likely to have more influence than those from outside of Spain

The Spanish initiative

* Critical issues:
  - » Assure appropriate resources (don't under-fund)
  - » Staff with appropriate expertise
  - » Assure appropriate membership expertise
  - » Assure independence of decision-making
    - – From policy makers and funders
    - – From advocates and specialty organizations
  - » Pay attention to dissemination and implementation plans (translation into practice)