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A need for improved understanding about USPSTF and other evidence-based recommendations

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Anderson et al. (Anderson et al., 2014) have provided valuable insights regarding the opinions of obstetrician and gynecologists (obgyns) from a survey conducted in 2010, when the Patient Protection and Affordable Care Act (as amended by the Healthcare and Education Reconciliation Act and referred to collectively as the Affordable Health Care Act) was passed (The Patient Protection Affordable Care Act, 2010). One provision of the Act is the requirement that new private health plans eliminate cost-sharing for a variety of preventive services, including those recommended by US Preventive Services Task Force (USPSTF) with an 'A' or 'B' rating (Koh and Sebelius, 2010). In 2009 the USPSTF released new breast cancer recommendations changing the recommended screening frequency from 1–2 years to biennial screening and drawing a distinction on the overall effectiveness of mammography for women older and younger than 50 years of age. In 2009, the USPSTF concluded that the overall benefit was smaller for women 40 to 49 years old and recommended that these women discuss the potential harms and benefits of screening with their doctors before making an individualized decision. This occurred during the time period when the health reform legislation was being finalized. As a result, some may have misunderstood the revised recommendations for less frequent screening as a cost reduction measure under the Affordable Care Act rather than the evidence-based decision that the USPSTF intended it to be. Congress chose to allow for more expansive coverage than would have been required based on the 2009 USPSTF recommendations. As a result, when it was enacted in 2010 the Affordable Care Act required that annual breast cancer screenings be covered by new private health plans without cost-sharing to women aged 40 and older, based on the 2002 USPSTF recommendations USPSTF, 2002.

The USPSTF plays an increasingly important role in implementation of the Affordable Care Act as it will serve as the basis for coverage of key preventive health services. Anderson's (Anderson, et al., 2014) survey highlights several salient issues related to evidence-based recommendations. First, the results of this study suggest that providers did not have an accurate understanding of the makeup or the process of the USPSTF, which is an independent panel of nonfederal experts in prevention and evidence-based medicine (USPST

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Force, 2013). As an independent panel, the USPSTF includes members from primary care and preventive medicine and includes the specialty of obstetrics and gynecology.

Second, the providers in the survey responded that potential cost-savings were factors that influence guidelines, but cost-effectiveness was not considered by the USPSTF. Instead, the USPSTF commissions decision analyses for some recommendations to estimate the balance of both clinical benefits and harms of preventive interventions. Cancer screening may be harmful by detecting abnormalities through screening that never progresses and more treatment that produces no benefit to the patient but instead may have adverse effects (Leach et al., 2012; Welch, 2013). Every screening test lends itself to a balanced discussion of benefits and harms, but it is especially important to understand in the context of opportunistic screening because the tendency is to screen for a cancer without an emphasis of the potential harms. A recent Cochrane review confirmed that most cancer screening trials do not even assess harms (Heleno et al., 2013). Due to the dearth of data on harms in clinical trials, the USPSTF often have to rely on other sources to assess harms of screening tests.

Third, respondents to this survey reported that besides breast care overall, they believed that the Affordable Care Act would have the biggest impact on overall practices and frequency of annual exams. This concern about the frequency of the annual exam has been highlighted in studies examining the impact of new cervical cancer screening guidelines where screening intervals have been lengthened to 3 to 5 years (Roland et al., 2011; Saraiya et al., 2010; Yabroff et al., 2009). Under the law, at least one well woman visit must be covered by new private health plans, thus providing an opportunity to focus on the quality (rather than the frequency) of the annual exam by offering many recommended clinical preventive services and increase the continuity of care (Gee, 2012). The Institute of Medicine report highlights that the well woman exam is not about conducting procedures but about focusing on comprehensive services, including counseling services (National Research Council, 2011). Gee et al. state that this means greater coordination of care between primary care clinicians who can provide the chronic disease care and the ob-gyn (Gee and Rosenbaum, 2012).

Finally, an important area for discussion, especially for ob-gyns, will be what may be included in the annual well-woman visit. The last iteration of the American College of Obstetricians and Gynecologists (ACOG) consensus guidelines included services that are not-evidence based and equated ob-gyns as primary care clinicians (ACOG, 2011). Even when clinical guidelines are evidence-based, primary care clinicians, including ob-gyns, deviate from such guidelines when recommending and overseeing cancer screening. For example, many ob-gyns use in office fecal occult blood testing (FOBT) to screen for colorectal cancer, when the USPSTF recommendation is to screen with a home FOBT annually (Nadel et al., 2010; Preventive, 2002). Other examples include cervical cancer screening intervals that are shorter than the recommended intervals (Roland et al., 2011), use of clinical breast exam for women younger than 40 years of age ACOG, 2012; ACOG., 2011 and the use of pelvic examinations to screen for cancer (Henderson et al., 2012; Stormo et al., 2012). Greater reliance on evidence-based recommendations could be valuable when recommending and overseeing cancer screening services during a well-woman visit.

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