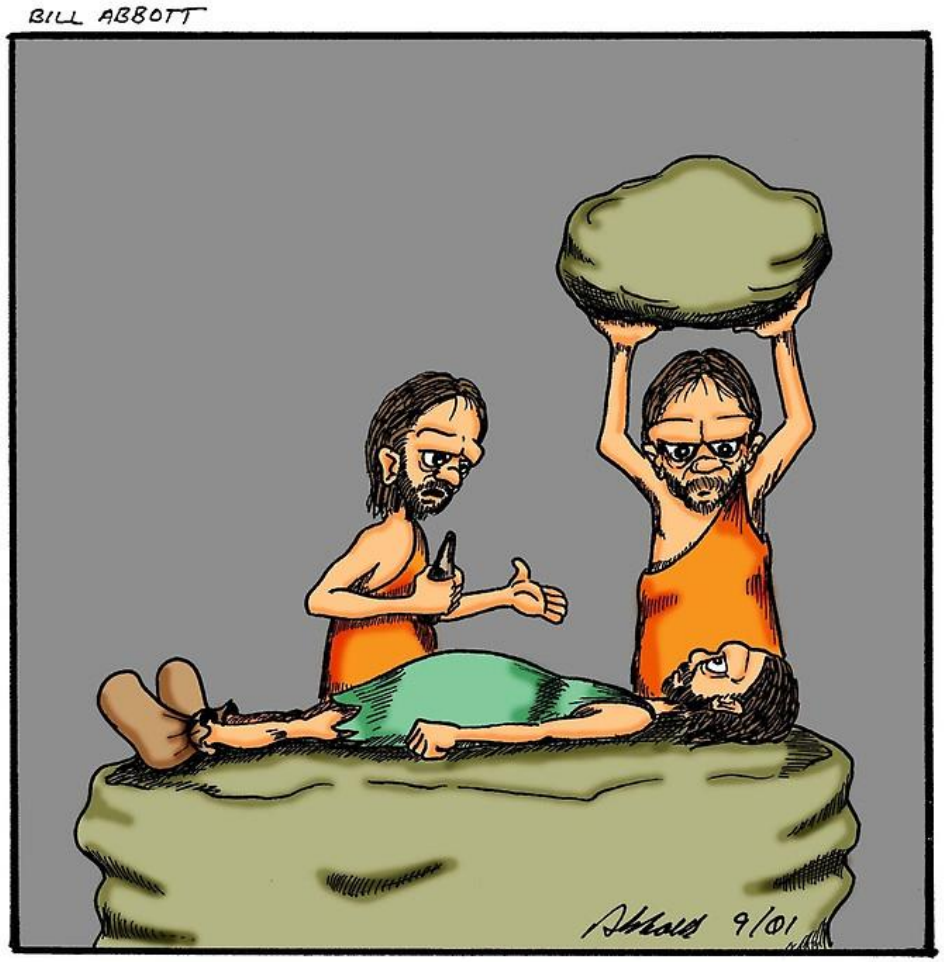
Quality Council

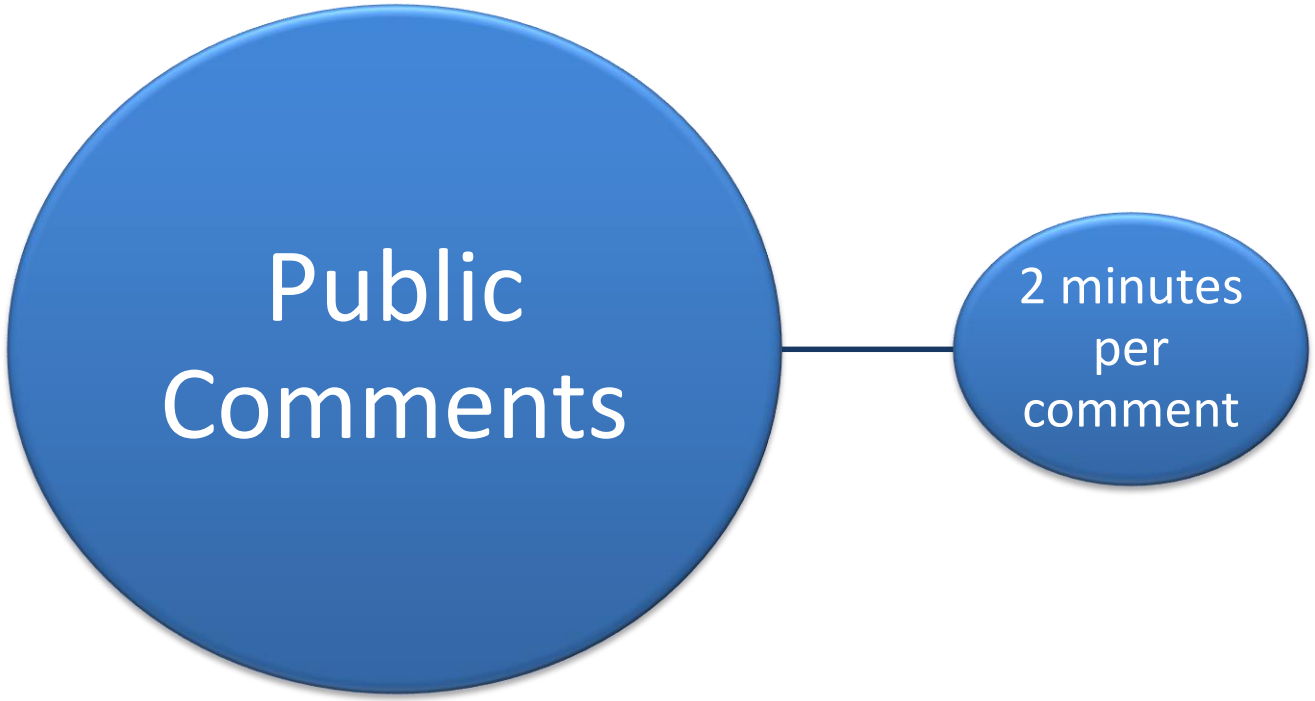
January 10, 2018



"...and this is Ralph, your anesthesiologist."

Meeting Agenda

Item	Allotted Time
1. Introductions/Call to order	5 min
2. Public comment	5 min
3. Approval of the Minutes	5 min
4. Purpose of Today's Meeting	5 min
5. Follow Up From 12/13/17	15 min
6. New Measures for Consideration	15 min
7. Reporting Measure Set Review	20 min
7. Public Scorecard Update	55 min
8. Next Steps and Adjournment	


Public Comments
2 minutes per comment

Approval of the Minutes

Purpose of Today's Meeting

Other Business

Healthcare Cabinet Recommendations to the Quality Council

- The Cabinet was established to advise Governor Dannel P. Malloy, Lt. Governor Nancy Wyman and the Office of Health Reform & Innovation on issues related to federal health reform implementation and development of an integrated healthcare system for Connecticut and is chaired by the Lieutenant Governor
- Current focus is on pharmaceutical costs
- Recommendations from the Cabinet for the Quality Council Include:
  - Add Quality Measures to the Core Measure Set related to:
    - Medication adherence, assistance and monitoring
    - Communication with patients about drug prices, barriers, and clinical value of each prescription
    - Patient priority setting and alternatives
- Discussion – Quality Council's response to the Healthcare Cabinet

Recap from 12/13/17 Meeting

Follow Up: NQF Measure Endorsement Process

- Steward completes Intent to Submit Form 3 months prior to cycle including the following Information:

Planned submission date (cycle and year) • Measure name • Measure description • Measure title • Measure type • Level of analysis Data source • Numerator/Denominator statement • Testing information (NQF measure testing attachment)

- NQF Measure Process:

- For more details on how to submit measures, and what the application entails:
  - http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx

Follow Up: Asthma Medication Management #1799

- Measure Description: The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported.
  - 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period.
  - 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.

- The Council asked what the purpose was to have two thresholds in the numerator
  - NCQA Response: The measure is based on guidelines from multiple societies, which recommend daily long-term control medication for patients who have persistent asthma. These guidelines do not include thresholds (50%, 75%); the thresholds were suggested by our expert panels. The higher threshold (75%) is used in our information products because it sets a higher bar for performance. Since this measure captures a very broad population, the lower rate allows plans to target their non-compliant population and see the movement between the two thresholds

Follow Up: Female HPV #1959 vs Immunizations for Adolescent #1407

- Adolescent HPV Discussion
  - PMO contacted NCQA re: Immunizations for Adolescents Measure (IMA #1407) and its inclusion of HPV for males and females
    - NCQA is seeking continued NQF endorsement for IMA with the inclusion of male/female HPV in the Annual Update process
    - CQMC already recommends IMA and specifically acknowledges the update to include HPV
    - NCQA is considering whether to continue stewardship of the HPV for Female Adolescents measure (#1959)
  - Quality Council did not include IMA in Core Measure Set due to being topped out
    - Including IMA in Core Set would in essence be measuring HPV rates for improvement for males/females
    - Measure would no longer be topped out because opportunity for improvement would likely reflect performance on HPV
- Recommendation: Replace Female HPV #1959 with IMA #1407

New Measures for Consideration

Substance Use Screening and Prevention

- **Behavioral Health Design Group**
  - Initially recommended screening tools rather than quality measures (January 2015) in the domains of mental health, substance use, trauma, well-being
  - After re-focusing on commonly used quality measures, they ultimately recommended (March 2015):
    - Unhealthy Alcohol Use Screening (# 2152)
  - They did not consider drug use screening measures
    - The United States Prevention Services Task Force (USPSTF) recommendations did not appear to be a consideration in the final recommendation
- **Quality Council**
  - Due to newly endorsed broad-based measures of alcohol and drug use screening and uncertainty about whether Unhealthy Alcohol Use Screening is the best and most aligned measure, deferred alcohol/drug screening as a development priority

United States Prevention Services Task Force

- **What is USPSTF?**
  - USPSTF decides on topics and guidelines regarding relevance to prevention and primary care, importance for public health, potential impact of recommendations and whether there is new evidence that may change current recommendations
  - Assigns letter grade based on strength of evidence, balance benefits and harms
  - Does NOT consider costs
  - Evaluates services only offered in primary setting or referred by PCP

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	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.	Offer or provide this service.
C	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.	Offer or provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

United States Prevention Services Task Force

- **What does USPSTF have to say about substance use screening?**
  - Currently assigns grade of **B** to unhealthy alcohol use screening (ages 18+)
  - Assigns a grade of **I (Insufficient)** to illicit drug use screening
  - Screening for trauma and anxiety receive no grade in final recommendations
  - For details regarding the USPSTF assessment go to:

https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/drug-use-illicit-screening

U.S. Preventive Services TASK FORCE

United States Prevention Services Task Force

- **Importance:** Illicit drug use and abuse are serious problems among adolescents, adults, and pregnant women in the United States, ranking among the 10 leading preventable risk factors for years of healthy life lost to death and disability in developed countries. (Please note that tobacco use and alcohol misuse are considered in separate screening recommendations of the USPSTF.)

- **Detection:** While standardized questionnaires to screen adolescents and adults for drug use/misuse have been shown to be valid and reliable, there is insufficient evidence to assess the clinical utility of these instruments when applied widely in primary care settings.

- **Benefits of detection and early treatment:** There is good evidence that various treatments are effective in reducing illicit drug use in the short term. Evidence is insufficient, however, either to demonstrate that treatment reliably improves social and legal outcomes for patients, or to link treatment directly to longer term improvements in morbidity or mortality. Since all but one published clinical trial of treatment interventions involved individuals who had already developed problems due to their drug use, it is not known whether the findings are generalizable to asymptomatic individuals whose illicit drug use is detected through screening. There is fair evidence that, regardless of the patient's history of treatment, reducing or stopping drug use is associated with improvement in some health outcomes.

United States Prevention Services Task Force

- **Harms of detection and early treatment:** There is little evidence of harms associated with either screening for illicit drug use or behavioral interventions used in treatment. Several clinical trials of pharmacotherapy for drug misuse have reported mild to serious adverse events, although some of these events were likely related to underlying drug use. The specific adverse events noted to occur more frequently in the treatment arm of trials (compared to placebo) have been previously recognized as potential side effects of the treatment medication and cited on its product label.
- **USPSTF assessment:** The USPSTF concludes that for adolescents, adults, and pregnant women, the evidence is insufficient to determine the benefits and harms of screening for illicit drug use.

Substance Use Screening and Prevention

Snapshot of Professional Society Recommendations:

Professional Society	Alcohol Use Screening	Drug Use Screening	Comment
American Academy of Pediatrics	X	X	
American Academy of Family Physicians	X		By reference to USPSTF
American College of Physicians	-	-	No information

NCQA PCMH 2017 Standard Recommendations

- Updated Standards include recommendations for Alcohol AND Drug Use
- On a menu of 7 screening options - neither are required

KM 04 (1 Credit) Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.)

A. Anxiety.
B. Alcohol use disorder.
C. Substance use disorder.
D. Pediatric behavioral health screening.
E. Post-traumatic stress disorder.
F. Attention deficit/hyperactivity disorder.
G. Postpartum depression.

Current NQF Endorsed Substance/Alcohol Use Measures

NQF Measure Title	Measure	Notes
NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (AMA) Method of Collection: EMR, Registry	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user	Included in Development Measure Set Endorsed: 1/11/17
NQF #2597 Substance Use Screening and Intervention Composite (ASAM) Method of Collection: EMR	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for **tobacco** use, **unhealthy alcohol** use, **nonmedical prescription** drug use, and **illicit** drug use AND who received an intervention for all positive screening results	Composite Measure Including: - Tobacco Screening & Cessation (0028) - Unhealthy Alcohol Use (2152) - Drug Use Screening *Approved for Trial Use 3/6/15 - Included in annual update*
NQF #0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NCQA) Method of Collection: Claims, EMR	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following: - Initiation of AOD Treatment. - Engagement of AOD Treatment.	Included in Reporting Measure Set Endorsed: 2/8/16
NQF #2940 Use of Opioids at High Dosage in Persons Without Cancer (PQA) Method of Collection: Claims	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer. A lower rate for this measure indicates better performance	Endorsed: 1/26/17
NQF# 2951 Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer (PQA) Method of Collection: Claims	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids with a daily dosage greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.	Endorsed: 1/26/17
NQF# 2950 Use of Opioids from Multiple Providers in Persons Without Cancer (PQA) Method of Collection: Claims	The proportion (XX out of 1,000) of individuals without cancer receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies	Endorsed: 1/26/17

Substance Use Screening and Prevention

- **Options for Quality Council:**
  - Defer pending additional information
  - Defer until next annual evaluation; perhaps NQF will endorse composite
  - Add Unhealthy Alcohol Use (#2152) now and re-assess composite at next annual evaluation

Reporting Measure Set

Reporting Measure Set

#	Reporting Only	NQF	Steward	NQF Endorsement Status	Date of Update
	Coordination of Care				
1	30 day readmission		MMDLN		
2	% PCPs that meet Meaningful Use		CMS		
	Prevention				
3	Non-recommended Cervical Cancer Screening in Adolescent Female		NCQA		
4	Well-child visits in the third, fourth, fifth and sixth years of life (Medicaid only)	1516	NCQA	✓	9/2/2015
5	Frequency of Ongoing Prenatal Care (FPC)	1391	NCQA	☒	10/25/2016
6	Oral Evaluation, Dental Services (Medicaid only)	2517	ADA	✓	10/3/2017
7	Long Acting Reversible Contraception (LARC)	2904	OPA	✓	10/25/2016
	Acute and Chronic Care				
8	Cardiac strss img: Testing in asymptomatic low risk patients	0672	ACC	✓	6/29/2015
	Behavioral Health				
9	Adult major depressive disorder (MDD): Coordination of care of patients with specific co-morbid conditions		APA		
10	Anti-Depressant Medication Management	0105	NCQA	✓	2/28/2014
11	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004	NCQA	✓	2/8/2016
12	Follow up after hospitalization for mental illness, 7 & 30 days	0576	NCQA	✓	7/28/2017

LARC Measure added to Reporting Set 12/13/17

Reporting Measure Set Quality Payment Program (QPP) Alignment

#	Reporting Only	NQF	Steward	QPP-MIPS
	Coordination of Care			
1	30 day readmission		MMDLN	
2	% PCPs that meet Meaningful Use		CMS	
	Prevention			
3	Non-recommended Cervical Cancer Screening in Adolescent Female		NCQA	✓
4	Well-child visits in the third, fourth, fifth and sixth years of life (Medicaid only)	1516	NCQA	
5	Frequency of Ongoing Prenatal Care (FPC)	1391	NCQA	
6	Oral Evaluation, Dental Services (Medicaid only)	2517	ADA	
7	Long Acting Reversible Contraception (LARC)	2904	OPA	
	Acute and Chronic Care			
8	Cardiac strss img: Testing in asymptomatic low risk patients	0672	ACC	
	Behavioral Health			
9	Adult major depressive disorder (MDD): Coordination of care of patients with specific co-morbid conditions		APA	✓
10	Anti-Depressant Medication Management	0105	NCQA	✓
11	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004	NCQA	✓
12	Follow up after hospitalization for mental illness, 7 & 30 days	0576	NCQA	✓

- **5 of 12 Measures in QPP**
- **42% Alignment**

Quality Payment
PROGRAM

Reporting Measure Set Core Quality Measures Collaborative

#	Reporting Only	NQF	Steward	CQMC
	Coordination of Care			
1	30 day readmission		MMDLN	
2	% PCPs that meet Meaningful Use		CMS	
	Prevention			
3	Non-recommended Cervical Cancer Screening in Adolescent Female		NCQA	✓
4	Well-child visits in the third, fourth, fifth and sixth years of life (Medicaid only)	1516	NCQA	✓
5	Frequency of Ongoing Prenatal Care (FPC)	1391	NCQA	✓
6	Oral Evaluation, Dental Services (Medicaid only)	2517	ADA	
7	Long Acting Reversible Contraception (LARC)	2904	OPA	
	Acute and Chronic Care			
8	Cardiac strss img: Testing in asymptomatic low risk patients	0672	ACC	
	Behavioral Health			
9	Adult major depressive disorder (MDD): Coordination of care of patients with specific co-morbid conditions		APA	
10	Anti-Depressant Medication Management	0105	NCQA	
11	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004	NCQA	
12	Follow up after hospitalization for mental illness, 7 & 30 days	0576	NCQA	

- **3 of 12 Measures in CQMC**
- **25% Alignment**

CMS.gov
Centers for Medicare & Medicaid Services

Reporting Measure Set National Quality Forum Alignment

#	Reporting Only	NQF	Steward	NQF Endorsement Status	Date of Update
	Coordination of Care				
1	30 day readmission		MMDLN		
2	% PCPs that meet Meaningful Use		CMS		
	Prevention				
3	Non-recommended Cervical Cancer Screening in Adolescent Female		NCQA		
4	Well-child visits in the third, fourth, fifth and sixth years of life (Medicaid only)	1516	NCQA	✓	9/2/2015
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7	Long Acting Reversible Contraception (LARC)	2904	OPA	✓	10/25/2016
	Acute and Chronic Care				
8	Cardiac strss img: Testing in asymptomatic low risk patients	0672	ACC	✓	6/29/2015
	Behavioral Health				
9	Adult major depressive disorder (MDD): Coordination of care of patients with specific co-morbid conditions		APA		
10	Anti-Depressant Medication Management	0105	NCQA	✓	2/28/2014
11	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004	NCQA	✓	2/8/2016
12	Follow up after hospitalization for mental illness, 7 & 30 days	0576	NCQA	✓	7/28/2017

- **7 of 12 Measures NQF Endorsed**
- **58% Alignment**

NATIONAL QUALITY FORUM

Reporting Measure Set

#	Reporting Only	NQF	Steward	QPP-MIPS	NQF Endorsement Status	CQMC
	Coordination of Care					
1	30 day readmission		MMDLN			
2	% PCPs that meet Meaningful Use		CMS			
	Prevention					
3	Non-recommended Cervical Cancer Screening in Adolescent Female		NCQA	✓		✓
4	Well-child visits in the third, fourth, fifth and sixth years of life (Medicaid only)	1516	NCQA		✓	✓
5	Frequency of Ongoing Prenatal Care (FPC)	1391	NCQA		☒	✓
6	Oral Evaluation, Dental Services (Medicaid only)	2517	ADA		✓	
7	Long Acting Reversible Contraception (LARC)	2904	OPA		✓	
	Acute and Chronic Care					
8	Cardiac strss img: Testing in asymptomatic low risk patients	0672	ACC		✓	
	Behavioral Health					
9	Adult major depressive disorder (MDD): Coordination of care of patients with specific co-morbid conditions		APA	✓		
10	Anti-Depressant Medication Management	0105	NCQA	✓	✓	
11	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004	NCQA	✓	✓	
12	Follow up after hospitalization for mental illness, 7 & 30 days	0576	NCQA	✓	✓	

Measure Program Alignment
1 or Less Programs
2 out of 3 Programs
3 Programs

Reporting Measure Set

#	Reporting Only	NQF	Steward	NQF Endorsement Status	Date of Update
	Coordination of Care				
1	30 day readmission		MMDLN		
2	% PCPs that meet Meaningful Use		CMS		
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Measure #2

- Medicare MU program no longer in existence
- Medicaid MU closed to new entrants, phase out 2021

Measure #5

- No longer endorsed
- Being retired and no longer stewarded

Reporting Measure Set

- **Recommendations**
  - Remove Measures #2 (PCPs Compliant with MU) and #5 (Frequency of Ongoing Prenatal Care) from the reporting set as they are either no longer applicable and/or not being stewarded
  - Retain the remainder of the measure set and include in 2018 Annual Review

Public Scorecard Update

Agenda: Online Healthcare Scorecard

- Status Update
- Attribution
- User Interface Demonstration
- Information Source Review
- Discussion of QC subcommittee

Status Update

Decision Points: Previous Decisions

☑ Data Source

- APCD
- CAHPS

☑ Measures:

- Quality Council's Core and Reporting Sets (claims based)
- Consider reporting set review and update

☑ Unit of analysis:

- Advanced Networks
- FQHCs

☑ Purpose/Use Cases:

- Quality improvement through transparency
- Policy makers assessing performance

Decision Points: Timing of Pending Decisions

- ❑ Attribution
- ❑ Presentation/web hosting/ external content
- ❑ Benchmarks
- ❑ Scoring/Rating
- ❑ Risk Adjustment
- ❑ Finalize scorecard

January Meeting

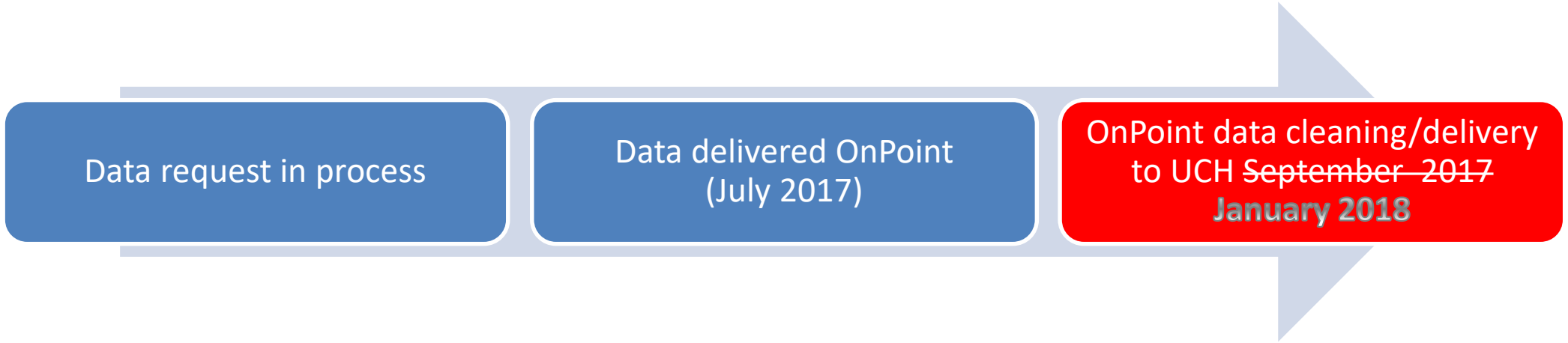
Pushing this discussion to next meeting given time constraints

Discussion after receipt of data

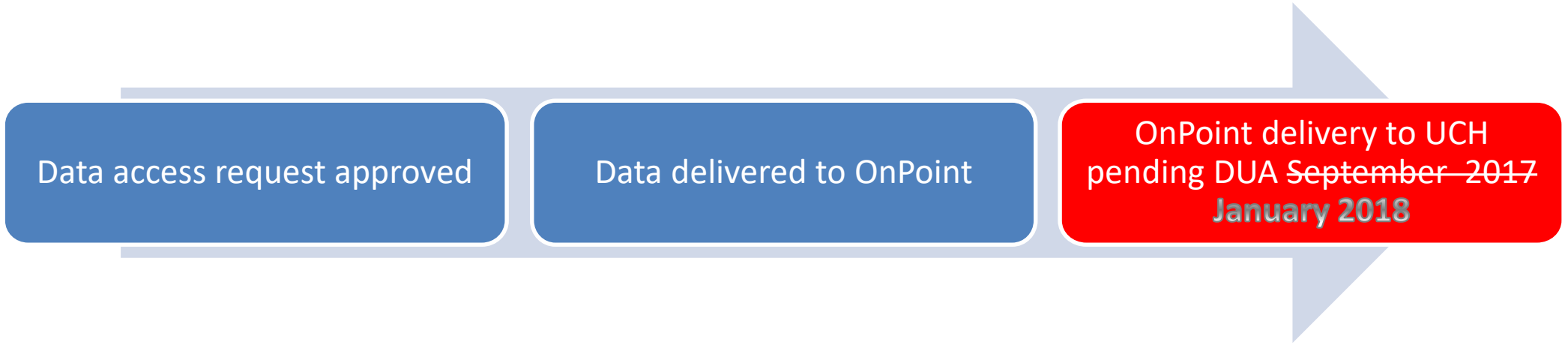
Pre-publication presentation anticipated for ~~March~~ April meeting?

Data Status Update: Claims Data

- [ ] Medicare data



- [ ] Non-Medicare APCD data from commercial claims



- [ ] Medicaid data – Data release decision pending

Update on Measures: Measures and Coding (1 of 4)

- Core and Reporting measures were reviewed for analytic feasibility
- Available measure-related value sets (diagnostic and procedure codes) and tables (drug lists) were obtained from NCQA website
- Conducted a search for repositories/libraries for R statistical code
- Python (analytic) code was created for screening APCD data for specific value sets
- Steps for statistical coding were established considering inclusion and exclusion criteria for measures

Update on Measures: Measures and Coding (2 of 4)

- Next steps
  - Develop statistical code
  - Apply statistical code to fabricated claims data
  - Revise (if needed) and finalize statistical code.

Update on Measures: Coding Challenges (3 of 4)

Challenges and Limitations: (See handout)

#1: Anchor dates related to age

APCD data provides year of birth. A number of measures require patient's age to be determined relative to an anchor date during the measurement year or the prior year.

Example 1: Well-Child Visits in the First 15 Months of Life

Population: Children 15 months old during the measurement year.

- Potential solution: Obtain pre-screened dataset from APCD.

Example 2: Chlamydia Screening in Women

Population: 16-24 years as of December 31 of the measurement year

- Potential solution: Modify specification to make it relative to claim date instead of December 31 of the measurement year.

Update on Measures: Coding Challenges (4 of 4)

#2: Electronic medical records data (See handout)

Some measures require electronic medical record data for operationalization; others have hybrid measurement recommendations with administrative and EMR data together.

❑ EMR required

- Cervical Cancer Screening

➢ Potential solution: mention in methodology that laboratory results related exclusions not considered.

❑ Hybrid/dual measures

- Adolescent female immunizations HPV, Well-child visits in the first 15 months of life, Adolescent well-care visits

➢ Potential solution: only present administrative component.

Attribution

Attribution (1 of 3)

- What is attribution?
  - Assigning a provider who will be held accountable for a member based on an analysis of the member's claims data. The attributed provider is deemed to be responsible for the patient's quality of care and cost.

- Why is attribution important for Value-based Payment (VBP) contracts?
  - Attribution determines which patients are assigned to what (groups of) providers, thereby determining the analysis of the outcomes, total costs of care, potential shared savings per VBP arrangement per provider combination.

Sources:
1. Pantely SE. Whose patient is it? Patient attribution in ACOs. Milliman Healthcare Reform Briefing Paper. 2011 Jan.
2. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_patient_attribution.pdf

Attribution: Strategies & Methods (2 of 3)

Entities	Attribution methods	Comments
Other state scorecards	• Submitting organization attributes patients (CA, CT, Medicaid)	• Not feasible for commercial or Medicare claims
	• Patient attributed to provider if >= 2 associated claims within previous 2 years + at least 1 claim within previous year (WI)	• Results in multiple attributions for same patient
	• Patients attributed to provider with most claims (MN, WA)	• Misattribution to non-PCP providers (e.g. radiologists)
CMS Medicare SSP	• Patients attributed to PCP provider(s) within entity (ACO) that charged the most for primary care services	• Driven by cost of services rather than frequency • Complex-uses prospective attribution with retrospective reconciliation.
Treo Solutions/3M approach	• Define PCPs/identify physician groups • Attribute patient to the group with most E&M services • Fine-tuned two-step tie-breaking process	• Needs to be adapted for CT scorecard since our scored entities are ANs/FQHCs, not providers

Attribution (3 of 3)

- Reviewed plans for attribution methods to be incorporated in the CT's Core Data Analytics Solution
  - CDAS still in conceptual phase
  - Attribution for CDAS will be extended to incorporate EHR/clinical data
  - Limitations in CT APCD related to the data that can be released (e.g., DOB, DOS)

- Agreement: we will work collaboratively to have consistency in attribution between Scorecard, CDAS

User Interface Demonstration

Information Source Review

Information source review (1 of 7)

- Scorecard can include links to external content on:
  - Disease/health condition, tests, quality measures

- Potential sources
  - General resources, e.g.:
    - CDC
    - WebMD
    - Mayo Clinic
  - Health domain/disease specific/population specific authority, e.g.:
    - National Cancer Institute
    - American Diabetes Association,
    - American Association of Pediatricians

- Issue: Copyrighted materials:
  - Medline Plus (NIH)

Information source review: Example (2 of 7)

- Example: Breast Cancer Screening Page

Breast Cancer Screening

What is this measuring? The percentage of female patients ages 50-75 who had a screening mammogram in the past 2 years. Find out more *(clicking will display 3 options)*

  - *Breast cancer & cancer screening and mammograms (clicking will display links)*
  - *Measure rationale, methods and national results (clicking will display links to measure specification and information from measure steward)*
  - *Scorecard data analysis and scoring methods (clicking brings user to methods page)*

Information source review: Example (3 of 7)

Breast cancer screening and mammograms- linked content options

- Breast cancer screening (CDC or MedlinePlus-Encyclopedia or NCI)
- Mammograms (CDC or NCI or MedlinePlus –Topics or MedlinePlus-Encyclopedia or Mayo Clinic) DC or MedlinePlus-Encyclopedia or NCI)
- Breast Cancer – What You Need To Know – CDC Fact Sheet

Information source review: Example (4 of 7)

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

SEARCH

CDC A-Z INDEX

Breast Cancer

- Breast Cancer
- Basic Information
  - What Is Breast Cancer?
  - What Are the Symptoms?
  - What Are the Risk Factors?
  - What Can I Do to Reduce My Risk?
  - Who Is at High Risk?
  - **What Is Breast Cancer Screening?**
  - What Is a Mammogram?
  - What Are the Benefits and Risks of Screening?
  - How Is Breast Cancer Diagnosed?

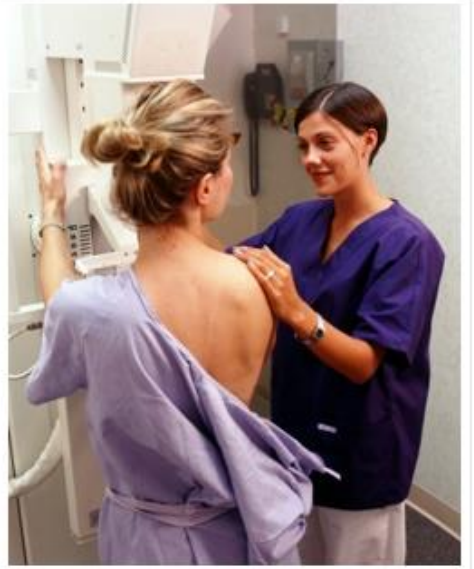
CDC > Cancer Home > Breast Cancer > Basic Information

What Is Breast Cancer Screening?

Language: English (US)

Breast cancer screening means checking a woman's breasts for cancer before there are signs or symptoms of the disease. The Breast Cancer Screening Chart [PDF-180KB] compares recommendations from several leading organizations. All women need to be informed by their health care provider about the best screening options for them. When you are told about the benefits and risks and decide with your health care provider what screening test, if any, is right for you, this is called *informed and shared decision-making*.

Although breast cancer screening cannot prevent breast cancer, it can help find breast cancer early, when it is easier to treat. Talk to your doctor about which breast cancer screening tests are right for you, and when you should have them.



Breast Cancer Screening Recommendations

The United States Preventive Services Task Force (USPSTF) is an organization made up of doctors and disease experts who look at research on the best way to prevent diseases and make recommendations on how doctors can help patients avoid diseases or find them early.

Information source review: Example (5 of 7)

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Breast cancer screening

Breast cancer screenings can help find breast cancer early, before you notice any symptoms. In many cases, finding breast cancer early makes it easier to treat or cure. But screenings also have risks, such as missing signs of cancer. When to start screenings may depend on your age and risk factors.

Mammograms

A mammogram is the most common type of screening. It is an x-ray of the breast using a special machine. This test is done in a hospital or clinic and only takes a few minutes. Mammograms can find tumors that are too small to feel.

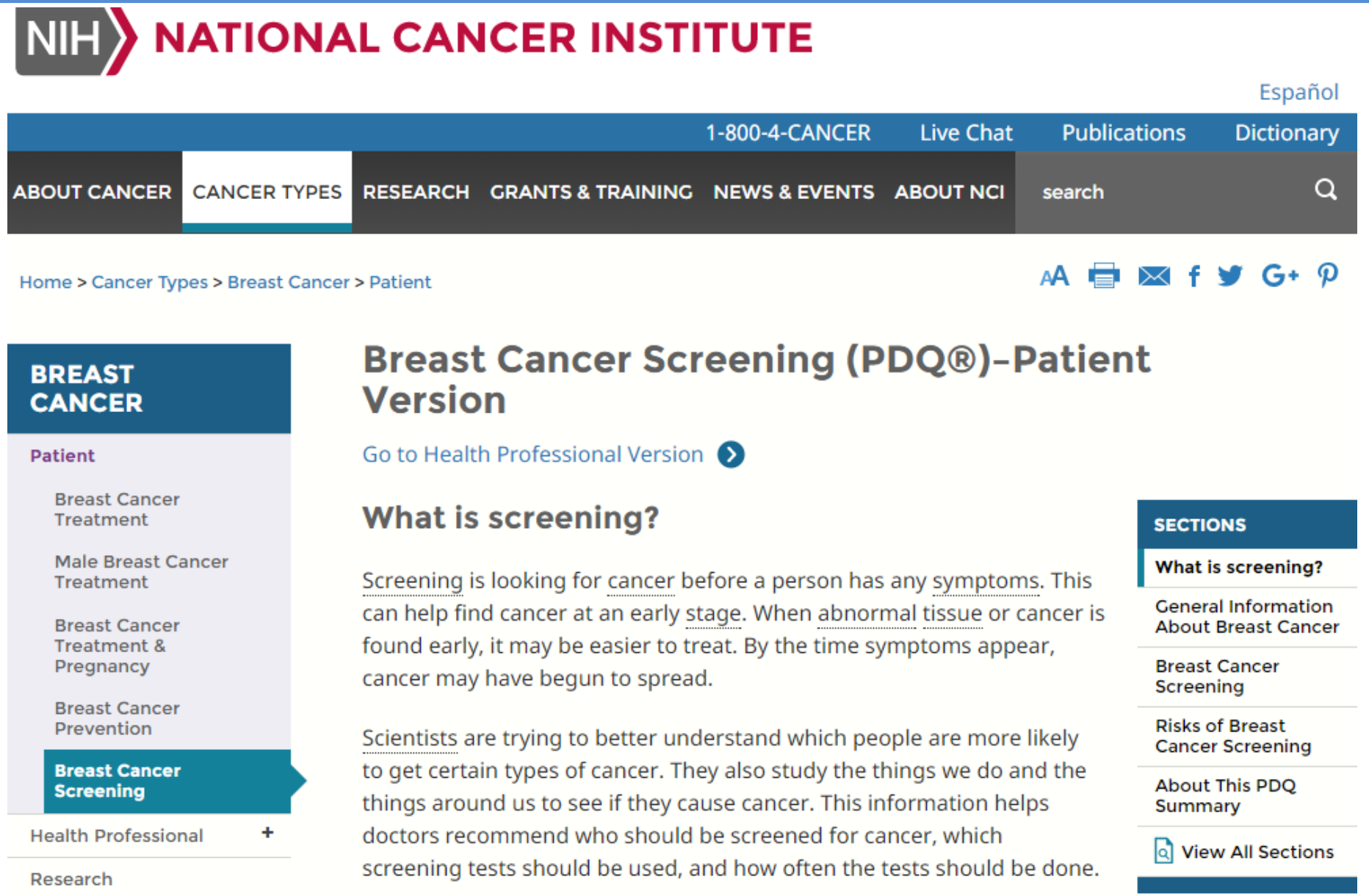
Mammography is performed to screen women to detect early breast cancer when it is more likely to be cured. Mammography is generally recommended for:

- Women starting at age 40, repeated every 1 to 2 years. (This is not recommended by all expert organizations.)
- All women starting at age 50, repeated every 1 to 2 years.
- Women with a mother or sister who had breast cancer at a younger age should consider yearly mammograms. They should begin earlier than the age at which their youngest family member was diagnosed.

Related MedlinePlus Health Topics

Breast Cancer
Mammography

Information source review: Example (6 of 7)



Information source review: Process (7 of 7)

- Propose Quality Council subgroup formed to review information sources
  - Goal for scorecard implementation 1.0: single informational link for each disease/condition specific measure to the disease or health domain
    - ~18-20 measures
    - Version 2.0 will expand this to include links to tests/screening approaches
  - Suggested process (refined by QC subgroup):
    - ❖UConn Health provides set of recommendations for links
    - ❖Subgroup reviews subset of measures (5) and selects links weekly via conference call
    - ❖Summary report prepared by UCH presented to full Quality Council at February meeting

Next steps

Next Steps

- UCH team present R Shiny interface to Health Information Technology Officer, PMO
- QC Subgroup for information source review
- QC Review, discussion, and approval of attribution strategy (February meeting)

Next Steps
Adjourn