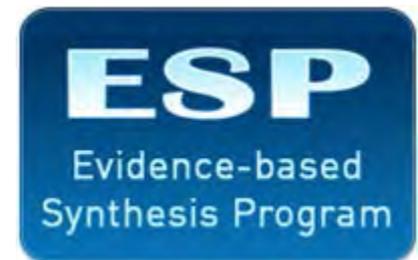


Improving Health Care Value: A VA-Health Services Researcher's Journey to Identify, Communicate and Implement High Value Care

Timothy J. Wilt, MD, MPH

Minneapolis VA

Center for Chronic Diseases Outcomes Research



Awardee Assessment Metrics

- Improving our understanding of factors that affect the health of Veterans and the quality of their care
- Contributing to the future of VA health services research by inspiring and training a new generation of investigators
- Enhancing the visibility of VA research through national recognition within the research community.

Slow and Old!



BACKGROUND CHECK

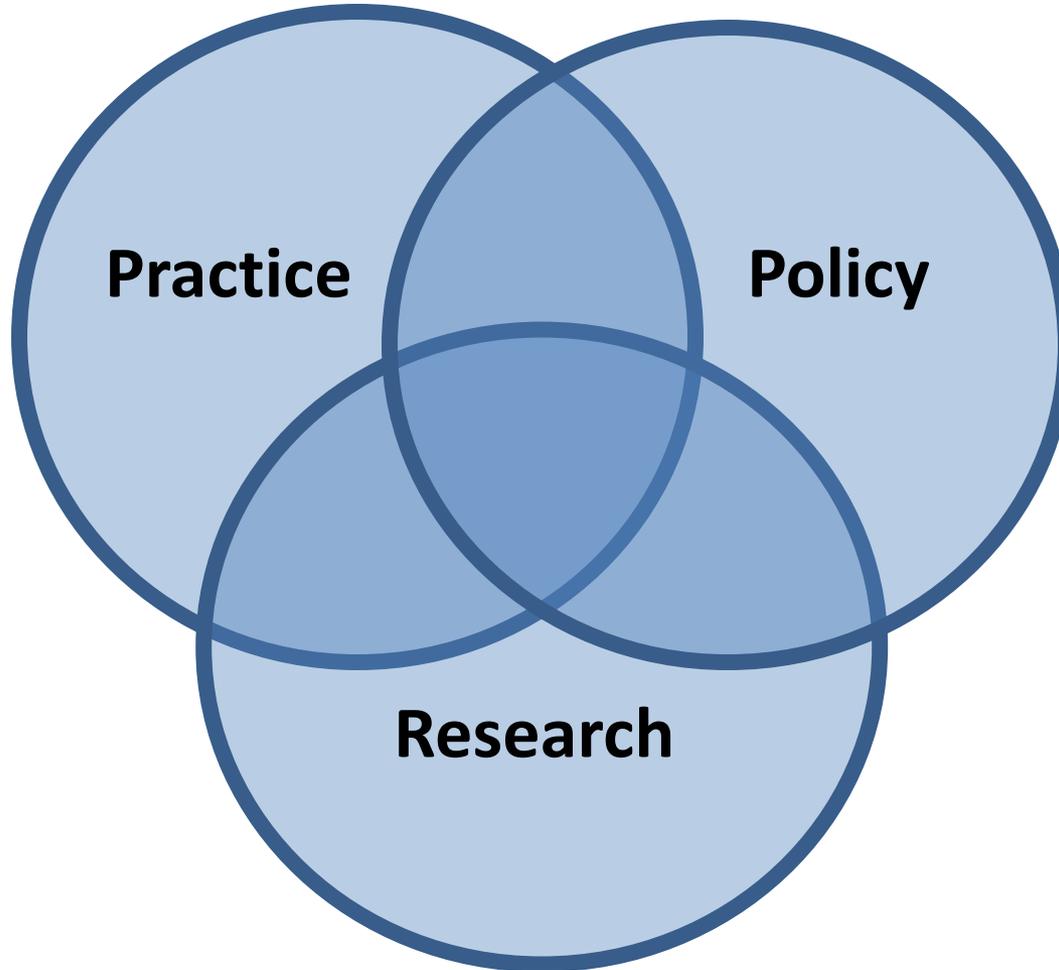




Me



High-value Healthcare



My Research Goals

- **Improve health care delivery by defining, identifying, communicating and implementing high-value care with an emphasis on reducing overuse of low-value care.**

Research Focus

- **Health Promotion and Disease Prevention, Detection & Treatment**
 - Chronic Conditions in Older Adults
 - Cancer screening & treatment
 - Urological diseases

Research Methods

- Primary research to identify new evidence
 - RCT's, databases, observational
- Systematic reviews to evaluate existing evidence
- Clinical Practice Guidelines to disseminate & implement best evidence

Key to success





福

GOOD FORTUNE

An Outstanding Nominator



Maureen Murdoch

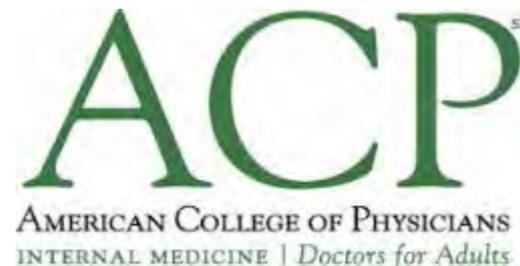
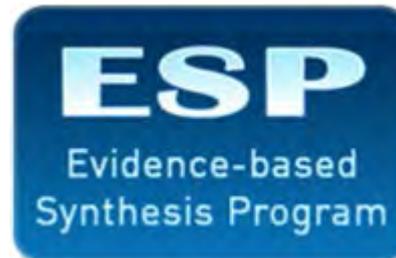
A Great Research Team



Supportive Leadership



Opportunities, Collaborators, Funders









Original Research in Prostate Cancer Screening & Treatment

Prostate Cancer Background

- **Common**
 - 200,00 men diagnosed per year
- **Serious**
 - 30,000 deaths per year
- **Health Care Utilization High**
 - 90% undergo early Tx; > US \$12 billion/yr
- **Detection & Treatment Uncertain**
 - PSA screening benefits, harms & costs
 - Treatment options: WW, AS, RP, EBRT
- **PCP Have Important Role**

Physician Performance and Patient Perceptions during the Rectal Examination

TIMOTHY J. WILT, MD, MPH, ALAN F. CUTLER, MD

Objective: To describe internal medicine residents' training and performance as well as patients' attitudes and knowledge regarding the rectal examination.

Design: Description survey of university-trained internal medicine residents and general medicine clinic patients.

Setting: General internal medicine residents' longitudinal clinic at a university-affiliated Veterans Affairs Medical Center.

Patients/participants: Ambulatory male veterans attending their general internal medicine clinic, all of whom were over the age of 40 years and had previously had a rectal examination ($n = 100$), as well as all second- and third-year University of Minnesota internal medicine residents ($n = 78$) were surveyed using a self-administered questionnaire.

Measurements and main results: Residents differed in their training in, practice of, and understanding of indications for the rectal examination. Little formal instruction regarding patient comfort had been provided to residents, and many residents had never received supervised instruction in the rectal examination. Patients frequently were uncertain about why the examination had been performed, lacked understanding of the results of the examination, and often had preferences for examination comfort measures that differed from those utilized by their physicians.

Conclusions: Increased supervised instruction in the rectal examination in medical training programs is recommended. This should emphasize not only appropriate indications for this procedure but also attention to patient communication and comfort.

Key words: rectal examination; medical education; ambulatory care; preventive medicine; patient attitudes; physician-patient communication. *J GEN INTERN MED* 1991;6:514-517.

received considerable attention.^{6,7} Physicians, however, have received little attention, physicians anecdotally describe emotions when performing them. Patients frequently describe the procedure as emotional as well as physically discomforting and are often reluctant to undergo the examination.

Rectal examinations are frequently performed for diagnostic purposes and recommended for their use in screening for prostate cancer.⁸ Physicians receive little supervised instruction in appropriate indications and techniques for performing rectal examinations or in assuring patient comfort following the rectal examination. Patient attitudes toward the procedure have not been systematically investigated. We conducted a survey of internal medicine residents and medical students at an ambulatory care clinic to determine their training and practice as well as patient knowledge and attitudes during the rectal examination.

SUBJECTS AND METHODS

All second- and third-year internal medicine residents at the University of Minnesota medical school and general medicine clinic (including the ambulatory care clinic) included in the study. They were asked to participate in an anonymous survey designed to determine their performance and perceptions of patients during rectal examinations. They were



Early “Healthy Skepticism”

We agree with Johansson et al “that without evidence of benefit from controlled clinical trials, the radical treatment of early-stage prostate cancer remains in its experimental phase.” We disagree with the editorial statement by Oesterling that recommends “a serum . . . PSA concentration *and* . . . DRE. If

Such an editorial position is of particular concern because an ongoing national prostate cancer screening program, organized and sponsored by a pharmaceutical corporation, also pressures physicians to adopt screening strategies of unproven benefit.

JAMA, December 9, 1992—Vol 268, No. 22

Timothy J. Wilt, MD, MPH
Anne M. Joseph, MD, MPH
Kristine E. Enstud, MD, MPH

EDITORIAL

**Informing Patients about Prostate Cancer
Screening: Identifying and Meeting the Challenges
While the Evidence Remains Uncertain**

Melissa R. Partin, PhD, Timothy J. Wilt, MD, MPH

**Reducing PSA Anxiety: The Importance of
Noninvasive Chronic Disease Management in
Prostate Cancer Detection and Treatment**

Timothy J. Wilt, MD, MPH, Melissa R. Partin, PhD

INVITED COMMENTARY

ONLINE FIRST

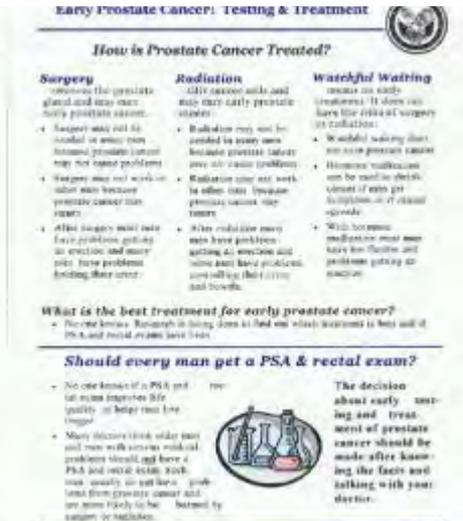
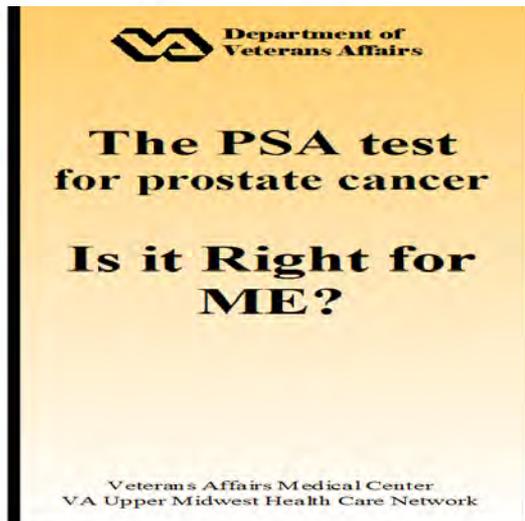
Screening

Simple Messages . . . Sometime! Timothy J. Wilt, MD, MPH
Melissa R. Partin, PhD



Randomized Trial Examining the Effect of Two Prostate Cancer Screening Educational Interventions on Patient Knowledge, Preferences, and Behaviors

Melissa R. Partin, PhD, David Nelson, PhD, David Radosevich, PhD, Sean Nugent, BA, Ann B. Flood, PhD, Nancy Dillon, RN, PhD, Jeremy Holtzman, MD, MPH, Michele Haas, BA, Timothy J. Wilt, MD, MPH



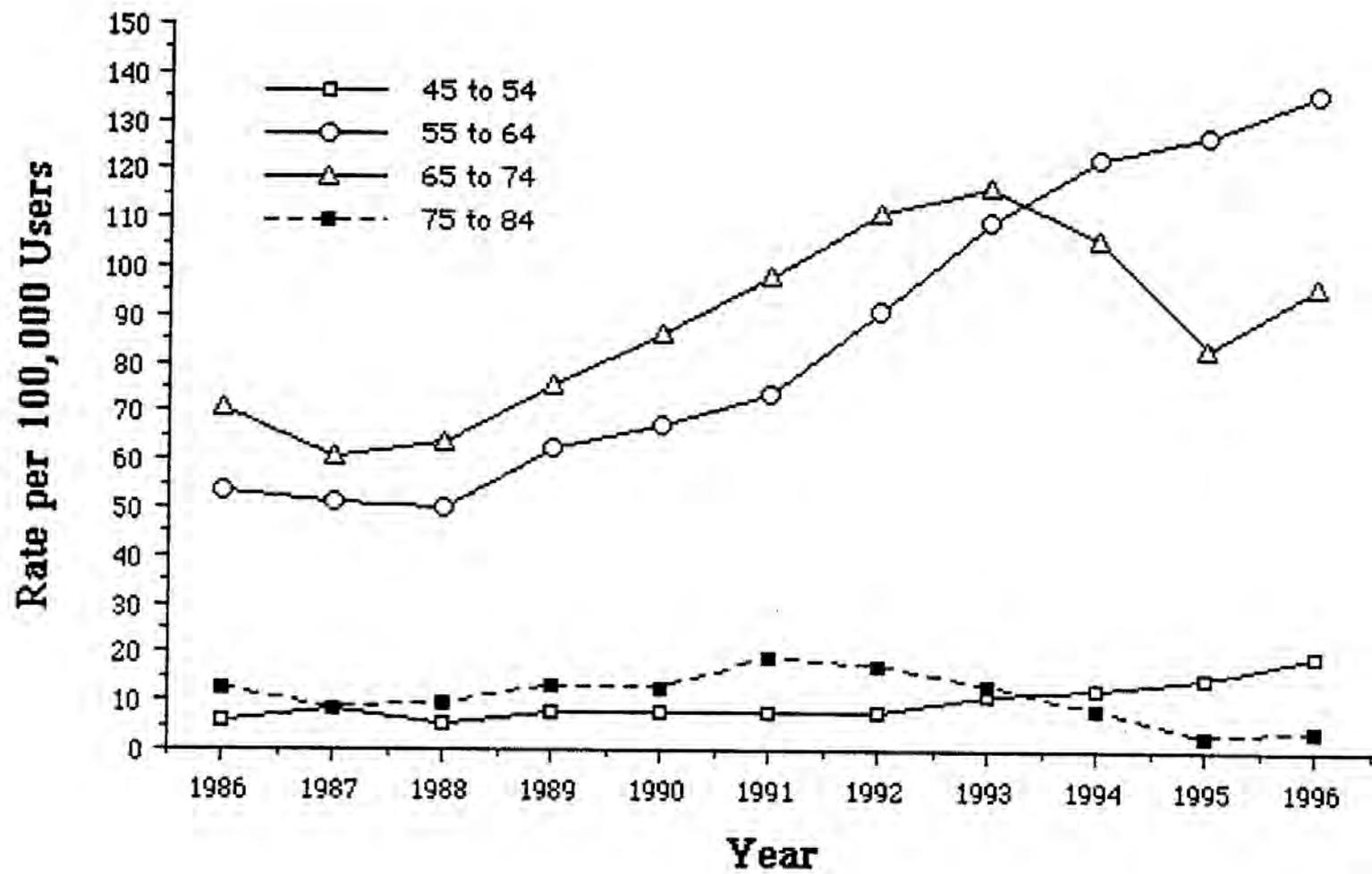
CONCLUSIONS: Mailed interventions enhance patient knowledge and self-reported participation in decision making, and alter screening preferences. The pamphlet and video interventions evaluated are comparable in effectiveness. The lowest-cost pamphlet approach is an attractive option for clinics with limited resources.

Higher Value!

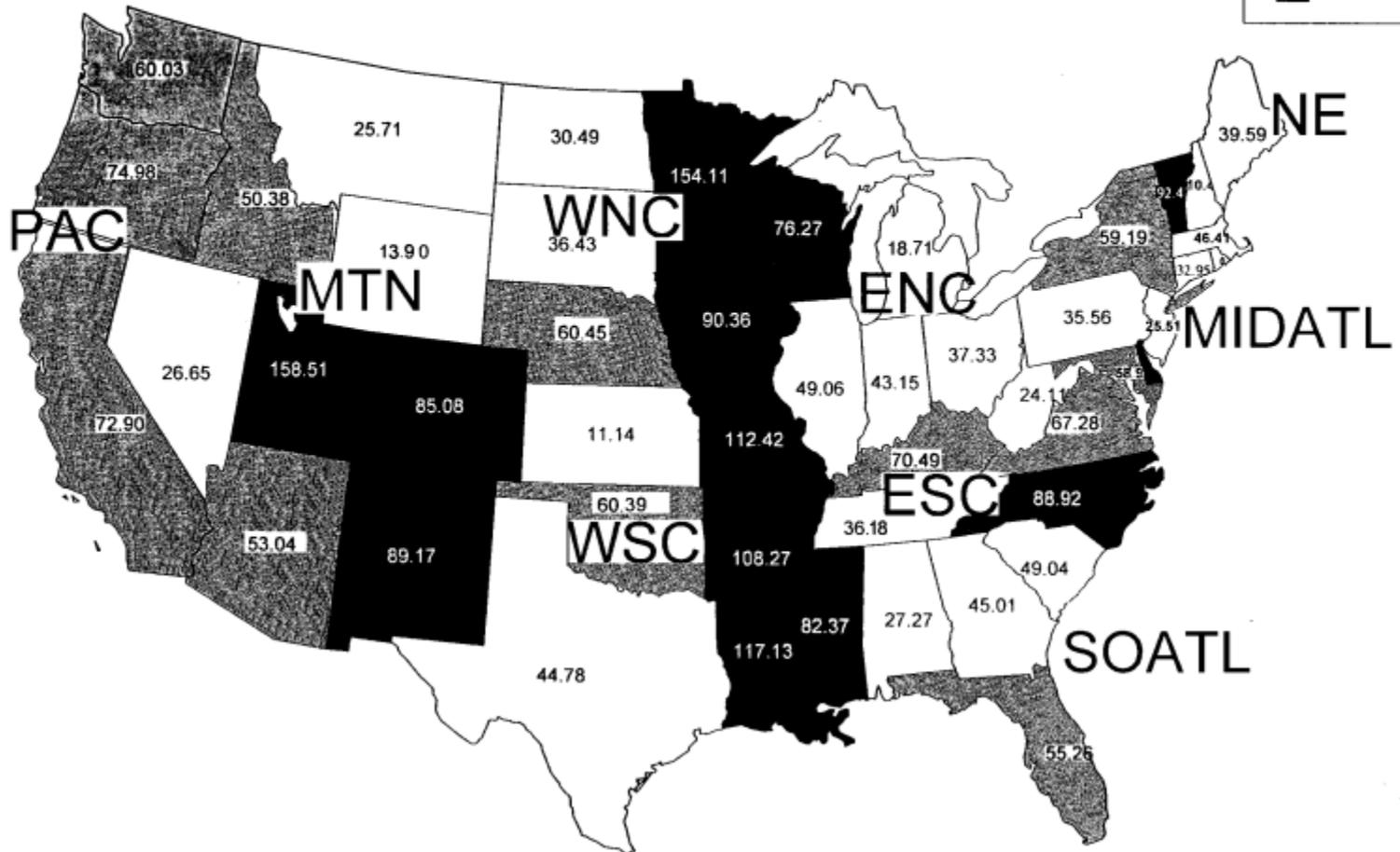
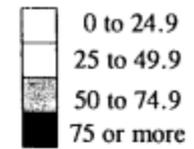
**An Evaluation of Radical Prostatectomy at Veterans
Affairs Medical Centers: Time Trends and Geographic
Variation in Utilization and Outcomes.**

Wilt, TJ; Cowper, DC; Gammack, JK; Going, DR.; Nugent, S; Borowsky, SJ.

Medical Care. 37(10) October 1999



N per 100,000



Conclusions

Utilization of RP @ VAMC increased over time and varied across geographic areas

Differences in utilization may be due to uncertainty regarding effectiveness of early detection and treatment of prostate cancer.



Systematic Review: Comparative Effectiveness and Harms of Treatments for Clinically Localized Prostate Cancer

Timothy J. Witt, MD, MPH; Roderick MacDonald, MS; Indulis Rutks, BA; Tatyana A. Shamliyan, MD, MS; Brent C. Taylor, PhD; and Robert L. Kane, MD

Background: The comparative effectiveness of localized prostate cancer treatments is largely unknown.

Purpose: To compare the effectiveness and harms of treatments for localized prostate cancer.

Data Sources: MEDLINE (through September 2007), the Cochrane Library (through Issue 3, 2007), and the Cochrane Review Group in Prostate Diseases and Urologic Malignancies registry (through November 2007).

Study Selection: Randomized, controlled trials (RCTs) published in any language and observational studies published in English that evaluated treatments and reported clinical or biochemical outcomes in localized prostate cancer.

Data Extraction: 2 researchers extracted information on study design, sample characteristics, interventions, and outcomes.

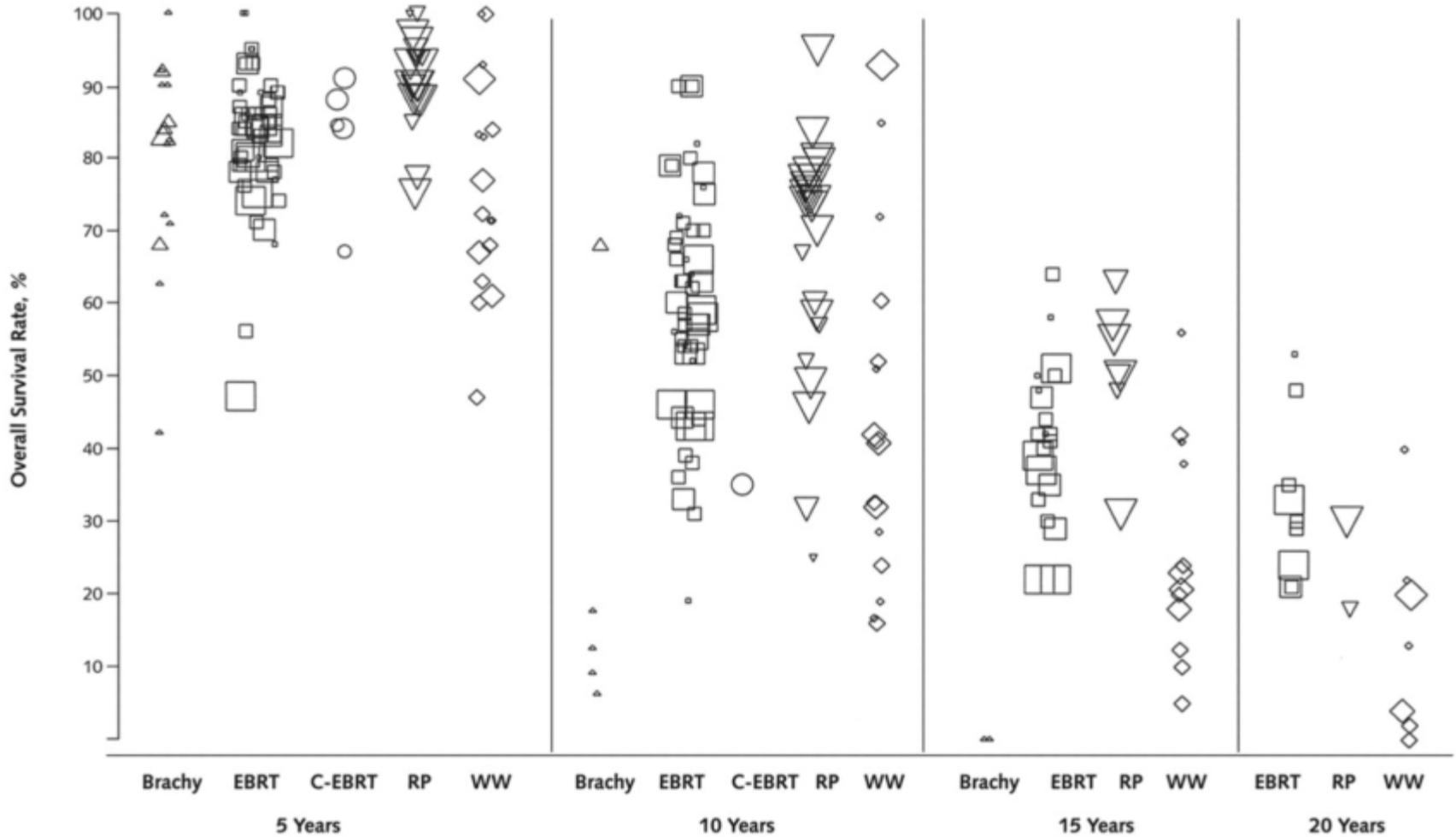
Data Synthesis: 18 RCTs and 473 observational studies met inclusion criteria. One RCT enrolled mostly men without prostate-specific antigen (PSA)-detected disease and reported that, compared with watchful waiting, radical prostatectomy reduced crude all-cause mortality (24% vs. 30%; $P = 0.04$) and prostate cancer-specific mortality (10% vs. 15%; $P = 0.01$) at 10 years. Effectiveness was limited to men younger than age 65 years but was not associated with Gleason score or baseline PSA level. An older, smaller trial found no significant overall survival differences between radical prostatectomy and watchful waiting (risk difference, 0% [95% CI, -19% to 18%]). Radical prostatectomy reduced disease recurrence at 5 years compared with external-beam radiation therapy in 1 small, older trial (14% vs. 39%; risk difference, 21%; $P =$

0.04). No external-beam radiation regimen was superior to another in reducing mortality. No randomized trials evaluated primary androgen deprivation. Androgen deprivation used adjuvant to radical prostatectomy did not improve biochemical progression compared with radical prostatectomy alone (risk difference, 0% [CI, -7% to 7%]). No randomized trial evaluated brachytherapy, cryotherapy, robotic radical prostatectomy, or photon-beam or intensity-modulated radiation therapy. Observational studies showed wide and overlapping effectiveness estimates within and between treatments. Adverse event definitions and severity varied widely. The Prostate Cancer Outcomes Study reported that urinary leakage (≥ 1 event/d) was more common with radical prostatectomy (35%) than with radiation therapy (12%) or androgen deprivation (11%). Bowel urgency occurred more often with radiation (3%) or androgen deprivation (3%) than with radical prostatectomy (1%). Erectile dysfunction occurred frequently after all treatments (radical prostatectomy, 58%; radiation therapy, 43%; androgen deprivation, 86%). A higher risk score incorporating histologic grade, PSA level, and tumor stage was associated with increased risk for disease progression or recurrence regardless of treatment.

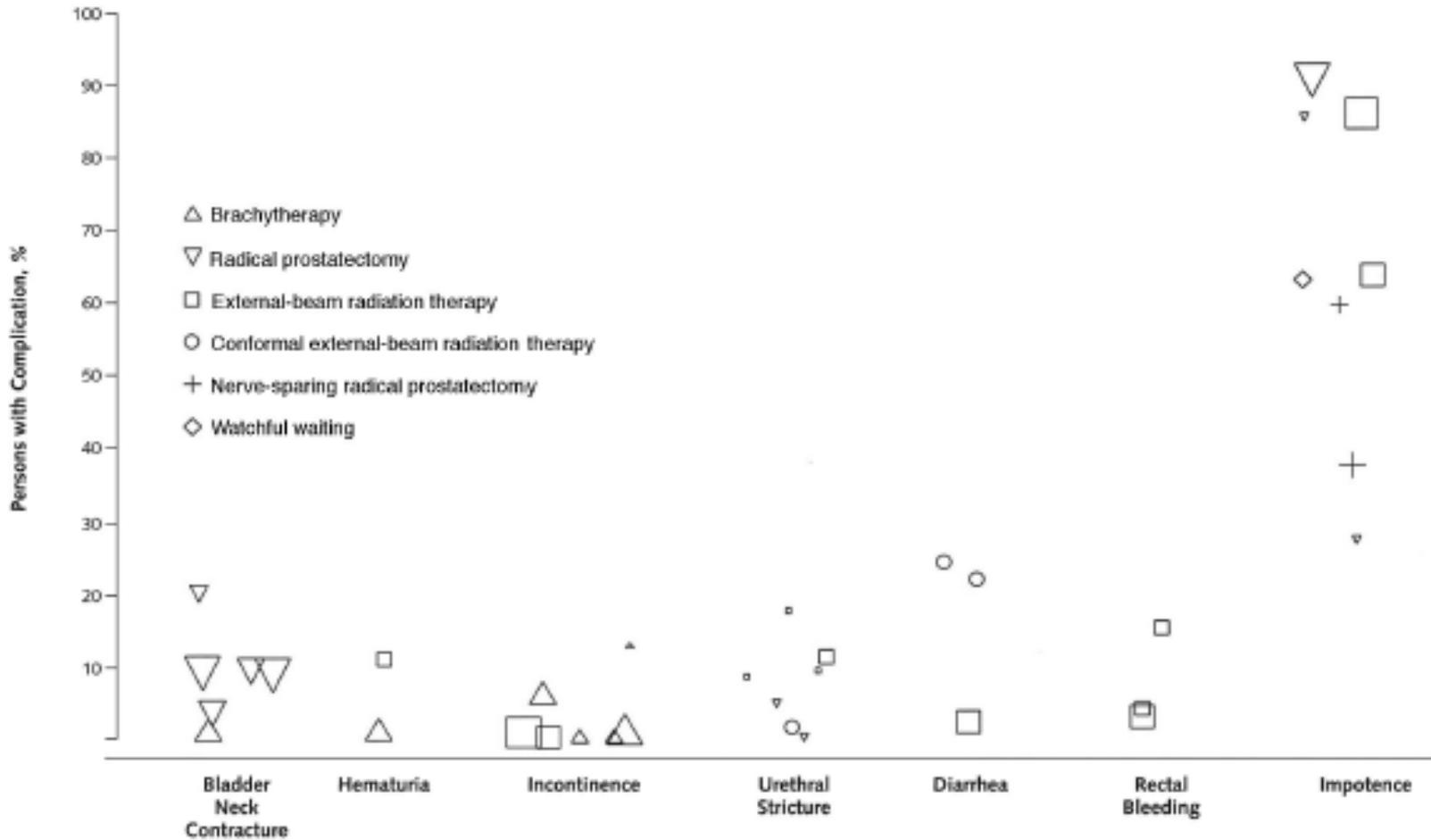
Limitations: Only 3 randomized trials compared effectiveness between primary treatments. No trial enrolled patients with prostate cancer primarily detected with PSA testing.

Conclusion: Assessment of the comparative effectiveness and harms of localized prostate cancer treatments is difficult because of limitations in the evidence.

Overall survival



Adverse events



Conclusion

- Assessment of the comparative effectiveness and harms of early stage prostate cancer treatment is difficult due to the limitations in the evidence.

**VA, NCI, AHRQ Cooperative Study #407:
Prostate cancer
Intervention Versus Observation Trial
(PIVOT)**

Timothy J. Wilt, MD, MPH

Minneapolis VA

**Center for Chronic Disease Outcomes
Research**



Objective

Among men with clinically localized prostate cancer detected during the early PSA era, does the intent to treat with radical prostatectomy reduce all-cause & prostate cancer mortality compared to observation?

“I am afraid that although this is an excellent question...I would recommend that this proposal not be entertained, because in my opinion it would never be completed”

Anonymous CSP Reviewer, 1992

Such a study would be far more important than virtually any study ongoing in the U.S. for prostate cancer

Anonymous CSP Reviewer, 1992

Timeline of Prostate Cancer Treatment

1960's- 70s

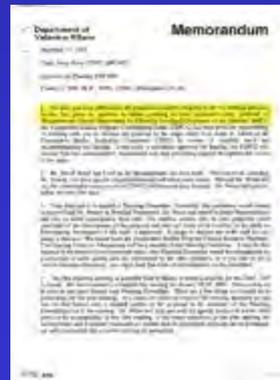
VA-CURG CaP Treatment
Trials begin



July 2012

December, 1992

PIVOT planning
approved



Jan 2010

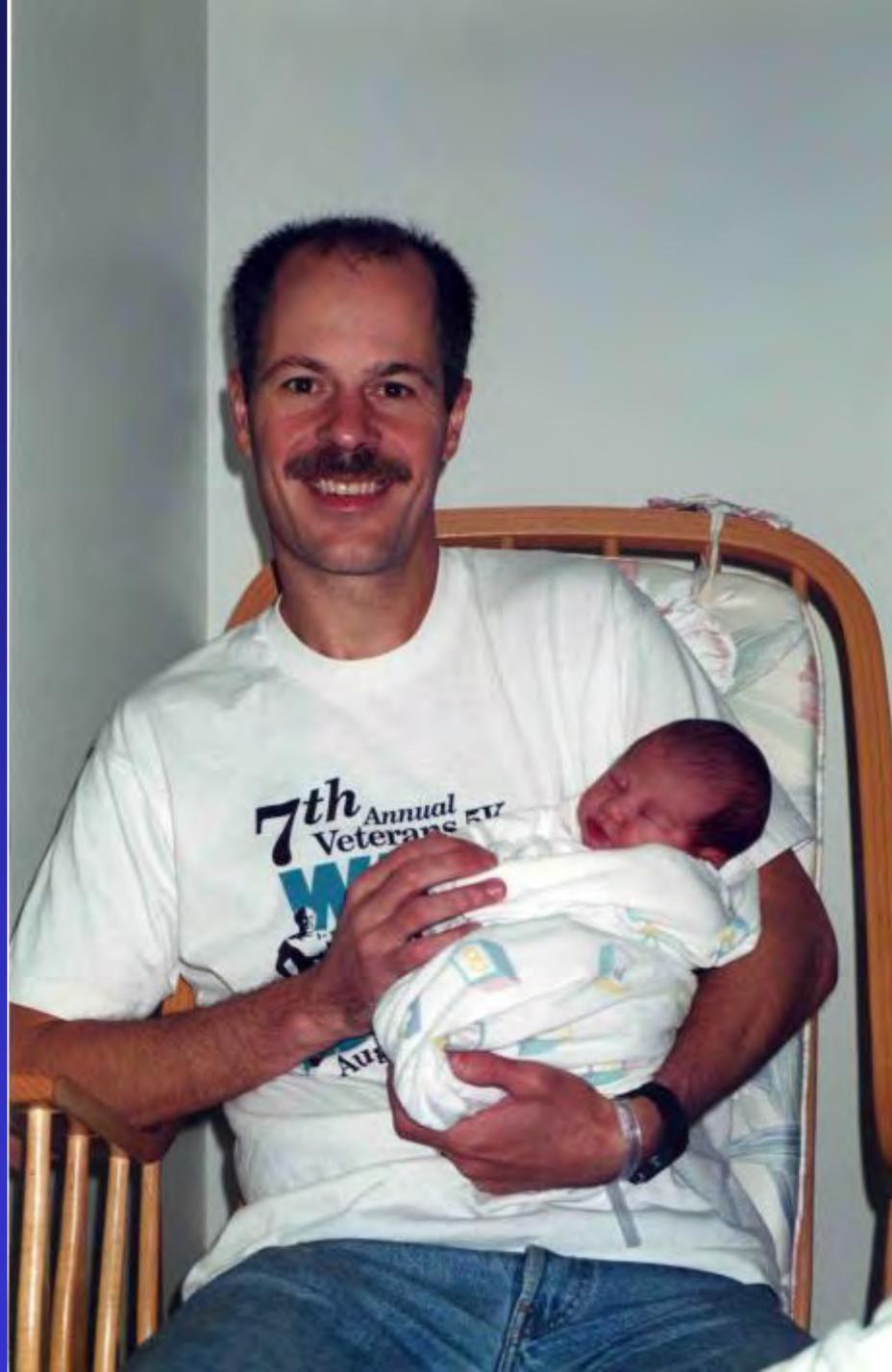


Close-Out



1904

Young first
RP for CaP





DEPARTMENT OF VETERANS AFFAIRS
Medical Center (151-1)
150 South Huntington Avenue
Boston, MA 02130

COOPERATIVE STUDIES PROGRAM
In Reply Refer To: **CSP #407**

*April 1, 1994

Timothy J. Wilt, M.D., MPH
VA Medical Center (111-0)
1 Veterans Drive
Minneapolis, MN 55417

Dear Dr. Wilt:

I am writing to inform you that I am authorizing funding of sites for your Cooperative Study #407, "Prostate Cancer Intervention Versus Observation Trial (PIVOT): A Randomized Trial Comparing Radical Prostatectomy Versus Palliative Expectant Management for the Treatment of Clinically Localized Prostate Cancer", as of August 1, 1994. Funding for your office is authorized for June 1, 1994. We expect you will plan your kick-off meeting for the month of August.

As you know, we are limited in the number of new studies we can support, so I am pleased that your research is included in the category of funded studies. I wish you and your colleagues every success in the conduct of this important research.

Sincerely,

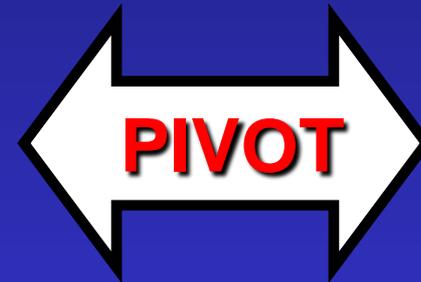


Daniel Daykin, M.D.
Chief, Cooperative Studies Program

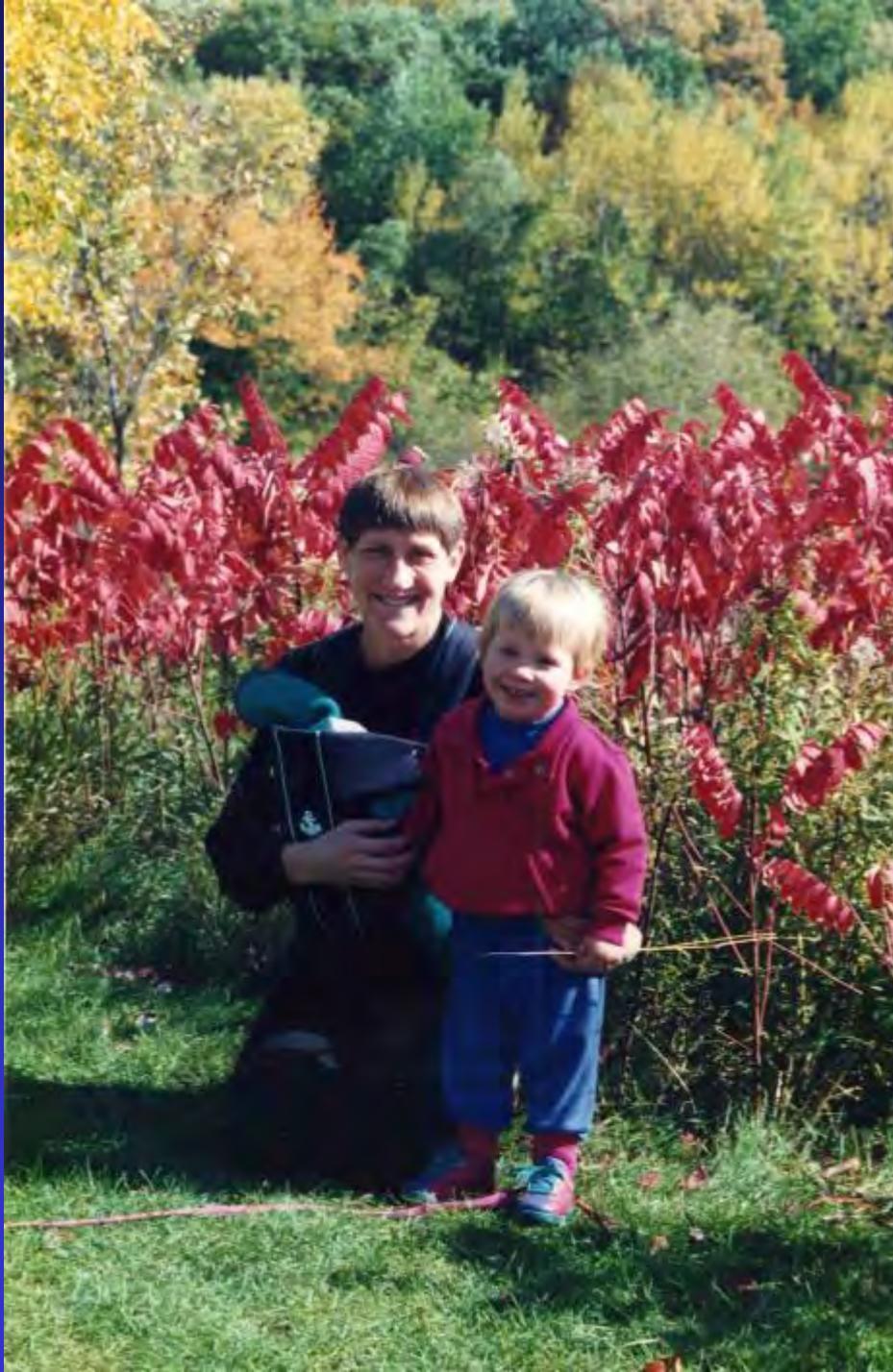
cc: Ping Huang, Ph.D.
Joseph Collins, Sc.D.
Mike Sather, M.S., F.A.S.H.P.
Michael David Levitt, M.D., ACOS for R&D, VAMC, Minneapolis, MN

April, 1st 1994

No April Fool's Joke !!!



funding approved











**ROUGH
ROAD**

1999-Judgment Day: PIVOT faced...Termination!

Department of Veterans Affairs

Date: May 28, 1999

From: Chief Research and Development Officer 

Subj: CSP #407 - PIVOT Recruitment

To: Joe Collins, PhD/David Weiss, PhD

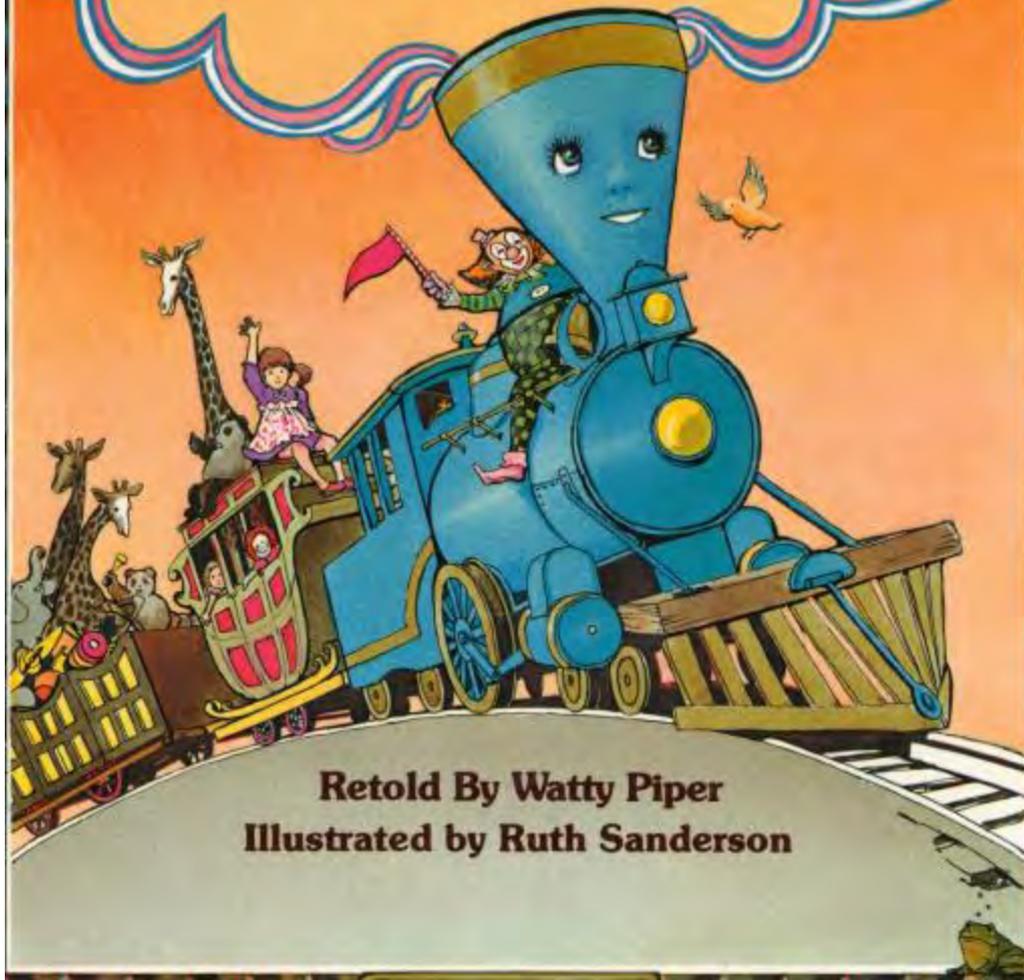


1. I reviewed your memo (dated May 10, 1999) regarding the latest PIVOT (CSP#407) enrollment figures for April 1999. I am increasingly concerned about the feasibility of completing this study. Over the past year, the study has failed to achieve the agreed upon recruitment target (95%). Given the current trend of the data, we project that the study will fall below 80% target recruitment within the next year.
2. Please prepare a contingency plan that includes possible termination of the study in 12/99. In the plan, include:





The Little Engine That Could



Retold By Watty Piper
Illustrated by Ruth Sanderson

Results

Notification of 1⁰ Outcome

Tim,

Rather than preface this with a drum roll or a big fanfare, thought I'd just send along the primary outcome analysis for your review (survival analysis and curves). I'm not sure whether or not you had an inkling of this but, as you can see...

Results

Notification of 1⁰ Outcome

Tim,

Rather than preface this with a drum roll or a big fanfare, thought I'd just send along the primary outcome analysis for your review (survival analysis and curves). I'm not sure whether or not you had an inkling of this but, as you can see... I'm leaving the office for the day so I'll leave you to digest overnight.

Karen

email... 1:58 pm August 10, 2010



Publication acceptance (4/23/12)



Dear Dr. Wilt and co-authors,

Thank you for the article, "Radical Prostatectomy Versus Observation for Localized Prostate Cancer," which the Journal is pleased to accept for publication...

Sincerely yours,

Jeffrey M. Drazen, M.D.
Editor-in-Chief

New England Journal of Medicine
Distinguished Parker B. Francis Professor of Medicine
Harvard Medical School



The NEW ENGLAND
JOURNAL of MEDICINE

The NEW ENGLAND JOURNAL *of* MEDICINE

ESTABLISHED IN 1812

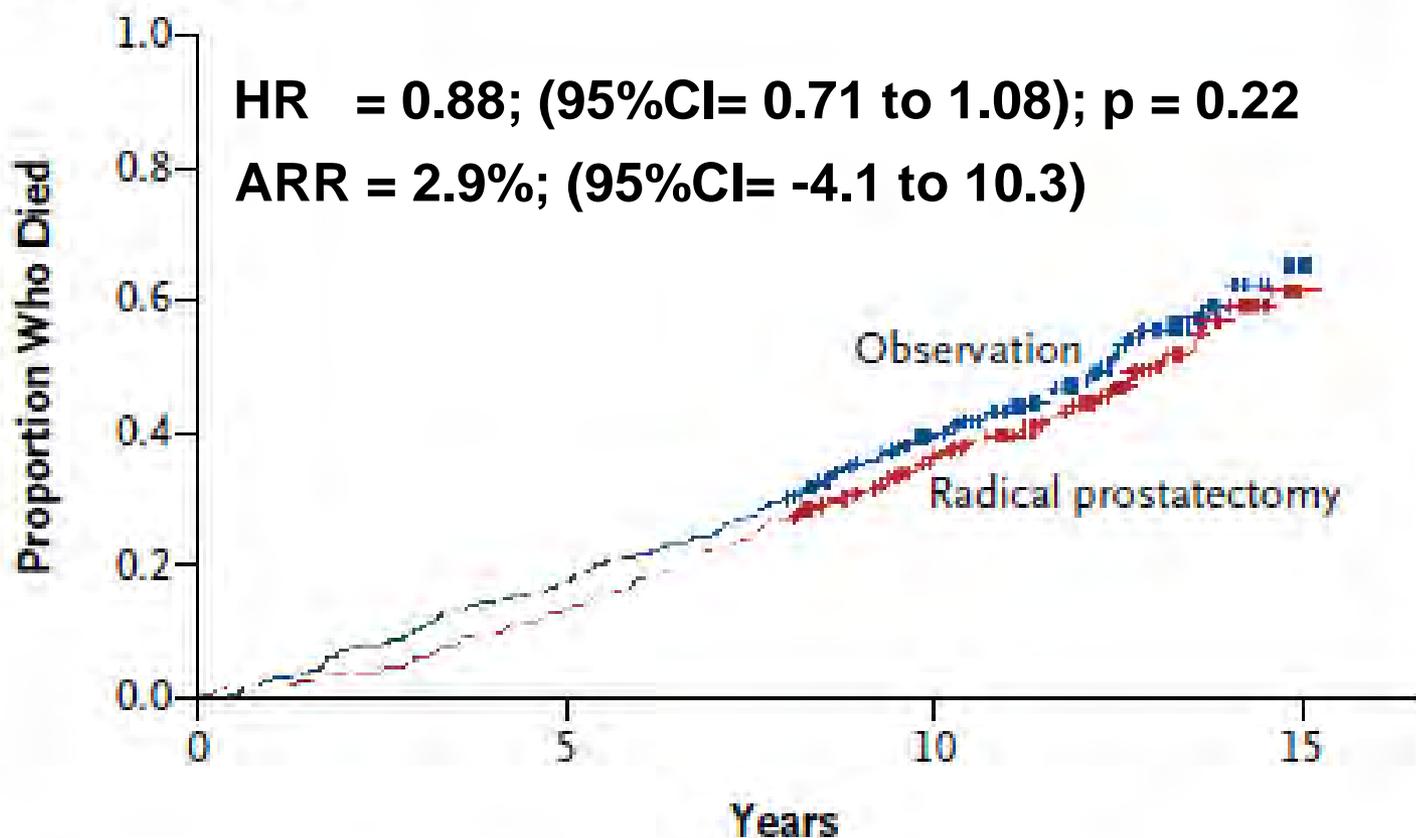
JULY 19, 2012

VOL. 367 NO. 3

Radical Prostatectomy versus Observation for Localized Prostate Cancer

Timothy J. Wilt, M.D., M.P.H., Michael K. Brawer, M.D., Karen M. Jones, M.S., Michael J. Barry, M.D.,
William J. Aronson, M.D., Steven Fox, M.D., M.P.H., Jeffrey R. Gingrich, M.D., John T. Wei, M.D.,
Patricia Gilhooly, M.D., B. Mayer Grob, M.D., Imad Nsouli, M.D., Padmini Iyer, M.D., Ruben Cartagena, M.D.,
Glenn Snider, M.D., Claus Roehrborn, M.D., Ph.D., Roohollah Sharifi, M.D., William Blank, M.D.,
Parikshit Pandya, M.D., Gerald L. Andriole, M.D., Daniel Culkin, M.D., and Thomas Wheeler, M.D.,
for the Prostate Cancer Intervention versus Observation Trial (PIVOT) Study Group

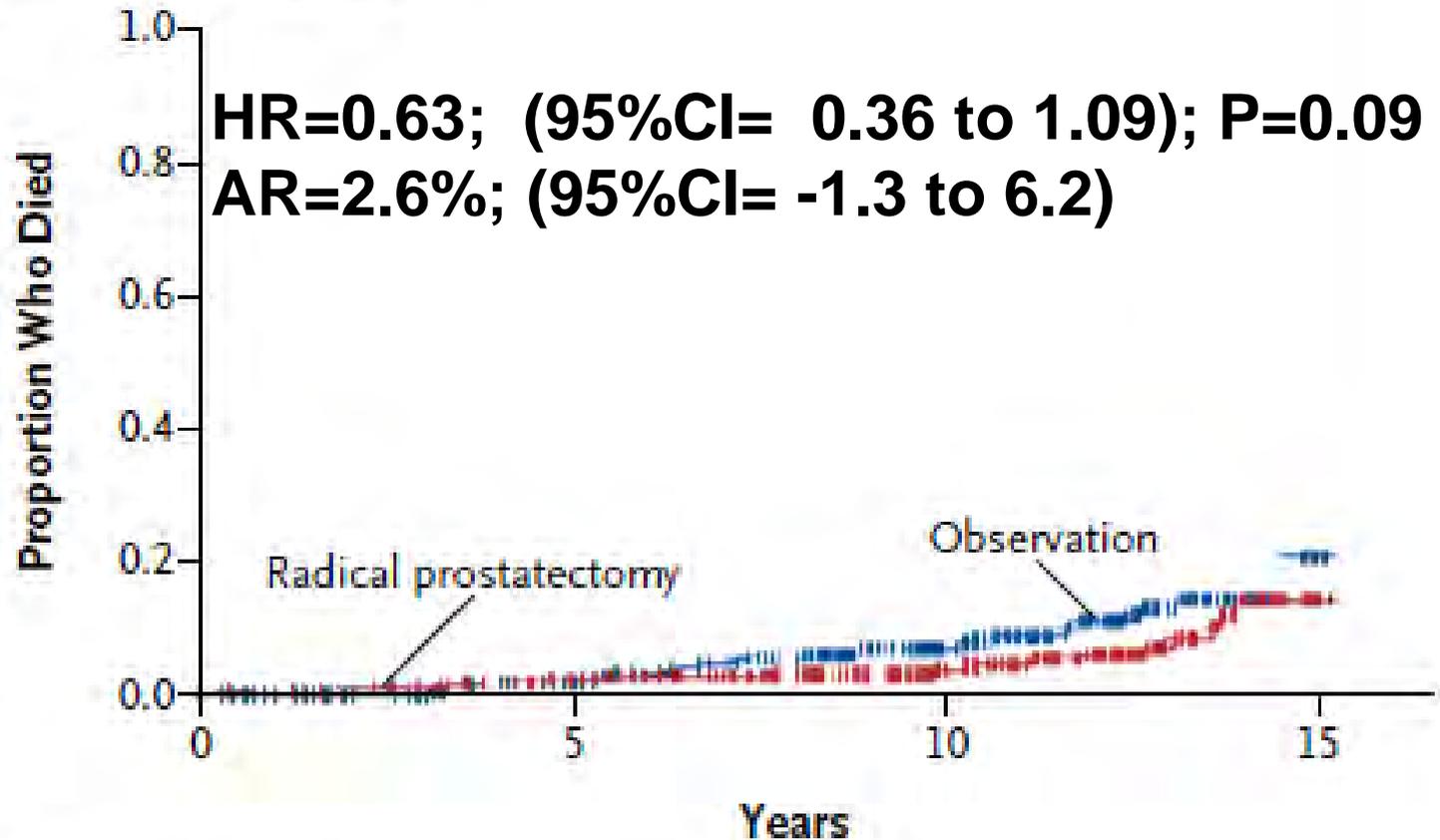
A Death from Any Cause



No. at Risk

Observation	367	341	315	288	258	176	106	26	0
Radical prostatectomy	364	352	329	300	267	187	126	36	0

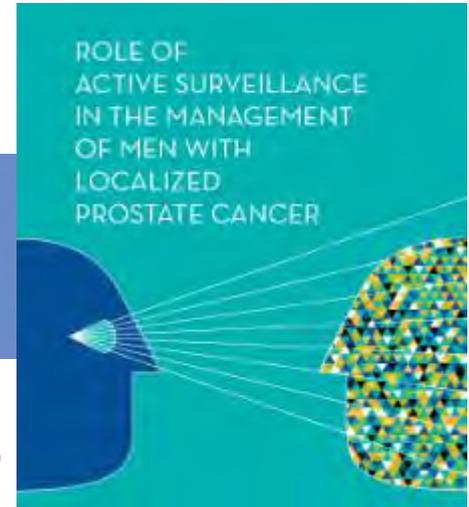
B Death from Prostate Cancer



No. at Risk

Observation	367	341	315	288	258	176	106	26	0
Radical prostatectomy	364	352	329	300	267	187	126	36	0

Improving Screening and Treatment Value



- **Recommend Observation/AS**
 - Maintain overall, prostate cancer mortality & QOL
 - Reduce treatment harms
 - Lower resource utilization and health care costs

Evidence Synthesis to Inform Clinical Practice & Policy

Management of Stable Chronic Obstructive Pulmonary Disease: A Systematic Review for a Clinical Practice Guideline

Timothy J. Wilt, MD, MPH; Dennis Niewoehner, MD; Roderick MacDonald, MS; and Robert L. Kane, MD

Background: Chronic obstructive pulmonary disease (COPD) is a common and disabling condition in adults. Information about therapeutic effectiveness and adverse effects of common treatment options and how clinical and spirometric characteristics affect outcomes is not well known but is important for clinicians caring for patients with stable COPD.

Purpose: To evaluate the effectiveness of COPD management strategies.

Data Sources: English-language publications in MEDLINE and the Cochrane Library through March 2007.

Study Selection: Randomized, controlled trials (RCTs) and previous systematic reviews of inhaled therapies, pulmonary rehabilitation, disease management, and supplemental oxygen in adults with COPD.

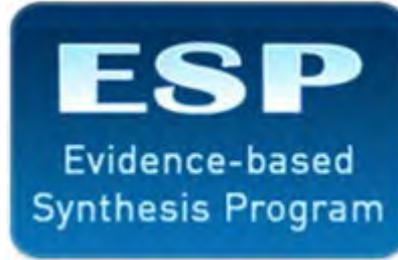
Data Extraction: Participant, study, and intervention characteristics; exacerbations; deaths; respiratory health status; exercise capacity; hospitalizations; and adverse effects.

Data Synthesis: Eight meta-analyses and 42 RCTs examined inhaled therapies: short-acting anticholinergics ($n = 7$), long-acting anticholinergics ($n = 10$), long-acting β_2 -agonists ($n = 22$), corticosteroids ($n = 14$), dual D_2 dopamine receptor- β_2 -agonist ($n = 3$), or short-acting β_2 -agonist plus ipratropium ($n = 3$). Evidence for nonpharmacologic therapies included 3 reviews of 39 RCTs plus 6 additional RCTs of pulmonary rehabilitation, 2 reviews of 13 RCTs plus 2 additional RCTs of disease management, and 8 RCTs of

oxygen. Overall, long-acting inhaled therapies, used alone or in combination, reduced exacerbations more than placebo by 13% to 25% and had similar effectiveness to each other. Average improvements in health status scores were less than what is considered to be clinically noticeable. Inhaled monotherapy did not reduce mortality rates. Inhaled corticosteroids plus long-acting β_2 -agonists reduced deaths in relative terms compared with placebo (relative risk, 0.82 [95% CI, 0.69 to 0.96]) and inhaled corticosteroids alone (relative risk, 0.79 [CI, 0.67 to 0.94]) but not compared with long-acting β_2 -agonists alone (relative risk, 0.82 [CI, 0.52 to 1.28]). Absolute reductions were 1% or less and were not statistically significant. Pulmonary rehabilitation improved health status and dyspnea but not walking distance. Neither disease management nor ambulatory oxygen improved measured outcomes. Supplemental oxygen reduced mortality rates among symptomatic patients with resting hypoxia (relative risk, 0.61 [CI, 0.46 to 0.82]). Insufficient evidence supports using spirometry to guide therapy.

Limitations: Articles were limited to those in the English language. Treatment adherence, adverse effects, and effectiveness may differ among clinical settings. Short-acting inhalers for "rescue therapy" were not evaluated.

Conclusion: Long-acting inhaled therapies, supplemental oxygen, and pulmonary rehabilitation are beneficial in adults who have bothersome respiratory symptoms, especially dyspnea, and FEV₁ less than 60% predicted.



DVA
Operational Partner

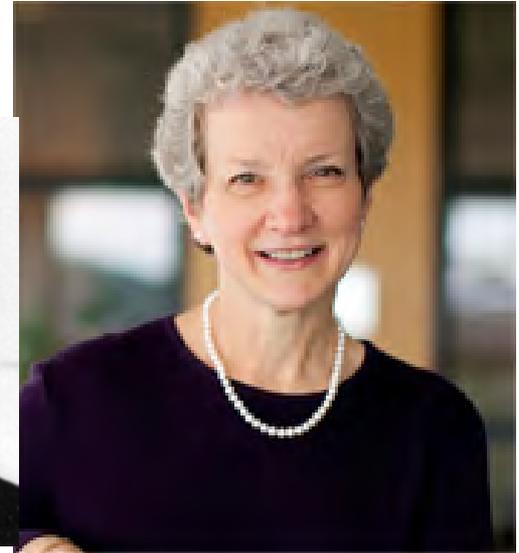
Department of Veterans Affairs
Health Services Research & Development Service | Evidence-based Synthesis Program

QUERI

**Screening Pelvic Examinations
in Asymptomatic Average
Risk Adult Women**

Hanna Bloomfield et al

September 2013



Linda Humphrey

Linda Kinsinger

Prepared for:
Department of Veterans Affairs
Veterans Health Administration
Quality Enhancement Research Initiative
Health Services Research & Development Service
Washington, DC 20420

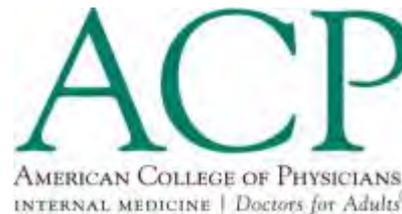
Investigators:
Principal Investigator:
Hanna E. Bloomfield, M.D., M.P.H.

Co-investigators:
Andrew Olson, M.D.
Amy Cantor, M.D., M.H.S.
Nancy Greer, Ph.D.

Prepared by:
Evidence-based Synthesis Program (ESP) Center
Minneapolis, MN
Timothy J. Wilt, M.D., M.P.H., Director

Research Associates:
Roderick MacDonald, M.S.
Indulis Rutks, B.A.

NOTE: This publication is for internal use of the Department of Veterans Affairs and should not be distributed outside the agency.



No data supporting use of the pelvic examination in asymptomatic average risk women...may cause pain, fear, discomfort, anxiety and/or embarrassment in about 30% of women

Health Care Policy and Clinical Practice Guidelines



U.S. Preventive Services
TASK FORCE



ACP

American College of Physicians

Best Practice Advice



Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement

U.S. Preventive Services Task Force*

Description: Update of the 2002 U.S. Preventive Services Task Force (USPSTF) recommendation statement on screening for breast cancer in the general population.

Methods: The USPSTF examined the evidence on the efficacy of 5 screening modalities in reducing mortality from breast cancer: film mammography, clinical breast examination, breast self-examination, digital mammography, and magnetic resonance imaging in order to update the 2002 recommendation. To accomplish this update, the USPSTF commissioned 2 studies: 1) a targeted systematic evidence review of 6 selected questions relating to benefits and harms of screening, and 2) a decision analysis that used population modeling techniques to compare the expected health outcomes and resource requirements of starting and ending mammography screening at different ages and using annual versus biennial screening intervals.

Recommendations: The USPSTF recommends against routine screening mammography in women aged 40 to 49 years. The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take into account patient context, including the patient's values regarding specific benefits and harms. (Grade C recommendation)

The USPSTF recommends biennial screening mammography for women between the ages of 50 and 74 years. (Grade B recommendation)

The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older. (I statement)

The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination beyond screening mammography in women 40 years or older. (I statement)

The USPSTF recommends against clinicians teaching women how to perform breast self-examination. (Grade D recommendation)

The USPSTF concludes that the current evidence is insufficient to assess additional benefits and harms of either digital mammography or magnetic resonance imaging instead of film mammography as screening modalities for breast cancer. (I statement)

Ann Intern Med. 2009;151:716-726.

For author affiliation, see end of text.

* For a list of the members of the USPSTF, see the **Appendix** (available at www.annals.org).

www.annals.org

TODAY

NO. 1 IN THE USA



By MACE SAVINS, AP
Moon rises: Kristen Stewart at premiere.

the season

- Fewer films in mix at theaters. Highlights, 1-3D
- Premiere of *New Moon*, 4D

USA TODAY investigation

ools in the dark tainted lunches



New focus in breast cancer screening

Report: Most don't need tests until 50

Mammogram shift: Not a conspiracy

- Our understanding of things evolves, and our practices must adapt.

By SUSAN LOVE

Although we all would like to think that public health pronouncements are the unmitigated truth about any issue, rarely is that the case. We can only give our best guess, based on the available data and our understanding of the disease. Luckily, research continues, hypotheses are reformulated and new recommendations are made.

Sometimes clinical practice gets ahead of the data and has to be pulled back. This is what happened with postmenopausal hormone therapy when the large Women's Health Initiative trial demonstrated that the then-common practice of giving women hormones at menopause was causing more harm than good. How big was the harm? We know that after the report came out, many women abruptly stopped taking their hormones, and

February 2010 Vol. 30 No. 2

American College of Physicians News for Internists www.acpinternist.org

Mammogram Debate Took Group Off Guard

By GINA KOLATA

The federal Preventive Services Task Force, the group that created a political firestorm this week with its recommendation that women get less-frequent mammograms, was created to be insulated from politics.

Yet, some observers say, its spottily earned stature may have made it naive about just how strongly Congress, some professionals, 500 radiologists; advocacy groups, like the American Cancer Society; and members of the public would react.

As soon as the task force's guidelines were released on Monday, recommending against routine mammograms for most

...the task force's message was distorted, he said, into a purely negative one, when the group meant to empower women to make their own decisions.

"It's partly our fault," Dr. LeFevre said, adding that the group would now be trying to figure out how they could have gotten their point across without stirring such a controversy.

But Dr. Philip Lee, who was an assistant secretary for health in the Clinton administration, said he was surprised by how politically naive the task force members seemed.

"Here we are on the lip of health care reform," he said, a time when people are suspicious of any talk of taking away bene-



ACP INTERNIST



Calmer talk needed about mammography

By Kathy Holliman

For many physicians, the controversy following the recent release of the U.S. Preventive Services Task Force's (USPSTF) breast cancer screening recommendations was another reminder that practicing evidence-based medicine

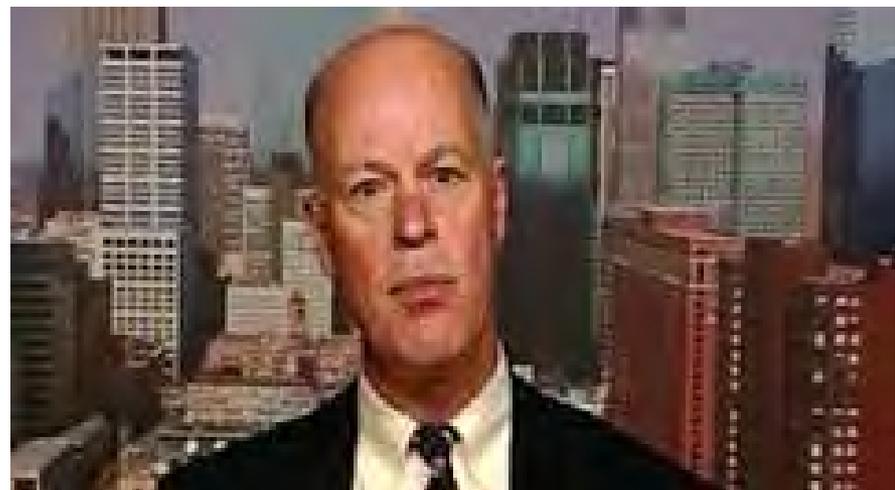
ing with patients," Dr. Han said.

Larissa Nekhlyudov, ACP Member, MPH, recently published a dialogue model to help physicians engage women in their 40s in decision making about breast cancer screening.

...the timing and manner of their release has done more to set back healthcare and the cause of evidence-based medicine than anything I can imagine. The potential damage of releasing such a shocking reversal of recommendations on an extremely emotional disease with no preparation or education of the public in the midst of a contentious debate on healthcare reform should have been so obvious that it's difficult to conclude that that damage was not inflicted on purpose.

What in heaven's name were you people thinking? I happen to be in favor of evidence-based medicine and wonder whether you are, too.

Scottsdale, AZ





Mammography Screening for Breast Cancer



The VHA *recommends* screening for breast cancer with mammography every 2 years for [average risk](#) women age 50 through 74.



The decision to start regular screening every 2 years with mammography for [average risk](#) women age 40 to 49 years should be an *individual decision* and take the patient's values into account including values about specific benefits and harms.



The VHA *neither recommends for or against* screening for breast cancer for women age 75 and older. The current evidence is insufficient to assess the balance of benefits and harms of screening for breast cancer with mammography in women age 75 and older. If screening for breast cancer with mammography is offered, patients should understand the uncertainty about the balance of benefits and harms.

Screening for Prostate Cancer: U.S. Preventive Services Task Force Recommendation Statement

Virginia A. Moyer, MD, MPH, on behalf of the U.S. Preventive Services Task Force*

Description: Update of the 2008 U.S. Preventive Services Task Force (USPSTF) recommendation statement on screening for prostate cancer.

Methods: The USPSTF reviewed new evidence on the benefits and harms of prostate-specific antigen (PSA)-based screening for prostate cancer, as well as the benefits and harms of treatment of localized prostate cancer.

Recommendation: The USPSTF recommends against PSA-based screening for prostate cancer (grade D recommendation).

This recommendation applies to men in the general U.S. population, regardless of age. This recommendation does not include the use of the PSA test for surveillance after diagnosis or treatment of prostate cancer; the use of the PSA test for this indication is outside the scope of the USPSTF.

Ann Intern Med. 2012;157.

www.annals.org

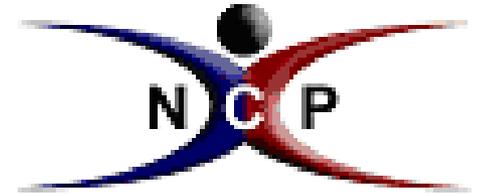
For author affiliation, see end of text.

* For a list of the members of the USPSTF, see **Appendix 1** (available at www.annals.org).

This article was published at www.annals.org on 22 May 2012.

<http://www.uspreventiveservicestaskforce.org/prostatecancerscreening.htm>





PSA screening for Prostate Cancer



...VHA recommends that any decision to initiate or continue prostate cancer screening with PSA for any man should be based on a decision between the patient and the provider...



VHA does not recommend prostate cancer screening with PSA for:

- Men ages 45-70 who are NOT at increased risk of prostate cancer,**
- Men younger than age 45 or older than 70, and**
- Men of any age or risk status who have an estimated life expectancy of less than approximately 15 years....**



U.S. Department of Veterans Affairs
 Veterans Health Administration
 Research, Quality, and Statistics
 Health Promotion and Disease Prevention

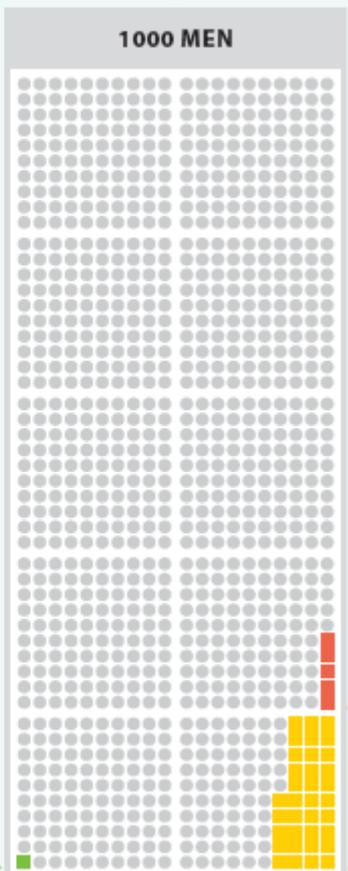
The PSA Test for Prostate Cancer Screening:

Why some doctors no longer recommend testing

BENEFITS and HARMS Experienced by Men Ages 55–69 Who Are Screened for Prostate Cancer With PSA Every 1–4 Years for 10 Years as Compared to Those Who Are Not Screened

BENEFITS of Screening*

1000 MEN



0–1 fewer men in 1000 will DIE from PROSTATE CANCER

HARMS of Screening*

- 4–5 more men in 1000 will experience a SERIOUS HARM from testing and treatment:
 - 1–2 more men in 1000 will be HOSPITALIZED from INFECTION received during biopsy
 - 3 more men in 1000 will experience a HEART ATTACK or BLOOD CLOT because of treatment
 - Less than 1 in 1000 will DIE from complications of biopsy or treatment

35 more men in 1000 will develop problems with SEXUAL FUNCTION or BLADDER CONTROL from treatment

3 The information in this graph was obtained from: Moyer, VA. Screening for Prostate Cancer. U.S. Preventive Annals of Internal Medicine. 2012 Jun;157(2):120-134.

Poll Results: Physicians' Opinions on the New USPSTF Recommendation Against PSA Screening

I AGREE, and I will no longer initiate discussions of PSA screening.	22%
--	-----

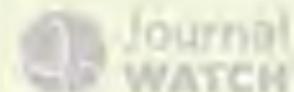
I AGREE, but I'll still bring up screening selectively, depending on my perception of the patient's expectations.	40%
---	-----

I AGREE, but I'll still bring up screening routinely, because the current standard of care is to offer the test.	16%
--	-----

I DISAGREE; I believe the USPSTF is wrong and that benefits of screening clearly outweigh harms.	8%
--	----

I DISAGREE; the USPSTF analysis has some merit, but it should have stayed with its previous "C" recommendation.	14%
---	-----

Journal Watch readers responded to this online poll in June 2012.



Who recommends PSA screening?

1) USPSTF

2) AUA

3) ACS

4) ACP

5) ASCO

6) VA

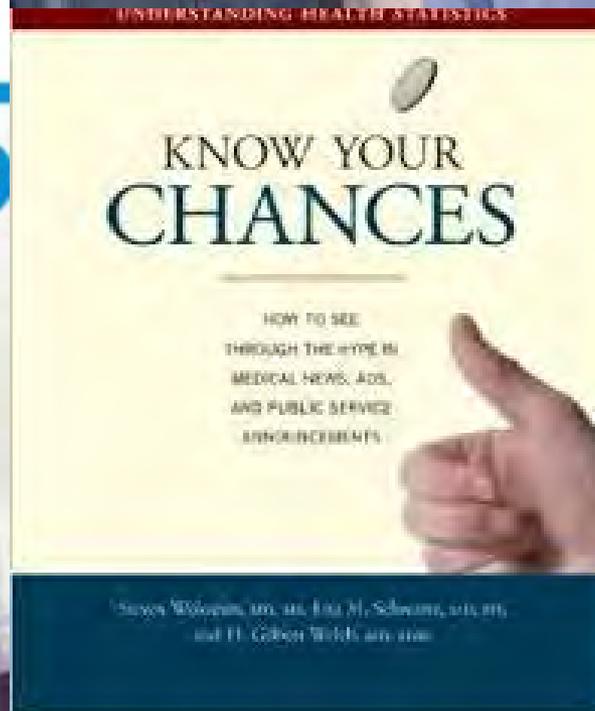
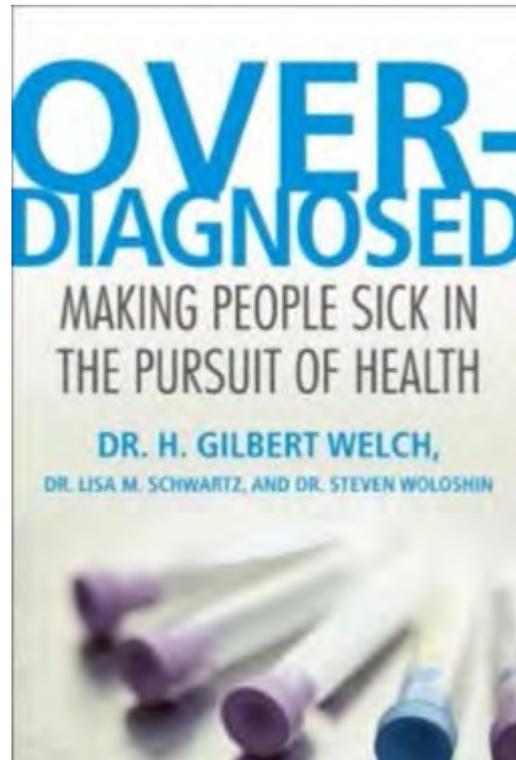
Future Goals Made Possible by VA Undersecretary's Award

- **Develop High Value Care Center:
Hi VACC**
- **Mission:**
 - Bring together clinicians, researchers, educators, policy makers and patients to define, identify, communicate and implement high-value care with an emphasis on reducing overuse of low-value care



PREVENTING OVERDIAGNOSIS

Winding back the harms of too much medicine



High-Value, Cost-Conscious Health Care: Concepts for Clinicians to Evaluate the Benefits, Harms, and Costs of Medical Interventions

Douglas K. Owens, MD, MS; Amir Qaseem, MD, PhD, MHA; Roger Chou, MD; and Paul Shekelle, MD, PhD, for the Clinical Guidelines Committee of the American College of Physicians*

High-Value care = good benefit relative to harms & costs



Doug Owens



Linda Humphrey



Paul Shekelle



ACP

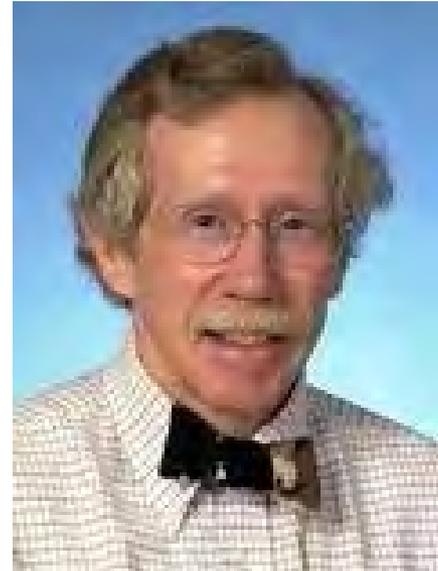
American College of Physicians

Best Practice Advice

ACP Clinical Guidelines Committee and Staff: 2013-2014

High Value Cancer Screening

- **Screening intensity**
 - Population Screened
 - Screen frequency
 - Screen sensitivity



Russ Harris

Five Screening Value Concepts

- 1. Screening is a cascade of events**
- 2. Cancers are heterogeneous**
- 3. Individuals are heterogeneous**
- 4. Screening is a double-edged sword**
- 5. Increasing screening beyond an optimal point leads to disproportionate increase in harms and costs, and lower value**

Screening Strategies & Value

- **Maximum detection strategy**
 - Seeks to maximize cancer detection and prevention
 - High Intensity
 - Not always highest value
 - Small incremental benefits; large increase harms/cost
- **Value strategy**
 - Science-based incorporation of screening & treatment decision making factors (benefits, harms & costs)
 - Optimizes balance between benefits, harms & costs
 - Ethical cost-conscious stewardship of health care resources
 - Often lower intensity
 - Maximizes value

Screening Strategy Value

Cancer Type	High Value* Cancer Screening: Population-Test, Frequency Encourage or Neutral Discussion	Low Value* Cancer Screening: Population-Test Discourage
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Screening Strategy Value

Cancer Type	High Value* Cancer Screening: Population-Test, Frequency Encourage or Neutral Discussion	Low Value* Cancer Screening: Population-Test Discourage
<i>Breast</i>	<p>Women ages 60-69[†] (encourage): Biennial mammography</p> <p>Women ages 40-59 and 70-75 in good health (neutral discussion): Discuss once (or more as patient requests) with women in good health: Biennial mammography</p>	

Screening Strategy Value

Cancer Type	High Value* Cancer Screening: Population-Test, Frequency Encourage or Neutral Discussion	Low Value* Cancer Screening: Population-Test Discourage
<i>Breast</i>	<p>Women ages 60-69[†] (encourage): Biennial mammography</p> <p>Women ages 40-59 and 70-75 in good health (neutral discussion): Discuss once (or more as patient requests) with women in good health: Biennial mammography</p>	<p>Women aged < 40 or > age 75; women of any age with life expectancy less than 15 years; Mammography</p> <p>Any group: Annual mammography; MRI; tomosynthesis</p> <p>Any group: Regular systemic Breast self-exam</p>

Screening Strategy Value

Cancer Type	High Value* Cancer Screening: Encourage	Low Value* Cancer Screening: Population-Test Discourage
--------------------	--	--

<i>Prostate</i>	None	Men ages 55-69 who have not had an informed discussion and have expressed a clear preference for testing after the discussion: PSA Men aged < 50 or > 70; men of any age with life expectancy less than 15 years: PSA
-----------------	-------------	--

VHA effort to provide High-Value Care by reducing inappropriate cancer screening

- **Prostate cancer screening**
 - PSA in men \geq 75 years
- **Cervical cancer screening**
 - Women $>$ 65 with adequate Pap smears
 - Women with total hysterectomy for benign Dz
- **Colorectal cancer screening**
 - Adults \geq 85
 - Redundant screening
 - Screening colonoscopy intervals $<$ 10 years

Summary

- My career journey as a VA-HSR&D researcher has been exciting and fun. It has provided me rewarding opportunities to learn from others and contribute to improving the health care we deliver and resulting health outcomes.
- The future is likely to be equally enjoyable and hopefully productive!

Lessons Learned



DEDICATED TO THE AUSTRALIAN BOY SCOUT

THE FAMOUS
BOY SCOUT
MARCHING SONG

We're Prepared

COPYRIGHT



PRICE 2/- NETT

WRITTEN AND COMPOSED BY
JACK FEWSTER
WRITER OF
SISTER OF PAL O' MINE, BROTHER BILLIE & C. & C.

Published in 1947 by the Boy Scouts of Australia, Inc. in association with the Australian Boy Scouts Association, Sydney.

The image is a vintage sheet music cover for the song "We're Prepared". It features a central illustration of a young boy scout in a brown uniform and hat, blowing a bugle. The title "We're Prepared" is written in large, red, stylized letters across the top. Above the title, it says "THE FAMOUS BOY SCOUT MARCHING SONG" and "DEDICATED TO THE AUSTRALIAN BOY SCOUT". Below the illustration, the price is listed as "PRICE 2/- NETT". At the bottom, it credits the song to "WRITTEN AND COMPOSED BY JACK FEWSTER" and lists him as the "WRITER OF SISTER OF PAL O' MINE, BROTHER BILLIE & C. & C.". A small copyright notice is visible to the right of the title.

THICK SKIN



**DR. KHO'S
"HOW TO GET
INSTANT
ABS OF STEEL"**



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Private use only. No rep

PAULDING.BLOGSPOT

m) Lake Nakuru National Park, Kenya.
n more at <http://panda.org/whiterhinos>



Curious George

Let's Get Curious!

To Do:

1. Don't Worry
2. Be Happy

wang·chung



EVERYBODY HAVE FUN TONIGHT

THE POWER OF A
**POSITIVE
NO**

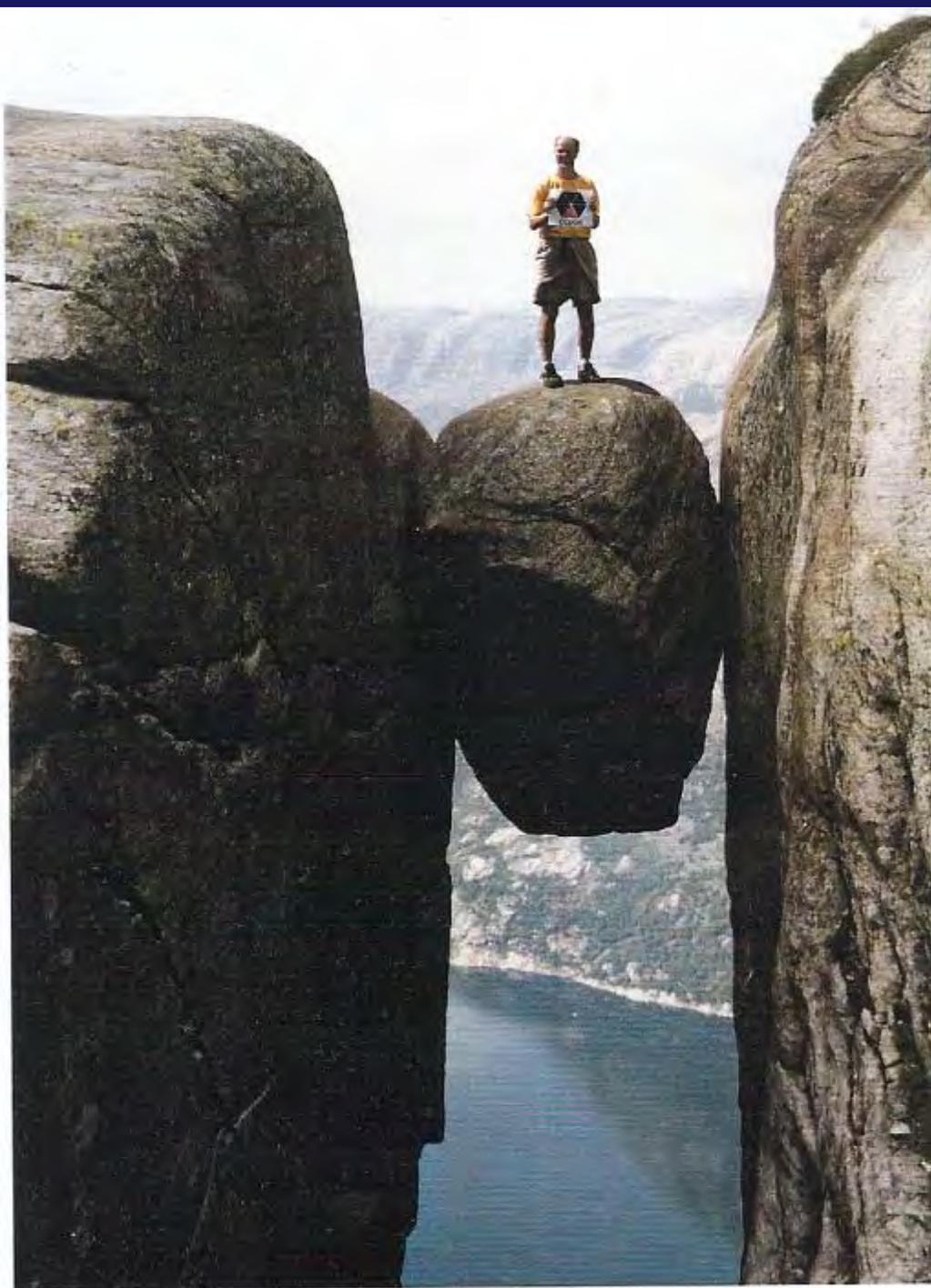
HOW TO SAY NO &
STILL GET TO YES

WILLIAM URY, Ph.D.

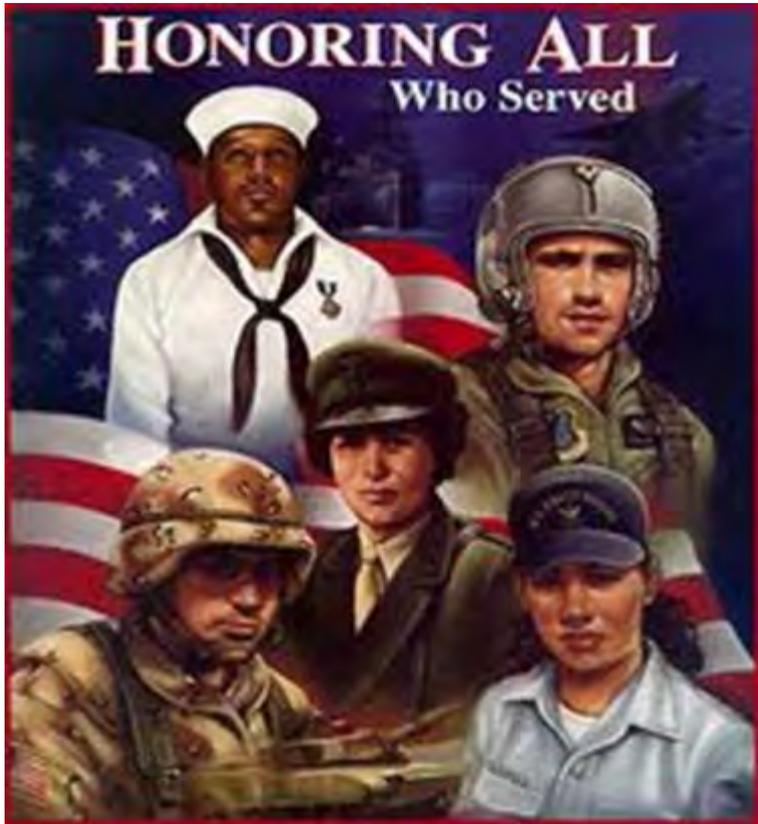
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DON'T BE
AFRAID TO
FAIL

Be afraid not
to try.







WOMEN VETERANS HEALTH CARE

*You served, you deserve
★ the best care anywhere.*



Words Matter



Thank You!!!

Questions, Comments, Collaborations

- Timothy Wilt: Minneapolis VA Center for Chronic Disease Outcomes Research, 1 Veterans Drive, Minneapolis, MN 55417
- CCDOR Web (and my) Link
 - www.hsrd.minneapolis.med.va.gov/
 - http://www.hsrd.minneapolis.med.va.gov/PI_Wilt.asp
- Email: tim.wilt@va.gov