SOCIETY OF BEHAVIORAL MEDICINE

POSITION STATEMENT:

Society of Behavior Medicine (SBM) Urges Congress to Ensure Affordable Care Act Coverage of Prostate Cancer Screening Support Services for High-Risk Men

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Authors: Karriem Watson, DHSc, MS, MPH, University of Illinois at Chicago; Joanna Buscemi, PhD, DePaul University; Marian Fitzgibbon, PhD, University of Illinois at Chicago; Marcus Murray, MPH, BA; Adam Murphy, MD, MSc, MBA, Northwestern University; Michael Abern, MD, University of Illinois at Chicago; Peter Gann, MD, ScD, University of Illinois at Chicago; Josef Ben Levi, EdD, Northeastern Illinois University; James Stinson, MS; Michael Diefenbach, PhD, Northwell Health; Robert A. Winn, MD, University of Illinois at Chicago

RECOMMENDATIONS

- Expand the provisions within the ACA that support the use of patient navigators to ensure care coordination of cancer screening and follow up for high-risk men.
- Expand the provisions within the ACA that support training of health care providers (i.e., physicians, nurses, physician assistants) in shared-decision making with high-risk men.

The Society of Behavioral Medicine supports the United States Preventive Services Taskforce (USPSTF) guideline for the consideration of prostate cancer screening for high-risk men between the ages of 55-69. SBM encourages policymakers to include provisions for coverage of patient navigation services in the Affordable Care Act (ACA) to facilitate shared-decision making between providers and patients regarding screening.

THE PROBLEM

Prostate cancer (PCa) remains the second most common cancer in men, behind only skin cancer [1]. In 2017, 161,360 new cases of prostate cancer occurred in the United States (US) [1]. Men in the US have an 11.2% lifetime risk of being diagnosed with prostate cancer. Disparities in incidence and mortality exist for African American (AA) men. AA men carry a 70% greater risk of being diagnosed with PCa compared to white men [1, 2] and are twice as likely to die from PCa.

Given this disparity, the United States Preventive Services Task Force (USPSTF) issued an updated recommendation statement on serum Prostate Specific Antigen (PSA)-based screening for PCa [3]. In 2012, the USPSTF recommended against PSA-based screening for any men aged 55 to 69, concluding that any morbidity and mortality benefits were outweighed by harms related to overdiagnosis and overtreatment (e.g., anxiety from false positive tests, morbidity from treatment of indolent tumors) [(D rating; see Table 1); 4]. Following this recommendation, rates of PSA screening declined substantially, among men in all risk levels. In 2018, a new USPSTF panel revised PSA screening to a C recommendation based mainly on: 1) cumulative evidence that the previous analysis had underestimated the mortality benefit, and 2) emerging evidence that active surveillance was a safe option for men with low-risk cancer, which could thus reduce harm due to overtreatment. The latest guideline recommends that care providers and men aged 55-69 engage in a shared decision process about benefits and risks before PSA screening is started. While concluding that too few data were available to definitively assess the relative benefits and harms, and thus promulgate separate recommendations, for high risk men such as African Americans, the panel noted that decision analysis models indicate that benefits could be greater for these

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.

Table 1. United States Preventive Services Task Force(USPSTF)Recommendations

men, especially if initiated before age 55. Furthermore, the latest USPSTF panel encouraged clinicians to perform a risk assessment and to inform AA men and those with a positive family history about their increased risk as part of shared decision-making [USPSTF, JAMA 319:1901, 2018].

POLICY GAPS

This new recommendation will require providers to educate high-risk men on the benefits and harms of PSA-based PCa screening so that they can make an informed decision [3]. The ACA includes provisions of service coverage for patient navigators who can help patients decide whether screening is appropriate given potential risks and benefits, and training of health care providers in shared-decision regarding screening/treatment. These services can be utilized to support health care providers to better adhere to the new guideline. However, recommendations that are given a C rating or lower are not consistently reimbursed through many plans, including those offered through the ACA marketplace. Given that the updated screening recommendation for high-risk men was given a C rating, there are limitations in terms of reimbursement for these essential services. Compared to many other interventions, shared decision making regarding PCa screening is a complex issue for patients, especially for those who are high-risk or may have relatively low health literacy. Thus, care providers must be given adequate time and reimbursement in order for this C recommendation to be carried out effectively.

SUMMARY STATEMENT

The updated recommendation for PCa screening represents an important step towards addressing continuing inequities in PCa that exist for high-risk populations, including AA men and men with a family history of PCa [5-7]. However, if PCa screening is deemed appropriate given risk factors, provider recommendation, and patient preference, patient navigation services and training should be reimbursed through the ACA regardless of recommendation rating.

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