



# NEVADA BREAST CANCER SCREENING ASSESSMENT REPORT

Developing a better understanding of provider approaches and practices specific to breast cancer screening and early detection.

June 2016



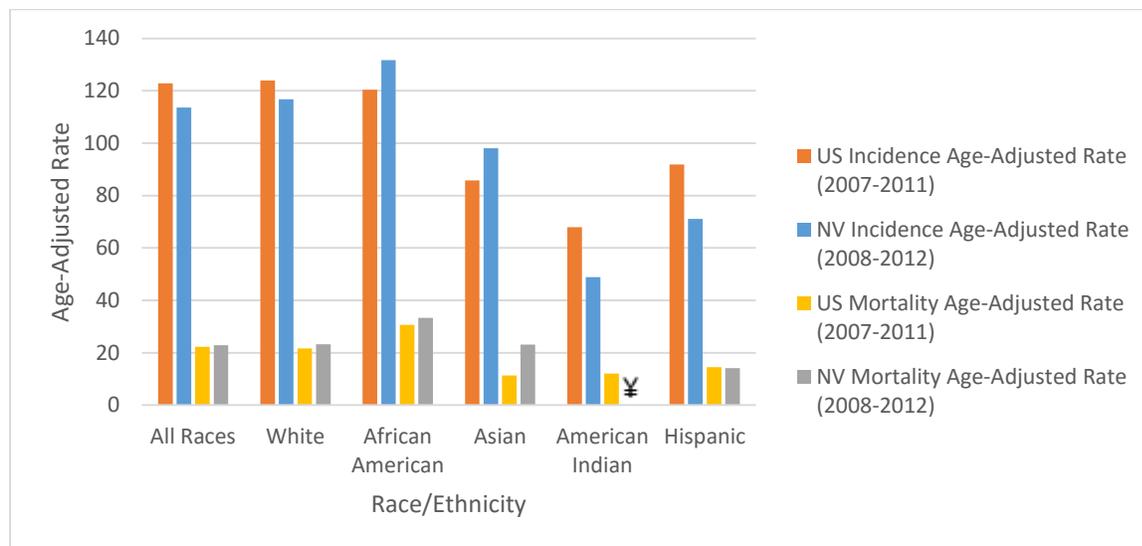
[NevadaCancerCoalition.org](http://NevadaCancerCoalition.org)

## Introduction

Breast cancer is the most commonly diagnosed cancer among women in Nevada and is the second leading cancer killer among women in the state. It is estimated that 2,010 women in Nevada will be diagnosed with breast cancer in 2016 and 380 women in Nevada will die of the disease. While Nevada's incidence rate for breast cancer is below the national rate, at just 114 per 100,000 versus 123.1 per 100,000, the mortality rate for breast cancer in Nevada is higher than the national rate, at 23.3 per 100,000 versus 21.9 per 100,000.<sup>i</sup>

Breast cancer incidence rates help explain the distribution of cancer in a population; however, it is important to take into account that a person must have access to screening services and a recommendation to receive screening in order to receive an early diagnosis and to receive quality treatment.

**Figure 1: Breast Cancer Incidence and Mortality Age-Adjusted Rates by Race/Ethnicity, 5-Year Period, Nevada vs. United States**



*Data Source: Nevada Comprehensive Cancer Report, January 2015, Office of Public Health Informatics and Epidemiology. † indicates data has been removed due to counts more than zero but less than or equal to five due to confidentiality and reliability issues.*

National statistics show that for breast cancer cases, 61.1 percent are diagnosed at the local or early stage and approximately 38 percent are diagnosed as late-stage, either regional or distant. The five-year relative survival rate for early-stage localized breast cancer is 98.6 percent, but drops to just 25.9 percent when diagnosed at a later, distant stage.<sup>ii</sup> In Nevada, data for stage at diagnosis is similar to national rates, with 62.5 percent of breast cancers diagnosed as early-stage and 37.5 percent diagnosed as late-stage.<sup>iii</sup>

## Breast Cancer Screening

Regular mammograms are the most effective method doctors have to find breast cancer early, sometimes up to three years before it can be felt.<sup>iv</sup> Most major health organizations agree that breast

cancer screening with mammography saves lives. However, there is still much debate as to when women should begin screening with mammography and whether the benefits of earlier screening outweigh the possible risks of additional testing and unnecessary biopsies for breast cancer. Below are recommendations from some of the major health organizations for women at average risk for breast cancer:

### **United States Preventive Services Task Force (USPSTF)**

*Issued January 2016*

*Women ages 50 – 74, recommend screening mammography every 2 years for women ages 50 to 74 years, B recommendation. (This upholds the organization's 2009 recommendation.)*

*Women ages 40 – 49, the decision to start screening mammography in women before age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms, may choose to begin screening every 2 years between the ages of 40 and 49 years. C recommendation.*

*The current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women age 75 years and older.<sup>v</sup>*

*These recommendations build upon the organization's 2009 B recommendation that women ages 50 – 74 screen with mammography every two years, which replaced the organization's 2002 B recommendation for women ages 40 and older to receive screening with mammography every one to two years.<sup>vi</sup>*

American Academy of Family Physicians aligns with the USPSTF recommendation.

### **American Cancer Society**

*Issued October 2015*

*Women ages 40 to 44 should have the choice to start annual breast cancer screening with mammograms if they wish to do so. The risks of screening as well as the potential benefits should be considered.*

*Women age 45 to 54 should get mammograms every year.*

*Women age 55 and older should switch to mammograms every 2 years, or have the choice to continue yearly screening.*

*Screening should continue as long as a woman is in good health and is expected to live 10 more years or longer.*

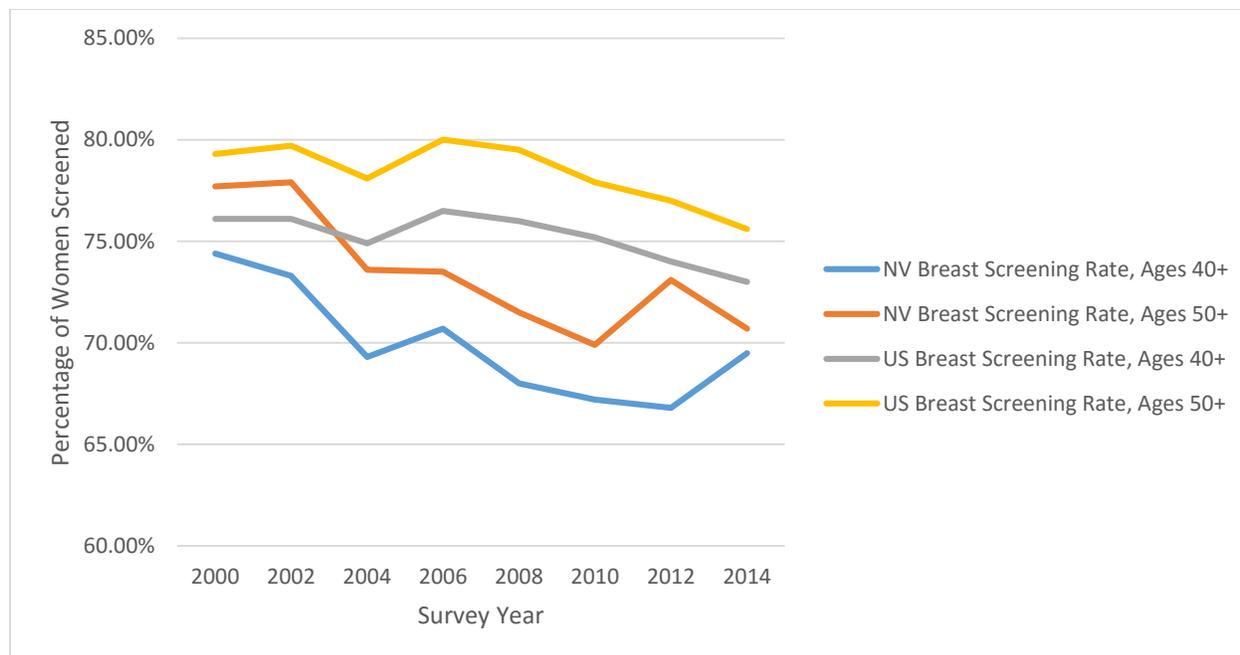
*These recommendations replace the organization's previous recommendation, which was to begin regular screening at age 40.<sup>vii</sup>*

### **National Comprehensive Cancer Network, American College of Radiology, Society of Breast Imaging, American College of Obstetricians and Gynecologists**

*Women ages 40 and older should receive annual screening mammogram.*

The debate of when to begin screening for breast cancer and at what intervals to screen, combined with the varying recommendations and opinions by major health organizations, may have contributed to some confusion for women on the importance of screening with mammography. While trends in breast cancer screening among women ages 40 and over have gone down from 2000 to 2014 both in Nevada and nationwide, the reduction in screening rates cannot be solely attributed to this confusion.

**Figure 2: Women Who Have Had a Mammogram Within the Past Two Years, 2000 - 2014, Nevada vs. United States**



*Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data [online]. 2016. Rates are at 95 percent confidence interval for percent.*

## Assessment

### Previous Research

In 2013 Master of Public Health (MPH) student and Nevada Cancer Coalition MPH intern Charlotte Drumm conducted a series of focus groups with women in rural Nevada to better understand barriers they faced or had overcome in seeking breast cancer screening with mammography. The findings were evaluated and included in her professional paper, “Improving Mammography Screening in the State of Nevada: Barriers and Solutions.” Among the responses in the focus groups, women indicated that reminders from physicians and better education on screening had influenced or motivated them to get screened for breast cancer, and that reminders from physicians would improve the chances they would pay attention to information about breast cancer screening.<sup>viii</sup>

With this research at hand, there was a better understanding of women's attitudes and beliefs about breast cancer screening within Nevada. However, there continued to be a lack of understanding about physician attitudes and practices specific to breast cancer screening.

In early 2016 Nevada Cancer Coalition (NCC), in partnership with early detection stakeholders, developed an assessment tool to gain a better understanding of provider recommendations and information surrounding breast cancer screening. Assessment questions explored use of the various screening guidelines and provider knowledge of varying screening and diagnostic technologies, as well as knowledge about advancing issues, such as genetic counseling and dense breast tissue.

The assessment was open to primary care providers practicing in Nevada who are in a position to refer women for breast cancer screening as part of their regular practice. This included primary care providers, obstetricians and gynecologists, and practitioners at levels ranging from physicians and physician assistants to nurses and medical assistants. Distribution of the assessment was through a variety of channels including:

**Email:** Distributed via email invitation to NCC membership

**Social Media:** Invitation to participate published on NCC blog and Facebook page

**Partner Organizations:** Invitation to participate and link to online assessment provided to partners including Steinberg Diagnostic Imaging, Las Vegas HEALS, Las Vegas Medical District, Clark County Medical Society, Washoe County Medical Society, Nevada Academy of Family Physicians, Access to Healthcare Network, Women's Health Connection, Nevada Primary Care Association, and American Cancer Society in Nevada.

**In-Person Meetings with Women's Health Connection (WHC) Providers:**

- Community Health Alliance, 7 WHC locations, 5/5/16
- Carson City Health and Human Services, 2 WHC locations, 5/5/16
- First Person Care Clinic, 5/11/16
- Nevada Rural Community Health Nursing, 13 WHC locations, 5/16/16
- University Medical Center, 5/18/16
- Guadalupe Medical Center, 4 WHC locations, 5/18/16
- Nevada Health Centers, 18 WHC locations, 5/18/16 and 5/19/16

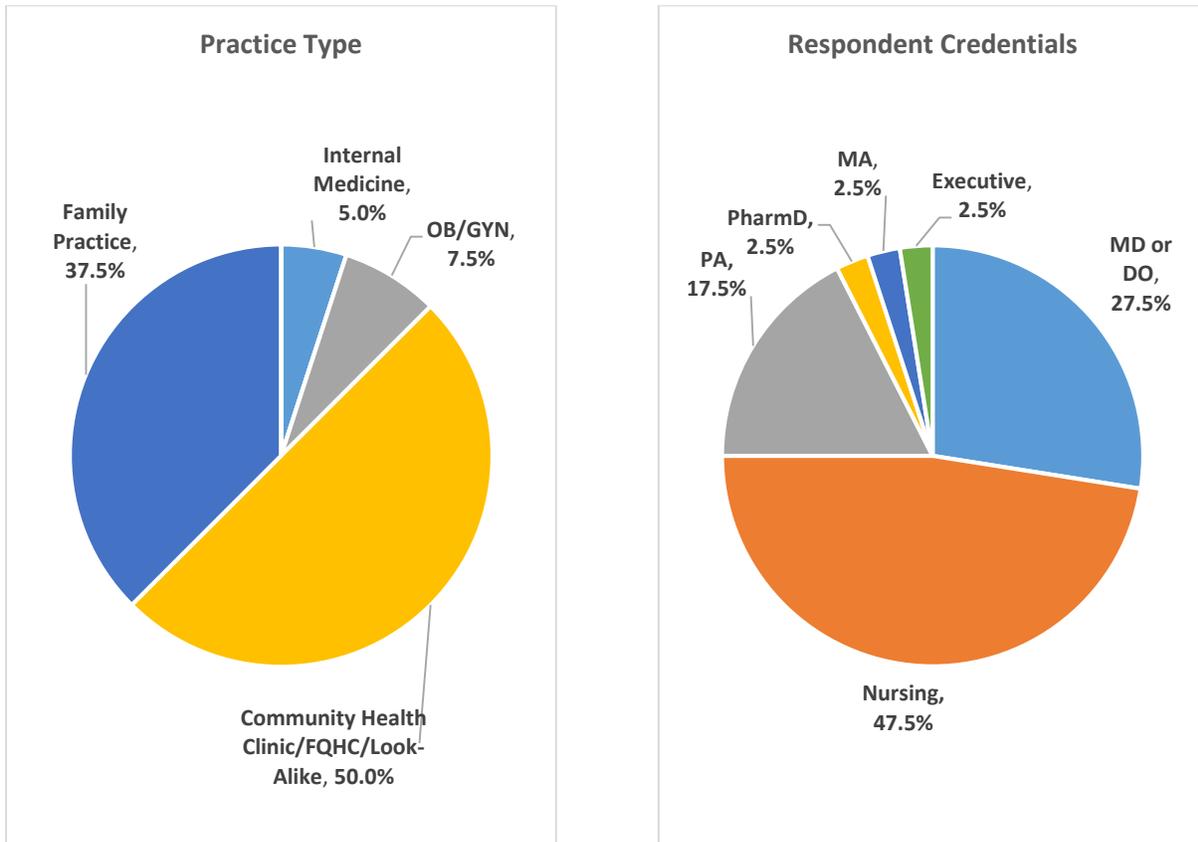
The assessment was opened April 15, 2016 and remained open through May 31, 2016. A copy of the assessment is provided at the end of this report.

## **Assessment Key Data and Findings**

A total of 42 responses were recorded in the online assessment. Of those, two responses were excluded. One response was from a community organization with no medical care services and was excluded. The second excluded response was from a Chief Operations Officer with no direct patient contact and whose medical team was adequately represented within the assessment responses.

Respondents overwhelmingly felt that breast cancer screenings were important for their patients, with 90% rating them as either somewhat important or very important.

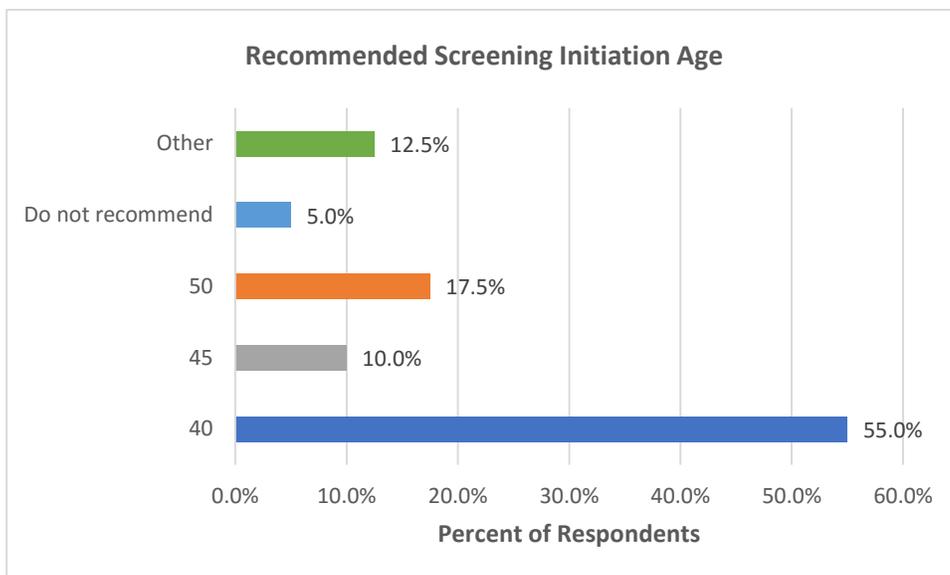
Figures 3 and 4: Composition of Assessment Respondents Based on Practice Type and Credentials



Assessment respondents are primarily from community health clinics including county health departments, community health nursing clinics, federally qualified health centers (FQHCs) and FQHC look-alikes. Nearly half of respondents are in the nursing field with credentials including Advance Practice Registered Nurse (APRN), Registered Nurse (RN), Certified Nurse Midwife (CNM), Women’s Health Nurse Practitioner (WHNP) or Nurse Practitioner (NP), with some also credentialed with Bachelor of Science Nursing (BSN) or Master of Science Nursing (MSN). One respondent was both a NP and assistant medical director, and a second respondent was both a DO and a medical director. Based on zip code data, 60% of assessment respondents practice in the Reno/Sparks area in northern Nevada, 27.5% practice in rural communities, and 12.5% practice in the Las Vegas area.

The majority of assessment respondents, 55%, recommend to their patients to begin screening at age 40. Of those that responded “do not recommend” they also indicated that breast cancer screenings are “very important” for their patients, indicating that perhaps the “do not recommend” response was due to not being in a role to make the direct recommendation to patients.

Figure 5: At what age do you recommend average risk patients begin screening for breast cancer via mammography?



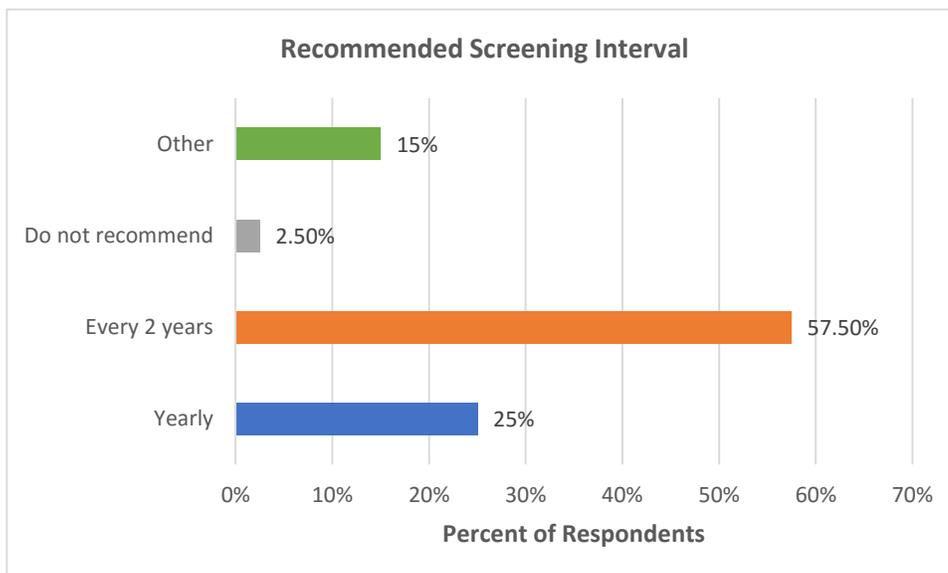
Those responding “other” for recommended screening initiation age mentioned shared decision-making and variations in screening guidelines as creating a more flexible recommendation system. Comments included:

- “Depends on if [patient] has family history; especially if with 1st degree relative.”*
- “I offer at 40 but I explain the differing recommendations between organizations and review that average risk [patients] are safe to begin surveillance at 50.”*
- “Usually 40, but explain that USPTF recommends 50.”*
- “I have had many patients diagnosed of breast cancer in their thirties so I get baseline after age 30, if normal repeat age 35 start every year at age 40.”*
- “No later than 50, earlier optional based on shared decision making.”*

The majority of respondents advise patients to screen every two years; this group varies on screening initiation age with about one-third recommending 50 years old, just under half recommending 40, and the rest either recommending 45 or shared decision-making. All respondents who recommend annual screening also recommend screening begin at age 40. One respondent indicated “do not recommend,” again, as they are likely not in a position to make a direct recommendation. Those respondents who indicated “other” screening intervals generally have varying recommendations based on age and varying guidelines, and also recommended initiating screening or beginning shared decision-making at earlier ages (40 or 45). Comments included:

- “Every 2 years 40-50, then yearly.”*
- “Every 1-2 years.”*
- “I offer every year after 40 but explain that a 2-year interval is evidence-based as well.”*
- “One to two depending on when we start.”*

**Figure 6: At what interval do you recommend average risk patients screen for breast cancer via mammography?**



In reviewing the assessment responses there was no apparent correlation between screening initiation or interval recommendation and type of practice or type of credential.

Only 17.5% of respondents felt that there was inadequate time to discuss breast cancer screening and early detection with patients, while 77.5% felt that they had adequate time. The “adequate time” respondents included all of those providers who used shared decision-making with patients.

**Figure 7: On a scale from 1 (not confident) to 5 (very confident), how confident are you in discussing the following with your patients:**

	Average
<b>Overall breast cancer risk</b>	4.250
<b>Varying screening guidelines</b>	4.075
<b>Screening mammography vs. diagnostic mammography</b>	4.425
<b>Dense breast tissue</b>	4.050
<b>Genetic counseling and BRCA mutation</b>	3.125

Respondents felt somewhat to very confident in discussing most breast cancer screening topics with their patients, especially the difference in screening versus diagnostic mammography. Providers were least confident in discussing genetic counseling and BRCA mutation, and several made comments regarding this topic.

*“Out of pocket costs for BRCA are unattainable for many patients, unless this has changed recently.”*

*“I discuss BRCA, however there is still question regarding this testing. I most request if there are multiple family members with breast cancer in a patient under age 45 presenting with breast complaints of any kind or any patient that have to recommendations for repeat bx (screening) to help determine how aggressive treatment should be.”*

*“I usually send patients with personal or family risk to the genetic counselor for BRCA testing.”*

Figure 8: On a scale from 1 (not knowledgeable) to 5 (very knowledgeable), please rate your knowledge level about the following screening and diagnostic techniques:

	Average
2D Mammography	3.300
3D Mammography	2.875
Diagnostic Mammography	4.000
Breast Ultrasound	4.075
Automated Breast Ultrasound	2.325
Breast MRI	3.150

Respondents were less confident about their knowledge of certain screening and diagnostic techniques, with automated breast ultrasound, known by names such as A-BUS or SonoCine, ranking lowest. The difference in 2D versus 3D mammography may be a challenge for some providers. One respondent commented:

*“It would be helpful to know what each service can offer a woman in detail so we can order the correct testing for certain high risk situations.”*

When it comes to in-office tools and reminders, only half of respondents use reminder flags or other prompts in their electronic health records (EHR) to cue a reminder for a patient’s breast cancer screening. Some of those with system reminder flags note that they are not easy to use within the EHR. Those without reminder flags in use primarily cited EHR system issues including: inability to set them up/lack of technical resources, cannot find them in the set-up, the system doesn’t offer them, or they haven’t been trained to use them.

The most frequently used tools and resources for educating patients were brochures and handouts, with 80% of respondents using one or the other, or both. Other resources used include posters, interpretation services and diagrams or models. One provider uses a grant-funded nurse to educate patients about breast cancer screening. Respondents indicated that additional tools that would be beneficial in educating patients included:

**Tailored Brochures:**

*“A brochure that explains the differing recommendations between organizations and helps patients make an informed choice for themselves.”*

*“A brochure that outlines what risks and benefits for each age category to determine screening guidelines for them.”*

**Bilingual Videos:**

*“A short video about risks and benefits of screening in multiple languages.”*

**Self-Awareness Tools:**

*“Advise on how to complete self-assessment.”*

*“Breast models.”*

*“Reminder cards with self-exam reminders on them.”*

**Bilingual Materials**

**Posters**

**Provider Education**

In addition to those mentioning provider education as a beneficial tool to educate patients on breast cancer screening, 77.5% of assessment respondents indicated they would be interested in continuing education credit opportunity on the topic.

## Conclusion

While assessment respondents felt somewhat or very confident in discussing breast cancer screening with their patients, they also made clear that they are open to using additional tools and resources to assist them in both making the recommendation and educating patients on their choices. Providers are also interested in refining their knowledge and skills through continuing education opportunities and, for those not already using system flags, enhancing their EHRs to put their technological resources to better use.

Additionally, while a majority of respondents recommend screening begin at age 40, and a majority also recommend screening every two years, those groups do not necessarily overlap. Screening recommendations vary from provider to provider, in the same fashion that they vary among organizations establishing national guidelines. Shared decision-making was mentioned repeatedly among assessment respondents, and many also indicated that they felt there was adequate time to have these discussions with their patients.

## Recommended Systems and Policy Changes

There were several needs identified through this assessment that could help increase breast cancer screening rates within the state.

### EHR Flags and Reminders

First, numerous respondents suggested a need for technical support to activate EHR flags and reminders to enhance their internal systems for breast cancer screening reminders. Of the 40 respondents, eight different EHR systems were identified in use, so hiring statewide staff to provide technical support to providers for fully activating their use of EHR systems may not be feasible, as it would be difficult to find one person with expertise in all systems. Additionally, previous research has identified that some EHR providers charge additional fees for additional functionality to be activated, meaning that some providers may not be using EHR system flags due to cost.

### *Recommendations:*

Create a micro-grant opportunity to award recipients with funds to pay for EHR system flag activation and/or technical support, as well as education on the set-up and use of system flags and reporting tools.

Create an incentive program for providers' use of EHR system flags and reporting for breast cancer screening to reward those using flags and reminders, and to encourage those not using them to begin to do so.

These recommendations would not only positively impact breast cancer screening rates, but also any other clinical recommendation such as cervical or colorectal cancer screening, diabetes and cholesterol checks, immunizations, etc.

### Policy Changes

Second, the majority of assessment respondents begin screening patients at age 40, and a handful more use shared decision-making beginning at age 40 or even earlier. Based on this screening initiation age, it's important to preserve access to screening, diagnostics, and treatment for women beginning at age

40, or prior to that for high-risk patients, in order to sustain and increase breast cancer screening rates. Several statewide policies have already been implemented to this end, based on previous work by NCC.

***Recommendations:***

Increase access to Women’s Health Connection breast cancer screening with mammography to women ages 40 – 49, and earlier for high-risk patients. ***Policy implemented in FY 2015-2016.***

Increase access to Medicaid for women diagnosed with breast cancer who are eligible for Women’s Health Connection participation, regardless of whether they were screened and/or diagnosed within the Women’s Health Connection program. ***Policy to be implemented in FY 2016-2017.***

Preserve requirement for insurance coverage to include annual breast cancer screening with no cost-sharing for women aged 40 and over, and for those at high risk who are under 40. An addition to this policy would be to reduce or eliminate the number of plans that are grandfathered in to the Affordable Care Act and do not have to comply with this requirement.

Preserve requirement for insurance coverage to include breast cancer genetic test counseling (BRCA) with no cost-sharing for women at higher risk for breast cancer. An addition to this policy would be to reduce or eliminate the number of plans that are grandfathered in to the Affordable Care Act and do not have to comply with this requirement. In order to make this policy effective, additional policy to expand and certify the workforce of genetic counselors within Nevada could be beneficial.

Establish more clear-cut laws regarding dense breast tissue, including requirements for reporting and consistency in classification. Additionally, establish clear guidelines for insurance coverage of secondary screening tests for women with dense breast tissue.

**Interventions and Resources**

Last, with several various recommendations for screening initiation age and interval by providers and national organizations, patients can potentially feel overwhelmed by the volume of differing guidelines and information and/or avoid educating themselves on breast cancer screening, and the potential benefits and harms. With the identified use of shared decision-making by providers with patients, the creation of high-quality, multi-lingual educational tools and small media is an opportunity to foster that process. Additionally, with a variety of new screening and diagnostic technologies available, as well as awareness of certain risk factors such as BRCA genetic mutation and dense breast tissue, the creation of quick-reference tools and educational opportunities for providers could ease the patient education process and enhance a provider’s confidence level when referring patients for breast cancer screening and diagnostic procedures.

***Recommendations:***

Collaborate with providers from multiple disciplines and practice types to develop or source high-quality, multi-lingual educational tools for patients to cover topics such as risk factors, various screening guidelines, potential benefits and harms of screening at each age, benefits of shared decision-making, breast self-awareness, and additional considerations such as BRCA mutation and dense breast tissue. Tools could be a combination of brochures/handouts/small media, posters, and videos.

Identify additional provider and patient tools that are evidence-based that are available for providers to order from other vendors/organizations and create a “resource store” for simplified “shopping.”

Collaborate with screening and diagnostic imaging partners to develop educational opportunities for providers to learn more about the various screening and diagnostic tests/equipment, how they work/example of an exam, and the process for referral to ensure the right test is ordered and performed. This could include a quick-guide printed tool for providers to use in-office, a CE opportunity online, a series of on-site/in-person CE opportunities at an imaging center, or any combination of these.

Work with provider offices to identify a breast cancer screening “champion” who can serve as the onsite expert in educating patients (and other team members) and having more detailed conversations and shared decision-making sessions. These champions could undergo additional training (see CE opportunities mentioned above) and be recognized via a statewide “Breast Cancer Screening Champion” badge or annual certification earned through CE.

Collaborate with insurance enrollers and health plans to educate patients on insurance coverage for breast cancer screening, as well as extent of coverage for genetic counseling and dense breast tissue screening.

Implement a Clinical Liaison program to work with provider offices in implementing best practices and identifying opportunities for improvement and use of various interventions and resources. This liaison could identify “champions,” offer clinical education, assist with systems change recommendations, and identify best use of resources to increase screening rates.

## Next Steps

NCC will share the findings and recommendations of this assessment with the NCC’s statewide Early Detection, Diagnosis, and Treatment Task Force, with assessment participants, and with the Women’s Health Connection program within the Nevada Division of Public and Behavioral Health, Chronic Disease and Health Promotion Section, to identify opportunities and funding sources to implement and further refine the recommendations.

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<sup>i</sup> American Cancer Society Cancer Statistics Center, <https://cancerstatisticscenter.cancer.org>, June 2016

<sup>ii</sup> SEER Stat Fact Sheets, Breast Cancer, <http://seer.cancer.gov/statfacts/html/breast.html>

<sup>iii</sup> Comprehensive Cancer Report. State of Nevada. 2015.

<sup>iv</sup> Centers for Disease Control and Prevention

<sup>v</sup> United States Preventive Services Task Force, Screening for Breast Cancer, <http://screeningforbreastcancer.org/>

<sup>vi</sup> United States Preventive Services Task Force

<sup>vii</sup> American Cancer Society, June 2016,

<http://www.cancer.org/cancer/breastcancer/moreinformation/breastcancerearlydetection/breast-cancer-early-detection-ac-recs>

<sup>viii</sup> [http://nevadacancercoalition.org/wp-content/uploads/2016/04/BreastCancerScreeningReport\\_January2014.pdf](http://nevadacancercoalition.org/wp-content/uploads/2016/04/BreastCancerScreeningReport_January2014.pdf)