



The Advocate

This month we are featuring a timely article by our member radiology experts on the recent breast cancer screening guidelines. This commentary focuses on issues physicians will need to consider when making recommendations to their patients. We encourage you to seek additional resources listed at the end of the article.

A Response to the U.S. Preventive Services Task Force Recommendations on Screening Mammography

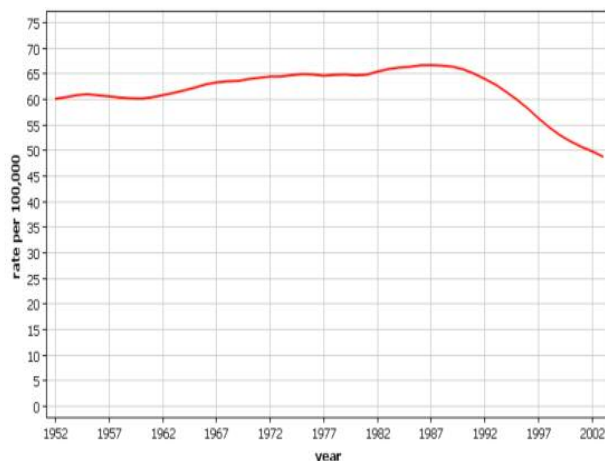
By Lora Barke, D.O.

Jean R. Paquelet, M.D., FACR

R. Edward Hendrick, Ph.D., FACR

Breast cancer is the second leading cause of death among women in the U.S. The death rate from breast cancer in the U.S. increased slightly from 1940-1987, prior to widespread use of screening mammography (Figure 1). In the mid-1980s, the American Cancer Society embarked on an aggressive campaign to promote screening mammography and its use increased dramatically over the following decade. In 1987, only about 30% of women aged 40 and over were getting screened with mammography. By 1998, over two-thirds of U.S. women were getting screening mammography at least every two years. As a result, since 1987, the death rate from breast cancer has declined by about 30% (Figure 1). This 30% mortality reduction means that approximately 10,000 more women each year survive breast cancer than did two decades ago. Screening mammography has played an important role in reducing breast cancer deaths by decreasing the incidence of advanced stage breast cancer.

Figure 1: Age-standardized U.S. Mortality Rate from Breast Cancer, Ages 40-85+ (from the International Agency on Research from Cancer (IARC) – December 2009)



Inside this issue:

A Response to the USPSTF Recommendations on Screening Mammography.....	2,6
Your Practice Needs a Business Plan for Disasters.....	3
Upcoming Meeting Dates.....	4
Classifieds.....	4
Doctors Care article.....	5
Calendar	8

Screening article cont'd on pages 2,6

Screening Recommendations Cont'd

In November 2009, the U.S. Preventive Services Task Force (USPSTF) issued new recommendations dropping their previous (2002) recommendation that women 40-49 should get regular screening mammography. They suggested that only women at high-risk for breast cancer get screening mammography prior to age 50. They also recommended that women aged 50-74 should get screened only once every two years and women aged 75 and older should not get screening mammography. They also recommended against clinical breast exams and breast self-exams. Needless to say, these recommendations have created confusion among women and their referring physicians.

Here, we address the USPSTF recommendations on screening mammography.

- The majority of women diagnosed with breast cancer (75%) have no identifiable risk factors. Screening only those women in their 40s with risk factors would result in the majority of breast cancer being missed until they present clinically, when it is often too late to treat conservatively or successfully. A woman's chances of surviving breast cancer are increased markedly if her cancer is diagnosed before symptoms develop. For this reason, regular mammograms are an important part of women's preventive health care beginning at age 40.
- In recommending against screening mammography in asymptomatic, normal risk women aged 40-49, the USPSTF ignored its own (and other recent) summaries of randomized controlled trials (RCTs) of screening mammography, which showed a statistically significant 15% (or higher) mortality benefit in women aged 39-49. In fact, this benefit is remarkably similar to the mortality benefit shown by RCTs in women age 50-59. Nothing happens at age 50 to make a breast cancer more detectable than it was a year (or several years) prior.
- In recommending against screening mammography for women 40-49, the USPSTF focused on computer modeling to emphasize the "harms" of mammography, such as recall and biopsy, while minimizing the direct data from RCTs on over 360,000 women demonstrating the benefit of screening. They also ignored modeling results (their own and others) showing the improved mortality results from annual mammography (compared to biennial) mammography in women 50-74.
- In examining screening mammography, the USPSTF ignored the fact that RCTs underestimate the true benefit of screening. This is because RCTs randomly assign women to an "invited to screen" group or a control group, but an average of about 30% of women assigned to the "invited to screen" group failed to attend screening, yet their deaths from breast cancer were still attributed to the "screening" group.
- The USPSTF failed to consider more recent evidence showing the benefit of screening mammography outside of RCTs. Data from service screening in Sweden show that women aged 40-74 who actually attend mammography screening had a 44% lower breast cancer death rate than women not getting screened, and women aged 40-49 who attended screening had a 48% lower rate of breast cancer deaths compared to women not getting screened. Similar data from British Columbia show a 40% decrease in deaths among women aged 40-79 who attended screening mammography, and a 39% reduction in deaths among women aged 40-49 at the time of their first screen, compared to women who were not screened.
- The USPSTF failed to consider the improvements that have occurred in mammography practice in the U.S. in the past several decades. These include standardized quality control at every site in the U.S., standardized mammography reporting, and the improvement in mammography quality since the RCTs were conducted, including the shift from screen-film to digital mammography. As of January 1, 2010, over 60% of mammography in the U.S. is performed on digital equipment.
- The USPSTF failed to consider the dramatic improvements that have occurred in patient care when suspicious findings are detected at screening mammography. Ultrasound and follow-up mammography resolve most of those findings and when tissue histology is needed, procedures are minimally invasive through the use of image-guided needle biopsy (techniques pioneered right here in Colorado).

Article cont'd on page 6

Your Practice needs a Business Plan For Disasters!

Be prepared. Physician's offices are businesses. All physician offices should prepare for their business needs. Below are relative "tips" for making sure you are prepared for any disaster. You can also find a fillable form at <http://www.cms.org/disasterprep.html> that can help the process of making your plan as simple as filling in the blanks.

How quickly your office can get back to business after a terrorist attack, a tornado, a fire, or a flood often depends on emergency planning done today. While the Department of Homeland Security is working hard to prevent terrorist attacks, the lessons of the 1993 World Trade Center bombing, the 1995 Oklahoma City bombing and the September 11, 2001 terrorist attacks demonstrate the importance of being prepared.

When you also consider that the number of declared major disasters nearly doubled in the 1990's compared to the previous decade, preparedness becomes an even more critical issue. Though each situation is unique, any organization can be better prepared if it plans carefully, puts emergency procedures in place, and practices for emergencies of all kinds.

Continuity of operations planning:

1. Carefully assess how your office functions, both internally and externally, to determine which staff, materials, procedures and equipment are absolutely necessary to keep the business operating.

Review your business process flow chart if one exists.

Identify operations critical to survival and recovery.

Include emergency payroll, expedited financial decision-making and accounting systems to track and document costs in the event of a disaster.

Establish procedures for succession of management. Include at least one person who is not at the company headquarters, if applicable.

2. Identify your suppliers, shippers, resources and other businesses you must interact with on a daily basis.

Develop professional relationships with more than one company to use in case your primary contractor cannot service your needs. A disaster that shuts down a key supplier can be devastating to your business

Create a contact list for existing critical business contractors and others you plan to use in an emergency. Keep this list with other important documents on file, in your emergency supply kit and at an off-site location.

3. Plan what you will do if your building is not accessible. This type of planning is often referred to as a continuity of operations plan, or COOP, and includes all facets of your business.

Consider if you can run the business from a different location.

Develop relationships with others to use their facilities in case a disaster makes your location unusable.

4. Plan for payroll continuity.

5. Decide who should participate in putting together your emergency plan.

Include co-workers from all levels in planning and as active members of the emergency management team.

Consider a broad cross-section of people from throughout your organization, but focus on those with expertise vital to daily business functions.

6. Define crisis management procedures and individual responsibilities in advance. Make sure those involved know what they are supposed to do.

Train others in case you need back-up help.

7. Coordinate with others.

Meet with other businesses in your building or industrial complex.

Talk with first responders, emergency managers, community organizations and utility providers.

Plan with your suppliers, shippers and others you regularly do business with.

Share your plans and encourage other businesses to set in motion their own continuity planning and offer to help others.

8. Review your emergency plans annually. Just as your business changes over time, so do your preparedness needs. When you hire new employees or when there are changes in how your company functions, you should update your plans and inform your people.

Check out <http://www.cms.org/disasterprep.html> for an easy to use Office Plan guide.

**Mark your Calendars with
these important dates:**

April 30 - May 2, 2010
CMS Spring Conference
Sonnenalp Resort, Vail

May 13, 2010
ADEMS Annual Dinner Meeting
Cherry Hills Country Club

September 10-12, 2010
CMS Annual Meeting
Vail Cascade

**Classified
Member Ads:**

Practice part time, economically!
Established South Denver practice is offering part
time physicians office sharing space beginning March
2010. Brand new office, dedicated space, and
knowledgeable staff in obstetrics and gynecology.
Ultrasound with 2-D, 3-D and 4-D capability offered
in-house. Procedure room available for cryotherapy,
colposcopy and hysteroscopy. Prime location across
from Sky Ridge Medical Center.
Reasonable flat monthly rate based on usage, no
upfront investment. Practice part time,
professionally and improve profitability.
303-902-5817.

Looking for a new position, office space or equip-
ment for sale? ADEMS is now offering our members
space on our website classifieds page to post their
needs. If interested, contact ADEMS at
303.761.2887

Go to www.ademedicalsociety.org and click on
Classifieds!

Some restrictions apply

ARAPAHOE-DOUGLAS-ELBERT MEDICAL MANAGER ASSOCIATION
PROUDLY PRESENTS...

FRAUD/ABUSE/ID THEFT
LEGISLATIVE UPDATE AND FRAUD PREVENTION

TUESDAY, FEBRUARY 2ND, 2010
LITTLETON ADVENTIST HOSPITAL
CONFERENCE RM. 1
12NOON- 1PM
LUNCH PROVIDED

SPEAKER: JOHN CHAPMAN, BA, CITRMS
MASTER TRAINER, TBG FRAUD SOLUTIONS
CERTIFIED ID THEFT RISK MANAGEMENT SPECIALIST
RED FLAGS EXPERT

RSVPs APPRECIATED BY FRIDAY, JAN. 29TH - 303-761-2887

Non-members are welcome to attend for \$10 at the door. this cost may be applied towards 2010 ADEMMA dues

DOCTORS CARE - Accessible Care for the Underserved

This time last year, Janice lived in Michigan and was diagnosed with severe fibromyalgia and depression - not exactly 'happy-holiday' news. Her daily life included blackouts, tremors, leg freezing and depression. Due to these debilitating symptoms, Janice was fired from her job, and she moved back to her home state of Colorado in 2009.

Janice was referred to Doctors Care by her roommate who heard about the program through her job in Douglas County services. Living in the service area (Arapahoe, Douglas and Elbert County, excluding Aurora) and not having insurance, Janice qualified for the program and completed the application process. Next she was assigned to a primary care physician, Joyce Wells NP, who saw a potential neurological diagnosis and referred her through the Doctors Care Program staff for a neurological evaluation. Dr. Allen Bowling next saw the patient, reviewed the MRI scan taken the year before and was able to detect lesions which pointed to a MS investigation. For her mental health concerns, Doctors Care psychiatric Physician Assistant Jen Grinspoon determined a medication regimen appropriate to Janice's mental health concerns and supported her through counseling. While Janice is still mid-treatment, she is well on her way to managing her health problems through access to appropriate medical care.

These providers needed to refer Janice for tests, medication and specialists with more to come. Working with Littleton Adventist Hospital and Radiology Imaging Associates, these physicians were able to move quickly on treatment. No one physician should be responsible for the needs of all the uninsured in our community. However, through a team of five local hospitals, their laboratories and pharmacies, 750 volunteer physicians in more than 70 specialties and radiology and anesthesia partners, each patient's medical needs can effectively be met.

Janice has relayed to the Doctors Care staff she feels listened to, respected and treated with high quality care by each provider. This is the kind of care our community deserves.

Interested in being part of the health care solution? Learn more by contacting Michelle Hartman, Program Director at 720-257-7783 or mhartman@drscare.org and at www.drscare.org.

T H A N K Y O U !

To all the Women Physicians who attended our annual

Women Physicians' Holiday Dinner

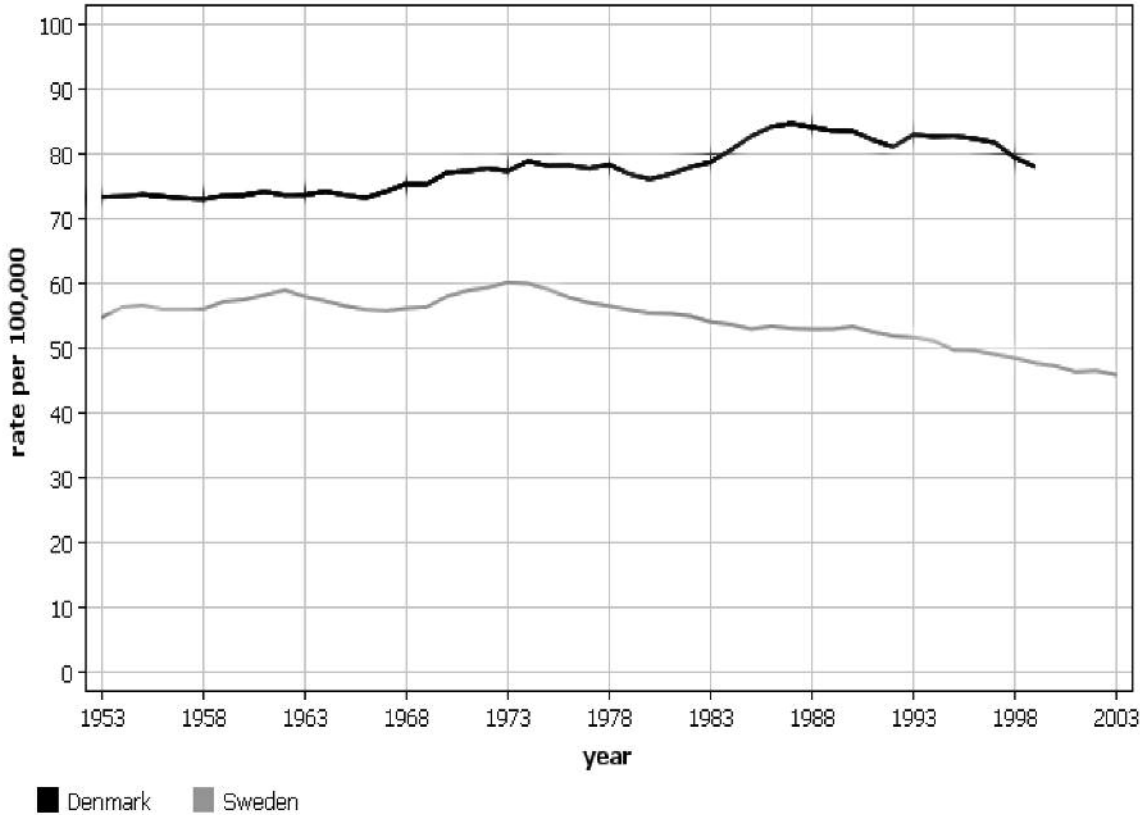
Special thanks to our wonderful hospital partners and their staff who really make this fantastic event possible each year:

L i t t l e t o n A d v e n t i s t H o s p i t a l
P a r k e r A d v e n t i s t H o s p i t a l
P o r t e r A d v e n t i s t H o s p i t a l
S k y R i d g e M e d i c a l C e n t e r
S w e d i s h M e d i c a l C e n t e r

Screening Recommendations Cont'd

In spite of the fact that a number of members of the USPSTF come from public health backgrounds, the USPSTF squandered a unique opportunity to advance public health and further reduce breast cancer deaths by failing to recommend a national mammography screening program in conjunction with health care reform. Most developed countries have nationally-based mammography screening programs. One country that has, until recently, failed to adopt screening mammography is Denmark. Figure 2 compares the breast cancer mortality rate in Denmark to that of Sweden, one of the earliest adopters of screening mammography. In Denmark, the decision to screen is made on a county-by-county basis. Today, some counties in Denmark would like to begin screening, but cannot, because of the lack of radiologists and technologists with mammography experience. The USPSTF failed to consider the “non-scientific” concept that once dismantled, the elements needed for an effective national mammography screening program are not easily recovered.

Figure 2: Age-standardized Breast Cancer Mortality Rates in Denmark (red) and Sweden (green), Ages 40-85+ (from the International Agency on Research from Cancer (IARC) – December 2009)



For additional information about screening mammography, see http://www.sbi-online.org/associations/8199/files/Detailed_Response_to_USPSTF_Guidelines-12-11-09-Berg.pdf

**IF YOUR
DIAGNOSTIC
EQUIPMENT
FAILS
WILL YOUR
BUSINESS
INSURANCE
AGENT KNOW HOW TO
TREAT IT?**



EQUIPMENT REPRESENTS A SERIOUS INVESTMENT. AND YOU NEED A BUSINESS INSURANCE agent who truly understands its value. Someone with extensive experience in assessing health care risks, like the insurance specialists at COPIC Financial. Working with a variety of carriers, we make sure you, your staff, and your equipment are adequately covered. We save you time and money.

COPIC Financial offers all types of insurance for your practice and your people — worker's compensation, business liability, disability insurance, Medicare Supplements, personal and group health insurance, life insurance, employee benefits, long-term care insurance and retirement plans and investment planning.

Make sure your insurance coverage doesn't fail you. Call 720.858.6280 or 800.421.1834. COPIC



**Arapahoe-Douglas-Elbert
Medical Society**

8080 SouthPark Lane
Littleton, CO 80120

Phone: 303-761-2887
Fax: 303-761-4172

info@ademedicalsociety.org

Presorted
Standard
U.S. Postage
PAID
Denver, CO
Permit #1818

U p c o m i n g E v e n t s

**Arapahoe-Douglas-Elbert
Medical Society**

Phone: 303-761-2887

Fax: 303-761-4172

info@ademedicalsociety.org

www.ademedicalsociety.org

Jan 26	6:00pm	Legislative Night 2010 Warwick Hotel - Downtown
Feb 2	12noon	ADEMMA Program - Fraud/Abuse/ID Theft Littleton Adventist Hospital - Conf. Rm 1
Feb 16	5:30pm	ADEMS Finance Committee Meeting
Feb 16	6:30pm	ADEMS Board Meeting ADEMS Office
March 1-3		AMA President's Forum/ National Advocacy Conference - Washington D.C.
March 3	6-8:00pm	ADEMS MRC – ICS Training 100/700 ADEMS Office
March 8	12noon	ADEMS Retired Physicians Luncheon Swedish Medical Center – Pine C