

# Prevention Brief



VA National Center for Health Promotion and Disease Prevention  
Office of Patient Care Services, Veterans Health Administration

<http://www.prevention.va.gov>

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## US Preventive Services Task Force



### Bottom Line

- The USPSTF will continue to issue recommendations on new topics and update existing recommendations at least every 5 years.
- New USPSTF methods include a structured recommendation statement and an assessment of the certainty of evidence.
- Routinely offer services graded as "A" and "B".
- Do not routinely offer services graded as "C" or "D".

For many clinicians, the US Preventive Services Task Force (USPSTF) is the authority on what to do and what NOT to do with respect to the delivery of clinical preventive services to patients within the primary care setting. This independent panel of experts and practicing clinicians, which is supported by the Agency for Healthcare Research and Quality (AHRQ), has been reviewing the evidence and issuing clinical preventive service

recommendations since the late 1980s. This group was one of the first to use transparent methods and explicit criteria to review evidence and make its recommendations.

The July 17, 2007 issue of *Annals of Internal Medicine* features four articles from the USPSTF, AHRQ, and the Evidence-Based Practice Center that support the USPSTF's work. One article features the current process that the Task Force uses to select, review, and issue its recommendations.

The second article updates a previous 2001 article, which described the USPSTF methods, and introduces the Task Force's new structured recommendation statement and one-page clinical summary that will be developed alongside each new recommendation.

The last two articles feature an update of the "Screening for Chlamydia Infection" topic using the new recommendation statement along with the systematic evidence review in support of this updated recommendation.

## Current USPSTF Processes

### Your VA Liaison to the Task Force



Dr. Linda Kinsinger has served as the VA liaison to the USPSTF since 2002. She regularly attends the Task Force meetings held three times a year, reviews evidence reports and draft recommendation statements relevant to the VA, and provides topic selection input to ensure topics relevant to the VA are represented in the USPSTF portfolio. If you have ideas or concerns you would like share with the USPSTF, please contact her at [linda.kinsinger@va.gov](mailto:linda.kinsinger@va.gov).

The USPSTF has developed a thoughtful approach to ensuring transparency, accountability, consistency, and independence of its work. In a world of competing priorities and constantly evolving science, the USPSTF now divides its universe of topics into four groups: NEW topics, UPDATES to existing topics, REAFFIRMATION topics, and INACTIVE topics. Furthermore, a new review process to include full reviews, staged reviews, and targeted reviews ensures that resources are used efficiently.

The USPSTF solicits new topics from the public, professional organizations, and USPSTF liaisons and partner organizations. Once a recommendation is issued, it comes up for review as an "Update" every 5 years or sooner if seminal

evidence is published that might change the recommendation. Reaffirmation topics (such as screening for hypertension) are those that are well-established in practice and for which new evidence is unlikely to result in a change in the recommendation. Inactive topics are those that either the USPSTF no longer considers within its scope or which have become irrelevant based on changes in technology.

Once a topic is chosen for review, the USPSTF works with staff from AHRQ and an Evidence-Based Practice Center to determine the analytic framework that will guide the review. Following these initial steps, a search for evidence begins and staff systematically evaluate candidate studies for threats to validity, magnitude and

precision of benefits and harms, consistency across the body of evidence, and directness of the evidence to the key questions established in the analytic framework.

What make the USPSTF reviews different from those of other groups are the final two steps in its process. First, the USPSTF estimates the magnitude of NET benefit, that is the benefits minus the harms, and it evaluates the certainty of that evidence. In the new scheme, the evaluation of "certainty" is much more explicit than it has been in the past (see the next section).

Lastly, the USPSTF disseminates its findings via publications, the AHRQ website, and partner organizations.

**Table 1. What the U.S. Preventive Services Task Force Grades Mean and Suggestions for Practice\***

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 against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small.	Offer or provide this service only if other considerations support the offering or providing the service in an individual patient.
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.

\* USPSTF = U.S. Preventive Services Task Force.

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## New Recommendation Statement

New recommendations and updates to existing recommendations are now issued using the new recommendation statement, which has the following sections: preamble, summary of recommendation and evidence, structured rationale, clinical considerations, other considerations, discussion, recommendations of others, references, and tables. Furthermore, a one-page summary will now be appended for busy clinicians who may not have time to read the full statement.

In the past, the USPSTF issued its letter grade recommendations based on the magnitude of net benefit and the overall assessment of the evidence. Going forward, the USPSTF will still issue letter grades, but will no longer include a good, fair, or poor assessment of the overall evidence. Instead, it will take into account its level of certainty about the net benefit in terms of high, moderate, or low certainty. This is a subtle change but better represents the assessment that the USPSTF actually makes. The USPSTF assigns a level of certainty based on the number, quality, consistency, and primary care practice representativeness of the studies. The certainty tag represents the likelihood that the USPSTF

assessment of net benefit is correct. Recommendations made with high certainty have sufficient evidence behind them such that new evidence is unlikely to substantially alter the recommendation.

The wording for the letter grades has changed (see sidebar for letter grade explanations). The USPSTF recommends that clinicians routinely offer services graded as "A" and "B" and recommends against routinely offering services graded as "D". The biggest change in recommendation wording is for services graded "C", which was used for services where the evidence was too close to call in terms of net benefit. The new "C" recommendation wording now recommends against *routinely* offering the service and is based on the rationale that although there might be moderate certainty of a small net benefit, this is probably not enough to justify routine, widespread implementation. Lastly, services graded with an "I" are no longer called recommendations; they are called statements. This change reflects the fact that tagging a service with "I" is just a statement about the sufficiency of evidence for that service and in fact is not a recommendation for or against the service itself.

## Additional Resources

### Patient Resources

- Checklist summaries of USPSTF recommendations for men, women, and patients aged  $\geq 50$ . Also available in Spanish. <http://www.ahrq.gov/clinic/ppipix.htm#tools>

### Clinician Resources

- Guirguis-Blake et al. Current Processes of the US Preventive Services Task Force: Refining Evidence-Based Recommendation Development. *Ann Intern Med* 147(2):117.
- Barton et al. How to Read the New Recommendation Statement: Methods Update from the US Preventive Services Task Force. *Ann Intern Med* 147(2):123.
- 2006 Pocket Guide to Clinical Preventive Services <http://www.ahrq.gov/clinic/pocketgd.htm>
- Adult Preventive Care Timeline <http://www.ahrq.gov/ppip/marketing.htm>

### Independence Matters



The USPSTF's primary focus is evaluating the evidence; thus, it is less likely to let advocacy, opinion, and personal or organizational preferences influence its recommendations.

Many opportunities for stakeholder input into the topic selection and review process exist. This helps to ensure that the products that the USPSTF and AHRQ disseminate are relevant, high-quality, and able to withstand rigorous scrutiny.