**Measure Title**  
MAMMOGRAPHY SCREENING FOR WOMEN AGES 50-69 YEARS

**Disease State**  
Breast Cancer

**Indicator Category**  
Prevention

**Strength of Recommendation**  
A

**Quality of Evidence**  
Good

**Physician Specialties**  
Primary: Family Practice, General Practice, Internal Medicine, Mixed Specialty, Obstetrics/Gynecology, Gynecology

**Clinical Rationale**

- In women, breast cancer is the second leading cause of cancer death falling behind lung cancer.[1]
- Beginning in the fourth decade of life, the risk of breast cancer increases with age.[2]

**Reason for Indicated Intervention or Treatment**

- Screening for breast cancer with mammography every 12-33 months significantly reduces mortality from breast cancer.[3]

**Evidence Supporting Intervention or Treatment**

- Eight randomized, controlled trials have been conducted on breast cancer screening, all using mammography with or without clinical breast examination.[4-15] Screening mammography was associated with a 9% to 32% reduction in breast cancer mortality.[2] In their meta-analysis, the United States Preventive Services Task Force (USPSTF) found that the relative risk of breast cancer death among women of all ages randomized to screening was 0.84 (95% CI, 0.77-0.91).[2]

**Clinical Recommendation**

- In its second edition, the USPSTF recommended screening for breast cancer in women over the age of 50 every 1-2 years.[16]
- In its third edition, the USPSTF recommends screening for breast cancer in women over age 40 every 1-2 years. They note that the evidence for screening in all women over age 50 is stronger than for those women aged 40-49.[3]
- Several other organizations support screening with mammography starting at age 50: The Canadian Task Force on Preventive Health Care, the American Academy of Family Physicians, and the American College of Preventive Medicine.[17-19]
- Reflecting the controversy around the appropriate age at which to begin screening, other organizations support screening with mammography and clinical breast exam starting at age 40: the American Medical Association, the American College of Obstetricians and Gynecologists, the American College of Radiology, and the American Cancer Society.[20-23]

**Comparative Baseline Data**

In 2000, almost 79% of women in the United States, aged 50-64 years, had a mammogram within the past two years.[24]

**Denominator**

Continuously enrolled women aged 52-69 years as of the end of the reporting period.

**Denominator**  
Members with two unilateral mastectomies or a bilateral mastectomy at any time.
| **Exclusion** | prior to the end of the reporting period. |
| **Numerator** | Members who received at least one mammogram during the reporting period or year prior. |
| **Interpretation of Score** | High score implies better performance. |
| **Physician Attribution** | Score all physicians (in the selected specialties) who saw the member during the reporting period. |
| **Source** | Health Plan Employer Data and Information Set (HEDIS®) 2005 Technical Specification |
| **External Files Required** | None |
References

Indicator Category (Adapted from Health Plan Employer Data Information Set (HEDIS®) technical specifications and U.S. Preventive Services Task Force (USPSTF) Methodology)

Effectiveness

Primary Prevention Measures: Those that are applicable to individuals who are asymptomatic and are designed to prevent the onset of the targeted condition (e.g. immunizations);

Secondary Prevention Measures: Those that are applicable to asymptomatic patients who have risk factors or pre-clinical disease but in whom the condition has not become clinically apparent (e.g. pap smears, screening for elevated blood pressure);

Tertiary Prevention Measures: Those that are applicable to individuals who are diagnosed with a condition and are part of the treatment or management of patients with that condition (e.g. cholesterol reduction in patients with diabetes).

Strength of Recommendation (Based on U.S. Preventive Services Task Force (USPSTF), 3rd Edition Criteria)

A
It is strongly recommended that clinicians provide the service to eligible patients. There is good evidence that the service improves important health outcomes and that benefits substantially outweigh harms.

B
It is recommended that clinicians provide the service to eligible patients. There is at least fair evidence that the service improves important health outcomes and that benefits outweigh harms.

C
Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

D
It is recommended that clinicians DO NOT routinely provide the service to eligible patients. There is at least fair evidence that the service is ineffective or that harms outweigh benefits.

I
The evidence is insufficient to recommend for or against routinely providing the service. Evidence that the service is effective is lacking, or poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

Quality of Evidence (Based on U.S. Preventive Services Task Force (USPSTF), 3rd Edition Criteria)

Good: Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair: Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor: Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Quality of Evidence (Based on U.S. Preventive Services Task Force (USPSTF), 3rd Edition Criteria)

I:
Evidence obtained from at least one properly randomized controlled trial.

II-1:
Evidence obtained from well-designed controlled trials without randomization.

II-2:
Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
II-3: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience descriptive studies and case reports or reports of expert committees.