American Society of Clinical Oncology Policy Statement: The Role of the Oncologist in Cancer Prevention and Risk Assessment

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ABSTRACT

Oncologists have a critical opportunity to utilize risk assessment and cancer prevention strategies to interrupt the initiation or progression of cancer in cancer survivors and individuals at high risk of developing cancer. Expanding knowledge about the natural history and prognosis of cancers positions oncologists to advise patients regarding the risk of second malignancies and treatment-related cancers. In addition, as recognized experts in the full spectrum of cancer care, oncologists are afforded opportunities for involvement in community-based cancer prevention activities.

Although oncologists are currently providing many cancer prevention and risk assessment services to their patients, economic barriers exist, including inadequate or lack of insurance, that may compromise uniform patient access to these services. Additionally, insufficient reimbursement for existing and developing interventions may discourage patient access to these services.

The American Society of Clinical Oncology (ASCO), the medical society representing cancer specialists involved in patient care and clinical research, is committed to supporting oncologists in their wide-ranging involvement in cancer prevention. This statement on risk assessment and prevention counseling, although not intended to be a comprehensive overview of cancer prevention describes the current role of oncologists in risk assessment and prevention; provides examples of risk assessment and prevention activities that should be offered by oncologists; identifies potential opportunities for coordination between oncologists and primary care physicians in prevention education and coordination of care for cancer survivors; describes ASCO's involvement in education and training of oncologists regarding prevention; and proposes improvement in the payment environment to encourage patient access to these services.

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INTRODUCTION

Until recently, the practice of oncology focused on interventions to slow or reverse cancer. However, oncologists now have knowledge and tools—the result of an enhanced understanding of cancer susceptibility and access to preventive strategies—to advise and intervene in different ways. Oncologists have substantial experience in the conduct and interpretation of clinical trials designed to reduce the risk for primary and second primary tumors, and that knowledge informs their delivery of risk assessment and prevention services. Knowledge of carcinogenesis is advancing, and oncologists will be able to utilize the understanding of the natural history of cancer to intervene before malignant transformation begins in the cancer survivor and in the individual at increased risk of cancer. Oncologists also have the expertise to evaluate the strength of evidence for cancer prevention and early detection and integrate these findings into standard clinical practice.

In 2002, the American Society of Clinical Oncology (ASCO) demonstrated its commitment to cancer prevention as a critical element of oncology research and practice by establishing the standing Cancer Prevention Committee (CAPC) and charging it with ensuring the integration of cancer prevention into oncology practice and research. The activities of the CAPC have been guided by the cancer prevention and control objectives of the 2004 to 2007 ASCO Strategic Plan. These objectives are to advocate for rapid, worldwide reduction and ultimate elimination of tobacco products and exposure to environment tobacco smoke, in collaboration with other organizations and professional societies; to increase core knowledge about cancer risk and risk reduction through new educational initiatives; to promote clinical, behavioral, and translational research, and education and training in cancer prevention and control; to work to eliminate health care disparities in cancer risk assessment and early detection; and to provide prevention-oriented messages

for individuals with a prior history of cancer and for the general public.¹

The CAPC, a diverse group of academic and community oncologists involved in cancer care and research, has undertaken a series of activities to facilitate the inclusion of cancer risk assessment and prevention counseling as an integral part of oncology practice. These efforts include a survey of oncologists' attitudes regarding their involvement in prevention, an evaluation of third-party reimbursement for prevention services, ongoing efforts to influence public and private payers to improve payment for risk assessment and prevention counseling, and development of a cancer prevention curriculum. ASCO also has set forth a policy for genetic testing for cancer susceptibility in a statement originally published in 1996 and updated in 2003.

Oncologists have an enhanced understanding of cancer susceptibility and access to preventive strategies that permit them to intervene with their patients in ways not anticipated a few years ago. The sophisticated knowledge of oncologists regarding carcinogenesis and cancer susceptibility, combined with the prevention curriculum and other tools advanced by ASCO, create the environment for widespread incorporation of risk assessment and cancer prevention in oncology practice.

This statement describes the current involvement of clinical oncologists in risk assessment and cancer prevention. It also seeks to identify barriers to incorporation of prevention in clinical oncology practice, including current reimbursement standards, and the outlook for appropriate reimbursement for preventive services in the future. The statement does not include an inventory of all specific risk assessment and prevention recommendations for each cancer and/or patient type. Instead, it relies on the ASCO prevention curriculum and other resources that provide comprehensive information about prevention and assumes that clinical oncologists offer preventive services according to those guidelines. The CAPC acknowledges that a diverse group of individuals specialize in the care of patients with cancer. Although this article refers to oncologists, many of the issues confronted by other oncology professionals are similar to those presented in this statement.

The CAPC acknowledges that this statement does not address the challenges faced by international colleagues involved in cancer prevention services. Cancer has emerged as a major public health problem in developing countries, which collectively account for more than 50% of the world's cancer burden, whether defined by the number of cases or number of deaths. However, the prevalence of specific cancers and associated risk factors will vary in different regions of the world. In addition, the challenges in implementing cancer prevention activities in the United States, including the reimbursement issues addressed here are not the same outside of the United States. For these reasons, the scope of this article is limited to issues affecting primarily US oncologists. The important global issues of cancer prevention and risk assessment will be addressed by the CAPC in future initiatives.

ONCOLOGISTS' INVOLVEMENT IN PREVENTION

To enhance understanding of its members' needs related to prevention and control, in 2004, ASCO surveyed its membership regarding their roles in cancer prevention and early detection.² This survey was designed to complement, supplement, and update a 1989 survey of

ASCO members, with additional content and questions related to chemoprevention trials and survivorship.³

The survey revealed that oncologists provide a wide range of cancer prevention services and consider cancer prevention an important element of their practice, although there are some variations in the provision of prevention or risk assessment activities according to diagnosis. ASCO members indicated that they are interested in more training in prevention from ASCO, perhaps to fill gaps in their formal training in prevention. The prevention activities of ASCO members are not limited to their own practices, as many indicated that they participate in community-based prevention education efforts.

Although the responses varied by cancer diagnosis and intervention, taken as a whole the responses confirmed that ASCO members are actively engaged in cancer prevention, similar to the findings of the 1989 survey. In some cases (eg, chemoprevention for breast cancer), oncologists provide prevention services in their offices. In others—risk reduction for prostate cancer, smoking cessation counseling, and cervical and colon cancer screening—services are provided primarily through referral. The consistent message from the survey was that oncologists are committed to providing cancer prevention and risk assessment services and make choices regarding the best site for providing those services.

Oncologists see cancer survivors as an important group to receive risk assessment and prevention services, and they are increasingly providing counseling and services to that group. The survey also suggested that oncologists define their role in cancer prevention and risk assessment quite broadly and beyond providing services in their own practices.

In a manner consistent with the 1989 survey, respondents in 2004 identified economic barriers to incorporating prevention activities in practice. More than three fifths of respondents said that, "There is insufficient reimbursement for prevention activities in my clinical practice."

EVOLVING OPPORTUNITIES FOR RISK ASSESSMENT AND PREVENTION BY ONCOLOGISTS

Oncologists are becoming more involved over time in risk assessment and prevention, according to the available evidence. Moreover, oncologists are increasingly asked about risk assessment and prevention strategies by their patients and must be prepared to respond to those patients regarding the appropriateness of utilizing these strategies. The following section describes the risk assessment and prevention activities in which oncology providers are currently engaged, suggests areas where their involvement may expand as evidence becomes available to support additional interventions, and identifies issues on which patients will increasingly seek advice. This section is not intended to serve as a practice guideline for oncologists and instead describes current and anticipates future practice activities.

TOBACCO CESSATION AND OTHER AREAS OF BEHAVIORAL MODIFICATION

Tobacco Cessation

ASCO has had a long-term and active involvement in efforts to reduce the use of tobacco. ASCO's intense involvement in efforts to end tobacco use is commensurate with the impact of tobacco use,

including the special risks it poses for patients with cancer. Tobacco use is the most preventable cause of death in the US, is responsible for 30% of all cancer deaths and 87% of lung cancer deaths, and is associated with increased risk for at least 15 types of cancer.^{4,5} In addition, smoking may compromise the effectiveness of treatment, increase the risk of treatment-related complications, and increase the risk of a second primary cancer.⁶⁻⁸

In particular, ASCO recognizes the importance of tobacco prevention in young adults. Approximately 4,000 young people between the ages of 12 and 17 years initiate cigarette smoking each day in the United States,⁹ and increased initiation of tobacco use by adolescents has been a major barrier to the eventual reduction of tobacco-related morbidity and mortality.

ASCO has taken strong steps to integrate tobacco control into oncology practice. The most important step toward this integration is the development of the ASCO Cancer Prevention Curriculum, which examines the biologic basis of nicotine addiction, addresses potential barriers to promoting cessation in patients with cancer, discusses adverse effects of continued smoking on cancer treatment outcomes, and recommends referral and consultation resources for patients requiring intensive clinical interventions.

ASCO recommends that smoking cessation treatment by oncologists be tailored to the specific needs of cancer patients. A basic element of that treatment should be education about the link between cancer and smoking because higher cessation rates are associated with patient awareness of the relationship between smoking and the cancer diagnosis. The time of cancer diagnosis has been described as “a teachable moment” for intervening with smokers and providing cessation treatment.¹⁰

In addition to underscoring the link between cancer and smoking, when offering cessation treatment the oncologist has a role in: considering the physical limits that result from cancer and its treatment, managing contraindications to pharmacologic cessation treatments, addressing psychological issues that affect cancer patients, and noting the potential for a delayed relapse in patients with cancer that may occur after surgery or other treatment.

ASCO recommends that oncologists consider the US Public Health Service clinical practice guideline, which identifies five steps referred to as the five As: ask, advise, assess, assist, and arrange.¹¹ An oncologist following the five As guideline should: document the patient’s tobacco use; urge every tobacco user to quit; assess the willingness of the patient to quit; offer counseling and pharmacotherapy treatment; and schedule follow-up meetings and counseling.

In 2005, the Centers for Medicare and Medicaid Services (CMS) responded positively to a public request that the agency grant coverage for tobacco cessation counseling and established a policy of reimbursing for two cessation attempts per year. Each attempt may include up to four intermediate or intensive sessions, with the total annual benefit covering up to eight sessions in a 12-month period. These counseling services will be covered for outpatient and hospitalized beneficiaries who are smokers and have a disease or adverse health effect that is tobacco-related or who are taking a medication whose metabolism or effect is affected by tobacco use.¹²

Although the ASCO survey found that 61% of oncologists offer smoking cessation counseling to their patients, since Medicare coverage for this service went into effect in 2005, preliminary data indicate that few claims have been submitted by any Medicare providers, including oncologists, for this service.¹³ It is not clear if oncologists are

providing this service but are not aware of the ability to bill Medicare for it, or if they do not have updated billing systems to include this code. Alternatively, it is possible that oncologists are not providing this service to Medicare beneficiaries. Oncologists have an important role to play in smoking cessation, as they provide ongoing care to a substantial proportion of cancer survivors.

ASCO will evaluate the necessity of undertaking an educational and awareness campaign to alert oncologists to the availability of Medicare payment for tobacco cessation counseling provided to smokers with a tobacco-related diagnosis or whose treatment will be affected by their tobacco use to ensure that this important source of payment is utilized. Education regarding the availability of payment may be a useful step in encouraging more active involvement by oncologists in offering smoking cessation services. Beyond this immediate effort, ASCO will assess whether Medicare payment influences the provision of smoking cessation services.

Other Behavioral Modifications for Cancer Prevention

In addition to tobacco modification, there has been considerable research examining the effect of other behaviors or risk factors on cancer incidence, including sun exposure, obesity, diet, and physical activity. ASCO’s Cancer Prevention Curriculum describes the important role oncologists and other health care providers play in helping their patients understand potential links between behavior and cancer risk. Counseling patients about behavioral modifications may reduce their risk of developing cancer. Examples of the types of behavioral prevention activities addressed more comprehensively in the ASCO Curriculum are provided in Table 1.¹⁴⁻²²

CANCER SURVIVORSHIP

Over the past three decades, the number of cancer survivors has increased dramatically due to improved early detection of first malignancies and effective primary oncologic therapies. As advances in detection, treatment, and care continue, the number of survivors will increase, a trend that will accelerate further as the population ages and life expectancy increases overall.²³ Furthermore, cancer survivors will routinely consult their oncologists for their expertise in management of potential late effects of increasingly complex oncology interventions, which primary care professionals may not have the knowledge or experience to manage.

Cancer survivors face several distinct and serious health care issues. In addition to the risk of progressive or recurrent disease, cancer survivors are at risk of a second primary cancer as a result of

Table 1. ASCO Curriculum Interventions

Prevention Activity	Behavioral Intervention
Skin cancer prevention	Reduction of ultraviolet radiation exposure ¹⁴
Counseling regarding obesity	Weight reduction in clinically overweight and obese individuals ¹⁵
Diet	Counseling about the relationship among some dietary components, and cancer risk and cancer treatment ¹⁶⁻¹⁸
Physical exercise	Prescription for regular physical activity ¹⁹⁻²²

Abbreviation: ASCO, American Society of Clinical Oncology

host susceptibility, a clustering of risk factors, common carcinogenic exposures, treatment for the first cancer, diagnostic surveillance, a chance event, or a combination of factors. Cancer survivors are at heightened risk for a variety of other conditions as well, including diabetes, cardiovascular disease, osteoporosis, and decreased functional status.²⁴

The transition of a patient with cancer to a cancer survivor has been identified as a “teachable moment” when oncologists have an opportunity to encourage behavioral and lifestyle interventions that may help cancer survivors prevent a recurrence of their cancer, reduce risks of other diseases, and improve the quality and length of life.²⁵ Because of cancer survivors’ increased risk of developing second primary cancers, cardiovascular disease, diabetes, and osteoporosis, oncologists must be prepared to offer survivors advice on a number of interventions, taking primary responsibility for some and sharing responsibility with other providers for others.^{26,27}

Oncologists currently employ a range of risk reduction strategies including smoking cessation therapy, screening for possible second cancers and monitoring the possible long-term effects of cancer treatment, and advice concerning diet, exercise, and alcohol use—all risk factors for heart disease and diabetes. However, counseling for survivors regarding strategies for follow-up care should be tailored to the individual and his or her therapeutic exposure, include referrals to appropriate subspecialists, and incorporate a summary of treatment and an outline of recommended monitoring and follow-up care. Chemotherapy treatment plan and summary templates have been developed by ASCO and published online in a modifiable format, allowing oncologists to customize and adapt them to suit their own practices.²⁸

Although respondents to the ASCO survey did not specifically mention issues related to payment for survivor counseling, survivors themselves have suggested that reimbursement for these services should be enhanced. The National Coalition for Cancer Survivorship, a leading cancer survivor organization, is advocating Congressional approval of the Comprehensive Cancer Care Improvement Act, a bill that would establish a new Medicare service for the development of cancer care plans and treatment summaries. In advocating for this proposal, cancer survivors have suggested that they are seeking proper payment so that their oncologists can assume the responsibility for coordination of their care, including their survivorship care, and so their oncologists can communicate treatment plans or summaries directly to them. Patient advocates hope, through care planning services, to facilitate the coordination of care in a manner described and endorsed by the Institute of Medicine National Cancer Policy Board.²⁹

The scope of counseling of cancer survivors regarding the treatment plan and transition to survivorship will only expand as knowledge of the late and long-term effects of therapies deepens and as survivors increasingly seek information about diet, physical exercise, genetic susceptibility to cancer, and other issues affecting their treatment and survivorship. The task of providing a cancer risk assessment for survivors will become an increasingly complex effort.

CANCER RISK ASSESSMENT

Cancer risk prediction models have been used to estimate the overall burden of cancer, plan intervention trials, and design prevention strategies for those who are at increased risk. For example, the Gail model for prediction of risk of invasive breast cancer is the best known of the cancer

risk prediction models. The Gail model, as well as additional models for lung, prostate, and colon cancer risk, are readily available on the National Cancer Institute (NCI) and other cancer educational web sites.³⁰⁻³⁵

The consumer demand for risk assessment and prevention counseling services from both primary care physicians and oncologists may increase as consumers consult materials on risk assessment that are available on a wide range of heavily utilized web sites. NCI has a new web site that aims to educate consumers about cancer risk generally as well as their personal cancer risk. In addition to the risk web site maintained by NCI, other general cancer risk sites are maintained by the medical schools, cancer centers, cancer cooperative groups, and others, and these sites encourage individuals to utilize various tools to predict their risk of developing cancer.³⁶⁻⁴⁰

ASCO anticipates that oncologists will face an increased demand for counseling services from individuals who analyze their personal risk of cancer using risk models available online or through other avenues and then seek an explanation of that risk. This may be an area where oncologists find that reimbursement is difficult to obtain. This obstacle will exist in Medicare because the patient does not have a cancer diagnosis that would trigger reimbursement and in private plans because there may be an expectation that this service—if provided at all—will be provided by primary care physicians.

INHERITED CANCER SUSCEPTIBILITY

Oncologists are well-positioned to identify individuals affected by cancer as the result of an inherited predisposition. Individuals with germline susceptibility are at heightened risk to develop additional malignancies, often of a different primary site from the presenting cancer. Recognition of this propensity allows the early introduction of appropriate prevention or surveillance strategies in both the patient and his or her presymptomatic family members.⁴¹ A detailed family cancer history taken at the first visit with the oncology provider can raise the suspicion of a hereditary cancer syndrome and prompt further investigation. After the initial visit, the ongoing relationship between the oncologist and the patient provides multiple opportunities for possible evaluation for a potential genetic predisposition. The field of germline cancer predisposition is advancing rapidly, and the long-term relationship between the oncologist and cancer survivor affords repeated opportunities for reassessment and recognition of newly described syndromes.

In 1996, ASCO published a policy statement on Genetic Testing for Cancer Susceptibility to foster expanded access to medical care for patients and families affected by cancer family syndromes, as well as to enhance continued advances in the quality of that care.⁴² This statement was updated in 2003.⁴³ ASCO has also developed two editions of the *ASCO Curriculum: Cancer Genetics & Cancer Susceptibility Testing* to support ASCO members in their important role as those most likely to identify patients with a hereditary predisposition. ASCO maintains that germline genetic testing should only be performed in the context of appropriate pretest and post-test counseling. While this counseling is often provided by genetic counselors, the ASCO Curriculum, and educational activities at the ASCO Annual Meeting are designed to assist oncology providers who provide such counseling themselves.

The process of hereditary cancer risk assessment and counseling is time-consuming, and it is not clear how best to document and bill for this service. Payer policies are not firmly established, especially with

respect to counseling individuals without a personal history of cancer.⁴⁴ ASCO supports clarification of these policies because concerns about adequate reimbursement present a barrier to provision of preventive services, such as counseling for inherited risk.⁴⁵ In addition, as cancer risk assessment and risk reduction become more complex, the burden on oncologists associated with fully explaining these issues to patients will also intensify.

PROPHYLACTIC SURGERY

Genetic testing for cancer susceptibility identifies individuals who may potentially benefit from prophylactic surgery. Randomized trials addressing the efficacy of prophylactic surgery are not likely to be feasible, but there are studies comparing outcomes among individuals who elected prophylactic surgery with those who did not. For *BRCA1* and *BRCA2* mutation carriers, prophylactic oophorectomy is associated with a 90% lower risk of ovarian cancer and a 50% lower risk of breast cancer, while mastectomy is associated with a 90% lower rate of breast cancer.⁴⁶⁻⁴⁹ Yet, cancer screening and chemoprevention are also important considerations for these patients.^{50,51} Prophylactic surgery also plays an important role in the treatment of patients with an inherited predisposition for colon cancer. Patients with familial adenomatous polyposis will inevitably develop colorectal cancer and proctocolectomy or total colectomy should be offered. Guillem et al⁵² refer to these data. Those who carry the mutation for hereditary nonpolyposis colorectal cancer are likely to develop colon cancers proximal to the splenic flexure and may benefit from subtotal colectomy or, alternatively, choose colon cancer screening.⁵² Patients with hereditary nonpolyposis colorectal cancer are also at increased risk for extracolonic cancers, and may wish to consider total abdominal hysterectomy. Finally, thyroid resection has increasingly been accepted as the treatment of choice for carriers of the *RET* proto-oncogene.⁵³

These examples illustrate the expanding role of prophylactic surgery in the treatment of mutation carriers. As genetic testing for cancer susceptibility increases, greater numbers of candidates for prophylactic surgery will be identified and policies to ensure broad insurance coverage will be required. Some individuals with a strong family history of cancer might refuse genetic testing but wish to proceed with prophylactic surgery. Also, there might be individuals with a strong family history suggestive of a hereditary cancer syndrome who test negative but still wish to proceed with prophylactic surgery. Policies concerning insurance coverage in such instances should be delineated. Oncologists will bear expanded responsibility for assisting patients in evaluation of their options, including navigating a potentially uncertain reimbursement situation for prophylactic surgery.

CANCER PREVENTION THERAPIES

Oncologists have access to a number of chemoprevention agents, and their role in prescribing these therapies—to cancer survivors and healthy individuals—will likely expand. In certain cases, the discussion about these agents may be initiated by cancer patients and healthy individuals who are worried about their cancer risk and wish to know the benefits and risks of chemoprevention.

The ideal preventive agent is low in toxicity, morbidity, and cost. When oncologists prescribe preventive agents to healthy individuals,

they must carefully consider risks and benefits and discuss those with the patient. The level of risk must be considered in the context of the individual's overall health status, life expectancy, and risk category.

Assessment of appropriate chemoprevention strategies is a time-consuming task that entails a careful review of the literature and employment of sophisticated risk-benefit analysis to determine if these agents are appropriate. The use of tamoxifen and raloxifene in the reduction of the risk of breast cancer for women at increased risk for the disease and celecoxib for patients with familial adenomatous polyposis are approved by the US Food and Drug Administration. Additional agents for chemoprevention that may be considered by oncologists are listed in Table 2.⁵⁴⁻⁷⁷

ASCO EDUCATIONAL ACTIVITIES RELATED TO PREVENTION

As the role of cancer prevention in oncology science and practice has grown, ASCO has placed increased importance on providing oncologists with the tools and interventions necessary to identify, assess, and reduce individual cancer risk. Through a variety of mechanisms, the ASCO has demonstrated a commitment to disseminating evidence that supports effective prevention interventions in the clinical practice setting. These initiatives first began through ASCO's cancer genetics education efforts, including two editions of the *ASCO Curriculum: Cancer Genetics & Genetic Susceptibility Testing*, as stated earlier. The primary goal of ASCO's cancer genetics efforts has been to foster expanded access to, and continued advances in, medical care provided to patients and families affected by hereditary cancer syndromes.

ASCO has broadened its scope to develop a full range of educational offerings in cancer prevention, including development of a Cancer Prevention Track at the ASCO Annual Meeting as well as integration of cancer prevention in site-specific Thematic Meetings. The ASCO Curriculum on Cancer Prevention was developed in response to a lack of resources available for the systematic education of medical students, residents, oncology trainees, and practicing physicians in cancer prevention. The evidence-based curriculum includes topics on the epidemiology of common cancers, primary and secondary prevention strategies, chemoprevention, genetic susceptibility and high-risk patients, strategies for incorporating cancer prevention into practice, and interpretation and application of cancer screening guidelines. The curriculum targets specialists in all areas of oncology as well as family and internal medicine physicians, and specialists in gynecology, gastroenterology, pulmonology, dermatology, and urology. An important function of this curriculum is to educate physicians on how

Table 2. Chemoprevention Agents for Consideration

Cancer Type	Chemopreventive Strategy
Breast	Tamoxifen, ^{54,55} raloxifene ⁵⁶
Prostate	Finasteride ⁵⁷⁻⁶⁰
Colorectal	Calcium, ⁶¹ antioxidants, nonsteroidal anti-inflammatory drugs, ^{62,63} COX-2 inhibitors, aspirin, menopausal hormone therapy ⁶⁴
Head and neck	Retinoids, ⁶⁵⁻⁶⁹ COX-2 inhibitors ⁷⁰⁻⁷³
Hepatocellular	Hepatitis B vaccine ^{74,75}
Cervical	HPV vaccine ^{76,77}
Abbreviations: COX-2, cyclooxygenase 2; HPV, human papillomavirus.	

to judge the strength of evidence provided by the growing number of cancer prevention and early-detection studies and on incorporating the definitive findings of such studies into standard practice.

Another venue by which oncologists can increase their own knowledge of prevention strategies is by becoming investigators in prevention trials. ASCO has encouraged physician participation in clinical trials through a variety of initiatives, including removing the reimbursement barriers to physician participation and patient enrollment in clinical studies, conducting programs to train oncologists to design and conduct clinical trials, and pursuing responsible public policies to create an environment conducive to clinical research. In addition to the training and education benefits, broad-based physician experience with clinical trials will serve to expand patients' opportunities to enroll in such trials.

COLLABORATION WITH PRIMARY CARE PROFESSIONALS

The role of the oncologist in providing a wide range of risk assessment and prevention counseling services for those with a cancer diagnosis or at high risk of developing cancer is significant and expanding. However, the primary care professional will continue to be the first provider or the point of referral for certain screening and prevention services. The role of the primary care professional may be clearest in the case of those individuals with a low or average risk of developing cancer. Because of the complementary and overlapping involvement of oncology and primary care professionals in prevention, and in the care for cancer survivors, collaboration between these groups is essential. Moreover, oncologists have a role in aiding primary care physicians to more clearly identify high-risk populations. One of the most promising findings from the 2004 ASCO survey was the strong involvement of oncologists in community education and outreach efforts related to cancer screening and prevention. Survey respondents said they demonstrated commitment to the local community in ways, such as delivering lectures on prevention, serving as advisors on related committees and by participating in screening fairs in their local communities.⁷⁸

EFFORTS TO ENHANCE THIRD-PARTY PAYMENT FOR PREVENTION SERVICES

Because respondents to the ASCO survey on prevention indicated that the manner in which prevention services are reimbursed may pose an impediment to the integration of prevention into clinical practice, ASCO commissioned a study of Medicare and private payer reimbursement policies for prevention services.⁷⁹ Although the medical directors who were interviewed believe that primary care physicians have principal responsibility for most standard preventive services, they acknowledge the role of oncologists in providing cancer prevention services to patients who have a cancer diagnosis or who are at a high risk of developing cancer.⁸⁰ The third-party payers who were interviewed anticipate that prevention counseling services will be provided as part of evaluation and management services, although a higher-level evaluation and management code may be justified for the service, depending on the time spent with the patient and the complexity of the services provided.

Oncologists' responsibilities for risk assessment and prevention counseling are expanding due to a complex set of factors: oncologists

must address a wide range of issues in prevention counseling for a single patient; the follow-up care and monitoring of cancer survivors is a long-term responsibility, entails consideration of a number of different issues, and may require coordination with other specialists; and prevention counseling increasingly includes family members of those with a cancer diagnosis. Even if some oncologists can currently obtain adequate reimbursement for their prevention services through evaluation and management codes, it is not clear that this will be the case as the complexity and scope of prevention services increases. ASCO will seek to ensure that third-party reimbursement practices reflect the prevention knowledge base and the intensity of risk assessment and prevention services oncologists provide. Such an effort may require sustained dialogue with third-party payers regarding the role of oncologists in risk assessment and prevention ensuring benefits encompass the wide range of proven interventions and counseling services provided by oncologists. ASCO can play an important role in encouraging third-party payers and hospital systems to provide access to, and financial assistance for, prevention among uninsured, underinsured, minority, and medically underserved populations. Additional elements of this initiative to improve the payment environment will be the ongoing effort to refine the elements of cancer care and survivorship care planning. Communicating the centrality of cancer care planning to quality oncology practice as a means of ensuring that risk assessment and prevention counseling services are provided is paramount to the success of a comprehensive cancer care plan.

CONCLUSION

Oncologists place a high value on cancer prevention and demonstrate their commitment by providing prevention counseling, risk assessment, and preventive interventions in their own practices and by participating actively in community-based prevention activities. As the understanding of carcinogenesis and cancer susceptibility continues to expand, oncologists expect to increase prevention activities within their clinical practice.

ASCO recommends several strategies to assist oncologists in fully incorporating appropriate prevention and risk assessment in their practice. In addition, ASCO is committed to providing education to oncologists in cancer risk assessment and reduction, encouraging community participation to keep people engaged in healthy lifestyle, and encouraging collaboration with other professionals in providing preventive services to patients. Furthermore, ASCO proposes that adequate, uniform reimbursement for prevention counseling, interventions and therapies be provided among payers and that economic barriers to the provision of these services are removed. Reimbursement for prevention services should continue to be monitored to ensure it keeps pace with the growth in proven prevention interventions.

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Appendix

The policy statement was reviewed and transmitted to the ASCO Board of Directors by ASCO's Cancer Prevention Committee:

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