

In conclusion, the VA has increased its HIV testing from 2009 to 2010; however, there is still room for improvement. It is current VA policy that every veteran be offered HIV testing at least once in a lifetime, regardless of risk factors and age, and that all veterans identified as HIV positive be linked to high-quality comprehensive care in a timely manner. The VA's OPH will continue to collect annual HIV testing data and strive to improve HIV testing rates throughout the entire VA system.

James Halloran, RN, MSN, CNS
Maggie Czarnogorski, MD
Erin K. Dursa, PhD, MPH
Bryan D. Volpp, MD
Janet M. Durfee, RN, MSN, APRN
Ronald O. Valdiserri, MD, MPH
Victoria J. Davey, PhD, MPH, RN
David Ross, MD, PhD

Published Online: October 24, 2011. doi:10.1001/archinternmed.2011.510

Author Affiliations: Department of Veterans Affairs, Office of Public Health, Washington, DC (Mr Halloran; Drs Czarnogorski, Dursa, Davey, and Ross; and Ms Durfee); Department of Veterans Affairs, Veterans Affairs Northern California Health Care System, Washington, DC (Dr Volpp); and Department of Health and Human Services, Office of the Assistant Secretary for Health, Washington, DC (Dr Valdiserri).

Correspondence: Dr Czarnogorski, Office of Public Health and Environmental Hazards, Department of Veterans Affairs, 810 Vermont Ave NW, 10P3B, Washington, DC 20420 (Maggie.Czarnogorski@va.gov).

Author Contributions: Mr Halloran and Dr Dursa had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. *Study concept and design:* Halloran, Czarnogorski, Dursa, Durfee, Valdiserri, Davey, and Ross. *Acquisition of data:* Halloran, Czarnogorski, Dursa, and Volpp. *Analysis and interpretation of data:* Halloran, Czarnogorski, Dursa, Volpp, Valdiserri, Davey, and Ross. *Drafting of the manuscript:* Czarnogorski and Dursa. *Critical revision of the manuscript for important intellectual content:* Halloran, Czarnogorski, Volpp, Durfee, Valdiserri, Davey, and Ross. *Statistical analysis:* Dursa, Volpp, and Ross. *Obtained funding:* Ross. *Administrative, technical, and material support:* Halloran, Dursa, and Valdiserri. *Study supervision:* Czarnogorski, Durfee, Valdiserri, Davey, and Ross.

Financial Disclosure: None reported.

Funding/Support: This study was not supported by external funding.

Role of the Sponsors: The Office of Public Health, Department of Veterans Affairs, reviewed and approved this article before submission.

Additional Contributions: We acknowledge the contribution of the technical support staff at VA facilities who installed the electronic data extract routine to produce reports and laboratory directors and HIV lead clinicians at each facility who reviewed locally generated reports prior to submission.

1. Public Health Strategic Healthcare Group. The state of care for veterans with HIV. December 2009. <http://www.hiv.va.gov/provider/state-of-care/index.asp>. Accessed April 24, 2011.
2. Branson B, Hansfield H, Lampe M, et al. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR Recomm Rep*. 2006;55(RR-14):1-17.

LESS IS MORE

Older Patient Experiences in the Mammography Decision-Making Process

The benefit of mammography for breast cancer screening among women older than 75 years is unclear owing to competing comorbidity and lack of evidence.¹ In this area of uncertainty, an individualized approach to cancer screening that considers a patient's age, health status, and preferences is desirable.² Such an approach would optimize screening practices and avoid screening women unlikely to benefit; a phenomenon that may apply to 2 of every 5 mammograms in this age group.³

When considering cancer screening, shared decision making is particularly important for older persons. In the absence of evidence-based recommendations, patients should have the opportunity to discuss the pros and cons of screening with their health care providers. Individualizing cancer screening in this age group requires a balanced patient-provider conversation that considers patients' overall health, communicates the potential benefits and adverse outcomes of screening, and elicits patients' preferences. We conducted this study to (1) describe the patient-provider conversation surrounding screening mammography among women older than 75 years and (2) evaluate if the patients' perceptions of their health care providers' screening recommendations varied according to age and health status.

Methods. We analyzed responses from the breast cancer screening module within the DECISIONS study, a national random-digit dial telephone survey with a 51% weighted response rate, conducted between 2006 and 2007.⁴ Respondents were limited to those 40 years and older without a history of breast cancer. A complete description of the survey design, including questions, response scales, and survey weights, is available from the Inter-University Consortium for Political and Social Research.⁴

To account for the sampling design, weighted frequency comparisons were performed using PROC SURVEYFREQ (SAS version 9.2; SAS Institute Inc). These analyses compared the frequency with which women discussed reasons to have or not have a mammogram, whether their preferences were elicited, and if a physician recommendation was given across age (40-74 vs ≥ 75 years) and self-reported health (excellent to good vs fair to poor) groups.

Results. Responses from 873 women were included; 10% were 75 years or older. Most women were white, had at least a high school education, and were insured. Annual

Table. Patient-Reported Description of Mammography Counseling by Age Group^a

Mammography Counseling	Age 40-74 y, % ^b (n=782)	Age ≥75 y, % ^b (n=91)	P Value	Self-Reported Health Status, %		P Value
				Excellent to Good (n=785)	Fair to Poor (n=88)	
Discussed reasons <i>to have</i> a mammogram	92	83	.02	91	94	.32
Discussed reasons <i>not to have</i> a mammogram	19	21	.81	21	12	.09
Health care provider asked your <i>preference</i> about having a mammogram	38	39	.93	38	41	.64
Received a screening mammography recommendation	79	78	.92	79	76	.50
Health care provider thought you should have a mammogram ^c	99	98	.35	99	100	>.99

^aLimited to women 40 years and older without a history of breast cancer and who completed the breast cancer module (women may or may not have a screening mammogram in the last 2 years).

^bPair-wise comparisons are shown.

^cOf those who received a recommendation.

income, self-reported health status, and perceived risk of breast cancer decreased with age.

Women 75 years and older were less likely to discuss reasons to have a mammogram than younger women (40-74 years, 92%, vs ≥75 years, 83%; $P=.02$). A discussion that included reasons not to have a mammogram (19% vs 21%; $P=.81$) or one that elicited a patient's screening preference (38% vs 39%; $P=.93$) was relatively uncommon across both age groups. The receipt of any health care provider recommendation did not vary by age (79% vs 78%; $P=.92$) and was nearly always in favor of screening (99% vs 98%; $P=.35$; **Table**).

Compared with women in excellent-good health, women in fair-poor health were as likely to discuss reasons to have a mammogram (fair to poor, 94%, vs excellent to good, 91%; $P=.32$) or not have a mammogram (12% vs 21%; $P=.09$). A discussion that elicited a patient's screening preference (41% vs 38%; $P=.64$) or the receipt of a recommendation to undergo screening (99% vs 98%; $P=.35$) did not vary according to health status. When restricting this analysis to patients 75 years and older and evaluating these same end points across health status groups, similar results were observed.

Comment. Older patients are concerned about how screening and treatment will or will not affect their overall survival and independence.⁵ Unfortunately, we found that health care providers were less likely to discuss the reasons to undergo screening mammography with women 75 years or older and infrequently discussed reasons to not undergo mammography. Furthermore, only 39% believed that their health care providers sought their preferences about screening mammography. This imbalance in counseling was mirrored in health care providers' universally recommending screening mammography across health or age groups.

This failure to discuss "the good with the bad" of mammographic screening or consider a patient's likelihood to benefit when making recommendations could lead to screening women unlikely to benefit. Studies based on the National Health Interview Survey and regional populations suggest

that women older than 74 years receive screening mammograms despite poor health status and may account for up to 40% of women who receive screening in this age group.⁶ Lack of clinical time, sensitivity of the discussion, and the position of mammography in popular culture may all contribute to a suboptimal patient-provider discussion surrounding mammography use or screening cessation.⁷

To address this issue, we must create patient-centered decision aids that facilitate an informed cancer screening discussion between patients and health care providers. System-level incentives should allow time for dedicated wellness visits, include electronic reminders to *discuss* rather than *order* screening tests, and involve a more thoughtful tailoring of performance measures toward appropriate, patient-centered testing.⁸

Justin Fox, MD

Brian J. Zikmund-Fisher, PhD

Cary P. Gross, MD

Author Affiliations: Robert Wood Johnson Foundation Clinical Scholars Program, Yale University, New Haven, Connecticut (Drs Fox and Gross); Department of Health Behavior and Health Education, University of Michigan School of Public Health, and Division of General Internal Medicine, University of Michigan Medical School, Ann Arbor (Dr Zikmund-Fisher); and Division of General Internal Medicine and Cancer Outcomes Policy and Effectiveness Research (COPPER) Center, Yale School of Medicine, and Yale Comprehensive Cancer Center (Dr Gross). **Correspondence:** Dr Fox, Robert Wood Johnson Foundation Clinical Scholars Program, Yale University School of Medicine, 333 Cedar St, Room SHM 1E-61, PO Box 208088, New Haven, CT 06520-8088 (justin.p.fox@yale.edu).

Author Contributions: *Study concept and design:* Fox and Gross. *Acquisition of data:* Zikmund-Fisher. *Analysis and interpretation of data:* Fox and Zikmund-Fisher. *Drafting of the manuscript:* Fox. *Critical revision of the manuscript for important intellectual content:* Zikmund-Fisher and Gross. *Statistical analysis:* Fox. *Study supervision:* Gross.

Financial Disclosure: None reported.

Funding/Support: Drs Fox and Gross are involved with the Clinical Scholar's Program, which is supported by the Robert Wood Johnson Foundation. Dr Zikmund-Fisher is supported by a career development award from the American Cancer Society (MRS-06-130-01-CPPB). The DECISIONS study was funded by the Foundation for Informed Medical Decision Making.

1. US Preventive Services Task Force. Screening for breast cancer, topic page. 2010. <http://www.uspreventiveservicestaskforce.org/uspstf/uspstf/uspstf.htm>. Accessed April 26, 2011.
2. Walter LC, Covinsky KE. Cancer screening in elderly patients: a framework for individualized decision making. *JAMA*. 2001;285(21):2750-2756.
3. Schonberg MA, Silliman RA, Marcantonio ER. Weighing the benefits and burdens of mammography screening among women age 80 years or older. *J Clin Oncol*. 2009;27(11):1774-1780.
4. Zikmund-Fisher BJ, Couper MP, Singer E, et al. The DECISIONS study: a nationwide survey of United States adults regarding 9 common medical decisions. *Med Decis Making*. 2010;30(5)(suppl):205-345.
5. Fried TR, McGraw S, Agostini JV, Tinetti ME. Views of older persons with multiple morbidities on competing outcomes and clinical decision-making. *J Am Geriatr Soc*. 2008;56(10):1839-1844.
6. Schonberg MA, McCarthy EP, Davis RB, Phillips RS, Hamel MB. Breast cancer screening in women aged 80 and older: results from a national survey. *J Am Geriatr Soc*. 2004;52(10):1688-1695.
7. Quanstrum KH, Hayward RA. Lessons from the mammography wars. *N Engl J Med*. 2010;363(11):1076-1079.
8. Walter LC, Davidowitz NP, Heineken PA, Covinsky KE. Pitfalls of converting practice guidelines into quality measures: lessons learned from a VA performance measure. *JAMA*. 2004;291(20):2466-2470.

EDITOR'S NOTE

Making Decisions About Screening Mammography in Older Women

The US Preventive Services Task Force notes that there are insufficient data to recommend breast cancer screening among women older than 70 years. Yet, as Walter¹ points out, older women have a high incidence of breast cancer, screening does not suddenly stop being effective in older women, and many live long enough to benefit from screening. On the other hand, the

See also page 62

benefit of screening is lower in older women with a life expectancy less than 10 years, and the risk of harm, including false-positive results and overdiagnosis, is high. Thus, among women older than 70 years, those who are relatively healthy and have at least a 5-year life expectancy are likely to benefit, while frail older women are likely to be harmed and should not undergo mammography. This situation requires that clinicians individualize the decision regarding breast cancer screening in older women. However, this article by Fox et al suggests that clinicians do not alter their recommendations for breast cancer screening based on age or health status and overwhelmingly recommend screening.

Deborah Grady, MD, MPH

1. Walter LC. What is the right cancer screening rate for older adults? *Arch Intern Med*. 2011;171(22):2037-2039.

RESEARCH LETTERS

ONLINE FIRST

Optimal Medical Therapy Use Among Patients Receiving Implantable Cardioverter/Defibrillators: Insights From the National Cardiovascular Data Registry

Current guidelines predicate primary prevention cardioverter/defibrillator (ICD) implantation on patients receiving "optimal medical therapy" (OMT), defined as use of both β -blocker and angiotensin-converting enzyme inhibitor or angiotensin receptor blocker (ACEI/ARB) in the absence of contraindications.¹ These recommendations promote clinical optimization of patients with low left ventricular ejection fraction (LVEF) as well as cost-effective allocation of high-cost device therapy. While prior studies hint at significant care gaps among select ICD recipients,² the ICD Registry offered the opportunity to examine national patterns of OMT use among first-time ICD recipients in contemporary, real-world practice.

Methods. Details regarding the ICD Registry, including data definitions and quality, have been published previously.^{3,4} Among 1201 centers reporting data on consecutive ICD procedures from January 1, 2007, to June 30, 2009, we examined 175 757 patients undergoing first-time ICD implantation and excluded those younger than

See Invited Commentary at end of letter

18 years, who had an LVEF higher than 35%, or who had in-hospital death or unknown OMT status. Patients enrolled in a study necessitating blinding or with documented contraindications to β -blocker or ACEI/ARB use were counted toward medication use. Patients' clinical and procedural characteristics and implanting physician and hospital characteristics were compared among patients stratified by OMT use. Multivariable hierarchical logistic regression modeling using backward variable selection ($P < .01$) examined factors associated with OMT, β -blocker, and ACEI/ARB use. Missing values were imputed (continuous variables to the median; categorical to the mode).

Results. Among 175 757 initial ICD recipients with an LVEF of 35% or lower, 45 240 (25.7%) were eligible for but did not receive OMT. Similar rates were observed when ICD placement was the primary purpose of hospitalization (24.6%) and among primary prevention ICD recipients (25.6%). The rate of OMT prescription by site ranged from 0% to 100%, with a median of 73.5% (interquartile range, 64%-82%). Patients receiving OMT were more likely to be younger, have commercial insurance, and have a diagnosis of hypertension and were less likely to have a history of ischemic heart disease, recent heart failure hospitalization, atrioventricular node conduction abnormalities,