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Proactive Medicine and Proximity Health Services, Fundamental Primary Tools for Breast Cancer Screening: The Role of the "micro-team" in Primary Care

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Abstract

Background: The recent results published in the annual report HOLOGIC GLOBAL WOMEN'S HEALTH INDEX have shown that Italian women are among the least involved in cancer prevention programs: in fact, only 11% have undergone an organised screening pathway in the last 12 months, while the average in Europe is 20%.

Aim: Through an active call, a path of proactive medicine has been realized by attracting all women between 40 and 74 whose computerized medical records did not show the execution of a mammography in the last two years.

Material and Methods: Starting from MilleWin medical records management software, MilleG-PG search engine has been used to extract from the total number of patients (1630) all women between 40 and 74 years who had not performed a mammography in the last two years. The women were contacted by telephone by the clinic nurse, who ascertained that the mammogram had not been performed during the previous two years and, in compliance with the regional guidelines of breast cancer screening, short motivational counselling was carried out to highlight the importance of prevention and achieve individual empowerment in order to increase adherence to screening. In detail, for the achievement of the goal, a dematerialized prescription was sent to women aged between 40 and 44, those aged 44 to 49 were sent a dematerialised prescription with an exemption code, while women aged 50 to 74 were redirected to organised regional screening.

Women with a previous diagnosis of breast cancer were excluded from the active call.

Results: In a group of 874 women, out of a total of 1630: 53 were in the 40-44 age group, 72 in the 45-49 age group, 313 in the 50-74 age group, and 36 (4%) had had a breast cancer. The extrapolation of the data from the medical records showed that there were no results of mammography performed in the previous two years in: 24 out of 53 in the 40-44 age range, 37 out of 72 in the 45- 49 age range and in 156 out of 313 in the 50-74 age range.

All these patients were contacted by phone with a confirmation of not having performed a mammography in 11 out of 24 women in the 40-44 age group; in the 45-49 age group 4 out of 37 women had performed one more than 2 years ago and 10 had never performed one; in the 50-74 age group 60 out of 156 women had performed a breast screening more than 2 years ago while 5 had never performed one. 37 patients never answered the active call. The total analysis showed that 217 women were not reported in the folder, 37 of these did not respond, 90 had performed the test without declaring it and 90 other were redirected to screening.

Conclusions: Our study project confirmed that Italian women adhere less to cancer screening than women in other European states, the reasons are multiple but the prevailing cause is the workload and the same dedication to the family that characterizes the Italian woman as the caregiver of the whole family. Despite the many reasons, the numerous organizational obstacles and the different strategies between the Regions, the structuring of a proactive medical path allows to increase the adhesion to cancer screening by realizing without additional costs a support and a strengthening in Primary Care to the network of organized screening. This project shows that proximity medicine also serves to produce health and not only to provide social and health care, and that the "microteam" of the Primary Care Physician can be a valid territorial unit in cancer screening.

Keyword: cancer screening; proactive medicine; proximity health services; motivational; counselling

Introduction

Breast cancer (BC) is the most common malignancy in women (25% of all cancers) and is responsible for 14.3% of female cancer deaths [1].

In Italy, BC is the most frequently diagnosed cancer (considering the entire population, women and men together) [2] and it represents the most frequent cancer in women in all age groups although with different percentages (41% of total diagnosed neoplasms in the range up to 49 years of age versus 22% in the elderly). On average, for an Italian woman, the risk of contracting BC over the course of her life is now 13%: about one in 45 women contracts BC by the age of 50, one in 19 between 50 and 69, and one in 23 between 70 and 84 [3].

The significant increase in survival that we have seen in recent years is certainly due to several variables, including diagnostic anticipation (linked to screening) and the improvement of therapies (such as the spread of adjuvant systemic therapy). Today we have a wider coverage of the national territory with organized breast screening programs aimed at women between 50 and 69 years of age, and an increasing awareness in young women who undergo the same programs in greater number. Some Regions, on the recommendation of the Ministry of Health, are extending such programs to women between 45 and 49 years with an annual interval, and to women between 70 and 74 years with a biennial interval (See Table 1). Several studies have shown that breast screening can reduce BC mortality (by about 20%) and increase treatment options [3-5]. In women without signs and/or symptoms of BC, treatment is more effective and the likelihood of recovery is higher.

Despite all this evidence, Italian women do less prevention than their European peers: the data emerges from the Global Women's Health Index of Hologic [6].

	Age range	*Maximum extendable age*	*Frequency at which mammography is offered*	*Ways of involve ment*
Abruzzo	50-69	69	2 years	letter
Basilicata	45-74	74	2 years	letter
Calabria	50-69	69	2 years	letter
Campania	45-74	74	2 years	letter
Emilia Romagna	45-74	74	45-49 every year. Under 50 every 2 years	Letter
Friuli Venezia Giulia	45-74	74	2 years	letter
Lazio	Over 45	74	45 to 49 years old:the letter is not sent,but it's possible to do it for free with a doctor's prescription with exemption.	letter
Liguria	50-69	69	2 years	letter
Lombardy	45-74	74	45-49 every year.50-74 every 2 years.	letter
Marche	50-69	69	2 years	letter
Molise	50-69	69	2years	letter
Piedmont	50-69	69	2 years	letter
Puglia	50-69	69	2 years	letter
Sardinia	50-69	69	2 years	letter
Sicily	50-69	69	2 years	letter
Tuscany	45-74	74	Under 50 years old:every year Above 50years old:every 2 years. Above 70 years old:they will receive an invitation only if they have done it in the previous years.	
Trentino-Alto Adige	50-69	69	2 years	letter

Table 1: Italian regional Screening.

The annual survey, now in its third edition, is one of the most comprehensive initiatives measuring the state of health of 97% of the world's women and girls aged 15 and over. The Hologic Global Women's Health Index aims to be a permanent reference point for measuring and monitoring changes in behavior and attitudes that affect women's access to quality healthcare in every corner of the world. The index showed that Italian women are the least involved in cancer prevention programs as only 11% say they have undergone a cancer test in the last 12 months against a European average of 20%. In this context, it may be useful to activate a strategy of proactive medicine.

Aim of the study

A path of proactive medicine has been carried out through an active call of all women between 40 and 74 in which there was no evidence of a mammography in the last two years.

Material and Methods

Starting from MilleWin medical records management software, MilleGPG search engine has been used to extract from the total number of patients (1630) all women between 40 and 74 years who had not performed a mammography in the last two years. The women

were contacted by telephone by the clinic nurse, who ascertained that the mammogram had not been performed during the previous two years and, in compliance with the regional guidelines of breast cancer screening, short motivational counselling was carried out to highlight the importance of prevention and achieve individual empowerment in order to increase adherence to screening. In detail, for the achievement of the goal, a dematerialized prescription was sent to women aged between 40 and 44, those aged 44 to 49 were sent a dematerialised prescription with an exemption code, while women aged 50 to 74 were redirected to organised regional screening.

Women with a previous diagnosis of breast cancer were excluded from the active call.

Results

In a group of 874 women, out of a total of 1630: 53 were in the 40-44 age group, 72 in the 45-49 age group, 313 in the 50-74 age group, and 36 (4%) had had a breast cancer. The extrapolation of the data from the medical records showed that there were no results of mammography performed in the previous two years in: 24 out of 53 in the 40-44 age range, 37 out of 72 in the 45- 49 age range and in 156 out of 313 in the 50-74 age range.

All these patients were contacted by phone with a confirmation of not having performed a mammography in 11 out of 24 women in the 40-44 age group; in the 45-49 age group 4 out of 37 women had performed one more than 2 years ago and 10 had never performed one; in the 50-74 age group 60 out of 156 women had performed a breast screening more than 2 years ago while 5 had never performed one. 37 patients never answered the active call. The total analysis showed that 217 women were not reported in the folder, 37 of these did not respond, 90 had performed the test without declaring it and 90 other were redirected to screening (See table 2).

		Women with data in the medical records		***Women contacted by phone***					
Age	***Total women***	***Mammography frequency***		***No. women***	***Frequency at which the mammography is performed***				
		Within 2 years	***Every year***		***Within 2 years***	***ASL screening adherence***	***> 2 years***	***never***	***No answer***
40-44	53	29	11 /29	24	4	/	0	11	9
45-49	72	27	15 / 27	37	10	/	4	10	13
50-74	313	157	53 / 157	156	78	52	60	5	13

Table 2: Summary of Results.

Conclusions

By proactive healthcare we mean a model of management of chronic diseases that does not wait for the citizen in the hospital (reactive healthcare), but which & quot; meets & quot; them before the diseases arise or worsen, thus ensuring adequate and differentiated interventions to the patient in relation to the level of risk, also focusing on prevention and education. The reference is the Chronic Care Model, which is based on the profitable interaction between the patient (made more informed with appropriate training and training) and doctors, nurses and health workers [7].

The objectives of this model are both the prevention and the improvement of the management of chronic diseases at all stages and therefore it concerns all levels of the health system, with expected positive effects on citizens' health and the sustainability of the system itself. In various Italian regions this model has been identified to respond effectively to the ageing of the local population (highlighted by epidemiological and demographic studies), which brings with it an increase in the relevance of chronic diseases and a change in the demand for care.

At the end of 2022, data from the report & quot; Health at a Glance: Europe 2022 & quot; prepared by the Organisation for Economic Cooperation and Development (OECD) in collaboration with the European Commission, was published [8]. The report, which is issued every two years, compares the data of member states with those of the 37 OECD countries.

OECD countries typically offer screening checks every two years for women between 50 and 69. The screening rate varies considerably between OECD countries. In the last period it reached a maximum of 83% of the target population in Denmark and a minimum in Turkey, where less than 25% of women in the target age group have performed a mammographic examination in the last two years. As recently confirmed by data from the Global Women's Health Index of Hologic, already in this report, Italy was below the European average, with a percentage of 56%, which is on the decrease compared to the past.

In Italy women live longer than men, but they get ill more often and spend on average one third of their life in poor health. The imbalance between the health of women and men is due to the lack of essential levels of assistance that, not being guaranteed in the same way throughout the country, creates long waiting lists and a different access to services from Region to Region [9]. In addition, the different economic possibilities of women, in a context of government policies that over time have put in place a process of dismantling public services in favour of private centers, make access to care difficult compared to men who historically have greater economic power.

Our study project confirmed that Italian women adhere less to cancer screening than women in other European countries. The reasons are many, but the main cause is the workload and the same dedication to the family that characterizes Italian women as the caregivers of the whole family.

In this context, the active call and the motivational counselling to highlight the importance of prevention and achieve individual empowerment are strategies peculiar to the general practitioner.

Despite the many reasons, the numerous organizational obstacles and the different strategies between the Regions, the structuring of a proactive medical path allows to increase the adhesion to cancer screening by providing Primary Care support to the network of organized screening without additional costs.

However, in order to be viable, proactive medicine requires professional skills and adequate resources (i.e. infrastructure, nurses, and secretaries).

This project shows that proximity medicine also serves to produce health and not only to provide social and health care, and that the & quot; micro-team & quot; of the General Practitioner can be a valid territorial center in cancer screening.

It is desirable that in the near future further investments will be made in order to have a widespread presence on the territory of the family nurse and consequently of the micro-teams of primary care.

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