

# A Purchaser's Guide to Clinical Preventive Services: Moving Science into Coverage

## Overview of a Purchaser's Guide to Clinical Preventive Services

*A Purchaser's Guide to Clinical Preventive Services: Moving Science into Coverage (Purchaser's Guide)* is an information source for employers on clinical preventive service benefit design. This document provides guidance for the selection of clinical preventive services shown to be effective by the U.S. Preventive Services Task Force (USPSTF), the Centers for Disease Control and Prevention (CDC), and other authoritative organizations.

The *Purchaser's Guide* builds upon the National Business Group on Health's previous publication, sponsored by the Robert Wood Johnson Foundation (RWJF) and reviewed by the Agency for Healthcare Research and Quality (AHRQ): *An Employer's Guide to Clinical Preventive Services — Improving Health. Improving Business* (referred to as the *Employer's Guide*).

The *Purchaser's Guide* provides several new and important components that will assist employers in improving coverage for clinical preventive services. Namely, the *Purchaser's Guide* includes the scientific evidence and detailed benefit language employers need to implement comprehensive and structured clinical preventive service benefits.

Below is an annotated table of contents that describes the information, resources, and tools provided in each part of the *Purchaser's Guide*.

### Introduction

Provides an overview of how the *Purchaser's Guide* was developed and background on the sources of its recommendations.

1

### Part I: The Role of Clinical Preventive Services in Disease Prevention and Early Detection

Provides information for employers on improving beneficiary health and reducing healthcare costs through the implementation of comprehensive and structured clinical preventive service benefits within a medical benefit plan.

**In order to protect and promote beneficiary health and control healthcare costs, employers must provide coverage for clinical preventive services.**

Within a given benefit plan, employers may select which preventive services are covered and at what level. Many preventive services are available. Some are known to be effective; others are known to be relatively ineffective or even harmful; others may be effective but the proof of effectiveness is weak. The *Purchaser's Guide* provides guidance for the selection of clinical preventive services proven to be clinically effective and of value to employers.

**2** *Part II: Summary Plan Description (SPD) Language Statements for Recommended Clinical Preventive Service Benefits*

Provides 46 condition specific summary plan description (SPD) language statements designed to assist benefits staff as they design benefit structures, discuss clinical preventive services with a healthcare consultant, set coverage guidelines with a health plan, or negotiate covered services with a union or consumer group. The SPD language statements were adapted from recommendations of the U.S. Preventive Services Task Force (USPSTF), the Centers for Disease Control and Prevention (CDC), and other authoritative organizations.

Each preventive service SPD statement contains detailed benefit language regarding the:

- Necessary content of the recommended clinical preventive service.
- Age at which the service should be initiated and ceased.
- Recommended frequency of the service.

Applicable current procedural terminology (CPT) codes are provided for employers and health plans to facilitate the implementation and reimbursement of clinical preventive service benefits.

**3** *Part III: Evidence-Statements for Recommended Clinical Preventive Service Benefits*

Provides evidence-statements for each of the 46 recommended clinical preventive service benefits. Each evidence-statement includes information about the:

- Prevalence and/or incidence of the condition.
- Risk factors associated with the condition.
- Economic burden of the condition and the economic benefit of early identification/intervention.
- Cost-benefit/cost-effectiveness of the recommended intervention.
- Cost of the recommended preventive intervention.
- Purpose of the preventive intervention.
- Benefits and risks of the preventive intervention.

**4** *Part IV: The Prioritization and Strategic Implementation of Clinical Preventive Service Benefits*

Provides practical “how-to” information on the development and implementation of structured clinical preventive service benefits. Real-world examples of each prioritization method are provided.

**5** *Part V: I Statements and C and D Recommendations and of the U.S. Preventive Services Task Force (USPSTF)*

Provides information on clinical preventive services that were reviewed by the USPSTF, but were not included in the *Purchaser’s Guide* because the USPSTF:

1. Found that there was insufficient evidence to make a recommendation either for or against providing the service (I statement);

2. Made no recommendation regarding the provision of the service based on an analysis of evidence of effectiveness, benefits, and harms (C recommendation); or
3. Recommended against routine provision of the service for asymptomatic patients based on an analysis of the evidence of effectiveness, benefits, and harms (D recommendation).

This information may assist benefits staff in determining which clinical preventive services currently offered in their health plan(s) should be re-evaluated and, possibly, eliminated.

## **6** *Part VI: Leveraging Benefits: Opportunities to Promote the Delivery and Use of Preventive Services*

The *Purchaser's Guide* is designed to help employers select and implement clinical preventive services that are delivered by healthcare providers. Employers can strengthen prevention efforts by supporting public health interventions that may occur in the workplace or communities. Part VI provides information and tips for employers on promoting the delivery and use of clinical and community-based preventive services, including:

- An overview of the *Community Guide to Preventive Services*.
- A crosswalk between the recommendations proposed in the *Purchaser's Guide* and the *Community Guide*.
- Case examples of large employers who have successfully implemented worksite health promotion programs and/or supported community-based interventions.

## **7** *Part VII: Resources & Tools*

Provides additional information and resources on clinical preventive service benefit design, including:

- The Life Course Charts — visual guides to clinical preventive services across the lifespan
  - > Recommended Schedule of Preventive Care for Adults
  - > Recommended Schedule of Preventive Care for Children and Adolescents
  - > Recommended Schedule of Preventive Preconception, Prenatal, and Postpartum Care
- A crosswalk between the *Purchaser's Guide*, the U.S. Preventive Services Task Force's A/B recommendations, the 2007 HEDIS® Measures, the NCQA State of Healthcare Quality Report, and the U.S. Department of Health and Human Service's *Healthy People 2010* Goals.
- Clinical Preventive Services Glossary
- Links to additional resources and cost-calculators.
- A CD containing PDF versions of all the materials included in the *Purchaser's Guide*.

## **An Introduction to A *Purchaser’s Guide* to Clinical Preventive Services**

### ***Clinical Preventive Service Topic Selection***

The clinical preventive services recommended for coverage in the *Purchaser’s Guide* were selected by the National Business Group on Health with the technical assistance of experts from two federal agencies, the Centers for Disease Control and Prevention (CDC) and the Agency for Healthcare Research and Quality (AHRQ).

The *Purchaser’s Guide* coverage recommendations are mainly based on the U.S. Preventive Services Task Force (USPSTF) recommendations on clinical preventive services for the general asymptomatic population. The USPSTF, sponsored by the Agency for Healthcare Research and Quality (AHRQ) (part of the U.S. Department of Health and Human Services), is an independent panel of experts in primary care and prevention that makes recommendations regarding clinical preventive services after a careful review of the scientific literature. The *Purchaser’s Guide* includes all of the USPSTF “A” and “B”-rated recommendations published before March 2006.

**The *Purchaser’s Guide* also includes** clinical preventive service recommendations from other recognized sources such as the Centers for Disease Control and Prevention (CDC); other Federal agencies such as the National Health, Lung, and Blood Institute (NHLBI), a division of the National Institutes of Health (NIH); and professional organizations such as the American Academy of Pediatrics (AAP).

Recommendations from sources other than the USPSTF were added to support USPSTF recommendations, or inserted in place of a USPSTF recommendation, when:

1. No current USPSTF recommendation was available (e.g., screening for elevated blood lead levels); or
2. When a newer recommendation superseded the existing USPSTF recommendation (e.g., lipids screening).

In order to be included in the *Purchaser’s Guide*, clinical preventive service recommendations were required to meet the following criteria:

1. Be based on medical evidence or recommended guidance.
2. Address a serious health threat in terms of morbidity (illness), mortality (death), or quality of life (including risk of disability).
3. Address a condition that results in substantial direct (e.g., treatment costs) or indirect costs (e.g., absenteeism, lost productivity) for payers.

Forty-six (46) services met the inclusion criteria outlined on the previous page. These services are discussed in further detail in *Part II: Summary Plan Description (SPD) Language Statements for Recommended Clinical Preventive Service Benefits* and *Part III: Evidence-Statements for Recommended Clinical Preventive Service Benefits*.

The evidence for clinical preventive services is growing. Purchasers are encouraged to periodically check the U.S. Preventive Services Task Force (USPSTF) website ([www.ahrq.gov/clinic/uspstfix.htm](http://www.ahrq.gov/clinic/uspstfix.htm)) for up-to-date recommendations on clinical preventive services.

### **Figure A: Sources of Information Used in the *Purchaser's Guide***

- Advisory Committee on Childhood Lead Poisoning Prevention (ACCLP)
- Advisory Committee on Immunization Practices (ACIP)
- Agency for Healthcare Research and Quality (AHRQ)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Alliance for Cervical Cancer Prevention; Program for the Appropriate use of Technology in Health (PATH)
- American Academy of Audiology
- American Academy of Bariatric Surgery
- American Academy of Family Physicians (AAFP)
- American Academy of Neurology
- American Academy of Pediatric Dentistry (AAPD)
- American Academy of Pediatrics (AAP)
- American Association of Clinical Endocrinologists (AACE)
- American Cancer Society (ACS)
- American College of Cardiology
- American College of Emergency Physicians (ACEP)
- American College of Obstetricians and Gynecologists (ACOG)
- American College of Preventive Medicine (ACPM)
- American College of Surgeons (ACS)
- American Dental Association (ADA)
- American Diabetes Association (ADA)
- American Heart Association (AHA)
- American Medical Association (AMA)
- American Psychological Association (APA)
- American Society of Addiction Medicine (ASAM)
- American Society of Clinical Oncology (ASCO)
- American Speech, Language, and Hearing Association
- Center for Medicare & Medicaid Services (CMS)
- Centers for Disease Control and Prevention (CDC)
- Committee on Educational Interventions for Children with Autism, National Research Council, National Academies
- Directors of Speech and Hearing Programs in State Health and Welfare Agencies
- Employee Benefits Institute
- Food and Drug Administration (FDA)
- George Washington University, Center for Health Services Research and Policy
- Harvard Medical School

**Figure A: Sources of Information Used in the *Purchaser's Guide* (Continued)**

- Health Resources and Services Administration (HRSA)
- *Healthy People 2010*, U.S. Department of Health and Human Services
- Institute of Medicine (IOM)
- Internal Revenue Service (IRS), Department of Treasury
- International Agency for Research on Cancer (IARC)
- Jacobs Institute of Women's Health (JIWH)
- Joint Committee on Infant Hearing (JCIH)
- Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure
- March of Dimes
- Maternal Child Health Bureau (MCHB)
- National Academy of Sciences (NAS)
- National Academy of Sciences, Institute of Medicine (IOM)
- National Association of Pediatric Nurse Practitioners (NAPNAP)
- National Business Group on Health
- National Cancer Institute (NCI)
- National Center for Education in Maternal and Child Health
- National Center for Health Statistics (NCHS)
- National Center for Hearing Assessment and Management (NCHAM)
- National Center for Injury Prevention and Control
- National Cholesterol Education Program (NCEP)
- National Cholesterol Education Program Adult Treatment Expert Panel-III
- National Health and Nutrition Examination Survey (NHANES)
- National Heart, Lung, and Blood Institute (NHLBI)
- National Highway Traffic Safety Administration (NHTSA)
- National Institute on Alcohol Abuse and Alcoholism (NIAAA)
- National Institutes of Health (NIH)
- National Institutes of Mental Health (NIMH)
- National March of Dimes Birth Defects Foundation
- National Osteoporosis Foundation (NOF)
- National Research Council, Committee on Educational Interventions for Children with Autism, Division of Behavioral and Social Sciences and Education
- Partnership for Prevention
- Peer-reviewed research
- Preeclampsia Foundation
- Royal College of Obstetricians and Gynecologists
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- U.S. Department of Agriculture (USDA)
- U.S. Department of Health and Human Services (USDHHS)
- U.S. Department of Transportation (DOT)
- U.S. Environmental Protection Agency (EPA)
- U.S. Preventive Services Task Force (USPSTF)
- U.S. Public Health Service (USPHS)
- U.S. Surgeon General
- World Health Organization (WHO)

## The Evidence for Clinical Preventive Services

All of the recommendations in the *Purchaser's Guide* are based on science.

### **The U.S. Preventive Services Task Force (USPSTF)**

Most of the recommendations featured in the *Purchaser's Guide* were adapted from the U.S. Preventive Services Task Force (USPSTF). The USPSTF is recognized as the gold-standard in clinical preventive service recommendations; it is an independent panel of experts in primary care and prevention that conducts rigorous, impartial assessments of the scientific evidence for the effectiveness of clinical preventive services.<sup>1</sup>

The USPSTF is mandated by Congress to evaluate preventive services and publishes recommendations and evidence synthesis, which are the culmination of an extensive literature review, debate, and analysis of critical comments from expert reviewers.<sup>1</sup> USPSTF recommendations are based on an objective process that weighs the benefits and the harms of a preventive service. Each recommendation is given a letter grade (A-D, I) based on the strength of evidence available to support the particular clinical preventive service and the magnitude of net benefit for that service. The net benefit of a clinical preventive service is defined as the benefits of the service (e.g., years of life saved through early cancer detection) minus the harms of the service (e.g., risks associated with false-positive test results).

By definition, the foundational source of USPSTF recommendations is research published in peer review journals. USPSTF recommendations are therefore limited to clinical preventive services that have been systematically studied and published. Services that are commonly provided in clinical practice but have not been well-studied or have been poorly documented in the literature may not be reviewed. For instance, some interventions have not been systematically studied due to ethical concerns (e.g., withholding treatment) or lack of funding for research. In other cases, evidence exists but it is conflicting. These interventions are given an “I” rating (“I” for insufficient evidence) by the USPSTF.

**THE USPSTF publishes the annual *Guide to Clinical Preventive Services*, which includes abridged versions of the USPSTF's recommendations on screening, counseling, and preventive medication presented in a user friendly format for clinicians. The complete USPSTF recommendations and reviews are available on the web and provide information about which clinical preventive services should be delivered by prudent clinicians in the course of routine clinical care. For more information on the USPSTF please visit: [www.ahrq.gov/clinic/prevenix.htm](http://www.ahrq.gov/clinic/prevenix.htm)**

### **Evidence-Based Recommendations, Evidence-Based Medicine, and Evidence-Based Benefits**

Many of the clinical preventive service recommendations presented in the *Purchaser's Guide* are evidence-based. Evidence-based services have a longer and stronger base of research to support their efficacy, safety, and cost-effectiveness. Generally, the term “evidence-based” refers to medical interventions that scientific studies have evaluated and determined to be effective and to have a measurable effect on health outcomes.

All of the recommendations derived from the USPSTF are evidence-based. Other recommendations featured in the *Purchaser's Guide* are based on “recommended guidance.” Recommended guidance is based on the best-available information for a given topic, but lacks the scientific research support needed to be considered evidence-based.

**There is strong scientific evidence to support the provision of a broad range of clinical preventive services for normal-risk children, adolescents, and adults.**

**Definition Box B: Evidence**

**Evidence-based medicine:** Two common definitions of evidence-based medicine include the following:

1. “Evidence-based medicine is the conscientious, explicit, and judicious use of current best-evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.”<sup>2</sup>
2. Evidence-based recommendations require, “First, good evidence that each test or procedure recommended is medically effective in reducing morbidity or mortality; second, the medical benefits must outweigh the risks; third, the cost of each test or procedure must be reasonable compared to its expected benefits; and finally, the recommended actions must be practical and feasible.”<sup>2</sup> [Note: The USPSTF does not consider cost as a factor in its recommendations.]

**Recommended guidance:** A recommendation or guideline that is based on the best available information for a condition, disease, or health service, but that does not yet have the scientific research support in order to be considered evidence-based (as determined by a systematic review process). Expert opinion, expert judgment, and consensus opinion, are considered forms of recommended guidance.

**Evidence-based benefit design:** Aims to promote healthcare with demonstrated effectiveness by providing “...more generous coverage for services supported by strong evidence of effectiveness and less generous coverage for services that are unproven or evidence indicates may be ineffective or unsafe, given patient characteristics and history.”<sup>3</sup>

To make the sources, types, and strength of scientific evidence used in the *Purchaser's Guide* fully transparent, each evidence-statement featured in *Part III: Evidence-Statements for Recommended Clinical Preventive Service Benefits* contains an evidence-box as a summary.

Each evidence-box contains the following information:

- A description of where the information used in the recommendation originated from (e.g., the American Academy of Family Physicians (AAFP), CDC, or the USPSTF).

- The level of evidence used in constructing the recommendation:
  - > Evidence-based research
  - > Recommended guidance
- The strength of the evidence. For example, the USPSTF grades each of its clinical preventive service recommendations on a 5-point scale (A-D, I). The grade is determined by the strength of scientific evidence supporting a clinical preventive service and the magnitude of net benefit (defined as benefits minus harms).<sup>4</sup>

**Figure C: Sample Evidence-Boxes**

**Strength of Evidence for the Clinical Preventive Service (Colorectal Cancer Screening)**

The level of evidence supporting the recommendations contained in this chapter is described below.

***Evidence-Based Research:***

U.S. Preventive Services Task Force (USPSTF)

Strength of Evidence: A (Strongly Recommended/Good Evidence)

- The USPSTF found fair to good evidence that several screening methods are effective in reducing mortality from colorectal cancer. The USPSTF concluded that the benefits from screening substantially outweigh potential harms, but the quality of evidence, magnitude of benefit, and potential harms vary with each method.

**Strength of Evidence for the Clinical Preventive Service (Immunizations)**

The level of evidence supporting the recommendations contained in this chapter is described below

***Recommended Guidance:***

Advisory Committee on Immunization Practices (ACIP)

Centers for Disease Control and Prevention (CDC)

Strength of Evidence: Expert Consensus

- The ACIP and CDC recommend that all children and adolescents with no contraindications receive all routinely recommended childhood vaccinations. Children and adolescents who fall into high-risk groups because of health conditions, behaviors, or membership in certain communities should receive additional immunizations.
- The ACIP and CDC recommend that all adults with no contraindications receive three routinely recommended vaccines (age-dependent). Adults who fall into high-risk groups because of health conditions, behaviors or exposures, as well as those without a history of immunization for certain diseases, should receive additional immunizations.

**Figure D: U.S. Preventive Services Task Force (USPSTF) Strength of Evidence Scale<sup>5</sup>**

- A Strongly Recommended**  
The USPSTF strongly recommends that clinicians provide the service to eligible patients. The USPSTF found good evidence that the service improves important health outcomes and concludes that the benefits substantially outweigh harms.
- B Recommended**  
The USPSTF recommends that clinicians provide the service to eligible patients. The USPSTF found at least fair evidence that the service improves important health outcomes and concludes that the benefits outweigh harms.
- C No Recommendation Either For or Against**  
The USPSTF makes no recommendation either for or against routine provision of the service. The USPSTF found at least fair evidence that the service can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.
- D Recommend Against**  
The USPSTF recommends against routinely providing the service to asymptomatic patients. The USPSTF found at least fair evidence that the service is ineffective or that the harms associated with the service outweigh benefits
- I Insufficient Evidence in Order to Make a Recommendation**  
The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing the service. Evidence that the service is effective is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

**Figure E: American Academy of Family Physicians (AAFP) Strength of Evidence Scale<sup>6</sup>**

- SR Strongly Recommended**  
Good quality evidence exists which demonstrates substantial net benefit over harm; the intervention is perceived to be cost-effective and acceptable to nearly all patients.
- R Recommended**  
Although evidence exists which demonstrates net benefit, either the benefit is only moderate in magnitude or the evidence supporting a substantial benefit is only fair. The intervention is perceived to be cost-effective and acceptable to most patients.
- NR No Recommendation Either For or Against**  
Either good or fair evidence exist of at least a small net benefit. Cost-effectiveness may not be known or patients may be divided about acceptability of the intervention.
- RA Recommend Against**  
Good or fair evidence exist which demonstrates no net benefit over harm.
- I Insufficient Evidence to Recommend Either For or Against**  
No evidence of even fair quality exists or the existing evidence is conflicting.
- IHB** Healthy behavior is identified as desirable, but the effectiveness of physician's advice and counseling is uncertain.

## References:

1. U.S. Preventive Services Task Force. Questions and answers. Background: What is the USPSTF? Agency for Healthcare Research and Quality. [cited 2005 Dec 5]. Available from: <http://www.ahrq.gov/clinic/uspsfaqs.htm>.
2. Eddy DM. Evidence-based medicine: A unified approach. *Health Aff* 2005; 24(1): 9-17.
3. National Business Group on Health. National Committee on Evidence-Based Benefits. Washington, DC: National Business Group on Health; 2005.
4. Agency for Healthcare Research and Quality. *The Guide to Clinical Preventive Services: Recommendations of the U.S. Preventive Services Task Force*. Rockville, MD: Agency for Healthcare Research and Quality; 2005.
5. Agency for Healthcare Research and Quality. *The Pocket Guide to Clinical Preventive Services 2005*. AHRQ Publication No. 05-0570. Rockville, MD: Agency for Healthcare Research and Quality; 2005.
6. American Academy of Family Physicians. *Summary of Policy Recommendations for Periodic Health Examinations*. AAFP Policy Action. Revision 6.0; August 2005.