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The Prioritization and Strategic Implementation of Clinical Preventive Service Benefits

Overview:

Practical advice about the prioritization and strategic implementation of clinical preventive service benefits.

Sections include:

- The Purpose and Process of Prioritizing Recommended Clinical Preventive Services in order to:
 - Provide Economic and Health Value
 - Address Demographic Needs
 - Address Beneficiary Risk and Reduce Specific Healthcare Costs
- Employer Scenarios

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Prioritization of Clinical Preventive Services in a Strategic Implementation Plan

The Purpose and Process of Prioritizing Recommended Clinical Preventive Services

Employers with limited resources, or those facing competing demands, may not be able to add all of the 46 recommended clinical preventive service benefits in a single benefit revision cycle. These employers should consider a strategic implementation approach and prioritize benefit expansion.

There are multiple ways to prioritize the clinical preventive services recommended in the *Purchaser's Guide*. Several methods of prioritization are listed below.

Prioritization methods are not listed in preferential order; nor are they mutually exclusive. Each method has its own strengths and weaknesses and employers may want to consider combining multiple approaches.

Employers should evaluate their current clinical preventive service benefits and the needs of their own beneficiary population, before selecting prioritization methods.

Health outcomes in the United States could be improved at less expense if the healthcare system, clinicians, and patients gave priority to services that were most beneficial and offered the greatest value.¹

*Partnership for Prevention
Priorities for America's Health, 2006*

Value - An Important Variable

Like any investment aimed at keeping a workforce healthy and productive, clinical preventive services offer value. The “value” of an individual preventive service is determined by its ability to prevent a significant amount of morbidity and mortality in relation to the cost of offering the service. Because offering a clinical preventive service has a real (monetary) cost and an opportunity cost (there is a finite amount of services that can be delivered/received in a given period of time), it is important for purchasers to quantify the value of clinical preventive services in relation to one another when making coverage decisions.

Employer Guidance

Strength of evidence for a given clinical preventive service should be the first filter used in prioritization and strategic implementation efforts. The U.S. Preventive Services Task Force (USPSTF) uses a lettered grading system:

A-B: Employers should implement coverage for all services recommended in the *Purchaser's Guide*, (particularly the USPSTF “A” and “B” recommendations and all ACIP recommended services immediately.)

I: Employers have discretion as to whether to provide coverage for services with limited or conflicting evidence (services that received an “I” rating). The provision of coverage for “I”-rated services should be secondary to the provision of coverage for all recommended services featured in the *Purchaser's Guide* (“A” and “B”-rated services and equivalencies*).

C: Employers should provide coverage for USPSTF “C”-rated services only if there is a population-specific and compelling reason to do so as there appears to little or no health value derived from these interventions. The provision of coverage for “C”-rated services should be secondary to the provision of coverage for all recommended services featured in the *Purchaser's Guide* (“A” and “B”-rated services and equivalencies*).

D: Employers should not provide coverage for “D”-rated clinical preventive services for their asymptomatic beneficiary population. However, employers may choose to cover these services on a case-by-case basis as determined by beneficiary risk or medical necessity criteria. Further, these services should be covered when part of a medical treatment plan for an existing condition/disease or when an individual is determined to be at high risk for the respective condition/disease.

*Other organizations have comparable rating systems. For example, the American Academy of Family Physicians (AAFP) uses a SR (Strongly Recommended), R (Recommended), NR (No Recommendation), RA (Recommend Against), I (Insufficient Evidence to Recommend Either For or Against) rating system. For more information on AAFP’s grading system please refer to the Introduction of the *Purchaser's Guide*.

Figure 4.0: Methods of Prioritization in a Strategic Implementation Plan

Method of Prioritization	Explanation	Purpose	Requires
Provide Economic and Health Value	Rank order clinical preventive services by their economic value and health impact.	Provide cost-effective and life-saving benefits	Current list of high-value clinical preventive services
Address Demographic Needs	Rank order clinical preventive services by their ability to meet the needs of a defined population based on age and gender.	Address population-specific needs based on age and gender	Beneficiary demographic data
Address Beneficiary Risk and Reduce Specific Healthcare Costs	Rank order clinical preventive services by their ability to address 1) the risk profile of a population based on results from an employer-sponsored health risk appraisal (HRA) and/or 2) conditions and diseases frequently seen in healthcare cost data.	Address population-specific needs based on risk; Address preventable healthcare costs	HRA data Medical claims data Disability claims data

Methods of Prioritization: An Overview

Rank order clinical preventive services by their economic and health value. The National Commission on Prevention Priorities has rank-ordered clinical preventive services according to their cost-effectiveness and ability to prevent disease, injury, or premature death. “High-

Provide Economic and Health Value

value” services are those services that, when delivered appropriately, are both cost-effective and reduce the burden of disease within a population. *Employers interested in providing coverage for the clinical preventive services that provide a good value for their money should consider this method.*

Rank order clinical preventive services by their ability to meet the needs of a defined population based on age and gender. Many employers have beneficiary populations that are demographically homogeneous (i.e., their beneficiary population is mostly male or mostly female, mostly young adults [20s, 30s, 40s], mostly older adults [50s, 60s, 70s]). Similarly,

Address Demographic Needs

many clinical preventive services are relevant only for one age or gender group (e.g., cervical cancer screening is only recommended for women). *Employers who have a relatively homogenous beneficiary population and who want to provide coverage for the clinical preventive services that are most likely to meet the needs of that population should consider this method.*

Rank order clinical preventive services by their ability to address the risk profile of a population based on results from a population risk assessment such as an health risk appraisal (HRA) or conditions and diseases frequently seen in healthcare cost data.

Employers who sponsor HRAs can use the results of the assessment to establish a beneficiary risk profile. This group risk profile can then inform the selection of clinical preventive service benefits. Similarly, analyzing healthcare cost data (e.g., medical claims data, disability claims data) can alert employers to high-frequency and/or high-cost claims that are a result of a preventable disease (e.g., hospitalization for chickenpox) or modifiable behavior (e.g., tobacco use).

Address Beneficiary Risk & Reduce Specific Healthcare Costs

Clinical preventive service benefits can then be prioritized for implementation based on their ability to address the preventable conditions reflected in the employer’s healthcare cost data. *Employers interested in providing coverage for clinical preventive services that 1) address the specific health risks of their beneficiary population and/or 2) address their beneficiaries’ preventable healthcare costs should consider this method.*

Provide Economic and Health Value

Rank order clinical preventive services by their economic and health value.

The National Commission on Prevention Priorities (NCCPP), a blue-ribbon panel of thought-leaders on prevention chaired by former Surgeon General Dr. David Satcher and staffed by Partnership for Prevention, recently ranked the 25 preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP) according to health impact and cost-effectiveness.

NCCPP used a rigorous methodology to rank the selected clinical preventive services. A clinical preventive services was deemed “high-value” when it was determined to be both cost-effective (it cost a “reasonable” amount of money for the added quality of life or life-years gained) and impacts the clinical preventable burden of a disease (the service prevented a substantial proportion of disease, injury, or premature death when delivered appropriately). Employers interested in maximizing the value of their investment in preventive services, within a large population and over a sustained period of time, may want to consider using this approach to prioritization.

Additional information on the **National Commission on Prevention Priorities** is available online at: www.prevent.org/content/view/46/96/

Figure 4.1: Top 25 High-Value Preventive Services (evaluated in terms of the preventable burden of disease and cost-effectiveness)²

High-Value Clinical Preventive Service	As noted in the <i>Purchaser's Guide</i>	Clinically Preventable Burden of Disease (CPB) Max Score = 5	Cost-Effectiveness (CE) Max Score = 5	Combined Score (CPB) and CE, Max Score = 10
Aspirin Chemoprophylaxis	Aspirin Therapy for the Prevention of Cardiovascular Disease, <i>Counseling</i>	5	5	10
Childhood Immunization Series	Immunizations (Child, Adolescent, Adult)	5	5	10
Tobacco Use Screening and Brief Intervention	Tobacco Use Treatment, <i>Screening, counseling, and treatment</i>	5	5	10
Problem Drinking Screening and Brief Counseling	Alcohol Misuse, <i>Screening and counseling</i>	4	4	8
Colorectal Cancer Screening	Colorectal Cancer, <i>Screening</i>	4	4	8
Hypertension Screening	Hypertension, <i>Screening, counseling, and treatment</i>	5	3	8

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Figure 4.1: Top 25 High-Value Preventive Services (evaluated in terms of the preventable burden of disease and cost-effectiveness)² (Continued)

High-Value Clinical Preventive Service	As noted in the Purchaser's Guide	Clinically Preventable Burden of Disease (CPB) Max Score = 5	Cost-Effectiveness (CE) Max Score = 5	Combined Score (CPB) and CE, Max Score = 10
Influenza Immunization	Immunizations (Child, Adolescent, Adult)	4	4	8
Pneumococcal Immunization	Immunizations (Child, Adolescent, Adult)	3	5	8
Vision Screening (Adults)	Not included in the <i>Purchaser's Guide</i>	3	5	8
Cervical Cancer Screening	Cervical Cancer, <i>Screening</i>	4	3	7
Cholesterol Screening	Lipid Disorders, <i>Screening, counseling, and treatment</i>	5	2	7
Breast Cancer Screening	Breast Cancer, <i>Screening</i>	4	2	6
Calcium Chemoprophylaxis	Not included in the <i>Purchaser's Guide</i>	3	3	6
Chlamydia Screening	Chlamydia, <i>Screening</i>	2	4	6
Vision Screening (Children)	Vision, <i>Screening</i>	2	4	6
Folic Acid Chemoprophylaxis	Folic Acid Supplementation, <i>Counseling and preventive medication</i>	2	3	5
Obesity Screening	Obesity, <i>Screening, counseling, and treatment</i>	3	2	5
Depression Screening	Depression, <i>Screening</i>	3	1	4
Hearing Screening	Newborn Hearing, <i>Screening</i>	2	2	4
Injury Prevention Counseling	Motor Vehicle-Related Injury Prevention, <i>Counseling</i>	1	3	4
Osteoporosis Screening	Osteoporosis, <i>Screening and treatment</i>	2	2	4
Cholesterol Screening (High-Risk)	Lipid Disorders, <i>Screening, counseling, and treatment</i>	1	1	2
Diabetes Screening	Diabetes (type 2), <i>Screening</i>	1	1	2
Diet Counseling	Healthy Diet, <i>Counseling</i>	1	1	2
Tetanus and Diphtheria Booster	Immunizations (Child, Adolescent, Adult)	1	1	2

Method suggested for: Employers with large and diverse populations (in terms of age and gender) and who want to provide services with the greatest value to their employees.

Employer Scenario: Employer *A* has 100,000 employees, 60,000 dependents, and 10,000 retirees. Employer *A* provides health insurance coverage for all beneficiaries, including Medicare Part B coverage for retirees. The beneficiary population is very diverse: 49% of beneficiaries are female and the average age of a beneficiary is 35 (but ranges from 0 to 81 years). After reviewing HRA information and medical claims data, no single preventable condition emerges as a major health or cost problem. Rather, many preventable conditions affect the population. Employer *A* is facing cost cutbacks relative to medical spending and wants to ensure it receives a good value for any new benefit it implements. In order to receive the most value from its clinical preventive service benefit expansion, employer *A* decides to implement “high-value” clinical preventive services that received a score of ≥ 8 immediately, and then implement the remaining services over the next two benefit revision cycles.

In the abovementioned scenario, employer *A* would implement benefits for the following services:

Immediate Implementation

High-Value Clinical Preventive Service	As noted in the Purchaser's Guide	Combined Score (CPB) and CE, Max Score =10
Aspirin Chemoprophylaxis	Aspirin Therapy for the Prevention of Cardiovascular Disease, <i>Counseling</i>	10
Childhood Immunization Series	Immunizations (Child, Adolescent, Adult)	10
Tobacco Use Screening and Brief Intervention	Tobacco Use Treatment, <i>Screening, counseling, and treatment</i>	10
Problem Drinking Screening and Brief Counseling	Alcohol Misuse, <i>Screening and counseling</i>	8
Colorectal Cancer Screening	Colorectal Cancer, <i>Screening</i>	8
Hypertension Screening	Hypertension, <i>Screening, counseling, and treatment</i>	8
Influenza Immunization	Immunizations (Child, Adolescent, Adult)	8
Pneumococcal Immunization	Immunizations (Child, Adolescent, Adult)	8
Vision screening (Adults)	Not included in the <i>Purchaser's Guide</i>	8

Subsequent Implementation – Benefit Revision Cycle 2

High-Value Clinical Preventive Service	As noted in the Purchaser's Guide	Combined Score (CPB) and CE, Max Score =10
Cervical Cancer Screening	Cervical Cancer, <i>Screening</i>	7
Cholesterol Screening	Lipid Disorders, <i>Screening, counseling, and treatment</i>	7
Breast Cancer Screening	Breast Cancer, <i>Screening</i>	6
Calcium Chemoprophylaxis	Not included in the <i>Purchaser's Guide</i>	6
Chlamydia Screening	Chlamydia, <i>Screening</i>	6
Vision Screening (Children)	Vision, <i>Screening</i>	6

Subsequent Implementation – Benefit Revision Cycle 3

High-Value Clinical Preventive Service	As noted in the Purchaser's Guide	Combined Score (CPB) and CE, Max Score =10
Folic Acid Chemoprophylaxis	Folic Acid Supplementation, <i>Counseling and preventive medication</i>	5
Obesity Screening	Obesity, <i>Screening, counseling, and treatment</i>	5
Depression Screening	Depression, <i>Screening</i>	4
Hearing Screening	Newborn Hearing, <i>Screening</i>	4
Injury Prevention Counseling	Motor Vehicle-Related Injury Prevention, <i>Counseling</i>	4
Osteoporosis Screening	Osteoporosis, <i>Screening and treatment</i>	4
Cholesterol Screening (High-Risk)	Lipid Disorders, <i>Screening, counseling, and treatment</i>	2
Depression Screening	Depression, <i>Screening</i>	2
Diabetes Screening	Diabetes (type 2), <i>Screening</i>	2
Diet Counseling	Healthy Diet, <i>Counseling</i>	2
Tetanus and Diphtheria Booster	Immunizations (Child, Adolescent, Adult)	2

Address Demographic Needs

Rank order clinical preventive services by their ability to meet the needs of a defined population based on age and gender.

Many clinical preventive services are specifically intended for a particular group of people based on their age, gender, or other risk factor. For example, newborn hearing screening is only relevant for beneficiaries who have (or who are) infants that will need this age-dependent service. When an employer's beneficiary population is relatively homogenous (e.g., mostly male, mostly old) it may be wise to first implement the specific clinical preventive services that are most relevant for the majority population.

Method suggested for: Employers with a homogenous beneficiary population that is heavily weighted towards one gender or age group.

Employer Scenario: Employer *B* has 7,000 employees and provides health insurance for an additional 2,000 dependents, and 4,000 retirees. The beneficiary population is homogenous; the average age of a beneficiary is 53 and 73% of the beneficiary population is male. In order to best address the needs of the majority population, employer *B* decides to implement clinical preventive services recommended for normal risk males in their 40s, 50s, and 60s in the first year of the implementation program and then add benefits for clinical preventive services that address the needs of other populations over the subsequent 5 years.

In the abovementioned scenario, employer *B* would implement benefits for the following services immediately. Examples are listed in alphabetical order, but could be implemented according to health impact and economic value.

- Abdominal Aortic Aneurysm, *Screening*
- Alcohol Misuse, *Screening and counseling*
- Aspirin Therapy for the Prevention of Cardiovascular Disease, *Counseling*
- Colorectal Cancer, *Screening*
- Depression, *Screening*
- Diabetes (type 2), *Screening*
- Healthy Diet, *Counseling*
- Hypertension, *Screening, counseling, and treatment*
- Influenza, *Immunization*
- Lipid Disorders, *Screening, counseling, and treatment*
- Obesity, *Screening, counseling, and treatment*
- Pneumococcal disease, *Immunization*
- Tobacco Use Treatment, *Screening, counseling, and treatment*

Address Beneficiary Risk and Reduce Specific Healthcare Costs

Rank order clinical preventive services by their ability to address:

1. The risk profile of a population based on results from a population risk assessment such as a health risk appraisal (HRA); and/or
2. Conditions, diseases, or behaviors frequently seen in healthcare cost data.

Analyzing healthcare cost data can help employers identify the specific health problems that are afflicting their beneficiaries. Targeting these behaviors, conditions, or diseases may provide the “biggest bang for the buck” by reducing beneficiaries’ burden of disease and overall healthcare costs simultaneously.

Method suggested for: Employers who currently have a HRA (or other population risk assessment tool) in place and the ability to analyze those data to determine a beneficiary population risk profile and employers who are able to analyze their healthcare cost data and determine which preventable behaviors, conditions or disease account for a substantial proportion of medical, disability, or other health-related claims costs.

Employer Scenario 1: Employer *C* has 15,000 employees and provides health insurance for an additional 13,000 dependents. For the past three years, employer *C* has required all beneficiaries to complete an HRA. Employer *C* carefully analyzed the group data from the past year’s HRA and determined the following,

1. Beneficiaries are significantly overweight; the average BMI of a beneficiary is 30 kg/m².
2. Beneficiaries do not get an adequate amount of physical activity; the average beneficiary reports only 15 minutes of physical activity per week.
3. Beneficiaries report unhealthy diets; they consume excess amounts of total fat, saturated-fat, and cholesterol, and inadequate amounts of fruits, vegetables, and whole grains.
4. Forty-five percent (45%) of employees use tobacco products, far above the national average.
5. Thirty-seven percent (37%) of adult beneficiaries consume more than 7 alcoholic beverages per week.

Based on this data, employer *C* knows that its beneficiary population is at high risk for alcohol misuse, cancer, obesity, type 2 diabetes, heart disease, hypertension, and smoking-related illnesses. To best address the risks of its beneficiary population, employer *C* decides to immediately implement benefits for the clinical preventive services that address these behaviors and diseases, including (examples are listed in alphabetical order, but could be implemented according to health impact and economic value):

- Alcohol Misuse, *Screening and counseling*
- Breast Cancer, *Counseling and preventive medication*

- Breast Cancer, *Screening*
- Cervical Cancer, *Screening*
- Colorectal Cancer, *Screening*
- Diabetes (type 2), *Screening*
- Healthy Diet, *Counseling*
- Hypertension, *Screening, counseling, and treatment*
- Lipid Disorders, *Screening, counseling, and treatment*
- Motor Vehicle Related Injury Prevention, *Counseling*
- Obesity, *Screening, counseling, and treatment*
- Tobacco Use Treatment, *Screening, counseling, and treatment*

Employer Scenario 2: Employer *D* provides health benefits for 36,000 employees and 40,000 dependents. Over three-quarters of the employee population is female and most are relatively young. Further, employee demographic data show that 45% of beneficiaries are African-American. A large portion of employer *D*'s medical claims are for labor and delivery charges and a large proportion of employer *D*'s disability claims are paid for short- and long-term disabilities related to complications of pregnancy. Employer *D*'s beneficiaries have a higher than normal rate of preterm births and neonatal intensive care (NICU) admissions. Employer *D* knows that African-Americans are at increased risk for poor birth outcomes including preterm birth, low birth weight, and infant mortality.³ Employer *D* would like to reduce its medical claims related to pregnancy complications and reduce racial and ethnic disparities in healthcare by ensuring that all its beneficiaries have access to high-quality preconception, prenatal, and postpartum care.

To promote access, employer *D* decides to immediately implement benefits for all clinical preventive services related to pregnancy, infant care, and childhood health promotion. Further, employer *D* decides to provide “safe-harbor” coverage for preventive services in HDHP and HSA-qualified plans and to eliminate copays for preventive care in HMO, PPO, and POS plans.

Clinical preventive services aimed at promoting healthy pregnancies include:

- Alcohol Misuse, *Screening and counseling*
- Asymptomatic Bacteriuria, *Screening*
- Breastfeeding, *Counseling*
- Prenatal Diagnosis of Chromosomal Abnormalities and Neural Tube Defects (NTDs), *Screening and testing*
- Folic Acid Supplementation, *Counseling and preventive medication*
- Group B Streptococcal Disease (GBS), *Screening and preventive medication*
- Hepatitis B Virus (HBV), *Screening, immunization, and treatment*
- Human Immunodeficiency Virus (HIV), *Screening, counseling, preventive medication*
- Influenza, *Immunization*

- Preeclampsia, *Screening*
- Rh (D) incompatibility, *Screening and preventive medication*
- Rubella, *Screening*
- Syphilis, *Screening*
- Tetanus, *Immunization*
- Tobacco Use Treatment, *Screening and counseling*

Clinical preventive services specific to infants and children include:

- Child Development, *Screening*
- Child Immunizations, *Immunization*
- Dental Caries Prevention through Oral Fluoride Supplementation, *Preventive medication*
- Lead, Elevated Blood Level, *Screening*
- Newborn Screening for Genetic and Endocrine Disorders, *Screening, medical foods, and treatment*
- Newborn Hearing, *Screening*
- Vision, *Screening*

The United States spends billions on healthcare services of questionable value while basic, evidence-based preventive services are not getting done as often as they should. Yet the time available to deliver healthcare services is limited. Brief clinician office visits must address chronic conditions, acute illness, and preventive care. In this environment, prioritization of healthcare services is occurring, but it is rarely systematic or rational. And the consequences of misplaced priorities are high: people die and illnesses worsen because the most important preventive services do not get done.¹

*Partnership for Prevention
Priorities for America's Health: Capitalizing on Life-Saving, Cost-Effective
Preventive Services, 2006*

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