Executive Summary

Person-Centered Preventive Healthcare: Prioritizing Clinical Preventive Services

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Prioritizing Clinical Preventive Services

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Prepared by

RTI International
3040 E. Cornwallis Road, PO Box 12194
Research Triangle Park, NC 27709

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Report Authors

Daniel Jonas*
Laurie Hinnant
Manny Schwimmer*
Sean Riley*
Colleen Barclay
Christiane Voisin*
Alison Banger
Shivani Reddy
Leila Kahwati

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*The Ohio State University

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Background

Clinical preventive services (CPS) can help individuals live longer, healthier lives, but suboptimal delivery of CPS has been well documented. In addition, delivering every recommended CPS requires substantial time and resources. Multiple groups have developed and updated lists of high-priority CPS over the past decades. Specifically, the Agency for Healthcare Research and Quality (AHRQ) commissioned a national steering committee in 2012 to identify high-priority services for adults, which AHRQ used to develop a composite measure of CPS receipt monitored with the Medical Expenditure Panel Survey (MEPS). Since then, recommendations for new services have been released, existing recommendations may have greater importance in the context of ongoing epidemics and pandemics, and some services may have less importance because of new evidence and changes in recommendations. In 2022, AHRQ commissioned an update to a list of high-priority CPS for adults over the age of 35 as part of the larger Person-Centered Preventive Health Care (PCPHC) project for use in measuring Agency progress in this area.

Methods

To update a previously developed AHRQ list of high-priority CPS for adults aged 35 and older, we conducted an environmental scan, performed key informant interviews, and engaged a technical expert panel (TEP) in a modified Delphi process. AHRQ defined the scope of CPS included in this task as recommendations from the U.S. Preventive Services Task Force (USPSTF) or Center for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) because these correspond to services AHRQ monitors with the MEPS. We presented our initial task approach to the PCPHC project's 30-member Stakeholder Panel that included representatives of AHRQ's Primary Care Learning Community, health system leadership, nonprofit organizations working in the health or public health space, clinicians and researchers working in primary care or preventive services, state policymakers, payors, and other federal agencies. This Stakeholder Panel also provided feedback on the findings of this task and suggestions for disseminating results.

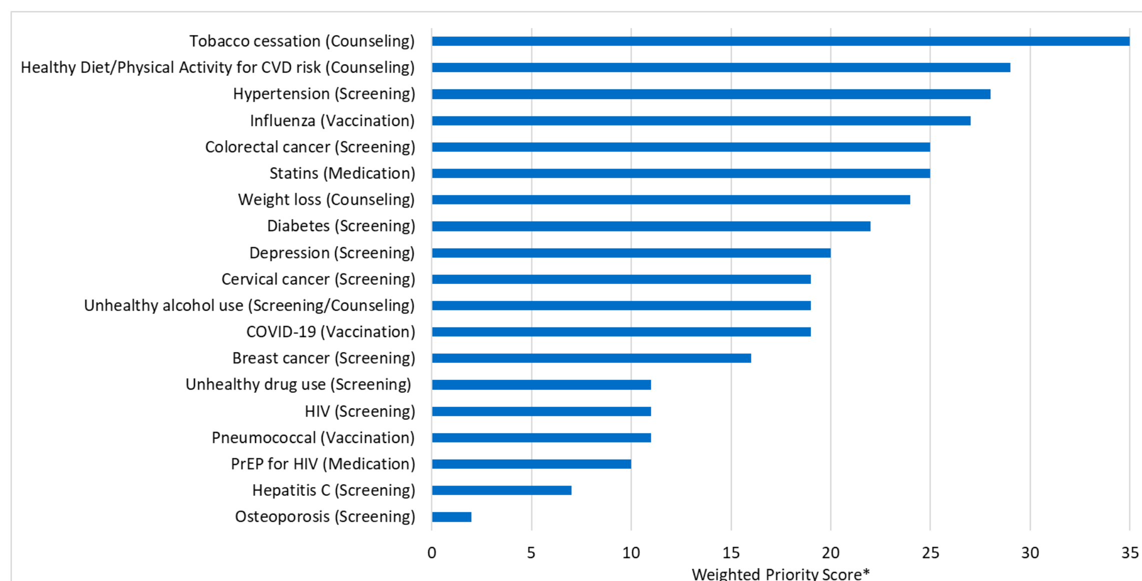
We conducted four key informant interviews to refine our approach to the environmental scan and to inform our discussions with the TEP. Our scan searches focused on information generated in the United States, prioritizing systematic reviews and documents generated by or for the USPSTF and ACIP, supplemented with targeted searches. For a CPS to be eligible, we required a grade A or B recommendation from the USPSTF or a recommendation from ACIP focused on the general adult population. The scan summarized information on appropriateness, importance (including prevalence, morbidity, and mortality of the relevant health condition), preventable burden of disease, receipt in current clinical practice, disparities, and availability of workforce or supplies to deliver the service. We recruited 10 experts and 2 patient representatives to participate in two virtual meetings, with some asynchronous work before the first meeting and between meetings. Prior to the first meeting, we provided TEP members with

results of the environmental scan. We then conducted a modified Delphi process to prioritize candidate CPS, providing them with data from the scan on mortality, preventable burden, and current rate of receipt for each CPS. However, we did not limit the TEP from using other criteria to prioritize services. As part of the TEP meetings, we also facilitated discussions about the uses of and concerns with a prioritized CPS list, challenges with the prioritization process, and future research needs related to prioritizing CPS. We generated tabular and graphical summaries of the prioritized CPS and identified themes from TEP and Stakeholder Panel discussions and feedback.

Results

The modified Delphi process resulted in a prioritized list of 19 CPS (Figure ES-1) from a candidate list of 25 services. The services considered by the TEP in early rounds of the modified Delphi process, but not prioritized high enough to make the final list of candidates for prioritization, included lung cancer screening, shingles vaccination, tetanus vaccination, fall prevention interventions, preventive medications to reduce risk of breast cancer, and BRCA-related risk assessment, counseling, and testing. Services that were new to the high-priority list included counseling on healthy diet and physical activity for cardiovascular disease (CVD) prevention for adults with CVD risk factors, COVID-19 vaccination, statins for CVD prevention, screening for prediabetes and diabetes, screening and counseling for unhealthy drug use, preexposure prophylaxis for HIV, and screening for hepatitis C.

Figure ES-1. Prioritized List of Clinical Preventive Services Sorted from Highest to Lowest Priority



*Weighted Priority Scores were calculated as follows: 3 points for each TEP member ranking the service in the top tier (i.e., top 5); 2 points for each TEP member ranking the service in the second tier (6 to 10); 1 point for each TEP member ranking the service in the third tier (11 to 15); and 0 points for each TEP member ranking the service in the bottom tier (position 16 or higher). The maximum score that a CPS could obtain was 36 and the minimum score possible was 0.

Abbreviations: CVD, cardiovascular disease; HIV, human immunodeficiency virus; PrEP, pre-exposure prophylaxis

Challenges during the process of prioritizing services. These included the lack of data on cost and cost-effectiveness, rankings vary by perspective (i.e., population health vs. individual patient), uncertainty about the use for the priority list, variation in the importance of services across different individuals and communities, and balancing the importance of the underlying target condition versus the feasibility of providing the service in primary care or the community.

Potential uses of a list of high-priority CPS beyond AHRQ's intended use. These included informing quality improvement efforts and future research needs, measuring accountability within healthcare financing models, monitoring progress on national health objectives and health equity, informing public health campaigns, clinician education and training, and health policy.

Concerns about how a list of high-priority CPS would be used beyond AHRQ's intended use. These included the risk of focusing provider and system attention on the list of CPS to the detriment of more pressing priorities of individuals and communities. This overfocus might also divert resources away from other critical areas within healthcare. TEP members also expressed concerns that using the list as an "all or none" composite measure may not be scientifically sound, would put further demands on primary care, does not consider inequities in resources available to deliver the CPS in different communities, and that the list requires regular updating to remain relevant.

Our findings have several limitations. The scope of services prioritized was limited. We provided data for only three criteria that TEP members could use for prioritization and did not provide additional guidance to TEP members for how to consider these data in their prioritization nor did we limit TEP members from using other data or criteria (e.g., feasibility, availability, perceived effectiveness or cost-effectiveness).

Future research opportunities were identified. These included exploring various ways to prioritize services, assessing public values related to CPS, and research related to inequities in preventable burden and CPS receipt, implementation of person-centered workflows, and sustainable business models and coverage for CPS, particularly ones requiring long-term behavioral interventions.

Conclusions

We convened a technical expert panel to prioritize clinical preventive services. The panel identified 19 services as high priority and conditions defined by health behaviors comprised more than a quarter of the services. The panel highlighted potential uses for the list, beyond AHRQ's intended use, challenges with the process of prioritizing services, and concerns related to the use of a high-priority list. This included that some use cases for the list do not reflect a person-centered approach to healthcare. We recommend future efforts prioritizing CPS consider early patient, clinician, and other stakeholder involvement in defining the use cases for prioritization, identifying the most salient prioritization criteria, and being receptive to alternative approaches.

Key Finding

Person-centered care is increasingly valued yet setting population-level priorities for preventive services may complicate the ability to tailor care to individual needs and preferences.

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