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# Priorities Among Effective Clinical Preventive Services

## A Commentary

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In this issue, Maciosek et al.<sup>1-5</sup> provide fascinating insights on the most valuable clinical preventive services. I had the privilege of chairing the National Commission on Prevention Priorities, which guided the approach used to rank these services. Our intent was to identify preventive services that produce the greatest population health benefit and cost effectiveness in order to help inform decision makers at multiple levels about which preventive services are most valuable. We make no claim that the ranking should prescribe decisions, only inform them. We offer tools and a synthesis of the evidence currently available. The next step is yours: Use what is offered here to make decisions about which preventive services to tackle first.

The authors identify which of the highest-value clinical preventive services have the lowest utilization rates nationally, including tobacco-use screening and brief intervention, colorectal cancer screening, pneumococcal immunization, and Chlamydia screening. For these interventions in particular, healthcare leaders, employers, policymakers, and researchers should closely monitor utilization trends, identify the specific barriers that are impeding greater utilization, and direct resources to overcoming these impediments.

Of course you should consider the profile of your population or individual patients when applying these rankings. Unfortunately, we currently lack sufficient quantitative data on subpopulations to develop separate rankings by gender, age, race/ethnicity, or socioeconomic status, and thus cannot tell you if priorities should be different for these groups. For a variety of reasons, some services may be more or less effective in a subpopulation compared to the general population. In many cases, incidence of disease or prevalence of risk factors is substantially different for a subpopulation compared to the general population of the United States on which the ranking is based. These differences may not change the relative priority of services for subpopulations,

but should be carefully considered. One of the two goals of *Healthy People 2010*<sup>6</sup>—the comprehensive set of health objectives for the nation—is to eliminate health disparities among different segments of the population.

To help you determine priorities for subpopulations, we are providing an online resource to accompany the ranking (go to [www.prevent.org](http://www.prevent.org)). Click on each service in the ranking and find data tables with mortality rates, incidence rates, and risk factor prevalence by subpopulation when those data are available. These data tables will also help you identify where there are differences in the utilization of preventive services among subpopulations and the U.S. population, which is important in pinpointing high-priority missed opportunities for improving health. Using as their starting point utilization rates among the U.S. population, Maciosek et al.<sup>1-5</sup> draw attention to the highest-ranking preventive services for which the most disease and death could be prevented if utilization were increased to 90% above current levels. If the starting point had been utilization among Hispanics or among African-American men rather than among the general U.S. population, a different set of services might demand attention.

The National Commission on Prevention Priorities plans to revise the ranking of clinical preventive services periodically, updating the estimates when new evidence becomes available and expanding the list to include new recommendations. We will use this list as a report card, drawing the nation's attention to the highest value services where gaps in utilization are resulting in the most unnecessary disease, disability, and death.

So much is lost because too many people are uninsured and lack access to primary care or receive primary care of poor quality. The data underlying our ranking of services quantifies that loss. For example, nearly 2 million quality-adjusted life years would be saved if utilization rates were improved for just three services: tobacco-use screening and brief intervention, colorectal cancer screening, and influenza immunization. I hope we can all reach agreement that these and other high-value preventive services are worth the upfront costs to save lives, increase national productivity, and start to get a handle on downstream healthcare costs.

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Evidence-based guidance for improving the delivery of some clinical preventive services, including immunizations and cancer screening, may be found in the *Guide to Community Preventive Services*,<sup>7</sup> an effort sponsored by the Centers for Disease Control and Prevention and led by the independent Task Force on Community Preventive Services. These evidence-based recommendations need to be expanded and the Task Force should use our ranking to guide the topics that they tackle next. Translating evidence-based recommendations into very specific “how to” guidance should be part of the process.

Regardless of how you interpret and use the ranking, it should help you choose a small, focused set of services within the broader preventive services agenda for initial improvement efforts. We encourage you to consider evidence-driven approaches such as the one used here to set priorities wisely and then target attention and resources where they can do the greatest good for your population or for your patients.

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