



## Beyond Betty Crocker

Prevention is a good thing, right? Benefits managers should design their plans so that preventive services are covered, right? After all, the law allows preventive services to escape the sting of substantial personal cost in High Deductible Health Plans, right? Well, yes, maybe, sort of. Just because a medical service is preventive by definition, by its nature or by its objective, does that mean benefits managers don't have to apply the filter of efficacy before extending the subsidy of plan coverage to those services? And if a diligent benefits manager wants to apply that filter, how can he or she do that?

One sound technique to bringing confidence to the choice of plan covered preventive services and exclusions is to rely on the growing body of peer reviewed and methodologically sound medical studies. In other words, rely on the results of evidence based medicine. Yes, there may still be the occasional octogenarian physician who rails against autonomy-destroying, hence ego deflating "cookbook medicine". And the results of medical research studies properly designed and executed may butt up against the "common knowledge" of some vocal employees. Nevertheless, the way out of the morass of vague and various definitions of "medically appropriate" is to look for that "cookbook" and find the right recipe for preventive services.

So, is there a cookbook for preventive services? Happily, the answer is "Yes". It's called The Guide to Clinical Preventive Services: Recommendations of the U.S. Preventive Services Task Force. The Task Force operates under the auspices of the federal Agency for Healthcare Research and Quality and includes 32 members and hundreds of research associates, all largely medical professionals from universities and medical centers. Since its inception 21 years ago, the mission of the Task Force has been to "evaluate the benefits of primary and secondary preventive services in apparently healthy persons based on age, sex, and risk factors for disease".

The Task Force employs rigorous analytic methodologies that govern its systematic review of the research on scores of preventive services. This analysis ultimately includes identification of benefits and harms associated with each service and a determination of the net balance of those harms and benefits. These assessments are then converted to a brief series of ratings:

Rating	Meaning of the Rating
A	Strongly recommend that clinicians provide this service. There is good evidence that the service improves health outcomes.
B	Recommend that clinicians provide this service. There is at least fair evidence that the service improves health outcomes.
C	No recommendation for or against providing the service. The balance of harms

	and benefits is too close to justify a recommendation.
D	Recommend against providing the service. There is fair evidence that the service is either ineffective or that the harms outweigh the benefits.
I	The evidence is insufficient to support a recommendation. The body of evidence is too little, or of poor research quality or conflicting.

Many familiar preventive services received an “A” rating from the Task Force. However, not all did. Following is a summary of Task Force ratings and comments for several well known preventive services that did not receive an “A”:

<b>Preventive Service</b>	<b>Rating</b>	<b>Summary Comments</b>
Mammography, with or without Clinical Breast Examination, every 1-2 years for women age 40 and older	B	The precise age at which the benefits of mammography screening justify the harms is a subjective judgment.
Performance of Clinical Breast Examination without mammography	I	Performance of Clinical Breast Examinations alone is likely to increase the incidence of biopsies.
Lung cancer screening	I	The benefit of screening has not been established for any group, including older smokers.
Prostate cancer screening	I	The balance of benefits and harms of early detection screening is uncertain. Therefore, the net benefit of screening is unknown.
Coronary Heart Disease (CHD) screening	D	The factors that lead to CHD are well known, allowing the probability of contracting CHD to be calculated in other ways that create no risk of harms.
Hepatitis B virus screening of people without symptoms	D	There is a paucity of good quality evidence on the effectiveness of this screening.

The Task Force’s Guide to Clinical Preventive Services is in the hands of over 400,000 clinicians across the county. *In Focus* readers can access The Guide for themselves at:<http://www.ahrq.gov/clinic/pocketgd07/pocketgd07.pdf>.

### **Did You Know?**

“We can, perhaps, alter the proximate cause of death – the diagnosis on the death certificate – but I am aware of no data to support the premise that we can alter the date of death.” Nortin M. Hadler, M.D. in *The Last Well Person*.