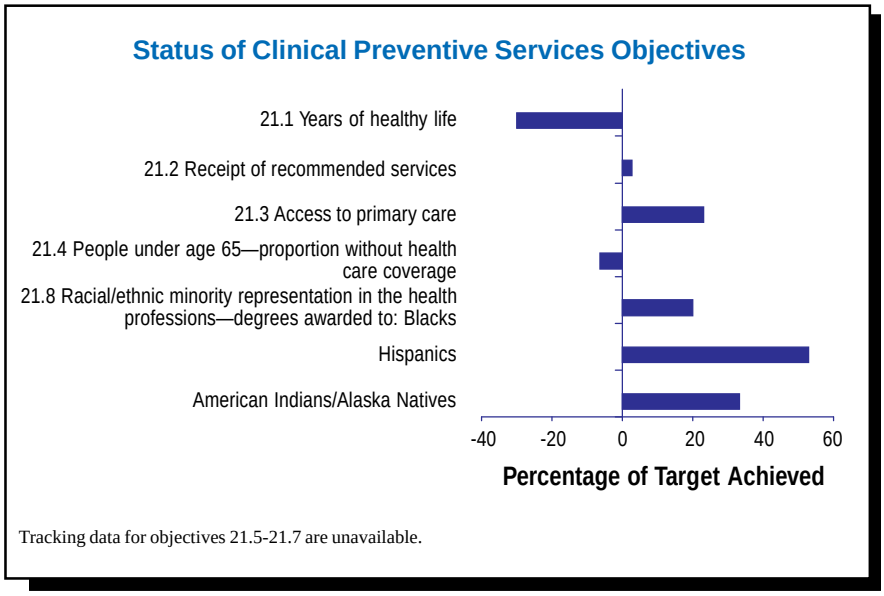
21 Clinical Preventive Services



Lead Agencies: ***Health Resources and Services Administration***
Centers for Disease Control and Prevention

CLINICAL PREVENTIVE SERVICES

Since the U.S. Preventive Services Task Force (USPSTF) was convened in 1984, national attention has been focused increasingly on the importance and effectiveness of preventive services in clinical settings in improving the Nation's health. Evidence continues to mount that immunizations, screening tests for early detection of disease, chemoprophylaxis, and patient education and counseling to improve health-related behaviors can reduce the incidence of the leading causes of disease and disability in the United States. In addition to being clinically effective and having a positive impact on quality of life, preventive health care has a strong probability of being cost-effective. Enhancing the provision and delivery of clinical preventive services (CPS) is critical to achieving the goals of HEALTHY PEOPLE 2000.

The *Guide to Clinical Preventive Services* (the *Guide*), with comprehensive recommendations for the provision of CPS based on the evaluation of 169 preventive interventions, was released in 1989. In 1990 the USPSTF reconvened to continue its scientific assessment of preventive interventions, the reexamination of established preventive interventions for which new clinical evidence/outcomes measures become available, the evaluation of the efficacy and effectiveness of less-researched preventive services, and the preparation of a new guide.

The *Guide* and implementation strategies that followed address this fact: many primary care providers do not deliver important CPS—such as immunizations, pneumococcal vaccine for elderly people, clinical breast examination, and counseling on high-risk behaviors—at the recommended intervals. Studies indicate provider uncertainty about services and intervals, skepticism about the efficacy of some CPS, disagreement on methodology, lack of reimbursement, and outdated or missing clinical information on the effectiveness of CPS. Since 1990, new empirical data, along with information provided by the *Guide*, have led the Public Health Service (PHS), numerous national-level provider organizations, and a growing number of health-related associations to endorse the routine inclusion of CPS in periodic health examinations and the reimbursement for preventive services as part of a basic package of insurance benefits. Since 1993, payment to providers for the provision of preventive services has increased as Federal agencies have collaborated to update and assign processing codes to preventive services—a prerequisite to filing reimbursement claims with private and public insurers.

In August 1994 the PHS announced the national campaign Put Prevention Into Practice (PPIP), a Federal strategy developed to promote the delivery of CPS by primary care providers and to achieve the goals of HEALTHY PEOPLE 2000. A partnership between the public and private sectors, PPIP is a research-based approach featuring a kit with implementation and educational materials. The dissemination of PPIP in clinical and health professions training settings has been increasing, and the initiative is being adopted for use by a growing number of national-level managed care plans.

The *Guide*, PPIP, and the National Coordinating Committee on Clinical Preventive Services together support the implementation of strategies to achieve the CPS objectives in HEALTHY PEOPLE 2000. With States, communities, primary care providers, and payor organizations, the PHS is working to encourage a shift to preventive health care.

Review of Progress

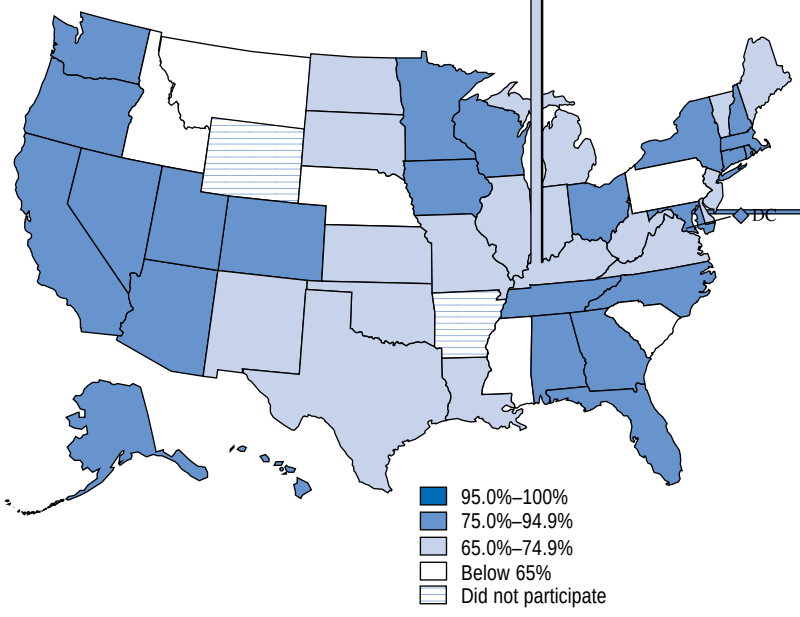
The Clinical Preventive Services priority area contains eight objectives. For those objectives for which progress can be measured, results have been mixed. For example, for the objective on the years of healthy life, data indicate movement away from the targets for the total population and for blacks. People having a routine source of care increased from the 1991 baseline. The 1990–91 data for the three minority groups (Hispanics, blacks, and American Indians/Alaska Natives) show improvements in representation of these groups in health professions degrees.

Baseline data for all objectives have been established, and followup data sources are available for all objectives except 21.5. The co-lead agencies, Health Resources and Services Administration (HRSA) and Centers for Disease Control and Prevention (CDC), continue to work with the National Center for Health Statistics to address data issues. Improved data comparability and better data for special population groups are needed to assess progress in CPS. A key focus of HRSA and CDC's efforts has been to expand national-level surveys and to identify other data sources that could be modified or used to track progress on the CPS objectives. Since 1993, more data have been provided by expansion of the National Health Interview Survey.

1995 Revisions

For the Midcourse Review special population targets were added to objectives 21.3 and 21.4. Objective 21.2 was expanded to show the receipt of a range of individual rather than aggregated clinical preventive services received by population groups. To better target strategies, special population targets were organized by the individual clinical preventive

Objective 21.3: ***Increase to 95 percent the proportion of people who have a specified source of primary care for coordination of their preventive and episodic health care***



Source: CDC, BRFSS, 1992

services as well as by age, gender, and special population groups (when there was at least a 10 percent disparity with the total population). A new subobjective was added to 21.8 to track the entry of underrepresented racial and ethnic minority groups into U.S. schools of nursing.