MedStar Health
Ambulatory Best Practice Group
Recommended Screening Guidelines for Adults 2023

"These guidelines are provided to assist physicians and other clinicians in making decisions regarding the care of their patients. They are not a substitute for individual judgment brought to each clinical situation by the patient's primary care provider in collaboration with the patient. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication but should be used with the clear understanding that continued research may result in new knowledge and recommendations".

This document is a summary of recommendations for the appropriate screening of adult patients by primary care practitioners in the MedStar Health system. In each of the sections the recommendations are alphabetized. Note that the provision of preventive services may occur in a periodic health maintenance visit devoted to screening, counseling and prevention or be incorporated into follow up or urgent visits based on patient and clinician preferences and office workflows.

Adult Populations

Preventive Service	Guideline
Personalized Recommendations per USPSTF	▪ To offer any patient, for age, gender, and risk factor-based recommendations and level of evidence, see **Electronic Preventive Services Selector;** ▪ *The **grade-definitions** used for this guideline are as defined by the United States Preventive Services Task Force (USPSTF).*
Abdominal Aortic Aneurysm[1, 66, 86-87]	**USPSTF[1]** ▪ For men aged 65-75 who have ever smoked: One-time screening for abdominal aortic aneurysm by ultrasonography **[B]** ▪ For men aged 65-75 who have never smoked: Selectively offer screening for abdominal aortic aneurysm by ultrasonography based on patient's medical history, family history, other risk factors and personal values. **[C]** ▪ For women aged 65-75 who have ever smoked or have a family history of AAA: evidence for screening for AAA is insufficient **[I]** ▪ For women aged 65-75 who have never smoked and have no family history of AAA: Do not screen for AAA **[D]** **Net benefit estimates are driven by biologic sex (i.e., male/female) rather than gender identity.* **Definition: "ever smoker" as someone who has smoked at least 100 or more cigarettes in their lifetime.* **ACC/AHA** Aortic Disease Screening recommends: ▪ Ultrasound screening for AAA is recommended in men ≥65 years who have ever smoked and in men or women ≥65 years with a first-degree relative with AAA. Ultrasound screening is reasonable in women ≥65 years who have ever smoked.[66] **The Society of Vascular Surgery** (SVS) recommends: ▪ screening men and women ages 65 to 75 years with either a history of smoking or a family history of AAA, as well as men and women over the age of 75 with a smoking history in otherwise good health who have not previously undergone screening. [66,86,87]
Anal Cancer Screening [79-81]	**USPSTF:** ▪ An update for this topic is in progress; Currently, no national screening guidelines for anal cancer. **American Cancer Society (ACS):** ▪ Some people at increased risk for anal intraepithelial neoplasia1 (AIN) and anal cancer might benefit from screening. This

Preventive Service	Guideline
	includes people living with HIV, men who have sex with men (regardless of HIV status), women with history of cervical, vaginal, or vulvar intraepithelial neoplasia/cancer, iatrogenic immunosuppression (such as people who have received an organ transplant or are on long-term steroids). Some experts recommend screening anyone with a history of anogenital warts and women with history of cervical HPV 16 infection. Screen with anal cytology testing (anal Pap test) [82-84] if access to appropriate referral for follow-up, including high-resolution anoscopy, is available. ▪ There is no consensus on the optimal time to initiate screening. Recommendation to defer screening in persons living with HIV and those with other forms of immune suppression until after 25 years of age and defer screening at-risk immunocompetent individuals until after 40 years of age.[80, 81] ▪ Screening intervals: annually in at-risk people who are HIV-positive, and in at-risk individuals without HIV every two to three years [80, 81] ▪ Inquire as to whether at-risk patients have received the HPV vaccine. [90]
Aspirin chemoprevention [2-6]	**USPSTF** recommends: ▪ decision to initiate low-dose aspirin use for the primary prevention of CVD in adults aged 40 to 59 years who have a 10% or greater 10-year CVD risk should be an individual one. **[C]** • Evidence indicates that the net benefit of aspirin use in this group is small. Persons who are not at increased risk for bleeding and are willing to take low-dose aspirin daily are more likely to benefit. Annual bleeding events in individuals without risk factors for increased bleeding (e.g., history of gastrointestinal bleeding risk, history of peptic ulcer disease, or use of nonsteroidal anti-inflammatory drugs or corticosteroids) are rare, but risk for bleeding increases modestly with advancing age. For persons who have initiated aspirin use, the net benefits continue to accrue over time in the absence of a bleeding event however become progressively smaller with advancing age because of an increased risk for bleeding, with data suggesting that it may be reasonable to consider stopping aspirin use around age 75 years. ▪ USPSTF recommends against initiating low-dose aspirin use for the primary prevention of CVD in adults ≥60years. **[D]** ▪ USPSTF concluded that the evidence is inadequate that low-dose aspirin use reduces CRC incidence or mortality. **ACC/AHA** recommend: ▪ Low-dose aspirin use (75 to 100mg/d) might be considered for the primary prevention of ASCVD among select adults 40 to 70 years of age who are at higher ASCVD risk but not at increased bleeding risk. [67,68,71] ▪ Low-dose aspirin use is not recommended on a routine basis for primary prevention of CVD in adults older than 70 years or among adults of any age who are at increased risk of bleeding. **Women's Health:** ▪ USPSTF & ACOG recommend: Prophylactic low-dose aspirin after 12 weeks of gestation in persons who are at high risk for preeclampsia and should be considered in those at moderate risk **[B]**. [67,68]
Asymptomatic Bacteriuria in Adults [88]	**USPSTF:** ▪ Screen pregnant persons for asymptomatic bacteriuria using a midstream, clean-catch urine culture at the first prenatal visit or at 12 to 16 weeks of gestation, whichever is earlier. A urine culture showing >100,000 CFU/mL of a single uropathogen or >10,000 CFU/mL if the pathogen is group B streptococcus indicates treatment. **[B]**

© Copyright MedStar Health, 2014

Preventive Service	Guideline
Blood Pressure [7-8]	**USPSTF** recommends: ▪ Screening for hypertension in adults 18 years or older without known hypertension with office blood pressure measurement (OBPM). They recommend obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation with validated and accurate home blood pressure monitoring (HBPM) or Ambulatory blood pressure monitoring (ABPM) before starting treatment. **[A]** ▪ The USPSTF suggests annual screening for hypertension in adults 40 years or older and for adults at increased risk for hypertension (such as Black persons, persons with high-normal blood pressure, or persons who are overweight or obese). Screening less frequently (i.e., every 3 to 5 years) is appropriate for adults aged 18 to 39 years not at increased risk for hypertension and with a prior normal blood pressure reading. **ACC/AHA** guideline recommends: ▪ Annual screening for HTN in all normotensive patients (BP < 120/80) with more frequent monitoring and management for patients with higher blood pressure readings. They also suggest screening for masked hypertension with ABPM or HBPM in adults who consistently have systolic blood pressure measurements of 120 to 129 mm Hg or diastolic blood pressure measurements of 75 to 79 mm Hg in the office[7,28] and screening for white coat hypertension in adults who consistently have systolic blood pressure measurements of 130 to 160 mm Hg or diastolic measurements of 80 to 100 mm Hg in the office.
Breast Cancer Screening in average risk women and transgender men who have not undergone "top" surgery: Breast self-exam Clinical Breast exam Mammography [9-13]	Average risk: For screening purposes, a woman is considered to be at average risk if she doesn't have a personal history of breast cancer, a strong family history of breast cancer, or a genetic mutation known to increase risk of breast cancer (such as in a *BRCA* gene) and has not had chest radiation therapy before the age of 30. **USPSTF:** ▪ **Breast self-exam (BSE) [10-13]:** Breast self-examination is not recommended in average-risk women because there is a risk of harm from false-positive test results and a lack of evidence of benefit. **[D]**; Average-risk women should be counseled about breast self-awareness. The importance of promptly reporting changes, such as pain, a mass, new onset of nipple discharge, or redness in their breasts to a physician is emphasized.[73] ▪ **Clinical Breast Exam:** The USPSTF and the ACS do not routinely recommend Clinical Breast Exam (CBE) in average risk women at any age without breast symptoms or abnormalities, based on insufficient evidence. **[I]** ▪ **Mammography:** • **For women in their 40's**, the decision to perform mammography and the frequency of mammograms should be individualized. Women who place a higher value on the potential benefit that the potential harms may choose to begin biennial screening between the ages of 40 and 49 years. While screening in this age group may reduce the risk for breast cancer death, the number of deaths averted is smaller than that in older women and the number of false-positive results and unnecessary biopsies is larger. The balance of benefits and harms is likely to improve as women move from their early to

© Copyright MedStar Health, 2014

Preventive Service	Guideline
	late 40s. Additionally, screening at a younger age and screening more frequently may increase the risk for overdiagnosis and subsequent overtreatment. Women with a parent, sibling, or child with breast cancer are at higher risk for breast cancer. Epidemiologic data suggests that having a first degree relative with breast cancer doubles the risk of breast cancer for women in their 40's. This information may be helpful in counseling patients in their 40's about when to initiate breast cancer screening. **[C];** Decision aids can be helpful when discussing the patient's risk of developing breast cancer, the potential benefits and harms of screening, and the patient's preferences and values. • **For women ages 50-74**, mammograms should be performed biennially. **[B]** • **For women > 75** years of age, the decision to continue screening should be individualized. Screening should be discontinued for women with a life expectancy <10 years. **[I]** • USPSTF concludes that the current evidence is insufficient to recommend digital breast tomosynthesis (DBT) as a primary screening method for breast cancer [I]; also states insufficient evidence to recommend adjunctive screening for breast cancer using breast ultrasonography, magnetic resonance imaging, DBT, or other methods in women identified to have dense breasts on an otherwise negative screening mammogram. **[I]**
Breast Cancer: Risk assessment and Risk Reduction [14-15]	**Risk assessment:** ▪ USPSTF recommends women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with BRCA 1 / 2 gene mutations should be assessed with an appropriate brief familial risk assessment tool. Those with a positive result should receive genetic counseling, and if indicated, genetic testing. **[B]** Suitable screening tools include the Ontario Family History Assessment Tool, Manchester Scoring System, Referral Screening Tool, Pedigree Assessment Tool, 7-Question Family History Screening Tool, Tyrer-Cuzick tool and brief versions of BRCAPRO. **Risk Reduction:** ▪ USPSTF: Clinicians should offer to prescribe risk reducing medications such as tamoxifen, raloxifene or aromatase inhibitors to women aged 35years or older at increased risk for breast cancer (women with LCIS, atypical ductal or lobular hyperplasia and 5yr risk > 3% calculated by NCI Breast Cancer Risk Assessment Tool) and at low risk for adverse medication effects. Use of raloxifene and aromatase inhibitors is indicated only in postmenopausal women; only tamoxifen is indicated for risk-reduction of primary breast cancer in premenopausal women. **[B]** ▪ USPSTF: **Let's Talk about it_ Discussion Guide Medicines that help prevent breast cancer**
Cervical Cancer Screening & Prevention in average and high-risk women and transgender men who have a cervix[17-18]	**USPSTF:** ▪ Screening for Cervical cancer • should begin at age 21 years (regardless of sexual history or HPV vaccination history*). Screening before age 21 should be avoided because women less than 21 years old are at very low risk of cancer.* **[D]** *Screening these women may lead to unnecessary and harmful evaluation and treatment* (ACOG 2009). • Women from ages 21 to 29 should be screened every three years, using either the standard Pap or liquid-based cytology. HPV co-testing (cytology + HPV test administered together) should **not be** used for women aged <30 years**[A]** • Women ages 30-65 may be screened once every three years with either the standard Pap or liquid-based cytology OR every 5 years with HPV testing alone or every 5 years with co-testing (cytology + HPV test administered together) **[A]** • The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate

Initial Approval Date and Reviews:	**Most Recent Revision and Approval Date:**	**Next Scheduled Review Date:**
By 2010, 01/12, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 3/20 (interim update), 1/21, 3/21 (interim update), 6/21 (interim update), 1/22, 1/23 Ambulatory Best Practice Committee	**January 2023** © Copyright MedStar Health, 2014	January 2024 Ambulatory Best Practice Committee

Preventive Service	Guideline
	prior screening and are not otherwise at high risk for cervical cancer. **[D]** ▪ USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer. As part of the clinical evaluation clinicians should confirm through review of surgical records or direct examination that the cervix was removed. ▪ Adequate prior screening is defined as 3 consecutive negative cytology results or 2 consecutive negative co-testing results within 10 years before stopping screening, with the most recent test occurring within 5 years. ▪ Routine screening should continue for at least 20 years after spontaneous regression or appropriate management of a precancerous lesion, even if this extends screening past age 65 years. Once screening has stopped, it should not resume in women older than 65 years, even if they report having a new sexual partner. ▪ Women with HIV, post solid organ or hematopoietic stem cell transplants, with SLE, with Rheumatoid Arthritis or Inflammatory Bowel Disease on immunosuppressants, who were exposed to diethylstilbestrol (DES) in utero, or who have been treated for cervical intraepithelial neoplasia (CIN)2, CIN 3 or cervical cancer are not average risk and should be screened more frequently. ▪ Screening for **Cervical abnormalities in HIV** [78, 79] ▪ Additional recommendations for Cervical Cancer prevention: Centers for Disease Control and Prevention's Advisory Council on Immunization Practice recommends routine HPV vaccination. (See Immunization Section). ▪ The USPSTF found insufficient evidence to assess the balance of benefits and harms of performing screening pelvic examinations in asymptomatic women for the early detection and treatment of a range of gynecologic conditions.
Chlamydia & Gonorrhea Infection[19]	**USPSTF recommends screening in:** ▪ Sexually active women aged 24 years and younger and other asymptomatic women at increased risk for infection (those who have a new or multiple sex partners or a sex partner who has an STI) including pregnant persons **[B]** ▪ Insufficient evidence to assess balance or benefits and harms of screening for gonorrhea & chlamydia in men. [I] ▪ For additional information, see section: STI Screening in Special Population
Cholesterol Screening[21-23, 75, 91]	▪ The age at which screening should begin should be based on an individual's other cardiac risk factors and desire to be screened. Screening may begin in non-pregnant adults at any age but no later than age 40 (the age at which statin therapy for primary prevention is recommended). The development of diabetes or clinical ASCVD should prompt evaluation as well. ▪ 10-year risk should be re-evaluated every 4-6 years between the ages of 40 and 75. ▪ For adults 20 to 39 years of age, ACC/AHA believes that it is reasonable to assess traditional ASCVD risk factors at least every 4 to 6 years. ▪ For adults 20 to 39 years of age and for those 40 to 59 years of age who have <7.5% 10-year ASCVD risk estimating lifetime or 30- year ASCVD risk may be considered. ▪ Screening may be done with either a fasting lipid profile or non-fasting total cholesterol and HDL measurement. If a non-fasting measurement reveals a triglyceride value >400, a fasting lipid profile should be measured.

Preventive Service	Guideline
Cholesterol: Statin use for Primary Prevention of CVD in Adults: Preventive Medication [20, 21, 75]	**USPSTF recommends:** ▪ statin be prescribed for primary prevention of CVD for adults aged 40-75 years who have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk if a CV event of 10% or greater. **[B]** ▪ For statins to be selectively offered if estimated 10-year risk of a cardiovascular event of 7.5 to less than 10%. **[C]** ▪ Current evidence being insufficient to assess the balance of benefits and harms of initiating a statin for the primary prevention of CVD events and mortality in adults 76 years or older. **[I]** ▪ These recommendations do not apply to adults with a low-density lipoprotein cholesterol (LDL-C) level greater than 190 mg/dL (4.92 mmol/L) or known familial hypercholesterolemia. **ACC/AHA guidelines:** ▪ define cardiovascular risk categories as high (10-year risk of cardiovascular events ≥20%), intermediate (10-year risk of cardiovascular events ≥7.5% to <20%), and borderline (10-year risk of cardiovascular events 5% to <7.5%). The guidelines recommend initiation of statin therapy in persons at intermediate or high risk and a risk discussion for persons at borderline risk, and recommend consideration of risk enhancers to refine risk assessments based on the Pooled Cohort Equations and inform decision-making for persons at intermediate and borderline risk.[75] The risk enhancers include family history of early coronary heart disease, presence of chronic kidney disease, metabolic syndrome, preeclampsia, premature menopause, inflammatory diseases, HIV, and South Asian ancestry. ▪ **ACC/AHA Risk Calculator**
Cognitive Impairment in older adults[23]	USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for cognitive impairment in older adults. **[I]**
Colorectal Cancer Screening[25-27]	**USPSTF and the American Cancer Society recommend:** ▪ Beginning at age 45, both men and women at *average risk* for developing colorectal cancer should be offered one of the screening tests below. **[A, B].** The tests that are designed to find both early cancer and polyps are preferred if these tests are available, and the patient is willing to undergo one of these more invasive tests. **Tests that find polyps and cancer** (**Direct Visualization Tests):** • Colonoscopy every 10 years • Flexible sigmoidoscopy every 5 years* • CT colonography (virtual colonoscopy) every 5 years* (consider community availability) • Combination Flex sig every 10 yrs. with annual FIT testing* **Tests that mainly find cancer** (Stool-based Tests) * • High sensitivity gFOBT every year, **, *** • Fecal immunochemical test (FIT) every year *** • FIT- DNA test (sDNA-FIT), q 1 to 3 years

Initial Approval Date and Reviews:	**Most Recent Revision and Approval Date:**	**Next Scheduled Review Date:**
By 2010, 01/12, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 3/20 (interim update), 1/21, 3/21 (interim update), 6/21 (interim update), 1/22, 1/23 Ambulatory Best Practice Committee	**January 2023** © Copyright MedStar Health, 2014	January 2024 Ambulatory Best Practice Committee

Preventive Service	Guideline
	*Colonoscopy should be done if test results are positive. **If high sensitivity gFOBT is used as a screening test, the take-home multiple sample method should be used. Requires dietary restrictions, High sensitivity versions (e.g., Hemoccult SENSA) have superior test performance characteristics than older tests (e.g., Hemoccult II) ***A high sensitivity gFOBT or FIT done during a digital rectal exam in the doctor's office is not adequate for screening. ▪ The USPSTF recommends against screening in adults older than age 85; they recommend that decisions between ages 75-85 should be individualized based on prior screening and overall health risks **[C].** ▪ Screening should be considered earlier and/or more often for individuals with any of the following colorectal cancer risk factors: personal Hx of colorectal cancer, a personal history of chronic inflammatory bowel disease (Crohn's disease or ulcerative colitis), a strong family history of colorectal cancer or polyps (cancer or polyps in a first-degree relative [parent, sibling, or child] younger than 60 or in 2 or more first-degree relatives of any age), a known family history of hereditary colorectal cancer syndromes such as familial adenomatous polyposis (FAP) or Lynch syndrome. ▪ Patients for whom there is concern for a hereditary or genetic colorectal cancer syndrome may be referred for genetic counseling and possible testing if available.
Counseling [29-38, 92,93]	**Family history collection is important in primary care to identify and manage individuals at increased risk for various diseases.** The history should be as detailed as possible and include: ▪ Current ages or ages at death for relatives ▪ Occurrences of chronic diseases, such as cancer and heart disease (type, age at diagnosis) ▪ Information on first-, second- and third-degree relatives as possible **For all adults, screen using appropriate screening tools for the following conditions not covered elsewhere:** ▪ Birth control/sexual behavior—assess the person's risk for acquiring STIs; aim to increase motivation or commitment to safer sex practices, and provide training in condom use, communication about safer sex. **[B]** ▪ Violence detection/counseling ▪ Dental health ▪ Smoking—Tobacco cessation is a high priority intervention from a health and cost-effectiveness standpoint. Smokers should be offered pharmacologic therapy with proven effectiveness and established safety and behavioral interventions. **[A]**; Per USPSTF current evidence is insufficient to assess the balance of benefits and harms of electronic cigarettes (e-cigarettes) for tobacco cessation in adults, including pregnant persons. [I] ▪ Diet/nutrition— Dietary guidelines from both the U.S. Department of Health and Human Services and the ACC/AHA recommend following a healthy eating pattern that consists of a variety of vegetables, whole fruits, legumes, nuts, whole grains, and fish while minimizing intake of added sugars, saturated and trans fats, sodium, and refined carbohydrates. Recommend water as the drink of choice. ▪ Exercise— at least 150 minutes of moderate intensity or 75 minutes of vigorous intensity exercise per week in addition to engaging in strengthening activities at least twice per week. ▪ Fall/ Injury Prevention— including seat belt use, use of safety helmets for motorcycles and bicycles, and home safety

Preventive Service	Guideline
	measures, should be emphasized. Advise use of smoke alarms in the home and to set water heaters to lower than 49 ^{0}C (120 ^{0}F) in households with infants and young children. The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls. **[B];** recommends against Vitamin D to prevent falls. **[D]** ▪ Elder abuse and abuse of vulnerable adults: Insufficient evidence to screen. **[I]**; Risk factors for elder abuse include isolation and lack of social support, functional impairment, and poor physical health. For older adults, lower income and living in a shared living environment with a large number of household members (other than a spouse) are associated with an increased risk of financial and physical abuse. No valid, reliable screening tools in the primary care setting to identify abuse of older or vulnerable adults without recognized signs and symptoms of abuse. ▪ Skin Protection—particularly for adults less than 24 years of age and with fair skin types **[B];** Selectively offer counseling about minimizing exposure to UV radiation to adults older than 24years with fair skin type. **[C]**; Consider presence of risk factors for skin cancer in determining if counseling appropriate e.g., Persons who use tanning beds and those with a history of sunburns or previous skin cancer are also at greatly increased risk of skin cancer. Other factors that increase risk include an increased number of nevi (moles) and atypical nevi, family history of skin cancer, HIV infection, and history of receiving an organ transplant. Insufficient evidence to counsel self-skin examination. [I] **USPSTF recommends:** **For women of childbearing age**: ▪ Screen for intimate partner violence. **[B]** Women who screen positive should be provided or referred for appropriate interventions. Available screening tools include the Hurt, Insult, Threaten, Scream (HITS); Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT); Slapped, Threatened, and Throw (STaT); Humiliation, Afraid, Rape, Kick (HARK); Modified Childhood Trauma Questionnaire-Short Form (CTQ-SF); and Woman Abuse Screening Tool (WAST). **Domestic Violence Hotline Local Resources** ▪ Folic Acid Supplementation: Advise women planning or capable of pregnancy to take a folic acid supplement of 0.4-0.8 mg daily **[A]** **Alcohol use screening and counseling:** ▪ Unhealthy alcohol use: All adults aged 18 and over should be screened for unhealthy alcohol use **[B]** using the AUDIT-C or single question screening tool. Patients who screen positive for risky or hazardous drinking should receive brief behavioral counseling interventions. Patients with alcohol abuse or dependence should be referred for specialty treatment. Risky drinking is defined as more than 4 drinks per day or 14 drinks per week for men ages 21-64 and more than 3 drinks per day or 7 drinks per week for women of any age and men 65 or older. ▪ Individuals who do not drink alcohol should not be advised to start. ▪ Individuals who already drink alcohol should be advised to drink in moderation--for women ≤ 1 drink/day and for men ≤ 2 drinks per day. * ▪ Alcohol consumption has been associated with an increased risk of developing hypertension and cancer (including breast, colorectal, liver, stomach and aerodigestive) ▪ There is evidence that moderate alcohol consumption may be protective in at least some people against coronary artery

Preventive Service	Guideline
	disease. ▪ A standard drink is defined as 5 ounces of wine, 12 ounces of beer or 1.5 ounces of distilled spirits **Drug Screening & Counseling:** ▪ Unhealthy use of other drugs: All adults aged 18 and should be screened for unhealthy drug use by asking questions (not testing biological specimens). **[B]**; A one sentence screening question: "How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?" is highly sensitive and specific both for drug use in the past year as well as a drug use disorder. ▪ Multiple other screening tools including the NIDA Quick Screen (4 questions), or longer tools (such as ASSIST) are also available. **Obesity:** ▪ All patients who are overweight or obese should undergo counseling on the benefits of a health weight, regular exercise, and a healthy diet. Refer adults with a BMI of 30 or more to intensive multi-component behavioral counseling. **[B]** **Adults with cardiovascular disease (CVD) risk factors:** ▪ The USPSTF recommends offering or referring adults with CVD risk factors to behavioral counseling interventions to promote a healthy diet and physical activity. **[B]**
Diabetes Mellitus and Pre-Diabetes [39, 40]	**USPSTF recommends:** ▪ Screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 35 to 70 years who are overweight or obese; to refer patients with prediabetes to effective preventive interventions. **[B]** ▪ Screening at an earlier age should be considered for those with a family history of diabetes, personal history of PCOS or gestational diabetes, or who are members of high-risk ethnic groups. ▪ USPSTF recommends screening for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or after. **[B]** **American Diabetes Association recommends:** ▪ All individuals 35 years and older be screened for diabetes and pre-diabetes. ▪ Testing should be considered in all adults who are overweight (BMI≥25 kg/m2 or ≥23 kg/m2 in Asian Americans) who have one or more additional risk factors: • 1st degree relative with diabetes. • Physically inactive. • High-risk ethnic group (African American, Latino, Native or Asian Americans, Pacific Islanders). • Hypertension (≥140/90) or on therapy for hypertension. • PCOS (polycystic ovary syndrome). • Plasma high-density lipoprotein cholesterol level <35 mg/dl or triglyceride level >250 mg/dl. • History of CVD. • Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)

© Copyright MedStar Health, 2014

Preventive Service	Guideline
	▪ Women planning pregnancy who are overweight or obese and/or have one or more additional risk for diabetes should be screened for diabetes and pre-diabetes. ▪ Patients with HIV should be screened for diabetes and pre-diabetes with a fasting glucose test before starting antiretroviral therapy, at the time of switching antiretroviral therapy, and 3-6 months after starting or switching antiretroviral therapy. If initial screening results are normal, fasting glucose should be checked annually. ▪ The **ADA Diabetes Risk Test** is a tool which may be used to assess appropriateness of screening. **Screening Methods**: ▪ Fasting plasma glucose, 2 hr. plasma glucose following 75 gm OGTT or A1C are equally acceptable modalities. **Screening Frequency**: ▪ Re-screening should occur at a minimum every 3 years if results are normal with more frequent screening based on individual results and risk. ▪ Individuals with pre-diabetes (A1C 5.7-6.4%), impaired glucose tolerance (140-199 mg/dl) or impaired fasting glucose (100-125 mg/dl) should be tested annually. ▪ Women with a history of gestational diabetes should have lifelong testing at least every 3 years; Women with a history of gestational diabetes mellitus found to have prediabetes should receive intensive lifestyle interventions and/or metformin to prevent diabetes.
Depression[41]	**USPSTF recommends:** ▪ Screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment & appropriate follow-up. **[B]** ▪ Screening for symptoms of depression should occur at the initial visit for all new patients and then annually for existing patients. The patient may complete screening during the office visit with a patient self-reported questionnaire or using one of the various screening measures that have been specifically designed to detect depression. Physicians can choose the screening measures that are appropriate for their patients and practice setting and for monitoring change in patients who are receiving treatment for depression.
Eye Disease Screening[42]	▪ Baseline screening should start at age 40 for adults with no signs or risk factors for eye disease. Patients of any age with eye disease risk factors, such as high blood pressure, family history or diabetes, should consult with their ophthalmologist about frequency of eye exams. ▪ Women with type 1 or type 2 diabetes should receive a comprehensive eye examination before conception and then early in the first trimester of pregnancy.[85]
Hearing [43,44]	▪ USPSTF found insufficient evidence to recommend screening for hearing loss in asymptomatic adults 50years or older. [I] Providers should perform subjective hearing screening periodically with counseling on hearing aid devices and making referrals as appropriate.
Height and Weight[31], BMI	▪ Baseline height, weight and BMI are indicated for all adults 18 years of age and older annually; Weight Reduction Counseling

Preventive Service	Guideline
	should be recommended for all patients with BMI > 25kg/m^2; USPSTF recommends that clinicians offer or refer adults with a BMI of 30 or higher to intensive, multicomponent behavioral interventions designed to help participants achieve or maintain a 5% or greater weight loss through a combination of dietary changes and increased physical activity. **[B]**; Nutrition counseling should be given to those who are underweight (BMI < 18.5 kg/m2). ▪ The ACC/AHA and the Obesity Society recommend annual screening with BMI and waist circumference measurements.
Hepatitis B Screening[45]	**USPSTF recommends:** ▪ Screening for hepatitis B virus infection in adolescents and adults at increased risk for infection using HBsAg testing. **[B]** Persons at increased risk include: • Persons who have used intravenous drugs in the past or currently • Men who have sex with men • HIV infected persons • Sexual partners or household contacts of hepatitis B infected persons • Needle-sharing contacts • Adults and adolescents born in countries with ≥ 2% prevalence of hepatitis B • Adults and adolescents born in the US and who did not receive the hepatitis B vaccine as children and who are children of parents born in countries with ≥ 8% prevalence of hepatitis B (Link to Countries with moderate and high prevalence of Hepatitis B) ▪ Clinical judgment should be used to determine screening frequency. ▪ Screening is recommended for pregnant women at their first prenatal visit. **[A]**
Hepatitis C Screening [46,47]	**USPSTF recommends:** ▪ Screening all adults 18-79 for hepatitis C one time. Persons at continued risk (persons with past or current injection drug use) should be screened periodically. **[B]**
HIV Testing [48-49]	**USPSTF:** **Screening:** ▪ Testing for HIV infection should be performed routinely for all patients aged 15--65 years in an "opt out" fashion. All persons likely to be at high risk should be screened at least annually. USPSTF recommends clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown. **[A]** ▪ High risk patients include: injection-drug users and their sex partners, unprotected anal or vaginal intercourse with more than 1 partner whose HIV status is unknown, persons who exchange sex for money or drugs (transactional sex), sex partners of HIV-infected persons, having other STI, persons who request testing for STIs, men having sex with men or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test. ▪ No written consent is required, however documentation in the medical record of informed consent is necessary in the state of Maryland.

Preventive Service	Guideline
HIV Pre-exposure Prophylaxis (PrEP) [50]	**PrEP**: ▪ USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition **[A]**: 1. Men who have sex with men, are sexually active, and have 1 of the following characteristics: • A serodiscordant sex partner (i.e., in a sexual relationship with a partner living with HIV) • Inconsistent use of condoms during receptive or insertive anal sex • A sexually transmitted infection (STI) with syphilis, gonorrhea, or chlamydia within the past 6 months 2. Heterosexually active women and men who have 1 of the following characteristics: • A serodiscordant sex partner (i.e., in a sexual relationship with a partner living with HIV) • Inconsistent use of condoms during sex with a partner whose HIV status is unknown and who is at high risk (e.g., a person who injects drugs or a man who has sex with men and women) • An STI with syphilis or gonorrhea within the past 6 months 3. Persons who inject drugs and have 1 of the following characteristics: • Shared use of drug injection equipment • Risk of sexual acquisition of HIV (see above) ▪ Transgender women and men who are sexually active may be at increased risk of HIV acquisition and should be considered for PrEP based on the criteria outlined above. Transgender women are at especially high risk of HIV acquisition.
Lung Cancer Screening [51]	**USPSTF:** ▪ Annual screening for lung cancer using low-dose CT scanning in adults aged 50-80 with a 20 pack-year smoking history and who are current smokers or have quit within the past 15 yrs. Screening should be discontinued once a person has not smoked for 15 years, develops a health problem substantially limiting life expectancy, or is unable or unwilling to have curative lung surgery. **[B]**
Obstructive Sleep Apnea[94]	**USPSTF:** ▪ Current evidence is insufficient to assess the balance of benefits & harms of screening for Obstructive Sleep Apnea (OSA). **[I]**
Osteoporosis Screening [52, 53]	**USPSTF and the American College of Obstetricians and Gynecologists (ACOG):** ▪Screening for osteoporosis in all women aged 65 years or older **[B]** and in women younger than 65 years who are at increased risk for osteoporosis, as determined by a formal risk assessment tool. **[B]**; The WHO Fracture Risk Assessment, **FRAX** is commonly used clinical risk assessment tool. ▪Women who have a 10-year FRAX risk for major osteoporotic fracture equal to of higher than that of a 65-year-old woman without additional risk factors (10-year risk of 8.4%) should undergo screening for osteoporosis. ▪Screening most commonly is accomplished by measuring Bone Mineral Density (BMD) with dual-energy x-ray absorptiometry of the hip and lumbar spine.

Initial Approval Date and Reviews:	Most Recent Revision and Approval Date:	Next Scheduled Review Date:
By 2010, 01/12, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 3/20 (interim update), 1/21, 3/21 (interim update), 6/21 (interim update), 1/22, 1/23 Ambulatory Best Practice Committee	**January 2023**	January 2024 Ambulatory Best Practice Committee

© Copyright MedStar Health, 2014

Preventive Service	Guideline
	▪Timing of repeat screening should be individualized based on baseline results but should occur not more often than every 2 yrs. ▪Routine screening of men aged 70 and older regardless of additional risk factors is not recommended by the USPSTF **[I]** but is by the National Osteoporosis Foundation and other groups. Screening may be considered in men if at higher risk for osteoporosis (use of oral glucocorticoids in a daily dose of ≥ 5mg prednisone or equivalent for ≥3months associated with low bone mass, previous fragility fracture, alcohol use, and androgen deprivation through pharmacologic agents or orchiectomy, radiographic osteopenia, primary hyperparathyroidism). The Endocrine Society recommends screening in men older than 70 years and adults aged 50-69 years with significant risk factors or fracture after the age of 50 years.
Ovarian Cancer Screening [54]	USPSTF recommends against screening average risk asymptomatic women for ovarian cancer. **[D];** This recommendation does not apply to women with known genetic mutations that increase their risk for ovarian cancer (e.g., BRCA1/2 mutations); these women need to be referred for genetic counseling and, if indicated, genetic testing.
Pancreatic Cancer[55]	USPSTF recommends against screening for pancreatic cancer in asymptomatic adults **[D]**
Prostate Cancer Screening in average and high-risk men and transgender women with a prostate [56-61]	**USPSTF:** ▪ The USPSTF recommends that for men ages 55-69, the decision to screen for prostate cancer be individualized after a discussion of risks and benefits and based on patient preference. **[C]** [57] ▪ USPSTF recommends against PSA-based screening for prostate cancer in men 70 years and older. **[D]** ▪ Decision aids also often ask patients to identify what outcomes are most important to them and can facilitate the discussion. An example of decision aid for prostate cancer screening discussion can be found here: • **Testing for Prostate Cancer Handout** • USPSTF Infographic: **Is Prostate Cancer Screening Right for You?** **American Cancer Society (ACS):** ▪ Age 40-44 y: Engage men at higher risk (≥2 first-degree relatives [father, brothers] with prostate cancer before age 65 y) in shared decision making ▪ Age 45-49 y: Engage men at high risk (African American race or first-degree relative with prostate cancer before age 65 y) in shared decision making ▪ Age ≥50 y with life expectancy >10 y: Engage in shared decision making ▪ Men who choose to be tested who have a PSA of less than 2.5 ng/ml may only need to be retested every 2 years. Screening (if done) should be done yearly for men whose PSA level is 2.5 ng/ml or higher. **American Urological Association (AUA):** ▪ Age <40 y: Recommend against screening ▪ Age 40-54 y: Do not recommend routine screening; Screening men at higher risk (African American race or with positive family history): Individualize screening decisions ▪ Age 55-69 y: Engage men considering PSA-based screening in shared decision making; proceed based on patient values and preferences. If proceeding with screening, consider PSA testing every 2 y or more

© Copyright MedStar Health, 2014

Preventive Service	Guideline
	▪ Age ≥70 y or with life expectancy <10-15 y: Do not recommend routine screening Digital rectal examination (DRE): DRE is not recommended for prostate cancer screening either as an adjunct to prostate-specific antigen (PSA) testing or as a standalone test. However, if a DRE is performed, men with a nodule, induration, or asymmetry on prostate examination should be referred to a urologist, regardless of the PSA result. Family History: Patients for whom there is concern for a hereditary or genetic prostate cancer syndrome may be referred for genetic counseling and possible testing if available.
STI Screening in special populations[89]	**CDC recommendations:** ▪ **CDC-STI screening-recommendations** ▪ **Detection of STI in Special Populations** ▪ **STI-treatment guide mobile app**
Syphilis Screening [62]	**USPSTF:** ▪ All pregnant patients and all non-pregnant patients at increased risk of syphilis exposure should be screened. **[A]**; Such patients include but may not be limited to men who have sex with men, HIV infected patients, commercial sex workers, young adults, and persons with history of incarceration, military service, diagnosis of another STI, and patients living in areas of high prevalence. A substantial percentage of heterosexual syphilis transmission occurs among persons who use illicit drugs, particularly methamphetamine.
Testicular Self-Exam [63]	**USPSTF:** ▪ Testicular cancer screening (by clinicians or by patient self-exam) is not recommended because of the uncommon nature of the condition and the high cure rate when detected. **[D]**
Tuberculosis Screening [64]	**USPSTF:** ▪ Screening for latent tuberculosis should be performed in groups at increased risk of exposure and increased risk of developing active disease including patients living in homeless shelters or correctional institutions, patients coming from countries with high prevalence of TB, immunosuppressed patients, patients with silicosis, and patients with TB exposure (household contacts or occupational exposure). **[B]**
IMMUNIZATIONS	For complete CDC recommendations for Adult Immunizations consult: **ACIP Website**

References:

1) U.S. Preventive Services Task Force (USPSTF, December 2019). Screening for Abdominal Aortic Aneurysm: Recommendation Statement. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/abdominal-aortic-aneurysm-screening1

2) U.S. Preventive Services Task Force (USPSTF, April 26, 2022). Aspirin Use to Prevent Cardiovascular Disease https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/aspirin-to-prevent-cardiovascular-disease-preventive-medication

Initial Approval Date and Reviews:	**Most Recent Revision and Approval Date:**	**Next Scheduled Review Date:**
By 2010, 01/12, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 3/20 (interim update), 1/21, 3/21 (interim update), 6/21 (interim update), 1/22, 1/23 Ambulatory Best Practice Committee	**January 2023** © Copyright MedStar Health, 2014	January 2024 Ambulatory Best Practice Committee

3) Effects of Aspirin for Primary Prevention in Persons with Diabetes Mellitus. ASCEND Study Collaborative Group, Bowman L, Mafham M, Wallendszus K, Stevens W, Buck G, Barton J, Murphy K, Aung T, Haynes R, Cox J, Murawska A, Young A, Lay M, Chen F, Sammons E, Waters E, Adler A, Bodansky J, Farmer A, McPherson R, Neil A, Simpson D, Peto R, Baigent C, Collins R, Parish S, Armitage J N Engl J Med. 2018;379(16):1529. Epub 2018 Aug 26.
4) Effect of Aspirin on All-Cause Mortality in the Healthy Elderly.McNeil JJ, Nelson MR, Woods RL, Lockery JE, Wolfe R, Reid CM, Kirpach B, Shah RC, Ives DG, Storey E, Ryan J, Tonkin AM, Newman AB, Williamson JD, Margolis KL, Ernst ME, Abhayaratna WP, Stocks N, Fitzgerald SM, Orchard SG, Trevaks RE, Beilin LJ, Donnan GA, Gibbs P, Johnston CI, Radziszewska B, Grimm R, Murray AM, ASPREE Investigator Group N Engl J Med. 2018;379(16):1519. Epub 2018 Sep 16.
5) Use of aspirin to reduce risk of initial vascular events in patients at moderate risk of cardiovascular disease (ARRIVE): a randomized, double-blind, placebo-controlled trial. Gaziano JM, Brotons C, Coppolecchia R, Cricelli C, Darius H, Gorelick PB, Howard G, Pearson TA, Rothwell PM, Ruilope LM, Tendera M, Tognoni G, ARRIVE Executive Committee Lancet. 2018;392(10152):1036. Epub 2018 Aug 26.
6) 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: Executive Summary. JACC 2019. 74: 1376-1414).
7) U.S. Preventive Services Task Force (USPSTF, April 27, 2021). Hypertension in Adults (Screening). https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hypertension-in-adults-screening
8) ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Whelton PK, Carey RM, Aronow WS, Casey DE Jr, Collins KJ, Dennison Himmelfarb C, DePalma SM, Gidding S, Jamerson KA, Jones DW, MacLaughlin EJ, Muntner P, Ovbiagele B, Smith SC Jr, Spencer CC, Stafford RS, Taler SJ, Thomas RJ, Williams KA Sr, Williamson JD, Wright JT Jr Hypertension. 2018;71(6): e13. Epub 2017 Nov 13.
9) U.S. Preventive Services Task Force (USPSTF, January 2016); Breast Cancer: Screening. http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/breast-cancer-screening1
10) Breast Cancer Screening for Women at Average Risk: 2015 Guideline Update from the American Cancer Society. *JAMA.* 2015; 314(15):1599-1614. doi:10.1001/jama.2015.12783.
11) Saslow, Debbie et al. American Cancer Society Guidelines for Breast Screening as an Adjunct to Mammogram. CA Cancer J Clin 2007; 57:75-89.
12) Breast Cancer Screening. ACOG Practice Bulletin Number 122. Obstetrics & Gynecology 2011; 118: 372-382.
13) The Breast cancer Risk Assessment Tool. http://www.cancer.gov/bcrisktool
14) Risk Assessment, Genetic Counseling, and Genetic Testing for BRCA-Related Cancer. US Preventive Services Task Force Recommendation Statement. JAMA 2019; 322 (7): 652-665.
15) Medication Use to Reduce Risk of Breast Cancer. US Preventive Services Task Force Recommendation Statement. JAMA 2019; 322 (9): 857-867.
16) U.S. Preventive Services Task Force (USPSTF August 2018). Cervical Cancer: Screening. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2?ds=1&s=cervical cancer screening
17) Saslow, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology Screening Guidelines for the Prevention and Early Detection of Cervical Cancer. Am J Clin Pathol 2012; 137: 516-542.
18) Cervical cytology screening. ACOG Practice Bulletin No. 157. American College of Obstetricians and Gynecologists. Obstet Gynecol 2016; 127: e1
19) U.S. Preventive Services Task Force (USPSTF, September 2021). Chlamydia and Gonorrhea: Screening. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/chlamydia-and-gonorrhea-screening
20) U.S. Preventive Services Task Force (USPSTF, August 2022). Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/statin-use-in-adults-preventive-medication
21) Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Risk in Adults, *Journal of the American College of Cardiology* (2013), doi: 10.1016/j.jacc.2013.11.02

Initial Approval Date and Reviews:	**Most Recent Revision and Approval Date:**	**Next Scheduled Review Date:**
By 2010, 01/12, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 3/20 (interim update), 1/21, 3/21 (interim update), 6/21 (interim update), 1/22, 1/23 Ambulatory Best Practice Committee	**January 2023** © Copyright MedStar Health, 2014	January 2024 Ambulatory Best Practice Committee

22) Prognostic value of fasting versus non-fasting low-density lipoprotein cholesterol levels on long-term mortality: insight from the National Health and Nutrition Examination Survey III (NHANES-III). Doran B, Guo Y, Xu J, Weintraub H, Mora S, Maron DJ, Bangalore S Circulation. 2014;130(7):546. Epub 2014 Jul 11.
23) U.S. Preventive Services Task Force (USPSTF, February 2020). Cognitive Impairment in Older Adults: Screening. https://uspreventiveservicestaskforce.org/uspstf/recommendation/cognitive-impairment-in-older-adults-screening#fullrecommendationstart
24) Wolf, Andrew at el. Colorectal Cancer Screening for Average Risk Adult: 2018 Guideline Update from the American Cancer Society. CA Cancer J Clin 2018; 68: 250-281
25) Levin, Bernard et al. Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyps, 2008: A Joint Guideline from the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology. CA Cancer J Clin 2008; 58: 130-160.
26) Screening for Colorectal Cancer. US Preventive Services Task Force Recommendation Statement. JAMA 2021; 325(19):1965-1977.
27) Rex et al. American College of Gastroenterology Guidelines for Colorectal Cancer Screening 2008; Am J Gastroenterol 2009; 104: 739-750.
28) U.S. Preventive Services Task Force (USPSTF, July 11, 2017). Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults: Behavioral Counseling. https://uspreventiveservicestaskforce.org/uspstf/recommendation/healthful-diet-and-physical-activity-for-cardiovascular-disease-prevention-in-adults-without-known-risk-factors-behavioral-counseling
29) U.S. Preventive Services Task Force (USPSTF, May 2013). Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care. http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care
30) U.S. Preventive Services Task Force (USPSTF, November 24, 2020). Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling Interventions. https://uspreventiveservicestaskforce.org/uspstf/recommendation/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd
31) U.S. Preventive Services Task Force (USPSTF, September 18, 2018). Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions. https://uspreventiveservicestaskforce.org/uspstf/recommendation/obesity-in-adults-interventions
32) U.S. Preventive Services Task Force (USPSTF, August 18, 2020). Sexually Transmitted Infections: Behavioral Counseling. https://uspreventiveservicestaskforce.org/uspstf/recommendation/sexually-transmitted-infections-behavioral-counseling
33) U.S. Preventive Services Task Force (USPSTF, January 19, 2021). Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons. https://uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions#bootstrap-panel--7
34) https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/folic-acid-for-the-prevention-of-neural-tube-defects-preventive-medication
35) https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening
36) U.S. Preventive Services Task Force (USPSTF, June 9, 2020). Unhealthy Drug Use: Screening. https://uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening
37) McNeely J, et al. Validation of Self-Administered Single-Item Screening Questions (SISQs) for Unhealthy Alcohol and Drug Use in Primary Care Patients. J Gen Intern Med. 2015 Dec;30(12):1757-64
38) Drinking patterns and their definitions. https://www.arcr.niaaa.nih.gov/arcr391/article02.htm
39) U.S. Preventive Services Task Force (USPSTF, August 24, 2021). Prediabetes and Type 2 Diabetes: Screening. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-for-prediabetes-and-type-2-diabetes
40) Classification and Diagnosis of Diabetes: Standards of Medical Care in Diabetes—2022. Diabetes Care 2022 Jan; 45(Supplement 1): S17-S38.
41) U.S. Preventive Services Task Force (USPSTF January 2016). Depression in Adults: Screening. http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1

Initial Approval Date and Reviews:	**Most Recent Revision and Approval Date:**	**Next Scheduled Review Date:**
By 2010, 01/12, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 3/20 (interim update), 1/21, 3/21 (interim update), 6/21 (interim update), 1/22, 1/23 Ambulatory Best Practice Committee	**January 2023** © Copyright MedStar Health, 2014	January 2024 Ambulatory Best Practice Committee

42) American Academy of Ophthalmology, (February 2015) Policy Statement, Retrieved from https://www.aao.org/clinical-statement/frequency-of-ocular-examinations
43) U.S. Preventive Services Task Force (USPSTF, March 2021). Hearing loss in Older Adults: Screening. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hearing-loss-in-older-adults-screening
44) Quality indicators for the care of hearing loss in vulnerable elders. J Am Geriatr Soc. 2007; 55 Suppl 2: S335.
45) U.S. Preventive Services Task Force (USPSTF December 15, 2020). Screening for Hepatitis B in Adolescents and Adults. https://uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening
46) U.S. Preventive Services Task Force (USPSTF March 2020). Screening: Hepatitis C virus infections in adolescents and adults. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening
47) http://www.cdc.gov/hepatitis/HCV/GuidelinesC.htm
48) Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, September 22, 2006 / 55(RR14);1-17 http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm
49) U.S. Preventive Services Task Force (USPSTF, June 2019). HIV Infections: Screening. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening
50) U.S. Preventive Services Task Force (USPSTF, June 11, 2019). Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis. https://uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-human-immunodeficiency-virus-hiv-infection-pre-exposure-prophylaxis
51) U.S. Preventive Services Task Force (USPSTF, March 9m 2021). Lung Cancer: Screening. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening
52) Clinician's Guide to Prevention and Treatment of Osteoporosis. National Osteoporosis Foundation Revised January 2010.
53) U.S. Preventive Services Task Force Recommendation Statement. (USPSTF January 2018). Osteoporosis to Prevent Fractures: Screening. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/osteoporosis-screening1Qaseem, Amir et al. Screening for Osteoporosis in Men: A Clinical Practice Guideline from the American College of Physicians. Ann Intern Med. 2008; 148: 680-684.
54) U.S. Preventive Services Task Force (USPSTF, February 2018). Ovarian Cancer Screening https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/ovarian-cancer-screening
55) U.S. Preventive Services Task Force (USPSTF August 2019). Pancreatic Cancer: Screening https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/pancreatic-cancer-screening1
56) U.S. Preventive Services Task Force (USPSTF May 2018). https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/prostate-cancer-screening
57) Recommendations for Prostate cancer early detection, American Cancer Society. Updated February 25, 2014. Retrieved from http://www.cancer.org/cancer/prostatecancer/moreinformation/prostatecancerearlydetection/prostate-cancer-early-detection-acs-recommendations
58) Screening for Prostate Cancer: A Guidance Statement from the Clinical Guidelines Committee of the American College of Physicians .Ann Intern Med 2013; 158: 761-769.
59) Early Detection of Prostate Cancer: AUA Guideline. April 2013. http://www.auanet.org/education/guidelines/prostate-cancer-detection.cfm
60) http://www.aafp.org/dam/AAFP/documents/patient_care/clinical_recommendations/cps-recommendations.pdf
61) Screening for Prostate Cancer in U.S. Men. ACPM Position Statement on Preventive Practice. Am J Prev Med 2008;34(2):164–170) © 2008 American Journal of Preventive Medicine.
62) Syphilis Screening in Non pregnant Adults and Adolescents: Screening. June 2016. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/syphilis-infection-in-nonpregnant-adults-and-adolescents
63) Testicular Cancer: Screening. April 2011. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/testicular-cancer-screening

Initial Approval Date and Reviews:	**Most Recent Revision and Approval Date:**	**Next Scheduled Review Date:**
By 2010, 01/12, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 3/20 (interim update), 1/21, 3/21 (interim update), 6/21 (interim update), 1/22, 1/23 Ambulatory Best Practice Committee	**January 2023** © Copyright MedStar Health, 2014	January 2024 Ambulatory Best Practice Committee

64) Latent Tuberculosis Infection: Screening. September 2016. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/latent-tuberculosis-infection-screening
65) American College of Cardiology (ACC)/American Heart Association (AHA): Guideline for the diagnosis and management of aortic disease (2022)
66) The Society for Vascular Surgery practice guidelines on the care of patients with an abdominal aortic aneurysm; Volume 67, Issue 1, P2-77. E2, January 01, 2018; DOI: https://doi.org/10.1016/j.jvs.2017.10.044
67) Low Dose Aspirin Use During Pregnancy: Obstetrics & Gynecology: ACOG Committee Opinion No. 743. American College of Obstetricians & Gynecologists. Obstet Gynecol 2018; 132: e44-52
68) 35. Arnett DK, Blumenthal RS, Albert MA, et. al. 2019 ACC/AHA guideline on the primary prevention of cardiovascular disease: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Circulation*. 2019;140(11): e596-e646.
69) Guirguis-Blake JM, Evans CV, Webber EM, Coppola EL, Perdue LA, Weyrich MS. *Screening for Hypertension in Adults: A Systematic Evidence Review for the U.S. Preventive Services Task Force*. Evidence Synthesis No. 197. Agency for Healthcare Research and Quality; 2021. AHRQ publication 20-05265-EF-1.
70) Guirguis-Blake JM, Evans CV, Webber EM, Coppola EL, Perdue LA, Weyrich MS. Screening for hypertension in adults: updated evidence report and systematic review for the US Preventive Services Task Force. *JAMA*. Published April 27, 2021. doi:10.1001/jama.2020.21669
71) Benjamin EJ, Blaha MJ, Chiuve SE, et al. Heart Disease and stroke statistics—2017 update: a report from the American Heart Association. *Circulation.* 2017;135(10): e146-e603. Medline:28122885
72) Breast Cancer Risk Assessment and Screening in Average-Risk Women; ACOG/Clinical Practice Bulletin; No. 179; July 2017. Reaffirmed 2021.
73) Hereditary cancer syndromes and risk assessment. Committee Opinion No. 634. American College of Obstetricians and Gynecologists. Obstet Gynecol 2015;125: 1538–43. (Level III)
74) Workowski KA, Bachmann LH, Chan PA, et al. Sexually transmitted infections treatment guidelines, 2021. *MMWR Recomm Rep*. 2021;70(4):1-187. Medline:34292926 doi:10.15585/mmwr.rr7004a1
75) Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA guideline on the management of blood cholesterol: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Circulation*. 2019;139: e1082–1143.
76) U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans. 2nd edition. Published 2018. Accessed June 7, 2022. https://health.gov/paguidelines/second-edition/pdf/Physical_Activity_Guidelines_2nd_edition.pdf
77) NYSDOH AIDS INTITUTE GUIDELINE: SCREENING FOR CERVICAL DYSPLASIA AND CANCER IN ADULTS WITH HIV | www.hivguidelines.org
78) Screening for Cervical Abnormalities-Concomitant Screening for anal cancer & STI in HIV: https://www.hivguidelines.org/hiv-care/anal-cancer/
79) American Cancer Society. Anal Cancer.
80) Primary Care Guidance for Persons With Human Immunodeficiency Virus: 2020 Update by the HIV Medicine Association of the Infectious Diseases Society of America; Published CID, 12/8/2021 *Clinical Infectious Diseases*, Volume 73, Issue 11, 1 December 2021, Pages e3572-e3605, https://doi.org/10.1093/cid/ciaa1391
81) Anal Squamous intraepithelial lesions: Epidemiology, clinical presentation, diagnosis, screening, prevention, and treatment: 2023 UpToDate, Inc.
82) Thin Prep Anal Cytology Specimen Collection-Hologic
83) Anal-Rectal Cytology Liquid Based Preparation-LabCorp
84) Anal-Rectal Cytology-Quest Diagnostics
85) Standards of Medical Care in Diabetes—2022 Clin Diabetes 2022;40(1):10–38 https://doi.org/10.2337/cd22-as01
86) Abdominal aortic aneurysm screening guidelines: USPSTF and Society of Vascular Surgery. Thomas F.X. O'Donnell MD and Marc L. Schermerhorn MD; Journal of Vascular Surgery, 2020-05-01, Volume 71, Issue 5, Pages 1457-1458
87) The Society for Vascular Surgery practice guidelines on the care of patients with an abdominal aortic aneurysm; Journal of Vascular Surgery, 2018-01-01, Volume 67, Issue 1, Pages 2-77. e2, Copyright © 2017 Society for Vascular Surgery

Initial Approval Date and Reviews:	**Most Recent Revision and Approval Date:**	**Next Scheduled Review Date:**
By 2010, 01/12, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 3/20 (interim update), 1/21, 3/21 (interim update), 6/21 (interim update), 1/22, 1/23 Ambulatory Best Practice Committee	**January 2023** © Copyright MedStar Health, 2014	January 2024 Ambulatory Best Practice Committee

88) U.S. Preventive Services Task Force (USPSTF, September 24, 2019). Asymptomatic Bacteriuria in Adults: Screening; Recommendation Statement. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/asymptomatic-bacteriuria-in-adults-screening
89) Center for Disease Control and Prevention: Sexually Transmitted Infections Treatment Guidelines 2021
90) Association of Human Papillomavirus Vaccination with the Incidence of Squamous Cell Carcinomas of the Anus in the US; Abbey B. Berenson, MD,PhD[1,2], Fangjian Guo, MD, PhD[1,2], Mihyun Chang, PhD[1]; *JAMA Oncol.* 2022;8(4):639-641. doi:10.1001/jamaoncol.2021.7652
91) 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines **Originally published**17 Mar 2019https://doi.org/10.1161/CIR.0000000000000678Circulation. 2019;140: e596–e646
92) U.S. Preventive Services Task Force (USPSTF March 2018). Skin Cancer Prevention: Behavioral Counseling https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/skin-cancer-counseling
93) U.S. Preventive Services Task Force (USPSTF **October** 2018).Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening
94) U.S. Preventive Services Task Force (USPSTF November 2022).Obstructive Sleep Apnea in Adults: Screening https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/obstructive-sleep-apnea-in-adults-screening

Initial Approval Date and Reviews:	**Most Recent Revision and Approval Date:**	**Next Scheduled Review Date:**
By 2010, 01/12, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 3/20 (interim update), 1/21, 3/21 (interim update), 6/21 (interim update), 1/22, 1/23 Ambulatory Best Practice Committee	**January 2023** © Copyright MedStar Health, 2014	January 2024 Ambulatory Best Practice Committee