Second Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services

November 2012

Submitted by:
Dr. Virginia Moyer, Chair
Dr. Michael LeFevre, Vice Chair
Dr. Albert Siu, Vice Chair
On behalf of the U.S. Preventive Services Task Force

U.S. Preventive Services
TASK FORCE

EXECUTIVE SUMMARY

The U.S. Preventive Services Task Force (USPSTF or Task Force) is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services and health promotion. The Task Force comprehensively assesses evidence and makes recommendations about the effectiveness of screening tests, counseling about healthful behaviors, and preventive medications for children, adolescents, adults, older adults, and pregnant women.

The Patient Protection and Affordable Care Act of 2010 charges the USPSTF with making an annual report to Congress that identifies gaps in the evidence base and recommends priority areas that deserve further examination. In its First Annual Report to Congress, the Task Force identified four screening tests and three behavioral interventions with significant evidence gaps deserving further research. Given the expected pace of research, one year is too soon to expect that these gaps would have been addressed. The Task Force, therefore, encourages Congress to continue promoting research to address these gaps.

In this annual report, its second, the USPSTF has identified specific topics from its past year of work as having important evidence gaps that may be addressed through research. More research in these areas would likely result in important new recommendations that will help to improve the health of Americans.

Clinical Preventive Services That Deserve Further Research:

1. Screening for Chronic Kidney Disease
2. Screening for Cervical Cancer With Human Papillomavirus (HPV) Tests
3. Screening for Prostate Cancer

In the Affordable Care Act, Congress also requested that the USPSTF identify evidence gaps that prevent it from making recommendations for specific populations or age groups. In this report, the USPSTF highlights three key areas.

Evidence Gaps Relating to Specific Populations and Age Groups That Deserve Further Research:

1. Screening for Chronic Kidney Disease in African-American Adults
2. Screening for Prostate Cancer in African-American Men
3. Counseling About Sun-Protective Behaviors in Families With Children Under Age 10 to Reduce the Risk for Skin Cancer

The USPSTF will continue to independently evaluate the evidence on clinical preventive services to empower health care professionals, health care systems, and the American people to make informed decisions about their health and health care.

The USPSTF believes that by identifying these evidence gaps and prioritizing these areas for research, it will inspire public and private researchers to collaborate and target their efforts to generate new knowledge and fill current evidence gaps.

Table of Contents

I. Introduction 1

II. Background 2

III. Major Activities of the USPSTF in 2011–2012 6

IV. Current Evidence Gaps Deserving of Further Research 11

V. Next Steps for the USPSTF in 2013 14

VI. Conclusion 14

Appendices

A. Summary of First Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services 16

B. 2012 Members of the USPSTF 17

C. USPSTF Implementation and Dissemination Partner Organizations 20

D. Complete Listing of All USPSTF Specific Recommendations as of October 2012 21

It is a fact that many medical interventions can cause both harm and benefit. It is only through understanding these interventions that we can hope to maximize benefit and minimize the harm. There is tremendous value in having a group with scientific expertise and no emotional or financial conflict of interest review the scientific data and make recommendations. The U.S. Preventive Services Task Force has set the bar high in being reasonable, courageous, and logical in its work.

Otis Webb Brawley, MD,
Chief Medical Officer
and Executive Vice President,
American Cancer Society

I. INTRODUCTION

The U.S. Preventive Services Task Force (USPSTF or Task Force) is an independent body of national experts in prevention and evidence-based medicine. Since its inception over 25 years ago, the Task Force has worked to improve the health of all Americans by making evidence-based recommendations about clinical preventive services and health promotion. These recommendations for adults and children include screening tests, counseling about healthful behaviors, and preventive medications.

The mission of the USPSTF is to improve the health of all Americans by making evidence-based recommendations about clinical preventive services and health promotion.

The Patient Protection and Affordable Care Act, Sec. 4003 (F), describes the duties of the USPSTF, which include:

> *"the submission of yearly reports to Congress and related agencies identifying gaps in research such as preventive services that receive an insufficient evidence statement, and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations."*

The USPSTF has prepared this report in response to this requirement to update Congress regarding key evidence gaps in clinical preventive services.

II. BACKGROUND

Certain clinical preventive services can have tremendous public health importance. When provided appropriately, they can identify diseases at earlier stages when they are more treatable or reduce a person's risk of developing a disease altogether. However, clinical preventive services can also fail to provide the expected benefit or may even cause harms. To make informed decisions, patients and health care professionals need access to trustworthy, objective information about the benefits and harms of clinical preventive services.

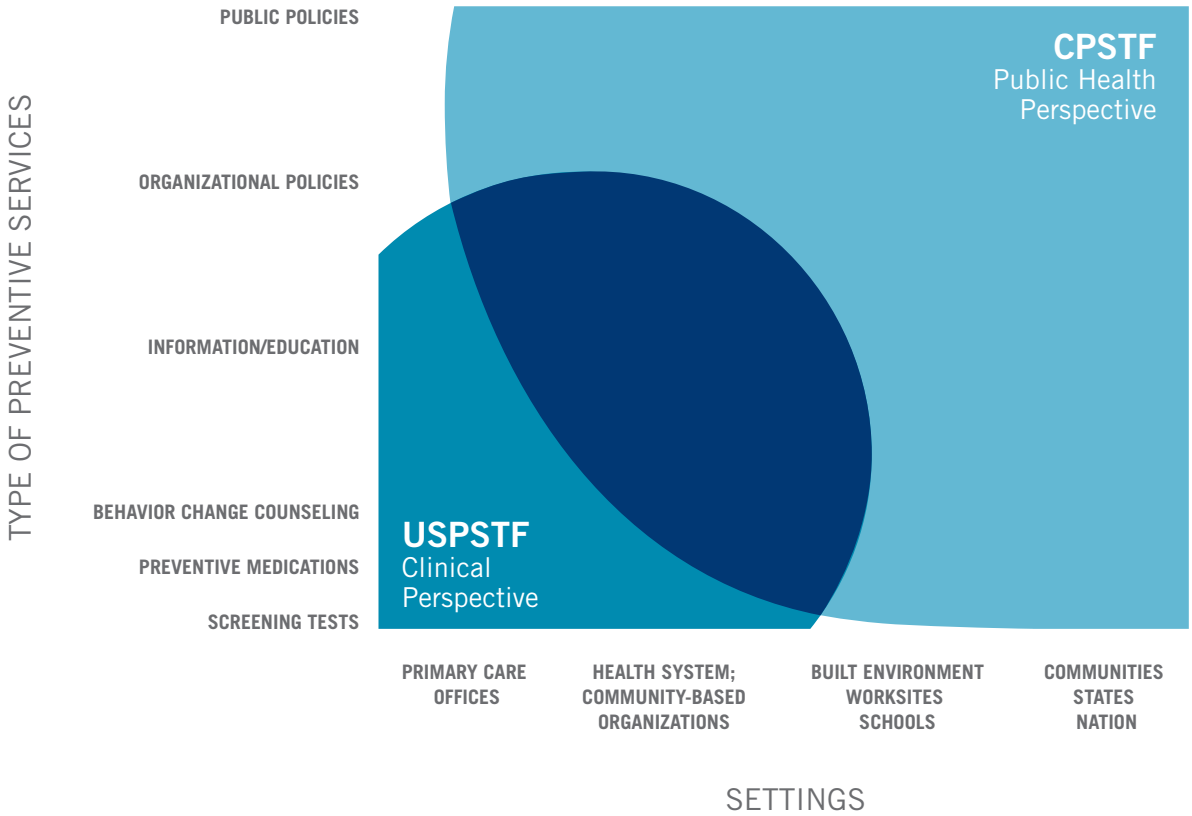
Established in 1984, the USPSTF is an independent panel of nonfederal experts in prevention and evidence-based medicine. The Task Force comprehensively assesses evidence and makes recommendations about the effectiveness of clinical preventive services including screening tests, counseling about healthful behaviors, and preventive medications for children, adolescents, adults, older adults, and pregnant women.

Its recommendations focus on interventions to prevent disease, and they only apply to people without signs or symptoms of the disease or condition under consideration. USPSTF recommendations address services offered in the primary care setting or services referred by primary care professionals. The Task Force makes recommendations to help primary care clinicians and patients decide together whether a preventive service is right for an individual's needs.

Since 1998, the Agency for Healthcare Research and Quality (AHRQ) has been authorized by Congress to convene the Task Force and to provide ongoing scientific, administrative, and dissemination support.

Complementing the work of the USPSTF, preventive services at the community level are addressed by the Community Preventive Services Task Force (CPSTF), which was established in 1996 by the U.S. Department of Health and Human Services. The CPSTF assists agencies, organizations, and individuals at all levels (national, state, community, school, worksite, and health care system) by providing evidence-based recommendations about community prevention programs and policies that are effective in increasing longevity and improving the quality of life of all Americans. The work of the CPSTF is supported by the Centers for Disease Control and Prevention. A diagram outlining the complementary domains of the USPSTF and the CPSTF is shown in **Figure 1**.

Figure 1. Complementary Work of the U.S. Preventive Services Task Force and the Community Preventive Services Task Force



The AOA relies on the USPSTF to provide independent, science-based recommendations on clinical preventive services. Our members look to the Task Force as an authoritative source in helping their patients make informed decisions about the use of clinical preventive services.

Robert S. Juhasz, DO, Board Member, American Osteopathic Association

Who Serves on the Task Force?

The Task Force is made up of 16 volunteer members who serve four-year terms and is led by a chair and two vice-chairs (see Appendix B for current members). Members are nationally recognized experts in the disciplines of preventive medicine and primary care, including behavioral health, family medicine, geriatrics, internal medicine, nursing, obstetrics and gynecology, and pediatrics. These specialists in primary care, preventive services, and the evaluation of scientific evidence provide important insights, because Task Force recommendations are addressed to primary care clinicians and apply to individuals who visit their generalists without specific concerns. All members volunteer their time to serve on the USPSTF. Most Task Force members are active clinicians who see patients regularly; many are respected researchers and distinguished professors, and all are dedicated to improving the health of Americans.

USPSTF members are appointed by the Director of AHRQ. Members are screened to ensure that they have no substantial conflicts of interest that could impair the scientific integrity of the work of the Task Force. For each preventive service under review and consideration, the financial, professional, and intellectual activities of Task Force members are evaluated to identify any real or potential conflicts of interest. In the unusual case where a conflict is identified for a member regarding a specific topic, the member is recused from participating in the development of the recommendation for that topic.

How the USPSTF Makes Recommendations

The Task Force makes recommendations based on a rigorous review of existing peer-reviewed evidence. It does not conduct research studies, but rather it reviews and assesses published research. The USPSTF follows a multi-step process when developing each of its recommendations (see **Figure 2**). The process starts with the USPSTF and researchers from an Evidence-based Practice Center (EPC) developing a research plan for the topic. The research plan includes key questions to be answered and target populations to be considered. The draft research plan is posted on the USPSTF Web site for public comment for four weeks, during which time anyone can comment on the plan, including stakeholders. The USPSTF and the EPC review all comments and consider them while making revisions to finalize the research plan.

Using the final research plan as a guide, EPC researchers gather, review, and analyze evidence on the topic from studies published in peer-reviewed scientific journals. The EPC summarizes this evidence in a comprehensive evidence report. External subject matter experts review the draft evidence report. Beginning in 2013, the Task Force will post the draft evidence report for four weeks for public comment, during which time scientists, researchers, health care professionals, and members of the general public will be able to comment.

Task Force members utilize the evidence report as the basis for their assessment of the effectiveness of the preventive service under consideration. They balance both the potential benefits and harms in making their recommendations.

Potential benefits of clinical preventive services include modification of risk factors that prevent disease, early identification of disease leading to earlier treatment, and, ultimately, improved health outcomes such as quality of life and length of life. Harms of preventive services can include adverse effects of the service itself as well as the harms of inaccurate test results that may lead to a cascade of additional follow-up tests (some of which are invasive and could cause harm) and unnecessary treatments. Potential harms also include side effects or complications of treatments. When appropriate and when evidence exists, the Task Force evaluates the benefits and harms based on age, sex, and risk factors for the disease.

Figure 2. Steps the USPSTF Takes to Make a Recommendation

The Task Force makes its recommendations based on its assessment of the effectiveness of each clinical preventive service. The Task Force does not explicitly consider costs in its appraisal of the effectiveness of a service. The USPSTF recognizes that insurance coverage decisions involve additional considerations besides the scientific assessment of the clinical benefit and harms.

The Task Force assigns each of its recommendations a letter grade (an A, B, C, or D) or issues an I statement, based on the certainty of the evidence and on the balance of benefits and harms of the preventive service (see **Table 1**). Clinical preventive services graded "A" and "B" are those services for which the USPSTF has determined that the benefits of the service substantially outweigh its harms. The Task Force recommends that clinicians offer and patients consider taking advantage of these services. Services with a grade of "D" are those for which there is no overall benefit or the harms outweigh the benefits. The Task Force recommends that clinicians not promote these services and that patients consider avoiding them. For services assigned a "C" grade, the net benefit is small. The USPSTF recommends that health care professionals selectively offer these services to individual patients based on professional judgment and patient preferences and values. The Task Force issues "I" statements when the evidence is insufficient to determine the balance of benefits and harms.

Table 1. Meaning of USPSTF Grades

Grade	Definition
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

To Learn More

To learn more about the USPSTF, its recommendations, and the science behind them, visit: **www.USPreventiveServicesTaskForce.org**.

- To read the **USPSTF Procedure Manual**, visit **www.uspreventiveservicestaskforce.org/uspstf08/methods/procmanual.htm**.
- To download, subscribe, or search the **Electronic Preventive Services Selector**, visit **www.epss.ahrq.gov**. The ePSS allows users to download the USPSTF recommendations to PDA or mobile devices, receive notifications of updates, and search and browse recommendations online. Users can search the ePSS for recommendations by patient age, sex, and pregnancy status.
- The 2012 ***Guide to Clinical Preventive Services*** contains USPSTF recommendations on 64 clinical preventive services which are presented in a one-page, at-a-glance clinical summary table. In addition, the *Guide* provides information on resources that clinicians can use to educate their patients, to train their students, and to enhance their practice.

III. MAJOR ACTIVITIES OF THE USPSTF IN 2011–2012

Over the past year, the members of the Task Force continued working on a full portfolio of topics. The current USPSTF library includes over 140 specific recommendations (see Appendix D for a complete listing of all current USPSTF specific recommendations). Between October 2011 and October 2012, the Task Force published 10 final recommendation statements, which included 19 specific recommendations in peer-reviewed journals and on its Web site (see **Table 2**). Over the past year, the USPSTF also posted 13 draft recommendation statements, for public comment. The Task Force devotes a significant amount of its time to making sure its recommendations are as up-to-date as possible and began the process of updating seven previously published recommendations in the past year as well.

Table 2. Final Recommendation Statements Published by the USPSTF, October 2011 to October 2012

Topic	Specific Recommendations
Screening for Cervical Cancer	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years. (Grade: A) The USPSTF recommends against screening for cervical cancer in women younger than age 21 years. (Grade: D) The USPSTF recommends against screening for cervical cancer in women older than age 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. (Grade: D) The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer. (Grade: D) The USPSTF recommends against screening for cervical cancer with HPV testing, alone or in combination with cytology, in women younger than age 30 years. (Grade: D)

Topic	Specific Recommendations
Screening for Chronic Kidney Disease	The USPSTF concludes that the evidence is insufficient to assess the balance of benefits and harms of routine screening for chronic kidney disease (CKD) in asymptomatic adults. (I Statement)
Screening for Coronary Heart Disease	The USPSTF recommends against screening with resting or exercise electrocardiography (ECG) for the prediction of coronary heart disease (CHD) events in asymptomatic adults at low risk for CHD events. (Grade: D) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening with resting or exercise ECG for the prediction of CHD events in asymptomatic adults at intermediate or high risk for CHD events. (I Statement)
Interventions to Prevent Falls in Community-Dwelling Older Adults	The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls. (Grade: B) The USPSTF does not recommend automatically performing an in-depth multifactorial risk assessment in conjunction with comprehensive management of identified risks to prevent falls in community-dwelling adults aged 65 years or older because the likelihood of benefit is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms on the basis of the circumstances of prior falls, comorbid medical conditions, and patient values. (Grade: C)
Behavioral Counseling to Promote a Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults	Although the correlation among healthful diet, physical activity, and the incidence of cardiovascular disease is strong, existing evidence indicates that the health benefit of initiating behavioral counseling in the primary care setting to promote a healthful diet and physical activity is small. Clinicians may choose to selectively counsel patients rather than incorporate counseling into the care of all adults in the general population. (Grade: C)
Screening for Hearing Loss in Older Adults	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for hearing loss in asymptomatic adults age 50 years and older. (I Statement) This statement applies to asymptomatic adults age 50 years and older. It does not apply to persons seeking evaluation for perceived hearing problems or for cognitive or affective complaints that may be potentially related to hearing loss. These individuals should be assessed for objective hearing impairment and treated when indicated.
Menopausal Hormone Therapy for the Primary Prevention of Chronic Conditions	The U.S. Preventive Services Task Force (USPSTF) recommends against the use of combined estrogen and progestin for the prevention of chronic conditions in postmenopausal women. (Grade: D) The USPSTF recommends against the use of estrogen for the prevention of chronic conditions in postmenopausal women who have had a hysterectomy. (Grade: D) This recommendation applies to postmenopausal women who are considering hormone therapy for the primary prevention of chronic medical conditions. This recommendation does not apply to women younger than age 50 years who have undergone surgical menopause. This recommendation does not consider the use of hormone therapy for the management of menopausal symptoms, such as hot flashes or vaginal dryness.
Screening for and Management of Obesity in Adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions. (Grade: B)

Topic	Specific Recommendations
Screening for Ovarian Cancer	The USPSTF recommends against screening for ovarian cancer in women. (Grade: D) This recommendation applies to asymptomatic women. Women with known genetic mutations that increase their risk for ovarian cancer (for example, BRCA mutations) are not included in this recommendation.
Screening for Prostate Cancer	The USPSTF recommends against prostate-specific antigen based screening for prostate cancer. (Grade: D)
Behavioral Counseling to Prevent Skin Cancer	The USPSTF recommends counseling children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer. (Grade: B) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of counseling adults older than age 24 years about minimizing risks to prevent skin cancer. (I Statement)

Table 2 (cont.). Final Recommendation Statements Published by the USPSTF, October 2011 to October 2012

In 2012, the USPSTF created a new opportunity for the public to offer feedback by posting all draft research plans for comment. The research plan establishes the scope for the systematic evidence review and identifies the key questions for which the Task Force needs evidence-based answers in order to make a recommendation about the balance of benefits and harms of a preventive service. Properly framing an evidence review and the Task Force's approach to a recommendation is critical to producing a final recommendation statement that is accurate and actionable. Scientists, clinicians, stakeholders, and the general public are invited to comment on each draft research plan, which is now posted on the USPSTF Web site for four weeks. The Task Force considers all comments before finalizing the research plan. The Task Force posted four draft research plans for public comment in 2012: screening for peripheral arterial disease; genetic risk assessment and BRCA mutation testing for breast and ovarian cancer susceptibility; prevention of dental caries in preschool-aged children; and screening for hepatitis B.

2012 Highlight: Expanded Dissemination

In 2012, the USPSTF produced plain language fact sheets for each of its final recommendations, designed to help Americans understand what each recommendation means for them. These fact sheets highlight that evidence-based recommendations are only one part of informed decisionmaking and encourage people to consider Task Force recommendations within the context of their own health status, their own values and preferences for health and health care, and alongside advice from a trusted health care professional. The fact sheets contain links to resources for learning more about each topic and encourage people to have informed discussions about clinical preventive services with their doctor or nurse.

> **The AAFP highly values the work of the U.S. Preventive Services Task Force. The scientific guidance USPSTF offers to family physicians helps us provide the best care to our patients. The Task Force is highly respected and we are grateful for the unbiased and high quality analyses it performs.**
>
> Glen R. Stream, MD, MBI, President, American Academy of Family Physicians

Because every recommendation is first shown to the public in draft form, this year, the USPSTF also began posting plain language fact sheets with each of its draft recommendation statements. In addition to breaking down the main points of each recommendation, these fact sheets explain how people can offer the USPSTF feedback about the recommendation. These fact sheets are available on the USPSTF Web site with the full draft recommendation statement.

In response to common questions posed to the USPSTF, the Task Force produced a series of materials explaining its mission, composition, and processes, including an introductory slide show "USPSTF 101." These materials complement the comprehensive USPSTF procedure manual that remains available to the public on the USPSTF Web site.

In order to help primary care clinicians learn about its recommendations and put them into practice, the Task Force partnered with Medscape/WebMD to produce and distribute a new 30-minute, free continuing education video. This video is designed to inform health care professionals about the role and purpose of the Task Force as well as its methods and process for making recommendations. Medscape is visited more than three million times by health care professionals each month.

2012 Highlight: Public Engagement

The Task Force is committed to making its work as transparent as possible. This includes both increasing stakeholders' and the public's understanding of and confidence in the approach of the Task Force and ensuring that its approach is recognized as open, credible, independent, and unbiased. Its intention is that expanded opportunities for public and stakeholder engagement will enhance the accuracy and relevance of its final recommendations.

> **The USPSTF has taken on the difficult task of organizing a long term approach to the science of prevention and adhering to a robust set of principles in doing so. That's good for science, good for the health care system, and good for the American people.**
>
> John Santa, MD, MPH, Director, Consumer Reports Health Ratings Center

As a result of efforts over the last two years, the Task Force engaged stakeholders and the public in many steps throughout its recommendation making process. Currently, stakeholders and the public can:

- Nominate new members to serve on the Task Force;
- Nominate new topics for Task Force consideration or request an update of an existing topic;
- Provide comments on all draft research plans; and
- Provide comments on all draft recommendation statements.

Over the past year, the Task Force continued to work with a group of standing implementation and dissemination partners (Appendix C). These partner organizations represent primary care clinicians, consumer organizations, Federal agencies, and other stakeholders involved in the delivery of primary care. These partners help the Task Force ensure that their recommendations are meaningful to the groups they represent. Partners are also a powerful vehicle for ensuring that America's primary care workforce remains up-to-date on USPSTF recommendations.

As part of its commitment to expand their engagement with stakeholders, in 2012, the USPSTF began convening Topic Groups for Stakeholders (TOPS). TOPS membership includes national organizations representing health professionals, the health care industry, business and manufacturing, and consumer and patient advocates. Through this process, national groups with interest and expertise in a specific topic are convened and encouraged to provide feedback at key points in the recommendation process. TOPS input helps the USPSTF build trust and confidence in its recommendations among the broader health care community while ensuring that the Task Force's recommendations are based on the most up-to-date evidence available.

In 2012, leaders of the Task Force met with several leading organizations representing and serving minority communities. These groups represented African Americans, Asians and Pacific Islanders, American Indians, and Hispanics. Together they explored opportunities for participation in the development of recommendations. Recognizing the lack of evidence about many preventive services for racial and ethnic minority groups, they opened discussions about how USPSTF recommendations could best serve minority communities.

EVIDENCE OF EFFECT OF EXPANDED PUBLIC ENGAGEMENT

Two recent examples demonstrate how posting draft research plans and draft recommendation statements for public comment have added value to the work of the Task Force.

In December 2011, the Task Force posted the draft research plan on screening for peripheral arterial disease (PAD) for public comment. PAD occurs when atherosclerosis causes narrowing of the arteries to the legs. Most people with PAD do not experience symptoms, but some can have intermittent leg pain. The draft research plan focused on the following question: Does screening with an ankle brachial index (ABI, the ratio of blood pressure in arm and leg) and treatment for PAD in asymptomatic adults lead to reduced mortality or morbidity from PAD?

Based on comments received, the Task Force recognized that its recommendation on screening for PAD would be more clinically relevant if it expanded the scope for the evidence review to include ABI as a predictor of cardiovascular disease, not just of PAD. If ABI could help clinicians better identify adults at risk for future heart attacks and strokes, they may be able to better target preventive interventions such as lifestyle changes and medications to those who would likely benefit. As a result of the public comments, the USPSTF expanded the outcomes to be considered in its systematic evidence review and will be positioned to make a more useful recommendation.

In the fall of 2011, the USPSTF posted a comprehensive draft recommendation statement regarding screening for cervical cancer. The draft statement included several specific recommendations, including a recommendation to screen all women ages 21 to 65 every 3 years using a Pap smear. The draft also included a statement that the evidence was insufficient to assess the evidence on the use of human papillomavirus (HPV) testing for cervical cancer screening. These recommendations were based on the best available evidence at the time of the USPSTF deliberations.

The USPSTF received hundreds of comments from the general public, experts, and professional organizations. In response, the USPSTF made several changes to its final recommendation statement. The final statement highlighted that the most effective way to prevent deaths from cervical cancer in the United States is to expand screening to women who have never been screened or have not been adequately screened (Please see the Implementation Needs Section of this report for more on this issue). Based on new evidence published after its initial deliberation and highlighted in public comments, the USPSTF determined that there was sufficient evidence to recommend HPV testing combined with a Pap smear ("co-testing") as a reasonable alternative for women aged 30 to 65 years who wish to extend the screening interval beyond three years. As a result of public comments and new evidence, the Task Force was able to provide better information to the public and to clarify many fine points in its recommendation, resulting in a more useable recommendation.

IV. CURRENT EVIDENCE GAPS DESERVING OF FURTHER RESEARCH

The Task Force issues evidence-based recommendations about clinical preventive services in order to improve the health of all Americans. The Task Force focuses on health conditions that have a high burden of suffering, with potentially important public health implications due to the expected effectiveness of a preventive service to reduce suffering. If implemented appropriately and effectively, Task Force recommendations can improve the health of the nation. However, significant gaps in key areas of knowledge limit the full realization of these benefits.

With the Affordable Care Act, Congress recognized the opportunity for new research to provide the necessary evidence base upon which the USPSTF can build more extensive recommendations. Congress specifically charged the USPSTF with identifying and reporting to the legislative branch each year on the critical evidence gaps in two areas: 1) areas where the current evidence is insufficient to make any recommendation on the use of a clinical preventive service, and 2) areas where evidence is needed to make recommendations for specific populations and age groups.

In its First Annual Report to Congress (see Executive Summary in Appendix A), the Task Force identified four screening tests and three behavioral interventions with significant evidence gaps deserving further research. These were: screening for coronary heart disease with new and old technologies; screening for colorectal cancer with new modalities; screening for hepatitis C; screening for hip dysplasia in newborns; moderate- to low-intensity counseling for obesity; interventions in primary care to prevent child abuse and neglect; and screening for illicit drug use in primary care. Given the expected pace of research, one year is too soon to expect that these gaps would have been addressed. The Task Force, therefore, encourages Congress to continue promoting research to address these gaps.

Below are specific topics that the USPSTF has identified during the past year as having important evidence gaps that may be addressed through research. More research in these areas would likely result in important new recommendations that will help to improve the health of Americans.

High-Priority Evidence Gaps for Clinical Preventive Services

Since October 2011, the USPSTF published final recommendation statements on 10 different topics (see **Table 2** on page 6). For all topics, regardless of the letter grade it assigns, the Task Force identifies gaps in the evidence. The USPSTF considered all recently published recommendations to determine which evidence gaps were of high priority and, if addressed with more research, could lead to more informative recommendations. It identified three clinical preventive services with high-priority evidence gaps deserving of further research: screening for chronic kidney disease; screening for cervical cancer; and screening for prostate cancer.

1. Screening for Chronic Kidney Disease

Chronic kidney disease is a common condition that occurs in approximately 11 percent of adults, affecting millions of Americans. The condition is usually asymptomatic until its advanced stages. It is associated with increased risk for death, cardiovascular disease, fractures, infections, cognitive impairment, and frailty. Most adults with mild to moderate chronic kidney disease have diabetes or high blood pressure, and people with these conditions are generally tested and monitored as an ongoing part of their care. When reviewing the evidence on whether to screen adults who do not have diabetes or high blood pressure, the USPSTF found several gaps in the evidence that prevented them from making a recommendation. In a statement published August 2012, the Task Force said the evidence was insufficient and the balance of benefits and harms could not be determined to recommend for or against screening adults for chronic kidney disease.

In addition to research on the overall benefits and harms of screening, evidence is needed on the accuracy of screening tests to detect chronic kidney disease. While there is evidence that some tests can identify current kidney disease, more information is needed about how well tests can pinpoint people who will have kidney disease that is "chronic," lasting at least three months.

For a related and important research gap regarding African-American adults, please see page 13.

2. Screening for Cervical Cancer With Human Papillomavirus (HPV) Tests

The incidence and mortality of cervical cancer have declined in the United States since the introduction of cervical cancer screening with Pap smears in the 1950s and 1960s. However, cervical cancer still remains a substantial public health issue. Approximately 12,000 new cases of cervical cancer and 4,000 deaths from the disease occurred in 2010. Incidence rates vary by age, race, and ethnicity. Hispanic and African-American women experience the highest rates, and cases occur most commonly in women 35-55 years of age.

In 2012, the USPSTF found convincing evidence that screening every three years for cervical cancer in women 21-65 years of age prevents cervical cancer and related deaths. Additionally, for the first time, the USPSTF stated that women aged 30-65 could get the same benefit with less frequent screening (every five years) if they added a test for HPV to the traditional Pap smear.

However, more research is needed to more fully understand both the optimal approach to screening for cervical cancer utilizing new technologies and the potential harms, including risks to future pregnancies, related to different screening and treatment options. Research in these areas would allow the USPSTF to provide more information to clinicians and women as they make decisions together about the best approach to screen for cervical cancer.

3. Screening for Prostate Cancer

Prostate cancer is the second most commonly diagnosed cancer among men in the United States after skin cancer. Older age is the strongest risk factor for the development of prostate cancer, and African-American men have an increased risk of developing and dying from the disease. In 2012, the USPSTF reviewed the evidence and determined that the small potential benefit of screening for prostate-specific antigen (PSA) does not outweigh the expected harms. Serious harms are common with biopsies and treatment for prostate cancer detected by PSA. These harms include death, pain, bleeding, impotence, and loss of bowel and bladder function. The Task Force therefore recommended against PSA-based screening.

Most cases of prostate cancer have a good prognosis even without treatment; however, some cases are aggressive and can affect quality or length of life. Unfortunately, at present, there are no highly reliable tools to distinguish between aggressive and non-aggressive cancers detected via screening. More research is needed to find tools that accurately identify aggressive prostate cancer that is likely to cause health problems so that those men can receive early treatment. This would limit the number of men who develop serious complications from unneeded diagnostic biopsies and treatment.

Another way to potentially reduce the number of men with localized prostate cancer unnecessarily subjected to these serious harms is known as “active surveillance,” in which men are monitored over time for signs of disease progression before intervention. Research is needed to understand which men might be appropriate candidates for active surveillance, how this approach might best be used, and the long-term benefits and harms of this delayed treatment strategy in men with screen-detected prostate cancer.

For a related and important research gap regarding African-American men, please see page 13.

Evidence Gaps Relating to Specific Populations and Age Groups That Deserve Further Research

Several clinical preventive services have been well studied for the general population, but important evidence gaps exist that prevent the USPSTF from making recommendations for some populations and age groups. This is often because these groups are underrepresented in health research. Prime examples of such groups are older adults, children, and members of racial and ethnic minorities. In the past, women were also underrepresented in medical research. Greater inclusion of these populations in research will help the USPSTF issue recommendations that can be used to improve the quality of preventive care for these groups and to eliminate disparities.

1. **Screening for Chronic Kidney Disease in African-American Adults**
   African-American adults are 3–5 times more likely than others with chronic kidney disease to progress to severe kidney disease requiring dialysis. More research is needed to explore the reasons for, and possible interventions to prevent, the disproportionate burden of severe kidney disease experienced by African Americans.

2. **Screening for Prostate Cancer in African-American Men**
   African-American men have an increased risk of developing and dying from prostate cancer compared to non-Hispanic white men. One possible reason, among others, for this disparity may be inadequate access to health care. It is possible that screening, early identification, and treatment of prostate cancer may have a more favorable or less favorable balance of benefit and harms in African American men than is seen in the general population. Studies that do not recruit minorities cannot provide definitive answers to the question of whether the effects of screening and treatment will differ in these subgroups. Additional research is needed to understand the underlying causes of the increased risk of developing and dying from the disease and to develop better screening and treatment options for African-American men.

3. **Counseling About Sun-Protective Behaviors in Families With Children Under Age 10 to Reduce the Risk for Skin Cancer**
   Based on available evidence, in 2012, the USPSTF recommended counseling children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce their risk for skin cancer. However, there is limited research on effective interventions in primary care to increase sun-protective behaviors in children under the age of 10. Given that sunburns in childhood are an important risk factor for skin cancer, this is a key gap in the evidence that has the potential to significantly impact skin cancer rates in the United States.

High-Priority Gaps in Implementation Research

The USPSTF notes that there are also critical questions about how Task Force recommendations can best be implemented in primary care practices. More implementation and translational research in this area will increase the value of the USPSTF's work. For example, research is needed to systematically evaluate the following:

1. **How can we best help women to get screened for cervical cancer?**
   Most cases of cervical cancer occur in women who have not been appropriately screened—they have never been screened, they have not been screened recently, or they did not have appropriate follow-up care for abnormal test results. Strategies that aim to ensure that all women are screened at appropriate intervals and receive adequate follow-up are most likely to be successful in further reducing cervical cancer in the United States. More research is needed to understand what factors are associated with inadequate screening and how to help deliver the best screening and treatment.

2. **Are targeted brief interventions delivered in primary care effective for weight loss, and what combinations of primary care and community interventions are most effective for weight loss?**
   In 2012, the USPSTF recommended screening all adults for obesity and offering or referring obese patients, those with a body mass index (BMI) of 30 kg/m^2 or higher, to intensive, multicomponent behavioral interventions. The USPSTF found that the most effective interventions were comprehensive and of high intensity (12 to 26 sessions in a year). Intensive interventions, however, may be impractical within many primary care settings and may be unavailable in many communities. Research is needed on the effectiveness of targeted, brief interventions for weight loss and the best strategies for weight loss interventions provided across primary care, specialty clinics, public health, and community-based organizations.

V. NEXT STEPS FOR THE USPSTF IN 2013

In the coming 12 months, it is expected that:

1. The USPSTF will continue its work on over 20 topics that are in process.
2. The USPSTF will begin work on 12 new topics, including topics nominated for consideration through the public topic nomination process.
3. The USPSTF will begin soliciting input from stakeholders and the public on draft systematic evidence reviews to ensure that the Task Force has identified all available published evidence and has accurately interpreted research findings.
4. The USPSTF will post nine draft research plans and 14 draft recommendation statements for public comment.
5. The USPSTF will release 12 final recommendation statements.
6. The USPSTF will continue to coordinate closely with the CPSTF to improve the nation's ability to benefit from the full spectrum of prevention.
7. The USPSTF will continue to enhance opportunities for public engagement and will build new partnerships with health care systems and primary care professional groups to improve the dissemination and implementation of its recommendations on effective clinical preventive services.
8. The USPSTF will prepare a third annual report for Congress on high-priority evidence gaps in the field of clinical preventive services.

VI. CONCLUSION

The USPSTF appreciates the opportunity to report on its activities, to highlight critical evidence gaps, and to recommend important new areas for research in clinical preventive services. The volunteer members of the Task Force look forward to their ongoing work to improve the health of all Americans.

Appendices

APPENDIX A. SUMMARY OF FIRST ANNUAL REPORT TO CONGRESS ON HIGH-PRIORITY EVIDENCE GAPS FOR CLINICAL PREVENTIVE SERVICES

The Patient Protection and Affordable Care Act of 2010 charged the USPSTF with making an annual report to Congress to identify gaps in the evidence base and recommend priority areas that deserve further examination. The first annual report from the USPSTF was delivered to Congress in October 2011. In this report, the USPSTF identified the following high-priority evidence gaps that can be addressed through targeted research:

Screening Tests That Deserve Further Research:

1. Screening for Coronary Heart Disease With New and Old Technologies
2. Screening for Colorectal Cancer With New Modalities
3. Screening for Hepatitis C
4. Screening for Hip Dysplasia in Newborns

Behavioral Intervention Research Topics That Deserve Further Research:

1. Moderate- to Low-Intensity Counseling for Obesity
2. Interventions in Primary Care to Prevent Child Abuse and Neglect
3. Screening for Illicit Drug Use in Primary Care

In the Affordable Care Act, Congress also requested that the USPSTF identify evidence gaps that prevent it from making recommendations that target specific populations or age groups. In its 2011 report, the USPSTF highlighted the following key areas:

Evidence Gaps Relating to Specific Populations and Age Groups That Deserve Further Research:

1. Screening for Osteoporosis in Men
2. Screening and Treatment for Depression in Children
3. Screening and Counseling for Alcohol Misuse in Adolescents
4. Aspirin Use to Prevent Heart Attacks and Strokes in Adults Ages 80 Years and Older

By identifying these evidence gaps and prioritizing these areas for research, the USPSTF hopes to have inspired public and private researchers to focus their efforts in these areas so that the USPSTF can develop definitive recommendations on these important topics in the near future.

To view the full report, visit: **www.uspreventiveservicestaskforce.org/annlrpt/index.html**.

APPENDIX B. 2012 MEMBERS OF THE USPSTF

Virginia A. Moyer, M.D., M.P.H. (Chair)

Dr. Moyer is a professor of pediatrics and head of the Academic General Pediatrics Section at Baylor College of Medicine and chief of the academic medicine service at Texas Children's Hospital. She is also a member of the board of directors for the American Board of Pediatrics, deputy editor of *Pediatrics*, the journal of the American Academy of Pediatrics (AAP), and a past member of AAP's Steering Committee on Quality Improvement and Management. Her areas of expertise include health services research, diagnostic testing, quality improvement, patient safety, and evidence-based medicine.

Michael L. LeFevre, M.D., M.S.P.H. (Co-Vice Chair)

Dr. LeFevre is a professor in the Department of Family and Community Medicine at the University of Missouri School of Medicine, Columbia, Missouri. He is the medical director for family medicine at Missouri University Health Care; is director of the Missouri University Health Care Electronic Medical Record project; chair of the credentialing committee for the Department of Family Medicine; and director of clinical services at the Department of Family Medicine. He has served on the Commission on Clinical Policies and Research of the American Academy of Family Physicians. Dr. LeFevre is a researcher, a published author and consultant, and has been invited to give many presentations across the country.

Albert L. Siu, M.D., M.S.P.H. (Co-Vice Chair)

Dr. Siu is the Ellen and Howard C. Katz chair and professor of the Brookdale Department of Geriatrics and Palliative Medicine at the Mount Sinai School of Medicine. He is also director of the Geriatric Research, Education, and Clinical Center at the James J. Peters Veterans Affairs (VA) Medical Center, and has served as deputy commissioner of the New York State Department of Health. Dr. Siu serves as a senior associate editor of *Health Services Research*. His research focuses on the measurement and improvement of functional outcomes in the elderly.

Linda Ciofu Baumann, Ph.D., R.N.

Dr. Baumann is professor emerita at the University of Wisconsin-Madison School of Nursing, affiliate faculty at the University of Wisconsin School of Medicine and Public Health, a Fellow of the Society of Behavioral Medicine, and a Fellow of the American Academy of Nursing. A certified adult nurse practitioner, Dr. Baumann is an experienced researcher, primary care clinician, and consultant. She is a widely-published author, and has co-authored two books, one of which—"Advanced Assessment and Clinical Diagnosis in Primary Care"—received the *American Journal of Nursing*'s Book of the Year award in advanced practice nursing in 2003. Dr. Baumann's areas of expertise are global public health, chronic disease management, and behavioral health promotion.

Kirsten Bibbins-Domingo, Ph.D., M.D.

Dr. Bibbins-Domingo is an associate professor of medicine and of epidemiology and biostatistics at the University of California, San Francisco (UCSF), and is co-director of the UCSF Center for Vulnerable Populations at San Francisco General Hospital. Dr. Bibbins-Domingo's research interests include understanding the interaction between social, behavioral, and biological factors that place vulnerable groups at risk for cardiovascular disease early in life and population-wide interventions that may prevent disease in these groups.

Adelita Gonzales Cantu, Ph.D., R.N.

Dr. Cantu is an assistant professor of family and community health systems at the University of Texas Health Science Center at San Antonio. She serves on the board of directors for the National Association of Hispanic Nurses. Dr. Cantu's research interests include cultural competency in nursing, health disparities among the Hispanic population, physical activity in older Hispanic women, and the recruitment and mentoring of Hispanic nursing students.

Susan J. Curry, Ph.D.

Dr. Curry is the dean of the College of Public Health and distinguished professor of health management and policy at the University of Iowa. She is currently vice chair of the American Legacy Foundation's board of directors and a former member of the National Cancer Institute's board of scientific advisors. Dr. Curry's research focuses on disease prevention and behavioral risk factor modification in the areas of tobacco use, healthful eating, alcohol misuse, and compliance with cancer screening. In addition to primary care-based behavior change interventions, Dr. Curry's health service research has focused on the use and cost effectiveness of tobacco cessation treatments under different health insurance plans and health care costs and utilization associated with tobacco cessation.

Mark Ebell, M.D., M.S.

Dr. Ebell is an associate professor of epidemiology and biostatistics at The University of Georgia with a background in family medicine. An author of more than 200 peer-reviewed publications and author and co-editor of seven books, Dr. Ebell is currently editor-in-chief of *Essential Evidence*, deputy editor of *American Family Physician*, and associate editor of *Family Practice*. His expertise and research interests include primary care research, point-of-care decision support, health information technology for the primary care setting, evidence-based medicine, and systematic reviews of screening and diagnostic tests.

Glenn Flores, M.D.

Dr. Flores is a professor of pediatrics, clinical sciences, and public health; Director of the Division of General Pediatrics; and the Judith and Charles Ginsburg Endowed Chair in Pediatrics at UT Southwestern and Children's Medical Center Dallas. He has published 158 articles and book chapters on a variety of topics, including many papers that address underserved children and racial/ethnic and linguistic disparities in children's health and health care. He received the 2006 American Academy of Pediatrics Outstanding Achievement Award in the Application of Epidemiologic Information to Child Health Advocacy, the 2008 Millie and Richard Brock Award for Distinguished Contributions to Pediatrics, the 2010 Helen Rodriquez-Trías Social Justice Award from the American Public Health Association, and the 2012 Academic Pediatric Association's Research Award.

David C. Grossman, M.D., M.P.H.

Dr. Grossman, a board-certified pediatrician recognized for his research on injury prevention and Native American health, is a senior investigator at the Group Health Research Institute. He is also a professor of health services and adjunct professor of pediatrics at the University of Washington. He serves on the Board of Scientific Counselors for the Centers for Disease Control and Prevention's National Center for Injury Prevention and Control. In 2007, the American Academy of Pediatrics awarded Dr. Grossman the Native American Child Health Advocacy Award. His current research focuses on innovations to improve the uptake and delivery of clinical preventive services in primary care.

Jessica Herzstein, M.D., M.P.H.

Dr. Herzstein is an expert in public health, screening, and preventive health services and is currently the global medical director at Air Products. In this position, Dr. Herzstein develops, implements, and oversees global health programs for 20,000 employees. She also works as an occupational and environmental health consultant and lecturer at the University of Pennsylvania School of Medicine. A member of the Council on Foreign Relations and the American Public Health Association, Dr. Herzstein is an accomplished public health specialist with more than 20 years of experience in teaching, research, patient care, and health care program administration. She has a focus on women's health, chronic disease management, and health education and behavior change.

Joy Melnikow, M.D., M.P.H.

Dr. Melnikow is a professor in the Department of Family and Community Medicine and director of the Center for Healthcare Policy and Research at the University of California Davis. She is currently a deputy editor of *Medical Care*, standing member of the Health Services Organization and Delivery Study Section at the National Institutes of Health, contributing member of the California Health Benefits Program Task Force for the University of California's Office of the President, and associate medical director of Healthwise, Inc. Dr. Melnikow's research interests include cost-effectiveness analysis to assist clinical and public health policy formulation, cancer prevention in women, patient preferences and decisionmaking, underserved populations, and health disparities.

Wanda Nicholson, M.D., M.P.H., M.B.A.

Dr. Nicholson, a board-certified obstetrician-gynecologist and a perinatal epidemiologist, is an associate professor in the Department of Gynecology and Obstetrics at the University of North Carolina, Chapel Hill School of Medicine. She is director of the Diabetes and Obesity Core at the Center for Women's Health Research. She is currently a member of the American Congress of Obstetricians and Gynecologists' committee on health care for underserved women and of the Centers for Disease Control and Prevention's public health working group on preconception care and health care. Dr. Nicholson's research focuses on the epidemiology of chronic conditions in women, including gestational diabetes, type 2 diabetes, obesity, and the effect of depressive symptoms on health-related quality of life.

Douglas K. Owens, M.D., M.S.

Dr. Owens is associate director of the Center for Health Care Evaluation at the VA Palo Alto Health Care System; Henry J. Kaiser, Jr., Professor and director of the Center for Health Policy in the Freeman Spogli Institute for International Studies; and director of the Center for Primary Care and Outcomes Research in the School of Medicine at Stanford University. He is a general internist and a senior investigator at the Department of Veterans Affairs (VA) Palo Alto Health Care System. Dr. Owens' research focuses on technology assessment, cost-effectiveness analysis, evidence synthesis, and methods for clinical decisionmaking.

Carolina Reyes, M.D., M.P.H.

Dr. Reyes is a practicing perinatologist in maternal and fetal medicine at Virginia Hospital Center in Arlington, Virginia. Dr. Reyes has earned numerous awards in recognition of her professional and community service, including awards from the Los Angeles Medical Women's Association, Los Angeles County Board of Supervisors, and California/Latino Medical Association. Dr. Reyes specializes in maternal and child health, interconception care, and diabetes, and is an advocate for improving health care quality and reducing disparities in care.

Timothy J. Wilt, M.D., M.P.H.

Dr. Wilt, a board-certified internal medicine specialist, is a professor in the Department of Medicine at the University of Minnesota and the Minneapolis Veterans Affairs Medical Center. As an investigator in the Minneapolis VA Health Services Research and Development Center for Chronic Disease Outcomes Research, his research interests include evidence-based chronic disease prevention and management. Dr. Wilt served on the Outcomes Research & Epidemiology Task Force in 1997 and currently sits on the editorial board of the *American Journal of Medicine*.

APPENDIX C. USPSTF IMPLEMENTATION AND DISSEMINATION PARTNER ORGANIZATIONS

Organizations Representing Primary Care Professionals

American Academy of Family Physicians

American Academy of Nurse Practitioners

American Academy of Pediatrics

American Academy of Physician Assistants

American College of Obstetricians and Gynecologists

American College of Physicians

American College of Preventive Medicine

American Osteopathic Association

National Association of Pediatric Nurse Practitioners

Federal Partners

Centers for Disease Control and Prevention

Centers for Medicare & Medicaid Services

Department of Defense/Military Health System

Food and Drug Administration

Health Resources and Services Administration

Indian Health Service

National Institutes of Health

Office of Disease Prevention and Health Promotion

Office of the Surgeon General

Veterans Health Administration

Policy, Population, and Systems Implementation Partners

AARP

America's Health Insurance Plans

National Committee for Quality Assurance

APPENDIX D. COMPLETE LISTING OF ALL USPSTF SPECIFIC RECOMMENDATIONS AS OF OCTOBER 2012

Grade	Title
A	**Aspirin to Prevent Myocardial Infarction: Men Ages 45 to 79 Years** The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit of a reduction in myocardial infarctions outweighs the potential harm of an increase in gastrointestinal hemorrhage.
A	**Aspirin to Prevent Ischemic Stroke: Women Ages 55 to 79 Years** The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
A	**Asymptomatic Bacteriuria: Screening in Pregnant Women** The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
A	**Cervical Cancer: Screening in Women Ages 21 to 65 (Pap Smear) or 30-65 (with HPV testing)** The USPSTF recommends screening for cervical cancer in women age 21 to 65 years with cytology (Pap smear) every 3 years or, for women age 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
A	**Chlamydia: Screening in Women Ages 24 Years and Younger or Older Women at Increased Risk** The USPSTF recommends screening for chlamydial infection in all sexually active, nonpregnant women ages 24 years and younger and in older nonpregnant women who are at increased risk.
A	**Colorectal Cancer: Screening in Adults Ages 50 to 75 Years** The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.
A	**Congenital Hypothyroidism: Screening in Newborns** The USPSTF recommends screening for congenital hypothyroidism in newborns.
A	**Folic Acid: Supplementation in Women Planning or Capable of Pregnancy** The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.
A	**HIV: Screening in Adults and Adolescents at Increased Risk** The USPSTF strongly recommends that clinicians screen for HIV in all adolescents and adults at increased risk for HIV infection.
A	**HIV: Screening in Pregnant Women** The USPSTF recommends that clinicians screen all pregnant women for HIV.
A	**Hepatitis B Virus: Screening in Pregnant Women** The USPSTF recommends screening for hepatitis B virus infection in all pregnant women at their first prenatal visit.
A	**High Blood Pressure: Screening in Adults Ages 18 Years and Older** The USPSTF recommends screening for high blood pressure in adults ages 18 years and older.

Grade	Title
A	**Lipid Disorders in Adults: Screening in Men Ages 35 Years and Older** The USPSTF recommends screening men ages 35 years and older for lipid disorders.
A	**Lipid Disorders in Adults: Screening in Women Ages 45 Years and Older at Increased Risk for Coronary Heart Disease** The USPSTF recommends screening for lipid disorders in women ages 45 years and older if they are at increased risk for coronary heart disease.
A	**Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication for All Newborns** The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
A	**Phenylketonuria: Screening in Newborns** The USPSTF recommends screening for phenylketonuria in newborns.
A	**Rh(D) Blood Typing: Screening in Pregnant Women at First Pregnancy-Related Visit** The USPSTF recommends Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
A	**Sickle Cell Disease: Screening in Newborns** The USPSTF recommends screening for sickle cell disease in newborns.
A	**Syphilis: Screening in Pregnant Women** The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.
A	**Syphilis: Screening in Adults at Increased Risk** The USPSTF recommends that clinicians screen for syphilis infection in adults at increased risk.
A	**Tobacco Use: Counseling and Interventions for Adults** The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.
A	**Tobacco Use: Counseling and Interventions for Pregnant Women** The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke.
B	**Abdominal Aortic Aneurysm: Screening in Men Ages 65 to 75 Years Who Smoke** The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.
B	**Alcohol Misuse: Screening and Behavioral Counseling for Adults and Pregnant Women** The USPSTF recommends screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
B	**BRCA Mutation Testing for Breast and Ovarian Cancer: Women at Increased Risk** The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in breast cancer susceptibility gene BRCA1 or BRCA2 be referred for genetic counseling and evaluation for BRCA testing.

Grade	Title
B	**Breast Cancer: Preventive Medication Discussion With Women at Increased Risk** The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.
B	**Breast Cancer: Screening With Mammography in Women Ages 50 to 74 Years*** The USPSTF recommends biennial screening mammography for women ages 50 to 74 years. **The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 USPSTF recommendation on breast cancer screening. This recommendation states, "The USPSTF recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women ages 40 and older (B recommendation)."*
B	**Breastfeeding: Primary Care Interventions to Promote Its Use in All Pregnant Women and New Mothers** The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.
B	**Chlamydia: Screening in Pregnant Women Ages 24 Years and Younger or Older Pregnant Women at Increased Risk** The USPSTF recommends screening for chlamydial infection in all pregnant women ages 24 years and younger and in older pregnant women who are at increased risk.
B	**Dental Caries: Oral Fluoride Supplementation in Preschool Children Ages 6 Months and Older** The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children ages 6 months and older whose primary water source is deficient in fluoride.
B	**Depression: Screening in Adolescents Ages 12 to 18 Years in Clinical Practices With Systems of Care** The USPSTF recommends screening for major depressive disorder in adolescents (ages 12-18 years) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and followup.
B	**Depression: Screening in Adults When Staff-Assisted Depression Care Supports Are in Place** The USPSTF recommends screening for depression in adults (ages 18 years and older) when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and followup.
B	**Falls Prevention: Exercise or Physical Therapy for Community-dwelling Adults 65 Years or Older at Increased Risk for Falls** The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.
B	**Falls Prevention: Vitamin D Supplementation for Community-dwelling Adults 65 Years or Older at Increased Risk for Falls** The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.
B	**Gonorrhea: Screening in Pregnant Women and Women at Increased Risk** The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
B	**Healthy Diet: Counseling for Adults With Hyperlipidemia and Other Risk Factors for Cardiovascular Disease** The USPSTF recommends intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
B	**Hearing Loss in Newborns: Universal Screening in Newborns** The USPSTF recommends screening for hearing loss in all newborn infants.

Grade	Title
B	**Iron Deficiency Anemia: Iron Supplementation in Asymptomatic Children Ages 6 to 12 Months at Increased Risk** The USPSTF recommends routine iron supplementation for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.
B	**Iron Deficiency Anemia: Screening in Asymptomatic Pregnant Women** The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.
B	**Lipid Disorders in Adults: Screening in Men Ages 20 to 34 Years at Increased Risk for Coronary Heart Disease** The USPSTF recommends screening for lipid disorders in men ages 20 to 35 years if they are at increased risk for coronary heart disease.
B	**Lipid Disorders in Adults: Screening in Women Ages 20 to 44 Years at Increased Risk for Coronary Heart Disease** The USPSTF recommends screening for lipid disorders in women ages 20 to 45 years if they are at increased risk for coronary heart disease.
B	**Obesity: Screening in Children and Adolescents Ages 6 to 17 Years** The USPSTF recommends that clinicians screen for obesity in children ages 6 years and older and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
B	**Obesity: Screening and Management for All Adults** The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.
B	**Osteoporosis: Screening in Women Ages 65 Years and Older and Younger Women at Increased Risk** The USPSTF recommends screening for osteoporosis in women ages 65 years or older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.
B	**Rh(D) Blood Typing: Antibody Testing in Unsensitized Rh(D)-Negative Pregnant Women** The USPSTF recommends repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24-28 weeks gestation, unless the biological father is known to be Rh(D)-negative.
B	**Sexually Transmitted Infections: Behavioral Counseling for Sexually Active Adolescents and Adults at Increased Risk** The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
B	**Skin Cancer: Behavioral Counseling for Children, Adolescents, and Young Adults Ages 10 to 24** The USPSTF recommends counseling children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
B	**Type 2 Diabetes Mellitus: Screening in Adults With Sustained Blood Pressure of 135/80 or Higher** The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
B	**Visual Impairment: Screening in All Children at Least Once Between Ages of 3 and 5 Years** The USPSTF recommends screening for vision impairment in all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.
C	**Abdominal Aortic Aneurysm: Screening in Men Ages 65 to 75 Years Who Do Not Smoke** The USPSTF makes no recommendation for or against screening for abdominal aortic aneurysm in men ages 65 to 75 years who have never smoked.

Grade	Title
C	**Breast Cancer: Screening With Mammography in Women Ages 40 to 49 Years*** The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms. **The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 USPSTF recommendation on breast cancer screening. This recommendation states, "The USPSTF recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women ages 40 and older (B recommendation)."*
C	**Chlamydia: Screening in Women Ages 25 Years and Older Not at Increased Risk** The USPSTF recommends against routine screening for chlamydial infection in women ages 25 years and older, whether or not they are pregnant, if they are not at increased risk.
C	**Colorectal Cancer: Screening in Adults Ages 76 to 85 Years** The USPSTF recommends against routine screening for colorectal cancer in adults ages 76 to 85 years. There may be considerations that support colorectal cancer screening in an individual patient.
C	**Depression: Screening in Adults When Staff-Assisted Depression Care Supports Are Not in Place** The USPTF recommends against routine screening for depression in adults (ages 18 years and older) when staff-assisted depression care supports are not in place. There may be considerations that support screening for depression in an individual patient.
C	**Falls Prevention: Multifactorial Risk Assessment with Comprehensive Management of Identified Risks for Community-dwelling Adults Ages 65 or Older** The USPSTF does not recommend automatically performing an in-depth multifactorial risk assessment in conjunction with comprehensive management of identified risks to prevent falls in community-dwelling adults aged 65 years or older because the likelihood of benefit is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms on the basis of the circumstances of prior falls, comorbid medical conditions, and patient values.
C	**HIV: Screening in Adults and Adolescents Not at Increased Risk** The USPSTF makes no recommendation for or against routine screening for HIV in adolescents and adults who are not at increased risk for HIV infection.
C	**Healthful Diet and Physical Activity: Counseling to Prevent CVD for All Adults (Without a Known Diagnosis of Hypertension, Diabetes, Hyperlipidemia, or Cardiovascular Disease)** Although the correlation among healthful diet, physical activity, and the incidence of cardiovascular disease is strong, existing evidence indicates that the health benefit of initiating behavioral counseling in the primary care setting to promote a healthful diet and physical activity is small. Clinicians may choose to selectively counsel patients rather than incorporate counseling into the care of all adults in the general population.
C	**Lipid Disorders in Adults: Screening in Men Ages 20 to 35 Years Not at Increased Risk for Coronary Heart Disease** The USPSTF makes no recommendation for or against routine screening for lipid disorders in men ages 20 to 35 years who are not at increased risk for coronary heart disease.
C	**Lipid Disorders in Adults: Screening in Women Ages 20 Years and Older Not at Increased Risk for Coronary Heart Disease** The USPSTF makes no recommendation for or against routine screening for lipid disorders in women ages 20 years and older who are not at increased risk for coronary heart disease.
D	**Abdominal Aortic Aneurysm: Screening in Women** The USPSTF recommends against routine screening for abdominal aortic aneurysm in women.

Grade	Title
D	**Aspirin to Prevent Myocardial Infarction: Men Younger Than Age 45 Years** The USPSTF recommends against the use of aspirin for myocardial infarction prevention in men younger than age 45 years.
D	**Aspirin to Prevent Ischemic Stroke: Women Younger Than Age 55 Years** The USPSTF recommends against the use of aspirin for stroke prevention in women younger than age 55 years.
D	**Asymptomatic Bacteriuria: Screening in Men and Nonpregnant Women** The USPSTF recommends against screening for asymptomatic bacteriuria in men and nonpregnant women.
D	**BRCA Mutation Testing for Breast and Ovarian Cancer: Women at Low Risk** The USPSTF recommends against routine referral for genetic counseling or routine breast cancer susceptibility gene (BRCA) testing for women whose family history is not associated with an increased risk for deleterious mutations in BRCA1 or BRCA2.
D	**Bacterial Vaginosis in Pregnancy: Screening in Asymptomatic Pregnant Women at Low Risk for Preterm Delivery** The USPSTF recommends against screening for bacterial vaginosis in asymptomatic pregnant women at low risk for preterm delivery.
D	**Blood Lead Levels: Screening in Children Ages 1 to 5 Years at Average Risk** The USPSTF recommends against routine screening for elevated blood lead levels in asymptomatic children ages 1 to 5 years who are at average risk.
D	**Blood Lead Levels: Screening in Pregnant Women** The USPSTF recommends against routine screening for elevated blood lead levels in asymptomatic pregnant women.
D	**Breast Cancer: Preventive Medication for Women at Average Risk** The USPSTF recommends against routine use of tamoxifen or raloxifene for the primary prevention of breast cancer in women at low or average risk for breast cancer.
D	**Breast Cancer: Teaching Breast Self-Examination*** The USPSTF recommends against teaching breast self-examination. **The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 USPSTF recommendation on breast cancer screening. The full 2002 recommendation may be accessed at http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca2002.htm.*
D	**Carotid Artery Stenosis: Screening in Adults** The USPSTF recommends against screening for asymptomatic carotid artery stenosis in the general adult population.
D	**Cervical Cancer: Screening With HPV testing in Women Younger Than Age 30 Years** The USPSTF recommends against screening for cervical cancer with HPV testing, alone or in combination with cytology, in women younger than age 30 years.
D	**Cervical Cancer: Screening in Women Younger than 21** The USPSTF recommends against screening for cervical cancer in women younger than age 21 years.
D	**Cervical Cancer: Screening in Women Older Than Age 65 and Who Have Had Adequate Prior Screening** The USPSTF recommends against screening for cervical cancer in women older than age 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer.

Grade	Title
D	**Cervical Cancer: Screening in Women Who Have Had a Hysterectomy** The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion (cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.
D	**Chronic Obstructive Pulmonary Disease: Screening Using Spirometry in Adults** The USPSTF recommends against screening for chronic obstructive pulmonary disease using spirometry in adults.
D	**Colorectal Cancer: Screening in Adults Older Than Age 85 Years** The USPSTF recommends against screening for colorectal cancer in adults older than age 85 years.
D	**Coronary Heart Disease: Screening With Electrocardiography—Adults at Low Risk** The USPSTF recommends against screening with resting or exercise electrocardiography (ECG) for the prediction of coronary heart disease (CHD) events in asymptomatic adults at low risk for CHD events.
D	**Genital Herpes: Screening in Asymptomatic Adolescents and Adults** The USPSTF recommends against routine serological screening for herpes simplex virus (HSV) in asymptomatic adolescents and adults.
D	**Genital Herpes: Screening in Asymptomatic Pregnant Women** The USPSTF recommends against routine serological screening for herpes simplex virus (HSV) in asymptomatic pregnant women at any time during pregnancy to prevent neonatal HSV infection.
D	**Gonorrhea: Screening in Adults at Low Risk** The USPSTF recommends against routine screening for gonorrhea infection in men and women who are at low risk for infection.
D	**Hemochromatosis: Screening in Asymptomatic Adults** The USPSTF recommends against routine genetic screening for hereditary hemochromatosis in the asymptomatic general population.
D	**Hepatitis B: Screening in Asymptomatic Adults** The USPSTF recommends against routine screening for chronic hepatitis B virus infection in the asymptomatic general population.
D	**Hepatitis C: Screening in Asymptomatic Adults** The USPSTF recommends against routine screening for hepatitis C virus infection in asymptomatic adults who are not at increased risk (general population) for infection.
D	**Idiopathic Scoliosis: Screening in Asymptomatic Adolescents** The USPSTF recommends against routine screening for idiopathic scoliosis in asymptomatic adolescents.
D	**Menopausal Hormone Therapy for the Primary Prevention of Chronic Conditions: Preventive Medication—Combined Estrogen and Progestin** The USPSTF recommends against the use of combined estrogen and progestin for the prevention of chronic conditions in postmenopausal women.
D	**Menopausal Hormone Therapy for the Primary Prevention of Chronic Conditions: Preventive Medication—Estrogen Only** The USPSTF recommends against the use of estrogen for the prevention of chronic conditions in postmenopausal women who have had a hysterectomy.

Grade	Title
D	**Ovarian Cancer: Screening in Women** The USPSTF recommends against screening for ovarian cancer in women. This recommendation applies to asymptomatic women. Women with known genetic mutations that increase their risk for ovarian cancer (for example, BRCA mutations) are not included in this recommendation.
D	**Pancreatic Cancer: Screening in Asymptomatic Adults** The USPSTF recommends against routine screening for pancreatic cancer using abdominal palpation, ultrasonography, or serologic markers in asymptomatic adults.
D	**Peripheral Arterial Disease: Screening in Adults** The USPSTF recommends against routine screening for peripheral arterial disease.
D	**Prostate Cancer: Prostate-Specific Antigen (PSA)-Based Screening in All Men** The USPSTF recommends against prostate-specific antigen (PSA)-based screening for prostate cancer.
D	**Routine Aspirin or NSAID Use for the Primary Prevention of Colorectal Cancer: Preventive Medication for Adults at Average Risk** The USPSTF recommends against the routine use of aspirin or nonsteroidal anti-inflammatory drugs to prevent colorectal cancer in adults at average risk for colorectal cancer.
D	**Syphilis: Screening in Asymptomatic Men and Women** The USPSTF recommends against routine screening for syphilis infection in asymptomatic men and women who are not at increased risk for syphilis infection.
D	**Testicular Cancer: Screening in Adolescents and Men** The USPSTF recommends against screening for testicular cancer in adolescents or adults.
D	**Vitamin Supplementation to Prevent Cancer and CVD: Preventive Medication—Beta Carotene** The USPSTF recommends against the use of beta-carotene supplements, either alone or in combination, for the prevention of cancer or cardiovascular disease.
I	**Alcohol Misuse: Screening and Behavioral Counseling for Adolescents** The USPSTF concludes that the evidence is insufficient to recommend for or against screening and behavioral counseling interventions to prevent or reduce alcohol misuse by adolescents in primary care settings.
I	**Aspirin to Prevent Cardiovascular Disease: Adults Ages 80 Years or Older** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of aspirin to prevent cardiovascular disease in adults ages 80 years or older.
I	**Bacterial Vaginosis in Pregnancy: Screening in Asymptomatic Pregnant Women at High Risk for Preterm Delivery** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for bacterial vaginosis in asymptomatic pregnant women at high risk for preterm delivery.
I	**Bladder Cancer: Screening in Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for bladder cancer in asymptomatic adults.
I	**Blood Lead Levels: Screening in Children Ages 1 to 5 Years at Increased Risk** The USPSTF concludes that evidence is insufficient to recommend for or against routine screening for elevated blood lead levels in asymptomatic children ages 1 to 5 years who are at increased risk.

Grade	Title
I	**Breast Cancer: Screening Using Clinical Breast Examination in Women Ages 40 Years and Older*** The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination beyond screening mammography in women ages 40 years or older. **The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 USPSTF recommendation on breast cancer screening. The full 2002 recommendation may be accessed at http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca2002.htm.*
I	**Breast Cancer: Screening Using Digital Mammography or Magnetic Resonance Imaging Instead of Film Mammography** The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of either digital mammography or magnetic resonance imaging instead of film mammography as screening modalities for breast cancer.
I	**Breast Cancer: Screening With Mammography in Women 75 and Older*** The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older. **The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act, utilizes the 2002 USPSTF recommendation on breast cancer screening. The full 2002 recommendation may be accessed at http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca2002.htm.*
I	**Coronary Heart Disease: Risk Assessment Using Nontraditional Risk Factors in Asymptomatic Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of using the nontraditional risk factors to screen asymptomatic adults with no history of coronary heart disease (CHD) to prevent CHD events. The nontraditional risk factors included in this recommendation are high-sensitivity C-reactive protein, ankle-brachial index, leukocyte count, fasting blood glucose level, periodontal disease, carotid intima-media thickness, coronary artery calcification score on electron-beam computed tomography, homocysteine level, and lipoprotein(a) level.
I	**Chlamydia: Screening in Men** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for chlamydial infection in men.
I	**Chronic Kidney Disease: Screening in Asymptomatic Adults** The USPSTF concludes that the evidence is insufficient to assess the balance of benefits and harms of routine screening for chronic kidney disease (CKD) in asymptomatic adults.
I	**Colorectal Cancer: Screening Using Computed Tomographic Colonography and Fecal DNA Testing** The USPSTF concludes that the evidence is insufficient to assess the benefits and harms of computed tomographic colonography and fecal DNA testing as screening modalities for colorectal cancer.
I	**Coronary Heart Disease: Screening with Electrocardiography in Adults at Intermediate or High Risk of CHD Events** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening with resting or exercise ECG for the prediction of CHD events in asymptomatic adults at intermediate or high risk for CHD events.
I	**Dementia: Screening in Older Adults** The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening for dementia in older adults.
I	**Dental Caries: Routine Risk Assessment in Preschool Children Older Than Age 6 Months** The USPSTF concludes that the evidence is insufficient to recommend for or against routine risk assessment of preschool children by primary care clinicians for the prevention of dental disease.

Grade	Title
I	**Depression: Screening in Children Ages 7 to 11 Years** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for depression in children ages 7 to 11 years.
I	**Drug Use—Illicit: Screening in Adolescents, Adults, and Pregnant Women** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use.
I	**Family and Intimate Partner Violence: Screening** The USPSTF found insufficient evidence to recommend for or against routine screening of parents or guardians for the physical abuse or neglect of children, of women for intimate partner violence, or of older adults or their caregivers for elder abuse.
I	**Gestational Diabetes Mellitus: Screening in Pregnant Women Before or After 24 Weeks Gestation** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for gestational diabetes mellitus either before or after 24 weeks gestation.
I	**Glaucoma: Screening in Adults** The USPSTF found insufficient evidence to recommend for or against screening for glaucoma in adults.
I	**Gonorrhea: Screening in Men at Increased Risk** The USPSTF found insufficient evidence to recommend for or against routine screening for gonorrhea infection in men at increased risk for infection.
I	**Gonorrhea: Screening in Pregnant Women Not at Risk** The USPSTF found insufficient evidence to recommend for or against routine screening for gonorrhea infection in pregnant women who are not at increased risk for infection.
I	**Hearing Loss: Screening in Older Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for hearing loss in asymptomatic adults aged 50 years or older.
I	**Hepatitis C: Screening in Men and Women at Increased Risk** The USPSTF found insufficient evidence to recommend for or against routine screening for hepatitis C infection in adults at high risk for infection.
I	**Hip Dysplasia: Screening in Infants** The USPSTF concludes that the evidence is insufficient to recommend routine screening for developmental dysplasia of the hip in infants as a means to prevent adverse outcomes.
I	**Hyperbilirubinemia: Screening in Infants to Prevent Chronic Bilirubin Encephalopathy** The USPSTF concludes that the evidence is insufficient to recommend screening for hyperbilirubinemia in infants to prevent chronic bilirubin encephalopathy.
I	**Iron Deficiency Anemia: Iron Supplementation in Asymptomatic Children Ages 6 to 12 Months at Average Risk** The USPSTF concludes that the evidence is insufficient to recommend for or against routine iron supplementation in asymptomatic children ages 6 to 12 months who are at average risk for iron deficiency anemia.
I	**Iron Deficiency Anemia: Iron Supplementation in Nonanemic Pregnant Women** The USPSTF concludes that the evidence is insufficient to recommend for or against routine iron supplementation in nonanemic pregnant women.

Grade	Title
I	**Iron Deficiency Anemia: Screening in Asymptomatic Children Ages 6 to 12 Months** The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening for iron deficiency anemia in asymptomatic children ages 6 to 12 months.
I	**Lipid Disorders: Screening in Children, Adolescents, and Young Adults Ages 1 to 20 Years** The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening for lipid disorders in infants, children, adolescents, or young adults (up to age 20 years).
I	**Low Back Pain: Counseling for Adults** The USPSTF concludes that the evidence is insufficient to recommend for or against the routine use of interventions to prevent low back pain in adults in primary care settings.
I	**Lung Cancer: Screening in Asymptomatic Adults** The USPSTF concludes that the evidence is insufficient to recommend for or against screening for lung cancer in asymptomatic adults with low-dose computerized tomography, chest x-ray, sputum cytology, or a combination of these tests.
I	**Oral Cancer: Screening in Adults** The USPSTF concludes that the evidence is insufficient to recommend for or against routinely screening for oral cancer in adults.
I	**Osteoporosis: Screening in Men** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis in men.
I	**Physical Activity: Behavioral Counseling in a Primary Care Setting** The USPSTF concludes that the evidence is insufficient to recommend for or against behavioral counseling in primary care settings to promote physical activity.
I	**Prevention of Motor Vehicle Occupant Injuries: Counseling in a Primary Care Setting for Driving Under the Influence of Alcohol** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine counseling of all patients in the primary care setting to reduce driving while under the influence of alcohol or riding with drivers who are alcohol-impaired.
I	**Prevention of Motor Vehicle Occupant Injuries: Counseling in a Primary Care Setting for Proper Use of Motor Vehicle Restraints** The USPSTF concludes that the current evidence is insufficient to assess the incremental benefit, beyond the efficacy of legislation and community-based interventions, of counseling in the primary care setting to improve proper use of motor vehicle occupant restraints (child safety seats, booster seats, and lap-and-shoulder belts).
I	**Sexually Transmitted Infections: Behavioral Counseling-Non-sexually-active Adolescents and Adults Not at Increased Risk** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of behavioral counseling to prevent sexually transmitted infections (STIs) in adolescents who are not sexually active and in adults not at increased risk for STIs.
I	**Skin Cancer: Behavioral Counseling in Adults Older Than Age 24 Years** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of counseling adults older than 24 years about minimizing risks to prevent skin cancer.

Grade	Title
I	**Skin Cancer: Screening in Men and Women** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of using a whole-body skin examination by a primary care clinician or patient skin self-examination for the early detection of cutaneous melanoma, basal cell cancer, or squamous cell skin cancer in the adult general population.
I	**Speech and Language Delay: Screening in Preschool Children Using Brief, Formal Instruments** The USPSTF concludes that the evidence is insufficient to recommend for or against the routine use of brief, formal screening instruments in primary care to detect speech and language delay in children ages 5 years and younger.
I	**Suicide Risk: Screening in Adults** The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening by primary care clinicians to detect suicide risk in the general population.
I	**Thyroid Disease: Screening in Men and Women** The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening for thyroid disease in adults.
I	**Tobacco Use: Screening and Counseling for Children and Adolescents** The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening for tobacco use or interventions to prevent and treat tobacco use and dependence among children or adolescents.
I	**Type 2 Diabetes Mellitus: Screening in Adults with Blood Pressure of 135/80 or Lower** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for type 2 diabetes in asymptomatic adults with blood pressure of 135/80 mm Hg or lower.
I	**Visual Acuity: Screening in Older Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for visual acuity for the improvement of outcomes in older adults.
I	**Visual Impairment: Screening in Children Younger Than Age 3 Years** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for vision impairment in children younger than age 3 years.
I	**Vitamin Supplementation to Prevent Cancer and Cardiovascular Disease: Vitamins A, C, E, and Multivitamins** The USPSTF concludes that the evidence is insufficient to recommend for or against the use of supplements of vitamins A, C, or E; multivitamins with folic acid; or antioxidant combinations for the prevention of cancer or cardiovascular disease.


U.S. Preventive Services
TASK FORCE