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

October 2011

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U.S. Preventive Services
TASK FORCE

EXECUTIVE SUMMARY

The U.S. Preventive Services Task Force (USPSTF or Task Force), an independent body of experts in preventive medicine and primary care, works to improve the health of all Americans by making evidence-based recommendations about the effectiveness of clinical preventive services and health promotion. The recommendations made by the USPSTF address clinical preventive services for adults and children, and include screening tests, counseling services, and preventive medications. The Task Force makes its recommendations based on comprehensive, systematic reviews and careful assessment of the available medical evidence.

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. This is the first annual report from the USPSTF, delivered to Congress in October 2011. In this report, the USPSTF identifies 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 this report, the USPSTF highlights 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

The USPSTF will continue its work 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 hopes 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 so that in the near future, the USPSTF will be able to develop definitive recommendations on these important topics.

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The USPSTF's recommendations are considered the "gold standard" for clinical preventive services … We fully support the USPSTF as an independent body to apply rigor and objectivity to the analysis of clinical preventive care …. Our common goal is to improve the health of all Americans, and we believe the Task Force is the best way to ensure clinical preventive recommendations are guided by science.

Open letter to HHS Secretary Kathleen Sebelius from
American Academy of Family Physicians (AAFP),
Society of Teachers of Family Medicine (STFM),
Association of Departments of Family Medicine (ADFM),
North American Primary Care Research Group (NAPCRG), and
Association of Family Medicine Residency Directors (AFMRD)
May 2010

I. INTRODUCTION

Since its inception over 25 years ago, the U.S. Preventive Services Task Force (USPSTF or Task Force), an independent body of experts in preventive medicine and primary care, has worked to improve the health of all Americans by making evidence-based recommendations about clinical preventive services and health promotion. The recommendations made by the USPSTF address clinical preventive services for adults and children, and include screening tests, counseling services, 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, Clinical and Community Preventive Services, describes the duties of the USPSTF, which include:

> *"(F) 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.

II. BACKGROUND

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

Established in 1984 by Congress, the USPSTF is an independent panel of nonfederal experts in prevention and evidence-based medicine. The Task Force carefully assesses the evidence and makes recommendations about preventive services such as screening tests, counseling services, or preventive medications that are provided in clinical settings, and are intended to prevent disease or improve health outcomes from heart disease, cancer, infectious diseases, and other conditions and events that affect the health of children, adolescents, adults, older adults, and pregnant women. The Agency for Healthcare Research and Quality (AHRQ) provides scientific, technical, logistical, and dissemination support to the USPSTF.

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 saving lives, increasing longevity, and improving Americans' quality of life. 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.

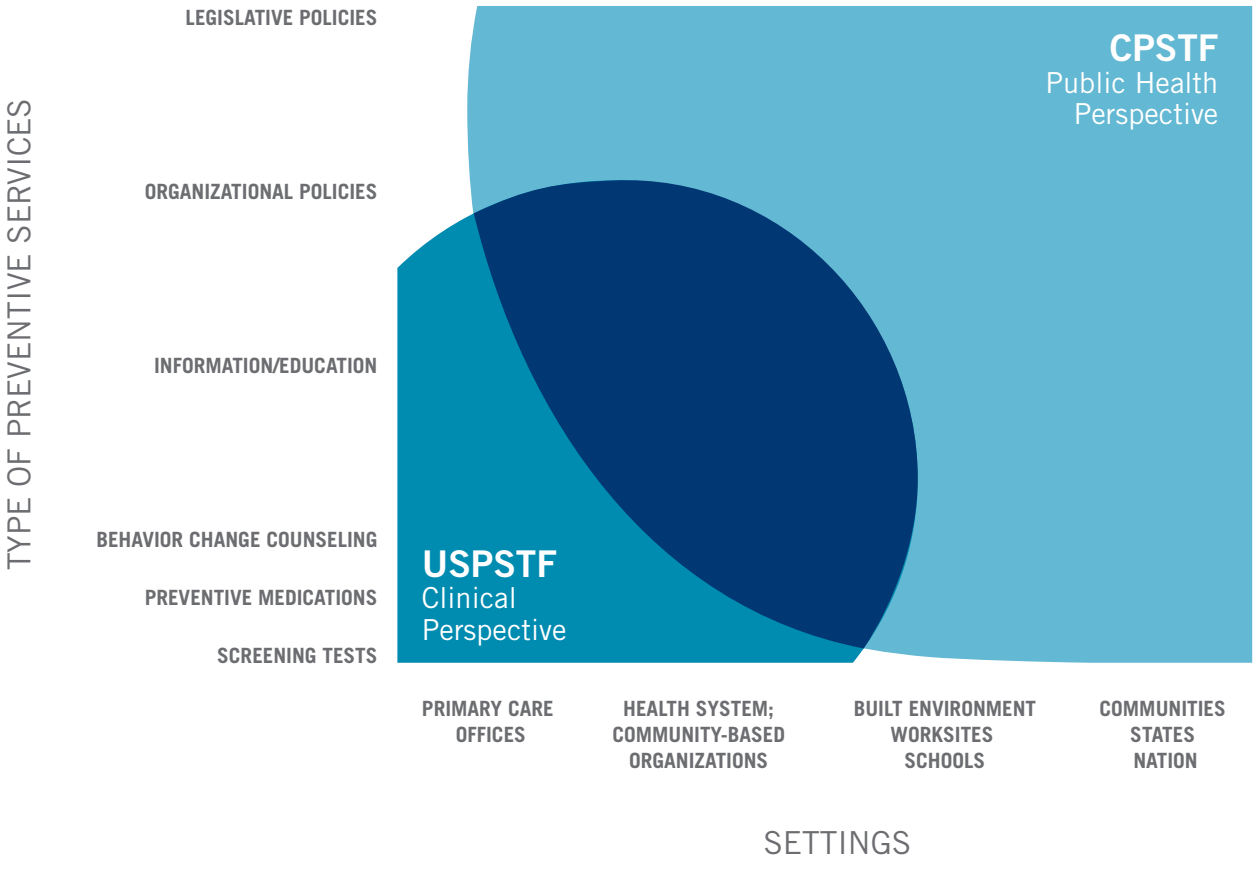

Figure 1. Complementary Work of the U.S. Preventive Services Task Force and the Community Preventive Services Task Force

Who Serves on the Task Force?

The USPSTF comprises 16 volunteer members who are nationally recognized experts in the disciplines of preventive medicine and primary care, including internal medicine, family medicine, geriatrics, pediatrics, preventive medicine, behavioral medicine, public health, obstetrics and gynecology, and nursing (see Appendix A for a current roster of members). All members volunteer their time to serve on the USPSTF, and most are practicing clinicians.

USPSTF members are appointed by the Director of AHRQ and serve a 4-year initial term. Members must have no substantial conflicts of interest that could impair the scientific integrity of the work of the Task Force. For each preventive service under consideration, the financial, professional, and intellectual activities of Task Force members are evaluated to identify any conflicts of interest that would require a member to recuse him- or herself from participation in the review of that topic.

What Does the Task Force Do?

The USPSTF makes recommendations on clinical preventive services, based on scientific evidence about the effectiveness of each service. These recommendations are primarily directed to the primary care professional who delivers these services. USPSTF recommendations are also used by individuals and families as they make decisions about their own health and health care, and by health care organizations as they consider their policies. USPSTF recommendations apply to preventive services that are offered in a primary care setting (such as a Pap smear to detect cervical cancer), services that are available through primary care referral (such as a colonoscopy to detect colorectal cancer), or behavioral counseling programs (such as counseling to help reduce obesity). USPSTF recommendations apply to people who have no signs or symptoms of a disease or condition.

Every USPSTF recommendation is based on a rigorous, systematic review of the scientific evidence published in peer-reviewed journals. To make its recommendations, the USPSTF evaluates the potential benefits and harms of clinical preventive services. When appropriate and when evidence exists, the Task Force evaluates the potential benefits and harms based on age, sex, and risk factors for disease. The potential benefits of preventive services include early identification of disease and improvement in health outcomes. The potential harms of preventive services can include adverse effects of the service itself or inaccurate test results that lead to a cascade of additional testing, some with attendant risks, or unneeded treatment.

USPSTF Grades

The USPSTF evaluates the balance of the potential benefits of a service against the harms and assigns a letter grade. Clinical preventive services graded "A" or "B" are those services for which the USPSTF has determined that the potential benefits of the service outweigh its potential harms. Services with a grade of "D" are those whose potential harms outweigh the benefits. A grade of "C" indicates that the balance of benefits and harms is a close call. The Task Force also issues "I" statements when the evidence is insufficient to determine the balance of benefits and harms.

Grade	Definition
A	The USPSTF recommends the service.
B	The USPSTF recommends the service.
C	**[The following statement is undergoing revision]** Clinicians may provide the service to selected patients depending on individual circumstances. However, for most individuals without signs or symptoms, there is likely to be only a small benefit from the service.
D	The USPSTF recommends against the service.
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.

Table 1: USPSTF Grades Explained

USPSTF Recommendation Statements: What Do They Mean and How Are They Used?

When it makes a recommendation, the USPSTF issues a Recommendation Statement that includes the rationale for the recommendation, clinical considerations, other considerations (including research needs and gaps), a discussion of the evidence, and the recommendations of other organizations or entities. Recommendation Statements provide information based on the best available evidence and support shared decisionmaking by clinicians and patients. When supported by the evidence, Task Force recommendations provide specific information regarding the timing and frequency of services and whether these differ based on risk characteristics. However, evidence of this type is not always available, and in such cases, the USPSTF, as a science-driven body, chooses not to comment on timing or frequency, and may instead identify these areas as important gaps to be addressed by future research.

The USPSTF 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 considerations in addition to the scientific assessment of the clinical benefit and harms alone.

Steps in Making a USPSTF Recommendation

The USPSTF regularly prioritizes new clinical preventive service topics and topics for updating based on public input and new evidence. The steps that the USPSTF takes once a topic has been selected for review are shown in Figure 2. The Task Force aims to update prioritized topics every 5 years.

(The USPSTF Procedure Manual serves as a full guide to the methods of the Task Force and is publicly available at http://www.uspreventiveservicestaskforce.org/Page/Name/procedure-manual)

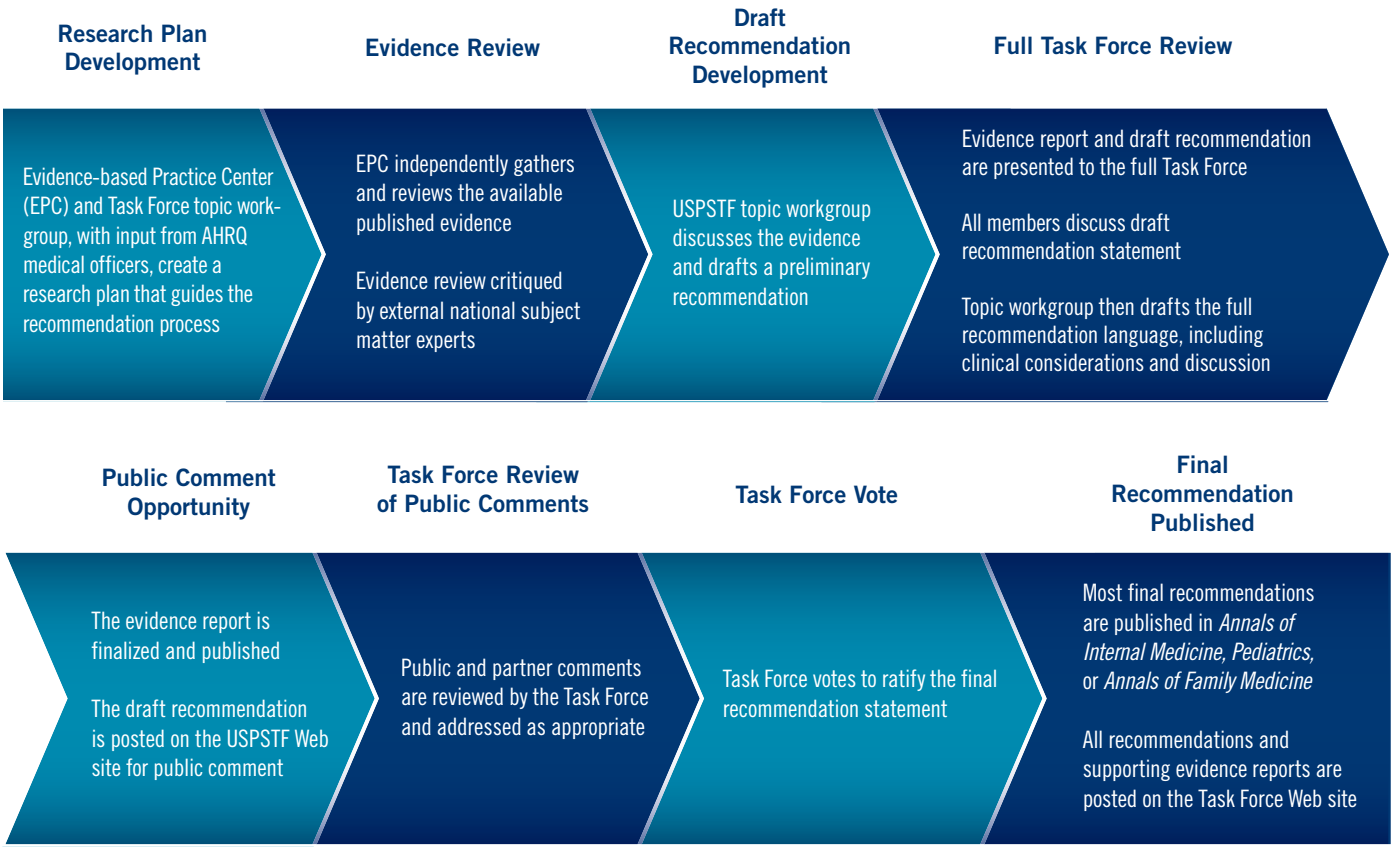

Figure 2: Stages in USPSTF Recommendation Development

Target Audiences

Since it began its work, the USPSTF has considered primary care clinicians the main audience for its recommendations. The medical literature that is the basis for the recommendations of the USPSTF provides evidence regarding the potential benefits and harms of clinical preventive services for large groups of people or populations. This type of information is useful to primary care clinicians and health systems when they consider how to provide care and organize their practices to produce the greatest health benefits. The USPSTF recognizes that skilled clinicians serve their patients by individualizing recommendations based on evidence from large groups of people to the specific circumstances, values, and perspectives of the individual patient. The USPSTF also recognizes the complexity involved in "translating" population-based recommendations to the specific care of individuals and has recently embarked on active efforts to make its population-based recommendations more easily understandable by the public.

USPSTF Engagement With Partners and the Public

> **AHIP and our member health insurance plans believe that the Task Force is the gold standard of evidence-based recommendations around preventive services.**
>
> Karen Ignagni, President & Chief Executive Officer, America's Health Insurance Plans

The USPSTF is committed to making its work as transparent as possible—both in terms of increasing stakeholders' and the public's understanding of and confidence in the approach of the USPSTF, and in ensuring that its approach is viewed as open, credible, independent, and unbiased. As part of this commitment, the USPSTF is working to provide additional opportunities for stakeholders and the public to engage at multiple points in the recommendation development process and offer feedback to the USPSTF.

The work of the USPSTF has been informed for much of its existence by 22 partner organizations (Appendix B). Partner organizations represent primary care clinicians, consumer organizations, federal agencies, and other stakeholders in the delivery of primary care. Currently, primary care organizations, the principal audience for Task Force recommendations, represent pediatrics, geriatrics, family medicine, preventive medicine, nursing, internal medicine, and osteopathic medicine. Eight federal agencies are partners of the USPSTF, including the Centers for Disease Control and Prevention, the National Institutes of Health, and the Centers for Medicare and Medicaid Services. Partner organizations provide input regarding which preventive services topics will be addressed, provide expert review of evidence reports and Recommendation Statements, and assist with the dissemination of USPSTF recommendations to their members. The breadth of scientific and practical expertise of partner organizations is highly valuable to the Task Force in increasing the usability and clarity of its recommendations.

The USPSTF is also committed to engaging the public and encouraging public comment on its processes and recommendations. Currently, the public can nominate new members and suggest new topics for consideration by the USPSTF at any time via the USPSTF Web site (www.uspreventiveservicestaskforce.org). In addition, all draft recommendations are posted for public comment on the Task Force Web site for 1 month, during which time anyone can provide feedback. All comments received from this process are reviewed by the Task Force and used to revise the final USPSTF Recommendation Statement. In the near future, the USPSTF will begin posting the topic research plans for public comment and posting the resulting draft evidence reports for public review (Figure 3).

Current Stakeholder Engagement Points

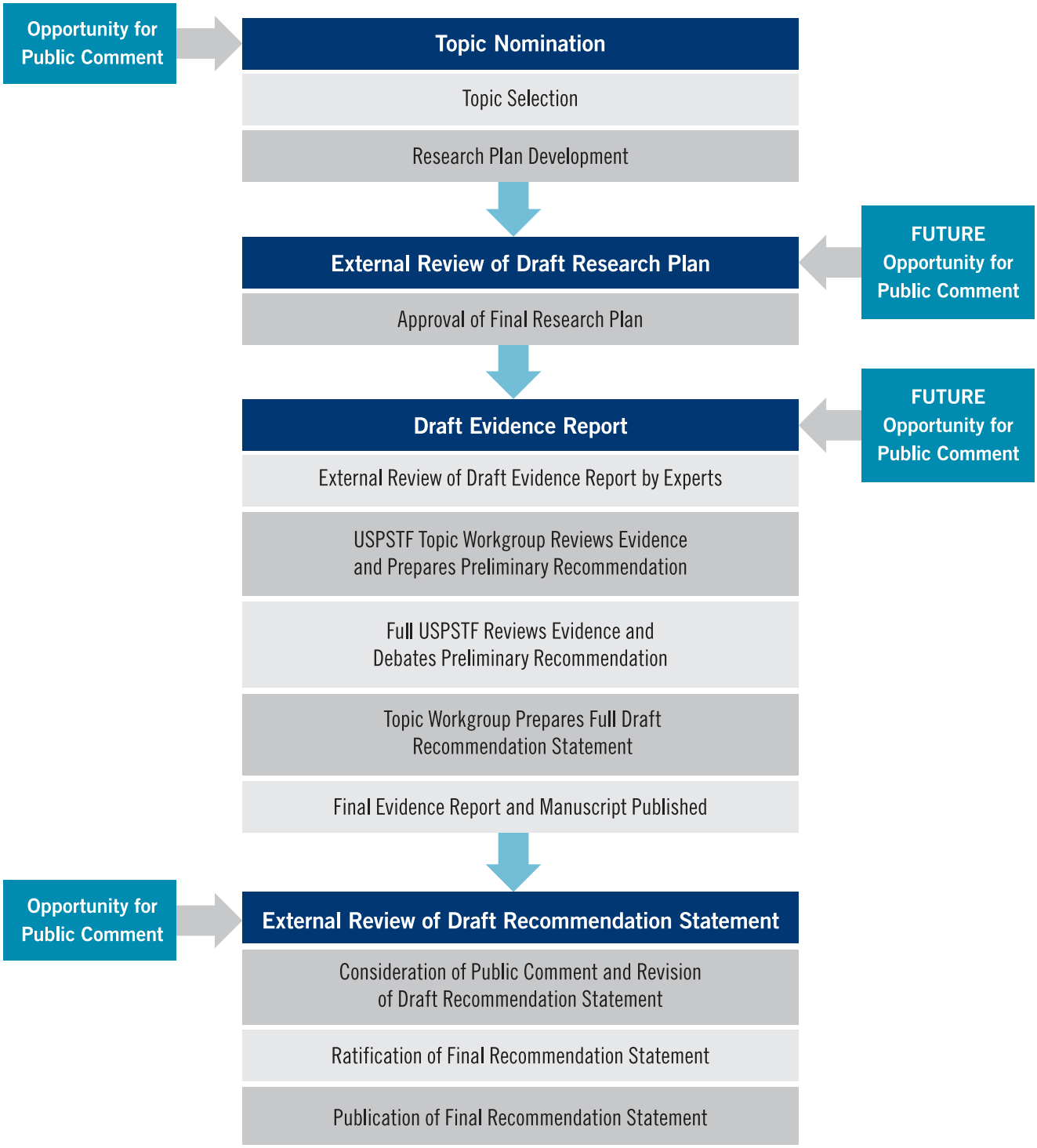

Figure 3: Stakeholder and Public Engagement Points

III. ROLE OF USPSTF IN CLINICAL PREVENTION

Dissemination of USPSTF Recommendations

The current USPSTF library includes over 100 preventive services topics with over 140 specific recommendations (topics can encompass multiple specific recommendations). Numerous methods, including publication in peer-reviewed medical journals, are utilized to help primary care clinicians and other audiences become more aware of and use the recommendations.

The full USPSTF library of recommendations, including evidence reports and other supporting materials, is available at www.uspreventiveservicestaskforce.org. Through this Web site, the USPSTF reaches hundreds of thousands of visitors each month. Between August 2010 and May 2011, the USPSTF Web site received over 1.5 million unique visits, resulting in over 9.8 million page views and more than 530,000 file downloads.

AHRQ publishes the *Guide to Clinical Preventive Services*, a free, pocket-sized book that is a compilation of current USPSTF recommendations in abridged form. It has been distributed widely through high-value dissemination efforts with other federal agencies and USPSTF partners.

Task Force recommendations are also available in an easy-to-use electronic tool, the electronic Preventive Services Selector (ePSS). ePSS can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors, to produce a list of recommendations that is individualized for the patient. It is available both as a Web-based tool and as a downloadable application for a variety of smartphones and other devices, such as tablet computers, and brings USPSTF recommendations, clinical considerations, and selected practice tools to the point of care. In 2010, over 31,000 individuals downloaded ePSS to a mobile device, and the Web-based version of the tool had over 200,000 visitors. ePSS is also available as a "widget," a stand-alone application that can be embedded into any Web page.

Major Implementation Initiatives

As part of its support of the Task Force, AHRQ has partnered with the Department of Health and Human Services, Office of Disease Prevention and Health Promotion to translate USPSTF recommendations with grades of "A" or "B" (services for which the benefits outweigh the harms) for members of the public. Consumers can go to the Personal Health Tool on the www.Healthfinder.gov Web site to get a list of USPSTF-recommended services based on their age and sex.

Top 10 iPhone Medical Apps for Internal Medicine Physicians and Residents

by Amit Patel, M.D., May 9, 2011

AHRQ ePSS's information is based on the U.S. Preventive Services Task Force (USPSTF) recommendations, and has proven itself as a useful tool in my continuity clinic, where preventive care plays an important part.

Especially at the outset of my training, AHRQ ePSS allowed me to input a patient's age and other demographic variables, generating the USPSTF-appropriate screening and counseling guidelines for the patient. Moreover, this app offers links to a handful of useful tools (including various screening instruments and patient brochures). In summary, AHRQ ePSS is a very useful tool for the primary care clinic setting, especially for screening, counseling, and preventive care.

Piedmont Healthcare, a large integrated health system in the Atlanta area, has successfully embedded ePSS into its electronic health record (EHR) system. The integration of ePSS into EHRs allows individualized USPSTF recommendations to be directly available to clinicians every time a patient comes for a visit. This new system also shows providers the date a patient received a preventive service, the results, and, if applicable, past medical history. Staff members working directly with the patients are trained to access the patient's medical record at the beginning of the visit and complete a summary of the patient's health profile. Providers are then informed whether the patient needs a referral for a test, such as colorectal screening, or counseling, such as smoking cessation support. Piedmont Healthcare is one of several examples of the seamless integration of ePSS into clinical care.

At the **University of North Texas Health Science Center** in Fort Worth, an education and training program for physician assistants is using the *Guide* as a tool for student research on clinical preventive services. Previous editions of the *Guide* have also been widely used in undergraduate and postgraduate medical and nursing education as a key reference for teaching preventive care.

At the **Colorado Area Health Education Center**, preceptors and medical students are instructed to use the ePSS tool for all preventive clinical service patients they see during their 8-week family practice rotation. The **University of Washington Medical School** has developed a similar program for medical students enrolled in clinical rotations so that they can easily identify appropriate preventive services for their patients.

Over time, State governments, individual practices, clinics, and hospitals have begun to integrate USPSTF tools and resources into practice in new and innovative ways.

The *Guide to Clinical Preventive Services* and ePSS are also used in a variety of educational settings to improve the preventive medicine training received by future primary care and public health providers.

IV. MAJOR ACTIVITIES OF THE USPSTF IN 2010-2011

The USPSTF holds three in-person meetings a year. The focus of these 2-day meetings is on reviewing evidence, deliberating on recommendations, prioritizing preventive services topics for consideration, and updating Task Force methods and processes. These meetings are also used to provide Task Force members with updates on the work of the CPSTF and dissemination and implementation activities. Task Force members also work throughout the year in small groups via conference calls and electronic communications. These small groups include workgroups for each topic, which are convened at the research plan development stage and continue through the release of the final Recommendation Statement, and standing workgroups for issues such as the prioritization of topics and improvement of methods. This year, the Task Force published a new paper outlining methodological issues in key preventive service areas for older adults.

Topic	Grade	Specific Recommendations
Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum	A	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
Screening for Bladder Cancer	I	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.
Screening for Osteoporosis	B	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.
	I	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis in men.
Screening for Testicular Cancer	D	The USPSTF recommends against screening for testicular cancer in adolescent or adult males.
Screening for Visual Impairment in Children Ages 1-5 Years	B	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.
	I	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of vision screening in children younger than age 3 years.

Table 2: Final Recommendation Statements Published By the USPSTF, September 2010 to October 2011

During the past 12 months, the USPSTF published five final Recommendation Statements (Table 2). This total is less than in previous years due to the decision by the USPSTF to begin the new process of posting all draft recommendations for public comment. All five of these recommendations were first shared with the public as draft recommendations. Additionally, this year the USPSTF published four other draft recommendations for public comment (Falls Prevention in Older Adults, Counseling to Promote a Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults, Counseling to Prevent Skin Cancer, and Screening for Hearing Loss in Older Adults). By the end of 2011, the USPSTF plans to release an additional four draft recommendations for public comment and two additional final Recommendation Statements. As this new process becomes well established, the Task Force expects to again publish 10 to 12 final Recommendation Statements each year.

While establishing this new process for completing their recommendations, the members of the USPSTF continued working on a full portfolio of topics. Table 3 lists all of the clinical preventive services under active consideration by the USPSTF over the past year.

To review a complete listing of all current USPSTF specific recommendations, please see Appendix C.

V. CURRENT EVIDENCE GAPS DESERVING OF FURTHER RESEARCH

There are many positive stories about the impact of USPSTF recommendations and tools. By definition, topics selected for review by the Task Force have a high burden of disease, with potentially important public health benefits for prevention if effective preventive services exist. Therefore, recommendations from the Task Force are likely to improve health when they are implemented appropriately and effectively.

However, significant gaps in key areas of knowledge limit the full realization of the benefits of evidence-based preventive services recommendations for the health of the entire population. With the Affordable Care Act, Congress recognized the opportunity for new research to provide the necessary evidence base upon which the USPSTF can build recommendations. Congress specifically charged the USPSTF with identifying and reporting to Congress 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.

Congress Was Right: New Research and New Evidence Results in New USPSTF Recommendations

In the past, when the USPSTF has identified specific gaps in the evidence needed for it to make recommendations, researchers have responded by embarking on important work to fill those gaps. Research gaps have been successfully filled for several areas that until recently were without sufficient evidence. For example:

1. **New evidence led to updating screening for hearing loss in newborns from insufficient evidence to recommended:** Screening for hearing loss in newborns was given an "I" rating for insufficient evidence in 2001. When the recommendation was updated in 2008, the Task Force was able to determine, on the basis of a new controlled trial, that the benefits of the service outweighed the harms, and gave it a positive recommendation ("B" grade).
2. **New evidence led to updating screening for obesity in children from insufficient evidence to recommended:** Screening for obesity in children was given an "I" rating in 2004, but a number of new studies were included in an evidence review conducted for an update in 2010. Based on the new evidence, the USPSTF gave this service a "B" grade, indicating confidence that the service would lead to moderate net benefits (i.e., benefits that outweighed harms).

Table 3: Topics Under Active Consideration by the USPSTF During the Past 12 Months

Counseling for Tobacco Cessation in Adolescents

Counseling to Prevent Skin Cancer

Counseling to Promote Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults

Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum

Prevention of Falls in Older Adults

Screening and Counseling for Alcohol Misuse

Screening for Bladder Cancer

Screening for Cervical Cancer

Screening for Coronary Heart Disease With Electrocardiography

Screening for Dementia

Screening for Glaucoma

Screening for Hearing Loss in Older Adults

Screening for Hepatitis C

Screening for HIV

Screening for Hypertension in Children and Adolescents

Screening and Counseling for Obesity in Adults

Screening for Oral Cancer

Screening for Osteoporosis

Screening for Ovarian Cancer

Screening for Prostate Cancer

Screening for Suicide Risk

Screening for Testicular Cancer

Screening for Visual Impairment in Children Ages 1-5 Years

3. **Evidence gaps identified by the USPSTF have also led to research efforts on a larger scale:** A major grants initiative by the National Institute on Drug Abuse (NIDA) that was initiated after a review by the Task Force indicated that there was insufficient evidence to recommend screening for drug abuse in primary care settings. The NIDA initiative provided funds for researchers to study the use of drug abuse screening in primary care to determine the effects of screening on health outcomes, directly addressing evidence gaps identified by the USPSTF in 2008.

In this first annual report to Congress, the members of the USPSTF have identified high-priority evidence gaps in the following three areas:

A. Screening Tests

B. Behavioral Interventions

C. Clinical Preventive Services Targeting Specific Populations and Age Groups

The report concludes with a brief discussion of the importance of additional research on how to implement clinical preventive services into primary care.

Process for Prioritizing

To encourage research that closes critical evidence gaps identified by the USPSTF, the Task Force developed a systematic, reproducible process for prioritizing research on clinical preventive services for which it has issued "I" statements. This process intentionally builds on the evidence reviews utilized by the USPSTF to make recommendations. In the prioritization process, all current "I" statements were ranked on four domains: potential preventable burden, potential harms, potential costs, and current practice. "I" statements for behavioral intervention and counseling topics were ranked separately from those for screening topics. Whereas the ability of primary care-based interventions to lead directly to changes in health outcomes is more distant, the overall health burden related to health behaviors is often significant. However, because the harms of most counseling services are considered to be small, counseling topics have a lower priority rating when the previously described rating system is applied.

For some topics currently under review, the USPSTF has not yet determined if previously identified research gaps in the evidence still exist. Examples of these topics include screening for dementia, glaucoma, and peripheral arterial disease. In future reports to Congress, the USPSTF may make recommendations for research in these areas.

A. High-Priority Evidence Gaps for Screening Tests

Below are four screening topics that the USPSTF has prioritized as having critical evidence gaps that may be addressed through research and that if filled are likely to result in important new recommendations:

1. **Screening for Coronary Heart Disease With New and Old Technologies**
   Coronary heart disease is the most common cause of death in adults in the United States. While enormous progress has been made in helping Americans prevent and manage coronary heart disease, current screening techniques fail to identify many individuals who go on to have significant heart disease. In 2004 and 2009, the USPSTF identified significant evidence gaps in our understanding of how older technologies, such as electrocardiography, and new tests, including blood tests and computed tomography (CT) scans, may or may not improve our ability to prevent coronary heart disease. Targeted research is needed to examine the incremental benefits and harms associated with use of these technologies in addition to and potentially as replacements for current risk-based screening and treatment methods.

2. Screening for Colorectal Cancer With New Modalities

Colorectal cancer screening is effective in saving lives in adults older than age 50 years. However, many adults do not get screened. Recently developed technologies hold promise for extending the reach of colorectal cancer screening programs and screening the population more efficiently. In 2008, the USPSTF was unable to make a recommendation about newer screening modalities due to evidence gaps. Research is needed on fecal DNA testing and CT colonography that defines the benefits and harms of these screening tests in comparison with current well-established screening methods, and that explores and illuminates the acceptability of these tests among populations who are unwilling to undergo testing with currently recommended strategies.

3. Screening for Hepatitis C

Viral hepatitis C is the most common blood-borne pathogen in the United States and results in as many as 10,000 deaths each year. Fortunately most people who have the infection do not develop liver problems. In 2004, the USPSTF found that although there are good screening tests that accurately identify individuals who are infected with the hepatitis C virus, there was not enough evidence about whether treating asymptomatic individuals found to have the infection through screening programs resulted in more long-term benefits and fewer harms when compared with treating people when they become symptomatic. The Task Force concluded that more research is needed to better understand the progression of the disease and which individuals are at highest risk of suffering from liver damage. Studies are also needed to better understand if early treatment of hepatitis C infection leads to improved outcomes and which individuals will benefit the most from early treatment, and to evaluate the effect of diagnosis and treatment on quality of life.

4. Screening for Hip Dysplasia

While rare, developmental dysplasia of the hip (DDH) can be associated with disability in youth and throughout life. In 2006, the USPSTF concluded that a more complete understanding of the natural history of spontaneous resolution of hip instability and dysplasia is needed before it will be possible to develop an evidence-based strategy for screening newborns for hip abnormalities and treating those abnormalities. Given the infrequent occurrence of DDH, multicenter studies of interventions that measure functional outcomes (including long-term outcomes) in a standardized fashion are needed. Studies designed to identify valid and reliable radiological outcomes of DDH as proxy measures of functional outcomes are also needed.

B. High-Priority Evidence Gaps for Behavioral Interventions

Below are three areas from the fields of behavioral intervention and health promotion that the USPSTF has prioritized as having critical evidence gaps that may be addressed through research and that if filled are likely to result in important new recommendations:

1. Moderate- to Low-Intensity Counseling for Obesity

The importance of obesity as a health problem in the United States is increasingly apparent. According to recent data, when obesity is defined as a body mass index of 30 kg/m^2 or more, 30 percent of American men and women are obese. Being obese is associated with health problems such as an increased risk of coronary heart disease, type 2 diabetes, various types of cancer, gallstones, and disability. In addition, obesity is associated with increased risk of premature death and decreased quality of life. In 2003, the USPSTF concluded that the available evidence supported recommending high-intensity interventions for obese adults and that the evidence was insufficient to make a recommendation about the use of moderate- or low-intensity counseling together with behavioral interventions to promote sustained weight loss in obese adults. In 2010, the USPSTF recommended screening and intensive counseling for obese children ages 6 years and older. The Task Force is currently completing an update of its 2003 recommendation for adults. Future research is needed in many areas concerning screening and counseling for obesity in children and adults. Continued development and testing of counseling and behavioral interventions with better and longer followup are needed, especially to understand the potential contribution of moderate- and low- intensity counseling. Additional research should also examine the long-term outcomes and effects of interventions delivered to overweight children and adults.

2. Interventions to Prevent Child Abuse and Neglect

Approximately 1 million abused children are identified in the United States each year. Despite the dedication and hard work of people in many sectors, no one has discovered an effective role for the primary care system and primary care professionals in preventing child abuse and neglect. The Task Force recognizes that the solution to this issue will include many other efforts and hopes that needed research to find effective interventions initiated in primary care will be conducted. Early research suggests that clinician referrals to home visitation by nurses during pregnancy and early childhood may reduce child abuse and neglect in selected populations, but additional research is needed. Future research must examine both the potential benefits and the potential unintended harms of interventions aimed at preventing child abuse and neglect.

3. Screening for Illicit Drug Use

Illicit drug use and abuse is a serious problem in the United States and ranks among the 10 leading preventable risk factors for years of healthy life lost to death and disability in developed countries. In 2008, the Task Force found that there was insufficient evidence to make a recommendation about screening for illicit drug use in primary care practices. Studies are needed to determine whether interventions found effective for treatment-seeking individuals with symptoms of drug misuse are equally effective when applied to asymptomatic individuals identified through screening. In addition, observational studies are needed to establish more clearly the effects of treatment on long-term health outcomes, including morbidity and mortality.

C. High-Priority Evidence Gaps in Clinical Preventive Services Targeting Specific Populations and Age Groups

For some clinical preventive services that have been well studied for the general population, important evidence gaps exist that prevent the USPSTF from making recommendations for targeted populations and age groups. This is often because these groups are underrepresented in health research. Prime examples of such groups are the elderly, children, and 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 to issue recommendations that can be used to improve the quality of preventive care available to all Americans and to eliminate disparities.

Below are four specific topics that the USPSTF has prioritized as having critical evidence gaps for targeted populations and age groups that may be addressed through research and that if filled are likely to result in important new recommendations:

1. Screening for Osteoporosis in Men

By 2012, approximately 12 million Americans older than age 50 years are expected to have osteoporosis. Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality. Although hip fractures are less common in men than in women, more than one-third of men who experience a hip fracture die within 1 year. In 2011, the USPSTF recommended screening for osteoporosis in women ages 65 years or older and in younger women at increased risk. However, the USPSTF found a lack of relevant studies on whether drug therapies reduce the risk for fractures in men who have no previous osteoporotic fractures. Because of this evidence gap, the USPSTF was unable to make a recommendation for men. Randomized trials of primary clinical fracture prevention in men who have osteoporosis are needed.

2. Screening for Depression in Children

Major depressive disorder (MDD) among youth is a disabling condition that is associated with serious long-term morbidity and risk of suicide. However, the majority of depressed youth are undiagnosed and untreated. In 2009, the USPSTF found inadequate evidence that screening tests accurately identify MDD in school-aged children, and that antidepressants (i.e., selective serotonin reuptake inhibitors [SSRIs] such as fluoxetine) reduce MDD symptoms in children. There are limited data on the benefits of psychotherapy and the benefits of psychotherapy plus SSRIs in children. Studies are also needed that examine collaborative care management approaches compared with usual clinical care, as well as epidemiologic studies that describe the prevalence

of MDD in children in primary health care settings according to age, sex, and race/ethnicity. Observational studies of risks for longer-term outcomes associated with the use of antidepressants would also contribute to addressing current evidence gaps.

3. **Screening and Counseling for Alcohol Misuse in Adolescents**
   High-risk alcohol use by adolescents is an important cause of preventable death and significant injury in this population. In 2004, the USPSTF found convincing evidence that screening and behavioral counseling for adults including pregnant women in primary care settings was effective. It found significant evidence gaps, however, regarding the effectiveness of interventions aimed at adolescents. More evidence is needed on the effects of alcohol misuse screening and counseling interventions targeting adolescents that can be implemented in primary care settings, or to which patients can be referred by primary care clinicians.

4. **Aspirin Use to Prevent Heart Attacks and Strokes in Adults Ages 80 Years and Older**
   In 2009, the USPSTF found good evidence that aspirin decreases the incidence of myocardial infarction in men and ischemic strokes in women and recommended that primary care clinicians discuss aspirin use with middle-aged men and women. While aspirin use has significant benefits, it also has significant risks, including gastrointestinal bleeding. While the incidence of heart attack and stroke is high in older adults and thus the potential benefit of aspirin is large, the relationship between increasing age and gastrointestinal bleeding is also well established, and thus the potential harms are also large. The USPSTF did not find enough evidence to balance the potential benefits and harms of aspirin use to prevent cardiovascular disease in adults older than age 80 years. Given the continuing aging of the U.S. population and longer expected life spans, it is important to study the effectiveness of clinical prevention in older adults. Specifically, research is needed to understand the potential benefits and harms of aspirin use to prevent heart attacks and strokes in adults ages 80 years and older.

Even when the Task Force has not made an "I" statement about a specific service, it understands that there are issues for specific groups that need additional attention in order for all people to be able to benefit from prevention. There are many reasons why clinical preventive services may have differential impact for specific populations, including potential biologic and genetic differences and social determinants of health that vary among communities. Examples of clinical preventive services with differential impact include such diverse topics as screening for hepatitis B in Asian Americans, screening for diabetes in American Indians, and counseling about breastfeeding for African American women and families.

Gaps in Implementation Research

In addition to targeted research in the high-priority areas identified above, the USPSTF notes that there are also critical questions about how evidence on the effectiveness of clinical preventive services can best be implemented in primary care practices. Additional implementation and translational research in this area will increase the value of the work of the USPSTF. Specifically, research is needed to systematically evaluate the following:

1. How do primary care professionals incorporate new evidence to change their practice?
2. What are the most effective strategies to assist primary care professionals in the translation of evidence-based clinical preventive services into practice?
3. How can primary care professionals share evidence with their patients to empower patients and families to make health care decisions about prevention?
4. How can health information technology, including electronic health records and personal health records, be utilized to increase the number of Americans receiving recommended clinical preventive services?
5. How can the USPSTF continue to improve its work to better meet the needs of primary care professionals and their patients?

VI. NEXT STEPS FOR THE USPSTF IN 2012

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 approximately 12 new topics, including topics nominated for consideration through the public topic nomination process.
3. The USPSTF will solicit input from stakeholders and citizens at the beginning or planning stages of the evidence review process, to ensure that the right questions are being asked.
4. The USPSTF will expand its work to translate and present draft recommendations in order to facilitate input from the full range of interested stakeholders, including the public, and release 10 more draft recommendations for comment.
5. The USPSTF will release 10 or more 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 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 second annual report for Congress on high-priority evidence gaps in the field of clinical preventive services.

VII. CONCLUSION

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

APPENDIX A. 2011 MEMBERS OF THE USPSTF

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APPENDIX B. USPSTF 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 Physicians

American College of Preventive Medicine

American Congress of Obstetricians and Gynecologists

American Osteopathic Association

National Association of Pediatric Nurse Practitioners

Federal Partners

Centers for Disease Control and Prevention

Centers for Medicare and Medicaid Services

Food and Drug Administration

Health Resources and Services Administration

Indian Health Service

National Institutes of Health

Department of Defense/Military Health System

Veterans Health Administration

Affiliates

- Office of Disease Prevention and Health Promotion
- Office of the Surgeon General

Policy, Population, and Systems Implementation Partners

AARP

America's Health Insurance Plans

National Committee for Quality Assurance

APPENDIX C. COMPLETE LISTING OF ALL USPSTF SPECIFIC RECOMMENDATIONS AS OF SEPTEMBER 2011

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 Who Are Sexually Active**
	The USPSTF recommends screening for cervical cancer in women who have been sexually active and have a cervix.
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	**Gonorrhea: Preventive Medication in Newborns**
	The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.
A	**HIV: Screening in Adults and Adolescents at Increased Risk**
	The USPSTF recommends that clinicians screen for HIV in all adolescents and adults at increased risk for HIV infection.

Grade	Title
A	**HIV: Screening in Pregnant Women**
	The USPSTF recommends that clinicians screen for HIV in all pregnant women.
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.
A	**Lipid Disorders in Adults: Screening in Men Ages 35 Years and Older**
	The USPSTF recommends screening for lipid disorders in men ages 35 years and older.
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	**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 for syphilis infection in all pregnant women.
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.
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.

Grade	Title
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	**Gonorrhea: Screening in Pregnant Women and Women at Increased Risk**
	The USPSTF recommends that clinicians screen for gonorrhea infection in all sexually active women, including those who are pregnant, if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors; go to Clinical Considerations section for further discussion of 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.
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 Intensive Counseling for Obese Adults**
	The USPSTF recommends that clinicians screen for obesity in all adults and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.

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	**RhD Blood Typing: Antibody Testing in Unsensitized RhD-Negative Pregnant Women**
	The USPSTF recommends repeated RhD antibody testing for all unsensitized RhD-negative women at 24–28 weeks gestation, unless the biological father is known to be RhD-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	**Type 2 Diabetes Mellitus: Screening in Adults With Sustained Blood Pressure of 135/80+**
	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.
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.

Grade	Title
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	**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.
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. This recommendation states, "The USPSTF concludes that the evidence is insufficient to recommend for or against teaching or performing routine breast self-examination (I statement)."*
D	**Coronary Heart Disease: Screening Using ECG, ETT, or EBCT in Adults at Low Risk**
	The USPSTF recommends against routine screening with resting electrocardiography, exercise treadmill test, or electron-beam computerized tomography scanning for coronary calcium for either the presence of severe coronary artery stenosis or the prediction of coronary heart disease (CHD) events in adults at low risk for CHD events.
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 in Women Older Than Age 65 Years at Average Risk**
	The USPSTF recommends against routine screening for cervical cancer in women older than age 65 years if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.
D	**Cervical Cancer: Screening in Women Who Have Had a Hysterectomy**
	The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.
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	**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.

Grade	Title
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 adults who are at low risk for infection.
D	**Hormone Replacement Therapy: Preventive Medication for Postmenopausal Women**
	The USPSTF recommends against the routine use of combined estrogen and progestin for the prevention of chronic conditions in postmenopausal women.
D	**Hormone Replacement Therapy: Preventive Medication for Postmenopausal Women Who Have Had a Hysterectomy**
	The USPSTF recommends against the routine use of unopposed estrogen for the prevention of chronic conditions in postmenopausal women who have had a hysterectomy.
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 the asymptomatic general population.
D	**Idiopathic Scoliosis: Screening in Asymptomatic Adolescents**
	The USPSTF recommends against routine screening for idiopathic scoliosis in asymptomatic adolescents.
D	**Ovarian Cancer: Screening in Women**
	The USPSTF recommends against routine screening for ovarian cancer.
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: Screening in Men Ages 75 Years or Older**
	The USPSTF recommends against screening for prostate cancer in men ages 75 years or older.
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 Adults**
	The USPSTF recommends against routine screening for syphilis infection in asymptomatic adults 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 Cardiovascular Disease: 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 use 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 and Mammography 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. 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)."*
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	**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	**Coronary Heart Disease: Screening Using ECG, ETT, or EBCT in Adults at Increased Risk**
	The USPSTF found insufficient evidence to recommend for or against routine screening with resting electrocardiography, exercise treadmill test, or electron-beam computerized tomography scanning for coronary calcium for either the presence of severe coronary artery stenosis or the prediction of coronary heart disease (CHD) events in adults at increased risk for CHD events.
I	**Cervical Cancer: Screening Using Human Papillomavirus Testing**
	The USPSTF concludes that the evidence is insufficient to recommend for or against the routine use of human papillomavirus testing as a primary screening test for cervical cancer.
I	**Cervical Cancer: Screening Using New Technologies**
	The USPSTF concludes that the evidence is insufficient to recommend for or against the routine use of new technologies to screen for cervical cancer.
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	**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	**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 by primary care clinicians in preschool children for the prevention of dental disease.
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: 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 for illicit drug use in adolescents, adults, and pregnant women.
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 in pregnant women 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	**Healthy Diet: Counseling for Unselected Patients in a Primary Care Setting**
	The USPSTF concludes that the evidence is insufficient to recommend for or against routine behavioral counseling to promote a healthy diet in unselected patients in primary care settings.
I	**Hepatitis C: Screening in Adults 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.

Grade	Title
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.
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	**Obesity: Screening and Counseling of Any Intensity in Overweight Adults**
	The USPSTF concludes that the evidence is insufficient to recommend for or against the use of counseling of any intensity and behavioral interventions to promote sustained weight loss in overweight adults.
I	**Obesity: Screening and Moderate-/Low-Intensity Counseling for Obese Adults**
	The USPSTF concludes that the evidence is insufficient to recommend for or against the use of moderate- or low-intensity counseling together with behavioral interventions to promote sustained weight loss in obese adults.

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	**Prostate Cancer: Screening in Men Younger Than Age 75 Years**
	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for prostate cancer in men younger than age 75 years.
I	**Sexually Transmitted Infections: Behavioral Counseling for Adolescents and Adults Who Are Not Sexually Active or 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: Counseling by Primary Care Physicians**
	The USPSTF concludes that the evidence is insufficient to recommend for or against routine counseling by primary care clinicians to prevent skin cancer.
I	**Skin Cancer: Screening in Adults**
	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.

Grade	Title
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 Adults**
	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 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.

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