

Preventive Health Recommendations for 2010 – Final

DEVELOPED BASED ON SCIENTIFIC EVIDENCE

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Authorized By: Medical Management Guideline Committee

Approval Date: 02/11/99

Revision Date: 04/08/99; 02/10/00; 02/08/01; 02/14/02; 04/11/02; 02/13/03; 03/16/04; 2/22/05; 9/1/05; 11/22/05; 2/22/06; 4/11/06; 8/22/06; 11/1/06; 2/20/07; 2/19/08; 3/18/2009; 2/15/2010

IMMUNIZATIONS
Centers for Disease Control and Prevention. Recommended Immunization Schedules for Persons Aged 0 through 18 years, United States, 2010. MMWR 2010; 58 (51&52). Centers for Disease Control and Prevention. Recommended Adult Immunizations Schedules, United States, 2010. MMWR 2010; 59 (1).

ASSESSMENT	0–10 years	11–24 years	25–64 years	65+ years
Abdominal Aortic Aneurysm ¹ USPSTF, 2/2005				<ul style="list-style-type: none"> • One-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65-75 who have ever smoked
Breast Cancer Screening ^{2,3} USPSTF, 12/2009 (Screening) and 9/2005 (BRCA Testing)			<ul style="list-style-type: none"> • Biennial screening mammography for women aged 50 to 74 years • Beginning biennial screening mammography before age 50 years should be an individual decision that takes into the individual's context into account, including values regarding benefits and harms. • Women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing. 	<ul style="list-style-type: none"> • Biennial screening mammography for women aged 50 to 74 years

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Cervical Cancer Screening ⁴ USPSTF, 1/2003		<ul style="list-style-type: none"> At least every 3 years beginning at age 21 or for women who are or have been sexually active, whichever comes first; interval as recommended by physician based on risk factors 	<ul style="list-style-type: none"> At least every 3 years for women who have a cervix; interval as recommended by physician based on risk factors 	<ul style="list-style-type: none"> May discontinue regular testing after age 65 in women who have had adequate recent screenings in which test results have been normal and who are otherwise not at risk
Chlamydia Infection Screening ⁵ USPSTF, 6/2007		<ul style="list-style-type: none"> At least annually for sexually active females age 24 years and younger 	<ul style="list-style-type: none"> At least annually for other asymptomatic females at increased risk for infection 	<ul style="list-style-type: none"> At least annually for asymptomatic females at increased risk for infection
Colorectal Cancer Screening ⁶ USPSTF, 10/2008			<ul style="list-style-type: none"> Screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy, beginning at age 50 and continuing until age 75 years. The risks and benefits of these screening methods vary. - 	<ul style="list-style-type: none"> Screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy, beginning at age 50 and continuing until age 75 years. The risks and benefits of these screening methods vary.
Depression Screening ⁷ USPSTF, 3/2009 (Children) and 12/2009 (Adults)	<ul style="list-style-type: none"> Screen adolescents (12-18 years) for major depressive disorder when systems are in place to assure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up 	<ul style="list-style-type: none"> Screening for adolescents and adults for depression when staff-assisted depression care supports are in place to assure diagnosis, effective treatment, and follow-up 	<ul style="list-style-type: none"> Screening for adults for depression when staff-assisted depression care supports are in place to assure diagnosis, effective treatment, and follow-up 	<ul style="list-style-type: none"> Screening for adults for depression when staff-assisted depression care supports are in place to assure diagnosis, effective treatment, and follow-up
Diabetes-Type 2 ⁸ USPSTF, 6/2008			<ul style="list-style-type: none"> Screening of asymptomatic adults with sustained blood pressure (treated or untreated) greater than 135/80mm Hg - 	<ul style="list-style-type: none"> Screening of asymptomatic adults with sustained blood pressure (treated or untreated) greater than 135/80mm Hg -

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Gonorrhea ⁹ USPSTF, 5/2005		<ul style="list-style-type: none"> Screening of all sexually active females, including those who are pregnant, if they are at increased risk for infection 	<ul style="list-style-type: none"> Screening of all sexually active females, including those who are pregnant, if they are at increased risk for infection 	<ul style="list-style-type: none"> Screening of all sexually active females if they are at increased risk for infection
Hearing ¹⁰ USPSTF, 1/1997 (adult) 7/2008 (newborn)	<ul style="list-style-type: none"> Screen all newborn infants for hearing loss 			<ul style="list-style-type: none"> At physician discretion
Height and Weight ¹¹ USPSTF, 1/1997 AAP, 3/2000	<ul style="list-style-type: none"> Growth chart plotted during office visit from birth on 	<ul style="list-style-type: none"> Periodically 	<ul style="list-style-type: none"> Periodically 	<ul style="list-style-type: none"> Periodically
High Blood Pressure ¹² (Hypertension) USPSTF, 12/2007		<ul style="list-style-type: none"> Periodic screening beginning at age 18 years 	<ul style="list-style-type: none"> Periodic screening 	<ul style="list-style-type: none"> Periodic screening
Human Immunodeficiency virus (HIV) ¹³ USPSTF, 7/2005, 4/2007		<ul style="list-style-type: none"> Screen all adolescents and adults at increased risk for HIV infection 	<ul style="list-style-type: none"> Screen all adolescents and adults at increased risk for HIV infection 	<ul style="list-style-type: none"> Screen all adults at increased risk for HIV infection

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Lipid Disorder Screening ¹⁴ USPSTF, 6/2008		<ul style="list-style-type: none"> Routine screening beginning at age 20 if other risk factors for coronary heart disease exist 	<ul style="list-style-type: none"> Routine screening for males age 35 and older Routine screening for females age 45 and older if they are at increased risk for coronary heart disease Routine screening for younger adults if other risk factors for coronary heart disease exist 	<ul style="list-style-type: none"> Routine screening for males Routine screening for females if they are at increased risk for coronary heart disease
Obesity ¹⁵ USPSTF, 12/2003 (Adult); 1/2010 (Children)	<ul style="list-style-type: none"> Screening for children aged 6 years and older – offer comprehensive, intensive behavioral interventions to promote improvement in weight status 	<ul style="list-style-type: none"> Routine screening for adults – offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults 	<ul style="list-style-type: none"> Routine screening for adults – offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults 	<ul style="list-style-type: none"> Routine screening for adults – offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults
Osteoporosis Screening ¹⁶ USPSTF, 9/2002			<ul style="list-style-type: none"> Routine screening beginning at age 60 for women at increased risk of osteoporotic fracture 	<ul style="list-style-type: none"> Routine screening for women
Prostate Cancer Screening ¹⁷ USPSTF, 12/2002; 8/2008			<ul style="list-style-type: none"> Discuss risks and benefits of screening with medical professional 	<ul style="list-style-type: none"> Discuss risks and benefits of screening, for men up to 75 years of age, with medical professional
Syphilis Screening ¹⁸ USPSTF, 7/2004		<ul style="list-style-type: none"> Screening for persons at increased risk for syphilis infection 	<ul style="list-style-type: none"> Screening for persons at increased risk for syphilis infection 	<ul style="list-style-type: none"> Screening for persons at increased risk for syphilis infection
Tuberculosis Screening ¹⁹ CDC 2000; 2005	<ul style="list-style-type: none"> Targeted testing of persons at high risk for recent latent tuberculosis infection 	<ul style="list-style-type: none"> Targeted testing of persons at high risk for recent latent tuberculosis infection 	<ul style="list-style-type: none"> Targeted testing of persons at high risk for recent latent tuberculosis infection 	<ul style="list-style-type: none"> Targeted testing of persons at high risk for recent latent tuberculosis infection

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Vision Screening ²⁰ USPSTF, 5/2004 (Screening Children); 7/2009 (Screening Older Adults); 3/2005 (Glaucoma)	<ul style="list-style-type: none"> Screening for amblyopia, strabismus and defects in visual acuity in children younger than age 5 years 	<ul style="list-style-type: none"> Refer high risk individuals for evaluation by eye specialist; frequency at physician discretion 	<ul style="list-style-type: none"> Refer high risk individuals for evaluation by eye specialist; frequency at physician discretion 	<ul style="list-style-type: none"> Refer high risk individuals for evaluation by eye specialist; frequency at physician discretion

NEWBORN/ PRENATAL	0–10 years	11–24 years	25–64 years	65+ years
	Recommended Topic:	Recommended Topic:	Recommended Topic:	Recommended Topic:
Newborn Care ²¹ USPSTF, 5/2005 (Gonorrhea) 7/2008 (Hearing Loss) 3/2008 (Hypothyroidism) 3/2008 (Phenylketonuria) 9/2007 (Sickle Cell Disease) Prenatal Care USPSTF, 5/2009 (Folic Acid) 11/2003 (tobacco use) 6/2009 (Hepatitis B) 4/2004 (drug use) 5/2009 (Syphilis testing) 7/2008 (Bacteriuria) 7/2005 (HIV testing) 5/2006 (Iron deficiency) 6/2007 (Chlamydial screening) 10/2008 (Breastfeeding) 4/2009 (Smoking)	<ul style="list-style-type: none"> Prophylactic ocular topical medication for all newborns⁹ Screen all newborns for <ul style="list-style-type: none"> hearing loss congenital hypothyroidism phenylketonuria sickle cell disease Interventions after birth to promote and support breast feeding³¹ 	<ul style="list-style-type: none"> To reduce the risk of neural tube defects in newborns, all women planning or capable of pregnancy should take a supplement containing 0.4 to 0.8 mg of folic acid daily²² Pregnant women should be advised to seek their first prenatal visit in the first trimester or as soon as pregnancy is known²³ During the first prenatal visit, perform Rh (D) blood typing and antibody testing²⁴ and screen for hepatitis B virus²⁵ and syphilis infection¹⁸; at 12-16 weeks' gestation or at the first prenatal visit if it occurs later than 12-16 weeks, screen for asymptomatic bacteriuria²⁶. During the first prenatal visit, screen all pregnant females age 24 and younger and all older pregnant females at increase risk for Chlamydial infection. For pregnant women who remain at increased risk and for those that acquire a new risk factor, also screen during the third trimester⁵. Screen all pregnant women for iron deficiency anemia²⁷ Screen all pregnant women for HIV¹³. Screen all pregnant women for tobacco use and provide augmented pregnancy-tailored counseling to those who smoke²⁸ Advise all pregnant women of the potential adverse effects of drug use on the development of the fetus³⁵ Interventions during pregnancy to promote and support breast feeding³¹ 		<ul style="list-style-type: none">

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COUNSELING	0–10 years	11–24 years	25–64 years	65+ years
	Recommended Topic:	Recommended Topic:	Recommended Topic:	Recommended Topic:
Cardiovascular Disease Prevention ²⁹ USPSTF, 3/2009			<ul style="list-style-type: none"> When the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage, use of aspirin for men age 45 to 79 years and for women age 55 to 79 years. 	<ul style="list-style-type: none"> When the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage, use of aspirin for men age 45 to 79 years and for women age 55 to 79 years.
Dental Health ³⁰ USPSTF, 1/1996 (dental care); 4/2004 (fluoride)	<ul style="list-style-type: none"> Regular dental care Floss, brush with fluoride toothpaste daily Prescribe oral fluoride supplementation for preschoolers with fluoride-deficient water supplies 	<ul style="list-style-type: none"> Regular dental care Floss, brush with fluoride toothpaste daily 	<ul style="list-style-type: none"> Regular dental care Floss, brush with fluoride toothpaste daily 	<ul style="list-style-type: none"> Regular dental care Floss, brush with fluoride toothpaste daily
Diet and Exercise ³¹ USPSTF, 1/1997, 1/2003 (dietary counseling); 10/2008 (breastfeeding), 5/2006 (iron supplementation)	<ul style="list-style-type: none"> Encourage breastfeeding of infants; diet of iron-enriched formula and foods Iron supplementation for asymptomatic children ages 6-12 months who are at increased risk for iron deficiency anemia Over age 2, limit fat and cholesterol, maintain caloric balance and emphasize fruits, vegetables, and grain products containing fiber 	<ul style="list-style-type: none"> Limit fat and cholesterol, maintain caloric balance and emphasize fruits, vegetables, and grain products containing fiber Adequate calcium intake (women) 	<ul style="list-style-type: none"> Limit fat and cholesterol, maintain caloric balance and emphasize fruits, vegetables, and grain products containing fiber Dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease³² Adequate calcium intake (women) 	<ul style="list-style-type: none"> Limit fat and cholesterol, maintain caloric balance and emphasize fruits, vegetables, and grain products containing fiber Dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease³² Adequate calcium intake (women)

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	Recommended Topic:	Recommended Topic:	Recommended Topic:	Recommended Topic:
Hormone Replacement Therapy ³³ USPSTF, 5/2005			<ul style="list-style-type: none"> Counsel women approaching menopause regarding alternatives to prevent chronic disease 	
Sexual Behavior ³⁴ USPSTF, 10/2008		<ul style="list-style-type: none"> Sexually Transmitted Disease: All sexually active adolescent and adults at increased risk for sexually transmitted infections counseled about effective measures to prevent infection Unintended pregnancy: Contraception 	<ul style="list-style-type: none"> Sexually Transmitted Disease: All sexually active adolescent and adults at increased risk for sexually transmitted infections counseled about effective measures to prevent infection Unintended pregnancy: Contraception 	<ul style="list-style-type: none"> Sexually Transmitted Disease: All sexually active adolescent and adults at increased risk for sexually transmitted infections counseled about effective measures to prevent infection
Substance Use and Substance Abuse ³⁵ USPSTF, 4/2009 (Tobacco use) 4/2004 (Alcohol misuse)	<ul style="list-style-type: none"> Effects of passive smoking Anti-tobacco message 	<ul style="list-style-type: none"> Regular screening for tobacco-use status and provide tobacco cessation interventions for those who use tobacco products Screening and behavioral counseling interventions to reduce alcohol misuse by adults 	<ul style="list-style-type: none"> Regular screening for tobacco-use status and provide tobacco cessation interventions for those who use tobacco products Screening and behavioral counseling interventions to reduce alcohol misuse by adults 	<ul style="list-style-type: none"> Regular screening for tobacco-use status and provide tobacco cessation interventions for those who use tobacco products Screening and behavioral counseling interventions to reduce alcohol misuse by adults

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Nothing in these guidelines should be construed to establish a new benefit under PacifiCare or indicate a change in federal or state required benefits. The PacifiCare/Secure Horizons member's Evidence of Coverage/Disclosure Form should be consulted for the specific coverage and limitations of benefits.

References: American Academy of Pediatrics (AAP), Centers for Disease Control and Prevention (CDC) and US Preventive Services Task Force (USPSTF). Unless otherwise specified, please note that the designations for each recommendation reflect the evidence rating assigned by the USPSTF. Designations: (A) strongly recommends the service based on good evidence; (B) recommends the service based on fair evidence; (C) makes no recommendation for or against the service based on fair evidence but concludes the balance of benefits and harms is too close to justify a general recommendation; (D) recommends against the service in asymptomatic patients based on at least fair evidence that the service is ineffective or that harms outweigh benefits; (I) insufficient evidence for or against the service based on evidence that the service is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined. For Child and Adult Immunization Schedules, see the Centers for Disease Control and Prevention recommendations from the Advisory Committee on Immunization Practices (ACIP) (www.cdc.gov/vaccines/hcp or www.cdc.gov/mmwr).

¹The USPSTF found good evidence that screening for abdominal aortic aneurysm (AAA) and surgical repair of large AAAs (5.5 cm or more) in men age 65-75 who have ever smoked (current and former smokers) leads to decreased AAA-specific mortality (B). There is good evidence that abdominal ultrasonography, performed in a setting with adequate quality assurance (i.e., in an accredited facility with credentialed technologists), is an accurate screening test for AAA. There is also good evidence of important harms of screening and early treatment, including an increased number of surgeries with associated clinically-significant morbidity and mortality, and short-term psychological harms. Based on moderate magnitude of net benefit, the USPSTF concluded that the benefits of screening for AAA in men aged 65 to 75 who have ever smoked outweigh the harms. The major risk factors for abdominal aortic aneurysm (AAA) include age (being 65 or older), male sex, and a history of ever smoking (at least 100 cigarettes in a person's lifetime). A first-degree family history of AAA requiring surgical repair also elevates a man's risk for AAA; this may also be true for women but the evidence is less certain. There is only a modest association between risk factors for atherosclerotic disease and AAA. Other lesser risk factors include family history, coronary heart disease, claudication, hypercholesterolemia, hypertension, cerebrovascular disease, and increased height. Factors associated with decreased risk include female sex, diabetes mellitus, and black race. As always, physicians must individualize recommendations depending on a patient's risk and likelihood of benefit. For example, some clinicians may choose to discuss screening with male nonsmokers nearing age 65 who have a strong first-degree family history of AAA that required surgery.

²The USPSTF recommends biennial screening mammography for women aged 50 to 74 years (B). 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 (C).

³The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluations for BRCA testing (B). Counseling, that allows for informed decision making, should be carried out by a suitably trained health care provider. There is insufficient evidence to determine the benefits of chemoprevention or intensive screening in improving health outcomes in these women if they test positive for deleterious BRCA1 or BRCA2 mutations. However, there is fair evidence that prophylactic surgery for these women significantly decreases breast and ovarian cancer incidence. Thus, the potential benefits of referral and discussion of testing and prophylactic treatment for these women may be substantial.

⁴The USPSTF strongly recommends cervical cancer screening for all women whom are or have been sexually active and who have a cervix (A). Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by screening

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within 3 years of onset of sexual activity or age 21 (which ever comes first) and screening at least every 3 years. The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer. (D) The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease. (D) The USPSTF concluded that the evidence is insufficient to recommend for or against the routine use of new technologies to screen for cervical cancer. (I)

⁵The USPSTF recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk (A). The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk (B). Screening for pregnant women who are at increased risk is recommended at the first prenatal visit. For pregnant women who remain at increased risk and for those who acquire a new risk factor, such as a new sexual partner, a screening should be conducted during the third trimester. The CDC recommends at least annual screening for women at increased risk. In addition to sexual activity and age, other risk factors for chlamydial infection include a history of chlamydial or other sexually transmitted infection, new or multiple sexual partners, inconsistent condom use, and exchanging sex for money or drugs.

⁶The 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 (B). The USPSTF recommends against routine screening for colorectal cancer in adults age 76 to 85 years. There may be considerations that support colorectal cancer screening in an individual patient (C). The USPSTF recommends against screening for colorectal cancer in adults older than age 85 years (D). 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). Screening programs incorporating fecal occult blood testing, sigmoidoscopy, or colonoscopy will all be effective in reducing mortality. Modeling evidence suggest that population screening programs between the ages of 50 and 75 years using any of the following three regimens will be approximately equally effective in life-years gained, assuming 100% adherence to the same regimen for that period: 1) annual high-sensitivity fecal occult blood testing, 2) sigmoidoscopy every 5 years combined with high-sensitivity fecal occult blood testing every three years, and 3) screening colonoscopy at intervals of 10 years.

⁷The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment and follow-up (B). Several depression screening instruments are available, including the Zung Self-Depression Scale, Beck Depression Inventory, General Health Questionnaire, Center for Epidemiologic Study Depression Scale, SelfCARE and the Geriatric Depression Scale. Most of these instruments have relatively good sensitivity (80 to 90%) but only fair specificity (70 to 85%). Most are easy to use and can be administered in less than 5 minutes. Short screening tests, including asking two simple questions about mood and anhedonia (“Over the past 2 weeks, have you felt down, depressed or hopeless?” and “Over the past 2 weeks, have you felt little interest or pleasure in doing things?”) seem to detect most depressed patients, and in some cases, do better than the original instrument from which they were derived. The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder when systems are in place to assure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal) and follow-up (B). The USPSTF concluded evidence is insufficient to assess the balance of benefits and harms of screening of children (7-11 years of age) (I).

⁸The 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). The optimal screening interval is not known. The American Diabetes Association, on the basis of expert opinion, recommends a 3-year interval.

⁹The 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 (young or have other individual or population risk factors) (A). The USPSTF also strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum (A).

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¹⁰The USPSTF concluded there is insufficient evidence to recommend for or against routine screening of newborns for hearing loss during the postpartum hospitalization (I). The USPSTF recommends screening older adults for hearing impairment by periodically questioning them about their hearing, counseling them about the availability of hearing aid devices and making referrals for abnormalities when appropriate. The optimal frequency of such screening has not been determined and is left for clinical discretion. (B).

¹¹The AAP and USPSTF recommend periodic height and weight measurements plotted on growth chart (B).

¹²The USPSTF strongly recommends screening adults aged 18 and older for high blood pressure (A). Evidence is lacking to recommend an optimal interval for screening adults for high blood pressure. The seventh report of the Joint National Committee of Prevention, Detection, Evaluation, and Treatment of High Blood Pressure recommends screening every two years for persons with SBP and DBP <120 Hg and 80 mm Hg, respectively, and every year with systolic blood pressure of 120 to 139 mm Hg or diastolic blood pressure of 80 to 90 mm Hg. The USPSTF concluded that the evidence is insufficient to recommend for or against routine screening for high blood pressure in children and adolescents to reduce the risk of cardiovascular disease (I). The decision to screen children and adolescents for hypertension remains a matter of clinical judgment.

¹³The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection (A). A person is considered at increased risk for HIV infection if he or she reports one or more individual risk factors or receives health care in a high-prevalence or high-risk clinical setting. Those at individual risk include: men who have had sex with men after 1975; men and women having unprotected sex with multiple partners; past or present injection drug users; men and women who exchange sex for money or drugs or have sex partners who do; individuals whose past or present sex partners were HIV-infected, bisexual, or injection drug users; persons being treated for sexually transmitted diseases; and persons with a history of blood transfusion between 1975 and 1985. Persons who request an HIV test despite reporting no individual risk factors may also be considered at increased risk, since this group is likely to include individuals not willing to disclose high risk behaviors. The USPSTF recommends that clinicians screen all pregnant women for HIV (A). Early detection of maternal HIV infection allows for discussion of elective cesarean section and avoidance of breast feeding, both of which are associated with lower infection in newborn. In November 2006, the USPSTF assess the research published by the CDC in September 2006 and confirmed the “C” recommendation for screening non-pregnant adolescents and adults who are not at increased risk for HIV infection.

¹⁴The USPSTF strongly recommends routinely screening men age 35 and older for lipid disorders (A); screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease (B); strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease (A); and screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease (B). The USPSTF makes no recommendations for or against routine screening for lipid disorders in men aged 20 to 35, or in women aged 20 and older who are not at increased risk for coronary heart disease (C).

¹⁵The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults (B). The USPSTF found good evidence that Body Mass Index (BMI), calculated as weight in kilograms divided by height in meters squared, is reliable and valid for identifying adults at increased risk for mortality and morbidity due to overweight and obesity. There is fair to good evidence that high-intensity counseling-about diet, exercise, or both – together with behavioral interventions aimed at skill development, motivation, and support strategies produces modest, sustained weight loss in adults who are obese. Although the USPSTF did not find direct evidence that behavioral interventions lower mortality or morbidity from obesity, the USPSTF concluded that changes in intermediate outcomes, such as improved glucose metabolism, lipid levels, and blood pressure, from modest weight loss provide indirect evidence of health benefits. No evidence was found that addressed the harms of counseling and behavioral interventions. The USPSTF concluded that the benefits of screening and behavioral interventions outweigh potential harms. The USPSTF also recommends that clinicians screen

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children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status (B). The USPSTF found that BMI was an acceptable measure for identifying children and adolescents with excess weight. The major update from the prior recommendations is that the USPSTF determined that a comprehensive moderate to high-intensity programs that include dietary, physical activity, and behavioral counseling components can result in improvement in weight status among obese children age 6 and older who complete the program.

¹⁶The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 for women at increased risk of osteoporotic fractures (B). The exact risk factors that should trigger screening in this age group are difficult to specify based on evidence. Lower body weight (weight <70kg) is the single best predictor of low bone mineral density. There is less evidence to support the use of other individual risk factors (for example, smoking, weight loss, family history, decreased physical activity, alcohol or caffeine use, or low calcium and vitamin D intake) as a basis for identifying high-risk women younger than 65. At any given age, African-American women on average have higher bone mineral density (BMD) than white women and are thus less likely to benefit from screening. Among different bone measurement tests performed at various anatomical sites, bone density measured at the femoral neck by dual-energy x-ray absorptiometry (DXA) is the best predictor of hip fracture and is comparable to forearm measurements for predicting fractures at other sites. Other technologies for measuring peripheral sites include quantitative ultrasonography (QUS), radiographic absorptiometry, single energy x-ray absorptiometry, peripheral dual energy x-ray absorptiometry, and peripheral quantitative computed tomography. Recent data suggest that peripheral bone density testing in the primary care setting can also identify postmenopausal women who have a higher risk of fracture over the short term (1-year). Further research is needed to determine the accuracy of peripheral bone density testing in comparison with DXA. The optimal interval for repeated screening is unknown. Because of limitations in the precision of testing, a minimum of 2 years may be needed to reliably measure a change in BMD; however, longer intervals may be adequate.

¹⁷The USPSTF does not recommend routine screening for prostate cancer. Patients who request screening should be given objective information about the potential benefits and harms of early detection and treatment. Despite the absence of firm evidence of effectiveness, some clinicians may opt to perform prostate screening for other reasons. Clinicians should not order the PSA test without first discussing the potential, but uncertain, benefits and possible harms. In 8/2008, the USPSTF reviewed the evidence and updated the guideline to recommend against screening for men age 75 years and older (D). The USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75 years.

¹⁸The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection (A). For women in high-risk groups, repeat serologic testing may be necessary in the third trimester and at delivery.

¹⁹The USPSTF does not wish to duplicate efforts of the Centers for Disease Control and Prevention (CDC). The CDC emphasizes targeted tuberculin testing among persons at high risk for recent latent tuberculosis infection (LTBI), regardless of age; testing is discouraged among persons at lower risk. Please refer to the CDC website at <http://www.cdcnpin.org/scripts/tb/cdc.asp>

²⁰The USPSTF recommends screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years (B). There is insufficient evidence to recommend for or against routine screening by primary care practitioners for elevated intraocular pressure or early glaucoma (C). Recommendations to refer high-risk patients for evaluation by eye specialist may be based on the substantial prevalence of unrecognized glaucoma in these populations, the progressive nature of untreated disease, and expert consensus that reducing intraocular pressure may slow the rate of visual loss in patients with early glaucoma or severe intraocular hypertension. Populations in whom the prevalence is >1% include blacks over age 40 and whites over age 65. Patients with family history of glaucoma, patients with diabetes, and patients with severe myopia are also at increased risk. The optimal frequency for glaucoma screening has not been determined and is left to clinical discretion.

Preventive Health Recommendations for 2010 – Final

DEVELOPED BASED ON SCIENTIFIC EVIDENCE

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²¹ The USPSTF recommends screening newborns for hearing loss (B); congenital hypothyroidism (A); and phenylketonuria (A). The USPSTF recommends screening all newborns for sickle cell disease regardless of birth setting (A). In general, birth attendants should make arrangements for samples to be obtained, and the first physician to see the child at an office visit should verify screening results. Confirmatory testing should occur no later than 2 months of age.

²² The USPSTF recommends that to reduce the risk of neural tube defects in newborns, all women planning or capable of pregnancy should take a daily supplement containing 0.4 to 0.8 mg of folic acid daily (A).

²³ The American College of Obstetricians and Gynecologists (ACOG) recommends prenatal care beginning early in pregnancy and continuing through the postpartum period.

²⁴ The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care (A). 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).

²⁵ The USPSTF strongly recommends screening for hepatitis B virus (HBV) infection in women at their first trimester prenatal visit (A).

²⁶ The USPSTF strongly recommends that all pregnant women be screened for asymptomatic bacteriuria using urine culture at 12-16 weeks' gestation or at the first prenatal visit, if later (A).

²⁷ The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women (B)

²⁸ The USPSTF strongly recommends that clinicians screen all pregnant women for tobacco use and provide augmented pregnancy-tailored counseling to those who smoke. The USPSTF found good evidence that extended or augmented smoking cessation counseling (5-15 minutes) using messages and self-help materials tailored for pregnant smokers, compared with brief generic counseling interventions alone, substantially increases abstinence rates during pregnancy, and leads to increased birth weight. Although relapse rates are high in the post-partum period, the USPSTF concluded that reducing smoking during pregnancy is likely to have substantial health benefits for both the baby and the expectant mother. The USPSTF concluded that the benefits of smoking cessation counseling outweigh any potential harms.

²⁹ The USPSTF recommends the use of aspirin for men age 45 to 79 years (A) and women age 55 to 79 years (A) when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage. The net benefit of aspirin depends on the initial risk for coronary heart disease events and gastrointestinal bleeding. Thus, decisions about aspirin therapy should consider the overall risks for coronary heart disease and gastrointestinal bleeding. The optimum dose of aspirin for preventing cardiovascular disease events is not known. Primary prevention trials have demonstrated benefits with various regimens, including dosages of 75 and 100 mg/d and 100 and 325 mg every other day. A dosage of approximately 75 mg/d seems as effective as higher dosages. The risk for gastrointestinal bleeding may increase with dose. Risk assessment for coronary heart disease should include ascertainment of risk factors: age, diabetes, total cholesterol levels, high-density lipoprotein cholesterol levels, blood pressure, and smoking. Available tools provide estimations of coronary heart disease risk. Risk factors for stroke include age, high blood pressure, diabetes, smoking, a history of cardiovascular disease, atrial fibrillation, and left ventricular hypertrophy. Tools for estimation of stroke risk are available (such as the calculator available at <http://www.westernstroke.org/PersonalStrokeRisk1.xls>).

³⁰ The USPSTF recommends that primary care clinicians prescribe oral fluoride supplements at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride (B). 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 (I). The USPSTF recognizes the importance of preventing dental and periodontal disease. It has determined that there is no new evidence regarding the role of the primary care clinician in counseling and will not update the 1996 recommendation (B).

Preventive Health Recommendations for 2010 – Final

DEVELOPED BASED ON SCIENTIFIC EVIDENCE

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³¹The USPSTF recommends adults and children over age 2 should limit dietary intake of fat (A) and cholesterol (B), maintain caloric balance in their diet (B), and emphasize fruits, vegetables, and grain products containing fiber (B). Women should be encouraged to consume recommended quantities of calcium (B). Clinicians who lack the time or skill to perform a complete dietary history, to address potential barriers to changes in eating habits, and to offer specific guidance on meal planning and food selection and preparation, should either have patients seen by other trained providers in the office or clinic or should refer patients to a registered dietician or qualified nutritionist for further counseling. Parents should be encouraged to offer breastfeeding to their infants (A) and to include iron-enriched foods in their diet (B). The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding (B). The USPSTF recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia (B). In the U.S., race, income, education, and other socioeconomic factors are associated with iron deficiency and iron deficiency anemia. Individuals considered at high risk for iron deficiency include adult females, recent immigrants and, among adolescent females, fad dieters, and those who are obese. Premature and low birth weight infants are also at increased risk for iron deficiency.

³²The USPSTF recommends intensive behavioral dietary counseling for adult patients 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).

³³The USPSTF recommends against the routine use of estrogen and progestin for the prevention of chronic conditions in postmenopausal women (D). The USPSTF concludes that the evidence is insufficient to recommend for or against the use of unopposed estrogen for the prevention of chronic conditions in postmenopausal women who have had a hysterectomy (D). Clinicians should develop a shared decision-making approach to preventing chronic diseases in perimenopausal and postmenopausal women. This approach should consider individual risk factors and preferences in selecting effective interventions for reducing the risks of fracture, heart disease, and cancer. Clinicians should discuss with patients other effective strategies for preventing osteoporosis and fractures.

³⁴The 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). The USPSTF concluded the current evidence is insufficient to assess the balance of benefits and harms of behavioral counseling to prevent STIs in non-sexually active adolescents and in adults not at increased risk for STIs (I). Periodic counseling about effective contraceptive methods is recommended for all women and men at risk for unintended pregnancy (B).

³⁵The USPSTF recommends pregnant women and parents with children living at home also should be counseled on the potentially harmful effects of smoking on fetal and child health (A). The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products (A). Brief tobacco cessation counseling interventions, including screening, brief counseling (3 minutes or less), and/or pharmacotherapy, have proven to increase tobacco abstinence rates, although there is a dose-response relationship between quit rates and the intensity of counseling. Effective interventions may be delivered by a variety of primary care clinicians. The USPSTF recommends screening and behavioral health counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings (B). Clinicians can choose screening strategies that are appropriate for their clinical population and setting. [Assessing Alcohol Problems: A Guide for Clinicians and Researchers](http://www.niaaa.nih.gov/publications/EducationTrainingMaterials/) is available at <http://www.niaaa.nih.gov/publications/EducationTrainingMaterials/> Effective interventions to reduce alcohol consumption can be delivered wholly or in part in the primary care setting. The USPSTF concluded 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 setting (I). The USPSTF also concluded 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).