USPSTF Recommendations—2015 Update

Use in Primary Care and Other Practices

BY BARBARA P. YAWN, MD, MSC

Each year, the U.S. Preventive Services Task Force makes recommendations on the preventive services the nation’s doctors and other health care providers should offer their patients. Although clinicians may be aware of these recommendations, they may not always know how best to implement them in practice. This article provides an explanation of how the Task Force arrives at its decisions and what its recommendations mean. It highlights recent changes to recommendations that represent significant changes for practice, and presents cases illustrating ways to apply the recommendations to individual patients.

Prevention is an important part of medicine’s efforts to improve health, prolong life and lower the burden of chronic illness. Commonly considered the job of primary care physicians, providing preventive services is the responsibility of all, including those who work in specialty clinics, emergency departments, hospitals, mental health facilities—any place where there are interactions with patients for any health-related reason. As such, all clinicians need to be knowledgeable about recommended prevention activities and the evidence for their use.

In the United States, several groups provide guidance for selecting and implementing prevention activities. The Advisory Committee on Immunization Practices (ACIP), supported by staff from the Centers for Disease and Control and Prevention (CDC), produces a yearly immunization schedule that outlines all recommended immunizations by age and risk group (www.cdc.gov/vaccines/acip/recs/). This schedule has become the standard for school and work requirements, quality metrics for practices and payment decisions by insurers. The Community Prevention Task Force is also supported by the CDC and makes recommendations for community-based prevention and policy decisions such as the use of seat belts and infant car seats, reducing tobacco use and secondhand smoke exposure, violence prevention and workplace safety (www.the-communityguide.org). The U.S. Preventive Services Task Force (USPSTF), supported by the Agency for HealthCare Research and Quality (AHRQ), reviews and recommends prevention activities to be incorporated into routine care for individuals of all ages. (It does not address those issues reviewed by the ACIP or the Community Prevention Task Force.)

The list of USPSTF recommendations is long and can be intimidating. But when broken down by age, sex and risk factors, the list is a little more manageable. And, when approached as something to be done not at a single visit but as part of ongoing care, delivering the recommended services becomes more doable. What follows is an explanation of how the Task Force develops its recommendations, an explanation of its “grading” system, recent changes to recommendations, and case presentations showing how to implement the recommendations.

How the Task Force Works
The USPSTF is made up of physicians and doctoral-level nurses who are selected by the Department of Health and Human Services because of their expertise and experience in evidence-based decision-making and daily clinical practice. The topics it considers (eg, aspirin use to prevent MI or vision screening in preschool children) are suggested by health care professionals, health care and advocacy organizations, insurers and the public. The Task Force selects topics for full review based on their frequency within the general population and the availability of evidence that can be reviewed and used to make a recommendation. It also updates existing recommendations.

An in-depth review of all of the evidence for a topic is completed by a team at an Evidence-Based Practice Center, which then writes a comprehensive report for the USPSTF to consider. Those reports are usually published in peer-reviewed journals and can be found online by searching for “USPSTF evidence reports.”

After reviewing the evidence, the Task Force gives the proposed recommendation a grade ranging from “A” to “D,” depending on its strength, or makes an “I statement” if there is insufficient evidence to make a recommendation (Table 1).

When assigning grades, the Task Force assesses the balance of benefit versus harm and the certainty of that assessment. High certainty means that the available evidence includes consistent results from
**TABLE 1**

**Strength of recommendations (grade and level of certainty)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial.</td>
</tr>
<tr>
<td>B</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.</td>
</tr>
<tr>
<td>C</td>
<td>The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.</td>
</tr>
<tr>
<td>D</td>
<td>The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.</td>
</tr>
<tr>
<td>I</td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the benefits versus the harms of the service. Evidence may be lacking, be of poor quality or conflicting, or the balance of benefits and harms cannot be determined.</td>
</tr>
</tbody>
</table>

Source: [www.uspreventiveservicestaskforce.org/Page/Name/methods-and-processes/](http://www.uspreventiveservicestaskforce.org/Page/Name/methods-and-processes/)

---

**TABLE 2**

**Additions and modifications to USPSTF recommendations with A and B ratings since 2013**

<table>
<thead>
<tr>
<th>Category</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>INFANTS AND CHILDREN</td>
<td>Prescribe oral fluoride supplementation beginning at 6 months of age, if no fluoride in water . . . B</td>
</tr>
<tr>
<td></td>
<td>Apply fluoride varnish to primary teeth, starting at age of primary tooth eruption . . . B</td>
</tr>
<tr>
<td></td>
<td>Provide education or brief counseling to prevent initiation of tobacco use . . . B</td>
</tr>
<tr>
<td>ADOLESCENTS</td>
<td>Intensive behavioral counseling for STI prevention if sexually active . . . B</td>
</tr>
<tr>
<td></td>
<td>Provide education or brief counseling to prevent initiation of tobacco use . . . B</td>
</tr>
<tr>
<td></td>
<td>Screen for HIV beginning at 15 years of age . . . A</td>
</tr>
<tr>
<td>PREGNANCY</td>
<td>Ask about and advise stopping smoking, offer behavioral intervention for smoking cessation . . A</td>
</tr>
<tr>
<td></td>
<td>Screen for perinatal depression if follow up and therapy available . . . B</td>
</tr>
<tr>
<td></td>
<td>Screen for gestational diabetes at 24+ weeks . . . B</td>
</tr>
<tr>
<td></td>
<td>Use low-dose (81 mg) aspirin after 12 weeks in women at high risk for preeclampsia . . . B</td>
</tr>
<tr>
<td></td>
<td>Screen all pregnant women for HIV, even those presenting in labor . . . A</td>
</tr>
<tr>
<td>ADULTS</td>
<td>Screen for high blood pressure beginning at age 18 years . . . A</td>
</tr>
<tr>
<td></td>
<td>Screen all adults, including postpartum women, for depression . . . B</td>
</tr>
<tr>
<td></td>
<td>Screen overweight and obese adults 40 to 70 years for abnormal glucose . . . B</td>
</tr>
<tr>
<td></td>
<td>Offer behavioral counseling or referral to promote healthful diet and activity in adults with CVD risk factors who are overweight/obese . . . B</td>
</tr>
<tr>
<td></td>
<td>Screen for interpersonal violence in women of childbearing age . . . B</td>
</tr>
<tr>
<td></td>
<td>Screen for alcohol misuse and provide brief behavioral counseling if involved in risky or hazardous drinking . . . B</td>
</tr>
<tr>
<td></td>
<td>Identify women at high risk of breast cancer</td>
</tr>
<tr>
<td></td>
<td>If at increased risk, and if benefits outweigh harms, offer tamoxifen or raloxifene . . . B</td>
</tr>
<tr>
<td></td>
<td>Screen women for family history of breast, ovarian, tubal or peritoneal cancer . . . B</td>
</tr>
<tr>
<td></td>
<td>If positive, screen for association with harmful mutations in BRCA 1 or BRCA 2 . . . B</td>
</tr>
<tr>
<td></td>
<td>If positive, refer for genetic counseling and counseling for BRCA if appropriate</td>
</tr>
<tr>
<td></td>
<td>Screen average-risk women with biennial mammography from age 50 to 74 years (Expect update early 2016) . . . B</td>
</tr>
<tr>
<td></td>
<td>Screen men 65 to 75 years of age who have ever smoked for abdominal aortic aneurysm . . . B</td>
</tr>
<tr>
<td></td>
<td>Recommend annual low-dose CT screening for adults 55 to 80 years who are current smokers with 30 pack/year use or those with 30 pack/year history who have quit in the past 15 years . . . B</td>
</tr>
<tr>
<td></td>
<td>Provide intensive behavioral counseling for STI prevention for all at increased risk . . . B</td>
</tr>
<tr>
<td></td>
<td>Screen for Chlamydia and gonorrhea in sexually active women &lt;25 years of age and older women who are at risk . . . B</td>
</tr>
<tr>
<td></td>
<td>Screen for hepatitis B in adults at high risk who are not pregnant . . . B</td>
</tr>
<tr>
<td></td>
<td>Screen all who are high-risk and those born between 1945 and 1965 for HCV . . . B</td>
</tr>
<tr>
<td></td>
<td>Screen all adults up to age 65 years for HIV . . . A</td>
</tr>
</tbody>
</table>

Source: [www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/](http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/)
portant flaws in study design or methods; inconsistency of findings across individual studies; gaps in the chain of evidence; the findings not being generalizable to routine primary care practice; and lack of information about important health outcomes. Recommendations about which there is moderate or low certainty are likely to change as more information becomes available.

In general, a grade of “A” or “B” means the recommendation should be implemented in all appropriate patients. A grade of “C” means the recommendation should be discussed with certain patients (Table 2). A “D” grade means the recommendation is not to be implemented in routine practice but may be appropriate in select individuals for specific evaluations. The “I” grade indicates there is little support for the recommendation in clinical practice. However, the “Clinical Considerations” section of “I” statements often provide suggestions for how to incorporate a topic when engaged in shared decision-making with patients (Table 3).

**New Recommendations by Age Group**

Each year, the USPSTF makes new recommendations and updates old ones. Table 2 presents the new or modified recommendations made in 2013, 2014 and 2015. A few that significantly change practice for physicians are discussed below.

**Changes in Recommendations for Children and Adolescents**

The focus on dental health and the recommendation to apply fluoride varnish is new for most family physicians and pediatricians. Assuring that oral fluoride supplementation is prescribed for those without fluoride in their water (bottled, tap or well) will require clinicians to have additional discussions with many parents. Most physicians will appreciate the new recommendations’ confirmation that providing education and brief counseling for patients of all ages, including pre-adolescents, regarding prevention of tobacco use is appropriate.

What could be considered a major change is the recommendation to screen all adolescents for HIV beginning at age 15. This is likely to be of concern to many physicians, as they may be reluctant to discuss sexuality with young adolescents and their parents. Some may feel they have rapport with the patient and their family and believe they know that no increased risk is present. But data suggest that risk is not always clear and not all sex among adolescents and young adults is consensual, putting even those not choosing to be sexually active at risk. In Minnesota and its surrounding states, assessment for suspected sexually transmitted diseases can be done without parental permission. This extends to screening for STIs in sexually active adolescents; it does not, however, extend to adolescents who deny sexual activity. Screening for HIV can be combined

---

**TABLE 3**

**Recent “I” Statements (2013-15)**

**INFANTS AND CHILDREN**
- Screen for dental caries by primary care provider
- Screen for speech and language delays and disorders in children up to 5 years of age
- Screen for primary hypertension
- Offer interventions to prevent child maltreatment

**ADOLESCENTS**
- Screen for suicide risk
- Advise and counsel adolescents about alcohol misuse, if use is uncertain

**PREGNANT WOMEN**
- Screen for gestational diabetes before 24 weeks
- Screen for iron deficiency anemia
- Provide iron supplementation
- Provide pharmacotherapy interventions for smoking cessation
- Provide electronic nicotine-delivery system intervention for smoking cessation

**ADULTS**
- Screen for thyroid dysfunction in asymptomatic adults
- Provide electronic nicotine-delivery system intervention for smoking cessation
- Screen women 65 to 75 years who have ever smoked for aortic aneurysm
- Screen for cognitive impairment
- Screen men for Chlamydia and gonorrhea
- Screen adults of all ages for suicide risk
- Screen for vitamin D deficiency
- Recommend multivitamins for CVD or cancer prevention
- Recommend single or paired-nutrient supplements for CVD or cancer prevention
- Screen elderly and vulnerable adults for abuse
- Screen for primary open-angle glaucoma
- Screen for oral cancer in adults who are asymptomatic
- Screen for PAD or CVD with ankle-brachial index (ABI)
- Recommend use of vitamin D and calcium in men
- Recommend use of <400 IU vitamin D3 plus 1,000 mg calcium for primary fracture prevention in non-institutionalized, post-menopausal women

Source: www.uspreventiveservicestaskforce.org/BrowseRec/Index
with behavioral counseling for STI prevention and tobacco use prevention.

Changes in Recommendations for All Adults
Several major changes have been made to recommendations for adults. These include a recommendation to counsel them about eating a healthful diet, exercising and not misusing alcohol. This is among the first recommendations to suggest advising specifically on healthful diet as well as an active lifestyle.

In 2015, the USPSTF gave strong support (an “A” recommendation) for asking all adults, including pregnant women, about smoking. Providing advice and behavioral intervention for smoking cessation was added in 2015. However, support for the provision of FDA-approved pharmacotherapy for cessation is limited to non-pregnant adults.

The USPSTF also recommended screening for abnormal blood glucose as part of cardiovascular risk assessment in adults 40 to 70 years of age who are overweight or obese. It also calls for intensive behavioral interventions to promote a healthful diet and lifestyle for those with abnormal glucose.

The 2015 recommendation for blood pressure screening for all adults 18 years and older has an interesting twist, encouraging blood pressure being measured outside the clinical setting before starting treatment.

Also new is a recommendation to screen for infections that are often transmitted through sex or blood including STIs, Chlamydia and gonorrhea in women, and hepatitis B and C and HIV in both men and women.

For men who have smoked, one-time screening for abdominal aortic aneurysm is now recommended. For both men and women with long-term histories of smoking, annual screening for lung cancer with low-dose CT is suggested. Accessibility of the required procedures and therapies must be considered. Many practices, especially those in smaller communities with fewer resources, will need to do thoughtful planning to identify ways to improve access for their patients. For example, mobile CT scanners likely could add low-dose CT lung scans to their offerings.

New Recommendations for Women
New for women is the recommendation to screen for family history of breast, ovarian, tubal and peritoneal cancer to determine the need for BRCA testing and consideration of preventive tamoxifen or raloxifene use in those at high risk. These are major changes to the recommendations for high-risk women. In addition, there is a new recommendation for screening for interpersonal violence for women of childbearing age—the age group at greatest risk.

When adding any of these to your practice, it is necessary to have clear follow-up plans in place that go beyond simply referring someone somewhere. For example, the recommendation for screening all adults annually for depression, which was expanded in 2015 to include women during pregnancy and the postpartum period, also requires that appropriate treatment such as cognitive behavioral therapy be readily accessible.

Mammography screening recommendation updates are near finalization. The 2015 draft recommendations published and opened for public comment recommend biennial mammography in low-risk women ages 50 to 74 (B recommendation) with a C recommendation for screening women 40 to 49 and an I recommendation for women 75 and older. All other forms of breast imaging, such as ultrasound and MRI for women with dense breasts remain I statements. A final recommendation about mammography screening is expected to be published in 2016.

Using USPSTF Recommendations in Practice

Young Patients

Case 1. M, a healthy 16-year-old male, comes in for a school sports physical. He has no family history of early CVD and only one grandparent with a history of cancer (colon cancer). Neither parent smokes. M denies smoking and sexual activity even after his parents leave the exam room. To complete the USPSTF recommendations for M, you will want to discuss tobacco use to prevent initiation. You have already screened for obesity with routine height and weight measurements and found no need for referral. Depression screening was completed using the PHQ 2 (two questions) by the nurse who roomed M. The nurse also took his vital signs and completed medication reconciliation (M uses occasional nonsteroidal anti-inflammatories for muscle aches when training for track). Skin cancer prevention—use of sunscreen—is easy to emphasize while completing the exam and can be mentioned to the parents if M doesn’t use it regularly. You will have to decide if today is the correct time for HIV screening.

Case 2. G, a 17-year-old, presents for an oral contraceptive refill. Although G reports that she seldom misses a pill, she says her boyfriend hates condoms and refuses to use them. During your visit,
G says she is excited about going to Florida for spring break and is worried about sunburn, so she is going to a tanning salon in preparation. You note that her BMI is 31. The two-question depression screening was negative. Pelvic examination and Pap smear are no longer recommended for females of her age and profile; the recommendations suggest completing a genital exam only if she has symptoms of an STI, although she should have a Chlamydia screening. Should you also suggest folic acid supplement because of her sexual activity?

How many other things can you cover during the visit—STIs, HIV, skin cancer, obesity, tobacco, alcohol misuse and illegal drug use? Most likely, you will choose topics related to recent or upcoming events, especially her upcoming trip to Florida. You can talk about use of sunscreen and strongly recommend against continuing tanning. Although counseling for alcohol misuse is considered an “I statement,” you can spend a little time to discuss the risk of drinking, and drinking and driving, and admonish against riding with anyone who has been drinking. Intimate partner violence screening is also appropriate, as the comment about her boyfriend’s refusal to use condoms may suggest G does not have an equal say in the relationship. Sending her for blood tests to screen for HIV and gonorrhea, but not syphilis (a D recommendation), can be accompanied by a discussion of lack of STI protection when condoms are not used.

Visits for school, college, sports physicals and contraception are excellent opportunities to assess for and discuss preventive measures. Unfortunately, not all adolescents will have such visits and the required preventive interventions will need to be incorporated into visits for colds, minor trauma and other acute problems. If that is the case, you will need to select what you feel is most important to the teen, even if the subject is not something you’re comfortable discussing.

Most teens will have more than one visit during the teen years, and counseling can be divided among those visits, repeating the most important topics, which usually range from STI prevention to smoking to skin cancer prevention. Bringing up HIV screening may be easier if you include statements about the importance of early detection and treatment even for those you may not suspect are at risk.

### Adult Patients

**Case.** J, 66, whom you haven’t seen for five years, comes in because his wife read about “some lung screening he is supposed to have because he won’t quit that awful smoking.” J reports he is healthy and works on his farm daily. He denies any symptoms. From the medical assistant’s notes, you learn he uses no regular medications, his PHQ-2 is 0, his BP is 158/94 and his BMI is 30.8. The medical assistant gave him his flu shot, a PCV12 and a Tdap, and he was given a referral and prescription for HZ vaccination to take to his pharmacy. You comment on the importance of these vaccines. Now what?

J’s blood pressure remains high when you recheck it, so that requires follow up. According to the USPSTF, J needs a low-density CT scan (the one his wife was referring to), abdominal aortic aneurysm screening, screening for lipids, and a fasting blood glucose test, as well as screening for hepatitis B and C. Colon cancer screening is also recommended.

That is not all. J also is a candidate for tobacco counseling and cessation therapy and screening for alcohol misuse (the medical assistant did the CAGE assessment and it was negative). He also may need daily aspirin therapy since he is obese and appears likely to have sustained high blood pressure; this also requires discussion about eating a healthful diet and exercising and perhaps a referral for intensive weight-loss counseling. As a farmer, J is certainly a candidate for discussion about skin cancer prevention and sunscreen use. And, finally, he is in the age group for discussions about fall prevention.

Even listing all of that may take longer than the 15 minutes scheduled for his visit. So how do you strategize? You begin by agreeing that his wife was correct and you’re glad he came. You note that because of his smoking other testing is also necessary. Ask if he is ready to think about quitting. If he isn’t, proceed with the visit. Before talking about the tests he came for, you mention that his blood pressure is a little high. You explain that you would like to do at least a partial exam of his lungs and heart. As he takes off his shirt you should comment on his “farmer tan” and ask about sunscreen. Since he is wearing a hat, you can mention that wearing a hat is good for sun protection. When completing the head, neck and chest exam, you can discuss his elevated blood pressure and the need to check that a couple of times, perhaps at the local drug store or at the clinic.

You suggest that you want to see J again in two weeks, after he has the lung CT and

---

**TABLE 5**

**Incorporating recommendations into patient care**

The following is an example of how to incorporate USPSTF recommendations when treating a teenaged girl.

**PRE-VISIT PLANNING**

- Medication reconciliation + immunization assessment
- If the patient is known to be sexually active—contraceptive visit, discussion of STI prevention
- Vitals to include BMI, smoking status and PHQ-2

**“TALK” ROUTINE**

- Skin cancer—If a patient mentions they’re planning a spring break trip, it provides a great opening
- Tobacco—Based on answer in vital signs assessment
- Intimate partner violence—Discuss as part of personal safety during spring break trip
- Obesity—Come back for follow up and consider a referral

**ROUTINE STI SCREENINGS**

- Discussion of STI prevention during examination and Chlamydia screening
- Prewritten lab orders for HIV and GC screening
an abdominal ultrasound for abdominal aortic aneurysm screening (he can have both during the same hospital visit). In two weeks, you’d like him to come in having fasted, so you can do a fasting blood glucose test to screen for diabetes, lipids and HIV, HCV and HBV. You discuss J’s concerns about the cost and whether Medicare will pay for these tests. Both J and his wife agree that they see no reason for the HIV screening and think that J probably was screened for HBV and HCV when he gave blood at a local blood drive. You agree and order only the fasting blood glucose and lipids for two weeks from today. You decide to delay the discussion about diet and activity until the next visit, when you will have information on glucose and lipids. The lack of any family history of colon cancer and J’s history of heavy smoking help you decide to make the low-dose CT and abdominal aortic aneurysm screening a priority over the colon cancer screening. It is very likely that J will require therapy for hypertension, which will provide you with additional opportunities to address colon cancer screening.

It is important to remember that for patients like J, not everything can be accomplished during one annual visit or even at a single age. Some of the “one-time” recommendations that are to begin at age 60 may be started at 58 or 59 or not be accomplished until age 61 or 62. Considering our low levels of completion of these recommendations, a slight delay as a result of addressing some of these over several visits will still be a major improvement and may help your quality scores.

Every physician knows that you must address the patient’s or family’s immediate concerns. During visits for these concerns, you can also highlight prevention recommendations. Use the margins of your paper notes or the special features of your electronic health record to prioritize and remind yourself of one or two issues you want to address at each future visit. These may change, of course. For example, with a smoker who comes in with a “bad cold that will not go away,” you will, of course, talk about smoking and assess readiness to quit. But you also can try to discuss other smoking-related issues such as the low-dose CT screening for lung cancer and the abdominal aortic aneurysm screening while addressing the acute bronchitis and smoking. Your choice of topics can be seasonal as well. For example, you might talk about skin cancer prevention and sunscreen use in the spring and summer, and fall prevention in the winter.

Some clinics and health systems use birthday letters (paper or electronic) to invite patients to come in for age-appropriate prevention measures such as colon cancer screening or mammography. Some may even provide a link to a site that discusses use of low-dose aspirin for prevention of heart disease. Posters about prevention placed in exam rooms not only provide patients with reading material while they wait but also may prompt them to ask questions about prevention activities. Also, patient newsletters, inserts into bills and electronic patient portals can be used to inform patients about the importance of prevention activities.

Finally, remember that the USPSTF also provides guidance for testing that does not provide the average person with more benefit than harm—the D list (Table 4). This list is also important to review, as you can use it to help explain why you are not suggesting a test.

**Conclusion**

The USPSTF makes its recommendations based on extensive reviews of the best available evidence. Yet, no list of recommendations is right for every patient, and the long list of USPSTF recommendations can be overwhelming for physicians and other clinicians already struggling to incorporate a growing list of requirements into daily practice. When thinking about how to address the recommendations with patients, consider the patient’s age, sex and behaviors. Then look for ways to individualize the process, setting realistic goals and developing a plan to provide the recommended care and counseling over multiple visits and even multiple years with the help and support of your entire staff and your electronic medical record (Table 5).

Prevention is central to improving the health of our patients, prolonging their lives and lowering the burden of chronic illness on them. The USPSTF aims to support us in our efforts to achieve those goals. MM

Barbara Yawn spent 14 years in rural family medicine practice and the past 26 years doing clinical research in primary care. She served as a member of the USPSTF for four years and has served on seven national and international evidence-based guideline panels.