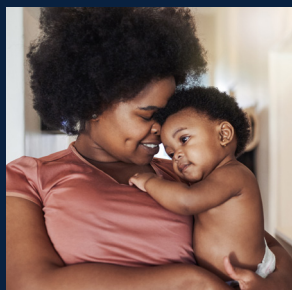




When women are **healthy**, communities **thrive**.



Recommendations for Well-Woman Care
2024 Clinical Summary Tables



Recommendations for Well-Woman Care

2024 Clinical Summary Tables

Updated January 2024

Recommendations for Well-Woman Care – Clinical Summary Tables were developed by the Women’s Preventive Services Initiative (WPSI) with research support from the Evidence Review Team at the Oregon Health & Science University and Kaiser Permanente School of Medicine. The Clinical Summary Tables include preventive services recommended by the WPSI, U.S. Preventive Services Task Force (USPSTF), and Bright Futures for adolescent and adult women age 13 and older, including those pregnant and postpartum. These tables and the related Well Woman Chart provide a framework for incorporating preventive health services for women into clinical practice during well woman and routine health care visits. These services may be completed at a single visit or as part of a series of visits that take place over time. While the Well-Woman Chart and Clinical Summary Tables provide recommendations for preventive services for pregnant and postpartum women, comprehensive clinical care recommendations for pregnant and postpartum women can be found in ACOG’s practice guidelines and other educational materials.

This information is designed as an educational resource to aid clinicians in providing preventive health services for women, and use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology. While every effort is made to present accurate and reliable information, this publication is provided “as is” without any guarantees or warranties of accuracy, reliability, or otherwise, either express or implied. The Chart and Tables are updated annually. The WPSI website (www.womenspreventivehealth.org) has the most up-to-date version of the Chart and Clinical Summary Tables.

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Alcohol Use Screening & Counseling

Rationale: Unhealthy alcohol use is one of the most common causes of preventable diseases, injuries, and premature mortality in the United States, and causes birth defects and developmental disabilities when used in pregnancy.

USPSTF Recommendation: Screen for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and provide adults engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.

Bright Futures Recommendation: Substance use should be evaluated as part of an age appropriate comprehensive history. A recommended assessment tool is available at <http://craftt.org>.

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| Ages and Frequency | ≥ 13 years at least annually |
| Clinical Practice | The USPSTF determined that 1-item to 3-item screening instruments have the best accuracy for assessing unhealthy alcohol use in adults including the abbreviated Alcohol Use Disorders Identification Test–Consumption (AUDIT-C) and the NIAAA-recommended Single Alcohol Screening Question (SASQ), “How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?” |
| Risk Assessment | Reviewing the adolescent’s environment can identify risk and protective factors for the development of alcohol or drug abuse. |
| References | <ul style="list-style-type: none"> • U.S. Preventive Services Task Force. Screening and behavioral counseling interventions to reduce unhealthy alcohol use in adolescents and adults: U.S Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2018;320(18):1899-1901. doi: 10.1001/jama.2018.16789. PMID: 30525341. • Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.90295442.924462059.1671580996-606362568.1671580995. Accessed December 11, 2023. |



GENERAL HEALTH

Anxiety Screening

Rationale: Anxiety disorders include several related conditions characterized by excessive, uncontrollable worry. They are the most frequent mental health disorders in the general U.S. population; and prevalence rates are higher in women than men, with approximately 40% of women experiencing anxiety disorders during their lifetimes. Anxiety is a common manifestation of posttraumatic stress disorder, stress, bullying, sexual harassment and assault, and other experiences common in women, and is associated with depression and substance abuse.

WPSI Recommendation: Screen for anxiety in adolescent and adult women age 13 and older, including those who are pregnant or postpartum. Given the high prevalence of anxiety disorders, lack of recognition in clinical practice, and multiple problems associated with untreated anxiety, clinicians should consider screening women who have not been recently screened.

USPSTF Recommendation: The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years and adults 19 to 64 years, including during pregnancy and postpartum.

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| Ages and Frequency | ≥ 13 years; optimal screening intervals are unknown and clinical judgement should be used to determine screening frequency |
| Clinical Practice | <p>Consider screening for anxiety in conjunction with screening for depression, which is already recommended, because of their frequent co-occurrence. Validated instruments that screen simultaneously for both disorders may be clinically efficient in practice settings (eg, Patient Health Questionnaire [PHQ] and the Hospital Anxiety and Depression Scale [HADS], among others). Brief screening tools specific to anxiety include the Generalized Anxiety Disorder (GAD) scale, and the Screen for Child Anxiety Related Emotional Disorders (SCARED) for adolescents, for example.</p> <p>When screening suggests the presence of anxiety, further evaluation is necessary to establish the diagnosis and determine appropriate treatment. Screening should ideally be implemented in conjunction with collaborative and team-based approaches to ensure accurate diagnosis, effective treatment, and appropriate follow up.</p> |
| Risk Assessment | All women are susceptible to anxiety and universal screening is recommended. |
| References | <ul style="list-style-type: none"> • Gregory KD, Chelmow D, Nelson HD, et al. Screening for anxiety in adolescent and adult women: a recommendation from the Women’s Preventive Services Initiative. <i>Ann Intern Med.</i> 2020; 173:48-56. doi: 10.7326/M20-0580. • Women’s Preventive Services Initiative. <i>Screening for Anxiety.</i> https://www.womenspreventivehealth.org/recommendations/screening-for-anxiety/. Published January 7, 2020. Accessed December 11, 2023. • U.S. Preventive Services Task Force. Screening for anxiety in children and adolescents: US Preventive Services Task Force recommendation statement. <i>JAMA.</i> 2022; 328:1438-1444. doi: 10.1001/jama.2022.16936. • U.S. Preventive Services Task Force. Screening for anxiety disorders in adults: US Preventive Services Task Force recommendation statement. <i>JAMA.</i> 2023;329(24):2163-2170. doi:10.1001/jama.2023.9301. • Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.90295442.924462059.1671580996-606362568.1671580995. Accessed December 11, 2023. |

| Blood Pressure Screening | |
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| <p>Rationale: High blood pressure is a major contributing risk factor for heart failure, heart attack, stroke, and chronic kidney disease. Screening for and treatment of high blood pressure reduces the incidence of cardiovascular events.</p> <p>USPSTF Recommendation: Screen for high blood pressure in adults aged 18 years or older and obtain measurements outside of the clinical setting for diagnostic confirmation before starting treatment.</p> <p>Bright Futures Recommendation: Children should have their blood pressure routinely measured beginning at 3 years of age.</p> | |
| Ages and Frequency | <p>13 to 21 years: annual</p> <p>22 to 39 years: at least every 3 to 5 years</p> <p>≥ 40 years or risk factors: annual</p> |
| Clinical Practice | <p>This recommendation applies to adolescent and adult women age 13 years or older without known hypertension.</p> <p>The USPSTF recommends screening for hypertension every year in adults 40 years or older and in adults at increased risk for hypertension (such as those who are Black, have high-normal blood pressure, or are overweight or obese). Adults age 18 to 39 years not at increased risk for hypertension and with a prior normal blood pressure reading can be screened less frequently (ie, every 3 to 5 years) as appropriate. Blood pressure obtained with an office blood pressure measurement is appropriate for screening, while blood pressure measurements outside of the clinical setting should confirm a hypertension diagnosis before starting treatment.</p> <p>Bright Futures recommends blood pressure screening routinely at well child visits beginning at age 3.</p> |
| Risk Assessment | <p>Although all adults should be screened for hypertension, factors that increase risk include older age, Black race, family history, excess weight and obesity, lifestyle habits (lack of physical activity, stress, and tobacco use), and dietary factors (diet high in fat or sodium, diet low in potassium, or excessive alcohol intake).</p> <p>For adolescents, risk factors include persistently elevated blood pressure (120-130/80 mmHg); obesity; sleep-disordered breathing; chronic kidney disease; and preterm birth. Prevalence is higher in boys, and Hispanic and non-Hispanic African American children.</p> |
| References | <ul style="list-style-type: none"> • US Preventive Services Task Force. Screening for hypertension in adults: US Preventive Services Task Force reaffirmation recommendation statement. <i>JAMA</i> 2021;325(16):1650-1656. doi:10.1001/jama.2021.4987. PMID: 33904861 • Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.90295442.924462059.1671580996-606362568.1671580995. Accessed December 11, 2023. • Flynn JT, Kaelber DC, Baker-Smith GM, et al.; American Academy of Pediatrics Subcommittee on Screening and Management of High Blood Pressure in Children. Clinical practice guideline for screening and management of high blood pressure in children and adolescents. <i>Pediatrics</i> 2017; 140(3): e20171904. doi: 10.1542/peds.2017-1904. PMID: 28827377. |

GENERAL HEALTH

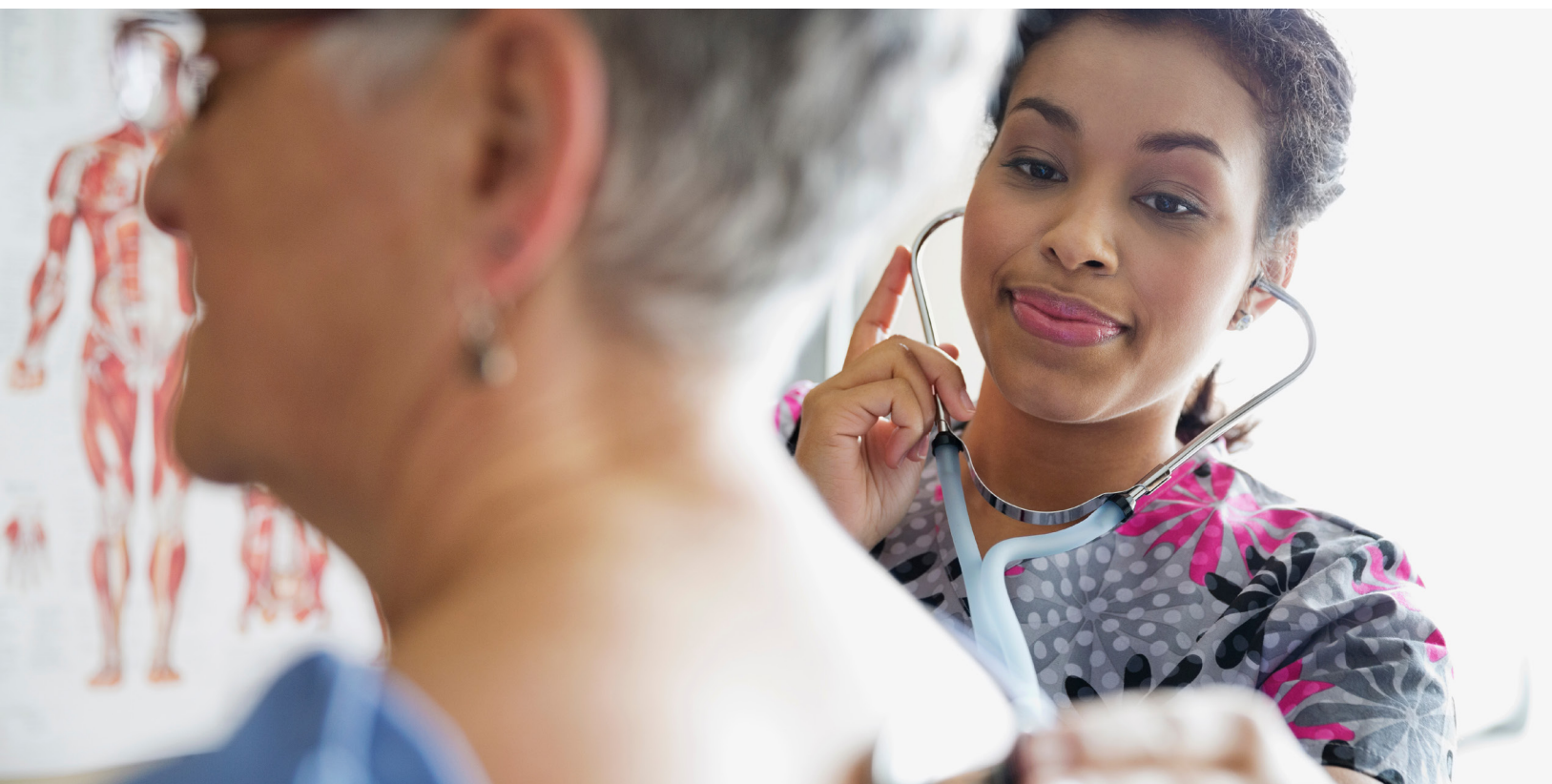
| Contraception & Contraceptive Care | |
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| <p>Rationale: Contraception and contraceptive care enable women to actively prevent unintended pregnancy and control the timing of a desired pregnancy.</p> <p>WPSI Recommendation: Provide adolescent and adult women access to the full range of contraceptives and contraceptive care to prevent unintended pregnancies and improve health outcomes.</p> | |
| Ages and Frequency | ≥ 13 years as needed for women with potential for pregnancy |
| Clinical Practice | <p>Contraceptive care includes screening, education, counseling, and provision of contraceptives, including in the immediate postpartum period. Contraceptive care also includes follow-up care (eg, management, evaluation, and changes, including the removal, continuation, and discontinuation of contraceptives).</p> <p>Contraceptive counseling occurs between an individual and clinician or appropriately trained professional, emphasizes patient-centered decision making, and includes discussion of the benefits, risks, and preferences of the full range of contraceptive options.</p> |
| Risk Assessment | Not applicable |
| References | <ul style="list-style-type: none"> • Women’s Preventive Services Initiative. <i>Contraception</i>. https://www.womenspreventivehealth.org/recommendations/contraception/. Published January 7, 2022. Accessed December 11, 2023. • Braverman PK, Adelman WP, Alderman EM, Breuner CC, Levine DA, et al. Contraception for adolescents. Committee on Adolescence. <i>Pediatrics</i> 2014;134:e1244-56. doi: 10.1542/peds.2014-2299. PMID: 25266430. • CDC Medical Eligibility Criteria, https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm. Accessed December 11, 2023. |

| Depression Screening | |
|---|---|
| <p>Rationale: Depression is among the leading causes of disability and is common in patients seeking care in the primary care setting and among pregnant and postpartum women. Perinatal depression affects as many as 1 in 7 women and is one of the most common complications of pregnancy and the postpartum period.</p> <p>USPSTF Recommendation: Screen for major depressive disorder in adolescents age 12 to 18 years and all adults, including during pregnancy and postpartum. Provide or refer pregnant and postpartum women who are at increased risk of perinatal depression to counseling interventions to prevent depression.</p> | |
| Ages and Frequency | ≥ 13 years at least annually, and all pregnant and postpartum women |
| Clinical Practice | <p>Commonly used depression screening instruments include the Patient Health Questionnaire and the Center for Epidemiologic Studies Depression Scale in adults; the Geriatric Depression Scale in older adults; and the Edinburgh Postnatal Depression Scale in postpartum and pregnant women.</p> <p>Positive screening results should lead to additional assessments that consider severity of depression and comorbid psychological problems, alternate diagnoses, and medical conditions. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.</p> <p>Counseling interventions, such as cognitive behavioral therapy and interpersonal therapy, are effective in preventing perinatal depression</p> |
| Risk Assessment | <p>Recommendations are for universal screening. The USPSTF recommends preventive counseling interventions for women with one or more of the following: a history of depression, current depressive symptoms that may not reach a diagnostic threshold, socioeconomic risk factors such as low income or adolescent or single parenthood, recent intimate partner violence, or mental health-related factors such as elevated anxiety symptoms or a history of significant negative life events.</p> |
| References | <ul style="list-style-type: none"> • U.S. Preventive Services Task Force. Interventions to prevent perinatal depression: U.S Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2019;321(6):580-587. doi:10.1001/jama.2019.0007. PMID: 30747971. • U.S. Preventive Services Task Force. Screening for depression and suicide risk in children and adolescents: U.S Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2022;328(15):1534-1542. doi:10.1001/jama.2022.16946. • U.S. Preventive Services Task Force. Screening for depression and suicide risk in adults: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2023;329(23):2057-2067. doi:10.1001/jama.2023.9297 • Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf Accessed December 11, 2023. |

GENERAL HEALTH

| Diabetes Screening | |
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| <p>Rationale: Type 2 diabetes mellitus is a metabolic disorder characterized by insulin resistance and relative insulin deficiency, resulting in hyperglycemia. Type 2 diabetes is a modifiable risk factor for cardiovascular disease and other adverse health outcomes.</p> <p>USPSTF Recommendation: Screen for prediabetes and type 2 diabetes in adults age 35 to 70 years who have overweight or obesity. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.</p> <p>WPSI Recommendation: In addition to the USPSTF recommendation, also screen women with a history of gestational diabetes who are not currently pregnant and who have not been previously diagnosed with type 2 diabetes.</p> | |
| Ages and Frequency | <p>35 to 70 years overweight or obese: every 3 years</p> <p>≥ 13 years with previous gestational diabetes: every 3 years for at least 10 years after pregnancy</p> |
| Clinical Practice | <p>This recommendation applies to overweight or obese women age 35 to 70 years who do not have symptoms of diabetes and are overweight or obese, and to women of any age who have been previously diagnosed with gestational diabetes.</p> <p>The optimal screening interval for adults in the general population with an initial normal glucose test result is not known, although studies suggest that rescreening every 3 years may be a reasonable approach.</p> <p>For women with previous gestational diabetes, initial testing should ideally occur within the first year postpartum and can be conducted as early as 4–6 weeks postpartum. For those with a positive screening test result in the early postpartum period, testing should be repeated at least 6 months postpartum to confirm the diagnosis of diabetes regardless of the type of initial test (eg, fasting plasma glucose, hemoglobin A_{1c}, oral glucose tolerance test). Repeat testing is also indicated for women screened with hemoglobin A_{1c} in the first 6 months postpartum regardless of whether the test results are positive or negative because the hemoglobin A_{1c} test is less accurate during the first 6 months postpartum. Screening should continue every 3 years for at least 10 years after pregnancy.</p> |
| Risk Assessment | <p>Consider screening at an earlier age if the patient is from a population with a disproportionately high prevalence of diabetes (American Indian/Alaska Native, Black, Hispanic/Latino, Native Hawaiian/Pacific Islander), and at a lower BMI (≥23) if the patient is Asian American.</p> |
| References | <ul style="list-style-type: none"> • US Preventive Services Task Force. Screening for prediabetes and type 2 diabetes. US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2021;326(8):736-743. doi:10.1001/jama.2021.12531 • Women’s Preventive Services Initiative. <i>Screening for Diabetes After Pregnancy</i>. https://www.womenspreventivehealth.org/recommendations/diabetes-after-pregnancy/. Published January 5, 2023. Accessed November 22, 2023. |

| Fall Prevention | |
|---|--|
| <p>Rationale: Falls are common and a leading cause of injury in women age 65 and older.</p> <p>USPSTF Recommendation: Exercise to prevent falls in community-dwelling adults age 65 years or older who are at increased risk for falls.</p> | |
| Ages and Frequency | ≥ 65 years annually |
| Clinical Practice | USPSTF recommends exercise interventions to prevent falls in community-dwelling adults age 65 years or older who are at increased risk for falls. Effective exercise interventions include supervised individual and group classes that included gait, balance, and functional training components. Clinicians may selectively offer multifactorial interventions for fall prevention that include combinations of exercise, psychological interventions, nutrition therapy, education, medication management, urinary incontinence management, environmental modification, and referrals to physical or occupational therapy, social or community services, or specialists (eg, ophthalmologist, neurologist, or cardiologist). |
| Risk Assessment | Risk factors to identify older adults who are at increased risk for falls include age; history of falls; and impairments in mobility, gait, and balance. Clinicians could also use assessments of gait and mobility to help determine risk. |
| References | <ul style="list-style-type: none"> U.S. Preventive Services Task Force. Interventions to prevent falls in community-dwelling older adults: U.S Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2018;319(16):1696-1704. doi: 10.1001/jama.2018.3097. PMID: 25996397. |



GENERAL HEALTH

| Folic Acid Supplementation | |
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| <p>Rationale: Neural tube defects are major birth defects of the brain and spine that occur early in pregnancy due to improper closure of the embryonic neural tube, and may lead to a range of disabilities or death. Daily folic acid supplementation before pregnancy and in the early pregnancy period can prevent neural tube defects.</p> <p>USPSTF Recommendation: All women with potential for pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.</p> | |
| Ages and Frequency | ≥ 13 years; daily, starting at least 1 month before pregnancy and continued through the first 2 to 3 months of pregnancy. |
| Clinical Practice | <p>Since half of all pregnancies are unplanned, this recommendation applies to women with potential for pregnancy. The critical period for supplementation starts at least 1 month before pregnancy and continues through the first 2 to 3 months of pregnancy.</p> <p>USPSTF recommendation does not apply to women who have had a previous pregnancy affected by neural tube defects or who are at very high risk due to other factors who may be advised to take higher doses of folic acid; or to patients taking medications known to block the function of folic acid.</p> |
| Risk Assessment | Factors that increase risk for neural tube defects include a personal, partner, or family history of neural tube defects; malabsorption caused by bariatric procedures; use of certain antiseizure medications; pregestational diabetes; obesity; and mutations in folate-related enzymes. Specific populations may be at higher risk of neural tube defects (eg, First Nation populations in Canada, Hispanic groups in California). |
| References | <ul style="list-style-type: none"> U.S. Preventive Services Task Force. Folic acid supplementation to prevent neural tube defects: US Preventive Services Task Force reaffirmation recommendation statement. <i>JAMA</i>. 2023;330(5):454-459. doi:10.1001/jama.2023.12876. PMID: 37526713. |

| Healthy Diet & Activity Counseling | |
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| <p>Rationale: A healthy diet and physical activity can benefit all individuals, although those with risk factors for cardiovascular disease (CVD) benefit most.</p> <p>USPSTF Recommendation: Offer or refer adults who are overweight or obese and have additional CVD risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.</p> | |
| Ages and Frequency | ≥ 18 overweight or obese with additional CVD risk factors |
| Clinical Practice | USPSTF recommends offering or referring adults who are overweight or obese and have additional CVD risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention. Many interventions are effective, particularly those that combine counseling on healthful diet and physical activity and have multiple contacts over extended periods. Healthful diet and physical activity counseling for adults without known CVD risk factors should be determined on an individual basis. |
| Risk Assessment | Major risk factors for cardiovascular disease include obesity, hypertension, dyslipidemia, abnormal blood glucose levels, and diabetes. |
| References | <ul style="list-style-type: none"> US Preventive Services Task Force. Behavioral counseling to promote a healthful diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2020;324(20):2069-2075. doi:10.1001/jama.2020.21749 |

GENERAL HEALTH

Interpersonal & Domestic Violence Screening

Rationale: Interpersonal and domestic violence are common among women in the United States, but are often undetected.

WPSI Recommendation: Screen adolescents and women for interpersonal and domestic violence, at least annually. When needed, provide or refer for initial intervention services that include, but are not limited to, counseling, education, harm reduction strategies, and referral to appropriate supportive services.

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| Ages and Frequency | ≥ 13 years at least annually |
| Clinical Practice | <p>Interpersonal and domestic violence includes physical violence, sexual violence, stalking and psychological aggression (including coercion), reproductive coercion, neglect, and the threat of violence, abuse, or both.</p> <p>Multiple brief screening questionnaires are accurate in identifying interpersonal and domestic violence in women. Screening should occur at least annually, although the frequency and intensity of screening may vary depending on a patient's situation.</p> |
| Risk Assessment | Although all women are at potential risk for abuse, factors that elevate risk include young age, substance abuse, relationship difficulties, and economic hardships, among others. |
| References | <ul style="list-style-type: none">• Women's Preventive Services Initiative. <i>Recommendations for Preventive Services for Women: Final Report to the U.S. Department of Health and Human Services, Health Resources & Services Administration</i>. Washington, DC: 2016. https://www.womenspreventivehealth.org/recommendations/interpersonal-and-domestic-violence/ Accessed January 3, 2024 |



Lipid Screening & Statin Use to Prevent Cardiovascular Disease

Rationale: Cardiovascular disease (CVD) is the leading cause of morbidity and mortality in the United States.

USPSTF Recommendation: The USPSTF recommends that clinicians prescribe a statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (ie, dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.

Bright Futures Recommendation: Lipid screening once between 9 and 11 years of age, and once between 17 and 21 years of age.

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| Ages and Frequency | <p>9 to 11 years: once during age interval</p> <p>18 to 21 years: once during age interval</p> <p>40 to 75 years: periodic assessment of CVD risk; measurement of lipid levels every 5 years</p> |
| Clinical Practice | <p>This recommendation applies to women without known CVD. Lipid screening includes measurement of total cholesterol, low-density lipoprotein cholesterol (LDL-C), and high-density lipoprotein cholesterol (HDL-C) levels.</p> <p>USPSTF recommends using a low- to moderate-dose statin for the prevention of CVD events and mortality when all the following criteria are met: 1) age 40 to 75 years; 2) have one or more CVD risk factors (eg, dyslipidemia, diabetes, hypertension, or smoking); and 3) have a calculated 10-year risk of a CVD event of 10% or greater. Clinicians may choose to offer a statin to adults who have a calculated 10-year risk of 7.5% to 10% and otherwise meet criteria.</p> |
| Risk Assessment | <p>Dyslipidemia is defined as an LDL-C level >130 mg/dL or HDL-C <40 mg/dL (to convert HDL-C values to mmol/L, multiply by 0.0259).</p> <p>10-year risk for first atherosclerotic CVD event (nonfatal myocardial infarction, coronary heart disease death, and fatal or nonfatal stroke) can be determined by a calculator derived from the American College of Cardiology/American Heart Association (ACC/AHA) (http://tools.acc.org/ASCVD-Risk-Estimator/).</p> |
| References | <ul style="list-style-type: none"> • U.S Preventive Services Task Force. Statin use for the primary prevention of cardiovascular disease in adults: U.S Preventive Services Task Force recommendation statement. JAMA. 2022;328(8):746-753. doi:10.1001/jama.2022.13044. • Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf Accessed December 12, 2023. |

GENERAL HEALTH

Obesity Prevention

Rationale: Women between 40 and 60 years of age are at increased risk of weight gain, some gaining an average of 1.5 lbs (0.7 kg) per year. Preventing obesity reduces risk of chronic health conditions such as heart disease, diabetes mellitus, arthritis, and certain cancers.

WPSI Recommendation: Counsel midlife women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.5–29.9 kg/m²) to maintain weight or limit weight gain to prevent obesity. Counseling may include individualized discussion of healthy eating and physical activity.

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| Ages and Frequency | 40 to 60 years |
| Clinical Practice | <p>Height and weight can be measured at most routine visits. In adults, normal BMI is defined as body mass index (BMI) 18.5–24.9 kg/m², overweight is defined as a BMI of 25–29 kg/m², and obesity as BMI of 30 kg/m² or higher.</p> <p>The WPSI recommends offering or referring women to individualized counseling based on assessment of a patient’s BMI and diet and exercise habits. Patients with normal weight and healthy habits can receive positive reinforcement. Women with overweight BMI and with unhealthy diet and exercise habits should receive at least brief counseling. Periodicity and intensity of reinforcement and counseling can be individualized based on the patient’s BMI, previously established habits, and acceptance.</p> |
| Risk Assessment | Not applicable. |
| References | <ul style="list-style-type: none"> • Women’s Preventive Services Initiative. <i>Recommendation for Preventing Obesity in Midlife Women</i>. https://www.womenspreventivehealth.org/recommendations/preventing-obesity/. Published January 11, 2022. Accessed December 11, 2023. |

| Obesity Screening & Counseling | |
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| <p>Rationale: Over 30% of adult women in the United States are obese. Obesity increases risks for cardiovascular disease, type 2 diabetes mellitus, cancer, gallstones, and disability.</p> <p>USPSTF Recommendation: Screen for obesity at age 6 years and older and offer or refer adults with body mass index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions.</p> <p>Bright Futures Recommendation: Children should have BMI calculated and classified at every well child visit.</p> | |
| Ages and Frequency | ≥ 13 years annually |
| Clinical Practice | <p>Height and weight are typically measured at most routine visits. In adults, overweight is defined as a body mass index (BMI) of 25-29 kg/m² and obesity as BMI of 30 kg/m² or higher.</p> <p>USPSTF recommends offering or referring patients with a BMI of 30 kg/m² or higher to intensive, multicomponent behavioral interventions. These interventions can lead to weight loss, as well as improved glucose tolerance and other physiologic risk factors for cardiovascular disease.</p> |
| Risk Assessment | Not applicable. |
| References | <ul style="list-style-type: none"> • Grossman DC, Bibbins-Domingo K, Curry SJ, et al. Screening for obesity in children and adolescents: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2017; 317(23):2417-26. doi: 10.1001/JAMA.2017.6803. PMID: 28632874. • US Preventive Services Task Force. Behavioral weight loss interventions to prevent obesity-related morbidity and mortality in adults: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2018;320(11):1163-1171. doi: 10.1001/jama.2018.13022. PMID: 25996397 • Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.90295442.924462059.1671580996-606362568.1671580995. Accessed December 11, 2023. |

GENERAL HEALTH

| Osteoporosis Screening | |
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| <p>Rationale: Approximately half of all postmenopausal women will have an osteoporosis-related fracture during their lifetime. Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality.</p> <p>USPSTF Recommendation: Screen for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women age 65 years and older and in postmenopausal women younger than 65 who are at increased risk.</p> | |
| Ages and Frequency | <p>≥ 65 years for all women</p> <p>Postmenopausal women younger than 65 years at increased risk</p> <p>There is no benefit from repeating bone measurement testing between 4 and 8 years after initial screening and a minimum of 2 years may be needed to reliably measure a change in bone mineral density (BMD).</p> |
| Clinical Practice | <p>This recommendation is intended for women without previous osteoporotic fractures.</p> <p>USPSTF recommends women age 65 and older have bone measurement testing to identify osteoporosis, which is a risk factor for fragility fractures. Women between the ages of 50 and 64 years with equivalent or greater 10-year fracture risks based on specific risk factors should also be tested. Women identified with low bone density can reduce their risk of fractures with osteoporosis medications.</p> <p>Bone measurement testing with central dual-energy x-ray absorptiometry (DXA) is the most commonly used and studied method for the diagnosis of osteoporosis. Measurement of BMD at central bone sites (hip and lumbar spine) is the established standard for diagnosis of osteoporosis and for guiding decisions about treatment. Use of DXA and quantitative ultrasound (QUS) at peripheral sites (such as wrist, forearm, and calcaneus) are alternative methods.</p> |
| Risk Assessment | <p>Postmenopausal women younger than age 65 years who have at least one risk factor (parental history of hip fracture, smoking, white race, excess alcohol consumption, low body weight) can be evaluated with a clinical risk assessment tool. Several tools to estimate risk are available for clinicians.</p> |
| References | <ul style="list-style-type: none"> US Preventive Services Task Force. Screening for osteoporosis to prevent fractures: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2018;319(24):2521-2531. doi: 10.1001/jama.2018.7498. PMID: 29946735. |

| Substance Use Screening & Assessment | |
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| <p>Rationale: Unhealthy drug use and abuse are serious problems in the United States, ranking among the ten leading preventable risk factors for years of healthy life lost to death and disability.</p> <p>USPSTF: The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older including pregnant and postpartum women. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.</p> <p>Bright Futures Recommendation: Substance use should be evaluated as part of an age appropriate comprehensive history. Reviewing the adolescent’s environment can identify risk and protective factors for the development of alcohol or drug abuse.</p> | |
| Ages and Frequency | ≥ 13 years annually |
| Clinical Practice | <p>For adults: Ask about unhealthy drug use. Clinicians can ask the questions or have patients share their answers on a form, computer, or tablet. Recommended screening tools include: NIDA quick screen, ASSIST, the PRO for pregnant people.</p> <p>For adolescents: Ask about alcohol and substance use. While many adolescents do not discuss substance use with their clinicians, the most common reason is because they were never asked. Screening tools, such as CRAFFT, accurately identify a diagnosis of substance problem use, abuse, or dependence.</p> |
| Risk Assessment | <p>Factors associated with a higher prevalence of unhealthy drug use in adults include age 18 to 25 years; having a mental health condition, personality or mood disorder, or nicotine or alcohol dependence; a history of physical or sexual abuse, parental neglect, or other adversity in childhood; or drug or alcohol addiction in a first-degree relative.</p> <p>Risk factors for adolescents include substance use by a family member, poor parental supervision, household disruption, low academic achievement and/or academic aspirations, and untreated attention-deficit/hyperactivity disorder.</p> |
| References | <ul style="list-style-type: none"> • US Preventive Services Task Force. Screening for unhealthy drug use: US Preventive Services Task Force Recommendation Statement. JAMA. 2020;323(22):2301–2309. doi:10.1001/jama.2020.8020 • Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.90295442.924462059.1671580996-606362568.1671580995. Accessed December 11, 2023. |

GENERAL HEALTH

Tobacco Screening & Counseling

Rationale: Tobacco use is the leading preventable cause of disease, disability, and death in the United States. In pregnant women, smoking increases the risk for congenital anomalies; perinatal complications; and neonatal or pediatric complications.

USPSTF Recommendation: Provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-age children and adolescents and advise those currently using tobacco to quit. Ask all adults, including pregnant women, about tobacco use and advise them to stop using tobacco. Provide behavioral interventions and U.S. Food and Drug Administration–approved pharmacotherapy for smoking cessation for nonpregnant adults, while counseling interventions alone can be used during pregnancy.

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| Ages and Frequency | ≥ 13 years at least annually |
| Clinical Practice | The 5 A's framework is a strategy for engaging patients in smoking cessation discussions. These include: 1) Asking every patient about tobacco use, 2) Advising them to quit, 3) Assessing their willingness to quit, 4) Assisting them with quitting, and 5) Arranging follow-up. |
| Risk Assessment | All adolescent and adult women should be asked about tobacco use. |
| References | <ul style="list-style-type: none"> • US Preventive Services Task Force. Primary care interventions for prevention and cessation of tobacco use in children and adolescents: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2020;323(16):1590-1598. doi:10.1001/jama.2020.4679 • US Preventive Services Task Force. Interventions for tobacco smoking cessation in adults, including pregnant persons: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2021;325(3):265-279. doi:10.1001/jama.2020.25019. PMID: 33464343. • Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?ga=2.90295442.924462059.1671580996-606362568.1671580995. Accessed December 11, 2023. |

| Urinary Incontinence Screening | |
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| <p>Rationale: Approximately 50% of women in the United States experience urinary incontinence that can adversely affect health, quality of life, and function.</p> <p>WPSI Recommendation: Screen women for urinary incontinence annually and provide or refer for further diagnostic evaluation if indicated.</p> | |
| Ages and Frequency | Women of all ages and those postpartum |
| Clinical Practice | <p>Several brief clinician or self-administered questionnaires accurately identify women with stress, urge, or mixed incontinence and can be used to guide diagnostic evaluations and management. Screening assesses the type and degree of urinary incontinence, situations in which it occurs, and how it impacts activities and quality of life.</p> <p>Once women with incontinence are identified, they may undergo individualized clinical diagnostic evaluations to determine appropriate treatment and management options including behavioral, pharmacologic, nonpharmacologic, and surgical interventions specific to the type and severity of incontinence and patient preferences.</p> |
| Risk Assessment | Although urinary incontinence is common among all groups of women, rates are higher for women with specific risk factors, particularly older age, obesity, and previous vaginal delivery. Additional risk factors include hysterectomy, cognitive impairment, functional impairment, and other chronic medical conditions. |
| References | <ul style="list-style-type: none"> • O’Reilly N, Nelson HD, Conry JM, et al. Screening for urinary incontinence: a recommendation from the Women’s Preventive Services Initiative. <i>Ann Intern Med.</i> 2018;169(5):320-328. doi: 10.7326/M18-0595. • Women’s Preventive Services Initiative. <i>Screening for Urinary Incontinence.</i> https://www.womenspreventivehealth.org/recommendations/urinary-incontinence/. Published January 7, 2020. Accessed December 11, 2023. |

 Infectious Disease



| Chlamydia & Gonorrhea Screening | |
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| <p>Rationale: Chlamydia and gonorrhea are the most commonly reported sexually transmitted infections (STIs) in the United States. Gonococcal infections are often asymptomatic in women but may lead to pelvic inflammatory disease and its associated complications, such as ectopic pregnancy, infertility, and chronic pelvic pain.</p> <p>USPSTF Recommendation: Screen for chlamydia and gonorrhea in sexually active women age 24 years or younger and in women 25 years or older who are at increased risk for infection.</p> <p>Bright Futures Recommendation: Screen all sexually active women 24 years and younger for chlamydia and gonorrhea annually.</p> | |
| Ages and Frequency | 13 to 24 years annually > 24 year with increased risk; interval based on new or continuing risk |
| Clinical Practice | Chlamydial and gonococcal infections are diagnosed with nucleic acid amplification tests using urine, endocervical, or provider-collected or patient self-collected vaginal specimens. |
| Risk Assessment | Infection rates are highest in sexually active women age 15 to 24 years. Risk factors include new or more than one sex partner, a sex partner with concurrent partners, or a sex partner with a STI; inconsistent condom use; previous or concurrent STI; exchanging sex for money or drugs; and history of incarceration. |
| References | <ul style="list-style-type: none"> • US Preventive Services Task Force. Screening for chlamydia and gonorrhea: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2021;326(10):949–956. doi:10.1001/jama.2021.14081. PMID: 34519796 • American Academy of Pediatrics Committee on Adolescence and Society for Adolescent Health and Medicine. Screening for nonviral sexually transmitted infections in adolescents and young adults. <i>Pediatrics</i>. 2014; 134 (1): e302–e311. doi: 10.1542/peds.2014-1024. PMID: 24982099. • Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.90295442.924462059.1671580996-606362568.1671580995. Accessed December 11, 2023. |

INFECTIOUS DISEASE

Hepatitis B Screening

Rationale: Approximately 700,000 to 2.2 million people in the United States have chronic hepatitis B virus (HBV) infection that can lead to cirrhosis, hepatic decompensation, and hepatocellular carcinoma, and serve as a reservoir for person-to-person transmission of HBV infection. Screening identifies chronically infected individuals who may benefit from treatment or other interventions, such as surveillance for hepatocellular carcinoma.

USPSTF Recommendation: Screen for HBV infection in adolescents and adults at high risk for infection and in pregnant women at their first prenatal visit.

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| Ages and Frequency | ≥ 13 years: all pregnant women and high-risk adolescents and adults who are not pregnant |
| Clinical Practice | <p>Chronic HBV infection is determined by immunoassays for detecting hepatitis B surface antigen (HBsAg).</p> <p>Periodic screening may be useful in patients with ongoing risk for HBV transmission who do not receive vaccination.</p> <p>Screening for HBV infection in pregnancy should occur at the first prenatal visit. Women should also be screened at delivery if they have unknown HBsAg status or new or continuing risk factors (such as injection drug use or STI).</p> |
| Risk Assessment | Risk increased: born in a country with a prevalence of HBV infection ≥2%; born in the U.S. but no vaccination in infancy and parents are from a country or region with prevalence ≥8%; positive for HIV; using injection drugs; who are household contacts or sexual partners of adolescents and adults with HBV infection; who have traveled to endemic areas and not completed hepatitis B vaccination series. |
| References | <ul style="list-style-type: none"> • LeFevre ML. Screening for hepatitis B virus infection in nonpregnant adolescents and adults: U.S. Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2014; 161(1):58-66. doi: 10.7326/m14-1018. PMID: 24863637. • U.S. Preventive Services Task Force. Screening for hepatitis B virus infection in pregnant women: U.S. Preventive Services Task Force reaffirmation recommendation statement. <i>JAMA.</i> 2019; 322(4):349-354. doi: 10.1001/jama.2019.9365. PMID: 25996397. • Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?ga=2.90295442.924462059.1671580996-606362568.1671580995. Accessed December 11, 2023. |

Hepatitis C Screening

Rationale: Hepatitis C virus (HCV) is the most common chronic blood borne pathogen in the United States and a leading cause of complications from chronic liver disease.

USPSTF Recommendation: Screen asymptomatic adults age 18 to 79 without known liver disease at least once. Periodically screen adults with past or current injection drug use.

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| Ages and Frequency | Screen all adults age 18 to 79 at least once Screen other ages and repeat screening for high risk |
| Clinical Practice | Anti-HCV antibody testing followed by confirmatory polymerase chain reaction testing accurately detects chronic HCV infection. |
| Risk Assessment | High risk includes past or current injection drug use. |
| References | <ul style="list-style-type: none"> • U.S. Preventive Services Task Force. Screening for hepatitis C virus infection in adolescents and adults: U.S. Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2020;323(10):970-975. doi: 10.1001/jama.2020.1123 • Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.90295442.924462059.1671580996-606362568.1671580995. Accessed December 11, 2023. |



INFECTIOUS DISEASE

| Human Immunodeficiency Virus Preexposure Prophylaxis | |
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| <p>Rationale: Human immunodeficiency virus (HIV) infection preexposure prophylaxis (PrEP) decreases the risk of HIV infection in adolescents and adults at high risk.</p> <p>USPSTF Recommendation: Prescribe PrEP using effective antiretroviral therapy to adolescents and adults who are at increased risk of HIV acquisition (eg, once-daily oral treatment with combined tenofovir disoproxil fumarate and emtricitabin) to decrease the risk of acquiring HIV. Adolescents and pregnant women can be considered for PrEP as well, although these groups were not included in medication trials.</p> | |
| Ages and Frequency | ≥ 13 years; ongoing treatment |
| Clinical Practice | Clinicians should routinely take a sexual and injection drug use history for all their patients. If a person is identified as potentially belonging to a high-risk group, then further discussion can identify behaviors that may make that person an appropriate candidate for PrEP. |
| Risk Assessment | <p>The USPSTF recommends that women with the following characteristics be considered for PrEP:</p> <ul style="list-style-type: none"> • Heterosexually active women: with a sexual partner who has HIV; or inconsistent or no use of condoms during sex with a partner whose HIV status is unknown and who is at high risk; or an STI with syphilis or gonorrhea within the past 6 months. • Uses injection drugs and shared use of drug injection equipment; or have a drug-injecting partner who has HIV. • Engaged in transactional sex, such as for money, drugs, or other. |
| References | <ul style="list-style-type: none"> • U.S. Preventive Services Task Force. Preexposure prophylaxis to prevent acquisition of HIV: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2023;330(8):736–745. doi:10.1001/jama.2023.14461. PMID: 37606666. |

Human Immunodeficiency Virus Risk Assessment & Screening

Rationale: Screening for human immunodeficiency virus (HIV) infection detects individuals who are unaware of their infection and would otherwise miss the opportunity to benefit from early therapy that can reduce serious AIDS-related events and death as well as disease transmission.

USPSTF Recommendation: Screen for HIV infection in adolescents and adults aged 15 to 65 years, and younger adolescents and older adults who are at increased risk of infection. Screen during pregnancy, including when presenting in labor or at delivery and HIV status is unknown.

WPSI Recommendation: Prevention education and risk assessment for HIV infection in adolescents and adults at least annually throughout the lifespan. Test all women for HIV at least once during their lifetimes, and all pregnant women upon initiation of prenatal care with retesting during pregnancy based on risk factors.

Bright Futures Recommendation: Screen once between the ages of 15 and 21; retest annually if increased risk (sexually active, injection drug use, tested for other STIs).

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| Ages and Frequency | >15 years; appropriate or optimal time intervals or strategies for repeat HIV screening are not known. Earlier or additional screening should be based on risk and rescreening annually or more often may be appropriate beginning at age 13 for adolescent and adult women with an increased risk of HIV infection. Repeat screening is reasonable for individuals known to be at increased risk of HIV infection or live or receive medical care in a high-prevalence setting, such as a sexually transmitted disease clinic. |
| Clinical Practice | This recommendation refers to routine HIV screening, which is different from incident-based or exposure-based HIV testing. Annual or more frequent HIV testing is recommended for women who are high risk. Screening is recommended for all pregnant women upon initiation of prenatal care with retesting during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant women who present in active labor with an undocumented HIV status. |
| Risk Assessment | Risk factors include injection drug use; unprotected vaginal or anal intercourse; multiple sexual partners; new sexual relationship; sexual partners who are HIV-infected, bisexual, or injection drug users; exchanging sex for drugs or money; victim of sex trafficking; incarceration; other STIs. |
| References | <ul style="list-style-type: none"> ● US Preventive Services Task Force. Screening for HIV infection: US Preventive Services Task Force recommendation statement. <i>JAMA</i> 2019;321(23):2326-2336. doi: 10.1001/jama.2019.6587. PMID: 31184701. ● Women’s Preventive Services Initiative. <i>Screening for Human Immunodeficiency Virus Infection</i>. https://www.womenspreventivehealth.org/recommendations/human-immunodeficiency-virus-infection/. Published January 7, 2022. Accessed December 11, 2023. ● Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.90295442.924462059.1671580996-606362568.1671580995. Accessed December 11, 2023. |

INFECTIOUS DISEASE

Sexually Transmitted Infections Prevention Counseling

Rationale: Sexually transmitted infections (STIs) are frequently asymptomatic and can be unknowingly spread to others. Serious sequelae of STIs include pelvic inflammatory disease, infertility, cancer and AIDS. Untreated STIs present during pregnancy or birth may cause perinatal infection, death, and serious physical and mental disabilities.

WPSI Recommendation: Behavioral counseling by a health care clinician or other appropriately trained individual for sexually active adolescent and adult women at an increased risk for sexually transmitted infections (STIs).

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| Ages and Frequency | <p>≥ 13 to 21 years</p> <p>>21 years for sexually active women with increased risk for STIs</p> |
| Clinical Practice | <p>Behavioral counseling may be delivered in primary care settings or other sectors of the health care system. Risk-reduction counseling may be offered by community organizations, schools, and health departments, or their affiliated STI clinics.</p> <p>Selection of behavioral counseling interventions should be based on their effectiveness, appropriateness to the patient population, and feasibility of implementation</p> |
| Risk Assessment | <p>All sexually active adolescents are at increased risk for STIs and should be counseled. Risk factors for STIs include having an STI currently or within the past year, not consistently using condoms, having multiple sex partners, or having sex partners within populations with a high prevalence of STIs. Increased STI prevalence rates are found among women seeking STI testing or attending STI clinics; sexual and gender minorities; and among those with HIV, using injection drugs, exchanging sex for money or drugs, or residing in correctional facilities.</p> |
| References | <ul style="list-style-type: none"> • Women’s Preventive Services Initiative. <i>Counseling for Sexually Transmitted Infections</i>. https://www.womenspreventivehealth.org/recommendations/sexually-transmitted-infections/. Published January 7, 2022. Accessed December 11, 2023. • U.S. Preventive Services Task Force. Behavioral counseling interventions to prevent sexually transmitted infections: U.S. Preventive Services Task Force Recommendation Statement. <i>JAMA</i>. 2020;324(7):674–681. doi:10.1001/jama.2020.13095. |



INFECTIOUS DISEASE

Syphilis Screening

Rationale: Although less common than other sexually transmitted infections (STIs), syphilis can cause blindness, paresis, tabes dorsalis, and dementia; inflammatory lesions causing cardiovascular or organ dysfunction; and congenital abnormalities when infecting pregnant women. Syphilis infection also increases the risk for acquiring or transmitting HIV infection.

USPSTF Recommendation: Screen for syphilis in adolescents and adults at increased risk for infection and in all pregnant women.

Bright Futures Recommendation: For high-risk teens, screen for syphilis at least once a year.

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| Ages and Frequency | ≥ 13 years: all pregnant women and high-risk adolescents and adults who are not pregnant |
| Clinical Practice | <p>Screening for syphilis infection is a two-step process involving an initial nontreponemal test (Venereal Disease Research Laboratory or rapid plasma reagin [RPR] test) followed by a confirmatory treponemal antibody detection test (fluorescent treponemal antibody absorption or Treponema pallidum particle agglutination test).</p> <p>All pregnant women should be tested early in their pregnancies. High risk pregnant women require repeat serologic testing in the third trimester and again at delivery.</p> |
| Risk Assessment | Risk factors include previous syphilis infection or other STIs, incarceration, or drug use; multiple or concurrent sex partners; living in high-prevalence areas; HIV infection; history of incarceration; exchanging sex for money or drugs. |
| References | <ul style="list-style-type: none"> • US Preventive Services Task Force. Screening for syphilis infection in nonpregnant adults and adolescents: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2022;328(12):1243-1249. doi:10.1001/jama.2022.15322. • US Preventive Services Task Force. Screening for syphilis infection in pregnant women: US Preventive Services Task Force reaffirmation recommendation statement. <i>JAMA</i>. 2018;320(9):911-917. doi: 10.1001/jama.2018.11785. PMID: 30193283. • Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?ga=2.90295442.924462059.1671580996-606362568.1671580995. Accessed December 11, 2023. |

| Tuberculosis Screening | |
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| <p>Rationale: Five to ten percent of individuals with latent tuberculosis infection progress to active tuberculosis disease. Identifying and treating latent tuberculosis is a key component of the strategy for reducing the burden of tuberculosis disease.</p> <p>USPSTF Recommendation: Screen for latent tuberculosis infection in populations at increased risk.</p> <p>Bright Futures Recommendation: Testing should be performed on recognition of high-risk factors.</p> | |
| Ages and Frequency | ≥ 13 years with increased risk |
| Clinical Practice | Screening tests include the Mantoux tuberculin skin test and interferon-gamma release assays. |
| Risk Assessment | Adolescent and adults from countries with increased tuberculosis prevalence; living in high-risk congregate settings (eg, homeless shelters, correctional facilities); exposure to individuals with active tuberculosis, such as health care workers and workers in high-risk congregate settings; immunosuppressed individuals; patients with silicosis. |
| References | <ul style="list-style-type: none"> • U.S. Preventive Services Task Force. Screening for latent tuberculosis infection in adults: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2023;329(17):1487–1494. doi:10.1001/jama.2023.4899. PMID: 37129649. • Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?ga=2.90295442.924462059.1671580996-606362568.1671580995. Accessed December 11, 2023. |



 Cancer



| Breast Cancer Screening | |
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| <p>Rationale: Breast cancer is the second-leading cause of cancer death among women in the United States.</p> <p>WPSI Recommendation: Initiate mammography screening no earlier than age 40 and no later than age 50 for women at average risk for breast cancer. Screening should continue through at least age 74 and age alone should not be the basis to discontinue screening.</p> | |
| Ages and Frequency | Age 40 to 50 years until at least 74 years; at least biennially and as frequently as annually |
| Clinical Practice | These recommendations are for women at average risk for breast cancer. The decision to screen women prior to age 50 and after age 74 should be an individual one. |
| Risk Assessment | Risk factors for breast cancer include increasing age; family history of breast or ovarian cancer (especially among first-degree relatives and onset before age 50 years); history of atypical hyperplasia or other nonmalignant high-risk breast lesions; previous breast biopsy; and extremely dense breast tissue. Women considered at high risk for breast cancer (previous breast or ovarian cancer; <i>BRCA1/2</i> mutation carrier; previous high-dose radiation to the chest) should also undergo periodic mammography screening and may require additional follow-up beyond the scope of this recommendation. |
| References | <ul style="list-style-type: none"> Women’s Preventive Services Initiative. <i>Recommendations for Preventive Services for Women: Final Report to the U.S. Department of Health and Human Services, Health Resources & Services Administration.</i> Washington, DC: 2016. https://www.womenspreventivehealth.org/recommendations/breast-cancer/. Accessed December 11, 2023. |



CANCER

| Cervical Cancer Screening | |
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| <p>Rationale: Cervical cancer deaths in the United States have decreased since the implementation of widespread cervical cancer screening and most cases occur in women who have not been adequately screened.</p> <p>USPSTF Recommendation: Periodic screening based on age and method (see below).</p> | |
| Ages and Frequency | <p>21 to 29 years: cervical cytology alone every 3 years</p> <p>30 to 65 years: screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (co-testing).</p> |
| Clinical Practice | <p>This recommendation applies to women who have a cervix, regardless of sexual history or HPV vaccination status.</p> <p>Women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion or cervical cancer are not at risk for cervical cancer and should not be screened.</p> |
| Risk Assessment | <p>Women with a previous diagnosis of high-grade precancerous cervical lesion or cervical cancer; in utero exposure to diethylstilbestrol; or immunocompromised (such as those who are HIV positive) require individualized follow-up.</p> |
| References | <ul style="list-style-type: none"> US Preventive Services Task Force. Screening for cervical cancer: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2018;320(7):674-686. doi: 10.1001/jama.2018.10897. PMID: 30140884. |

| Colorectal Cancer Screening | |
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| <p>Rationale: Colorectal cancer is most common among adults over age 45 years and early detection with screening can reduce mortality.</p> <p>USPSTF Recommendation: Screen for colorectal cancer starting at age 45 years and continuing until age 75 years.</p> | |
| Ages and Frequency | 45 to 75 years: frequency varies by method |
| Clinical Practice | <p>Screening methods include HSgFOBT (high-sensitivity guaiac-based fecal occult blood test) or FIT (fecal immunochemical test) every year; FIT-DNA (multitargeted stool DNA test) every 1-3 years; flexible sigmoidoscopy or computed tomography (CT) colonography every 5 years; and flexible sigmoidoscopy every 10 years with annual FIT or colonoscopy every 10 years.</p> <p>The decision to screen for colorectal cancer in adults age 76 to 85 years should be an individual one that considers the patient’s overall health and prior screening history.</p> |
| Risk Assessment | <p>Women who are Black; have a family history of colorectal cancer (a first-degree relative with early-onset colorectal cancer or multiple first-degree relatives with the disease); or other risk factors (obesity, diabetes, long-term smoking, unhealthy alcohol use) have increased risks for colorectal cancer and may consider screening at earlier ages.</p> |
| References | <ul style="list-style-type: none"> • U.S. Preventive Services Task Force. Screening for colorectal cancer: U.S. Preventive Services Task Force recommendation statement. JAMA. 2021;325(19):1965–1977. doi:10.1001/jama.2021.6238. PMID: 34003218. |

CANCER

Lung Cancer Screening

Rationale: Lung cancer is the second most common cancer and the leading cause of cancer death for women in the United States. The most important risk factor for lung cancer is smoking, which is associated with approximately 90% of lung cancer cases.

USPSTF Recommendation: Screen for lung cancer with low-dose computed tomography in adults age 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.

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| Ages and Frequency | 50 to 80 years annually |
| Clinical Practice | Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. |
| Risk Assessment | The incidence of lung cancer increases with age and occurs most commonly at age 50 years or older. Increasing age and cumulative exposure to tobacco smoke are the two most common risk factors for lung cancer. Approximately 228,820 adults in the United States were diagnosed with lung cancer in 2020; and 135,720 adults died of the disease. |
| References | <ul style="list-style-type: none">U.S. Preventive Services Task Force. Screening for lung cancer: U.S. Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2021;325(10):962–970. doi:10.1001/jama.2021.1117. PMID 33687470. |



| Medication Use to Reduce Breast Cancer Risk | |
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| <p>Rationale: Although screening for breast cancer may detect cancer early, screening does not prevent the development of cancer. Use of medications, such as tamoxifen, raloxifene, or aromatase inhibitors, reduces risk for estrogen receptor (ER) positive breast cancer.</p> <p>USPSTF Recommendation: Clinicians should offer to prescribe risk-reducing medications for women who are at increased risk for breast cancer and at low risk for adverse medication effects.</p> | |
| Ages and Frequency | ≥ 40 years; assess risk annually |
| Clinical Practice | USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk, and recommends against their use in women who are not at increased risk for breast cancer. |
| Risk Assessment | Risk factors for breast cancer include increasing age; family history of breast or ovarian cancer (especially among first-degree relatives and onset before age 50 years); history of atypical hyperplasia or other nonmalignant high-risk breast lesions; previous breast biopsy; and extremely dense breast tissue. Models suggest that women with an estimated 5-year breast cancer risk of 3% or greater are likely to have more benefit than harm, although the balance depends on age, race or ethnicity, the medication used, and whether the patient has a uterus. |
| References | <ul style="list-style-type: none"> US Preventive Services Task Force. Medication use to reduce risk of breast cancer: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2019;322(9):857-867. doi: 10.1001/jama.2019.11885. PMID: 31479144. |

CANCER

Risk Assessment for *BRCA1/2* Genetic Counseling & Testing

Rationale: Inherited pathogenic mutations of the *BRCA1/2* gene increase risks for breast, ovarian, fallopian tube, and peritoneal cancer. These mutations occur in an estimated 1 in 300 to 500 women (0.2% to 0.3%) in the general population but are more common within families with previously diagnosed cancer.

USPSTF Recommendation: Assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (*BRCA1/2*) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing. Women without positive family histories do not require genetic counseling or BRCA testing.

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| Ages and Frequency | ≥ 18 years: assess risk periodically |
| Clinical Practice | Genetic risk assessment and <i>BRCA1/2</i> mutation testing is a multistep process that begins with identifying patients with family or personal histories of breast, ovarian, tubal, or peritoneal cancer; family members with known pathogenic <i>BRCA1/2</i> mutations; or ancestry associated with pathogenic <i>BRCA1/2</i> mutations. Risk for clinically significant <i>BRCA1/2</i> mutations can be further evaluated with genetic counseling by suitably trained health care clinicians, followed by genetic testing of selected high-risk individuals and posttest counseling about results. |
| Risk Assessment | Family history factors associated with increased likelihood of potentially harmful <i>BRCA1/2</i> mutations include breast cancer diagnosis before age 50 years, bilateral breast cancer, presence of breast and ovarian cancer, presence of breast cancer in one or more male family members, multiple cases of breast cancer in the family, one or more family members with two primary types of BRCA-related cancer, and ancestry associated with pathogenic mutations, such as Ashkenazi Jewish ethnicity. These factors are included in clinical screening tools to identify women for referral to genetic counseling. |
| References | <ul style="list-style-type: none"> US Preventive Services Task Force. Risk assessment, genetic counseling, and genetic testing for BRCA-related cancer: US Preventive Services Task Force recommendation statement. <i>JAMA</i> 2019;322(7):652-665. doi: 10.1001/jama.2019.10987. PMID: 31429903. |

| Skin Cancer Counseling | |
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| <p>Rationale: Skin cancer, including melanoma and nonmelanoma types, is the most common cancer in the United States. Although invasive melanoma accounts for only 2% of all skin cancer cases, it is responsible for 80% of skin cancer deaths. Exposure to ultraviolet radiation increases risk.</p> <p>USPSTF Recommendation: Counsel fair-skinned young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet radiation to reduce risk of skin cancer (ages 6 months to 24 years).</p> | |
| Ages and Frequency | 13 to 24 years annually; consider older adults at risk |
| Clinical Practice | USPSTF recommends behavioral counseling interventions that target sun protection behaviors to reduce ultraviolet radiation exposure that damages DNA and causes skin cancer. These include the use of broad-spectrum sunscreen with a sun-protection factor of 15 or greater; wearing hats, sunglasses, or sun-protective clothing; avoiding sun exposure; seeking shade during midday hours (10 am to 4 pm); and avoiding indoor tanning equipment. |
| Risk Assessment | Radiation exposure during childhood and adolescence increases the risk of skin cancer later in life. Risk is higher for those with fair skin, light hair and eye color, freckles; those who sunburn easily; use tanning beds; have a history of previous skin cancer; family history of skin cancer; HIV infection; or history of an organ transplant. |
| References | <ul style="list-style-type: none"> US Preventive Services Task Force. Behavioral counseling to prevent skin cancer: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2018;319(11):1134-1142. doi: 10.1001/jama.2018.1623. PMID: 29558558. |



Pregnancy/Postpartum



| Bacteriuria Screening | |
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| <p>Rationale: In pregnant women, asymptomatic bacteriuria has been associated with an increased incidence of pyelonephritis and low birthweight.</p> <p>WPSI Recommendation: Screen for asymptomatic bacteriuria with urine culture for pregnant women at their first prenatal visit.</p> | |
| Ages and Frequency | All pregnant women; optimal timing and frequency is uncertain |
| Clinical Practice | Asymptomatic bacteriuria can be reliably detected through urine culture. The presence of at least 10 ⁵ colony-forming units per mL of urine of a single uropathogen from a midstream clean-catch specimen is considered a positive test result. |
| Risk Assessment | Universal screening |
| References | <ul style="list-style-type: none"> US Preventive Services Task Force. Screening for asymptomatic bacteriuria in adults: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2019;322(12):1188-1194. doi: 10.1001/jama.2019.13069. PMID: 31550038. |



PREGNANCY/POSTPARTUM

Breastfeeding Counseling, Services, & Supplies

Rationale: While breastfeeding is associated with multiple health benefits for infants and mothers, nearly half of all mothers in the United States who initially breastfeed stop doing so by 6 months.

WPSI Recommendation: Comprehensive lactation support services (including consultation; counseling; education by clinicians and peer support services; and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to optimize the successful initiation and maintenance of breastfeeding.

USPSTF Recommendation: Provide interventions during pregnancy and after birth to support breastfeeding. Interventions may include more than one component and be delivered over prenatal, perinatal, and postpartum periods.

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| Ages and Frequency | All pregnant and postpartum women |
| Clinical Practice | Lactation support services include consultation; counseling; education by clinicians and peer support services; and breastfeeding equipment and supplies. A lactation care clinician should deliver lactation support and provide services across the antenatal, perinatal, and postpartum periods to ensure successful preparation, initiation, and continuation of breastfeeding. |
| Risk Assessment | Not applicable |
| References | <ul style="list-style-type: none"> • Women’s Preventive Services Initiative. Breastfeeding Services and Supplies. https://www.womenspreventivehealth.org/recommendations/breastfeeding-services-and-supplies/. Published January 7, 2022. Accessed December 11, 2023. • U.S. Preventive Services Task Force. Primary care interventions to support breastfeeding. U.S. Preventive Services Task Force recommendation statement. JAMA. 2016;316(16):1688–1693. doi: 10.1001/jama.2016.14697. PMID: 27784102. |

| Diabetes Screening in Pregnancy | |
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| <p>Rationale: Gestational diabetes mellitus (GDM) is glucose intolerance detected during pregnancy. Pregnant women with gestational diabetes are at increased risk for maternal and fetal complications including preeclampsia, fetal macrosomia (which can cause shoulder dystocia and birth injury), and neonatal hypoglycemia. Women with GDM are also at increased risk for developing type 2 diabetes.</p> <p>WPSI Recommendation: Screen pregnant women for gestational diabetes mellitus after 24 weeks' gestation (preferably between 24 and 28 weeks) to prevent adverse birth outcomes. In addition, screen pregnant women with risk factors for type 2 diabetes before 24 weeks of gestation, ideally at the first prenatal visit.</p> <p>USPSTF Recommendation: Screen for gestational diabetes during pregnancy at 24 weeks of gestation or after.</p> | |
| Ages and Frequency | <p>All pregnant women after 24 weeks' gestation</p> <p>Pregnant women with risk factors at the first prenatal visit</p> |
| Clinical Practice | <p>Screening after 24 weeks: either the 50-g oral glucose challenge test (followed by a 3-hour 100-g oral glucose tolerance test if results on the initial oral glucose challenge test are abnormal) or a 2-hour 75-g oral glucose tolerance test.</p> <p>Screening prior to 24 weeks: optimal test is not known; acceptable modalities may include a 50-g oral glucose challenge test, a 2-hour 75-g oral glucose tolerance test, a hemoglobin A1C test, or a fasting plasma glucose test. If early screening is normal, screening with an oral glucose challenge test should be conducted at 24–28 weeks of gestation as described above.</p> |
| Risk Assessment | <p>Risk factors include overweight or obese body mass index (BMI), previous GDM, family history of first- or second-degree relatives with type 2 diabetes, maternal age of 35 years or older, previous delivery of an infant weighing 4,000 g or more, polycystic ovarian syndrome, or identifying with a racial or ethnic group with increased risk for type 2 diabetes (American Indian/Alaska Native, Asian American [at lower BMI], Black, Hispanic/Latino, Native Hawaiian/Pacific Islander).</p> |
| References | <ul style="list-style-type: none"> ● Women's Preventive Services Initiative. <i>Diabetes in Pregnancy</i>. https://www.womenspreventivehealth.org/recommendations/diabetes-in-pregnancy/. Published January 5, 2022. Accessed November 22, 2023. ● U.S. Preventive Services Task Force. Screening for gestational diabetes: U.S. Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2021;326(6):531-538. doi:10.1001/jama.2021.11922 |

PREGNANCY/POSTPARTUM

| Healthy Weight and Weight Gain during Pregnancy Counseling | |
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| | <p>Rationale: Obesity rates during pregnancy are high in the United States. Excess weight prior to pregnancy and excess gestational weight gain (GWG) have been associated with adverse maternal and infant health outcomes.</p> <p>USPSTF Recommendation: Offer pregnant adolescents and adults effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.</p> |
| Ages and Frequency | All pregnant adults and adolescents in primary care settings. |
| Clinical Practice | Clinicians can deliver effective in-person behavioral counseling interventions or refer patients to behavioral counseling interventions in other settings. |
| Risk Assessment | <p>Gestational weight gain is defined as the change in weight from before pregnancy (prepregnancy or during the first trimester) to the weight measured prior to delivery.</p> <p>Prepregnancy weight categories are based on World Health Organization definitions: underweight (body mass index [BMI] <18.5 [calculated as weight in kilograms divided by height in meters squared]), normal or healthy weight (BMI 18.5-24.9), overweight (BMI 25-29.9), and obese (BMI ≥30).</p> <p>The National Academy of Medicine recommendations for healthy gestational weight gain differ by prepregnancy weight category: 28 to 40 pounds for underweight; 25 to 35 for normal weight; 15 to 25 for overweight; and 11 to 20 for obese.</p> |
| References | <ul style="list-style-type: none">US Preventive Services Task Force. Behavioral counseling interventions for healthy weight and weight gain in pregnancy: US Preventive Services Task Force recommendation statement. JAMA. 2021;325(20):2087-2093. doi:10.1001/jama.2021.6949. PMID: 34032823. |



Hypertensive Disorders of Pregnancy Screening

Rationale: Hypertensive disorders of pregnancy include gestational hypertension, preeclampsia-eclampsia, and chronic hypertension with superimposed preeclampsia. Gestational hypertension and preeclampsia involve new-onset hypertension occurring after 20 weeks of gestation. The diagnosis of preeclampsia also requires proteinuria (excess protein in the urine) or other signs or symptoms involving multiple organ systems. Eclampsia is the onset of seizures among individuals with preeclampsia. Hypertensive disorders of pregnancy are among the leading causes of maternal morbidity and mortality, leading to complications such as stroke, eclampsia, and organ failure, as well as adverse perinatal outcomes for the fetus and newborn, such as fetal growth restriction, medically induced preterm birth, low birth weight, and stillbirth.

USPSTF Recommendation: Screen for hypertensive disorders with blood pressure measurements throughout pregnancy.

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| Ages and Frequency | All pregnant women at each prenatal visit |
| Clinical Practice | Blood pressure measurements should be obtained during each prenatal care visit throughout pregnancy. If a patient has an elevated blood pressure reading, the reading should be confirmed with repeated measurements. To achieve the benefit of screening, it is important that patients who screen positive receive evidence-based management of hypertensive disorders of pregnancy. |
| Risk Assessment | Risk factors include history of preeclampsia (including early-onset preeclampsia) or another hypertensive disorder; a previous adverse pregnancy outcome; maternal comorbid conditions (including type 1 or 2 diabetes prior to pregnancy, gestational diabetes, chronic hypertension, chronic kidney disease, and autoimmune diseases); and multifetal gestation. Other risk factors include nulliparity, obesity, family history of preeclampsia or early-onset cardiovascular disease, African American race, low socioeconomic status, and advanced maternal age. |
| References | <ul style="list-style-type: none"> U.S. Preventive Services Task Force. Screening for hypertensive disorders of pregnancy: US Preventive Services Task Force final recommendation statement. <i>JAMA</i>. 2023;330(11):1074-1082. doi:10.1001/jama.2023.16991. PMID: 37721605. |

PREGNANCY/POSTPARTUM

| Preeclampsia Prevention with Low-dose Aspirin | |
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| <p>Rationale: Preeclampsia is a hypertensive disorder occurring during pregnancy with potentially serious, even fatal health outcomes. Maternal complications include stroke, eclampsia, and organ failure; and adverse perinatal outcomes include intrauterine growth restriction, low birth weight, and stillbirth. Low-dose aspirin can reduce risk for preeclampsia.</p> <p>USPSTF Recommendation: Use low dose aspirin (81mg/d) as preventive medication after 12 weeks' gestation in women who are at high risk for preeclampsia.</p> | |
| Ages and Frequency | All pregnant women at high risk for preeclampsia |
| Clinical Practice | After 12 weeks' gestation, initiate daily low-dose aspirin in women at high risk for preeclampsia. |
| Risk Assessment | Risk factors include history of preeclampsia (including early-onset preeclampsia), intrauterine growth restriction (IUGR), or preterm birth; placental abruption or fetal death; maternal comorbid conditions (including type 1 or 2 pregestational diabetes, chronic hypertension, renal disease, and autoimmune diseases); and multifetal gestation. |
| References | <ul style="list-style-type: none">• US Preventive Services Task Force. Aspirin use to prevent preeclampsia and related morbidity and mortality: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2021;326(12):1186–1191. doi:10.1001/jama.2021.14781. PMID: 34581729. |

| Rh(D) Blood Typing | |
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| <p>Rationale: Rh(D) blood typing, anti-Rh(D) antibody testing, and intervention with Rh(D) immunoglobulin, as appropriate, prevents maternal sensitization and improves outcomes for newborns.</p> <p>USPSTF Recommendation: Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care, and repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh(D)-negative.</p> | |
| Ages and Frequency | All pregnant women |
| Clinical Practice | <p>Administration of a full (300 µg) dose of Rh(D) immunoglobulin is recommended for all unsensitized Rh(D)-negative women after repeated antibody testing at 24 to 28 weeks' gestation.</p> <p>Unless the biological father is known to be Rh(D)-negative, a full dose of Rh(D) immunoglobulin is recommended for all unsensitized Rh(D)-negative women after amniocentesis and after induced or spontaneous abortion; however, if the pregnancy is less than 13 weeks, a 50-µg dose is sufficient.</p> <p>If a Rh(D)-positive or weakly Rh(D)-positive infant is delivered, a dose of Rh(D) immunoglobulin should be repeated postpartum, preferably within 72 hours after delivery.</p> |
| Risk Assessment | Not applicable |
| References | <ul style="list-style-type: none"> • <i>Screening for Rh (D) Incompatibility: A Brief Evidence Update for the U.S. Preventive Services Task Force.</i> Rockville, MD, Agency for Healthcare Research and Quality, 2004. Available at http://www.uspreventiveservicestaskforce.org. |





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