2007 Prevention Guidelines For Adults

Contra Costa Health Plan and Contra Costa Regional Medical Center

These are minimal standards for health maintenance. Nothing in these guidelines is meant to preclude more extensive screening for people with higher than average risks. These guidelines are not a substitute for clinical judgment.

SCREENING	
History & Physical	**All CCHP Members:** Within 120 days of enrollment into Contra Costa Health Plan (CCHP), the California Department of Health Care Services (DHCS) requires: • "Staying Healthy" or Individual Health Education Behavioral Assessment (IHEBA) – as part of the initial health assessment using English, Spanish, Chinese, Hmong, Lao, Russian, or Vietnamese forms. Download forms at: http://www.dhs.ca.gov/ps/ocpm/html/staying%20healthy.htm • Initial Health Assessment (IHA) – Complete History and Physical including preventive care, a health risk assessment, education, and counseling. If a complete History and Physical is documented within 11 months, a full examination is not needed, but the language-specific IHEBA questionnaire is still required within 120 days of enrollment into the Health Plan. (California DHCS requirement)
Weight and BMI	**All Adults:** Weight annually for all patients seen for health care services. Screen for obesity using BMI (Body Mass Index). USPSTF 2006 (B).
Abdominal Aortic Aneurysm (AAA)	**Men aged 65 to 75 who have ever smoked:** Order a one-time AAA screening ultrasonography. USPSTF 2006 (B).
Blood Pressure	Blood pressure annually for all adults seen for health care services. USPSTF 2006 (A).
Breast Cancer - Mammogram	**Women ages 50-69:** Mammogram every one to two years, earlier if + family history of pre-menopausal breast cancer. Continue >69 depending on risks and life expectancy. **Women ages 40-49:** Review risks and benefits with provider and mutually decide about mammograms. USPSTF 2006 (B). NOTE: DHCS recommends clinical breast exams annually for women ≥40 years of age.
Breast Cancer – BRCA Mutation Genetic Counseling	**Women with family history associated with high risk for BRCA 1 or BRCA 2 genes**: • breast cancer diagnosed at an early age • bilateral breast cancer • history of both breast and ovarian cancer • presence of breast cancer in one or more male family members • multiple cases of breast cancer in the family • both breast and ovarian cancer in the family • one or more family members with two primary cancers • Ashkenazi Jewish background. Refer for genetic counseling and evaluation for BRCA testing. **Normal risk women:** Screening not recommemded. USPSTF 2006 (B).
Cervical Cancer - Pap Smear	**Women 3 years after the onset of sexual activity or ≥ 21:** Pap smears annually. After **two** normal annual Pap smears, repeat every 2-3 years. May stop in women with 3 consecutive normal results > age 65 or after hysterectomy for benign indications. USPSTF 2006 (A).
Colon Cancer	**All Average Risk (**no Family History of first degree relative with colon cancer before age 60, or two first degree relatives with colon cancer at any age **) patients ≥ 50:** Discuss and document discussion of colon cancer screening with all patients ≥ 50, and earlier with high risk patients as appropriate. Options include (1) Annual fecal occult blood testing (FOBT), (2) Sigmoidoscopy every 5 years, (3) Annual FOBT **and** every 5 year Sigmoidoscopy. USPSTF 2006 (A). Also, in the CCRMC system, average risk patients **≥ 55** may consider a colonoscopy every 10 years.
Prostate Cancer	**No recommendation.** Evidence insufficient that screening or treatment benefits men with prostate cancer. Discuss and document discussion of prostate cancer screening with men 50 years of age or older, and earlier with high risk patients as appropriate. USPSTF 2002 (I).
Cholesterol	**Men: age ≥35, Women: ≥45:** Screen cholesterol. USPSTF 2006 (A). **High Risk Men ages 20-34; High Risk Women ages 20-44:** Screen cholesterol. USPSTF 2006 (B).

	Screening interval depends on Coronary Heart Disease (CHD) Risk. The National Cholesterol Education Program (NCEP) defines CHD Risk equivalent patients as those with the following conditions: • Clinical CHD • Abdominal aortic aneurysm • Diabetes • Symptomatic carotid artery disease • Peripheral arterial disease Calculate CHD Risk based on Framingham tables in all other patients with 2+ of the following Major Risk Factors: • Cigarette smoking • Hypertension (BP 140/90 mmHg or on antihypertensive medication) • Family history of premature CHD (CHD in male first degree relative <55 years; CHD in female first degree relative <65 years) • Age (men 45 years; women 55 years) • Low HDL cholesterol (<40 mg/dl)* * HDL cholesterol 60 mg/dL counts as a "negative" risk factor; its presence removes one risk factor from the total count. Screen High risk every ≤ 1 year, Moderate risk q 2 years, Low risk q 5 years. NCEP 2002 (expert opinion).
Chlamydia	**All sexually active women age ≤25:** Screen for Chlamydia. Use urine testing if the patient is not scheduled for pelvic examination. USPSTF 2006 (A), CDC - STD 2006.
HIV	**High risk for HIV infection:** Screen annually. USPSTF 2006 (A). **All prenatal patients:** Screen at entry to prenatal care. USPSTF 2006 (A). **Normal risk adults:** CDC 2006 recommends and CCHP/CCRMC prefers offering HIV screening for all patients ≥ 13 in all health-care settings, regardless of risk. NOTE: USPSTF 2007 (C) neither recommends for nor against screening normal risk adults.
Osteoporosis	**All women aged ≥ 65 and high risk women starting at age 60:** Screen using DEXA or bone densitometry testing. USPSTF 2006 (B).
COUNSELING	
Alcohol Use	**All Adults:** Screen and offer behavioral counseling interventions to reduce alcohol misuse. USPSTF 2006 (B).
Tobacco Use	**All Adults:** Screen all adults and provide tobacco cessation interventions, especially for pregnant women. Document Tobacco use status. Counsel current and recent tobacco users periodically about quitting. USPSTF 2006 (A).
Aspirin	**Men ≥ age 40 years, postmenopausal women, and all with increased coronary heart disease risk (see Cholesterol section):** Discuss aspirin chemoprevention. USPSTF 2006 (A).
IMMUNZATIONS	
Human Papilloma Virus (HPV)	**Females age 11 to 26:** Offer to those who have not been previously vaccinated or who have not completed the full series. CDC/ACIP 2006 (expert opinion).
Influenza	**All adults 50 and older, all prenatal patients, and those at high risk:** Offer Influenza (Flu) shots annually. CDC/ACIP 2006 (expert opinion).
Measles, Mumps, Rubella (MMR)	**All persons born after 1956 who lack evidence of immunity:** Offer MMR vaccine. CDC/ACIP 2006 (expert opinion).
Pneumonia (Pneumovax)	**All adults 65 and older, and to all adults at increased risk for pneumococcal disease:** Offer 23 valent Pneumovax. CDC/ACIP 2006 (expert opinion).
Tetanus – Diphtheria (Td) or Tetanus – Diphtheria – acellular Pertussis (Tdap=Adacel)	**All Adults:** Complete series of Tetanus toxoids (Td) for adults who have not received the primary series. Give tetanus boosters every 10 years or once at age 50. **Adults ages 11-64 who have received a primary series:** Offer a SINGLE one-time dose of Tdap (ADACEL) to substitute for one of the Td boosters. **NOTE:** Td should be used rather than Tdap if Tdap is not available, and for: - Anybody who has already gotten Tdap, - Adults 65 years of age and older CDC/ACIP 2006 (expert opinion).
Shingles (Zostavax)	**All adults 60 and over:** Offer single dose. ACIP 2006 (expert opinion). Final CDC recommendations expected in 2007.

The U.S. Preventive Services Task Force Ratings (USPSTF)

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms). Contra Costa Health Plan and the Contra Costa Regional Medical Center generally recommend interventions with category A or B level evidence.
A.— The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. *The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.*
B.— The USPSTF recommends that clinicians provide [the service] to eligible patients. *The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.*
C.— The USPSTF makes no recommendation for or against routine provision of [the service]. *The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.*
D.— The USPSTF recommends against routinely providing [the service] to asymptomatic patients. *The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.*
I.— The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. *Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.*

REFERENCE INTERNET CITATIONS

- U.S. Preventive Services Task Force Ratings: Strength of Recommendations and Quality of Evidence. *Guide to Clinical Preventive Services,* 2006. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/pocketgd.htm

- National Institutes of Health. National Heart, Lung, and Blood Institute. National Cholesterol Education Program. Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). 2002. http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3_rpt.htm

- Centers for Disease Control and Prevention. 2006 Sexually Transmitted Disease Treatment Guidelines. http://www.cdc.gov/std/treatment/2006/toc.htm

- Centers for Disease Control and Prevention. Advisory Committee on Immunization Practices (ACIP). Recommended Adult Immunization Schedule 2006-2007. http://www.cdc.gov/nip/recs/adult-schedule.htm

- "Staying Healthy" Assessment Resources. State of California, Department of Health Services, Office of Clinical Preventive Medicine. http://www.dhs.ca.gov/ps/ocpm/html/staying%20healthy.htm

ADULT PREVENTION GUIDELINES GROUP

The Prevention Guidelines for Adults Group consisted of CCRMC primary providers and CCHP medical consultants. The guideline was sent out in draft form to all CCRMC and CPN primary providers and reviewed by specialists at CCRMC's Ambulatory Policy Committee in June and July 2007 for comment and correction.

Participants included: Jan Diamond MD, Troy Kaji MD, and John Lee MD.
Reviewers included: Roger Barrow MD, Judy Bliss MD, Kate Colwell MD, Diane Dooley MD, Chris Farnitano MD, Patricia Glatt MD, Erika Jenssen MPH, Laura Miller FNP, and Sonia Sutherland MD.