IDAHO PREVENTIVE CARE RECOMMENDATIONS ADULT- AGES 19 AND ABOVE

SCREENING TESTS

CONTENTS:

FAMILY HISTORY

Take a careful family history for cardiovascular risk factors such as hypertension, hyperlipidemia, heart disease, diabetes, obesity or exposure to second hand smoke. Other areas of family history to address include cancer, asthma, and mental illness, etc.

BLOOD PRESSURE

Measure blood pressure at each office visit. Blood pressure should be measured yearly for adults with Normal Blood Pressure (<120/80 mm Hg).

When measuring blood pressure, follow Intermountain's clinical staff education document, Obtaining an Accurate Blood Pressure Measurement. (This document can only be accessed within the Intermountain firewall). When measuring in-office blood pressure, use a recently calibrated aneroid sphygmomanometer. Wait at least 30 minutes after patient eats a heavy meal, ingests caffeine, alcohol or nicotine, or engages in heavy exercise before measuring blood pressure. Have patient empty his or her bladder if needed and allow the patient 3 to 5 minutes of rest before obtaining the measurement. Patient's legs should be uncrossed and their feet flat on the floor with their back

supported. Perform an average of 2 readings, at least 2 minutes apart. Confirm elevated readings in contralateral arm.

To categorize blood pressure, use average based on ≥2 readings obtained on ≥2 occasions. Out of office and self-monitoring (ambulatory or home monitoring) of BP measurements are recommended confirm the diagnosis of hypertension, for the titration of blood pressure lowering medications and to identify those with white coat hypertension.

Blood Pressure Categories
Normal BP: <120/<80 mm Hg
Elevated BP: 120-129/<80 mm Hg
Hypertension stage 1: 130-139 mm Hg systolic OR 80-89 mm Hg diastolic
Hypertension stage 2: ≥140 mm Hg systolic OR ≥90 mm Hg diastolic
Hypertensive crisis: Systolic over 180 mm Hg and/or diastolic over 120 mm Hg

Blood pressure goals with treatment are systolic <130 mm Hg and diastolic <80 mm Hg for most people, but the initiation and type of pharmacologic therapies varies depends on age, cardiovascular risk, underlying conditions, and primary vs. secondary prevention.

Lifestyle change is the recommended first line treatment for all instances where blood pressure is not normal. It is the primary treatment for Elevated Blood Pressure. Patients treated to goal with lifestyle changes (weight loss, hearth healthy diet, sodium reduction, potassium supplementation preferably through diet, increased physical activity, and abstinence or moderate use of alcohol) should be re-evaluated every three to six months. Patients on medication should be evaluated every four weeks until their blood pressure is at goal, and then can be evaluated every three to six months.

Refer to Intermountain's Management of High Blood Pressure Care Process Model and accompanying Fact Sheets.

CHOLESTEROL

Refer to the Intermountain Healthcare Cardiovascular Risk and Cholesterol Management CPM.

Heart healthy lifestyle habits are the foundation for atherosclerotic vascular disease (ASCVD) prevention; including 150 minutes per week of moderate to vigorous physical activity; following the principles of the Mediterranean and DASH diets; maintaining a healthy weight; and avoiding tobacco use and second-hand tobacco exposure.

Starting at age 20 years, screen with a full lipoprotein profile (including total cholesterol, LDL cholesterol, HDL cholesterol and triglycerides – fasting preferred) every 5 years.

For individuals ages 40 to 75 years, estimate 10-year ASCVD risk every 5 years using Pooled Cohort Risk Equation.

Statin therapy recommended for adults with

- Clinical ASCVD (high-intensity statin: age <75 years, moderate-intensity statin: age >75 years)
- LDL-C > 190 mg/dL (high-intensity statin)

- Diabetes (high-intensity statin if 10-y ASCVD risk >7.5% and age 40 to 75 years of age, otherwise moderate-intensity statin)

Consider statin therapy in individuals with

- 7.5% estimated 10-year risk of ASCVD (moderate-intensity statin or high-intensity statin in those with higher percentage of risk and/or additional risk factors)
- 5-7.5% estimated 10-years risk of ASCVD (moderate-intensity statin)

In selected individuals age <40 years, age >75 years, or individuals ages 40 to 75 years who have a 10-year ASCVD risk <5%, additional factors may be considered to inform decision making on potential statin therapy treatment. Additional factors include:

- Primary LDL-C > 160 mg/dL
- Family history of premature ASCVD
- Elevated Lifetime ASCVD risk, > 40%, calculated using Pooled Cohort Risk Equation
- Coronary Artery Calcium (CAC) score > 300 Agatson units or > 90th percentile for age and gender
- Ankle Brachial Index (ABI) < 0.9 or
- hs-CRP > 2.1 mg/L
- CKD stages 3 or 4

Prior to initiating statin therapy, the clinician and patient should have a shared decision making discussion, weighing the potential benefits of ASCVD risk reduction with the potential harms of adverse effects such as muscle aches or concerns about memory loss and drug-drug interactions. Patient preferences should be considered in determining initiation of statin therapy.

Prior to initiating therapy, the clinician and patient should have a discussion about healthy lifestyle, physical activity, and managing other risk factors such as blood pressure, diabetes, and abdominal obesity. Consider referral to dietitian for nutritional counseling.

Prior to initiating therapy, evaluate individual for secondary causes of dyslipidemia which include: diabetes, hypothyroidism, obstructive liver disease, chronic renal failure, or drugs that increase LDL cholesterol and decrease HDL cholesterol (progestins, anabolic steroids, and corticosteroids).

ABDOMINAL AORTIC ANEURISM (AAA)

A one-time abdominal ultrasound to check for the presence of an AAA is advised in all men ages 65 to 75 years of age who have ever smoked.

ELECTROCARDIOGRAPHY (ECG)

Electrocardiography is not recommended as a screen for cardiovascular disease risk in the general population, and evidence is not sufficient to recommend ECG for screening for atrial fibrillation in the general population.

OTHER CARDIOVASCULAR RISK TESTS

There are several cardiovascular risk tests that are not appropriate to be used as screening exams for the general adult population, but are to be used for symptomatic individuals, or to refine treatment decisions for those already identified at risk.

Carotid Ultrasound as a screen for asymptomatic carotid artery stenosis is not recommended in the general adult population.

Ankle-brachial index (ABI) to test for peripheral arterial disease or cardiovascular disease, coronary artery calcification (CAC) score, or hs-CRP do not have sufficient evidence to recommend as screening tests for the general adult population, although these tests may be used to advise certain patients in the shared decision process for determining statin therapy – see Cholesterol section.

Other non-traditional risk factor screens include carotid intima-media thickness, homocysteine level, and lipoprotein(a) level, and are not recommended for the general adult population.

ACTIVITY AND SEDENTARY BEHAVIOR

Assess self-reported physical activity of moderate or vigorous intensity as a vital sign (PAVs) with each visit, recording days per week and minutes per day of physical activity.

Assess hours per day of screen time or sitting.

BODY MEASUREMENT: HEIGHT, WEIGHT, BODY MASS INDEX (BMI), WAIST CIRCUMFERENCE

Practitioners should assess BMI (Weight in kg/Height in m^2) yearly to identify overweight and obesity.

The same BMI cut-offs can be used to classify the level of overweight and obesity for adult men, and adult non-pregnant women in generally all racial/ethnic groups.

For individuals with a BMI less than 34.9, Weight Circumference can be measured as an independent, additional risk factor. High risk is >40 inches for men, and >35 inches for women.

The Intermountain Healthcare Lifestyle and Weight Management Care Process Model provides guidance on the body measurement, risk assessment, and provides a treatment plan for individuals identified as overweight or obese. Patients with weight concerns should be assessed for comorbidities, possible contributory conditions and medications. Assessments of contributing factors such as obstructive sleep apnea using STOP-BANG risk factors and measurements of neck circumference, eating disorders using a modified ESP screen, or depression using PHQ-2 (the first 2 questions of the PHQ-9) should be considered. Intermountain's Lifestyle and Health Risk Questionnaire provides added insight into patient behaviors which contribute to obesity.

LIFESTYLE

Assess lifestyle behaviors such as eating habits, sleep, stress and social support which put patients at higher risk for disease using Intermountain's Lifestyle and Health Risk Questionnaire.

SLEEP

Assess hours of daily sleep.

Use "STOP-BANG" risk factors to identify patient at risk of obstructive sleep apnea. Refer patients with three or more STOP-BANG risk factors to a sleep specialist for consultation.

S – Snore loudly, T – Tiredness/fatigue, O – Observed apnea, P – Pressure/treated for high blood pressure, B – BMI≥ 35, A-Age over 50 years, N- Neck circumference greater than 15 ¾ inches (40 cm), G – Gender is male.

The American Academy of Sleep Medicine recommends screening those at risk of obstructive sleep apnea including those with obesity, congestive heart failure, a fib, treatment resistant hypertension, diabetes and stroke.

COLORECTAL CANCER

All average risk adults, ages 50 and older should be screened by one of several options on a regular basis. Screening should begin at age 45 years for African Americans.

The most effective screening modalities include:

- Colonoscopy – Every 10 years (preferred)
- Fecal immunochemical test for blood (FIT) – Annually
- FIT-DNA (Cologuard®) – Every 3 years (This is not a cost-effective strategy – see note below)*

Other options for screening include

- Sigmoidoscopy – Every 5 years
- High sensitivity fecal occult blood test (FOBT) – Annually

Clinicians should discuss the benefits and potential harms of each screening option before selecting one.

When patients have been screened with colonoscopy, further screening tests (such as annual FIT or FOBT) should not be performed on asymptomatic patients during the 10 year interval until the next colonoscopy or other colon cancer screen would be indicated.

If 1st degree relative is diagnosed with colon cancer at age <50 years, begin screening at age 40 years or 10 years prior to the age at diagnosis and screen every 3 to 5 years.

If 1st degree relative is diagnosed with colon cancer between ages 50 to 60 years, begin screening at age 40 years and screen every 5 years.

If 1st degree relative is diagnosed with colon cancer at age 60 years and older, begin screening at age 50 years and screen every 5 years.

Discontinuing screening is reasonable in patients at age 75 years, or whose age or comorbid conditions limit life expectancy.

Screening should not be performed in patients older than 85 years.

*Note: While FIT-DNA (Cologuard®) is covered by Medicare and Medicaid and by SelectHealth commercial plans in persons ages 50 to 85 years, it is not covered by many other commercial plans. FIT-DNA performed every three years is a more costly strategy than colonoscopy performed every 10 years when conducted outside of CMS discounted pricing.

BREAST CANCER (WOMEN)

Instruct patients to be aware of changes in breast and notify clinician of those changes.

Perform clinical breast exam every 1-3 years for women ages 19-39, annually for ages 40 and older

Screening mammography should be performed annually for women ages 40 and above. High-risk women with a family history of premenopausally diagnosed breast cancer in a first-degree relative should start regular screening mammography at an earlier age

Discontinuing screening is reasonable in patients whose age or comorbid conditions limit their life expectancy to 10 years or less.

Counsel patients prior to mammography about potential for and implications of false positive results

While the USPSTF reports that evidence is insufficient to recommend 3-D tomography, it may be considered when there is a strong family history or personal history of breast cancer, or for patients with dense breast tissue when covered by insurance.

For women ages 50 years or older, women with an estimated 5-year breast cancer risk of 3% or greater are likely to have more benefit than harm from using raloxifene (approved for post-menopausal women) or tamoxifen (approved for women age $\geq$ 35 years) for breast cancer risk reduction. These medications can increase the risk of other conditions (e.g thromboembolic events or endometrial cancer), and clinicians should disclose the possible harms and benefits in a shared decision process with their patients.

Use the National Cancer Institute (NCI) Breast Cancer Risk Assessment Tool to evaluate 5-year risk of breast cancer.

Due to increase risk with these medications, women should be assessed for risk of venous thromboembolic events. Due to the risk for tamoxifen-related endometrial cancer, women with a

uterus should have a baseline gynecologic examination prior to starting tamoxifen, with regular follow-up after the end of treatment.

Women whose family history is not associated with an increased risk for deleterious mutations in breast cancer susceptibility gene 1 (BRCA1) or breast cancer susceptibility gene 2 (BRCA2) should not be offered routine BRCA testing.

Women whose family history is associated with a HIGH RISK for BRCA1 or BRCA2 mutations should be referred for genetic counseling prior to testing.

Women at high risk (BRCA1, BRCA2 positive or 1st degree relative with breast or ovarian cancer) and high breast density may benefit from supplemental screening with a modality such as MRI or ultrasound.

CERVICAL/VULVAR CANCER (WOMEN)

First cervical cancer screening should begin at age 21. For women ages 21-29 years, cervical cytology screening is recommended every 3 years.

In women less than 30 years of age, HPV-DNA testing is only indicated with a cytology result of ASCUS (abnormal, but of undetermined significance).

For women age 30 years and above, cervical cytology screening is recommended every 3 years when not tested in combination with HPV-DNA test. The screening interval may be extended to every 5 years if both cytology and HPV-DNA testing are performed (preferred), and if HPV-DNA testing is performed alone.

Continue to provide cervical cancer screening with Pap and/or HPV DNA testing in women who have been vaccinated with the HPV vaccine.

Women of any age who are immunocompromised, are infected with HIV or were exposed in utero to DES should be screened annually.

Periodic, routine Pap is not indicated for women who have undergone hysterectomy (including removal of the cervix) for benign gynecologic disease, but pelvic exam should continue

Women who have undergone a hysterectomy, but who have a history of abnormal cell growth (classified as CIN 2 or 3) should be screened annually until they have three consecutive, negative vaginal cytology tests; then they may discontinue routine screening

Women 65 years of age or older who have had 3 or more normal Pap tests in a row and no abnormal Pap tests in the last 10 years may choose to stop having cervical cancer screening. Women with a history of cervical cancer, DES exposure before birth, HIV infection or a weakened immune system should continue to have screening as long as they are in good health.

In the absence of Pap testing, there is inadequate evidence on the benefits of screening for gynecologic conditions in asymptomatic women with pelvic examination.

OVARIAN CANCER (WOMEN)

Clinicians should be aware of possible signs and symptoms associated with ovarian cancer such as complaints of persistent pelvic/abdominal pain, increased abdominal size/bloating, difficulty eating/feeling full, or urinary urgency/frequency present multiple days per month.

The USPSTF recommends against routine laboratory or imaging testing to screen for ovarian cancer.

PROSTATE CANCER (MEN)

Expert groups disagree on the issue for or against Prostate Specific Antigen (PSA) testing mainly due to analyses weighted more toward the benefits by some groups and toward the harms by others. Due to the level of expert disagreement, a joint decision process between the patient and the clinician is recommended.

A synthesis of the various expert group recommendations is provided here, but Intermountain **does not endorse one recommendation** over the others.

The USPSTF recommends against prostate cancer screening in the general male population due to lack of evidence of decrease in mortality in the PLCO and ERSPC trials. Other groups including The Intermountain Urological Institute conclude that using risk stratification provides a more targeted approach with better outcomes.

The Intermountain Urological Institute has developed prostate cancer guidelines for men as follows:

Prostate cancer screening

1. Obtain a baseline PSA and Digital Rectal Exam (DRE) at age 45 years.
   1.1. If the PSA is 3 ng/ml or higher, recommend biopsy.
   1.2. If the PSA is between 1 ng/ml to 3 ng/ml, repeat PSA and DRE every 2 to 4 years. (Data is insufficient to recommend a specific periodicity.)
   1.3. If the PSA is less than 1 ng/ml, repeat PSA and DRE at age 55 years.
2. At age 55 and above, PSA tests conducted at Intermountain Healthcare labs will include a risk stratification calculation in the results.
   2.1. Stratification uses age, race, 5-alpha reductase inhibitor use, DRE, and PSA level to determine risk of high-grade prostate cancer as calculated from Intermountain Healthcare guidelines based on the Prostate Cancer Prevention Trial (PCPT) results.
3. Use risk stratification to guide a joint decision making process with the patient concerning the need for biopsy or the timing of next PSA and DRE. (There are no current data on the ideal interval between screening exams after age 55 years.)

Prostate cancer prevention

1. Daily Finasteride 5mg should be recommended for all men age 55 years and above with a normal age adjusted PSA.
2. Men can reduce the risk of prostate cancer by consuming 6 servings of fruits and vegetables daily.

References

BMJ 2013 April 15:346:f2023
J Clin Oncology 2012, Jul 20:30(21):2581-2584
BMJ 2010, Sept 14:341:c4521

The National Comprehensive Cancer Network (NCCN) also advises starting PSA screening at age 45 years. The American Urological Association (AUA) and American College of Physicians (ACP) advise initiating a shared decision process around PSA screening at age 55 years, and the ACP leans more toward informing men that they are likely to be more hurt than helped by screening.

The USPSTF, AUA, ACP and NCCN all recommend stopping prostate cancer screening at age 70 years.

Note that obese men may present with prostate cancer at lower serum PSA concentrations than non-obese men.

TESTICULAR CANCER (MEN)

Young adult males should be advised to perform self-examination of the testes and scrotum on a regular basis, and to seek prompt medical attention if they notice a testicular or intrascrotal abnormality

LUNG CANCER

Screen asymptomatic adults (no signs or symptoms of lung cancer) ages 55 through 77 years who meet **all** CMS screening criteria with low-dose computed tomography (LDCT). If no nodule(s) is/are identified on LDCT, screen annually for at least 3 years or until age 77 years. The USPSTF recommends screening through 80 years of age, which would apply to those with private health insurance.

CMS Criteria for screening include:

- Tobacco smoking history of at least 30 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes)
- Current smoker or one who has quit smoking within the last 15 years
- Has undergone a shared decision making process with the clinician that includes tobacco cessation counseling. The shared decision making process must be a separately scheduled visit
- Person is able to tolerate treatment (surgery or radiation), and cannot be on home oxygen

In order to meet CMS requirements for the initial LDCT lung cancer screening service: a beneficiary must receive a written order for the LDCT lung cancer screening during a lung cancer screening counseling and shared decision making visit, furnished by a physician, physician assistant, or nurse practitioner.

The Agency for Healthcare Research and Quality (AHRQ) has created a set of decision tools to assist clinicians in complying with CMS requirements including:

- Lung Cancer Screening: A Summary Guide for Primary Care Clinicians
- Lung Cancer Screening: A Clinician's Checklist
- Is Lung Cancer Screening Right for Me? decision aid handout for patients
- Is Lung Cancer Screening Right for Me? joint decision making tool for patient and health care professional

Other patients at high risk for lung nodules, but not approved to be screened by CMS includes those age ≥ 50 years and ≥ 20 pack-year history of smoking and at least one *additional risk factor*.

Additional risk factors include:

- Documented high radon exposure
- Occupational exposure to silica, cadmium, asbestos, arsenic, beryllium, chromium, diesel fumes or nickel
- History of lung cancer, lymphoma, cancer of the head and neck, or smoking related cancer
- Family history of lung cancer
- History of COPD or pulmonary fibrosis

University of Michigan has developed a lung cancer risk calculator based on USPSTF guidelines that can be helpful in calculating whether a patient may benefit from LDCT screening, and provides simple to understand education about their risk.

SKIN CANCER

Complete skin exam if:

- Family or personal history of skin cancer
- Clinical evidence of precursor lesion (e.g. dysplastic nevi)
- Increased exposure to sunlight

Consider "ABCDs" of skin lesions present (**A**symmetry, **B**order irregularity, **C**olor variability, **D**iameter > 6 mm) or recent change. Biopsy suspicious lesions

THYROID CANCER

Screening for thyroid cancer is not recommended in asymptomatic adults.

OSTEOPOROSIS

Adults should receive counseling regarding dietary calcium, Vitamin D, weight bearing and muscle strengthening exercise, fall prevention, and avoiding tobacco and excessive alcohol use.

Check for osteoporosis risk factors in post menopausal women and men 50 and over, to determine who may need a bone test before their senior years

Treat postmenopausal women and men 50 and older who have osteopenia (T-score between -1.0 and -2.5 at the femoral neck, total hip or spine), if they have at least a 20% risk of any major fracture

in the next decade, or at least a 3% risk of a hip fracture based on the U.S.-adapted WHO algorithm. The 10 year fracture probability is the output of a webbased tool: FRAX. When entering height and weight into the tool, kilograms and centimeters are used.

Women ages 65 and older and men ages 70 and older who are willing to consider treatment should be screened periodically for osteoporosis, no more often than every 2 years.

Women and men with known fragility fracture, or with ≥ 1.5 inches in height loss with back pain, or secondary cause of osteoporosis should be screened with a Bone Mineral Density measurement.

Central DeXA is the preferred method of BMD testing and is the only test covered by SelectHealth, when indicated. When testing to evaluate changes in treatment, a follow-up DeXA is only indicated every 2 to 3 years."

The National Osteoporosis Foundation's 2010 "Clinician's Guide to Prevention and Treatment of Osteoporosis" outlines the most appropriate approach to the diagnosis and management of osteoporosis.

DIABETES

Test for diabetes and pre-diabetes every three years using fasting plasma glucose or hemoglobin A1c in adults age ≥ 45 years, or in adults with BMI > 25 and an additional risk factor, including:

- High blood pressure
- HDL cholesterol <35
- Trigylerides > 250
- Vascular disease
- Polycyctic ovary syndrome
- Gestational diabetes
- Diabetes in parent, sibling or child
- Physically inactive
- High risk ethnicity such as Native American, Latino, African American, Asian American or Pacific Islander

Refer to the Diabetes Prevention Program Care Process Model.

CELIAC DISEASE

Evidence is not sufficient to recommend screening for Celiac Disease in asymptomatic adults.

INTERPERSONAL VIOLENCE

The USPSTF and Intermountain's Interpersonal Violence team recommend that all female patients starting at age 14 years be screened for Interpersonal Violence. Refer to Intermountain's Interpersonal Violence Care Process Model.

Provide a framing statement that introduces why you are asking the patient about partner violence. Script for framing statement – "1 in 3 women in Utah experience very unhealthy relationships with an

intimate partner in their lifetime. Since this affects health (and children's health) and identifying the problem and offering resources decreases violence and improves outcomes, we ask all female patients about this issue."

Disclose to patients that certain situations require by law that you the provider make a report to the police or DCFS. Reportable situations related to relationship violence include: treatment of an injury that was caused by someone else, being threatened with a lethal weapon, or when children are experiencing or are witnessing abuse.

Screening questions and potential responses include: (written or verbal)

1. Are you in a relationship now in which you are often ***emotionally*** *hurt* by your partner such as being frequently *insulted, put down, or controlled*?
   (No, Yes, Prefer not to answer, Already addressed with my provider)
2. Are you in a relationship now in which you are ***physically*** *hurt* by your partner such as being *hit*, *shoved, slapped*, *kicked*, or *choked*?
   (No, Yes, Prefer not to answer, Already addressed with my provider)
3. Are you in a relationship now in which you are *forced* by your partner to do anything ***sexually*** that you do not want to do?
   (No, Yes, Prefer not to answer, Already addressed with my provider)
4. *[If no to all the above]* **Have you *ever*** been in a relationship with a partner who hurt you *emotionally*, *physically*, or *sexually* in any of these kinds of ways or who otherwise scared you? *(No, Yes - but has been dealt with previously, Yes – and is something I am still dealing with)*

DEPRESSION AND SUICIDE

The Intermountain Depression Care Process Model recommends that the following patients be screened for depression:

- Patients that complain of depression or answer yes to either of the two screening questions below
- Patients that look depressed or have depressive signs and symptoms (e.g. fatigue, insomnia, weight changes, etc.)
- Patients with chronic pain, multiple chronic medical conditions, high utilization, and those with multiple physical complaints

Patients should be assessed for depression with the following two questions:

1. "Are you feeling down, depressed or hopeless?" and
2. "Have you lost interest or pleasure in doing things?"

If patients screen positive, a definitive diagnosis of depression should be made with further assessment

Assessment tools, such as the Zung, Beck, or PHQ-9 can all be used to measure treatment response. The Intermountain Depression Care Process Model recommends the PHQ-9 as the primary choice due to the fact that it supplies diagnostic information, a severity measure, and is available at no charge.

Instructions concerning suicidality in the primary care setting is found in the Intermountain Suicide Prevention Care Process Model. Evaluate suicide risk using the Columbia Suicide Severity Rating Scale (C-SSRS) Quick Screen. A suicide prevention Flash Card is available.

SUBSTANCE USE

Refer to the Substance Use Disorder CPM

Routinely ask about recreational drug use, prescription drug misuse, and alcohol use (frequency, quantity)

Use the Intermountain-Modified NIDA Quick Screen at preventive visits. If positive on one or more questions, then follow SBIRT intervention (SBIRT= Screen, Brief Intervention, Referral to Treatment). Brief Intervention includes:

- Inform users of health and injury risks
- More than 2 “drinks” per day may be an indication of problem drinking (a “drink” is defined as 12 oz. Beer, a 5 oz. glass of wine, or 1.5 oz. distilled spirits)
- Counsel IV drug users on the risks of contaminated injection equipment
- Counsel patients to avoid driving when using alcohol, drugs, or medications (OTC or prescription) which impair mentation
- Develop a treatment plan

For advice on where to send patients for alcohol and drug treatment in your local area:

- SelectHealth Plan Members: 1-800-876-1989 or 801-442-1989
- Non-SelectHealth Plan Members dial the Idaho Care Line at 211 for community resources

Naloxone hydrochloride is an emergency opioid antagonist that is FDA-approved for the treatment of opioid overdose. Naloxone is NOT a controlled substance. Idaho House Bill 108 allows for friends and family members of individuals with a drug use disorder to obtain naloxone. Under Idaho’s Good Samaritan Law, individuals who administer naloxone are protected from liability if they call 911.

VISION AND GLAUCOMA

Clinicians should periodically test visual acuity in elderly patients with the Snellen visual acuity chart

Glaucoma screening should be performed periodically by a trained specialist (optometrist/ ophthalmologist) for those at high risk:

High risk includes:

- African Americans over age 40
- Individuals $\geq$ age 65 (every 2 years)
- Family history of glaucoma
- Diabetes
- Severe myopia

HEARING

Clinicians should periodically question patients over age 65 about their hearing

Otoscopic exam and audiometric testing for those with hearing impairment

TUBERCULOSIS

Tuberculin skin test for all persons at increased tuberculosis (TB) risk using Mantoux tuberculin skin test or interferon-gamma release assay (IGRA), including:

- Persons infected with HIV
- Close contacts of persons with TB
- Native Americans
- Immigrants from Africa, Asia, Latin America, and Eastern Europe
- Medically underserved low income and indigent patients
- Individuals who have lived in high risk congregate settings (homeless shelters, correctional facilities)
- Residents of long-term facilities
- Alcoholics
- Injection drug users
- Patients with medical conditions associated with TB (diabetes, end stage renal disease, rapid weight loss, immunosuppressed or steroid treatment)

Tuberculin Skin Test should be evaluated 48 to 72 hours after placement by a trained health care provider. Results should be recorded as millimeters of induration.

Further evaluation indicated for induration of 10 mm for general population, 5 mm for immunosuppressed population, or for abnormal IGRA.

CDC provides recommendations for the treatment of LTBI.

HEPATITIS B/HEPATITIS C

Screen for hepatitis B virus infection using serologic testing for hepatitis B surface antigen (HBsAg) in persons at high risk, including:

- Persons born in countries where hepatitis B is common or unvaccinated persons whose parents were born in countries where hepatitis B is common
- People with HIV
- Injection drug users
- People living with or having sex with people infected with hepatitis B
- Men having sex with men
- Immunocompromised
- Kidney failure with dialysis

Adults born during 1945 through 1965 should receive one-time testing with and FDA approved test of antibody to HCV (anti-HCV) without prior ascertainment of HCV risk.

Routine HCV testing is recommended for persons who ever injected illegal drugs, persons who receive clotting factors concentrates produced before 1987, persons who were ever on chronic (long-term) hemodialysis, persons with persistently abnormal alanine aminotransferase levels, and persons who received a blood transfusion or organ transplant prior to July 1992.

Persons who test positive for anti-HCV should receive a follow-up HCV nucleic acid test (also known as HCV RNA test).

HIV

Screen all adults ages 19 through 64 years for HIV. The interval for further screening after the initial test should be determined by the provider based on assessed risk of the patient.

Individuals at high risk for HIV should be screened annually, including:

- Patients initiating treatment for TB
- Patients seeking treatment for STDs
- Injection-drug users and their sex partners
- Men having Sex with Men (MSM)
- Patients with multiple sex partners
- Patients who are foreign born

A separate consent form for HIV screening is not recommended.

SEXUALLY TRANSMITTED INFECTIONS

A questionnaire to assess a sexual health history on patients for family planning, contraception evaluation, or sexually transmitted disease risk is available at:

- Sexual Health History Form – Women
- Sexual Health History Form – Men

(These forms are adapted from the Planned Parenthood Association of Utah Health History Form)

Screen annually for chlamydia and gonorrhea in the following populations:

- All women ages 19-24
- All high risk women ages 25 and older (high risk are those having more than one sexual partner, having a sexually-transmitted disease in the past, not using condoms consistently and correctly)
- All patients with HIV, male and female

All women with chlamydia should be re-screened 3-4 months after treatment is completed.

Screen for syphilis in men having sex with men and persons living with HIV. Detection is improved when screening is performed every three months.

Serologic testing for genital herpes simplex virus infection is not recommended in asymptomatic adults.