14th Annual Report To Congress

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High-Priority Evidence Gaps Across the Lifespan, in All Communities

Commemorating 40 Years of Making Evidence-Based Recommendations for Preventive Services

SUBMITTED BY:

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ON BEHALF OF THE U.S. PREVENTIVE SERVICES TASK FORCE

U.S. Preventive Services TASK FORCE 40 YEARS OF IMPROVING HEALTH

EXECUTIVE SUMMARY

The U.S. Preventive Services Task Force (USPSTF or Task Force) is an independent, volunteer panel of national experts in prevention, primary care, and evidence-based medicine. This year, the USPSTF celebrates 40 years of making evidence-based recommendations about clinical preventive services that can be delivered or referred from primary care to improve the health of people nationwide. The Task Force assesses the strength of the evidence and the balance of benefits and harms of preventive services in people without signs or symptoms. These services include behavioral counseling, screening tests, and preventive medications.

In 2010, the U.S. Congress charged the Task Force with recommending priority gaps in research that deserve further examination. In some cases, clinical preventive services have been well studied, but there are important evidence gaps that prevent the USPSTF from making recommendations for specific populations. The Task Force recognizes that disparities persist in healthcare and health outcomes based on age, sex, race and ethnicity, sexual orientation, gender, geographical location, and social determinants of health, including economic and social conditions. Filling evidence gaps in health care and health outcomes for specific populations is a priority. Identifying these gaps to facilitate greater inclusion of populations disproportionately affected by health conditions in research will help the USPSTF issue recommendations that improve the quality of preventive care. In turn, this will reduce health disparities and increase health equity by leading to improved access to and use of these preventive services. This will help all people across the nation get the preventive care that they need throughout their lifespan.

In this 14th Annual Report to Congress, the Task Force calls for more research in high-priority areas from recent recommendations where evidence is lacking in order to improve the health of all people across the lifespan. These issues are especially important to study in underserved populations and high-risk groups.

40 Years of Making Evidence-Based Recommendations

Over the past 40 years, the Task Force has produced close to 300 evidence-based recommendations, helping people of all ages do what matters most: stay healthy and live well for years to come. Task Force recommendations empower patients and their clinicians to make informed choices based on what works and what doesn't work in preventive care.

In recent years, some of the Task Force's most impactful recommendations include:

- **Lung cancer:** New screening recommendations in 2021 that expanded the age range and pack-year eligibility criteria for annual screening, making more people eligible for a life-saving screening
- **Anxiety:** New screening recommendations for children, adolescents, and adults in 2022 and 2023 that reflected our growing understanding of mental health conditions and the need to identify and care for them
- **Breast and colorectal cancer:** Updated recommendations in 2024 and 2021 that lower the age to start screening due in part to the increased incidence in younger age groups
- **Aspirin use to prevent cardiovascular disease:** Updated recommendation in 2022 that highlighted our growing knowledge about potential harms and the need to shift the standard of care accordingly
- **PrEP for HIV prevention:** Updated recommendation in 2023 that reflected timely data around new forms of pre-exposure prophylaxis to help prevent HIV
- **Behavioral counseling interventions for healthy weight and weight gain in pregnancy:** New counseling recommendation in 2021 that identified effective behavioral counseling interventions that promote healthy weight gain in pregnancy

Where More Research Is Needed for Health Promotion Across the Lifespan

In this report, the USPSTF calls attention to high-priority research gaps from the past year that, if filled, have the potential to promote health across the lifespan, in all communities. The Task Force has a long-standing commitment to and specific methods for evaluating the evidence for clinical preventive services and making recommendations that promote health and prevent chronic conditions from infancy through adulthood. Although chronic health conditions may affect anyone, some groups of people are at higher risk because of their gender, race, ethnicity, income, geographic location, sex assigned at birth, or other factors. The Task Force hopes to improve health equity by highlighting high-priority evidence gaps across the lifespan, in all communities.

Empowering people through recommendations that cover a variety of preventive services such as screenings, behavioral counseling, and preventive medications can be a way to increase the lifespan for all people nationwide. Preventive services combined with a healthy lifestyle can substantially reduce the risk of diseases, disabilities, and death.[1,2]

Future research in the following areas is needed to help fill gaps and may result in new recommendations that will help improve the health of people nationwide:

- **Prevention of Child Maltreatment: Primary Care Interventions**
- **Speech and Language Delay and Disorders in Children: Screening**
- **High Body Mass Index in Children and Adolescents: Interventions**
- **Oral Health in Children, Adolescents, and Adults: Screening and Preventive Interventions**
- **Iron Deficiency and Iron Deficiency Anemia During Pregnancy: Screening and Supplementation**
- **Breast Cancer: Screening**
- **Falls Prevention in Community-Dwelling Older Adults: Interventions**

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"The American College of Preventive Medicine is dedicated to promoting the importance of preventive medicine. The USPSTF helps to achieve this by providing evidence-based guidance on how to prevent disease and promote good health. We applaud the USPSTF for focusing this year's report on the high-priority research gaps related to promoting health across the lifespan and in all communities. We hope that future research addresses these gaps to help further our efforts to advance the health and well-being of all people and communities."

Melissa Ferrari, CAE
Interim CEO
American College of Preventive Medicine

INTRODUCTION

The U.S. Preventive Services Task Force (USPSTF or Task Force) is an independent, volunteer group of national experts in prevention, primary care, and evidence-based medicine. For 40 years, the Task Force has made evidence-based recommendations about clinical preventive services that can be delivered or referred from primary care to improve the health of people nationwide (e.g., by improving quality of life and prolonging life). These recommendations include screening tests, behavioral counseling, and preventive medications.

The mission of the USPSTF is to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services.

The purpose of this report is to update Congress and the research community about high-priority evidence gaps in clinical preventive services identified by the Task Force in the past year that, if filled, have the potential to promote health across the lifespan, in all communities.

BACKGROUND

Clinical preventive services are available for many diseases and conditions, including strategies that intervene before a disease occurs (primary prevention) and detecting a disease at an early stage (secondary prevention) for early intervention and treatment.[3,4] These clinical preventive services have tremendous value in improving health throughout the lifespan.

The Task Force makes recommendations to help primary care clinicians, patients, and families decide together whether a particular preventive service is right for an individual's needs. Task Force recommendations:

- Apply only to people without recognized signs or symptoms of the disease or health condition
- Focus on counseling, screening, or medications to prevent the onset of disease or identify disease early when it is more treatable
- Address services offered in the primary care setting or services to which patients can be referred by primary care professionals

Since 1998, the Agency for Healthcare Research and Quality (AHRQ) has been authorized by Congress to convene the Task Force and to provide ongoing scientific, administrative, and dissemination support. AHRQ funds Evidence-based Practice Centers (EPCs), which are academic or research organizations that work with the Task Force to develop research plans and conduct the evidence reviews that the Task Force uses to inform its recommendations.

Who Serves on the Task Force?

The USPSTF is an independent group of national experts in prevention and evidence-based medicine who represent the diverse disciplines of primary care, including behavioral health, family medicine, geriatrics, internal medicine, nursing, obstetrics and gynecology, preventive medicine, and pediatrics. The Task Force is made up of 16 volunteer members who are appointed to serve 4-year terms, led by a chair and two vice chairs (see **Appendix A** for current members).

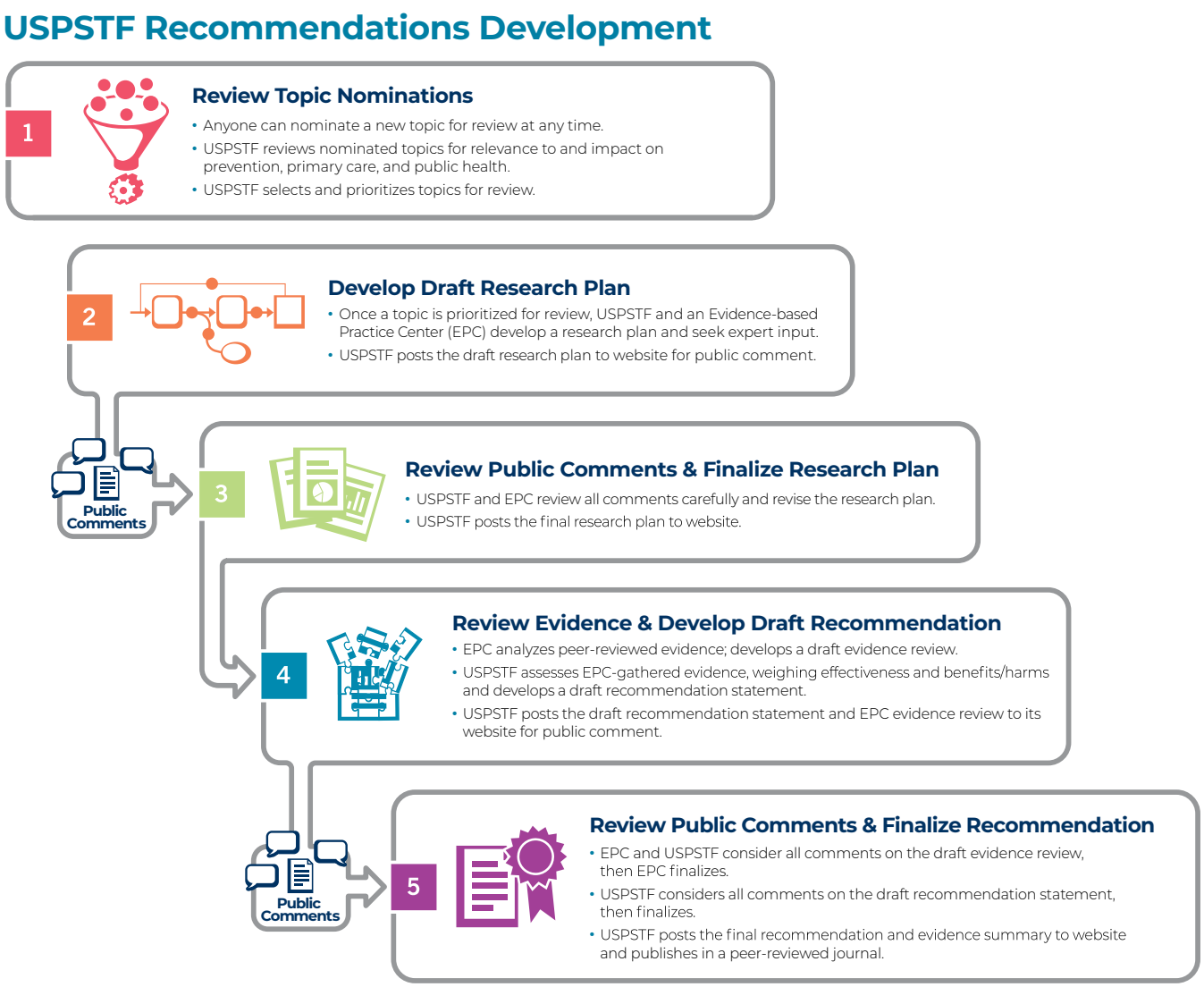
How Does the Task Force Minimize Potential Conflicts of Interest?

To ensure that USPSTF recommendations are balanced, independent, and objective, the Task Force has a long-standing and rigorous conflict of interest assessment and disclosure process.[5] The process for each member begins prior to appointment, and potential conflicts of interest are also reviewed at least three times each year.

How Does the Task Force Make Recommendations?

The Task Force's recommendations are based on a review of the best available research on the potential benefits and harms of the preventive service. The USPSTF does not conduct research studies but rather reviews and assesses published research. The Task Force follows a multistep process when developing each of its recommendations and obtains public input throughout the recommendation development process (see **Figure 1**).

Figure 1. Steps the USPSTF Takes to Make a Recommendation



When the Task Force reviews the evidence, it considers the benefits and harms of the preventive service for the overall population, as well as for specific segments of the U.S. population that may be disproportionately affected by a condition or that may benefit differently from the preventive service.[6]

Potential benefits of preventive services may include helping people stay healthy throughout their lifetime, improving quality of life, preventing disease, and prolonging life. Potential harms may include inaccurate test results, harms from invasive followup tests, harms from treatment of a disease or condition, diagnosis of a condition that would never have caused symptoms or problems in a person's lifetime (also known as "overdiagnosis") or receiving treatment when it is not needed or may not actually improve health (also known as "overtreatment").

The Task Force assigns each of its recommendations a letter grade (A, B, C, or D) or issues an "I statement" based on the certainty of the evidence and the balance of benefits and harms of the preventive service (see **Table 1** for the Grade Definitions).

Table 1. Meaning of USPSTF Grades

Grade	Definition
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

How Does the Task Force Engage the Public, Partners, Stakeholders, and Topic Experts in Developing Recommendations?

For each topic, the USPSTF actively seeks input from the public, its partners, stakeholders, and topic experts, including medical specialists—such as radiologists, oncologists, cardiologists, surgeons, and others. This ensures a focus on important clinical prevention topics for practicing clinicians and that the evidence relevant to each recommendation is considered.[7] At each step of the recommendation development process, the USPSTF solicits and reviews input. Anyone—the public, USPSTF partners, stakeholders, and topic experts—can nominate a new topic or propose an update to an existing topic, as well as submit comments on all Task Force draft materials (research plans, evidence reviews, and recommendation statements).

- **The Public.** All draft materials are posted on the Task Force website for a 4-week public comment period. The Task Force reviews and considers all comments as it finalizes the materials. Any organizations or individuals interested in being informed of Task Force activities can subscribe to the U.S. Preventive Services Task Force email list to receive announcements on opportunities to provide public comment on draft materials, notifications of when final materials are posted or published, and information about other Task Force activities.
- **Partners.** The Task Force works with national organizations that represent primary care clinicians (including organizations that represent specific populations working to advance health equity), consumers, and other primary care stakeholders and health-related Federal agencies. These organizations and agencies provide input on the recommendations as they are being developed and help the Task Force disseminate the final recommendations (see **Appendices B** and **C** for a list of partners).
- **Stakeholders.** The Task Force identifies relevant stakeholder groups for each topic and contacts their leadership, inviting them to comment on the drafts during the public comment periods. Stakeholder groups include national primary care, specialty, patient, advocacy, and other organizations with expertise and interest in a specific topic.
- **Topic experts.** The Task Force seeks input from different types of topic experts, including medical specialists such as radiologists, oncologists, cardiologists, and surgeons. In addition, the EPC team that conducts the evidence reviews for each topic always includes content experts who work with the EPC during the systematic evidence review. Expert reviewers provide input on the evidence supporting the draft recommendation statement.

Where Can I Find More Information About the Task Force?

The Task Force website (www.uspreventiveservicestaskforce.org) contains more information about the Task Force and its methods for developing recommendations, including engaging with experts, partners, and the public. More details are available on the "Task Force at a Glance" and "Methods and Processes" pages.

"We believe all infants, children, adolescents, and young adults deserve equitable, high-quality pediatric healthcare. When the USPSTF issues pediatric-focused recommendations, it directly impacts our ability to provide the highest quality care to children. The National Association of Pediatric Nurse Practitioners highly values how the Task Force outlines critical gaps in research for preventing disease and improving child health outcomes. Addressing important gaps in the evidence will allow the USPSTF to continue to develop evidence-based recommendations that help our members provide the best care to our Nation's youth."

Daniel Crawford, DNP, ARNP, CPNP-PC, CNE, FAANP
President
National Association of Pediatric Nurse Practitioners

CLINICAL PREVENTIVE SERVICES WHERE MORE RESEARCH IS NEEDED: PROMOTING HEALTH ACROSS THE LIFESPAN, IN ALL COMMUNITIES

The USPSTF was established in 1984 to systematically review the scientific evidence for clinical preventive services and make recommendations for primary care clinicians. To fulfill its mission to improve health by making evidence-based recommendations for preventive services, the USPSTF routinely highlights the most critical evidence gaps for making actionable preventive services recommendations. This includes calling attention to areas where evidence is lacking for populations that are disproportionately affected by health conditions.

There are two ways that the USPSTF highlights evidence gaps in its recommendation statements:

- **Issuing an "I statement."** The USPSTF issues an "I statement" when the current evidence is lacking, of poor quality, or conflicting. When the evidence is insufficient, the USPSTF is unable to assess the balance of benefits and harms of the preventive service.
- **Describing the "Research Needs and Gaps."** In all recommendation statements, the USPSTF points out where gaps in the evidence remain in a section called "Research Needs and Gaps."

In 2023, the USPSTF updated the "Research Needs and Gaps" section to better summarize key bodies of evidence needed to make a recommendation. The **Evidence Gaps Research Taxonomy Table** provides guidance to researchers and funders on the types of studies needed to expand the evidence to enable the USPSTF to make an evidence-based recommendation in the primary care setting and be inclusive of populations disproportionately affected. Studies addressing these gaps should do the following:

- Examine preventive services conducted in the **primary care setting** or that are referable from primary care
- Compare outcomes for people **who do and do not receive the preventive service**
- Include populations **without recognized signs or symptoms** of the condition
- Adopt a **rigorous study design** appropriate for the question, such as a randomized, controlled trial or a high-quality observational study
- Be **free of potential sources of bias**, such as high dropout rates among participants, biased assessment of outcomes, or heterogeneity in outcome measures

To develop recommendations that improve the health of people nationwide, the USPSTF needs high-quality evidence about the benefits and harms of the preventive service and about the ways specific population groups are affected. For some preventive services and for certain populations, lack of scientific evidence limits the ability of the Task Force to make recommendations. This is because particular populations are frequently not well represented in health research. Some examples include:

- Specific age groups, including children, adolescents, and older adults
- Racial and ethnic groups historically underrepresented in research and disproportionately affected by health conditions, such as Black, Hispanic/Latino, Indigenous American, and Asian American people
- People who are lesbian, gay, bisexual, transgender, queer (LGBTQ+)
- Individuals disproportionately affected by genetic, environmental, and social risk factors, such as financial strain or lack of access to affordable care

The Task Force is prioritizing topics that are likely to advance health equity and is calling for more research for some preventive services where the lack of scientific evidence limits its ability to make recommendations. In turn, this can help inform future recommendations, improve access to and use of preventive services, reduce disparities in healthcare, and increase health equity.

Focusing on Promoting Health Across the Lifespan, in All Communities

For this 2024 report, the USPSTF commemorates 40 years of making evidence-based recommendations about preventive services and calls attention to high-priority research gaps in the past year, with a continued focus on promoting the health of people nationwide, across the lifespan, in all communities.

Preventive services are critical for maintaining optimal health and well-being throughout the lifespan. Preventive services, such as screenings, preventive medicines, and counseling, facilitate the prevention or early detection of health issues. Early detection can lead to early intervention and better treatment outcomes, often preventing the progression of diseases and reducing the risk of disease complications.[8,9] Combining these types of preventive services with a healthy lifestyle can substantially reduce the risk for diseases, disabilities, and death.[8,9]

For 40 years, the Task Force recommendations have played a crucial role in promoting health and healthy behaviors across the lifespan. Each encounter with a patient and/or caregiver provides an opportunity for healthcare professionals to engage in a health promotion discussion, helping to assess needs, preferences, and readiness for change and recommending appropriate preventive care services. In the past year, the Task Force has called attention to high-priority research gaps related to promoting health across the lifespan, in all communities (**Table 2**).

Table 2. Key Research Gaps for Clinical Preventive Services From the Past Year—Promoting Health Across the Lifespan, in All Communities

USPSTF Recommendation	Gaps Where Research Is Needed
Primary Care Interventions to Prevent Child Maltreatment	Studies are needed that provide more information to: • Help primary care clinicians accurately identify families who might benefit from supportive interventions that may prevent child maltreatment. • Determine if accuracy of risk assessment tools differs by social factors and race and ethnicity. • Understand the optimal frequency of risk assessment considering chronicity, duration, intermittency, and severity of maltreatment. • Evaluate the effectiveness of primary care–feasible or referable preventive interventions designed to reduce exposure to maltreatment, including neglect. • Determine whether intervention effectiveness or child maltreatment reporting differs by social factors and race and ethnicity. • Evaluate the effectiveness of interventions using more accurate outcome measures that limit bias (e.g., surveillance). • Consistently provide outcome measure definitions, outcome types, and outcome timing across studies. • Identify the most effective ways to prevent child maltreatment (using more accurate outcome measures), including interventions that address the social determinants of health that can negatively affect families. • Determine whether there are unintended harms from risk assessment (e.g., stigma or legal risks related to Child Protective Services) and engagement in preventive interventions (e.g., risk of biased reporting for maltreatment). • Understand whether potential harms differ in children by social factors and race and ethnicity.

USPSTF Recommendation	Gaps Where Research Is Needed
Screening for Speech and Language Delay and Disorders in Children	Studies are needed that provide more information on: • Treatment of screen-detected populations that follow children over short and longer (>1 year) durations to detect improvement in outcomes such as academic performance, social and emotional health, or child and family well-being. These studies should focus on enrolling children from groups with the greatest burden of speech and language delay and disorders (Black and Hispanic/Latino children and children from households with low incomes). • Standardization of outcome measurement across studies. • The potential harms of screening and treatment such as labeling, stigma, parent anxiety, other psychosocial harms, and overdiagnosis.
Interventions for High Body Mass Index in Children and Adolescents	Studies are needed that provide more information on: • The benefits of behavioral and pharmacotherapy interventions on long-term health outcomes (at least 2 years). • The long-term harms (at least 2 years) of pharmacotherapy. • The long-term harms of behavioral interventions. Research is needed on the comparative benefits and harms of weight-loss versus weight-neutral healthy lifestyle interventions in children and adolescents with a high body mass index. • The best timing for interventions for weight management and to understand whether there are certain ages in childhood and adolescence when interventions might provide a higher likelihood of treatment benefit. Research is also needed on the maintenance of weight loss after behavioral interventions and assessment of long-term (>5 years) benefits and harms. • The best practices for initial and ongoing weight-related discussions with children and adolescents and their families.
Screening and Preventive Interventions for Oral Health in Children, Adolescents, and Adults	Studies are needed that provide more information on: • The effectiveness and harms of primary care–based oral health screening strategies on oral health outcomes. • The diagnostic accuracy of oral health examinations and risk assessment tools in the primary care setting to identify children ages 5 to 17 years and adults with oral health conditions. • The accuracy of primary care–based oral health examinations and risk assessment tools to identify children ages 5 to 17 years and adults at increased risk of oral health conditions. • The effectiveness and harms of preventive interventions, including but not limited to, fluoride gel, fluoride varnish, sealants, silver diamine fluoride, and xylitol in the primary care setting on oral health conditions. • The effectiveness and harms of oral health education and behavioral counseling interventions on oral health outcomes.

USPSTF Recommendation	Gaps Where Research Is Needed
Screening and Supplementation for Iron Deficiency and Iron Deficiency Anemia During Pregnancy	Studies are needed that provide more information on: • Whether changes in maternal iron status (e.g., because of supplementation or treatment for screen-detected populations) improve maternal and infant health outcomes in settings relevant to U.S. primary care clinical practice. • The benefits and harms of screening (e.g., with hemoglobin, hematocrit, or ferritin values) for iron deficiency and iron deficiency anemia during pregnancy on maternal (e.g., quality of life or need for transfusion) and infant (e.g., low birth weight or preterm birth) health outcomes. • The benefits and harms of treatment (e.g., oral or intravenous iron) in asymptomatic, screen-detected populations with iron deficiency and iron deficiency anemia during pregnancy on maternal and infant health outcomes in settings relevant to U.S. primary care clinical practice. • The benefits and harms of routine iron supplementation in asymptomatic pregnant persons without known iron deficiency or iron deficiency anemia on maternal and infant health outcomes. • The relationship between social determinants of health and risk factors for iron deficiency and iron deficiency anemia, including but not limited to, nutritional status, screening services, access to iron-rich foods, and access to prenatal care and timely healthcare in populations disproportionately affected by iron deficiency/iron deficiency anemia during pregnancy.

USPSTF Recommendation	Gaps Where Research Is Needed
Screening for Breast Cancer	Studies are needed that provide more information on: • The benefits and harms of screening for breast cancer in women age 75 years or older. • The best strategy for breast cancer screening in women found to have dense breasts on a screening mammogram, which occurs in more than 40% of women screened. • The benefits and harms of supplemental screening (e.g., ultrasonography, MRI [magnetic resonance imaging], or contrast-enhanced mammography) compared with usual care (digital breast tomosynthesis or digital mammography alone) for women with dense breasts. • Reasons for higher breast cancer mortality among Black women. • Why Black women are more likely to be diagnosed with breast cancers that have biomarker patterns that confer greater risk for poor health outcomes. • How variations in care (including diagnosis and treatment) lead to increased risk of breast cancer morbidity and mortality in Black women, across the spectrum of stages and biomarker patterns, and on effective strategies to reduce this disparity. • Whether the benefits differ for annual versus biennial breast cancer screening among women overall and whether there is a different balance of benefits and harms among Black women compared with all women. • Approaches to reduce the risk of overdiagnosis leading to overtreatment of breast lesions identified through screening that may not be destined to cause morbidity and mortality, including ductal carcinoma in situ (DCIS). • The natural history of DCIS and to identify prognostic indicators to distinguish DCIS that is unlikely to progress to invasive breast cancer.
Interventions for Falls Prevention in Community-Dwelling Older Adults	Studies are needed that provide more information on: • Feasible risk assessment tools that accurately predict risk for falls in community-dwelling adults age 65 years or older. • The comparison of benefits and harms of exercise plus multifactorial interventions with exercise interventions alone. • Methods to improve the availability and accessibility of effective fall prevention interventions (e.g., remote provision of intervention). • The effectiveness and harms of interventions in different functional groups (e.g., persons with frailty). • The benefits and harms of educational and psychological interventions.

"Since 1976, the Office of Disease Prevention and Health Promotion has supported efforts to help people live healthy and active lives. USPSTF recommendations give people the information that they need to make informed decisions for their health, but as highlighted in this report, there are still critical gaps in the evidence. Heeding the USPSTF's call for more research and filling these gaps will help to further both of our goals of advancing health equity and improving the health of all people nationwide."

Carter Blakey
Deputy Director
Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Resources

Primary Care Interventions to Prevent Child Maltreatment

Child maltreatment, which includes child abuse and neglect, can have profound effects on health, development, survival, and well-being throughout childhood and adulthood.[10,11] The prevalence of child maltreatment in the United States is uncertain and likely underestimated.[10] In 2021, an estimated 600,000 children were identified by Child Protective Services (CPS) as experiencing abuse or neglect and an estimated 1,820 children died of abuse and neglect.[12]

The USPSTF identified research needs to address high-priority gaps and expand the evidence in primary care interventions to prevent child maltreatment, inclusive of populations disproportionately affected:

- Research is needed to help primary care clinicians accurately identify families who might benefit from supportive interventions that may prevent child maltreatment.
- Research is needed to determine if accuracy of risk assessment tools differs by social factors and race and ethnicity.
- Research is needed to understand the optimal frequency of risk assessment considering chronicity, duration, intermittency, and severity of maltreatment.
- Studies are needed to evaluate the effectiveness of primary care–feasible or referable preventive interventions designed to reduce exposure to maltreatment, including neglect.
- Research is needed to determine whether intervention effectiveness or child maltreatment reporting differs by social factors and race and ethnicity.
- Studies evaluating the effectiveness of interventions using more accurate outcome measures that limit bias (e.g., surveillance) are needed.
- In addition, consistency in outcome measure definitions, outcome types, and outcome timing across studies is needed.
- Research is needed on the most effective ways to prevent child maltreatment (using more accurate outcome measures), including interventions that address the social determinants of health that can negatively affect families.
- Research is needed to determine whether there are unintended harms from risk assessment (e.g., stigma or legal risks related to CPS) and engagement in preventive interventions (e.g., risk of biased reporting for maltreatment).
- Research is needed to understand whether potential harms differ in children by social factors and race and ethnicity.

Screening for Speech and Language Delay and Disorders in Children

Speech and language delay and disorders can pose significant problems for children and their families. Evidence suggests that school-aged children with speech or language delays may be at increased risk of learning and literacy disabilities, including difficulties with reading and writing.[13-15] Observational cohort studies suggest that children with these conditions may also be at higher risk for social and behavioral problems in addition to learning problems, some of which may persist through adulthood.[16] Research is needed to determine whether identifying speech and language delays early (i.e., in children age 5 years or younger) and providing interventions helps prevent these issues before they interfere with school learning or psychosocial adjustment.

The USPSTF identified high-priority gaps to be addressed and expand the evidence in screening for speech and language delay and disorders in children, inclusive of populations disproportionately affected:

- Treatment studies are needed of screen-detected populations that follow children over short and longer (>1 year) durations to detect improvement in outcomes such as academic performance, social and emotional health, or child and family well-being. These studies should focus on enrolling children from groups with the greatest burden of speech and language delay and disorders (Black and Hispanic/Latino children and children from households with low incomes).
- Standardization of outcome measurement across studies is needed.
- Studies are needed on the potential harms of screening and treatment such as labeling, stigma, parent anxiety, other psychosocial harms, and overdiagnosis.

Interventions for High Body Mass Index in Children and Adolescents

Approximately 19.7% of children and adolescents ages 2 to 19 years in the United States have a body mass index (BMI) at or above the 95th percentile for age and sex, based on Centers for Disease Control and Prevention (CDC) growth charts from 2000.[17,18] BMI percentile is plotted on growth charts, such as those developed by the CDC, which are based on U.S.-specific, population-based norms for children age 2 years or older.[17,19] The prevalence of high BMI increases with age and is higher among Hispanic/Latino, Indigenous American, and non-Hispanic Black children and adolescents and children from lower-income families.[17,18]

The USPSTF identified high-priority gaps to expand the evidence in interventions for high body mass index BMI in children and adolescents, inclusive of populations disproportionately affected:

- Research is needed on long-term health outcomes (at least 2 years) and the benefits of behavioral and pharmacotherapy interventions.
- Research is needed on long-term (at least 2 years) psychosocial harms (e.g., quality of life) of pharmacotherapy.
- Research is needed on the benefits and harms of healthy lifestyle or weight-neutral interventions in children and adolescents with a high BMI.
- Research is needed on the best timing for interventions for weight management.
- Research is needed on the maintenance of weight loss after behavioral interventions and assessment of long-term (>5 years) benefits and harms.
- Research is needed on the best practices for weight-related discussions with children and adolescents and their families.
- Research is needed on the biochemical adaptations to weight loss in children and adolescents that may promote weight regain.

Screening and Preventive Interventions for Oral Health in Children, Adolescents, and Adults

Oral health is fundamental to overall health and well-being across the lifespan.[20, 21] Oral health conditions affect the daily lives of school-age children and adolescents, leading to the loss of more than 51 million school hours every year.[22,23] Despite declines in untreated tooth decay in the primary teeth of young children,[24,25] dental caries remains one of the most common conditions of childhood, and the prevalence of untreated caries increases as children age.[20,21,26] Dental caries can negatively affect a range of outcomes, including but not limited to, eating, speaking, learning, smiling, self-esteem, and quality of life.[20] Untreated oral health conditions can lead to tooth loss, irreversible tooth damage, and other serious adverse health outcomes.[20,24]

In the United States, oral health disparities are shaped by inequities in the affordability and accessibility of dental care and other disadvantages related to social determinants of health (e.g., living in a rural area or immigration status).[20,21,23,24] Dental caries and periodontitis disproportionately affect Asian, Black, Hispanic/Latino, and Indigenous American children, adolescents, and adults; children with special healthcare needs;[20] adults with disabilities; adults age 65 years or older or living in institutional settings; adults living in rural and urban underserved areas; adults without insurance or with public insurance; and adults experiencing homelessness.[20,21] Additional risk factors for developing oral health problems include lack of brushing and flossing teeth, high sugar diets from beverages and food, low fluoride exposure, tobacco use, and developmental defects in teeth.

The USPSTF research needs to address high-priority gaps and expand the evidence in screening and preventive interventions for oral health in children ages 5 to 17 years and adults, inclusive of populations disproportionately affected:

- Research is needed to assess the effectiveness and harms of primary care–based oral health screening strategies on oral health outcomes.
- Research is needed to assess the diagnostic accuracy of oral health examinations and risk assessment tools in the primary care setting to identify those with oral health conditions.
- Research is needed to assess the effectiveness and harms of preventive interventions, including but not limited to, fluoride gel, fluoride varnish, sealants, silver diamine fluoride, and xylitol in the primary care setting on oral health conditions.
- Research is needed to assess the effectiveness and harms of oral health education and behavioral counseling interventions on oral health outcomes.
- Research is needed to identify the effectiveness of strategies that can be delivered in primary care settings to improve quality of life, function, or other clinically important oral health outcomes.

Screening and Supplementation for Iron Deficiency and Iron Deficiency Anemia During Pregnancy

Iron deficiency is the leading cause of anemia during pregnancy.[27] According to National Health and Nutrition Examination Survey data from 1999 to 2006, the overall estimated prevalence of iron deficiency during pregnancy is near 18% and increases across the three trimesters of pregnancy (from 6.9% to 14.3% to 28.4%).[28] An estimated 5% of pregnant persons have iron deficiency anemia.[27,28] In the United States, there are disparities in the prevalence of iron deficiency anemia by race, ethnicity, and social factors (e.g., socioeconomic status, nutritional status, and food insecurity).[27,28] The aim of routine screening or iron supplementation for treatment of iron deficiency and iron deficiency anemia during pregnancy is to improve maternal and infant health outcomes.

The USPSTF needs research to address high-priority gaps and expand the evidence in screening and supplementation for iron deficiency and iron deficiency anemia during pregnancy, inclusive of populations disproportionately affected:

- Research is needed in pregnant persons with iron deficiency and iron deficiency anemia to assess whether changes in maternal iron status (e.g., because of supplementation or treatment for screen-detected populations) improve maternal and infant health outcomes in settings relevant to U.S. primary care clinical practice.
- Research is needed to assess the benefits and harms of screening (e.g., with hemoglobin, hematocrit, or ferritin values) for iron deficiency and iron deficiency anemia during pregnancy on maternal (e.g., quality of life or need for transfusion) and infant (e.g., low birth weight or preterm birth) health outcomes.
- Research is needed to assess the benefits and harms of treatment (e.g., oral or intravenous iron) in asymptomatic, screen-detected populations with iron deficiency and iron deficiency anemia during pregnancy on maternal and infant health outcomes in settings relevant to U.S. primary care clinical practice.
- Research is needed to assess the benefits and harms of routine iron supplementation in asymptomatic pregnant persons without known iron deficiency or iron deficiency anemia on maternal and infant health outcomes.
- Research is needed to assess the relationship between social determinants of health and risk factors for iron deficiency and iron deficiency anemia, including but not limited to nutritional status, screening services, access to iron-rich foods, and access to prenatal care and timely healthcare in populations disproportionately affected by iron deficiency/iron deficiency anemia during pregnancy.

Screening for Breast Cancer

Among all U.S. women, breast cancer is the second most common cancer and the second most common cause of cancer death. In 2023, an estimated 43,170 women died of breast cancer.[29] Non-Hispanic White women have the highest incidence of breast cancer (5-year age-adjusted incidence rate, 136.3 cases per 100,000 women), and non-Hispanic Black women have the second highest incidence rate (5-year age-adjusted incidence rate, 128.3 cases per 100,000 women).[30] Incidence gradually increased among women ages 40 to 49 years from 2000 to 2015 but increased more noticeably from 2015 to 2019, with a 2.0% average annual increase.[31] Despite having a similar or higher self-reported rate of mammography screening,[32] Black women are more likely to be diagnosed with breast cancer beyond stage I than other racial and ethnic groups, are more likely to be diagnosed with triple-negative cancers (i.e., estrogen receptor–negative [ER–], progesterone receptor–negative [PR–], and human epidermal growth factor receptor 2–negative [HER2–]), which are more aggressive tumors, compared with White women,[33] and are approximately 40% more likely to die of breast cancer compared with White women.[34]

Despite new research that led to the Task Force recommending all women get a mammogram starting at the age of 40, the USPSTF identified research needs to address several high-priority gaps to expand the evidence in screening for breast cancer, inclusive of populations disproportionately affected:

- Research is needed to determine the benefits and harms of screening for breast cancer in women age 75 years or older.
- Research is needed to help clinicians and patients understand the best strategy for breast cancer screening in women found to have dense breasts on a screening mammogram, which occurs in more than 40% of women screened.

  - Research is needed to determine the benefits and harms of supplemental screening (e.g., ultrasonography, MRI [magnetic resonance imaging], or contrast-enhanced mammography) compared with usual care (digital breast tomosynthesis or digital mammography alone) for women with dense breasts.
- Research is needed to understand and address the higher breast cancer mortality among Black women.
  - Research is needed to understand why Black women are more likely to be diagnosed with breast cancers that have biomarker patterns that confer greater risk for poor health outcomes.
  - Research is needed to understand how variations in care (including diagnosis and treatment) lead to increased risk of breast cancer morbidity and mortality in Black women across the spectrum of stages and biomarker patterns, and on effective strategies to reduce this disparity.
  - Research is needed to determine whether the benefits differ for annual versus biennial breast cancer screening among women overall and whether there is a different balance of benefits and harms among Black women compared with all women.
- Research is needed to identify approaches to reduce the risk of overdiagnosis leading to overtreatment of breast lesions identified through screening that may not be destined to cause morbidity and mortality, including ductal carcinoma in situ (DCIS).
  - Research is needed on the natural history of DCIS and to identify prognostic indicators to distinguish DCIS that is unlikely to progress to invasive breast cancer.

Interventions for Falls Prevention in Community-Dwelling Older Adults

Falls are the leading cause of injury-related morbidity and mortality among older adults in the United States.[35] In 2018, 27.5% of community-dwelling adults age 65 years or older reported at least one fall in the past year (714 falls per 1,000 older adults), and 10.2% reported a fall-related injury (170 fall-related injuries per 1,000 older adults).[36] Indigenous American older adults reported more falls (32.2%) and fall-related injuries (15.2%) compared with other racial and ethnic groups. Stratified by age, 25.9% of adults ages 65 to 74 years reported falling and 9.3% reported fall-related injuries; 28.5% of adults ages 75 to 84 years reported falling and 10.6% reported fall-related injuries; and 33.8% of adults age 85 years or older reported falling and 13.9% reported fall-related injuries.[36] In 2021, an estimated 38,742 deaths resulted from fall-related injuries.[33] Most fall-related deaths occur in adults age 85 years or older; this group also has the fastest-growing rate of death from falls.[36,37]

The USPSTF identified high-priority gaps related to interventions for falls prevention in community-dwelling older adults, inclusive of populations disproportionately affected:

- Research is needed to develop and validate primary care–feasible risk assessment tools that accurately predict risk for falls in community-dwelling adults age 65 years or older.
- Studies are needed that compare the benefits and harms of exercise plus multifactorial interventions with exercise interventions alone.
- Studies are needed on methods to improve the availability and accessibility of effective fall prevention interventions (e.g., remote provision of intervention).
- Studies are needed on the effectiveness and harms of interventions in different functional groups (e.g., persons with frailty).
- More studies are needed on the benefits and harms of educational and psychological interventions.

"Together, the Community Preventive Services Task Force and the USPSTF provide evidence-based recommendations on clinical and community preventive services. The research gaps identified by the USPSTF inform where future research is needed that can help people stay healthy. We join the USPSTF in its call for additional research for people across the lifespan and hope that by addressing these gaps, we can continue to work together to provide the best preventive healthcare to people of all ages and in all communities."

Alison Evans Cuellar, PhD
Chair
Community Preventive Services Task Force

THE USPSTF IN 2024 AND OTHER HIGHLIGHTS

Over the past year, the Task Force members continued working on a full portfolio of topics. The current USPSTF library includes 90 preventive service recommendation statements, with 142 specific recommendation grades. Many recommendation statements include multiple recommendation grades for different populations. In fiscal year 2024 (October 1, 2023, to September 30, 2024), the Task Force accomplished the following:

- Received 28 nominations for new topics and 25 nominations to reconsider or update existing topics
- Posted 8 draft research plans for public comment
- Posted 6 draft recommendation statements and 6 draft evidence reports for public comment
- Published 8 final recommendation statements with 4 recommendation grades in medical journals; posted 8 final evidence reports

For a listing of all final USPSTF recommendations released since the last report, see **Appendix D**.

Of the Task Force's portfolio of **90 topics**, the following posted or published this year.

Draft Research Plan

- Enhanced Risk Assessment for Cardiovascular Disease
- Interventions for Tobacco Use in Children & Adolescents
- Medication to Reduce the Risk of Breast Cancer
- Prevention of BRCA-Related Cancer
- Counseling to Prevent Food Allergies in Infants
- Screening & Interventions for Unhealthy Alcohol Use
- Screening for HIV
- Screening for Prostate Cancer

Final Research Plan

- Behavioral Counseling to Promote Healthy Lifestyle and/or Weight Loss in Adults
- Enhanced Risk Assessment for Cardiovascular Disease
- Medication to Reduce the Risk of Breast Cancer
- Prevention of BRCA-Related Cancer
- Counseling to Prevent Food Allergies in Infants
- Interventions for Tobacco Use in Children & Adolescents
- Screening & Interventions for Unhealthy Alcohol Use
- Screening for HIV
- Screening for Prostate Cancer

Draft Recommendation

- Interventions for High BMI in Children & Adolescents
- Interventions to Prevent Falls in Older Adults
- Screening & Supplementation for Iron Deficiency During Pregnancy
- Screening for Food Insecurity
- Screening for Intimate Partner Violence & Caregiver Abuse of Older or Vulnerable Adults
- Screening for Osteoporosis

Final Recommendation

- Interventions for High Body Mass Index in Children & Adolescents
- Interventions to Prevent Child Maltreatment
- Interventions to Prevent Falls in Older Adults
- Screening & Preventive Interventions for Oral Health in Adults
- Screening & Preventive Interventions for Oral Health in Children 5 Years & Older
- Screening & Supplementation for Iron Deficiency During Pregnancy
- Screening for Breast Cancer
- Speech & Language Delay & Disorders in Children

Partner Engagement to Develop and Disseminate Recommendations

The USPSTF continued to work with its partner organizations to enhance the accuracy and relevance of its recommendations, disseminate the work of the USPSTF, and facilitate implementation of the Task Force recommendations into practice. USPSTF partner organizations include Federal agencies that are stakeholders in the process and Dissemination and Implementation Partners that represent primary care clinicians, consumers, and other stakeholders involved in the delivery of primary care.

Partners are a powerful vehicle for ensuring that the nation's primary care workforce remains up to date on USPSTF recommendations. The complete list of partners is available in **Appendices B** and **C**.

Efforts to Reduce Disparities in Healthcare

The Task Force has worked to improve the health of people nationwide since it was established in 1984. Over the years, the Task Force methods have evolved to include a health equity framework. This health equity framework is used to help the Task Force more consistently approach the recommendation development for all populations that experience inequities in morbidity or mortality from disease related to age, sex, race and ethnicity, sexual orientation, gender, geographical location, and social determinants of health. This approach supports the Task Force's efforts to promote the highest level of health and well-being for everyone, in all communities.

The health equity framework includes a checklist of key items addressing how health equity issues can be approached at each phase of the USPSTF recommendation development process:

- Topic nomination, selection, and prioritization
- Development of research plan
- Evidence review
- Evidence deliberation
- Development of recommendation statement
- Recommendation dissemination

The Task Force continues to advance its approach to its recommendation development process aimed at reducing the effects of social injustices in healthcare and ultimately helping better equip clinicians with the evidence-based guidance they need to promote health and prevent disease across the lifespan, in all communities.

Dissemination Impact of USPSTF Recommendations

The USPSTF engages in several activities to disseminate its recommendations to increase their uptake. During the past fiscal year (October 1, 2023, to September 30, 2024), clinicians, patients, and other stakeholders viewed the USPSTF recommendations via the USPSTF website, the *Journal of the American Medical Association (JAMA)*, and the Prevention TaskForce app as follows:

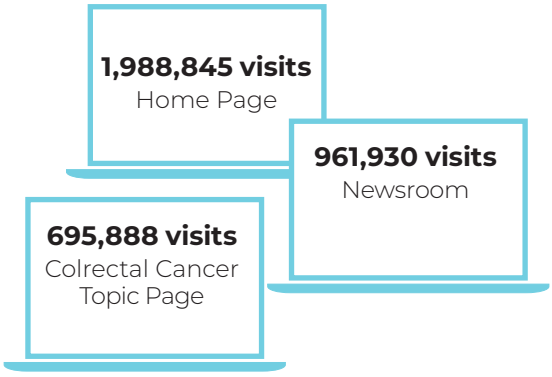
Email Outreach

109,943
Task Force email list subscribers notified regularly about topics and other activities

Digital Impact

33,186,187
Total page views of the Task Force website

8,083,446
Total unique visitors to the Task Force website



Top visited pages of the Task Force website

Clinical Practice Impact

207,088
Total page views of Task Force articles published on *JAMA* website

95,942
Number of new Prevention TaskForce app downloads

1,284,213
Total number of Prevention TaskForce app downloads

Efforts to Fill USPSTF Research Gaps

Key Research Gaps for Clinical Preventive Services Across the Lifespan, in All Communities

For each recommendation, regardless of whether the recommendation receives a letter grade or has insufficient evidence and receives an "I statement," the USPSTF routinely calls attention to evidence gaps and highlights areas where research is needed in the "Research Gaps and Needs" section of the recommendation and, whenever possible, an "Evidence Gaps Research Taxonomy Table," which was introduced in November 2023. Both the Research Gaps and Needs section of the recommendation and the Evidence Gaps Research Taxonomy Table include evidence gaps mapped to the analytic framework. However, the Taxonomy Table provides additional guidance to the research community on how the gaps can be filled, providing the following details:

- Key Questions or Contextual Questions to outline the additional evidence the USPSTF needs to develop recommendations
- Details on how the gaps are linked, directly or indirectly, to the analytic framework
- Details on the type of gap
  - Moving from an I statement to a letter grade
  - Change in letter grade (e.g., from C to B or C to D)
  - Health equity (e.g., populations with a disproportionate burden of the condition)
  - General gap (e.g., uptake of a clinical preventive service)
- Study characteristics: research methods and specific procedures for collecting and analyzing data
- Population: the group of individuals that are of interest or specific characteristics, including underserved populations and those groups disproportionately affected by a health condition
- Intervention/comparison: the treatment to be given and the reference group to compare with the intervention
- Outcomes/timing: how the results are measured to assess the intervention's effectiveness and for how long data should be collected
- Setting: the setting for the study (i.e., primary care)

In alignment with the USPSTF's commitment to advancing health equity, the Task Force hopes this systematic approach to communicating evidence gaps for funders and researchers will improve filling evidence gaps that affect health inequities. The USPSTF will continue to revise and identify best practices for articulating evidence gaps and future research needs in the upcoming years.

THE USPSTF IN 2025

In the coming 12 months, it is expected that the USPSTF will continue to:

Develop and release new recommendation statements

- Work on more than 23 topics that are in progress
- Work on 3 topics nominated for consideration through the public topic nomination process
- Post 4 draft research plans and 8 draft recommendation statements and evidence reports for public comment
- Publish 10 final recommendation statements

Coordinate with partners to develop and disseminate recommendations

- Coordinate with the USPSTF Dissemination and Implementation Partners and Federal Liaisons to solicit input and disseminate the recommendations to primary care clinicians and other stakeholders to achieve the benefits of screening tests, behavioral counseling, and preventive medications to improve health outcomes and reduce disparities.
- Continue close collaboration with AHRQ and the National Institutes of Health's Office of Disease Prevention to address evidence gaps and future research needs.
- Prepare the 15th Annual Report to Congress on high-priority evidence gaps (see **Appendix E** for a list of prior reports).

This year, the Task Force celebrates 40 years of prevention guidance (see **Appendix F** for a timeline of notable activities). The USPSTF appreciates the opportunity to report on its activities, to highlight critical evidence gaps, and to recommend important new areas for research in clinical preventive services. The members of the Task Force look forward to their ongoing work to improve the health of people nationwide.

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APPENDICES

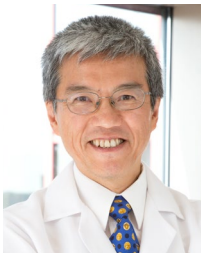
Appendix A: Members of the USPSTF (2024)

Wanda K. Nicholson, M.D., M.P.H., M.B.A., Chair

Dr. Nicholson is professor of prevention and community health at the Milken Institute School of Public Health at the George Washington University. She is an obstetrician-gynecologist; vice president of the board of directors of the American Board of Obstetrics and Gynecology; former editor of health equity, diversity, and inclusion for the *American Journal of Obstetrics and Gynecology;* past chair of the American College of Obstetricians and Gynecologists (ACOG) Diversity, Equity, and Inclusive Excellence Workgroup; and an immediate past member of the executive board of ACOG. Her clinical and research focus is on healthcare prevention across the woman's lifespan.

Michael Silverstein, M.D., M.P.H., Vice Chair

Dr. Silverstein is the George Hazard Crooker University professor of health services, policy, and practice at the Brown University School of Public Health and the director of Brown University's Hassenfeld Child Health Innovation Institute, which is charged with eliminating health inequities in pregnancy and childhood for Rhode Island families.



John B. Wong, M.D., MACP, Vice Chair

Dr. Wong is vice chair for academic affairs, chief of the Division of Clinical Decision Making, and a primary care internist in the Department of Medicine at Tufts Medical Center. He is also a professor of medicine at Tufts University School of Medicine.

David Chelmow, M.D., Member

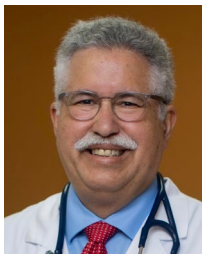
Dr. Chelmow is the Leo J. Dunn professor of obstetrics and gynecology and chair of the Department of Obstetrics-Gynecology at Virginia Commonwealth University (VCU) School of Medicine in Richmond, Virginia. He has been chair since 2010 and recently completed service as interim dean for the VCU School of Medicine.

Tumaini Rucker Coker, M.D., M.B.A., Member

Dr. Coker is division head of General Pediatrics and professor of pediatrics at the University of Washington School of Medicine and Seattle Children's. She serves as the co-director of the University of Washington's Child Health Equity Research Fellowship, which is funded by the National Institutes of Health.

Esa M. Davis, M.D., M.P.H., FAAFP, Member

Dr. Davis is a professor of family and community medicine, the associate vice president for community health at the University of Maryland Baltimore, and the senior associate dean of population and community medicine at the University of Maryland School of Medicine. She is the lead health equity strategist for the University of Maryland Institute for Health Computing. Dr. Davis is also the director of the Transforming Biomedical Research and Academic Faculty Through Leadership Opportunities, Training, and Mentorship (TRANSFORM) program.



Carlos Roberto Jaén, M.D., Ph.D., M.S., FAAFP, Member

Dr. Jaén is a professor and the Dr. and Mrs. James L. Holly distinguished chair in the Department of Family and Community Medicine at the Joe R. and Teresa Lozano Long School of Medicine at The University of Texas Health Science Center at San Antonio.

Marie Krousel-Wood, M.D., M.S.P.H., Member

Dr. Krousel-Wood is a professor and the Jack Aron endowed chair in primary care medicine in the Tulane School of Medicine Department of Medicine. She is the founding director of the Tulane Center for Health Outcomes, Implementation, and Community-Engaged Science (CHOICES). She serves in several leadership roles at Tulane, including associate provost for the health sciences, senior associate dean of faculty in the School of Medicine, and associate dean for public health and medical education.

Sei Lee, M.D., M.A.S., Member

Dr. Lee is a professor of medicine in the Division of Geriatrics at the University of California, San Francisco, and the Senior Scholar for the San Francisco Veterans Affairs Quality Scholars fellowship. Dr. Lee also chairs the American Geriatrics Society Quality and Performance Measurement Committee. He is a geriatrician and palliative care physician and has cared for patients in the clinic, hospital, and nursing home settings.

Li Li, M.D., Ph.D., M.P.H., Member

Dr. Li is a family physician and the Walter M. Seward professor and chair of family medicine at the University of Virginia (UVA) School of Medicine. He is also co-leader of the Cancer Prevention and Population Health program at the UVA Comprehensive Cancer Center.

Goutham Rao, M.D., FAHA, Member

Dr. Rao is the chair of the Department of Family Medicine and Community Health and chief clinician experience officer for the University Hospitals (UH) Health System. He practices family medicine and leads the medical obesity treatment program. He also serves as division chief of Family Medicine at UH Rainbow Babies & Children's Hospital. In addition, Dr. Rao is the Jack H. Medalie professor and chair of the Department of Family Medicine and Community Health at Case Western Reserve University School of Medicine.

John M. Ruiz, Ph.D., Member

Dr. Ruiz is a professor of clinical psychology in the Department of Psychology at the University of Arizona. He is also the associate director of inclusivity, diversity, equity, and accessibility (IDEA) in the University of Arizona Cancer Center.

James Stevermer, M.D., M.S.P.H., Member

Dr. Stevermer is vice chair and the Paul Revare, M.D., professor of family and community medicine at the University of Missouri (MU). He also practices and teaches rural primary care at MU Health Care Family Medicine–Callaway Physicians. His scholarly activities focus on dissemination and evidence-based medicine.

Joel Tsevat, M.D., M.P.H., Member

Dr. Tsevat is a general internist, professor of medicine, and Joaquin G. Cigarroa, Jr., M.D., distinguished chair in the Joe R. and Teresa Lozano Long School of Medicine at The University of Texas Health Science Center at San Antonio.

Sandra Millon Underwood, R.N., Ph.D., Member

Dr. Underwood is a professor emerita in the College of Nursing at the University of Wisconsin-Milwaukee. She is a nurse researcher, educator, and clinician with 40 years of experience in the design, implementation, and evaluation of evidence-based programs that aim to foster diversity, inclusion, and health equity, and improve health outcomes among diverse, underserved, at-risk population groups.

Sarah Wiehe, M.D., M.P.H., Member

Dr. Wiehe is the Jean and Jerry Bepko professor of pediatrics and associate dean of community and translational research at Indiana University School of Medicine. She is a research scientist at the Regenstrief Institute and adjunct professor of epidemiology at Fairbanks School of Public Health at Indiana University. Dr. Wiehe co-directs the Indiana Clinical and Translational Sciences Institute and leads its community engagement program.

Appendix B: USPSTF Dissemination and Implementation Partner Organizations (2024)

AARP
American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Physician Associates
American Association of Nurse Practitioners
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Preventive Medicine
American Geriatrics Society
American Medical Association
American Osteopathic Association
American Psychological Association
America's Health Insurance Plans
Association of American Indian Physicians
Business Group on Health
Canadian Task Force on Preventive Health Care
Community Preventive Services Task Force
GLMA: Health Professionals Advancing LGBTQ Equality
National Association of Pediatric Nurse Practitioners
National Committee for Quality Assurance
National Council of Asian Pacific Islander Physicians
National Hispanic Medical Association
National Medical Association/Cobb Institute
Patient-Centered Outcomes Research Institute

Appendix C: Federal Liaisons to the USPSTF (2024)

Centers for Disease Control and Prevention
Centers for Medicare & Medicaid Services
Department of Defense Military Health System
Department of Health and Human Services, Office of Minority Health
Department of Veterans Affairs National Center for Health Promotion and Disease Prevention
Health Resources and Services Administration
Indian Health Service
National Cancer Institute
National Institutes of Health
Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion
Substance Abuse and Mental Health Services Administration
U.S. Food and Drug Administration

Appendix D: USPSTF Final Recommendations Published October 2023–September 2024

Over the past year, the members of the Task Force continued working on a full portfolio of topics. It published 8 final recommendation statements with 14 recommendation grades in a peer-reviewed journal between October 1, 2023, and September 30, 2024. For a complete listing of all current USPSTF recommendations, see the USPSTF website (https://www.uspreventiveservicestaskforce.org/).

Appendix D Table. Final Recommendation Statements Published by the USPSTF, October 1, 2023, to September 30, 2024

Topic	Recommendation
Interventions for High Body Mass Index in Children and Adolescents	The USPSTF recommends that clinicians provide or refer children and adolescents 6 years or older with a high body mass index (BMI) (≥95th percentile for age and sex) to comprehensive, intensive behavioral interventions. **(Grade B)**
Interventions to Prevent Falls in Community-Dwelling Older Adults	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls. **(Grade B)** The USPSTF recommends that clinicians individualize the decision to offer multifactorial interventions to prevent falls to community-dwelling adults 65 years or older who are at increased risk for falls. Existing evidence indicates that the overall net benefit of routinely offering multifactorial interventions to prevent falls is small. When determining whether this service is appropriate for an individual, patients and clinicians should consider the balance of benefits and harms based on the circumstances of prior falls, presence of comorbid medical conditions, and the patient's values and preferences. **(Grade C)**
Primary Care Interventions to Prevent Child Maltreatment	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of primary care interventions to prevent child maltreatment. **(I statement)**
Screening and Preventive Interventions for Oral Health in Adults	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine screening performed by primary care clinicians for oral health conditions, including dental caries or periodontal-related disease, in adults. **(I statement)** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of preventive interventions performed by primary care clinicians for oral health conditions, including dental caries or periodontal-related disease, in adults. **(I statement)**

Topic	Recommendation
Screening and Preventive Interventions for Oral Health in Children and Adolescents Ages 5 to 17 Years	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine screening performed by primary care clinicians for oral health conditions, including dental caries, in children and adolescents ages 5 to 17 years. **(I statement)** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of preventive interventions performed by primary care clinicians for oral health conditions, including dental caries, in children and adolescents ages 5 to 17 years. **(I statement)**
Screening and Supplementation for Iron Deficiency and Iron Deficiency Anemia During Pregnancy	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for iron deficiency and iron deficiency anemia in pregnant persons to prevent adverse maternal and infant health outcomes. **(I statement)** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine iron supplementation in pregnant persons to prevent adverse maternal and infant health outcomes. **(I statement)**
Screening for Breast Cancer	The USPSTF recommends biennial screening mammography for women ages 40 to 74 years. **(Grade B)** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women 75 years or older. **(I statement)** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of supplemental screening for breast cancer using breast ultrasonography or magnetic resonance imaging (MRI) in women identified to have dense breasts on an otherwise negative screening mammogram. **(I statement)**
Screening for Speech and Language Delay and Disorders in Children	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for speech and language delay and disorders in children 5 years or younger. **(I statement)**

Appendix E: Prior Annual Reports to Congress on High-Priority Evidence Gaps for Clinical Preventive Services

The table below lists the prior annual Reports to Congress on High-Priority Evidence Gaps for Clinical Preventive Services. Electronic versions of each report are available on the USPSTF website at https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/reports-congress.

Appendix E Table. Prior Annual Reports to Congress

Year	Title	Theme
2023	Thirteenth Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services	Mental health and wellness for all ages and specific high-risk populations
2022	Twelfth Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services	Recent evidence gaps related to promoting healthy behaviors across the lifespan
2021	Eleventh Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services	Health equity in cardiovascular disease and cancer prevention
2020	Tenth Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services	Child and adolescent health and health inequities
2019	Ninth Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services	Mental health, substance use, and violence prevention
2018	Eighth Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services	Recent evidence gaps related to cancer prevention and cardiovascular health
2017	Seventh Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services	Recent evidence gaps
2016	Sixth Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services	Recent evidence gaps
2015	Fifth Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services	Women's health
2014	Fourth Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services	Child and adolescent health
2013	Third Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services	Older adult health
2012	Second Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services	Recent evidence gaps
2011	First Annual Report to Congress on High-Priority Evidence Gaps for Clinical Preventive Services	Recent evidence gaps

Appendix F: 40th Anniversary Timeline

Celebrating 40 years of Prevention Guidance

For 40 years, the U.S. Preventive Services Task Force (USPSTF or Task Force) has improved the health of people nationwide by making evidence-based recommendations on preventive services. Clinicians, healthcare professionals, patients, families, and communities all look to the Task Force to help them know what works and what doesn't in preventive care. **Join us as we celebrate 40 years of this important work!**

1980s

1984

Task Force first convened by the U.S. Department of Health and Human Services (HHS).

1989

First Guide to *Clinical Preventive Services* published; Task Force invites experts from the scientific community to provide input for the inaugural Guide.

1990s

1990

HHS convenes the second Task Force

1998

Congress gives authority to the Agency for Healthcare Research and Quality (AHRQ) to provide administrative, research, technical, and dissemination support to the Task Force in the **1998 Public Health Service Act**.

Third Task Force convened and established continuous operations.

2000s

2001 — [Task Force leads the establishment of methods to develop evidence-based guidelines and creates a systematic process aligning with evolving evidence-based principles.]

2005 — Task Force [solidifies partnerships] with national primary care and patient advocacy groups, Federal agencies, and other partners to help inform and disseminate the work of the Task Force.

2006 — Task Force launches the Electronic Preventive Services Selector (ePSS), which is now called [Prevention TaskForce], an application tool to assist primary care clinicians with current recommendations on preventive services. Two years after Prevention TaskForce was created, it became the first app (on iOS) from a federal agency and popular among health and medical apps.

2008 — Task Force recommendations are integrated into the Office of Disease Prevention and Health Promotion's [MyHealthfinder platform], a resource to help patients and families stay healthy.

2009 — To further its commitment to transparency, the Task Force began to pilot a public comment process on draft materials, which grew to include 4-week comment periods for all draft research plans, recommendation statements, and evidence reviews.

2010s

2010 — [Patient Protection and Affordable Care Act] reinforces AHRQ's support of and the importance of the Task Force and connects Task Force recommendations to coverage requirements.

2011 — Task Force issues its [first annual Report to Congress.]

Institute of Medicine (now National Academy of Medicine) issues report ["Clinical Practice Guidelines We Can Trust,"] identifying the USPSTF as a leader and a reference standard for guideline development processes.

2015 — Task Force [publishes a commentary] demonstrating its alignment with the gold standards of clinical practice guideline development and clarifying its role in evaluating the science to identify the most effective preventive services.

2018 — Task Force publishes [American Journal of Preventive Medicine supplement] on updated methods, reinforcing its commitment to continuously advancing its methods of making evidence-based recommendations.

Task Force evaluates its conflict-of- interest policy and [publishes best practices from guideline-making bodies], demonstrating its commitment to maintaining transparent, state-of-the-art policies and procedures.

2020s

2020

Task Force launches the Electronic Preventive Services Selector (ePSS), which is now called **Prevention TaskForce**, an application tool to assist primary care clinicians with current recommendations on preventive services. Two years after Prevention TaskForce was created, it became the first app (on iOS) from a federal agency and popular among health and medical apps.

2021

Task Force reinforces and **publishes its commitment to addressing health equity** in primary care.

2024

As of this year, the Task Force has recommendations on more than 88 topics.

U.S. Preventive Services TASK FORCE 40 YEARS OF IMPROVING HEALTH

...And Beyond

Looking ahead, the Task Force will continue serving as a trusted, valuable resource whose mission is to help people through evidence-based recommendations. Primary care clinicians, policymakers, patient groups, professional societies, and patients depend on the Task Force to identify what works and does not work to help prevent disease and prolong life.

Learn more about the Task Force's work today at:

www.uspreventiveservicestaskforce.org


U.S. Preventive Services
TASK FORCE
40 YEARS
OF IMPROVING HEALTH