Massachusetts
Health Quality Partners

2026

ADULT PREVENTIVE CARE GUIDELINES

Contents

About the MHQP Adult Preventive Care Guidelines

MHQP's 2026 guidelines were developed by a collaborative group of Massachusetts healthcare organizations. These are recommendations for providing preventive care to adult patients from the general population. These guidelines should not supplant clinical judgment or the needs of individual patients. These guidelines are intended as quality practice recommendations and are not intended as a description of benefits, conditions of payment, or any other legal requirements of any particular health plan or payor. Each health plan or payor makes its own determination of coverage and benefits. In the event that these practice recommendations are inconsistent with any applicable laws or regulations, such laws or regulations take precedence.

Social Determinants of Health (SDoH) and Health Related Social Needs (HRSN)

- Review a completed SDoH/HRSN screening tool, such as PRAPARE or the Social Needs Screening Tool, and incorporate into the plan of care.
- Assess health literacy by asking: "How confident are you filling out medical forms by yourself?"
- Develop an action plan at each visit with information available.
- Based on the screening, ensure patients receive accommodations, education, resources, and referrals as needed.

Screening Tools and Action Plans

Protocol for Responding and Assessing Patient's Assets, Risks and Experiences (PRAPARE): The PRAPARE screening tool screens for four main health-related social needs, including patient demographics; housing, food, transportation, and utilities; finance; and social and emotional health.

Social Needs Screening Tool: The Social Needs Screening tool screens for five core health-related social needs, which include housing, food, transportation, utilities, and personal safety, using validated screening questions, as well as the additional needs of employment, education, child-care, and financial strain.

Develop an Action Plan: A quick form to guide a discussion with patients about their social determinants of health and document a plan to address them. The form is available in seven languages.

Community Resources:

2-1-1: This resource helps individuals obtain information about receiving assistance in the event of a crisis, emergency, or natural disaster.

Find Help: This interactive tool helps individuals find free or reduced cost services related to food, housing, or transportation.

HelpSteps: This interactive tool provides information on how to access social services related to food, housing, and medical care.

General Resources:

The EveryONE Project Toolkit: This toolkit offers strategies for use among clinicians to promote diversity and advance health equity in all communities.

THRIVE: THRIVE is also a tool for engaging community members and practitioners in assessing the status of community determinants, prioritizing them, and taking action to change them in order to improve health, safety, and health equity.

A Practitioner's Guide for Advancing Health Equity: The purpose of the Health Equity Guide is to assist practitioners with addressing the well documented disparities in chronic disease health outcomes.

Cancer Disparities: This webpage provides examples of disparities in cancer, and the contributing factors behind these disparities.

Short Assessment of Health Literacy–Spanish and English (SAHL-S&E): The Short Assessment of Health Literacy–Spanish and English (SAHL– S&E) is a new instrument, consisting of comparable tests in English and Spanish, with good reliability and validity in both languages.

Vaccine Resource Hub: Access hundreds of free and accurate educational materials to support COVID-19 and flu vaccination in your community.

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DEFINITION OF THE SOCIAL DETERMINANTS OF HEALTH AND HEALTH RELATED SOCIAL NEEDS FOR MHQP'S GUIDELINES PROGRAM:
Root causes are power, policies, institutions, resources, and systems that shape Social Determinants of Health and determine an uneven distribution of opportunities for good health (Mass.gov, 2026).

Social Determinants of Health (SDoH) are the conditions under which people are born, grow, live, work, and age. SDoH can either help a patient's health (like living in a low crime neighborhood), or adversely affect it (such as living in a neighborhood with poor air quality and pollutants) (AAFP, WHO).

Health Related Social Needs (HRSN) are the urgent daily needs resulting from inequities in the social determinants of health, including access to stable housing, safe environments, nutritious food, utilities (such as heat and internet), transportation, health care, safety, education, employment, and social connection (Mass.gov, 2026).

Racism, Discrimination, and Health

A growing body of research shows that centuries of racism in this country has had a profound and negative impact on Black, Indigenous, and People of Color (BIPOC) communities. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships, and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment. These social determinants of health are key drivers of health inequities within BIPOC communities, placing those within these populations at greater risk for negative health outcomes.

Jones has defined 3 levels of racism.

- *Systemic, institutionalized, and structural racism:* "Structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by 'race' (e.g., how major systems—the economy, politics, education, criminal justice, health, etc. — perpetuate unfair advantage)."
- *Interpersonal and personally mediated racism:* "Prejudice and discrimination, where prejudice is differential assumptions about the abilities, motives, and intents of others by 'race,' and discrimination is differential actions towards others by 'race.' These can be either intentional or unintentional."
- *Internalized racism:* "Acceptance by members of the stigmatized 'races' of negative messages about their own abilities and intrinsic worth."

It is important for providers to examine the potential effects of racism in causing race-associated differences in health outcomes. Moreover, providers should acknowledge the influence of racism and discrimination in perpetuating disparities related to access to preventive services, the utilization of screening services, and delays in care. Providers should also examine whether their own implicit biases may lead to making inequitable care decisions.

The downstream effects of systemic racism, including race-based unfair interpersonal treatment, chronic vigilance to discrimination, and unequal access to resources and opportunities, can result in chronic stress, which has been shown to cause adverse health consequences within BIPOC communities (Sawyer et al., 2012; Health Affairs, 2022).

Other historically marginalized communities are also disproportionately subjected to discrimination. Discrimination is also attributed to gender identity, sexual orientation, and can also be directed toward individuals or communities with a variety of physical and social attributes such as age, body size, ability, social class, or religion—as well as the multiple intersections of these identities and characteristics (Health Affairs, 2020).

These guidelines stratify risk by modifiable and unmodifiable patient factors. When possible, MHQP's Clinical Workgroup utilized peer-reviewed studies that include nationally representative data for information on disparities in disease prevalence and screening rates. In areas where equity-related evidence is limited, smaller studies may be included if they provide critical insights into disadvantaged populations or context-specific barriers Note that missing health equity data elements (such as granular race, ethnicity, gender identity, sexual orientation, and disability data) and the lack of diversity in health research studies make it difficult to assess disparities in risk for many diseases and conditions. Subpopulations are referenced throughout the document as they are described in the cited literature.

Centuries of discrimination have also led to substantial medical mistrust, particularly within the Black community (Bazargan et al. 2021; Jack, 2021). The social stigmatization of an individual's intersecting identities, including gender identity, sexual orientation, body type, and ability, can also perpetuate medical mistrust. Medical mistrust leads to lower quality of care and the potential for adverse outcomes in multiple ways, including reduced usage of preventive services, loss of continuity of care, lack of follow up care, and dissatisfaction in patient-provider interactions (Allen et al. 2022); Bazargan et al., 2021; Duthely et al., 2021; Graham et al., 2015; Musa et al., 2009; Parnitzke Smith, 2017; Rokoske, 2022), highlighting the need for healthcare providers to address the role of racism and discrimination in perpetuating mistrust. Healthcare mistrust can be at the interpersonal and institutional levels (Ward, 2017).

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This guidance acknowledges that race is a social construct and not based in biology. Race was included in our risk-based analysis because race is a proxy for systemic racism, which perpetuates racial health inequities. Other social risk factors that intersect with racism (e.g., housing, education, and access to healthy foods) are also included to emphasize the multiple pathways to negative health outcomes.

RACE-BASED MEDICINE:

Risk calculators that use race and ethnicity as predictors, and laboratory test results with reference ranges that differ based on race and ethnicity, can exacerbate healthcare inequities. Clinical algorithms may embed racial and ethnic prejudices and stereotypes arising from historical and societal biases and can unconsciously reinforce these stereotypes (Cerdeña et al., 2020; Visweswaran et al., 2023)

Resources

Resources Confronting Institutionalized Racism: This article by Camara Phyllis Jones explores the pervasive and systemic nature of racism within institutions and offers a framework for addressing and dismantling this deeply rooted issue in society.

CDC Resources & Style Guides for Framing Health Equity & Avoiding Stigmatizing Language: This resource provides links to references, other resources, and style guides to frame health equity and avoid stigmatizing language.

Systemic And Structural Racism: Definitions, Examples, Health Damages, And Approaches to Dismantling: This article underscores that racism isn't always overt but can manifest as systemic and structural racism deeply ingrained in policies, practices, and beliefs, perpetuating unfair treatment and adverse health consequences for people of color, with examples such as residential aggregation, biased policing, and suggests the need for concerted, cross-sector efforts to dismantle these pervasive forms of racism.

Discrimination: A Social Determinant of Health Inequities: This article highlights the significant and wide-reaching impact of discrimination as a social determinant of health, discussing its role as a pervasive stressor with direct and indirect effects on the well-being of historically underserved communities, shedding light on its contribution to various health disparities.

Building Trust in Health Care—Why, Where, and How: This editorial discusses the significant decline in trust in the US healthcare system over the past half-century, citing statistics and high-profile events that have contributed to this erosion of confidence in medical leaders and institutions.

Re-Building Trust: This article discusses a collaborative effort involving over 120 healthcare stakeholders, exploring trust in various healthcare aspects and providing recommendations for improvement.

Periodic Health Evaluation

At every age

- Obtain initial/interval medical and family history. Screen for social determinants of health (see SdoH/HRSN section above for screening tools and resources)
- Perform age-appropriate physical exam.
- Provide preventive screenings and counseling as outlined below.
- Update immunizations. For current immunization schedules, refer to the AAFP Immunization Schedule
  - Assess vaccination status with attention to social risk factors, medical mistrust, personal beliefs, and other concerns associated with delaying or missing vaccinations.
  - Note that Black and Hispanic/Latino people have lower rates of vaccination compared to their White counterparts (Lu et al., 2015). These differences are likely due to a complex interaction of social determinants of health, including socioeconomic status, access to quality and equitable medical care, and medical mistrust.

18–29 Years	30–49 Years	50+ Years
• Annually for ages 18–21 • Every 1–3 years, depending on risk factors, for ages 22–29	• Every 1-3 years, depending on risk factors	• Annually

DEFINITION OF PERIODIC HEALTH EVALUATION FOR MHQP'S GUIDELINES PROGRAM

The periodic health evaluation (PHE) consists of one or more visits with a health care provider to assess patients' overall health and risk factors for preventable disease, and it is distinguished from the annual physical exam by its incorporation of tailored clinical preventive services and laboratory testing as part of health risk assessment. Source: CMS

Breast Cancer

18–39 Years	40–74 Years	75+ Years
• Screen patients with an increased risk for genetic mutations, including BRCA gene mutations, using appropriate screening tools. Offer genetic counseling for those with positive screening results. The tools evaluated by the USPSTF include the Ontario Family History Assessment Tool, Manchester Scoring System, Referral Screening Tool, Pedigree Assessment Tool, and FHS-7. • Consider prescribing risk-reducing medications to those who are 35 or older and are at increased (>1.7%) risk for breast cancer and at low risk for adverse medication effects using shared decision making ♦ Note that the USPSTF does not endorse any particular risk prediction tool. However, the NCI Breast Cancer Risk Assessment Tool and the Breast Cancer Surveillance Consortium Risk Calculator are based on models tested in US populations and are publicly available for clinicians and patients to use as part of the process of shared, informed decision-making about taking risk-reducing medications for breast cancer.		
• Only with patients at risk, use shared decision making to discuss the risks and benefits of initiating mammography or other screening exams.	• Conduct mammography every two years, or more frequently based on risk factors and shared decision making	• Determine need of further mammography based on shared decision making.

DISPARITIES AND RISK FACTORS

Disparities in Breast Cancer Prevalence

Breast cancer prevalence varies among racial and ethnic groups, with the highest rates among White patients and patients of Ashkenazi Jewish descent (CDC, 2021; Yedjou et al., 2019). Note that those of Ashkenazi Jewish descent have a higher risk of developing breast cancer at a young age, due to higher rates of BRCA gene mutation (Yedjou et al., 2019). Also, note that in women under age 50, breast cancer is more common in Black women (Xu et al., 2024). Black women are also more likely to die from breast cancer at any age (American Cancer Society, 2022). Patients may be more likely to get more aggressive forms of breast cancer and be diagnosed at a younger age if they are Black (American Cancer Society, 2022; Xu et al., 2024). Differences in breast cancer prevalence by race are likely due to complex interactions of social determinants of health, including access to affordable and equitable medical care.

Disparities in Breast Cancer Screening

Asian, Hispanic, and American Indian/Alaskan Native women have lower rates of screening compared to White and Black women (American Cancer Society, 2025). Members of the LGBTQ+ community are less likely to get screened for breast cancer compared to straight individuals (Herriges et al., 2021). People with disabilities are also less likely to get screened (CDC, 2024).

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Breast Cancer (continued)

Risk Factors for Breast Cancer

- Age, the risk for breast cancer increases with age; most breast cancers are diagnosed after age 50
- Having a first degree relative (parent, sibling, or child) with breast, ovarian, tubal, or peritoneal cancer or multiple relatives with breast cancer
- Having a genetic predisposition, such as BRCA gene mutation
- Having a personal history of ovarian cancer or high-risk breast biopsy result
- Having a history of chest radiation therapy at a young age
- Early menarche or late menopause
- Having dense breasts
- In utero diethylstilbestrol (DES) exposure
- Using hormone replacement therapy (HRT) or oral contraceptives
  - Note that combined estrogen and progesterone HRT and certain oral contraceptives increase the risk of breast cancer.
- Never having a full-term pregnancy, having a first pregnancy after age 30, or not breastfeeding
- Not being physically active
- Being overweight or obese after menopause
- Drinking alcohol
- Having barriers to getting screened or to follow-up care for an abnormal mammogram, including living in medically underserved area

Note that other factors such as smoking, being exposed to chemicals that can cause cancer, and changes in other hormones due to night shift working also may increase breast cancer risk.

Resources:

NCI Breast Cancer Risk Assessment Tool: NCI is a calculator that estimates a person's likelihood of developing breast cancer over a specific time period based on individual risk factors such as age, family history, and reproductive history.

Breast Cancer Surveillance Consortium: This tool estimates an individual's risk of developing advanced breast cancer by incorporating factors such as age, breast density, prior breast biopsy results, and other clinical and demographic information.

Doctor Decision Aid- Mammography Screening: This resource from the American College of Radiology provides information on the risk of breast cancer and screening recommendations.

Breast Cancer Screening Decision (For women 40-49): This is a screening tool designed to give women unbiased information that can help make an informed decision about when you should start and how often you should have screening mammograms.

Should I Continue with Mammogram Screening? (For women 75-84): This tool will help women over the age of 75 think about whether or not they may want to stop or continue having mammograms.

What Can I Do to Decrease My Risk: This resource provides information to help lower breast cancer risk.

Bring Your Brave – Breast Cancer Resources: The Bring Your Brave campaign provides information about breast cancer to women younger than age 45 by sharing real stories about young women whose lives have been affected by breast cancer.

Breast Cancer Risk and Prevention: This American Cancer Society resource outlines things patients can do that might lower their risk of breast cancer.

Cervical Cancer

18–20 Years	21–30 Years	31–65 Years	66+ Years
• Omit cervical cancer screening test if a person has had a hysterectomy for benign disease with removal of cervix and does not have a history of high-grade precancerous lesion or cervical cancer. • Note that the USPSTF states these recommendations do not apply to those with high grade precancerous lesions or cervical cancer or in utero DES exposure or a compromised immune system, including those with HIV.			
• No cervical cancer screening is indicated • Recommend HPV vaccination, if not previously vaccinated	• Recommend screening with pap every three years • Recommend HPV vaccination, if not previously vaccinated	• Recommend Screening as follows: ♦ Pap every three years OR ♦ HPV test every five years OR ♦ Pap/HPV co-test every five years • Using shared decision making, consider HPV vaccine if not previously vaccinated, up to age 45	• Discontinue cervical cancer screening after 65 years of age in women at low risk due to previous negative screening.

DISPARITIES AND RISK FACTORS

Disparities in Cervical Cancer Prevalence

Cervical cancer prevalence varies among racial and ethnic groups, with the highest rates among Black, American Indian, Alaska Native, and Hispanic/Latino patients (CDC, 2021). Hispanic/Latino women have the highest rates of developing cervical cancer, and Black women have the highest rates of dying from cervical cancer (CDC, 2024). These differences in rates of cervical cancer by race and ethnicity are likely due to complex interactions of social determinants of health, including access to affordable and equitable medical care.

Disparities in Cervical Cancer Screening

Asian, Hispanic, and American Indian/Alaskan Native women have lower rates of cervical cancer screening compared to White and Black women (American Cancer Society, 2025). Members of the LGBTQ+ community are less likely to get screened for cervical cancer compared to straight individuals (Herriges et al., 2021). People with disabilities are also less likely to get screened (Orji et al., 2024).

Risk Factors for Cervical Cancer

- Having a family history of cervical cancer
- Having a personal history of cervical dysplasia
- Having an infection with high-risk HPV (human papillomavirus)
- Having a history of sexually transmitted diseases (including HIV/AIDS and chlamydia)
- Engaging in sex without a condom or having multiple sexual partners
- Having a compromised immune system
- In utero diethylstilbestrol (DES) exposure
- Prolonged use of oral contraceptives (5 years or more)
- Smoking
- Having multiple full-term pregnancies, individuals who have had 3 or more full-term pregnancies have an increased risk of developing cervical cancer.
- Young age at first full-term pregnancy, women who were younger than 20 years when they had their first full term pregnancy are more likely to get cervical cancer later in life than women who waited to get pregnant until they were 25 years or older.
- Having barriers to getting screened or to follow-up care for an abnormal pap smear, including living in medically underserved area
- Low socioeconomic status

Resource:

Cervical Cancer Screening: This is a resource to aid women to learn about cervical cancer screening.

Colorectal Cancer

18–44 Years	45–75 Years	76-85 Years
Note that while colonoscopy is often considered to be the best screening test, other testing may be more accessible and acceptable to patients. There are significant barriers to completing the colonoscopy screening, such as lack of transportation to the procedure, lack of access to a reliable bathroom, not having someone to accompany a person to the procedure, and financial burdens associated with the colonoscopy procedure (Lee et al., 2023; Schwartz et al., 2022; Muthukrishnan, Arnold, & James, 2019). Recommended intervals for colorectal cancer screening tests include: ♦ High-sensitivity gFOBT or FIT every year ♦ SDNA-FIT every 1 to 3 years ♦ CT colonography every 5 years ♦ Flexible sigmoidoscopy every 5 years ♦ Flexible sigmoidoscopy every 10 years + FIT every year ♦ Colonoscopy screening every 10 years		
• Screenings are not routine except for patients at high risk –Patients at high risk may need to begin screening earlier than patients not at high risk. See notes in next column regarding age to begin screening based on family history • Consider reviewing signs and symptoms associated with colorectal cancer in all adult patients	• Screen for colorectal cancer and use shared decision making to select one of the methods/screening intervals listed above for people at average risk. • Patients with one first degree relative with colorectal cancer or advanced adenoma diagnosed **before age 60 or** who have two first degree relatives with colorectal cancer or advanced adenoma at any age should begin screening with colonoscopy ten years less than age at diagnosis of 1st degree relative or at age 40, whichever is earlier, repeating every 5 years. • Patients with one first degree relative with colorectal cancer, advanced adenoma **or** advanced serrated lesion diagnosed **after age 60** should begin screening with colonoscopy at age 40, with intervals same as average risk patients.	• Selectively offer screening for adults aged 76 to 85 years. Evidence indicates that the net benefit of screening all persons in this age group is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the patient's overall health, prior screening history, and preferences. • After age 86, screening is not recommended.

DISPARITIES AND RISK FACTORS

Disparities in Colon Cancer Prevalence

Colorectal cancer prevalence varies among racial and ethnic groups, with Black, American Indian, and Alaska Native patients having higher rates of colorectal cancer than White patients (CDC, 2021). Black patients have shorter stage specific survival and overall mortality rates of colorectal cancer compared with White patients (Rutter et al. 2022). Note that patients of Ashkenazi Jewish descent also have a higher incidence of colorectal cancer than other populations and that this observed incidence has a genetic component (Matis et al., 2024).

Disparities in Colorectal Cancer Screening

Young Black patients, as well as Hispanic patients with limited to no English proficiency are less likely to receive guideline-concordant screening for colon and rectal cancer compared to White patients (Nogueria et al., 2023; CDC, 2024). Up-to-date screening is lower among Hispanic Asian and American Indian or Alaska Native person compared to other racial groups (American Cancer Society, 2025). Additionally, transgender and gender-nonconforming individuals have lower odds of lifetime colorectal screening compared to cisgender men and women (Tabaac et al. 2018; Lin et al., 2023). These differences are likely due to complex interactions of social determinants of health, including access to affordable and equitable medical care.

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Colorectal Cancer (continued)

Risk Factors for Colorectal Cancer

- Family history
- Age: the risk of getting colorectal cancer increases with age. The vast majority of new cases of colorectal cancer occur in adults 45 years or older. However, incidence rates for adults younger than 50 have increased 3% annually since 2010 (American Cancer Society, 2023).
- Individuals with Ashkanzai Jewish descent with a family history of colorectal cancer
- Sex, males are more likely to get colorectal cancer than females.
- Having a history of inflammatory bowel disease or a genetic syndrome such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colorectal cancer (Lynch syndrome). Review screening guidelines specific to these conditions.
- Low socioeconomic status
- Having a diet low in fruits and vegetables, a diet low in fiber, or a diet high in fat or processed meats. Not being physically active
- Being overweight or obese
- Alcohol consumption
- Tobacco use

Resources:

Colorectal Cancer: Catching it Early: This guide helps patients understand who may be at higher risk for colorectal cancer, and determine the types of screening that may be the best for them.

Clinician's Reference: Stool-Based Tests for Colorectal Cancer Screening: This resource from the American Cancer Society provides information on stool-based test options for individuals at risk of developing colorectal cancer

ePrognosis Colorectal Cancer Screening Survey: This screening calculator is intended for clinicians to use as a rough guide to determine possible mortality outcomes.

CDC: Colorectal Cancer Screening Tests: This resource reviews colorectal cancer screening strategies.

Lung Cancer

18-50 Years	50-80 Years
• Counsel current smokers to quit smoking (see Tobacco, Smoking, and Vaping section for resources to help quit smoking)	• Counsel current smokers to stop smoking and counsel that lung cancer screening does not replace the need to quit smoking (see Tobacco, Smoking, and Vaping section for resources to help quit smoking) • Use shared decision making to discuss the risks and benefits of low dose computed tomography (LDCT) screenings for patients meeting the following criteria: ♦ 20 pack-year smoking history and either currently smoke or have quit within the past 15 years • If the decision is made to pursue screening, screen annually at a facility equipped to perform screening and evaluate results • Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery • Note that 86% of eligible adults did not receive a lung cancer screening in 2022 (American Cancer Society, 2025)

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Lung Cancer (continued)

DISPARITIES AND RISK FACTORS

Disparities in Lung Cancer Prevalence

Black, Hispanic/Latino, Asian, American Indian, and Alaska Native patients are less likely to be diagnosed early with lung cancer compared with White patients (American Lung Association, 2024). These differences are likely due to complex interactions of social determinants of health, including access to affordable and equitable medical care.

Risk Factors for Lung Cancer

- Having a family history of lung cancer
- Having a personal history of specific other cancers: small cell lung cancer, lymphoma including Hodgkin's, tobacco associated cancers like bladder and head and neck, cancers that required radiation treatment to the chest
- Having a history of COPD or pulmonary fibrosis
- Smoking (current smokers or smoking within the past 15 years)
- Exposure to secondhand smoke and other chemicals including radon, asbestos, and diesel fumes

Resources:

Is Lung Cancer Screening Right for Me? (Spanish): This article answers many frequently asked questions about lung cancer screenings, and helps patients determine if screening is right for them.

Prostate Cancer

18-39 Years	40-49 Years	50-69 Years	70+ Years
• For high-risk patients only, use shared decision making to discuss prostate specific antigen (PSA) screening.	• For high-risk patients only, use shared decision making to discuss prostate specific antigen (PSA) screening. • High-risk patients should be provided with the same screening education and options as patients aged 50-69.	• Screening for prostate cancer with PSA test should not be performed or offered routinely without shared decision making, including a clear explanation and understanding of the benefits and harms. • Only offer PSA screening for patients who express a clear preference for screening after shared decision making and who have a life expectancy of >10 years. • For patients who have chosen PSA screening, screen every 1-4 years. Consider annual screening in patients with higher PSA levels that are still below a cut-off for biopsy, and less frequent screening in patients with lower initial PSA levels. PSA screening is not recommended for patients with a life expectancy of < 10 years.	• PSA screening and routine discussion of screening are not recommended.

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Prostate Cancer (continued)

DISPARITIES AND RISK FACTORS

Disparities in Prostate Cancer Prevalence

Prostate cancer prevalence varies among racial and ethnic groups, with Black patients at a disproportionately higher risk than other racial/ethnic groups (CDC, 2021). Black men are twice as likely to die from prostate cancer than other men and tend to develop prostate cancer at a younger age (CDC, 2024). In addition, individuals with preexisting chronic complex activity limitation and movement difficulty are more likely to develop prostate cancer than those who do not have a preexisting disability (Iezzoni et al. 2020).

Disparities in Prostate Cancer Screening

Disparities exist for prostate cancer screenings. Transgender women and gay men are less likely to receive PSA screening compared to cisgender, straight men (Kalavacherla et al. 2024; Herriges et al., 2022). Men with disabilities are less likely to receive PSA screening compared to those who do not live with disabilities (Leong et al., 2022).These differences are likely due to complex interactions of social determinants of health, including access to affordable and equitable medical care, as well as genetics. Studies have shown that Black men with prostate cancer carry different genetic variants and often have more aggressive disease than men of other racial/ethnic groups (Chowdhury-Paulin, 2021; National Cancer Institute 2025).

Risk Factors for Prostate Cancer

- Age, while prostate cancer is rare in men younger than 40, the chance of having prostate cancer rises rapidly after age 50. About 6 in 10 cases of prostate cancer are found in men older than 65.
- Having a family history of prostate cancer, including a first degree relative (parent, sibling) diagnosed with prostate cancer before the age of 65, three first degree relatives with prostate cancer, three generations with prostate cancer on either the maternal or paternal line, or family history of breast, ovarian, or pancreatic cancer
- Having mutations of the BRCA1 or BRCA2 genes
- Having Lynch syndrome (hereditary non-polyposis colorectal cancer)
- Low socioeconomic status

Resources:

Testing for Prostate Cancer: This booklet includes information to help men understand testing for prostate cancer so they can decide with their doctor if testing is right for them.

CDC Prostate Cancer: This resource provides helpful information to patients about prostate cancer and testing. Note, this resource reflects the 2018 USPTSF recommendation to being screening average risk men at age 55.

Why Black Men Should Consider Earlier Screening for Prostate Cancer: Black men are at increased risk for prostate cancer and may benefit from more vigilant screening. This article outlines 3 things Black men should know about prostate cancer.

Skin Cancer

18+ Years

- Educate at-risk patients about skin cancer, including using the ABCDE guidelines to check moles
- Counsel to limit exposure to the sun (especially between 10 A.M. and 4 P.M.), to fully cover skin with clothing and hats, and to use sun block (SPF 15 or greater), especially those over 24 with fair skin types
- Discourage use of indoor tanning
- Consider inspecting skin for abnormalities when performing physical exam

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DISPARITIES AND RISK FACTORS

Disparities in Skin Cancer Prevalence

White patients are at higher risk of developing skin cancer than other racial groups (CDC, 2021) due to less melanin in the skin; however, when skin cancers occur in other racial/ethnic groups, they tend to be diagnosed at a later stage and, as a result, have a worse prognosis (Skin Cancer Foundation, 2025). Additionally, people with disabilities are more likely to develop skin cancer, especially later in life, compared to people without disabilities (Bowers et al., 2023). These differences are likely due to complex interactions of social determinants of health, including access to affordable and equitable medical care, as well as genetics. In addition, there's a lower public awareness overall of the risk of skin cancer among individuals of color. Patients and providers may be less familiar with the typical appearance of skin cancers on skin color (Skin Cancer Foundation, 2020).

Risk Factors for Skin Cancer

- Age, individuals who are 65 years of age or older are more likely to be get skin cancer
- Having a family or personal history of skin cancer
- Having a personal history of repeated sunburns early in life or chronic exposure to the sun
- Frequent use of indoor tanning beds
- Having certain characteristics to their skin, such as a large number of moles, fair skin, or sun sensitivity

Resources:

Skin Cancer in People of Color: This guide helps patients of color understand their skin cancer risk, and how to conduct self-exams.

Skin Cancer in People of Color Image Gallery – American Society for Dermatologic Surgery: This image gallery gives clinicians examples of what skin cancer looks like on people of color.

General Screening, Counseling, and Guidance

Cardiovascular Health (incl. screening for hypertension, lipid disorder/high cholesterol, and abdominal aortic aneurysm)

18+ Years

General

- Review and assess known cardiovascular risks, and counsel on mitigating any risks. See sections on diet and nutrition, obesity and overweight, and physical activity for additional counseling and guidance.
- Ask about access to safe, affordable, and accessible physical activity options
- Ask about access to healthy, affordable, and culturally appropriate food options
- Refer to SNAP or other food assistance services as indicated
- Offer or refer adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity

Tobacco

- Counsel current smokers to quit smoking (see Tobacco, Smoking, and Vaping section for resources to help quit smoking)

Lipids

- Screen for lipid disorder (high cholesterol) with either a non-fasting total cholesterol and HDL or a fasting lipid profile. Using a non-fasting lipid profile may result in needing a follow-up fasting lipid profile. Recommend follow-up fasting lipoprotein profile if total cholesterol is >200 mg/dl or HDL is <40 mg/dl.
- Recommend statin use in patients without CV disease aged 40-75 who have at least one risk factor for CVD and a 10 year risk of developing CVD of 10% or higher based on ASCVD Risk Factor Estimator Plus or PREVENT (USPSTF B recommendation). Note that the ASCVD Risk Estimator Plus generally assigns higher risk for Black persons than White persons when other factors are identical. Concerns about calibration of the Pooled Equations exist, as race is incorporated into the calculation and race is a social construct, not based in biology.
- Consider statin use in similar patients whose risk is 7.5% or higher based on ACC/AHA Pooled Cohort Equation (USPTF C Recommendation)
- Consider using ASCVD Risk Estimator Plus or PREVENT to evaluate 30 year or lifetime risk in patients with low or borderline risk in patients aged 30-59.
- Recommend using a 10 year risk assessment tool for patients aged 30-79, and assess results in the context of other risk factors and known limitations of the tool. Note that no risk estimator perfectly predicts ASCVD risk. Tools available include: PREVENT, ASCVD Risk Estimator Plus, Framingham CVD risk score, Reynolds CAD Risk | QxMD and QRISK tools.
- Consider CAC scoring in patients with borderline to intermediate risk

Blood Pressure

- Check blood pressure at every visit
  - Screen for hypertension every year in adults 40 years or older and in adults at increased risk for hypertension (such as persons with high-normal blood pressure, or persons who are overweight or obese)
  - Screen less frequently (ie, every 3-5 years) as appropriate for adults aged 18 to 39 years not at increased risk for hypertension and with a prior normal blood pressure reading
  - Offer ambulatory blood pressure measurements for those who have high blood pressure readings in the office
- Recommend less than 2,300 mg of sodium per day as part of a healthy eating pattern

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Abdominal Aortic Aneurysm

- Screen for abdominal aortic aneurysm once in males aged 65–75 who have ever smoked, and consider using shared decision making for others at risk

Aspirin

- Using shared decision making, consider low dose aspirin for adults aged 40-59 who have a 10% or greater 10 year risk of CVD, are not at risk for bleeding, have a life expectancy of 10 years or more and are willing to continue taking it for 10 years
- Offer or refer adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity

DISPARITIES AND RISK FACTORS

Disparities in Cardiovascular Diseases

Cardiac death rates and disease prevalence among racial and ethnic groups vary by source. However, Black individuals are more likely to die of heart disease than their White counterparts (CDC, 2019). In addition, Native American/Alaska Indian individuals are more likely to be diagnosed with coronary heart disease than their White counterparts (Hutchinson & Shin, 2014). Conditions which are themselves risk factors for developing heart disease, like diabetes and hypertension, also vary by race or ethnicity. Adults with disabilities have a higher prevalence of cardiovascular disease compared to those without disabilities (Jerome & Lily, 2024).These differences are likely due to complex interactions of social determinants of health, including access to healthy options for diet and exercise, and access to affordable and equitable medical care. Note that research has shown a significantly high association between experiences with stigma and discrimination and cardiovascular disease (Panza et al. 2019).

Risk Factors for Cardiovascular Disease

- Age, incidence for CVD is 40% from ages 40-59, 75% from ages 60-79, and over 80% for those 80 years and older
- Sex, males are more likely to develop cardiovascular disease than females
- Having a family history of premature heart disease
- Having a personal history of smoking, alcohol consumption, diabetes, hypertension, hyperlipidemia, low HDL, obesity (BMI over 30), or preeclampsia
- Low socioeconomic status
- Not being physically active
- Living in areas with low accessibility to healthy, affordable, and culturally appropriate food

Risk Factors for Abdominal Aortic Aneurysm

- Age, individuals are more likely to develop abdominal aortic aneurysm if they are age 65 years and older
- Sex, males are more likely to develop abdominal aortic aneurysm than females
- Having a family history of abdominal aortic aneurysm, coronary artery disease, peripheral vascular disease, and/or hypertension
- Regular use of tobacco

Resources:

ACC/AHA Pooled Cohort Equations: This calculator is intended for clinician use to help understand the 10-year risk of ASCVD in patients. Note that the ASCVD Risk Estimator Plus generally assigns higher risk for Black persons than White persons when other factors are identical. Concerns about calibration of the Pooled Equations exist, as the USPSTF recognizes that race is a social construct.

Note: If you use an application for risk calculation, make sure it is based on the ACC/AHA Pooled Cohort Equation.

PREVENT: This ACC/AHA calculator removes race, extends the age range to 30-79, and has a 10- and 30-year risk calculation

Aspirin Guide: The Aspirin-Guide app from researchers at Brigham and Women's Hospital, Harvard Medical School, helps clinicians decide which patients are candidates for the use of low-dose aspirin (75 to 81 mg/d) in the primary prevention of atherosclerotic cardiovascular disease (ASCVD) by balancing the ASCVD benefits against the risk of harm due to gastrointestinal (GI) or other bleeding.

2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: This guide is for clinicians to understand how to assess and estimate the risk of CVD in patients.

Statin Choice Decision Aid: This calculator is for patients, with aid from their clinicians, to understand how to use statins to reduce likelihood of heart attacks.

Diabetes (Type-2) and Pre-Diabetes

18+ Years

- Counsel on the benefits of physical activity and a healthy diet. See sections on diet and nutrition and physical activity for further guidance.
- Ask about access to safe, affordable, and accessible physical activity options
- Ask about access to healthy, affordable, and culturally appropriate food options
- Refer to SNAP or other food assistance services as indicated
- Screen for prediabetes and type 2 diabetes with fasting blood sugar, 2-hour oral glucose tolerance, or HbA1C test every three years in adults aged 35 to 70 years who have overweight or obesity. Offer or refer patients with pre-diabetes to effective preventive interventions. Consider screening in adults younger than 35 who have overweight and obesity and belong to a higher risk group
- Consider screening the general population every 3 years beginning at age 35. If the test results in diagnosis of pre-diabetes, recommend screening again in 6 months to 1 year, and counsel or refer for counseling on diet and lifestyle changes to prevent the onset of Type-2 diabetes.
- Consider the CDC training program recommendation for diabetic and pre-diabetic patients
- Emphasize that lifestyle changes that result in lower weight and increased physical activity are critical in managing Type-2 diabetes and pre-diabetes, including the potential for remission
- Consider the effect on weight when choosing between medications for management of diabetes
- Consider obesity management with weight loss medication for people with BMI ≥ 27 with comorbidity or BMI ≥ 30 and no comorbidities
- Refer for consideration of metabolic surgery for individuals with severe obesity and for individuals with moderate obesity who do not achieve durable weight loss and improvement in comorbidities (including hyperglycemia) with reasonable nonsurgical methods

DISPARITIES AND RISK FACTORS

Disparities in Diabetes Prevalence

Diabetes prevalence varies among racial and ethnic groups, with the highest rates observed among Hawaiian/Pacific Islander patients, followed by Hispanic/Latino patients, Black patients, American Indian/Alaska Native patients, and Asian patients, while White patients have the lowest prevalence (Zhu et al., 2019). Additionally, individuals living with intellectual and developmental disabilities are twice as likely to develop diabetes compared to those who do not have disabilities (Oyetoro et al., 2023; CDC 2024).These differences are likely due to complex interactions of social determinants of health, including access to healthy and affordable foods, access to safe, affordable, and accessible physical activity options, education about diet and exercise as prevention tools, socioeconomic status, and access to affordable and equitable medical care.

Risk Factors for Diabetes

- Age, individuals who are ages 45 years and older are more likely to develop diabetes
- Sex, males are more likely to develop diabetes than females
- Having a first degree relative with diabetes
- Having a personal history of being overweight/obese, high blood pressure (above 135/80mmHg), vascular disease, elevated cholesterol/lipid levels, gestational diabetes or birth of a baby >9 lbs, impaired glucose tolerance, and/or polycystic ovary syndrome
- Not being physically active (being physically active fewer than three times a week
- Living in areas with low accessibility to healthy, affordable, and culturally appropriate food

Resources:

CDC: Diabetes Prevention Recognition Program: This source outlines the CDC's standards for organizations offering the National Diabetes Prevention Program (National DPP) lifestyle change program) through various delivery modes (in-person, online, distance learning, and combination).

Obesity and Overweight

18+ Years

- Counsel on the benefits of physical activity and a healthy diet to maintain an appropriate weight for height. See sections on diet and nutrition and physical activity for further guidance.
- Ask about access to safe, affordable, accessible, and culturally appropriate physical activity options
- Ask about access to healthy, affordable, and culturally appropriate food options
- Refer to SNAP or other food assistance services as indicated
- Screen for obesity at every periodic health evaluation visit using the CDC's BMI charts, waist circumference and risk factors for metabolic disease as a guide. Note that the BMI should be used in conjunction with other clinical assessments including waist circumference and risk factors for metabolic disease before making a diagnosis of obesity and overweight. The correlation between BMI and percentage body fat is fairly strong; however, two people with the same BMI may have different percentages of body fat based on differences in skeletal and muscle mass.
- In these guidelines, consistent with the CDC's definition, a BMI of 25-29.9 with other indications of overweight is considered overweight. BMI of 30-39.9 with other indications of obesity is considered obesity. BMI of >40 with other indications of severe obesity is considered severe obesity. Note that individuals with smaller bone structure or low muscle mass may have overweight or obesity at lower BMI levels, while individuals with larger bone structure or greater muscle mass may not have overweight or obesity at these BMI levels
- Offer more focused evaluation and intensive counseling for obese or overweight adults with co-morbidities, to promote sustained weight loss. The USPSTF recommends that clinicians offer or refer patients with obesity to intensive, multicomponent behavioral interventions.
- Consider the CDC training program recommendation for diabetic and pre-diabetic patients. See diabetes section for diabetes-specific recommendations.
- Consider the effect on weight when choosing medications for medical management of chronic conditions and other medication needs.
- Consider obesity management with weight loss medication for people with BMI ≥27 with a comorbidity or BMI ≥ 30 and no comorbidities
- Refer for consideration of metabolic surgery for individuals with severe obesity and for individuals with moderate obesity who do not achieve durable weight loss and improvement in comorbidities (including hyperglycemia) with reasonable nonsurgical methods
- Note that the diagnosis of overweight and obesity carries significant emotional responses due to personal and societal biases. These may relate to the historical emphasis on dieting and willpower as primary approaches to managing overweight and obesity. Obesity is now recognized as a complex medical condition, driven in part by social determinants of health. Practitioners should use person-specific and neutral language, as well as techniques like motivational interviewing.

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Obesity and Overweight (continued)

DISPARITIES AND RISK FACTORS

Disparities in Obesity and Overweight Prevalence

Obesity and overweight prevalence varies among racial and ethnic groups, with higher rates among Black, American Indian, Alaska Native, and Hispanic/Latino patients (Hales et al., 2020; KFF, 2021). In addition, women are more likely than men to be diagnosed with obesity (Cooper et al. 2021). Additionally, transgender and gender diverse people are more likely to develop obesity compared to cisgender individuals (Taormina & Iwamoto, 2023). People living with disabilities, especially those with mobility, self-care, and cognition disabilities, have higher prevalence of obesity and overweight compared to those who do not have disabilities (Townsend et al., 2022). These differences are likely due to complex interactions of social determinants of health, including access to healthy and affordable foods, access to safe, affordable, accessible, and culturally appropriate physical activity options, access to health care, education about diet and exercise as prevention tools, socioeconomic status, and access to affordable and equitable medical care.

Risk Factors for Obesity/Overweight

- Living in areas with low accessibility to healthy, affordable, and culturally appropriate food
- Low socioeconomic status
- Not being physically active

Resources:

Stop Obesity Alliance: Strategies to Overcome and Prevent (STOP) Obesity Alliance is a coalition dedicated to addressing the obesity epidemic through advocacy, policymaking, and research

(STOP) Weight Can't Wait: Weight Can't Wait is a guide for the management of obesity in the primary care setting.

Obesity Action Coalition: Obesity Action Coalition is a nonprofit organization that focuses on raising awareness of obesity, providing education and support on obesity and its treatments

Physical Activity

18+ Years

- Ask about access to safe, affordable, accessible, and culturally appropriate physical activity options
- Counsel on the importance of regular physical activity including aerobic, strength, and flexibility training
- Advise that the CDC recommends 150 minutes of moderate-intensity or 75 minutes of vigorous-intensity aerobic activity/week, and muscle- strengthening activities 2 days/week
- Advise that any increase in physical activity can be beneficial in chronic disease prevention, even if not to the level of the CDC recommendation
- Emphasize the importance of balance training for older adults at risk for falling

DISPARITIES AND RISK FACTORS

Disparities in Physical Inactivity

Physical inactivity prevalence varies among racial and ethnic groups, with higher rates of inactivity outside of work among Hispanic patients, followed by Black, then American Indian and Alaska Native patients (CDC, 2025). These differences are likely due to complex interactions of social determinants of health, including access to safe, affordable, and accessible physical activity options, access to health care, education about exercise as a prevention tool, and socioeconomic status. In addition, note that individuals with mobility disabilities report barriers to engaging in aerobic exercise (CDC, 2024).

Transgender individuals and those who are gender minorities are less likely to engage in physical activity compared to cisgender individuals (Taormina & Iwamoto, 2023). These differences are likely due to complex interactions of socioecological factors, as well as lack of access to inclusive exercise facilities that have accessible bathrooms and locker rooms.

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Physical Activity (continued)

Risk Factors for Physical Inactivity

- Living in areas that lack safe and walkable neighborhoods, or low access to physical activity options or equipment
- Having a sedentary occupation or time limitations
- Low socioeconomic status

Resources:

WalkBoston: This webpage is for the organization WalkBoston, which advocates to make walking safer and easier in Massachusetts to encourage better health, a cleaner environment, and more vibrant communities.

Physical Activity for Adults: This guide helps patients understand the benefits of physical activity, and how to become more physically active.

Physical Activity for Older Adults: This guide helps seniors understand the benefits of physical activity, and how to become more physically active.

A Matter of Balance: A Matter of Balance: Managing Concerns About Falls is a program designed to reduce the fear of falling and increase activity levels among older adults.

Exercising on a Budget: This resource provides ways to exercise for little or no money, including many activities that can be done in the home.

Diet and Nutrition

18+ Years

- Ask about access to healthy, affordable, and culturally appropriate food options
- Refer to SNAP or other food assistance services as indicated
- Counsel on the importance of a healthy diet in the prevention of disease. A healthy diet:
  - Emphasizes nutrient dense foods including fruits, vegetables, whole grains, and low-fat dairy
  - Includes a variety of protein foods, such as seafood, lean meats and poultry, eggs, legumes (beans and peas), soy products, nuts, and seeds
  - Limits red and processed meat, refined carbohydrates, and food and beverages with added sugar, salt, saturated and trans fats
  - Stays within your daily calorie needs
- Screen for eating disorders by asking about body image and dieting patterns

DISPARITIES AND RISK FACTORS

Disparities in Diet and Food Insecurity

Often, race, ethnicity, and the social determinants of health are associated with dietary intake and related health disparities. Food insecurity and limited access to healthy foods is more common in Black, Hispanic/Latino, Native American, and Alaska Native households (USDA 2023). In addition, members of the LGBTQ Community (Ferrero et al., 2023), and people with disabilities (USDA, 2022) are more likely to experience food insecurity. Note that in the United States, the most economical food choices are often the least healthy, highly processed and high in added sugars, sodium, and saturated/trans fats.

Risk Factors for Poor Nutrition

- Low socioeconomic status
- Living in areas with low accessibility to healthy, affordable, and culturally appropriate food

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Diet and Nutrition (continued)

Resources:

CDC: Healthy Weight: This webpage helps patients understand how to use physical activity and nutritious meals to maintain a healthy weight.

SNAP: This webpage helps determine who is eligible for SNAP and how to apply for the food assistance program.

SNAP Benefits Healthy Incentives Program (HIP) for Clients: This webpage gives you information about the Healthy Incentives Program (HIP), which helps those who receive SNAP benefits to gain access to healthy food by finding HIP authorized farmers and vendors.

Farmers Market Nutrition Program: This webpage provides information about the Farmers Market Nutrition program, which gives eligible seniors and WIC families coupons to buy fresh produce at farmers markets across the state.

1Degree: One Degree is an interactive tool that helps you find free, life-improving resources related to food, health, housing, employment, and more near you.

Commodity Supplemental Food Program: Find your local program: This webpage provides contact information for the commodity supplemental food programs in every state.

Find Meals when Schools are Closed: This webpage provides information on where to find free meals for children when school is not in session.

Heart Healthy Recipes: This website provides hundreds of heart healthy recipes for breakfast, lunch, dinner, and dessert that are also tailored to different cultural groups.

Oral Health

18+ Years

18+ Years

- Ask about access to preventive dentistry and encourage visiting a dentist at least yearly
- Encourage use of fluoridated water and toothpaste
- Advise twice daily tooth brushing and daily flossing
- Counsel to avoid foods and drinks with added sugars
- Counsel to avoid tobacco use
- Counsel to limit alcohol use

DISPARITIES AND RISK FACTORS

Disparities in Poor Oral Health

Often, race, ethnicity, and social determinants of health are associated with lack of access to dental care. Non-Hispanic Black adults have the highest percentage of tooth decay (CDC, 2021). Additionally, Black men are less likely to visit the dentist, are twice as likely to experience tooth decay, and have greater tooth loss (Akintobi et al., 2018). People with intellectual and developmental disabilities have a higher prevalence of periodontal disease than people without intellectual and/or developmental disabilities (Wilson et al., 2019). Note that dental coverage for adult Medicaid recipients is not required by federal law and can vary by state, which limits access to dental care for individuals on public health insurance (CDC, 2024).

Risk Factors for Dental Caries, Gum Disease and Undiagnosed Oral Cancers

- Living in places with lack of access to dental care
- Living in places without fluoridated water
- Low socioeconomic status
- Consumption of foods and drinks with added sugars
- Regular use of alcohol
- Regular use of tobacco
- Lack of dental insurance

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Oral Health (continued)

Resources:

America's Tooth Fairy: This webpage provides resources for families to gain access to dental care, and education to help foster healthy habits to last a lifetime.

Massachusetts Dental Society: The resources on this webpage can help families find the best dentists for them, and learn about low-cost dental care options.

CDC Oral Health Tips: This source from the CDC lists recommendations on how to maintain good oral health

My Water's Fluoride: This resource from the CDC allows people to check whether their water source is fluoridated.

Oral Health Practice Guidelines: This resource from the Massachusetts Department of Public Health provides recommendations on pregnancy and early childhood oral health

Sexual Health, Sexual Orientation, and Gender Identity

18+ Years
General counseling regarding safe and healthy sexual behaviors: • Obtain sexual history and ask about involvement in sexual behaviors with sensitivity to sexual orientation and gender identity • Counsel about responsible sexual behaviors, including definition of consent • Discuss contraception with patients whose sexual practice might lead to pregnancy • Ask about use/motivation/access to use contraceptive methods to prevent STIs and unintended pregnancy • Consider preconception counseling (see Preconception Counseling section on page 37 for more details) • Offer PrEP (pre-exposure prophylaxis) if appropriate • Offer PEP (post-exposure prophylaxis) if appropriate • Consider monitoring in both transgender males and/or transgender females prolactin, metabolic disorders, and bone loss, as well as cancer risks in individuals who have not undergone surgical treatment
Resources: Evidence-Based Contraception – Common Questions and Answers: The article offers evidence-based recommendations for the use of contraception, covering different methods, their effectiveness, and considerations for patient care. Sexual Consent: This guide provides information on what consent is and how to provide it to a sexual partner. CDC: Sexual Violence is Preventable: This guide provides information on what sexual violence is and ways and resources for those in need. Treatment and Prevention of HIV Infection – Recommendations from the International Antiviral Society-USA Panel: This provides updated practice guidelines for the treatment and prevention of HIV infection. PrEP: This resource offers information and guidance on pre-exposure prophylaxis (PrEP) for HIV prevention, including eligibility, access, and care options. Fenway Health – AIDS Action: This resource from Fenway Health lists information related to HIV screening and prevention.

Sleep

18+ Years	61-64 Years	65+ Years
• Recommend consistent sleep and wake times throughout the week • Discourage exposure to blue light (including LED bulbs and electronic screens) for at least one hour before sleep onset • Recommend regular exercise to help promote sleep • Discourage alcohol, caffeine, and large meals before sleep • Discourage excess alcohol consumption throughout the day		
• Recommend 7 or more hours of sleep per night	• Recommend 7 to 9 hours of sleep per night	• Recommend 7 to 8 hours of sleep per night

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Sleep (continued)

DISPARITIES AND RISK FACTORS

Disparities in Sleep Disorders

There are racial and ethnic disparities in sleep duration. Black and Hispanic/Latino patients are more likely to report short sleep duration (Reitman, 2022; Whinnery et al., 2014). People with disabilities, especially those with independent living and mobility disabilities, are more likely to report shorter sleep duration (Okoro et al., 2020). These differences are likely due to complex interactions of social determinants of health, including socioeconomic status, psychosocial and/or emotional stressors, and occupational factors.

Risk Factors for Short Sleep Duration

- Living below the poverty line, having low educational attainment, working more than one job, being shift workers and/or unemployed
- Living in a crowded home and/or in a low-income neighborhood
- Having a mood disorder, such as depression or anxiety

Resources:

Healthy Sleep Habits: This guide gives information on how to establish healthy sleep habits to get a better night's sleep.

Sleep Wellness: This guide helps on how to establish better sleep hygiene.

Harvard Health Letter: Blue light has a dark side: This article talks about the effects of blue light on sleep, and how you can protect yourself from blue light at night.

Tobacco, Smoking, and Vaping

18+ Years

- Ask about tobacco, smoking, and vaping use at every visit
- Advise all tobacco and nicotine users to quit, especially people who are pregnant
- Assess readiness to quit
- Assist tobacco and nicotine users in quitting by providing behavioral interventions and US Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.
- Arrange follow-up
- Discuss lung illnesses associated with use of vaping products and urge people who vape to stop

DISPARITIES AND RISK FACTORS

Disparities in Tobacco, Smoking, and Vaping

American Indian and Alaska Native individuals have the highest smoking rate of any racial or ethnic group (American Lung Association, 2024). For about three in four Black people who smoke, the usual cigarette is menthol (American Lung Association, 2024). The menthol in cigarettes has been found to make it both easier to start smoking and harder to quit. Men are also more likely to smoke than women (NIH, 2020). LGBTQA+ communities also continue to be a disproportionately affected by tobacco use (Truth Initiative, 2025). In addition, according to the CDC, adults with disabilities are more likely to smoke than adults without disabilities (CDC, 2024). These differences are likely due to complex interactions of social determinants of health, including socioeconomic status, socioecological factors, and psychosocial and/or emotional stressors, as well as tobacco companies targeting marketing in low-income communities.

Risk Factors for Tobacco Use, Smoking, or Vaping

- Age, individuals who are younger than 65 years are more likely to use tobacco products, smoke, or vape

Resources:

Massachusetts Tobacco Cessation Program (MTCP): The MTCP is a statewide public health program focused on comprehensive approaches to reduce tobacco and nicotine use.

5-A's Framework: The 5-A's framework helps clinicians guide conversations with patients who use tobacco products to quit.

How to Quit Smoking: CDC: This website gives resources to patients on how to quit using tobacco products.

Smokefree.gov: This website provides tools and tips for how to begin thinking about quitting using tobacco products, and how to continue a patient's quit journey.

HHS Million Hearts: HHS Million Hearts which provides tools for clinicians, including a tobacco cessation change package and resources for patients on how they can quit smoking

Depression

18+ Years

- Screen for depression annually
  - Commonly used depression screening instruments include the Patient Health Questionnaires in various forms (PHQ-2 and PHQ-9) in adults, the Center for Epidemiologic Studies Depression Scale (CES-D), the Geriatric Depression Scale (GDS) in older adults, and the Edinburgh Postnatal Depression Scale (EPDS) in postpartum and pregnant persons.
- Recommend that the patient reach out to health plans for recommendations for resources to help manage depression

DISPARITIES AND RISK FACTORS

Disparities in Depression Prevalence

Depression prevalence varies among racial and ethnic groups, gender identities, and sexual orientations. Black and Hispanic/Latino individuals report higher levels of depression than White individuals (Rodriquez et al., 2018). Women (Mayo Clinic, 2019) and members of the LGBTQIA+ community (APA, 2025) are also more likely to experience depression. In addition, prevalence of depression is higher among adults with disabilities than adults without disabilities (CDC, 2021). These differences are likely due to complex interactions of social determinants of health, including access to health care and experiences of discrimination, and socioecological factors, including mental health stigma. Major depression goes undiagnosed and untreated at disproportionally greater rates in majority Black, Hispanic/Latino, and American Indian, and Alaska Native communities, leading to unnecessary suffering (Blue Cross Blue Shield: The Health of America, 2022; SAMHSA, 2017).

Risk Factors for Depression

- Age, young and middle-aged adults are more likely to be diagnosed with depression
- Having a family history of depression or other mental health disorders
- Being widowed or divorced
- Having a personal history of depression or other mental health disorders, or engaging in unhealthy alcohol or substance use
- Living with chronic illnesses (e.g., cancer or cardiovascular disease)
- Being in the perinatal period
- Having gone through recent stressful life events or traumatic experiences
- Having experienced adverse childhood experiences (ACEs)
- Having low educational attainment
- Being unemployed
- Low socioeconomic status

Resources:

PHQ-9: This tool asks about the frequency of depressed mood and anhedonia over the past two weeks.

PHQ-2: This tool asks about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

CES-D: This tool screens for depression in older adults.

GDS: This tool screens for depression in older adults.

EPDS: This tool screens for depression in postpartum and pregnant persons

Anxiety

18+ Years

- Screen for anxiety using the GAD-7 or other validated screening tool
- Consider screening for other types of anxiety by asking these four questions:
  1. Have you had a spell or attack when you suddenly felt frightened, anxious or uneasy? (Panic Disorder)
  2. Have you been bothered by feeling nervous, anxious or on edge over the last 6 months? (Generalized Anxiety Disorder)
  3. Have you had a problem being anxious or uncomfortable around people? (Social Anxiety Disorder)
  4. Have you had recurrent dreams or nightmares of trauma or avoidance of trauma reminders? (Post Traumatic Stress Disorder)
- Recommend that the patient reach out to health plans for recommendations for resources to help manage anxiety

DISPARITIES AND RISK FACTORS

Disparities in Anxiety Prevalence

Anxiety prevalence varies among racial and ethnic groups, gender identities, and sexual orientations. Black individuals are more likely to meet the criteria for post-traumatic stress disorder than other racial groups, while White individuals are more likely to be diagnosed with social anxiety disorder, generalized anxiety disorder, and panic disorder than other racial groups (Asnaani et al., 2010; MacIntyre, Zare, and William, 2023). Women (McLean et al., 2011) and members of the LGBTQIA+ community (American Psychiatric Association, 2019) are also more likely to experience anxiety. In addition, the prevalence of anxiety is higher among adults with disabilities than adults without disabilities (CDC, 2024). These differences are likely due to complex interactions of social determinants of health, including access to health care, experiences of discrimination, and socioecological factors, including mental health stigma. Anxiety disorder is underdiagnosed and undertreated at disproportionally greater rates in majority Black and Hispanic/Latino communities, leading to unnecessary suffering (Shao, Richie & Bailey, 2015; Williams et al., 2013).

Risk Factors for Anxiety

- Having a family history of anxiety, depression, or other psychiatric disorders
- Having a personal history of anxiety, depression, or other psychiatric disorders, and/or having other chronic illnesses or medical issues
- Being in the perinatal period
- Using alcohol or nicotine products
- Being widowed or divorced
- Having gone through recent stressful life events or traumatic experiences
- Having experienced adverse childhood experiences (ACEs)
- Low socioeconomic status

Resources:

GAD-7: This screening tool is used to determine whether or not a patient may have an anxiety disorder that needs treatment.

Brief Intervention for Anxiety in Primary Care Patients: This paper provides a simple, easy to learn, unified approach to the diagnosis, care management and pharmacotherapy of the four most common anxiety disorders (panic, generalized, and social anxiety disorders, and PTSD) in primary care

Unhealthy Alcohol and Substance Use

18+ Years

- Assess history of unhealthy substance use, including marijuana/THC, prescription drugs, or over-the-counter drugs
- Consider brief questionnaires (e.g. AUDIT, NIDA Quick Screen) to help assess likelihood of unhealthy alcohol use
- Consider more in depth screening for people who admit to unhealthy use of alcohol or other substances: NIDA, ASSIST
- Counsel about the effects of unhealthy alcohol and/or substance use
- Provide brief behavioral counseling to people engaged in or at risk of developing unhealthy alcohol/substance use
- Treat or refer for treatment if there is evidence of addiction
- Advise family and friends of persons with unhealthy opioid use to obtain NARCAN for emergency use.
- Discuss lung illnesses associated with use of vaping products
- Recommend that prescription medications are stored in a secure place and that any unused prescription medication is properly disposed of
- Counsel not to drive when under the influence of alcohol/substances, and not to ride with someone who is under the influence
- Advise people who are pregnant to stop drinking alcohol and using harmful substances during pregnancy, and advise them of the harmful effects of substance use on fetal development
- Recommend that the patient reach out to health plans for recommendations for resources to help manage unhealthy alcohol/substance use

DISPARITIES AND RISK FACTORS

Disparities in Substance Use Disorders

Substance use disorder prevalence varies among racial and ethnic groups, gender identities, and sexual orientations. Estimates of unhealthy alcohol and substance use are higher for American Indian and Alaska Native people than for all other racial and ethnic groups (SAMSHA, 2019). Members of the LGBTQIA+ community and people with disabilities (Medley et al., 2016; Czeisler et al., 2021) are also more likely to report unhealthy alcohol and substance use patterns. In addition, men are more likely than women to use all forms of illicit drugs (National Institute on Drug Use, 2020). These differences are likely due to complex interactions of social determinants of health, including access to health care, socioeconomic status, and experiences of discrimination.

Risk Factors for Unhealthy Alcohol and Substance Use Patterns

- Age, individuals who are ages 18-25 are more likely to engage in unhealthy substance use disorder
- Having a family history of unhealthy alcohol or substance disorder
- Having a personal history of mental health issues, and/or tobacco or alcohol dependence or binge drinking
- Having started using substances early on in life, and/or having used addictive substances like stimulants or opioids in the past
- Having a history of trauma, physical or sexual abuse, and/or childhood neglect

Resources:

Massachusetts Substance Abuse Information and Education Helpline: The Helpline is a statewide, public resource for finding substance use treatment, recovery, and problem gambling services.

MA Prescription Dropbox Locations: This webpage provides a list of prescription medication drop boxes around Massachusetts.

SBIRT: This toolkit was developed to assist Massachusetts healthcare providers and organizations in implementing regular Screening, Brief Intervention and Referral to Treatment (SBIRT) for unhealthy alcohol and drug use in clinics and practices.

Massachusetts Drug and Alcohol Addiction Treatment Centers: This webpage lists drug and alcohol addiction treatment centers in Massachusetts.

Safety/Injury Prevention

18+ Years

- Counsel about ways to prevent household and recreational injuries. For example:
  - Safe-keeping of prescription drugs or household chemicals
  - Motor-vehicle safety/seatbelt use
  - Helmet and other protective gear for cycling, skateboarding, scootering, and motorcycles
  - Water safety
  - Concussion and traumatic brain injury
  - Alcohol and substance use
  - Carbon monoxide risks and detectors
  - Fall prevention measures in the elderly. For more information on fracture prevention refer to section on Osteoporosis.
- Advise about the dangers of firearms possession, particularly handguns, in the home. Recommend the removal of guns from the home or secure home storage with safety locks on.
- Advise to keep guns away from children, and discuss other ways to reduce accidental injury or death from guns

Resources:

Fall Prevention Checklist: This resource helps you identify and implement safety measures in your home to prevent falls.

A Matter of Balance: This resource discusses how seniors can get involved with a program to reduce the fear of falling and increase activity level among older adults.

Injury Prevention-Evidence-Based Resources: This resource from Healthy People 2030 provides a comprehensive list of injury prevention resources

Stopping Elderly Accidents, Deaths, & Injuries (STEADI): Fall Prevention: This resource provides tips and resources for clinicians to help integrate fall prevention into routine clinical practice.

Water Safety: This resource provides safety tips on learning how to swim and being safe around bodies of water

Violence/Abuse in the Home

18+ Years

- Assess and screen for physical and behavioral signs of abuse and neglect
- Screen for intimate partner violence using the WAST-SF or HARK tools, with particular attention to those of child-bearing age
- Consider asking the following questions:
  - Have you ever been hurt or threatened by your partner, or anyone else (e.g. ex-partner, other family member)?
  - Do you ever feel afraid, controlled, or isolated by your partner or anyone else?

DISPARITIES AND RISK FACTORS

Disparities in Risk and Experience of Domestic Violence and Abuse

Certain racial and ethnic groups, gender identities, and sexual orientations are more at-risk for violence/abuse in the home. Approximately 1 in 4 women have been subjected to severe intimate partner physical violence, and/or intimate partner stalking (National Coalition Against Domestic Violence, 2012; National Intimate Partner and Sexual Violence Survey, 2012). Black, American Indian, Alaska Native, and Hispanic/Latino women are more likely to be a victim of physical violence, rape, and/or stalking by a partner in their lifetime (National Intimate Partner and Sexual Violence Survey, 2012). Lesbian and bisexual women are also more likely to experience physical violence, rape, and/or stalking by an intimate partner in their lifetime compared with their straight counterparts (National Intimate Partner and Sexual Violence Survey, 2012; Badenes-Riberia et al., 2015). Transgender individuals are 1.7 times more likely to experience IPV compared to cisgender individuals (Peitzmeier et al. 2020; Closson et al., 2024). In addition, people with disabilities are more likely to experience all forms of abuse (physical, sexual, and emotional abuse) than people without disabilities (National Coalition Against Domestic Violence, 2018). These differences are likely due to complex interactions of social determinants of health, including socioeconomic status, access to healthcare and social services, and experiences of discrimination. Barriers to disclosing intimate partner violence, especially for people of color, include concerns about safety, the consequences of disclosing abuse, mistrust of police, ; and unfamiliarity with laws, rights, and services (USPSTF, 2024)

Note that this section includes other categories of violence/abuse in the home, including elder and caregiver abuse. However, disparities research into elder and caregiver abuse prevalence was not available at the time of these guidelines.

Risk Factors for Violence or Abuse in the Home

- Age, elderly individuals are more likely to face violence or abuse in the home
- Being mentally or physically incapacitated or disabled, having a history of mental illness, or being caregivers of individuals who are mentally or physically incapacitated, disabled, or have a history of mental illness
- Being pregnant or postpartum
- Being socially isolated

Resources:

Understanding Intimate Partner Violence: This resource provides information about the signs of intimate partner violence, and resources to prevent it.

National Domestic Violence Hotline — 1-800-799-SAFE: This webpage provides resources and support for those who may be facing domestic violence.

HITS: This document is a compilation of existing tools for assessing intimate partner violence (IPV) and sexual violence (SV) victimization (defined below) in clinical/healthcare settings.

HARK: The four HARK questions accurately identify women experiencing IPV in the past year and may help women disclose abuse in general practice.

Forge Forward: This lengthy, trans-specific safety planning tool covers: basic facts about intimate partner violence; safety planning; groundwork; staying safe at home; emergency safety bag; financial planning; safe havens; safety in your new place; safety on the job and in public; orders of protection; protecting children and pets; and emotional support.

Sensory Screening

18+ Years

- Ask about hearing and vision impairment, and counsel or refer for further diagnosis around any issues
- Recommend eye exam at the following intervals:
  - 40-54: 2-4 years
  - 55-64: 1-3 years
  - 65+: 1-2 years
- Consider Glaucoma screening with a dilated eye exam every two years for:
  - High risk individuals ages 40 and over
  - All individuals ages 60 and over

DISPARITIES AND RISK FACTORS

Disparities in Vision Loss

There are racial/ethnic disparities in vision loss. Black Hispanic/Latino individuals have higher rates of diabetic retinopathy and and lower rates of up-to-date recommended screening compared with their White counterparts (Elam et al., 2022). Additionally, women are at a higher risk of vision loss compared to men (Aninye et al., 2021). These differences are likely due to complex interactions of social determinants of health, including socioeconomic status and access to quality and affordable healthcare. Black and Asian individuals have double the rate of glaucoma compared with their White and Hispanic/Latino counterparts (Elam et al., 2022). Research into genetic components of this increased risk warrant additional exploration. Additionally, these differences are likely due to complex interactions of social determinants of health, including socioeconomic status and access to quality and affordable healthcare.

Risk Factors for Vision Loss

- Having a family history of vision loss

Resource:

Massachusetts Commission for the Deaf & Hard of Hearing: MCDHH provides accessible communication, education, and advocacy to consumers and private and public entities so that programs, services, and opportunities throughout Massachusetts are fully accessible to persons who are deaf and hard of hearing.

Infectious Disease Screening

Traveler's Health (Vaccines, Medicines, Advice)

COVID-19

18+ Years

- Recommend vaccination to all eligible adults, with attention to underlying causes of vaccine hesitancy
- Advise patients on prevention measures including vaccination, wearing masks, social distancing, and avoiding places with poor ventilation and air circulation
- Counsel patients at higher risk of developing severe disease from COVID-19 on disease prevention, emphasizing the risk of developing more severe disease and the need for strict and consistent measures to avoid contact with potentially infected people

DISPARITIES AND RISK FACTORS

Disparities in COVID-19 Prevalence

The highest rates of COVID-related infection, hospitalization, and death are observed among Black, Hispanic/Latino, and Asian individuals, and where data exist, American Indian, Alaska Native, and Pacific Islander populations (Lopez et al., 2021; Tanne, 2023). People with intellectual and developmental disabilities are also more likely to develop severe complications from COVID-19 (CDC, 2025). These differences are likely due to complex interactions of social determinants of health, including socioeconomic status and access to quality and equitable healthcare services.

Risk Factors for Severe Complications from COVID-19 Infection

- Age, individuals who are age 65 and older are more likely to develop severe complications from COVID-19 infection
- Having multiple underlying medical conditions or living with disabilities
- Living in a congregate setting
- Not being physically active
- Being immunocompromised
- Having a personal history of the following medical conditions: asthma, cancer; cerebrovascular disease; chronic kidney disease; chronic liver disease (cirrhosis, non-alcoholic fatty liver disease, alcoholic liver disease, autoimmune hepatitis); chronic lung diseases, including COPD (chronic obstructive pulmonary disease), interstitial lung disease, bronchiectasis, pulmonary embolus, and pulmonary hypertension; cystic fibrosis; dementia; diabetes (type 1 or type 2); disabilities including but not limited to ADHD, autism, cerebral palsy, birth defects, intellectual and developmental disabilities, down syndrome, and spinal cord injuries; heart conditions, such as heart failure, coronary artery disease, cardiomyopathies; HIV; immunodeficiencies, mental health disorders (mood disorders and schizophrenia spectrum disorders; obesity; organ or stem cell transplantation; physical inactivity, pregnancy and recent pregnancy; smoking (current and former); tuberculosis; or use of corticosteroids or other immunosuppressive medications

Mpox

18+ Years

- Vaccinate individuals at risk of contracting Mpox including using vaccine for post-exposure prophylaxis

DISPARITIES AND RISK FACTORS

Disparities in Mpox Prevalence

Men who have sex with men and individuals who identify as transgender and gender diverse are at increased risk for contracting mpox (WHO, 2024). Additionally, Black and Hispanic/Latino individuals had the highest reported rates of mpox compared with other racial and ethnic groups (CDC, 2023). These differences are likely due to complex interactions of social determinants of health, including access to affordable and equitable sexual health services, socioecological factors, and experiences of discrimination.

Risk Factors for Mpox

- Having had sexual or intimate contact with someone who may have Mpox
  - Men who have sex with men and have had in the last 6 months, or expect to have, one or more sexually transmitted infections
  - Sexual or intimate contact with a person who is at risk of Mpox
  - Anonymous sexual or intimate contact, or more than one sexual partner, or sex at a large public venue where Mpox is likely to be present
  - Sexual partners of anyone who meets above criteria

Resources:

WHO: Mpox: This resource outlines Mpox transmission, treatment, and prevention

Mpox Vaccination Basics: This resource reviews Mpox vaccination basics.

Sexually Transmitted Infections (Chlamydia, Gonorrhea, Syphilis, HPV)

18+ Years

- Obtain sexual history
- Recommend condom use for anal, vaginal, and oral intercourse
- Counsel on effective ways to reduce the risk of infection based on patient's sexual history, current practices, and risk factors
- Assess risk to identify people who need more frequent screening

Chlamydia and gonorrhea

- Screen all sexually active female patients age 24 and younger annually
- Starting at age 25, screen if at risk

DISPARITIES AND RISK FACTORS

Disparities in Sexually Transmitted Infections Prevalence

Black, Hispanic/Latino, Asian, American Indian, Alaska Native, Native Hawaiian and other Pacific Islander individuals have higher rates of chlamydia and gonorrhea compared with their White counterparts (Chambers et al., 2018; Leston et al., 2022; Lieberman, Cannon, and Bourassa, 2020). These differences are likely due to complex interactions of social determinants of health, including socioeconomic status and access to affordable and equitable sexual health services.

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Sexually Transmitted Infections: chlamydia and gonorrhea (continued)

Risk Factors for Chlamydia or Gonorrhea Infection

- Engaging in anal, vagina, or oral intercourse without a condom
- Having sex with individuals who have chlamydia or gonorrhea
- Being sexually active under 25 years of age
- Having a personal history of or currently have sexually transmitted infections
- Having new or multiple sex partners, or their current partner(s) have other sexual partner(s)
- Using injection drugs
- Exchanging sex for money or drugs
- Having recently entered correctional facilities

Syphilis

- Screen if at risk

DISPARITIES AND RISK FACTORS

Disparities in Syphilis Prevalence

Black, Hispanic/Latino, Asian, American Indian, Alaska Native, Native Hawaiian and other Pacific Islander individuals have higher rates of syphilis compared with their White counterparts (OASH, 2024). Specifically, rates of congenital syphilis are highest in American Indian, Alaska Native, and other Pacific Islander individuals compared to other racial groups (ACOG, 2024). These differences are likely due to complex interactions of social determinants of health, including socioeconomic status and access to affordable and equitable sexual health services.

Note that most cases of syphilis in the United States are among men who have sex with men and individuals who identify as transgender and gender diverse (CDC, 2021). These differences are likely due to complex interactions of social determinants of health, including access to affordable and equitable sexual health services, socioecological factors, and experiences of discrimination.

Risk Factors for Syphilis

- Engaging in anal, vagina, or oral intercourse without a condom
- Having sex with individuals who have syphilis
- Having a personal history of or currently have sexually transmitted infections
- Having new or multiple sex partners, or their current partner(s) have other sexual partner(s)
- Having a partner(s) who is/are using injection drugs or exchanging sex for money or drugs
- Using injection drugs
  Exchanging sex for money or drugs
- Having recently entered correctional facilities
- Living in areas with increased syphilis morbidity

Resource:

NCHHSTP Atlas Plus: Syphilis: This resource provides the county-level rates of syphilis among women across the country.

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Sexually Transmitted Infections (continued)

HPV

- See cervical cancer screening section for screening recommendations.
- Counsel regarding schedule for HPV vaccine
- Recommend HPV vaccination for people age 26 and under, if not previously vaccinated
- Recommend HPV vaccination for healthcare workers who are occupationally exposed to the virus

Using shared decision making, consider HPV vaccine if inadequately or not previously vaccinated, for adults aged 27-45

DISPARITIES AND RISK FACTORS

Disparities in HPV Prevalence

Men who have sex with men and individuals who identify as transgender and gender diverse are at increased risk for contracting HPV (Meites et al., 2022). These differences are likely due to complex interactions of social determinants of health, including access to affordable and equitable sexual health services, socioecological factors, and experiences of discrimination.

Risk Factors for HPV

- Engaging in anal, vaginal, or oral intercourse without a condom
- Having sex with individuals who have HPV.
- Having HIV or another disease or condition that weakens the immune system.
- Having new or multiple sex partners, or their current partner(s) have other sexual partner(s)
- Using injection drugs
- Exchanging sex for money or drugs
- Having recently entered correctional facilities.
- Not being vaccinated for HPV

Resources:

HPV Vaccine Resources for Clinicians: Use the information and materials on this site to help you and your staff communicate effectively with parents about the importance of HPV vaccination.

HPV Vaccination for Adults Aged 27-45 Years: This resource is a shared decision-making tool to help providers discuss HPV vaccination with adult patients.

Sexually Transmitted Infections (STI) Fact Sheets: This webpage provides fact sheets for patients that answers basic questions about sexually transmitted infections.

NCHHSTP Atlas Plus: HIV, Viral Hepatitis, STD and TB: This resource provides the case rates of HIV across the country.

Hepatitis B

18-59 Years	60+ Years
• Counsel on risk factor reduction • Screen those at risk for hepatitis B who have not been vaccinated • Advise vaccination for all adults 18-59	• Counsel on vaccination for patients not vaccinated and at high risk • Offer vaccination to any unvaccinated adult over 60 who would like to be vaccinated

DISPARITIES AND RISK FACTORS

Disparities in Hepatitis B Prevalence

Hepatitis B virus infection prevalence varies among racial and ethnic groups, with the highest rates among Black, Asian, and Pacific Islander communities (HHS, 2025; Kim et al., 2017). Men who have sex with men and individuals who identify as transgender and gender diverse are also at increased risk for contracting Hepatitis B (Adeyemi et al., 2021). Differences in Hepatitis B virus infection prevalence by race, gender identity, and sexual orientation are likely due to complex interactions of social determinants of health, including access to affordable and equitable medical care, socioecological factors, and experiences of discrimination.

Risk Factors for Hepatitis B

- Having sex with individuals who have Hepatitis B
- Having a positive HIV infection and/or receive hemodialysis or cytotoxic immunosuppressive therapy
- Being an immigrant or having parents who have immigrated from high-risk areas (born in area with HBsAg prevalence >2% or born in US with parents born in area with HBsAg prevalence >8%) Sharing contaminated needles, syringes, and other injecting equipment and drug solutions when injecting drugs
- Having household or sexual contacts with persons with chronic HBV infection
- Being at risk for occupational exposure to blood or blood-contaminated body fluids as a healthcare and/or public safety workers
- Not being vaccinated for Hepatitis B
- See MHQP's Perinatal Guidelines for guidance for screening pregnant persons

Hepatitis C

18+ Years

- Counsel about risk factor reduction.
- Screen all adults aged 18 – 79 years
- Note that most adults need to be screened only once. However, persons with continued risk for HCV infection (eg. PWID) should be screened periodically
- Periodic testing of all patients at high risk

DISPARITIES AND RISK FACTORS

Disparities in Hepatitis C Prevalence

Hepatitis C virus infection prevalence varies among racial and ethnic groups, with the highest rates among Black, American Indian, and Alaska Native patients (HHS, 2025). In addition, men who have sex with men are at greater risk of contracting Hepatitis C if they are also engaging in higher risk sexual activities (CDC, 2024; Mayo Clinic, 2023). Differences in Hepatitis C virus infection prevalence by race are likely due to complex interactions of social determinants of health, including access to affordable and equitable medical care.

Risk Factors for Hepatitis C Infection

- Being born between 1945-1965
- Being a recipient of blood product for clotting problems before 1987
- Having had a blood transfusion or solid organ transplant before July 1992 (if not previously tested)
- Having long-term kidney dialysis
- Having HIV
- Being born to mother with Hepatitis C
- Current or past use of intranasal or injection drugs
- Having a tattoo or body piercing by non-sterile needle
- Having been incarcerated

HIV

18+ Years

- Counsel about risk factor reduction
- Screen all individuals 18 years of age and older, with annual testing for those at increased risk
- Test individuals at least once in their lifetimes
- Assess risk to identify people who need more frequent screening
- Offer pre-exposure prophylaxis for anyone who is currently HIV negative but is at significant risk for contracting HIV
- Offer post-exposure prophylaxis when indicated

DISPARITIES AND RISK FACTORS

Disparities in HIV Prevalence

Black and Hispanic/Latino communities are disproportionately affected by HIV compared to other racial/ethnic groups (HIV.gov, 2025). In addition, HIV infection continues to disproportionally affect transgender women (HIV.gov, 2025), gay, bisexual, and other men who have sex with men (HIV.gov, 2025). HIV prevalence is the highest among Black transgender women and Native American/Alaska Native transgender women (Girometti et al., 2021). These differences are likely due to complex interactions of social determinants of health, including socioeconomic status, access to affordable and equitable medical care, socioecological factors, and experiences of discrimination.

Risk Factors for HIV infection

- Engaging in anal or vaginal intercourse without a condom
- Having had more than one sex partner or having sex partners who have had more than one sex partner since their most recent HIV test
- Having a personal history of or currently have sexually transmitted infections
- Exchanging sex for money or drugs and/or having sex with individuals who have HIV
- Engaging in harmful use of alcohol and drugs in the context of sexual behavior
- Sharing contaminated needles, syringes, and other injecting equipment and drug solutions when injecting drugs
- Receiving unsafe injections, blood transfusions and tissue transplantation, and medical procedures that involve unsterile cutting or piercing
- Experiencing accidental needle stick injuries, including among health workers

Indications for pre-exposure prophylaxis: Ongoing sexual contact with partner who is HIV +, men who have sex with men, having anal intercourse without condoms or have had any STD within 6 months and are not in monogamous relationship, straight men or women who have sex without condoms with partner of unknown HIV status, IV drug users who have shared IV drugs or needles within past 6 months

Resources:

WHO – Global HIV, Hepatitis and STIs Programs: These guidelines offer evidence-based recommendations for the prevention, diagnosis, treatment, and care of individuals living with HIV, aimed at improving global health outcomes.

Treatment and Prevention of HIV Infection – Recommendations From the International Antiviral Society-USA Panel: This provides updated practice guidelines for the treatment and prevention of HIV infection., including post-exposure prophylaxis

PrEP: This resource offers information and guidance on pre-exposure prophylaxis (PrEP) for HIV prevention, including eligibility, access, and care options.

Tuberculosis (TB)

18+ Years

- Screen all patients at increased risk. Determine the need for repeat testing by the likelihood of continuing exposure to infectious TB.
  - Administer tuberculin skin test (TST) for individuals with no past BCG vaccination
  - Consider IGRA for individuals who have received BCG vaccination or who are at risk for not returning for reading of the TST

DISPARITIES AND RISK FACTORS

Disparities in TB Prevalence

The TB case rate is higher among Black, Hispanic/Latino, and Asian individuals than for White individuals (CDC 2025). These disparities are likely due to complex interactions of social determinants of health, including access to affordable and equitable medical care.

Risk Factors for Tuberculosis Infection

- Having a personal history of being immunosuppressed (HIV positive or using immunosuppressant drugs)
- Having a personal history of silicosis
- Being born in or resident of a country with high rates of TB
- Living in or have lived in communities where prevalence of TB is high (prisons, shelters, migrant farm settings)
- Having contacts of patients with active TB, and/or being workers exposed to high risk populations

Resources:

CDC: Tuberculosis (TB): This webpage provides resources for clinicians and patients about how to prevent TB.

NCHHSTP Atlas Plus: HIV, Viral Hepatitis, STD and TB: This resource provides the case rates of STIs across the country, as well as viral hepatitis, HIV, and TB.

Mosquito- and Tick-Borne Illnesses

18+ Years

Zika

- Note that there have been no disease cases in the US and its territories since 2019 (CDC, 2025)
- Refer to Preconception Counseling section for Zika recommendations

RISK FACTORS

Patients May be More Likely to Develop Zika Infection if They:

- Engage in unprotected intercourse with recent travelers from areas where Zika is present
- Have recently traveled to certain geographic locations, such as Africa, Southeast Asia, the Americas, the Caribbean, and the Pacific

Other Mosquito and Tick-Borne Illnesses

- Counsel on prevention of other mosquito-borne illnesses, including Eastern Equine Encephalitis (EEE) and West Nile Virus.
- Recommend that patients who are at risk of exposure to tick-borne diseases use insect repellents that provide protections for the amount of time they will be outdoors and to check skin and clothes for ticks every day.

Resources:

Zika Virus: This webpage provides information about how to prevent Zika infection when traveling abroad.

Eastern Equine Encephalitis: This webpage provides resources for patients on how to prevent EEE infection.

West Nile Virus: This webpage provides resources for patients on how to prevent WNV infection.

Protecting Yourself from Ticks and Mosquitoes: This resource provides information about tick and mosquito borne illnesses, and how you can protect yourself from being infected.

Screening and Guidance for Age Specific Conditions

Menstruation

18-55 Years

- Ask at every visit for the patient's first day of her last menstrual period and the pattern of menses
- Screen for abnormal menstrual patterns, such as painful menses and heavy bleeding. Heavy bleeding is defined as:
  - Bleeding that lasts more than 7 days
  - Bleeding that soaks through one or more tampons or pads every hour for several hours in a row
  - Needing to wear more than one pad at a time to control menstrual flow
  - Needing to change pads or tampons during the night
  - Menstrual flow with blood clots that are as big as a quarter or larger
- Consider asking the following questions to screen for endometriosis or other menstrual-related disorders:
  - Do you often experience pelvic/abdominal or lower back pain before, during, or between your periods that limits your activities or requires medication?
  - Over the last six months, have you regularly missed school or work because of your period?
- Educate about alternatives to traditional (one-time use) menstrual products
- Ask about access to menstrual products

Resources:

Period Products: This resource for patients provides information about the types of products to use during your period.

Eukia App: This app helps patients with tracking their menstrual cycle and ovulation, and keeps individuals safe from data sharing.

Period ImPact and Pain Assessment (PIPPA) Online Screening Tool: This tool can help patients identify how much of an impact their period is having on their life.

Painful Periods Screening Tool: The Painful Periods Screening Tool is a resource aimed to help providers better identify patients with endometriosis

Preconception Counseling

Note: See MHQP's Perinatal Guidelines for complete recommendations on prenatal care.

18–49 Years

- Advise all females of child-bearing age to take a daily multivitamin containing 0.4 – 0.8 mg folate Counsel current smokers to quit smoking (see Tobacco, Smoking, and Vaping section for resources to help quit smoking)
- Encourage scheduling a visit for preconception counseling to include review of appropriate immunization status, chronic illnesses, current medications, whether there is need to make any changes based on teratogenicity, and consideration of genetic testing
- Advise to seek fertility evaluation if conception does not occur despite regular unprotected intercourse:
  - After one year for people under 35
  - After six months for people aged 35-40
  - Immediately for people over age 40 or those with known risk factors
- Advise that decisions regarding SSRI treatment before or during pregnancy should be tailored to the individual
  - Note that in most cases, SSRI treatment should not be discontinued
- Discuss fertility preservation for individuals who have a medical condition and/or who are undergoing treatment that may impact their fertility
- Inform patients on the impact of alcohol, drug, tobacco, and environmental exposures in early pregnancy, often before pregnancy is diagnosed
- If patient is overweight or obese, recommend weight loss before becoming pregnant
- Recommend that patients with diabetes or pre-diabetes achieve optimal glycemic control prior to pregnancy
- Counsel patients of child-bearing age on the importance of oral health and routine dental care before pregnancy
- Recommend HIV testing for patient and partner
- Counsel on HIV prevention and ways to reduce HIV transmission during conception and pregnancy, and offer pre-exposure prophylaxis if indicated
- Recommend syphilis screening for patient and partner
- Counsel on increasing rates of congenital syphilis
- Review travel restrictions during pregnancy and the preconception period, including avoiding travel to an area with active Zika virus transmission
- Advise patients who have been exposed to or have had Zika to avoid conception for 8 weeks from the last exposure or onset of symptoms
- Advise partners who have been exposed to or have had Zika to avoid procreation for at least 3 months from the last exposure or onset of symptoms

DISPARITIES

Disparities in Poor Maternal Health Outcomes

Black, American Indian, and Alaska Native women have higher rates of pregnancy-related death compared to White women (KFF, 2024). Black, American Indian, Alaska Native, and Native Hawaiian and Other Pacific Islander women also have higher rates of preterm births, low birthweight births, or births for which they received late or no prenatal care compared to White women (KFF, 2024). Compared with women with no disability, women with disabilities had higher risk of maternal death, and complications, including preterm birth, and preeclampsia (Gleason et al., 2021). Bisexual and lesbian women have higher rates of pregnancy complications compared to straight women, including preterm births, stillbirths, and low birthweight births (Everett et al., 2019). These differences are likely due to complex interactions of social determinants of health, including access to quality and equitable health and maternal care, experiences of discrimination, and socioecological factors.

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Preconception Counseling (continued)

Disparities in Access to Fertility Services

Note that there are also racial and ethnic disparities in access, referrals to, and usage of fertility preservation services. Studies have shown that patients of color are significantly less likely to use fertility services, travel twice as far for services, and obtain fewer referrals to fertility services (Gadson et al., 2024). These differences are likely due to complex interactions of social determinants of health, including access to quality and equitable health and reproductive care, experiences of discrimination, and socioecological factors.

Resources:

CDC Travelers' Health: This webpage provides travel health notices in certain areas in the world, and suggests ways to prevent illness.

Preconception Counseling and Care of Women of Childbearing Age Living with HIV: This resource provides guidelines for clinicians on how to provide preconception counseling for HIV positive women.

Before Pregnancy: This resource provides information for women on what steps they must take to ensure the health of a baby in the future.

National Preconception Health and Health Care (PCHHC): The Preconception Resource Guide is designed to help primary care providers meet their patient's needs based on the response to this "vital sign" question: "Would you like to become pregnant in the next year?"

Perimenopause and Menopause

40+ Years

- Counsel symptomatic females on the management of perimenopause and menopause, including the risks and benefits of hormonal and non-hormonal therapies
- Individualized hormone therapy for management of menopausal symptoms is considered safe in younger women (under age 59 or within 10 years of menopause) by several medical societies including the AAFP
- Note that the USPSTF recommends against the use of combined estrogen and progestin or estrogen only in most females for the primary prevention of chronic conditions
- Counsel that perimenopausal abnormal uterine bleeding should be evaluated
- Counsel that any post-menopausal spotting or bleeding should be evaluated

Osteoporosis

50+ Years

- Counsel about preventive measures, including dietary calcium and vitamin D intake, weight-bearing exercise, and smoking cessation
- Counsel frail patients on specific measures to prevent falls
- Offer bone mineral density (BMD) testing to females over 65
- Recommend exercise interventions to prevent falls in community-dwelling adults ≥65 who are at increased risk for falls
- Consider offering multifactorial interventions to prevent falls in community-dwelling adults ≥65 who are at increased risk for falls
- Offer bone mineral density (BMD) testing to post-menopausal females <65 who are at high risk

DISPARITIES AND RISK FACTORS

Disparities in Osteoporosis Prevalence

Note that research shows that there are higher rates of osteoporosis in White and Asian women compared to their Black counterparts (Noel et al., 2021). Other ethnic disparities are understudied, and osteoporosis is severely underrecognized in Black individuals (Calikyan, Silverberg, and McLeod, 2023). Fracture risk also varies, although there is insufficient data on this. Black women who do suffer osteoporosis-related fractures have poorer outcomes than their White counterparts (National Council on Aging, 2024). These differences are likely due to complex interactions of social determinants of health, including socioeconomic status and access to healthcare and screening services.

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Osteoporosis (continued)

Risk Factors for Osteoporosis

- Age, the risk of fracture increases with age and individuals who are ages 50 and older are more likely to develop osteoporosis
- Sex, females are more likely to develop osteoporosis than males
- Having a history of fragility fractures
- Having parental histories of fractures as an adult
- Having a small bone structure and low body weight (under 127 lbs)
- Having certain menopause or menstrual histories HIV infection and using anti-retroviral therapy
- Not being physically active
- Using certain medications
- Having certain chronic diseases
- Using tobacco
- Unhealthy or excessive alcohol use

Resources:

WHO Fracture Risk Assessment Tool (FRAX): This calculator is used by clinicians to calculate the ten year probability of fracture.

Fall Prevention Checklist: This resource helps you identify and implement safety measures in your home to prevent falls.

Mayo Clinic Bone Health Choice Decision Aid: This decision guide is to be used with clinician during clinical encounter to determine which plan is best to reduce risk of fracture.

A Matter of Balance: A Matter of Balance: Managing Concerns About Falls is a program designed to reduce the fear of falling and increase activity levels among older adults

Cognitive Impairment

50+ Years

- Observe for possible signs of declining cognitive function in older patients. If signs/symptoms are present, conduct structured assessment using validated screening tool (e.g. GPCOG, MIS, Mini-Cog, MoCA)
- Evaluate mental status in patients who have problems performing daily activities

DISPARITIES

Disparities in Cognitive Impairment

Research has demonstrated that several adverse determinants such as poverty, low education, access to healthcare, isolation, and chronic conditions are associated with cognitive decline (Gupta, 2021).

End of Life Planning

18+ Years

- Discuss establishing advance directives for medical and end-of-life decisions, including a living will, designation of a proxy with durable power-of-attorney, or a medical directive established with a physician

Resources:

Making Decisions with Families at the End of Life: This resource helps clinicians on how to have fruitful and informative discussions with families during the end of life.

IHI: The Conversation Project: The Conversation Project has toolkits to help patients talk about their wishes for care through the end of life, so those wishes can be understood and respected.

PREPARE for your Care: This toolkit assists patients with how to talk to their doctors, and how to make medical decisions for themselves and others.