Health Net®

2017Adult Male Preventive Health Guidelines

Important Note

Health Net's Preventive Health Guidelines provide Health Net members and practitioners with recommendations for preventive care services for the general population, based on the best available medical evidence at the time of release. These guidelines apply to those individuals who do not have symptoms of disease or illness. A Health Net member's medical history and physical examination may indicate that further medical tests are needed. Guidelines may also differ from state to state based on state regulations and requirements. As always, the judgment of the treating physician is the final determinant of member care. Your benefit plan may or may not cover all the services listed here. Please refer to your certificate of coverage for complete details or contact the customer service number listed on your ID card.

Medicare Members: Please refer to Health Net's "Medicare Advantage Preventive Health Guidelines for Medicare Members

Physical Exam	19-25 years	26-39 years	40-49 years	50-65 years	65+ years
Health Maintenance Exam (HME)	Every year	Every year	Every year	Every year	Every year
Blood Pressure[1]	Every 1-2 years	Every 1-2 years	Every 1-2 years	Every 1-2 years	Every 1-2 years
Body Mass Index[2]	At HME	At HME	At HME	At HME	At HME
Dental	Twice Annually	Twice Annually	Twice Annually	Twice Annually	Twice Annually
Height Weight	AT HME	At HME	At HME	At HME	At HME
Prostate Cancer Screening[3] (PSA/DRE)	NA	NA	Discuss with provider [3]	Discuss with provider [3]	Discuss with provider [3]
Testicular Exam /Self Exam[12]	Discuss with provider	Discuss with provider	Discuss with provider	Discuss with provider	Discuss with Provider
Electrocardiogram (screening)[17]	Discuss risk level with provider	Discuss risk level with provider	Discuss risk level with provider	Discuss risk level with provider	Discuss risk level with provider

Screening	19-25 years	26-39 years	40-49 years	50-65 years	65+ years
Colorectal Cancer Screening [8]	NA	NA	If high risk, discuss with provider	Options for asymptomatic, average risk individuals include: High-sensitivity fecal Occult Blood Test or Fecal immunochemical tests (FIT) annually; or Multitargeted stool DNA testing (FIT-DNA) every 3 years; or Flexible sigmoidoscopy every 5 years; or Flexible sigmoidoscopy with FIT every 10 years plus FIT annually; or Computed tomography (CT) colonography every 5 years; or Colonoscopy every 10 years	
Depression Screening[4]	Discuss with provider	Discuss with provider	Discuss with provider	Discuss with provider	Discuss with provider
Hearing [13]	NA	NA	Discuss with provider	Discuss with provider	Discuss with provider
Ultrasound for Abdominal Aortic Aneurysm	NA	NA	NA	NA	One time in men 65 to 75 years who ever smoked or have never smoked but have additional risk factors.[10]
Vision[5]	Every 5-10 years	Every 5-10 years	40-54 every 2-4 years	55-64 every 1 – 3 years	Every 1-2 years
Aspirin Therapy [9]	NA	NA	Discuss with provider	Discuss with provider [9]	Discuss with provider [9]
Screening for Alcohol and Drug Use [14]	With HME	With HME	With HME	With HME	With HME
Human Immunodeficiency Virus [11]	One time screening, repeat screening for those at risk	One time screening, repeat screening for those at risk	One time screening, repeat screening for those at risk	One time screening, repeat screening for those at risk	Consult MD
Hepatitis C virus infection screening [15]	If at high risk	If at high risk	If at high risk	If at high risk	If at high risk

Hepatitis B Screening[18]	If at high risk	If at high risk	If at high risk	If at high risk	If at high risk
Lung Cancer Screening [16]	NA	NA	NA	Annual screening with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.	Annual screening with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
Syphllis Screening[19]	If at high risk	If at high risk	If at high risk	If at high risk	If at high risk
Suggested Laboratory Tests	**19-25 years**	**26-39 years**	**40-49 years**	**50-65 years**	**65+ years**
Glucose[6]	If high risk	If high risk	Screen as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese	If normal, rescreen every 3 years	If normal, rescreen every 3 years
Lipoprotein Screening[7]	Only if high risk	> 35 years old every 5 years	Every 5 years	Every 5 years	Every 5 years

Medication Use:

Statin Use[20]: For the Primary Prevention of Cardiovascular Disease in Adults Adults aged 40 to 75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater

Counseling and Education

In general, counseling and education should be carried out at each health maintenance visit and when dictated by clinical need.

Nutrition (healthy diet counseling)
Vitamin D supplementation
Nutrient balance and supplements
Weight loss for obese

Sexual Practices
HIV screening and couseling
STD Prevention (screen those at increased risk for STD and offer high-intensity counseling)
Unwanted Pregnancy Prevention
Tuberculosis Testing based on risk

Advance Directives

Physical Activity

Immunizations/Vaccinations

Injury and fall prevention
Seat belt use, helmet use
Fire safety (smoke detectors)
Firearm storage
Set water heater at 120 degrees
Domestic Violence (e.g., Intimate Partner Violence and Elderly Abuse), refer to intervention services if applicable)

Mental Health Awareness
Depression/Anxiety Disorders
Depression screening for post partum, MI, CVA and for those with chronic medical conditions
Coping Skills/Stress Reduction
Substance Abuse including tobacco use (provide cessation interventions for those who use tobacco products and US FDA approved pharmacotherapy for cessation for adults who use tobacco)
Alcohol Use

Skin cancer behavioral counseling
Use skin protection

Aspirin
Use in high risk to prevent coronary heart disease

Osteoporosis
Men over 70 at risk

---

1. Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) recommends screening every 2 years for persons with SBP and DBP below 120mm Hg and 80mm Hg, respectively, and more frequent intervals for screening those with blood pressure at higher levels. Screening every year with SBP of 120-139mmHg or DBP of 80-90. The USPSTF recommends screening for high blood pressure in adults age 18 years and older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment

2 The USPSTF recommends that clinicians screen all adult patients for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions

3. Men should be given information about the potential benefits and harms of screening and limits of current evidence in order to make an informed decision about screening. Important factors that must be considered include patient age, life expectancy, family history, and race. The USPSTF recommends against PSA-based screening for prostate cancer. Although the USPSTF discourages the use of screening tests for which the benefits do not outweigh the harms in the target population, it recognizes the common use of PSA screening in practice today and understands that some men will continue to request screening and some physicians will continue to offer it. The decision to initiate or continue PSA screening should reflect an explicit understanding of the possible benefits and harms and respect patients' preferences. Physicians should not offer or order PSA screening unless they are prepared to engage in shared decision making that enables an informed choice by patients. Similarly, patients requesting PSA screening should be provided with the opportunity to make informed choices to be screened that reflect their values about specific benefits and harms. Community- and employer-based screening should be discontinued. The American Urological Association recommends that PSA screening, in conjunction with a digital rectal examination, should be offered to asymptomatic men aged 40 years or older who wish to be screened, if estimated life expectancy is greater than 10 years. The American Cancer Society emphasizes informed decision making for prostate cancer screening: men at average risk should receive information beginning at age 50 years, and black men or men with a family history of prostate cancer should receive information at age 45 years. The American College of Preventive Medicine (ACPM) concludes that there is currently insufficient evidence to recommend routine population screening with digital rectal examination (DRE) or prostate-specific antigen (PSA). The College is in agreement with the American College of Physicians (ACP) that men should be given information about the potential benefits and harms of screening and limits of current evidence in order to make an informed decision about screening.

4 The USPSTF recommends screening for depression in the general adult population.. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. There is little evidence regarding the optimal timing for screening. The optimum interval for screening for depression is also unknown; more evidence for all populations is needed to identify ideal screening intervals. A pragmatic approach in the absence of data might include screening all adults who have not been screened previously and using clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted

5 Recommendations from the American Academy of Ophthalmology

6. The ADA recommends screening should be considered in adults of any age who are overweight or obese (BMI >25 kg/m2) and who have one or more additional risk factors for diabetes. In those without these risk factors, testing should begin at age 45 years. If tests are normal, repeat testing should be carried out at least at an interval of every 3 years. The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal

blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. Evidence on the optimal rescreening interval for adults with an initial normal glucose test is limited. Studies suggest that rescreening every 3 yrs may be a reasonable approach.

7 AAFP & USPSFT recommends total cholesterol (TC) and high-density lipoprotein cholesterol (HDL) every five years for men age 35 years and older. Screen younger men (age 20 to 35 years) for lipid disorders if they have other risk factors (DM, family history of cardiovascular disease before age 50 years in male relatives or age 60 years in female relatives, previous personal history of CHD or non-coronary atherosclerosis, tobacco use, hypertension, or obesity (BMI $\geq$ 30).

8 Some states have legislative mandates requiring that available colorectal cancer (CRC) screening options must include all tests identified in the current American Cancer Society (ACS) screening guidelines, including stool-based DNA (sDNA) screening and CT colonography. The USPSTF recommends recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. The risks and benefits of different screening methods vary. The decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history. The available options are noted above.

9. The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged 50 to 59 years who have a 10% or greater 10-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. The decision to initiate low-dose aspirin use for the primary prevention of CVD and CRC in adults aged 60 to 69 years who have a 10% or greater 10-year CVD risk should be an individual one. Persons who are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years are more likely to benefit. Persons who place a higher value on the potential benefits than the potential harms may choose to initiate low-dose aspirin.

10 Per the USPSTF, an "ever-smoker" is a person who has smoked at least 100 cigarettes in his or her lifetime. The USPSTF recommends that clinicians selectively offer screening for AAA in men ages 65 to 75 years who have never smoked but have additional risk factors. Important risk factors for AAA include older age and a first-degree relative with an AAA; other risk factors include a history of other vascular aneurysms, coronary artery disease, cerebrovascular disease, atherosclerosis, hypercholesterolemia, obesity, and hypertension. Factors associated with a reduced risk for AAA include African American race, Hispanic ethnicity, and diabetes

11. The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 - 65 years. Younger adolescents and older adults who are at increased risk should also be screened. The evidence is insufficient to determine optimum time intervals for HIV screening. One reasonable approach would be one-time screening of adolescent and adult patients to identify persons who are already HIV-positive, with repeated screening of those who are known to be at risk for HIV infection, those who are actively engaged in risky behaviors, and those who live or receive medical care in a high-prevalence setting. Given the paucity of available evidence for specific screening intervals, a reasonable approach may be to rescreen groups at very high risk for new HIV infection at least annually and individuals at increased risk at somewhat longer intervals (for example, 3- 5 years). Routine rescreening may not be necessary for individuals who have not been at increased risk since they were found to be HIV-negative.

12. The USPSTF recommends against screening adolescent or adult males for testicular cancer by clinician examination or patient self-examination. The American Academy of Family Physicians recommends against routine screening for testicular cancer in asymptomatic adolescent and adult males. The American Academy of Pediatrics does not include screening for testicular cancer in its recommendations for preventive health care. The American Cancer Society recommends a testicular exam by a doctor as part of a routine cancer-related check-up. The ACS does not make recommendations about regular testicular self-exams for all men.

13. The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for hearing loss in asymptomatic adults aged 50 years or older. It does not apply to persons seeking evaluation for perceived hearing problems or for cognitive or affective symptoms that may be related to hearing loss. These persons should be assessed for objective hearing impairment and treated when indicated. The American Speech-Language-Hearing Association recommends that adults be screened once per decade and every 3 years after age 50 years.

14. The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

15. The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection (e.g., past or current injection drug use, blood transfusion prior to 1992, long-term hemodiialysis etc) The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965. Persons in the birth cohort and those who are at risk because of potential exposure before universal blood screening and are not otherwise at increased risk need only be screened once. Persons with continued risk for HCV infection (injection drug users) should be screened periodically. Anti–HCV antibody testing followed by confirmatory polymerase chain reaction testing accurately identifies patients with chronic HCV infection.

16. The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. 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

17. The USPSTF recommends against screening with resting or exercise electrocardiography (ECG) for the prediction of coronary heart disease (CHD) events in asymptomatic adults at low risk for CHD events. Based on USPSTF: Coronary Heart Disease: Screening with Electrocardiography, July 2012

18. The USPSTF recommends screening for hepatitis B virus (HBV) infection in persons at high risk for infection. Periodic screening may be useful in patients with ongoing risk for HBV transmission (for example, active injection drug users, men who have sex with men, and patients receiving hemodialysis) who do not receive vaccination. Clinical judgment should determine screening frequency, because the USPSTF found inadequate evidence to determine specific screening intervals.

19. . The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection. Populations at increased risk for syphilis infection (as determined by incident rates) include men who have sex with men and engage in high-risk sexual behavior, commercial sex workers, persons who exchange sex for drugs, and those in adult correctional facilities. There is no evidence to support an optimal screening frequency in this population. Clinicians should use clinical judgment to individualize screening for syphilis infection based on local prevalence and other risk factors.

20. Statin Use: The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (ie, symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are aged 40 to 75 years; 2) they have 1 or more CVD risk factors (ie, dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Although statin use may be beneficial for the primary prevention of CVD events in some adults with a 10-year CVD event risk of less than 10%, the likelihood of benefit is smaller, because of a lower probability of disease and uncertainty in individual risk prediction. Clinicians may choose to offer a low- to moderate-dose statin to certain adults without a history of CVD when all of the following criteria are met: 1) they are aged 40 to 75 years; 2) they have 1 or more CVD risk factors (ie, dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 7.5% to 10%

Health Net uses the following sources to formulate the Preventive Health Guidelines:

Source	**Website**
United States Preventive Services Task Force (USPSTF), Grade A and B Recommendations	www.ahrq.gov http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
Centers for Disease Control (CDC),	www.cdc.gov
American College of Obstetrics and Gynecology (ACOG),	www.acog.org
American Cancer Society (ACS)	www.cancer.org
American Academy of Family Physicians (AAFP)	www.aafp.org
American Academy of Pediatrics (AAP)	www.aap.org
Advisory Committee for Immunization Practices (ACIP)	http://www.cdc.gov/nip/acip/
Other nationally recognized medical associations, colleges and academies	

Health Net updates these guidelines annually. Because new clinical evidence to support changing the guidelines may occur more frequently, changes to these guidelines may occur subsequent to the release. To ensure use of the most current recommended guidelines, Health Net suggests visiting the Web site of each specialty board, academy or organization.

Review History: January 2003, March 2004, March 2005, April 2006, February 2007, February 2008, March 2009, February 2010, February 2011, February 2012, February 2013, May 2013, February 2014, February 2015, May 2015, February 2016, May 16, July 2016