Risk Reduction for Alzheimer's and Other Dementias Focus Area

	Focus Area	Patient Perspective	Operational Details
1	**Risk Reduction & Delaying Progression**	*I and my family have spoken to our clinicians about how to maintain our brain health as we age. We have the knowledge and ability to improve our risk factors like blood pressure, diabetes, high cholesterol, hearing, and vision, and feel supported to ask for help from our care team and our community*	**Current State:** While some providers routinely screen for or address modifiable risk factors for dementia, many patients are either unaware of—or unable to act on—these risk factors to prevent or delay progression of dementia. Competing clinical priorities, social drivers of health, therapeutic inertia, and other system-level barriers hinder effective control of hypertension, diabetes, obesity, and hyperlipidemia, as well as routine screening for hearing and vision loss. These prevention efforts are rarely framed in terms of brain health or dementia risk reduction, and providers may lack clarity about which risk factors have the strongest evidence, how to prioritize prevention across the life course, or how to emphasize risk reduction in the uncertainty of individual brain health outcomes. **Intermediate Steps:** Practices work to integrate dementia risk reduction across chronic disease prevention and management and understand the connection between modifiable risk factors and brain health. Clear guidelines are available on how to counsel patients and their families about risk reduction across the life course, and how to accurately discuss prevention strategies without promising brain health outcomes. **Optimal Care:** • The patient has an identified primary care provider • Dementia risk reduction is embedded into routine chronic disease prevention and healthy aging care, rather than treated as a standalone initiative • Providers routinely frame management of cardiovascular and metabolic conditions as part of brain health and dementia risk reduction, using consistent, evidence-based messaging • Prevention efforts recognize reduction of risk across the life course but prioritize midlife and early older adulthood as key timepoints for intervention • Hearing and vision are routinely assessed and appropriately addressed • Depression, anxiety and social isolation are proactively identified and addressed through integrated behavioral health, care management, and community partnerships • Providers feel comfortable discussing dementia risk reduction with patients, including acknowledging uncertainty and emphasizing actions that support overall health and functioning

Background

As many as 45% of cases of Alzheimer's and other dementias might be preventable. In recent years, many studies have identified risk factors associated with increased incidence of Alzheimer's and other dementias. As many as 14 modifiable risk factors were identified by the Lancet report in 2024, spanning the entire life-course.[i] Risk reduction is important to begin as early and for as long as possible; while addressing risk factors earlier is ideal, there is benefit to reducing risk throughout life. All identified risk factors have potential for scale through changes in systems and policy; however, midlife and later life health interventions are also important to reduce risk at the community, family, and individual levels. The table below is adapted from the Lancet report on dementia prevention, intervention and care 2024:

Risk Factor	Percent	Risk Factor	Percent
Hearing loss	7%	Smoking	2%
High LDL	7%	Hypertension	2%
Less Education	5%	Obesity	1%
Depression	3%	Excessive alcohol	1%
Traumatic brain injury	3%	Social isolation	5%
Physical inactivity	2%	Air pollution	3%
Diabetes	2%	Visual loss	2%

Green = early life (<18 years old), Yellow = midlife (18-65 years), Blue = later life (>65)

The Lancet commission also provides several recommendations for specific actions to reduce dementia risk across the life course:

- Ensure good quality education is available for all and encourage cognitively stimulating activities in midlife to protect cognition
- Make hearing aids accessible for people with hearing loss and decrease harmful noise exposure to reduce hearing loss
- Treat depression effectively
- Encourage use of helmets and head protection in contact sports and on bicycles
- Encourage exercise because people who participate in sport and exercise are less likely to develop dementia
- Reduce cigarette smoking through education, price control, and preventing smoking in public places and make smoking cessation advice accessible
- Prevent or reduce hypertension and maintain systolic blood pressure of 130 mm Hg or less from age 40 years
- Detect and treat high LDL cholesterol from midlife

- Maintain a healthy weight and treat obesity as early as possible, which also helps to prevent diabetes
- Reduce high alcohol consumption through price control and increased awareness of levels and risks of overconsumption
- Prioritize age-friendly and supportive community environments and housing and reduce social isolation by facilitating participation in activities and living with others
- Make screening and treatment for vision loss accessible for all
- Reduce exposure to air pollution

Some risk factors for cognitive decline are more able to be directly influenced by the healthcare system. Risk factors such as air pollution and in early life educational attainment, are less easily impacted by hospital systems and clinicians. However, several conditions or behaviors that are associated with higher risk for dementia area already addressed as part of the primary care system: hypertension, hypercholesterolemia, diabetes, obesity, depression, sensory loss, smoking and excessive alcohol intake. Within the current landscape, **efforts in risk reduction in Washington state should revolve around existing initiatives to prevent chronic disease, address behavioral health, protect public safety, and create healthy living environments for all**, including targeted support and intervention for those underserved and marginalized. Many people may experience multiple risk factors at once, requiring multicomponent interventions to protect brain health holistically.

Many United States Preventive Services Task Force (USPSTF) grade A & B recommendations align with modifiable risk factors. This means services should be covered with no cost-sharing to the individual.

Topic	Year	Population	Recommendation Summary
Depression and Suicide Risk in Adults: Screening	2023	Adults, including pregnant and postpartum persons, and older adults (65 years or older)	The USPSTF recommends screening for depression in the adult population, including pregnant and postpartum persons, as well as older adults.[ii]
Falls Prevention in Community-Dwelling Older Adults: Interventions	2024	Community-dwelling adults 65 years or older	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.[iii]
Gestational Diabetes: Screening	2021	Asymptomatic pregnant persons at 24 weeks of gestation or after	The USPSTF recommends screening for gestational diabetes in asymptomatic pregnant persons at 24 weeks of gestation or after.[iv]

Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling Interventions	2020	Adults with cardiovascular disease risk factors	The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.[v] UPDATE IN PROGRESS
Hypertension in Adults: Screening	2021	Adults 18 years or older without known hypertension	The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.[vi]
Hypertensive Disorders of Pregnancy	2023	Asymptomatic pregnant persons	The USPSTF recommends screening for hypertensive disorders in pregnant persons with blood pressure measurements throughout pregnancy.[vii]
Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults: Screening	2025	Women of reproductive age, including pregnant and postpartum women	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age, including those who are pregnant and postpartum. See the "Practice Considerations" section for information on evidence-based multicomponent interventions and for information on IPV in men.[viii]
Perinatal Depression: Preventive Interventions	2019	Pregnant and postpartum persons	The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.[ix] UPDATE IN PROGRESS

Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication	2022	Adults aged 40 to 75 years who have 1 or more cardiovascular risk factors and an estimated 10-year cardiovascular disease (CVD) risk of 10% or greater	The USPSTF recommends that clinicians prescribe a statin for the primary prevention of CVD for adults aged 40 to 75 years who have 1 or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk of a cardiovascular event of 10% or greater.[x]
Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions	2021	Nonpregnant adults Pregnant persons	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and US Food and Drug Administration (FDA)--approved pharmacotherapy for cessation to nonpregnant adults who use tobacco. The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.[xi]
Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions	2018	Adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.[xii] UPDATE IN PROGRESS
Unhealthy Drug Use	2020	Adults age 18 years or older	The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about

			unhealthy drug use, not testing biological specimens.)[xiii]
Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions	2018	Adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.[xiv] UPDATE IN PROGRESS

The healthcare system can

The following are potential guidelines for our report audiences to address and promote risk reduction:

Audience	Potential Guidelines
Primary Care	1. Focus on midlife prevention: blood pressure control, diabetes, hyperlipidemia, hearing and vision, mood and anxiety disorders 2. Promote brain health through patient education/outreach 3. beginning at midlife (45+?) – utilize Dementia Action Collaborative (DAC) Brain health material 4. Identify patients with multiple risk factors for cognitive impairment and encourage multimodal risk reduction. Collaborate with allied health professionals (e.g., RDs, PTs, etc.) 5. Regularly update clinic workflows to be reflective of most up to date evidence-based guidelines related to risk factors for dementia, especially for: blood pressure screening and control, diabetes, hearing and vision loss, mental health and substance use, 6. Encourage connection to social networks available in the community. Direct patients and families to local resources (e.g., AAAs) 7. Identify and intervene upon SDOH
Residential Facilities	1. Provide routine residential care with integrated brain health and dementia risk reduction. Focus on maintaining function, diet, mobility, sensory health, mood, sleep, and social engagement for all residents, including adapting approaches for those with cognitive impairment 2. Provide regular opportunities for physical, cognitive, and social activity that is inclusive of all residents' preferences and abilities (e.g., mobility, sensory impairment)

	3. Identify and address modifiable clinical risk factors. Monitor residents for signs of worsening blood pressure, diabetes, substance use, mental health concerns, sleep problems, sensory impairment, fall risk and potentially harmful medication regimens. Alert and coordinate with medical providers to manage concerns. 4. Reduce isolation and promote meaningful engagement through structured opportunities for social connection, family involvement, cognitive stimulation, and culturally diverse activities. 5. Provide educational materials to residents and family members or caregivers about the importance of brain health and risk reduction of cognitive impairment and dementia. Adopt or adapt material from Washington's Dementia Action Collaborative (Brain Health)
Hospitals	1. Identify and intervene upon SDOH, connect to local community resources for risk reduction
Health plans	1. Member education annually on promotion of brain health (use DAC materials) 2. Notice to members of unused benefits age 50+? (e.g., nutrition, vision, behavioral healthcare, etc.?) 3. Promote Diabetes Prevention Program and BP self-monitoring support programs as aligned with keeping your brain healthy? Other physical activity classes or other programs? 4. Incentivize prevention and support plan members by helping with physical activity and fitness gym dues. 5. Support fruit and vegetable prescription programs for those at risk.
Employers	1. Assess your organization's alignment with brain-healthy workplace policies and practices 2. Adopt brain health-oriented workplace policies, such as employee resource groups, nonsmoking environments, and opportunities for healthy food and physical activity. 3. Increase employee education and information on dementia prevention.
State Agencies	1. Align with national and state-level plans for risk reduction of Alzheimer's and other dementias 2. DOH: Integrate promotion of brain health across overlapping initiatives and departments (e.g., chronic disease prevention, injury and violence prevention, etc.) 3. Collaborate with partners to develop a public health prevention model that promotes systems, policies, and environmental changes to establish and build efforts to treat and prevent dementia. 8. OIC/HCA:? Aspirational goal?: a "Brain Health Program" similar to the Diabetes Prevention Program offered and covered through Medicare that is more comprehensive of all risk factors – consider directive to the legislature to develop a workgroup at OIC to develop "Brain Health Prevention Program" with similar structure to DPP?

Evidence Review

Resources

Healthy Brain Initiative

Race, Ethnicity, and Alzheimer's in America

Non-Medical Factors that Affect Alzheimer's Disease and Related Dementias Risk | Alzheimer's Disease and Dementia | CDC

Brain Health At Work™ | Alzheimer's Association

Literature

Citation	Findings
Livingston G, Huntley J, Liu KY, Costafreda SG, Selbæk G, Alladi S, Ames D, Banerjee S, Burns A, Brayne C, Fox NC, Ferri CP, Gitlin LN, Howard R, Kales HC, Kivimäki M, Larson EB, Nakasujja N, Rockwood K, Samus Q, Shirai K, Singh-Manoux A, Schneider LS, Walsh S, Yao Y, Sommerlad A, Mukadam N. **Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission.** Lancet. 2024 Aug 10;404(10452):572-628. doi: 10.1016/S0140-6736(24)01296-0. Epub 2024 Jul 31. PMID: 39096926.	• 14 modifiable risk factors across the life course (adds vision loss and high LDL from the prior list) • ~45% of dementia cases are theoretically preventable if risk factors are addressed • Strongest available evidence supports vascular risk reduction (hypertension, smoking) and hearing loss treatment as key targets • Emphasizes life-course approach (education -> midlife vascular risk -> late life factors)
Tsai Do, B.S., Bush, M.L., Weinreich, H.M., Schwartz, S.R., Anne, S., Adunka, O.F., Bender, K., Bold, K.M., Brenner, M.J., Hashmi, A.Z., Keenan, T.A., Kim, A.H., Moore, D.J., Nieman, C.L., Palmer, C.V., Ross, E.J., Steenerson, K.K., Zhan, K.Y., Reyes, J. and Dhepyasuwan, N. (2024), **Clinical Practice Guideline: Age-Related Hearing Loss.** Otolaryngol Head Neck Surg, 170: S1-S54. https://doi.org/10.1002/ohn.750	• Recommends screening for hearing loss in older adults based on symptoms and risk • Strong endorsement of hearing aids and rehabilitative strategies to improve communication and quality of life • Recognizes emerging evidence linking untreated hearing loss to cognitive decline/dementia
Sabbagh, M. N., Perez, A., Holland, T. M., Boustani, M., Peabody, S. R., Yaffe, K., Bruno, M., Paulsen, R., O'Brien, K., Wahid,	11 consensus based recommendations building upon available evidence for dementia risk reduction; the workgroup selected 6 topics that

N., & Tanzi, R. E. (2022). **Primary prevention recommendations to reduce the risk of cognitive decline.** *Alzheimer's & Dementia, 18*(8), 1569–1579. https://doi.org/10.1002/alz.12535	had the strongest evidence and suitable to provide actionable guidance for clinical practice: neurovascular risk management, physical activity, sleep, nutrition, social isolation, and cognitive stimulation
Walsh S, Klee M, Hui EK, Saeed U, Waters S, Kuhn I, Siette J, Orgeta V, Stafford J, Smith LJ, Tamburin S, Jensen DEA, Mantovani E, Chandra A, James SN, Tang EYH, Llewellyn DJ, Foote IF, Chiesa ST, Geraets AFJ; DEMON SDOH International Research Group. **Social determinants of dementia: A scoping review.** Alzheimers Dement. 2025 Jul;21(7):e70524. doi: 10.1002/alz.70524. PMID: 40717690; PMCID: PMC12301702.	Scoping review to identify current evidence on social determinants of dementia through scoping review of systematic reviews and review of primary literature to address identified gaps; clear evidence supports association between some SDOH and dementia (education, air pollution, socioeconomic status, ethnicity) while evidence for others is emerging (housing quality/stability) or lacking (incarceration) Evidence comes mainly from high-income countries, and there's a complex intercorrelation between SDOD to demand nuanced analytical approach
Iso-Markku P, Kujala UM, Knittle K, Polet J, Vuoksimaa E, Waller K. **Physical activity as a protective factor for dementia and Alzheimer's disease: systematic review, meta-analysis and quality assessment of cohort and case-control studies.** Br J Sports Med. 2022 Jun;56(12):701-709. doi: 10.1136/bjsports-2021-104981. Epub 2022 Mar 17. PMID: 35301183; PMCID: PMC9163715.	• Higher physical activity is associated with reduced risk of dementia and Alzheimer's disease • Effect is moderate but consistent across cohort studies
Yeo BSY, Song HJJMD, Toh EMS, et al. **Association of Hearing Aids and Cochlear Implants With Cognitive Decline and Dementia: A Systematic Review and Meta-analysis**. JAMA Neurol. 2023;80(2):134–141. doi:10.1001/jamaneurol.2022.4427	• Hearing aids/cochlear implants are associated with 19% lower hazard ratio of long-term cognitive decline/dementia and ~3% shorter term cognitive score improvement • Evidence is largely observational, but treatment of hearing loss is associated with reduced cognitive decline risk
Jamil Y, Krishnaswami A, Orkaby AR, Stimmel M, Brown Iv CH, Mecca AP, Forman DE, Rich MW, Nanna MG, Damluji AA. **The Impact of Cognitive Impairment on Cardiovascular Disease.** J Am Coll Cardiol. 2025 Jul 1;85(25):2472-2491. Doi:	• Cognitive impairment worsens cardiovascular outcomes and leads to undertreatment and poor adherence • Bidirectional relationship requires integrated care

10.1016/j.jacc.2025.04.057. PMID: 40562512; PMCID: PMC12309292.	
The **SPRINT MIND** Investigators for the SPRINT Research Group. **Effect of Intensive vs Standard Blood Pressure Control on Probable Dementia: A Randomized Clinical Trial**. JAMA. 2019;321(6):553–561. doi:10.1001/jama.2018.21442	• Intensive blood pressure management (<120mmHg) significantly reduced combined incidence of MCI or probably dementia compared to standard treatment, although did not reach statistical significance for reduction in dementia alone. • May have been underpowered for this outcome
Baker LD, Espeland MA, Whitmer RA, et al. **Structured vs Self-Guided Multidomain Lifestyle Interventions for Global Cognitive Function: The US POINTER Randomized Clinical Trial.** JAMA. 2025;334(8):681–691. Doi:10.1001/jama.2025.12923	• Both interventions (structured versus self-guided multidomain lifestyle intervention) improved cognition over 2 years, but the structured intervention had greater improvement • Effect was consistent across subgroups (e.g., APOE genotype, sex, etc)
Ngandu T, Lehtisalo J, Solomon A, Levälahti E, Ahtiluoto S, Antikainen R, Bäckman L, Hänninen T, Jula A, Laatikainen T, Lindström J, Mangialasche F, Paajanen T, Pajala S, Peltonen M, Rauramaa R, Stigsdotter-Neely A, Strandberg T, Tuomilehto J, Soininen H, Kivipelto M. **A 2 year multidomain intervention of diet, exercise, cognitive training, and vascular risk monitoring versus control to prevent cognitive decline in at-risk elderly people (FINGER): a 10andomized controlled trial.** Lancet. 2015 Jun 6;385(9984):2255-63. Doi: 10.1016/S0140-6736(15)60461-5. Epub 2015 Mar 12. PMID: 25771249.	• First RCT of multidomain intervention (diet, exercise, cognitive training, vascular management) • Significantly improved composite cognitive score vs control • Larger gains in executive function, processing speed, and memory
Brodaty, H., Chau, T., Heffernan, M. et al. **An online multidomain lifestyle intervention to prevent cognitive decline in at-risk older adults: a randomized controlled trial.** Nat Med 31, 565–573 (2025). https://doi.org/10.1038/s41591-024-03351-6	• Digital multidomain intervention improved or preserved cognitive function vs control and demonstrated a scalable, remote delivery • Effects were generally modest but clinically meaningful for population-level prevention
Ellingjord-Dale M, Strand BH, Skirbekk V, Bratsberg B, Mekonnen T, Zotcheva E, Selbæk G, Stern Y, Håberg AK, Engdahl B.	• Quantified population-attributable dementia risk in Norway – confirms major contributors including hearing

Potentially modifiable risk factors for dementia in Norway (HUNT4 70+): a retrospective cohort study. Lancet Healthy Longev. 2025 Dec;6(12):100802. Doi: 10.1016/j.lanhl.2025.100802. PMID: 41475703.	loss, vascular risk factors, low education, and lifestyle factors • Reinforces that a large proportion of dementia is preventable in real-world populations
Nicola, L., Loo, S. J. Q., Lyon, G., Turknett, J., & Wood, T. R. (2024). **Does resistance training in older adults lead to structural brain changes associated with a lower risk of Alzheimer's dementia? A narrative review.** Ageing Research Reviews, 98, 102356. https://doi.org/10.1016/j.arr.2024.102356. PMID: 38823487	• Resistance training is associated with structural brain changes, improvements in cognition and neuroplasticity markers • Resistance training appears to be especially important for those with mild cognitive impairment
Reuben DB, Kremen S, Maust DT. **Dementia Prevention and Treatment: A Narrative Review.** JAMA Intern Med. 2024;184(5):563–572. doi:10.1001/jamainternmed.2023.8522	• Narrative review of dementia prevention strategies • Strongest evidence for vascular risk control, physical activity, and multidomain interventions (FINGER type • Risk reduction requires a multimodal approach
Sabayan B, Boden-Albala B, Rost NS. **An Ounce of Prevention: The Growing Need for Preventive Neurologists.** Neurology. 2025 Jul 8;105(1):e213785. Doi: 10.1212/WNL.0000000000213785. Epub 2025 Jun 12. PMID: 40505079.	• Narrative review from the preventive neurology perspective • Dementia risk factors overlap with cardiovascular disease, and prevention should be integrated into routine care early • System redesign suggestions to facilitate population-level risk reduction

[i] Livingston, G., Huntley, J., Liu, K. Y., Costafreda, S. G., Selbæk, G., Alladi, S., Ames, D., Banerjee, S., Burns, A., Brayne, C., Fox, N. C., Ferri, C. P., Gitlin, L. N., Howard, R., Kales, H. C., Kivimäki, M., Larson, E. B., Nakasujja, N., Rockwood, K., … Mukadam, N. (2024). Dementia prevention, intervention, and care: 2024 report of the Lancet standing Commission. The Lancet (British Edition), 404(10452), 572–628. https://doi.org/10.1016/S0140-6736(24)01296-0

[ii] US Preventive Services Task Force. Screening for Depression and Suicide Risk in Adults: US Preventive Services Task Force Recommendation Statement. JAMA. 2023;329(23):2057–2067. doi:10.1001/jama.2023.9297

[iii] US Preventive Services Task Force. Interventions to Prevent Falls in Community-Dwelling Older Adults: US Preventive Services Task Force Recommendation Statement. JAMA. 2024;332(1):51–57. doi:10.1001/jama.2024.8481

[iv] US Preventive Services Task Force. Screening for Gestational Diabetes: US Preventive Services Task Force Recommendation Statement. JAMA. 2021;326(6):531–538. doi:10.1001/jama.2021.11922

[v] US Preventive Services Task Force. Behavioral Counseling Interventions to Promote a Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: US Preventive Services Task Force Recommendation Statement. JAMA. 2020;324(20):2069–2075. doi:10.1001/jama.2020.21749

[vi] US Preventive Services Task Force. Screening for Hypertension in Adults: US Preventive Services Task Force Reaffirmation Recommendation Statement. JAMA. 2021;325(16):1650–1656. doi:10.1001/jama.2021.4987

[vii] US Preventive Services Task Force. Screening for Hypertensive Disorders of Pregnancy: US Preventive Services Task Force Final Recommendation Statement. JAMA. 2023;330(11):1074–1082. doi:10.1001/jama.2023.16991

[viii] US Preventive Services Task Force. Screening for Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults: US Preventive Services Task Force Recommendation Statement. JAMA. 2025;334(4):329–338. doi:10.1001/jama.2025.9009

[ix] US Preventive Services Task Force. Interventions to Prevent Perinatal Depression: US Preventive Services Task Force Recommendation Statement. JAMA. 2019;321(6):580–587. doi:10.1001/jama.2019.0007

[x] US Preventive Services Task Force. Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: US Preventive Services Task Force Recommendation Statement. JAMA. 2022;328(8):746–753. doi:10.1001/jama.2022.13044

[xi] US Preventive Services Task Force. Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons: US Preventive Services Task Force Recommendation Statement. JAMA. 2021;325(3):265–279. doi:10.1001/jama.2020.25019

[xii] US Preventive Services Task Force. Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults: US Preventive Services Task Force Recommendation Statement. JAMA. 2018;320(18):1899–1909. doi:10.1001/jama.2018.16789

[xiii] US Preventive Services Task Force. Screening for Unhealthy Drug Use: US Preventive Services Task Force Recommendation Statement. JAMA. 2020;323(22):2301–2309. doi:10.1001/jama.2020.8020

[xiv] US Preventive Services Task Force. Behavioral Weight Loss Interventions to Prevent Obesity-Related Morbidity and Mortality in Adults: US Preventive Services Task Force Recommendation Statement. JAMA. 2018;320(11):1163–1171. doi:10.1001/jama.2018.13022