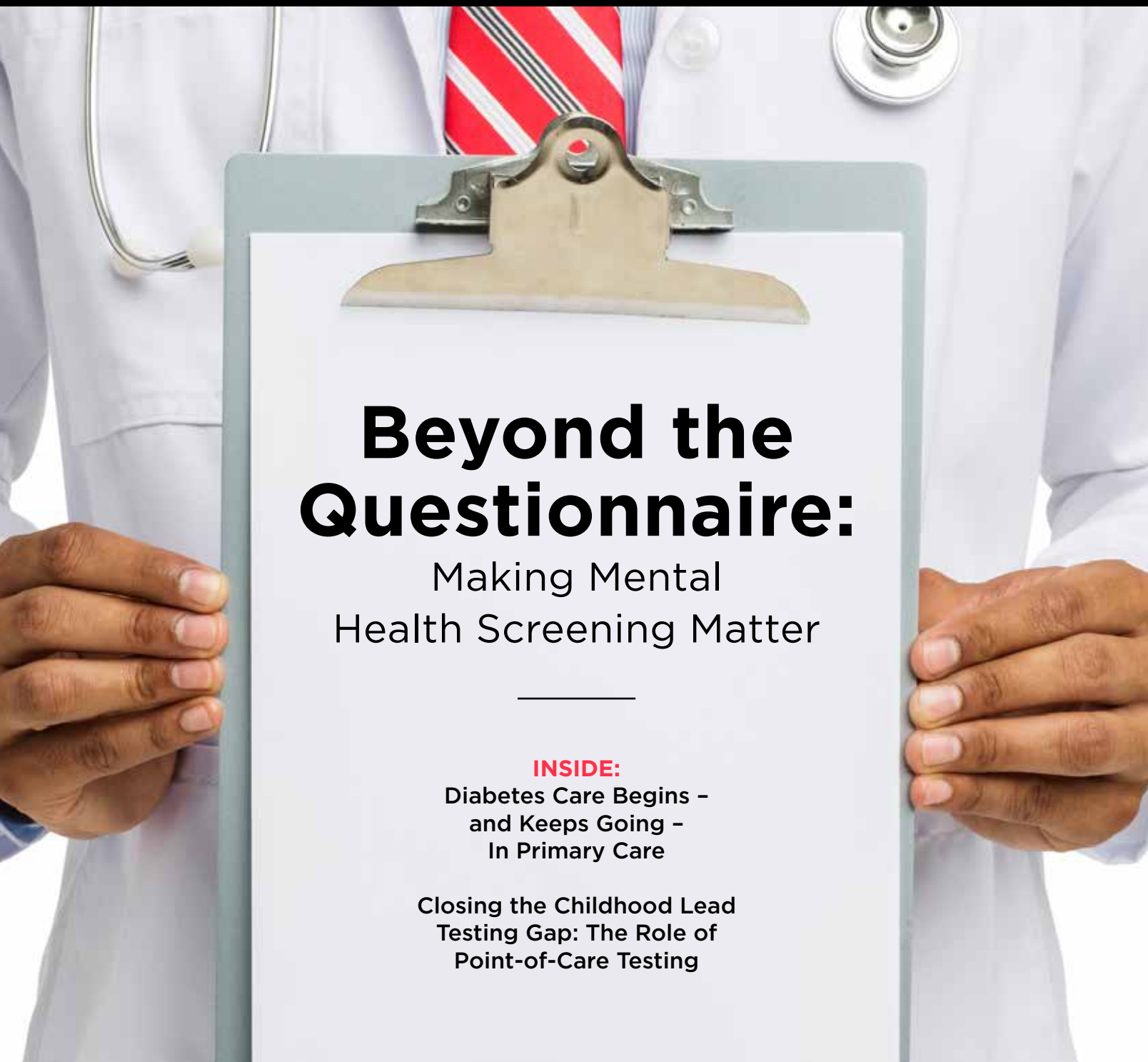
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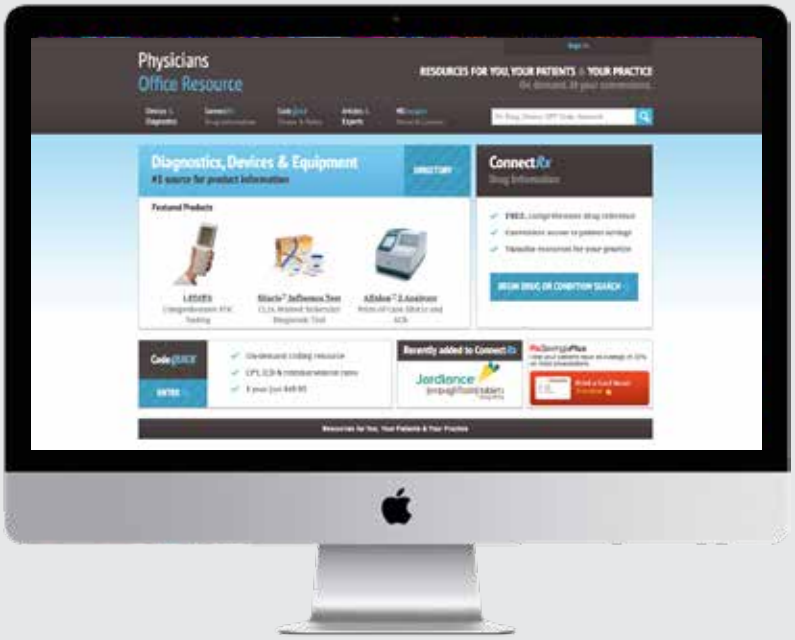
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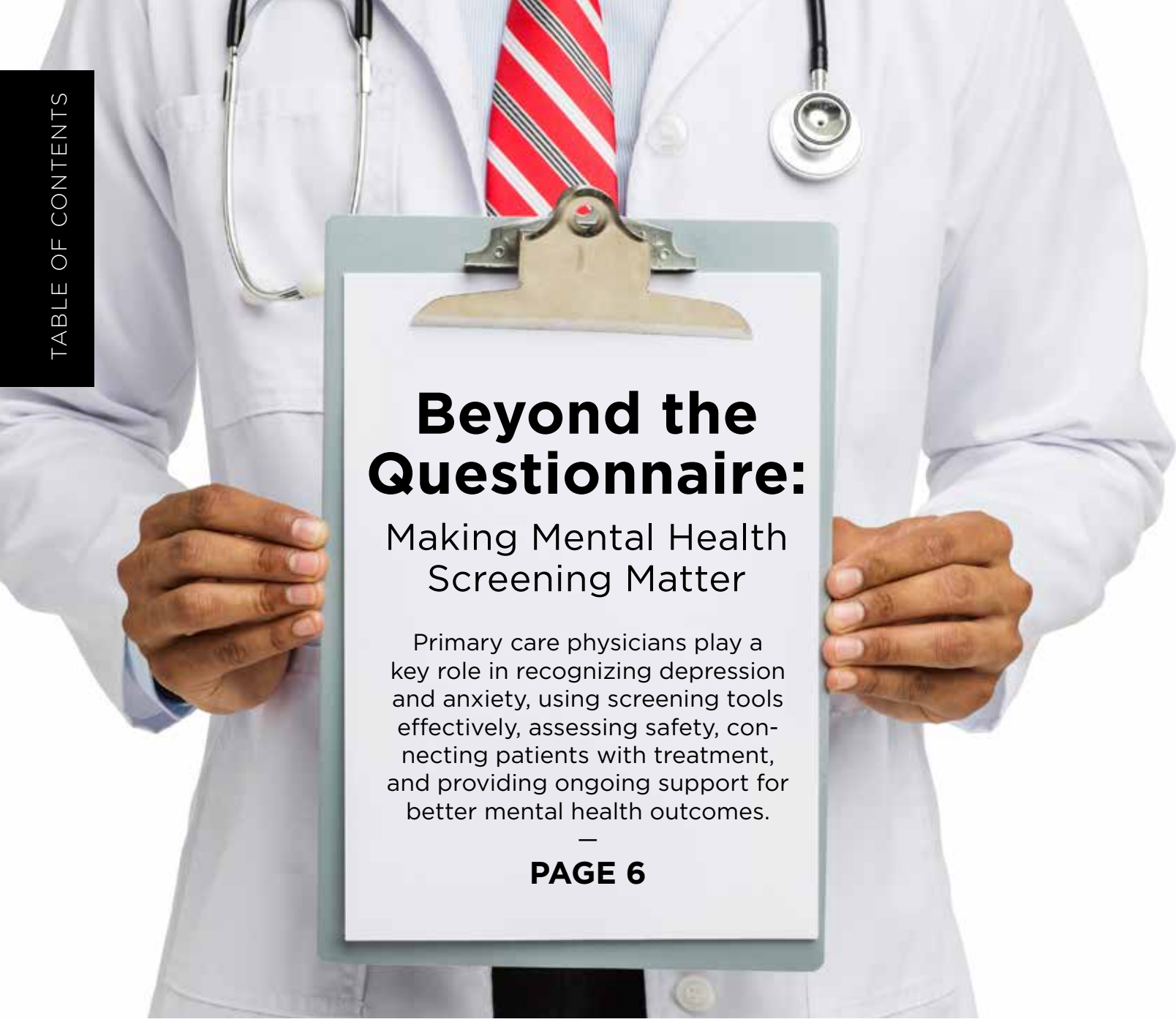
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# Beyond the Questionnaire:

## Making Mental Health Screening Matter

Primary care physicians play a key role in recognizing depression and anxiety, using screening tools effectively, assessing safety, connecting patients with treatment, and providing ongoing support for better mental health outcomes.

—

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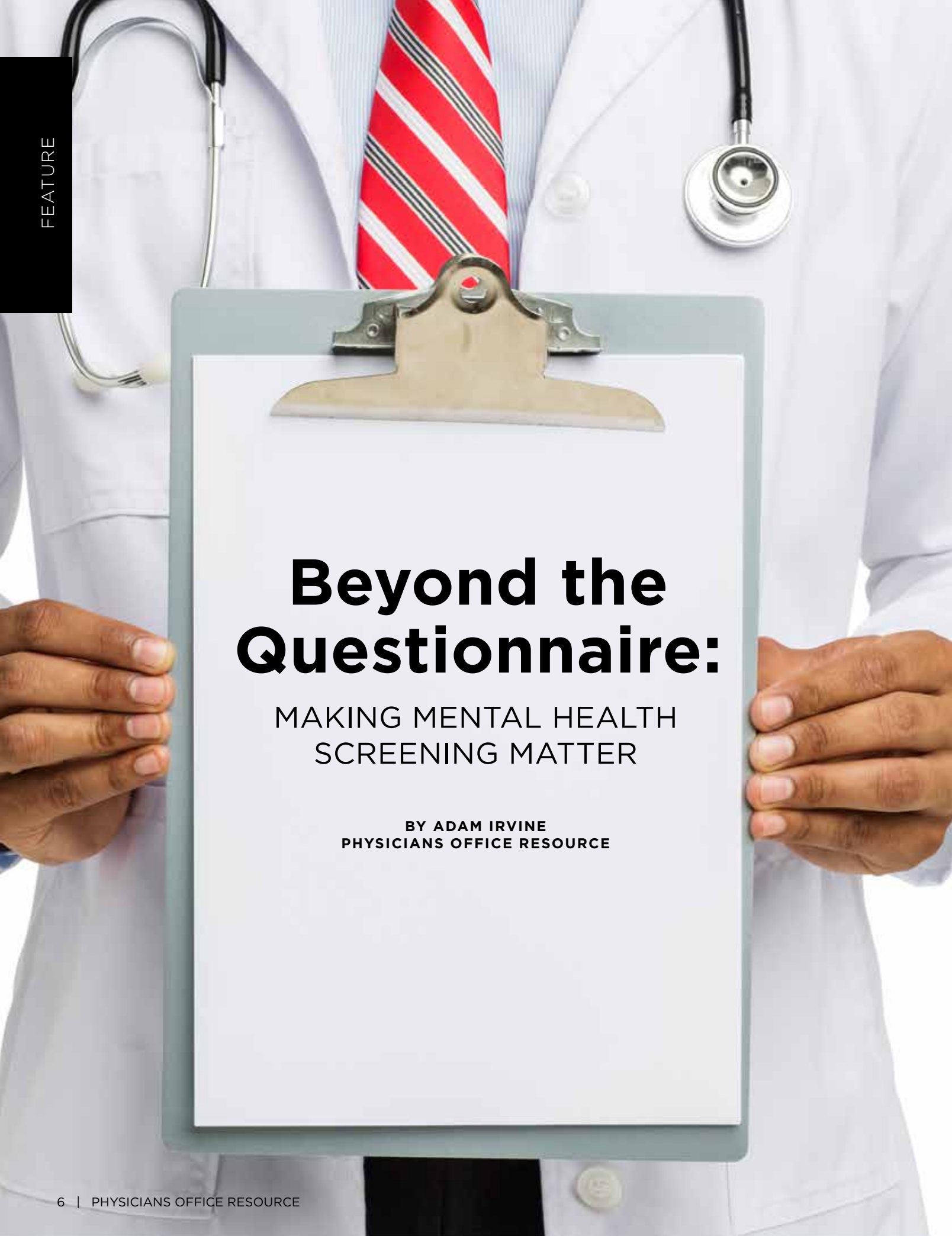
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# Beyond the Questionnaire:

## MAKING MENTAL HEALTH SCREENING MATTER

**BY ADAM IRVINE**
**PHYSICIANS OFFICE RESOURCE**

*For many patients, the first opportunity to identify depression or anxiety arrives during a visit scheduled for something else. A patient seeking help for fatigue may also be losing interest in daily activities. Someone returning for hypertension management may describe persistent worry and poor sleep. The primary care physician has an opportunity to recognize these concerns within the larger picture of the patient's health.*

Depression can involve changes in sleep, appetite, energy, and concentration, as well as physical symptoms such as headaches or digestive complaints. These presentations help explain why mental health assessment belongs in everyday primary care.1 Screening provides a structured opening, but its value depends on what follows: a conversation, diagnostic evaluation, appropriate treatment, and continued attention to the patient's progress.

### The clinical advantage of continuity

Primary care offers context that a questionnaire cannot supply. A physician may know that a patient recently became a caregiver, lost a spouse, or stopped attending appointments. Changes in functioning can become apparent across visits, even when the patient does not identify an emotional concern.

That continuity also creates opportunities to make disclosure easier. Asking about mood and worry alongside sleep, medications, and daily functioning signals that these concerns are part of medical care. A brief introduction can help: "We ask about emotional health because it affects overall health, and we want to understand how you are doing."

The physician should leave room for the patient's own description. Some patients readily discuss depression; others describe feeling overwhelmed, irritable, exhausted, or unable to cope. Asking what has changed and what has become difficult can connect a screening result to the experience that brought the patient into the office.

### Knowing whom to screen

The US Preventive Services Task Force recommends screening adults for major depressive disorder, including older adults and pregnant and postpartum patients. It also recommends anxiety screening for adults aged 19 through 64, including pregnant and postpartum patients. For anxiety screening in adults 65 years or older, evidence is insufficient to determine the balance of benefits and harms.[2,3]

These recommendations concern patients without an established relevant diagnosis or recognized symptoms. A patient reporting persistent sadness, panic, or substantial functional decline already needs clinical evaluation. A routine screening schedule should never delay that assessment. Similarly, questionnaires used for patients with known depression or anxiety serve a monitoring function rather than initial screening.

For practices caring for younger patients, the USPSTF recommends depression screening at ages 12 through 18 and anxiety screening at ages 8 through 18. Evidence is insufficient for routine depression screening in younger children and anxiety screening at age 7 or younger.[4,5] An insufficient-evidence statement does not mean that symptoms should be ignored; it identifies uncertainty about preventive screening in patients without recognized symptoms.

### Choosing tools that support the encounter

A practical adult depression workflow may begin with the two-item Patient Health Questionnaire, or PHQ-2, followed by the PHQ-9 when indicated. The longer questionnaire provides a more detailed symptom profile and can support subsequent monitoring. The Edinburgh Postnatal Depression Scale is another established option for perinatal assessment.[6]

For anxiety, practices commonly use the GAD-2 or GAD-7. These instruments are particularly useful for identifying possible generalized anxiety disorder, but their ability to identify every anxiety disorder is more limited. A negative result does not exclude panic disorder, social anxiety, or another clinically important presentation.[3]

Selection should reflect the population and the office's capacity to respond. Use age-appropriate instruments and validated language versions when available. Staff should understand how to administer and score the chosen tool, while clinicians should understand its limitations. Consistency makes results easier to interpret over time, but no score should replace the history or determine treatment by itself.

### A positive result begins the assessment

A positive depression screen identifies a need for further evaluation. Establish symptom duration, severity, associated distress, and effects on work, relationships, self-care, and daily responsibilities. Review previous episodes, treatment experiences, medications, substance use, and

relevant medical conditions. Confirm whether the presentation meets diagnostic criteria rather than labeling every elevated score as major depressive disorder.[6]

The differential diagnosis remains a primary care responsibility. Consider medical contributors when the history or examination suggests them; thyroid disease, medication effects, and other conditions may resemble or complicate depression. Laboratory testing should follow the clinical assessment rather than become an automatic panel ordered for every positive screen.[7]

Before treating a depressive episode, ask about past periods of elevated or unusually irritable mood, increased activity, reduced need for sleep, and impulsive behavior. Bipolar disorder can present during a depressive episode, and recognizing that history changes management. Suspected bipolar disorder warrants additional evaluation and often psychiatric consultation.[8]

The conversation should also explore circumstances that affect the plan. A patient facing eviction, caregiving demands, or relationship violence may need practical support alongside mental health treatment. Understanding these pressures helps the physician recommend care the patient can actually use.

### Responding directly to safety concerns

Suicide assessment deserves a clearly defined office pathway. The USPSTF finds insufficient evidence to recommend for or against routine suicide-risk screening in asymptomatic adults. That conclusion does not remove the need to assess risk when a patient reports suicidal thoughts or presents with concerning symptoms.[2]

Any endorsement of the PHQ-9 self-harm item should prompt direct clarification, regardless of the total score. Ask whether the patient is describing thoughts of death, self-injury, or suicide. Do not assume that a low depression score establishes safety. Asking directly about suicide does not cause or increase suicidal thoughts.[9]

A structured assessment should address current thoughts, intent, plans, access to lethal means, past attempts, and available supports. The National Institute of Mental Health provides an adult outpatient brief suicide safety assessment guide following a positive suicide-risk screen. Current suicidal thoughts require urgent evaluation, and the patient should not be left alone.[10]

For patients appropriate for outpatient management, develop a collaborative safety plan, discuss securing lethal means, and arrange timely follow-up. A safety plan identifies warning signs, coping strategies, supportive contacts, and crisis resources; a promise not to attempt suicide is not an adequate substitute. Emergency disposition should follow the clinical assessment and local protocol.[10]

### Making screening workable in a busy practice

An effective workflow begins before the physician enters the room. The practice should decide who offers the questionnaire, who checks completion, who scores it, and how the clinician receives the result. Staff need explicit instructions for immediately communicating concerning responses.

Previsit electronic questionnaires can save encounter time, but only when someone is responsible for reviewing them. Practices should explain when submissions are monitored and provide urgent-help instructions. Patients completing a form in the office should have their answers reviewed before departure, with safety concerns addressed promptly.

Privacy is equally practical. Offer an opportunity to complete screening without a partner or family member watching. For adolescents, provide developmentally appropriate private discussion and explain confidentiality and its safety-related limits under applicable law. Patients with limited literacy, language barriers, or disabilities may need assistance that preserves both comprehension and privacy.

The USPSTF has not established an optimal interval for adult depression or anxiety screening. A practice may choose an annual workflow for consistency, while using clinical judgment to reassess after major life events or changes in health. Annual screening is an operational choice rather than a proven universal interval.[2,3]

### Connecting identification with treatment

Once the diagnosis and safety needs are established, discuss options in language the patient understands. Treatment may include psychotherapy, medication, or both, depending on the condition, severity, previous response, comorbidities, and patient preference. Explain the expected course and agree on a follow-up plan.[2,3]

Referral should be specific enough to be useful. Ask whether the patient can afford visits, obtain transportation, use telehealth, and find a clinician accepting new patients. A referral list offers little help if every listed practice is unavailable. When access is delayed, define what the primary care team will manage and when specialty input is necessary.

A warm handoff to an available behavioral health clinician can make the next step more concrete. When that resource is absent, staff can help identify an appointment and confirm whether the patient connected with care. The referring physician should know who is

managing treatment and how information will return to the practice.

### Sharing responsibility through collaborative care

Collaborative care provides a structured approach to treating common mental health conditions within primary care. Typically, the primary care clinician works with a behavioral health care manager and a psychiatric consultant. A patient registry supports systematic follow-up, while repeated symptom measurements help identify patients whose treatment needs adjustment.[11]

The model has substantial evidence supporting improved depression and anxiety outcomes. Its strength is proactive management: patients who are not improving are identified and discussed, rather than waiting indefinitely for another visit. Psychiatric consultation supports the primary care team without requiring every patient to establish separate specialty care.[11]

Implementation requires staffing, defined responsibilities, communication, and financial planning. Smaller practices may begin by strengthening referral relationships and assigning responsibility for outreach. Whatever the structure, the office should be able to answer a basic question: who notices when a patient has not received care or is getting worse?

### Following symptoms and function

Screening creates a baseline that can inform later care. Repeating the same instrument helps track symptom changes, but follow-up should also address sleep, daily functioning, relationships, treatment adherence, adverse effects, and safety. A lower score matters most when it corresponds to meaningful improvement for the patient.

Schedule reassessment according to risk, clinical severity, and the treatment initiated. Patients should leave knowing when they will be contacted and what to do if symptoms worsen. If progress is limited, revisit the diagnosis, treatment exposure, barriers to adherence, and need for consultation.

Missed appointments deserve attention within the practice's outreach process. A patient who does not return may be struggling with access, motivation, or worsening illness. Document contact attempts and establish escalation procedures for concerning situations. Follow-up is easier to sustain when the responsibility belongs to a named team member rather than an unattended inbox.

### Measuring the care that follows

Practices should evaluate more than the percentage of patients screened. Useful measures include whether positive results received diagnostic assessment, whether treatment or referral occurred, and whether follow-up was completed. Reviewing a small sample of charts can reveal where patients lose contact with the system.

The primary care physician's role begins with recognizing that mental health belongs in the encounter and continues through the response to what screening reveals. A questionnaire can open the discussion. Clinical judgment, accessible care, and sustained follow-up give that discussion its value. When these elements work together, the physician's office becomes a dependable place for patients to disclose concerns and begin receiving help.

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# FROM EMERGENCY USE AUTHORIZATION TO 510(K) CLEARANCE:

## Preparing Physician Offices for the December 2026 Transition

**BY SEKISUI DIAGNOSTICS**

For physician offices that perform respiratory testing, December 26, 2026 is more than a date on the calendar. It is the day the federal declarations supporting emergency use authorization (EUA) of certain COVID-19 medical devices, including in vitro diagnostic tests used to detect or diagnose SARS-CoV-2, are scheduled to terminate.[3] On June 29, 2026, the U.S. Department of Health and Human Services (HHS) Secretary determined that circumstances no longer exist to justify those declarations, and HHS published the termination notice on July 2, 2026.[3] FDA states that, on December 26, 2026, the COVID-19 device EUAs currently listed on its website will no longer be in effect.[4]

Physician offices should identify tests that have an EUA designation, confirm each product's status, and adjust their purchasing and inventory appropriately. The transition does not mean practices must immediately stop using EUA-designated products already purchased or stocked. Rather, manufacturers cannot sell or ship EUA products as of December 26, 2026. Products already stocked at distributor warehouses or in healthcare facilities may continue to be sold and used until the expiration date stated on the product labeling.

### Understanding what changes in December

An EUA is an emergency authorization issued under section 564 of the Federal Food, Drug, and Cosmetic Act (FD&C Act).[3] An EUA is not the same as FDA clearance or approval, and it is designed for emergency circumstances only.

A 510(k) clearance is one traditional premarket pathway. Through a 510(k), FDA determines that a device is substantially equivalent to a legally marketed predicate device for its intended use.[4] Other traditional pathways may be appropriate for different devices, such as De Novo authorization or premarket approval. For physician offices, the key point is not to determine which pathway a manufacturer should pursue, but to verify that each test used after December 26 has an appropriate non-emergency regulatory status and is used according to its current labeling.

This December 2026 termination should not be confused with the end of the federal COVID-19 public health emergency. The public health emergency declared under section 319 of the Public Health Service Act expired on May 11, 2023, but FDA explains that the end of that public health emergency did not

automatically terminate device EUAs issued under section 564 of the FD&C Act.[4] Those device EUAs remained in effect until the separate EUA declarations for affected COVID-19 medical devices are terminated.

### Start with a testing-menu and inventory review

A smooth transition begins with a complete inventory of all COVID-19 diagnostic products in the medical practice. That includes stand-alone COVID-19 assays as well as combination assays that detect SARS-CoV-2 along with influenza or other respiratory pathogens.

The next step is to determine which products rely solely on an EUA and which have traditional FDA marketing authorization. Because product names, formats, and packaging can be similar across generations of a test, practices should verify status using FDA resources, the current instructions for use, and product-specific information from the manufacturer or distributor.[4] A general statement that a company offers a cleared test is not enough; the office should confirm the exact product and configuration it intends to order and use.

HHS provided 180 days' advance notice before the December 26 termination date. The Federal Register notice explains that this period is intended to provide sufficient time for appropriate product disposition and transition planning.

### Build a solid transition plan

Once EUA products are identified, practices can work to develop an operational transition plan. The goal is not to discard usable products on the deadline, but to manage purchasing, stocking, staff readiness, and replacement-product implementation in a controlled way.

The timing will differ by practice. A high-volume urgent care or primary care site may use remaining EUA-designated inventory quickly, while a smaller office may need to slow or stop reordering earlier to avoid stock that cannot reasonably be used before expiry.

Regulatory status is one consideration but not the only one. The replacement must also fit the practice's patient population, testing workflow, and documentation requirements.

For physician office laboratories (POLs), the review should also include laboratory-specific elements such as CLIA status, quality-control procedures, staff training, competency documentation, and written test procedures.

### Prepare the people and systems, not just the supply shelf

Before adopting a replacement product, the practice should update any standard operating procedure, test menu, standing order, staff training document, or testing workflows that name the outgoing product. Training should address the replacement test's intended use, specimen collection, step-by-step procedure, timing, control requirements, valid and invalid results and limitations. Staff should understand not only how to run the test, but also how the labeling describes appropriate use and interpretation.

### A 510(k) cleared option for the transition

For practices transitioning from an EUA-authorized COVID-19 or COVID-19/influenza combo test, the OSOM® COVID-19/Flu A&B Combo Test is an 510(k) cleared, CLIA-waived option to consider.1 The test is a lateral-flow immunochromatographic which differentiates COVID-19, influenza A, and influenza B from one anterior nasal swab with results in 15 minutes.[1], As with any diagnostic test, limitations should remain visible in protocols and staff education.

This type of product integration should be viewed as one part of a broader transition plan. A 510(k) cleared replacement can support continuity when practices are ready to move to a 510(k) cleared product, but implementation still requires review of the current instructions for use, updates to procedures and documentation, and staff readiness before the product becomes part of routine point-of-care testing.

### Use the transition to strengthen the testing program

Preparation should begin with the products already on the shelf and extend through the systems that support ordering, testing, reporting, and patient communication. By inventorying current tests, verifying regulatory status, managing remaining EUA-designated inventory through labeled expiration dates, selecting cleared replacement products early, and preparing staff before workflow changes occur, practices can maintain testing continuity while moving beyond emergency authorization in a planned and responsible way.

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ML00190 Rev A



# Diabetes Care Begins—and Keeps Going—in Primary Care

**BY MATT BAKER, PHYSICIANS OFFICE RESOURCE**

*From the first abnormal glucose result to long-term risk reduction, the physician's most valuable tool may be a workable plan and a continuing relationship.*

A patient arrives for a blood pressure follow-up, mentions getting up several times each night, and leaves with an order for diabetes testing. Another has lived with type 2 diabetes for a decade, takes medications faithfully, and still cannot explain why morning glucose readings keep climbing. A third has an A1C that looks reassuring but quietly skips lunch to afford prescriptions.

These are familiar primary care encounters. They also reveal why diabetes care cannot be reduced to a laboratory value or a medication algorithm. The disease intersects with nearly everything physicians already manage: cardiovascular risk, kidney function, weight, sleep, mental health, family responsibilities, and the cost of getting through the month.

For primary care physicians, the opportunity is substantial. Earlier recognition, thoughtful treatment, and consistent follow-through can change a patient's trajectory. The challenge is

making those elements fit into ordinary practice. Although the discussion here centers on adults with type 2 diabetes, recognizing patients who need a different diagnostic or treatment pathway remains essential.

### Find the disease before symptoms force the issue

Waiting for polyuria, polydipsia, or unexplained weight loss means missing opportunities to intervene earlier. The American Diabetes Association (ADA) recommends beginning screening by age 35 for otherwise eligible adults, with earlier testing for people with overweight or obesity and additional risk factors. Family history, prior gestational diabetes, hypertension, and other indicators of insulin resistance should sharpen clinical attention.[1]

Testing should answer a clinical question. A1C offers convenience because fasting is unnecessary; fasting plasma glucose is widely available; and a 75-g oral glucose tolerance test can clarify cases that other approaches miss. In nonpregnant adults, diagnostic thresholds include A1C ≥6.5%, fasting plasma glucose ≥126 mg/dL, or two-hour plasma glucose ≥200 mg/dL during an oral glucose tolerance test. Random plasma glucose ≥200 mg/dL establishes diabetes when accompanied by classic hyperglycemic symptoms or a hyperglycemic crisis. Without unequivocal hyperglycemia, confirmation requires two abnormal results.[1]

Prediabetes deserves an actionable response, too. An A1C of 5.7%–6.4% should prompt a conversation about risk and referral to an evidence-based prevention program when appropriate. Telling patients to "watch their sugar" leaves too much unanswered. A defined activity goal, nutrition support, and a scheduled reassessment create a more useful starting point.[2]

### Use office testing thoughtfully

Point-of-care A1C testing can make follow-up visits more productive by putting an actionable result into the conversation while the patient is still present. Its value depends on reliable performance and a workflow that turns the result into a decision.

Diagnosis requires additional care: ADA guidance restricts point-of-care A1C use for screening and diagnosis to FDA-approved diagnostic devices used by trained personnel in CLIA-certified laboratories performing moderate-complexity testing or higher. A device's usefulness for monitoring does not automatically establish its suitability for diagnosis.[1]

A1C also has limitations. Altered red cell turnover and some hemoglobin variants can disrupt its relationship with glycemia. When the result conflicts substantially with plasma glucose or the clinical picture, investigate rather than simply repeating the same assumption. Use plasma glucose criteria for diagnosis when A1C is unreliable.[1]

Finally, do not assume every adult has type 2 diabetes. Rapid deterioration, unintentional weight loss, ketosis, or an atypical presentation should raise concern for insulin deficiency and prompt appropriate evaluation and specialist involvement. Suspected ketoacidosis requires urgent assessment; outpatient diagnostic clarification must not delay necessary treatment.[1]

### Make the first treatment plan understandable

A new diagnosis often produces an avalanche of information. Patients may remember the word "diabetes" and very little afterward. The first conversation should establish what the diagnosis means, what happens next, and how to reach the practice with questions.

Ask what concerns the patient most. One may fear insulin because of a relative's experience; another may worry about losing a commercial driving job. Those concerns influence treatment acceptance as surely as a formulary does. Before adding instructions, determine what the patient already believes.

Diabetes self-management education and support (DSMES) and medical nutrition therapy belong early in the care plan. Referral is especially useful at diagnosis, when goals are not being met, when complications arise, and during transitions in care. Education should teach usable skills: taking medication, recognizing glucose patterns, treating hypoglycemia, and navigating meals, activity, and illness.[3]

A specific plan is easier to follow than a comprehensive lecture. Agree on one or two immediate priorities, use teach-back, and arrange follow-up before the patient leaves. The next visit can build on what worked.

### Treat glucose while protecting the person

For many nonpregnant adults, an A1C goal below 7% is appropriate, provided it can be achieved without significant hypoglycemia or excessive treatment burden. Individualization matters: frailty, cognitive impairment, comorbidities, life expectancy, and the patient's preferences may justify a different target.[4]

Medication selection should begin with the whole clinical picture. Metformin remains a useful, affordable option for many patients, subject to renal function and tolerability. But established atherosclerotic cardiovascular disease, heart failure, chronic kidney disease, and obesity can change treatment priorities. Agents with demonstrated cardiovascular or kidney benefits may be indicated regardless of whether A1C is already at goal.[5]

For appropriate patients, SGLT2 inhibitors and GLP-1 receptor agonists offer benefits beyond glucose reduction. Selection must reflect the specific agent's evidence, indications, kidney considerations, adverse effects, and affordability. Weight management may also influence the choice of GLP-1–based therapy, including dual GIP/GLP-1 receptor agonists. The practical question is which treatment best addresses this patient's risks and can realistically be sustained.[5]

Insulin should not become a threat reserved for "failure." Consider it promptly when hyperglycemia is symptomatic or severe, including A1C above 10% or blood glucose ≥300 mg/dL, particularly with catabolic features. Patients need a clear explanation, administration training, glucose monitoring, and a follow-up plan.[5]

Just as important, revisit medications when circumstances change. Weight loss, declining kidney function, reduced intake, or recurrent hypoglycemia may call for deintensification. A lower A1C is not automatically a better outcome if achieving it makes daily life unsafe.[4]

### Turn monitoring into clinical decisions

A1C provides a useful overview, but it cannot describe every high, low, or overnight excursion. ADA guidance recommends assessing glycemic status at least twice yearly in stable patients meeting goals and more frequently—often every three months—after treatment changes or when goals are unmet.[4]

Continuous glucose monitoring (CGM) can add context that an average cannot. The 2026 ADA recommendations support CGM for adults using insulin, those using noninsulin therapies that can cause hypoglycemia, and other patients when it helps management. Device selection should reflect individual needs and preferences.[5]

The prescription is only the beginning. Patients need help interpreting trends without reacting to every fluctuation, while practices need a reliable way to review the information. Decide what question monitoring should answer: Is fasting glucose driving the A1C? Are overnight lows being missed? Is the current regimen workable on employment days?

Hypoglycemia deserves a direct question at every relevant encounter. Ask about symptoms, episodes requiring assistance, and fear of low glucose. Provide treatment instructions and prescribe glucagon for patients taking insulin or otherwise at high risk, with education for those who may need to administer it.[5]

### Keep complication prevention on the agenda

Kidney protection begins with looking for disease. Assess both estimated glomerular filtration rate and urine albumin-to-creatinine ratio at least annually in all patients with type 2 diabetes. A reassuring creatinine result does not replace urine albumin testing. Established kidney disease requires monitoring tailored to severity.[6]

Abnormal findings should trigger confirmation when appropriate and a treatment review. Blood pressure management, indicated renin-angiotensin system blockade, and therapies with proven kidney benefit can alter risk. An SGLT2 inhibitor is recommended for eligible patients with type 2 diabetes and chronic kidney disease; additional therapies may be appropriate according to albuminuria, kidney function, and potassium. Progressive or atypical disease warrants nephrology involvement.[6]

Cardiovascular prevention deserves equal attention. Review blood pressure, lipids, tobacco use, and appropriate statin therapy rather than letting the glucose discussion consume the encounter. ADA's usual on-treatment blood pressure goal is below 130/80 mmHg when safely attainable; its 2026 guidance encourages a systolic goal below 120 mmHg for individuals with high cardiovascular or kidney risk when appropriate and safe.[7]

Eye and foot care should be routine parts of the plan. Arrange a comprehensive dilated eye examination at type 2 diabetes diagnosis, with subsequent timing based on findings and risk. Perform a comprehensive foot assessment at least annually, including skin, deformity, protective sensation, and vascular status; higher-risk patients need more frequent attention.[8]

The referral itself is not the endpoint. Confirm that the patient attended, obtain the findings, and act on them. A recommendation buried in the chart cannot protect vision or prevent an ulcer.

### Give lifestyle advice a chance to work

"Eat better and exercise" is familiar advice, but it provides little help with tonight's dinner or tomorrow's schedule. Ask about food access, cultural preferences, physical limitations, and what the patient is willing to change.

Nutrition counseling should emphasize an individualized, sustainable eating pattern. For most adults, the activity goal is at least 150 minutes of moderate-to-vigorous aerobic activity weekly, with resistance exercise and less sedentary time as appropriate. Someone who currently does very little may need to begin with a brief, achievable walk rather than a fully developed exercise prescription.[3]

For patients with overweight or obesity, sustained weight loss of 5%–7% can improve glycemia and other metabolic measures; larger losses may offer additional benefits. Discuss behavioral treatment, medication, and metabolic surgery when appropriate. Obesity deserves active treatment, without making patients feel that every glucose result is a verdict on their effort.[9]

### Make continuity part of the prescription

The most effective plan can unravel between appointments. A medication is denied, a sensor falls off, a patient develops nausea, or a caregiver becomes unavailable. Ask specifically about cost, side effects, diabetes distress, and practical barriers before labeling the problem nonadherence.

Primary care practices can make follow-through more dependable through previsit laboratory planning, standing workflows for overdue testing, medication reconciliation, and clearly assigned responsibility for referrals. Nurses, pharmacists, dietitians, and diabetes educators extend the physician's ability to respond. Small operational improvements can turn good intentions into completed care.

Every patient also needs individualized sick-day guidance: how to monitor, which medication adjustments may be necessary, when ketone testing is appropriate, and when to seek urgent help. Persistent vomiting, dehydration, altered mental status, or suspected ketoacidosis should never wait for a routine appointment.[4]

Diabetes care succeeds through repeated decisions made with the patient over time. Primary care physicians are positioned to connect those decisions—to notice the missed test, uncover the unaffordable prescription, adjust the treatment, and keep the next visit focused on what matters. The goal is a longer, healthier life supported by a plan the patient can actually use.

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# Closing the Childhood Lead Testing Gap:

## THE ROLE OF POINT-OF-CARE TESTING

**BY MERIDIAN BIOSCIENCE**

No safe blood lead level in children has been identified, and even low levels are linked to lower IQ, attention problems and poorer school performance.[1] Because the damage cannot be undone, the goal is to identify exposure early and remove the source before lead levels rise. In 2021, the CDC lowered its blood lead reference value (BLRV) from 5.0 to 3.5 µg/dL. The BLRV is not a "safe" threshold or a measure of toxicity. Rather, it is a population-based screening tool used to identify children with blood lead levels higher than those of most children ages 1–5. As a result, more children with potential lead exposure may now be identified for follow-up care.[2]

Most of these children have no symptoms, so a blood lead test is the only way to identify exposure. Medicaid requires testing at 12 and 24 months. Yet one CDC study found that only 43% of Medicaid-enrolled children were tested at 12 months, and just 28% at 24 months.[3] One barrier is that testing is often sent to an outside laboratory, which may require families to make a second trip, bring a child back for a venous blood draw, and take additional time off work. For many families, those barriers can mean testing never happens.

Point-of-care testing brings the test, and the answer, into the exam room. Here are three ways it can help.

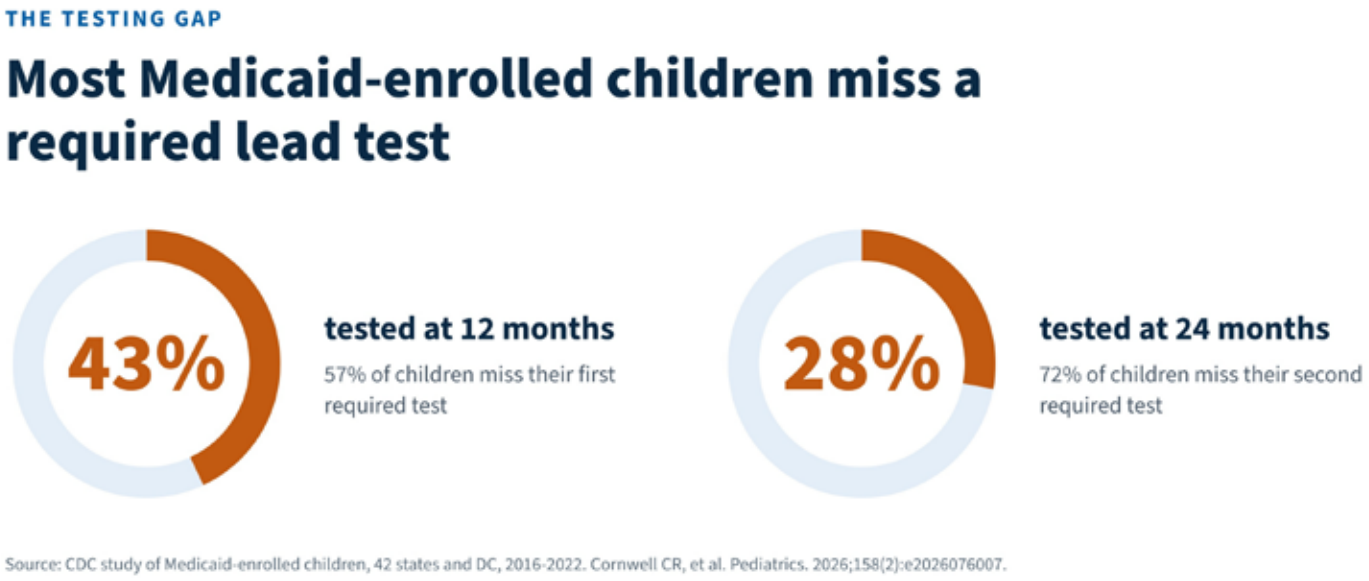
### 1. More children get tested

When testing happens during the wellness visit, more children complete recommended or required screening. In four Pennsylvania primary care offices, provider education alone barely moved screening rates. When one site added point-of-care testing, the odds of a child being screened at the 1- and 2-year visits rose more than fourfold and continued to improve month over month.[4] The difference wasn't a new guideline or a reminder. It was removing the extra step between ordering the test and completing it.

Higher screening rates matter most for the children who are hardest to reach. Families with limited transportation, inflexible work schedules, or several young children may be less likely to complete testing at an outside laboratory -- and may also be more likely to face environmental or social risk factors associated with lead exposure. Testing at the point-of-care reaches them without asking them to do more.

### 2. Answers and action before the family leaves

A fingerstick result is ready in minutes. If the result is at or above the CDC's blood lead reference value, the clinician can explain the result, order a confirmatory venous test, and connect the family with the local health department or other available resources before they leave. That matters: one study found that only 54% of Medicaid-enrolled chil-






dren with elevated screening results received the recommended follow-up test.[5]

Testing at the point-of-care is also an opportunity to remind families that lead exposure can come from sources beyond old paint. About 30% of children with elevated levels have no immediate lead paint source.[6] Clinicians can ask about other potential sources such as: soil, water, imported spices and candy, pottery, household dust, and lead brought home from a parent's job. Simple steps to reduce exposure, including handwashing, wet cleaning, and a diet rich in iron and calcium, can start the same day while the source of exposure is being investigated.

If the result is below the reference value, parents receive that information directly from their own clinician, with a chance to ask questions, not through a voicemail days later.

### 3. Less follow-up work, stronger quality performance

Outside lab orders create a hidden workload: tracking lab slips, matching results that arrive days later and calling families back -- sometimes more than once. When results are available during the visit, those extra steps are reduced, allowing staff to spend more time on patient care.

Lead testing is also connected to quality performance. The HEDIS Lead Screening in Children measure tracks the percentage of children with at least one blood lead test by their second birthday.[7] Many health plans tie this measure to quality scores and incentive payments, especially in Medicaid managed care. Testing completed in the office counts toward the measure, giving practices greater control over their performance instead of relying on families to complete testing at an outside laboratory.

Getting started is simpler than many practices expect: a CLIA certificate of waiver, a CLIA-waived analyzer, brief staff training, and reporting results to your health department as your state requires. Your state or local lead program can help you get set up.

10-SECOND SELF-CHECK

## Is point-of-care lead testing right for your practice?

Does your practice:

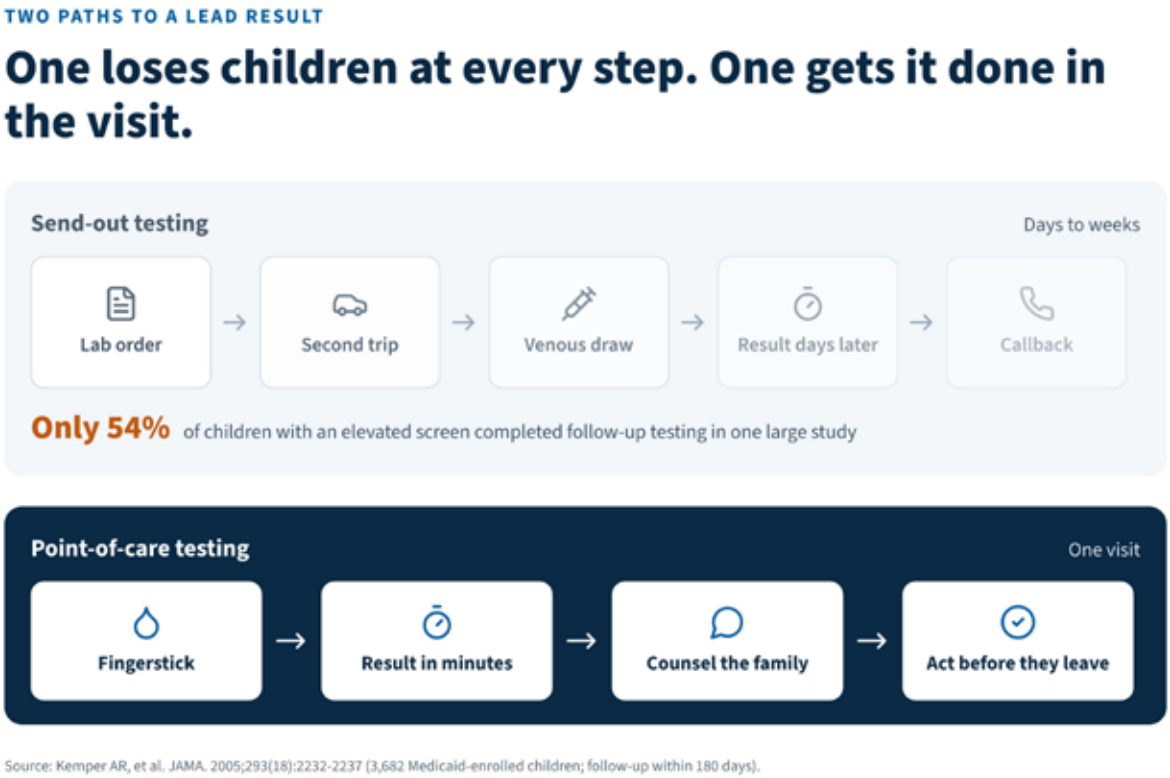
- ☐ See many **1- and 2-year-olds** for well visits?
- ☐ Care for a large share of **children enrolled in Medicaid**?
- ☐ Serve families who may have **difficulty getting to an outside lab**?
- ☐ Have lead testing orders that **never result in a completed test**?
- ☐ Fall short of its **HEDIS quality metrics**?

**Checked two or more? Point-of-care testing is worth a look.**

Getting started is simpler than many practices expect: a CLIA certificate of waiver, a CLIA-waived analyzer, brief staff training, and reporting results to your health department as your state requires. Your state or local lead program can help you get set up.

### The bottom line

Lead testing protects children when the test gets done and the result leads to immediate action. Point-of-care testing helps make both possible during a single visit. For practices that care for young children, it is one of the simplest ways to close the testing gap and turn a lab slip into an immediate answer. Point-of-care testing can make an immediate difference in a child's life—helping families identify lead exposure sooner and take steps to reduce further harm.




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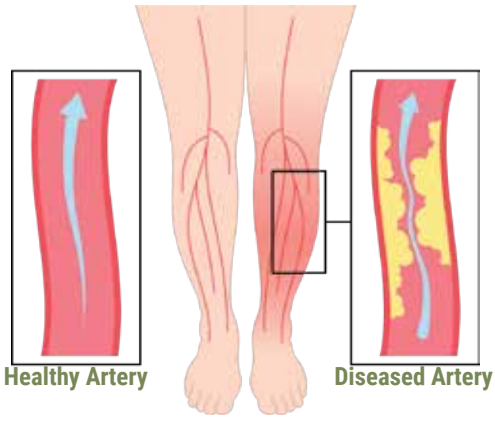
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The BD Veritor™ Plus System streamlines clinical and patient workflows by detecting three key respiratory viruses in one test, reducing the need for multiple sample collections. With multiple testing modes and workflow efficiencies, the analyzer empowers convenience and efficiency (1 kit = 30 tests).




*In the USA, the BD Veritor™ System for Rapid Detection of SARS-CoV-2 & Flu A+B has not been FDA cleared or approved but has been authorized by the FDA under an Emergency Use Authorization for use by authorized laboratories; use by laboratories certified under the CLIA, 42 U.S.C. §263a, that meet requirements to perform moderate, high, or waived complexity tests. The product is authorized for use at the Point of Care (POC), i.e., in patient care settings operating under a CLIA Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation.

This product has been authorized only for the detection of proteins from SARS-CoV-2, influenza A and influenza B, not for any other viruses or pathogens; and, in the USA, the emergency use of this product is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of in vitro diagnostics for detection and/or diagnosis of COVID 19 under Section 564(b)(1) of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. §360bbb-3(b)(1), unless the declaration is terminated or authorization is revoked sooner.

1. BD Veritor™ Plus System for Rapid Detection of SARS-CoV-2 and Flu A+B. Package insert. 500051910 Becton, Dickinson and Company.

## OSOM® ULTRA STREP A TEST

*From Sekisui Diagnostics*

**6922**

**SCAN TO LEARN MORE**

The OSOM® Ultra Strep A test is a color immunochromatographic assay intended for the qualitative detection of Group A Streptococcus antigen directly from throat swab specimens. Shown to be not statistically different than single swab culture. Sensitivity 95.7% and 100% Specificity. Includes two additional test sticks for External QC. CLIA Waived.




# ULTRASOUND

## ETHOS AUTOMATED ULTRASOUND PROBE CLEANER DISINFECTOR

*From CS Medical*

**6923**

**SCAN TO LEARN MORE**

The Ethos Automated Ultrasound Probe Cleaner Disinfector is the first FDA-cleared device to provide both cleaning and high-level disinfection of ultrasound probes in one system. It's fast and easy to use—simply place a soiled transvaginal, transrectal, or surface probe into the device, follow the prompts on the display, and a reprocessing report is printed at the end of the cycle. Ethos removes the unknowns of manual cleaning, giving healthcare professionals confidence and consistency with every cycle.



POC-24-NAM-5696

# Meet the Quadruple Aim in Diabetes Care with In-office HbA1c and uACR

Better outcomes. Lower costs. Better patient experience. Better clinician experience.



## Diabetes management solutions at the point-of-care

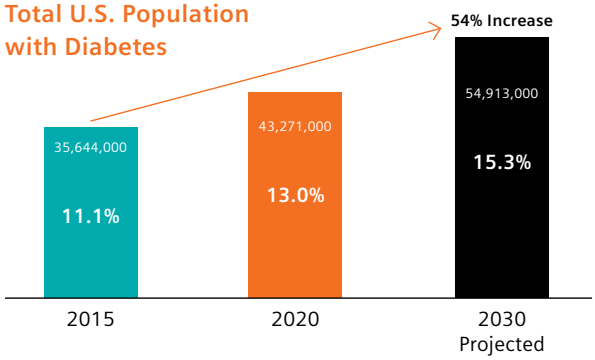
Gain insights into your patient's current status with real-time actionable results.

**DCA Vantage® Analyzer**
Rapid assessment of glycemic control and kidney health

HbA1c
- CLIA-waived

Albumin-to-creatinine ratio (ACR)
- CLIA Moderate Complexity

**CLINITEK Status® Connect System**
CLIA-waived analyzer for routine urinalysis, including kidney health
- CLINITEK® Microalbumin 2 Strip (ACR)




6924



## The Prevalence of Diabetes Among U.S. Adults is on the Rise[1]

## Help your patients reverse the trend

Customize your patient consultations to enhance physician-patient partnership toward improved outcomes.

SIEMENS Healthineers
Learn more

**siemens-healthineers.us/chronicdisease**

1. Rowley, William R et al. "Diabetes 2030: Insights from Yesterday, Today, and Future Trends." Population health management vol. 20,1 (2017): 6-12. doi:10.1089/pop.2015.0181.

SIEMENS Healthineers

# WOMEN'S HEALTH

## OSOM® BVBLUE®

*From Sekisui Diagnostics*

**6925**

SCAN TO LEARN MORE

The OSOM® BVBLUE® detects elevated vaginal fluid sialidase activity, an enzyme produced by bacterial pathogens associated with bacterial vaginosis including Gardnerella, Bacteroides, Prevotella and Mobiluncus. OSOM® BVBLUE® is more sensitive than Amsel criteria providing physicians with a more accurate diagnosis to treat and minimize serious health consequences such as early spontaneous preterm births and miscarriage.




## OSOM® TRICHOMONAS RAPID TEST

*From Sekisui Diagnostics*

**6926**

SCAN TO LEARN MORE

The OSOM® Trichomonas Rapid Test is intended for the qualitative detection of Trichomonas vaginalis antigens from vaginal swabs or from the saline solution. The OSOM® Trichomonas Rapid Test is a CLIA-waived rapid test available today. OSOM® Trichomonas is more sensitive than wet mount due to the assay being able to detect viable and non-viable organisms which offers significant benefits to the patient and clinician alike.




## ULTRA HCG COMBO TEST

*From Sekisui Diagnostics*

**6927**

SCAN TO LEARN MORE

The OSOM® Ultra hCG Combo test is a simple immunoassay for the qualitative detection of human chorionic gonadotropin (hCG) in serum or urine for the early confirmation of pregnancy. Internal studies have confirmed that the OSOM® Ultra hCG Combo test does not have a false negative result from hCG variants providing physicians with a higher level of confidence.



statID PRO™
COVID-19/Flu A&B



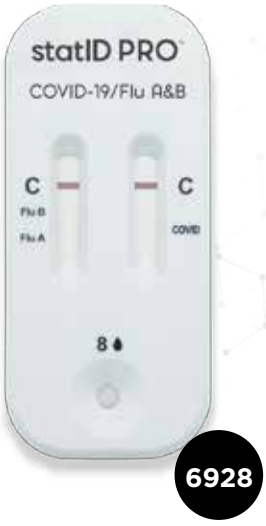
# Is it COVID or Flu?
# **Know in 15 Minutes.**

## One swab. Three answers. Faster decisions at the point of care.

When symptoms overlap, fast and accurate differentiation matters. StatID PRO™ helps you triage patients efficiently, improve patient flow, and deliver care when it matters most.

### StatID PRO™ Features:

- Clear, visual results to support confident decision-making
- CLIA-waived and FDA-cleared for use in physician offices and urgent care settings
- Support timely antiviral decisions during peak respiratory season
- Reduce unnecessary follow-up testing and visits
- Easy-to-use workflow with minimal hands-on time




6928

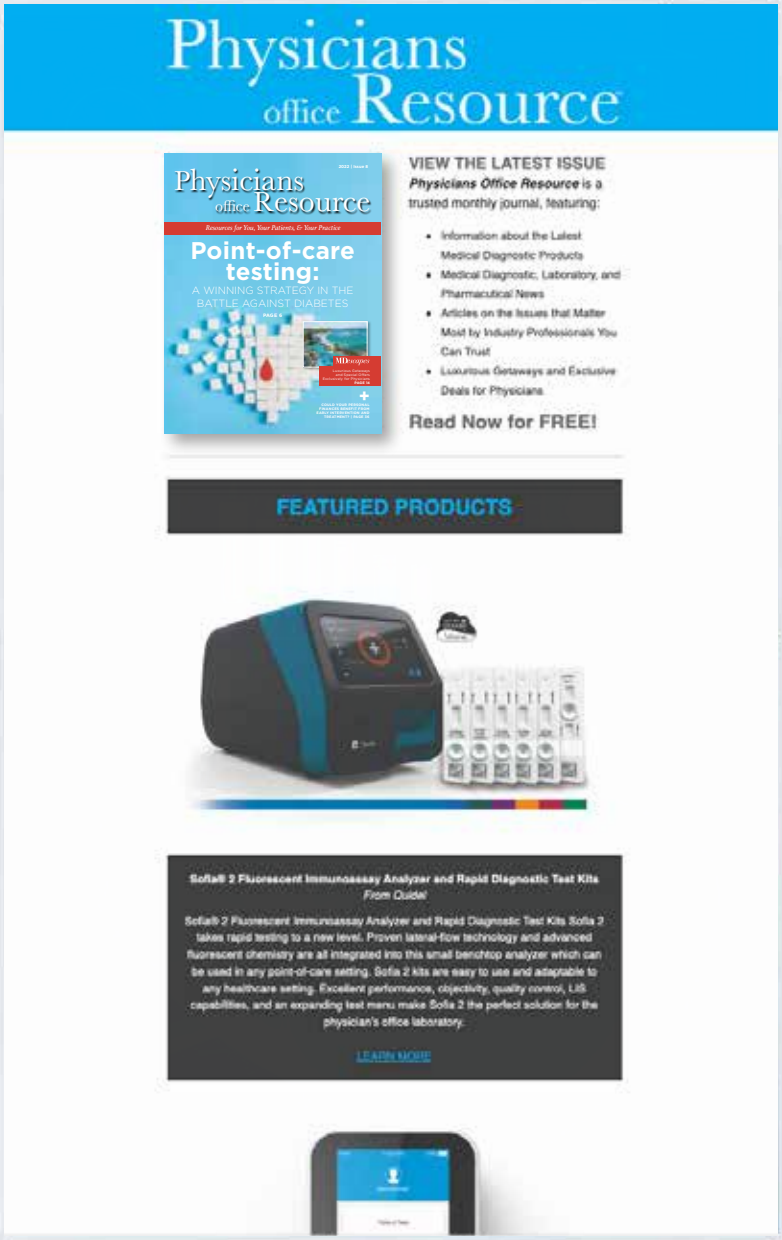
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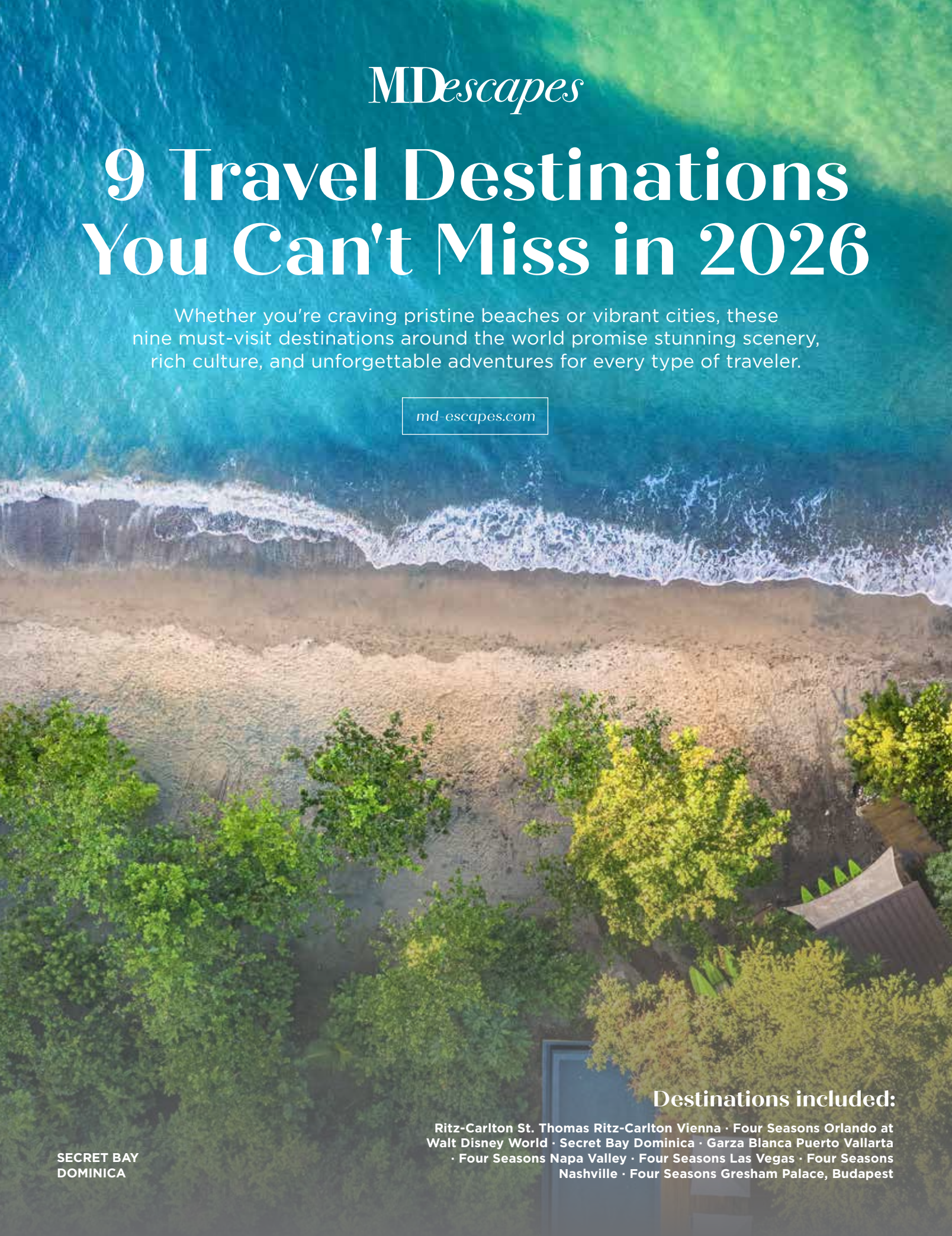

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MDescapes

# 9 Travel Destinations You Can't Miss in 2026

Whether you're craving pristine beaches or vibrant cities, these nine must-visit destinations around the world promise stunning scenery, rich culture, and unforgettable adventures for every type of traveler.

md-escapes.com



SECRET BAY
DOMINICA

## Destinations included:

**Ritz-Carlton St. Thomas Ritz-Carlton Vienna · Four Seasons Orlando at Walt Disney World · Secret Bay Dominica · Garza Blanca Puerto Vallarta · Four Seasons Napa Valley · Four Seasons Las Vegas · Four Seasons Nashville · Four Seasons Gresham Palace, Budapest**

MDescapes

## RITZ-CARLTON
ST. THOMAS

Escape to an island oasis surrounded by crystal blue waters, white sand and lush tropical greenery. A breathtaking 30 acre, oceanfront luxury hotel in St. Thomas, VI, The Ritz-Carlton, St. Thomas is a Caribbean marvel styled after traditional island architecture, but richly updated with all of the contemporary comforts for which the resorts of The Ritz-Carlton are known.

SCAN TO LEARN MORE



RITZ-CARLTON ST. THOMAS



THE RITZ-CARLTON VIENNA

## THE RITZ-CARLTON
VIENNA

In a city renowned for its beauty and culture, The Ritz-Carlton, Vienna distinguishes itself with a unique blend of modern luxuries, fine dining, and spa experiences, all housed within four 19th-century palaces. Situated in the heart of downtown Vienna, along the iconic Ringstrasse and adjacent to the Stadtpark, our luxury hotel offers 200 elegant guestrooms, including 43 exquisite suites, allowing you to indulge in tasteful living, distinctive designs, and breathtaking views.

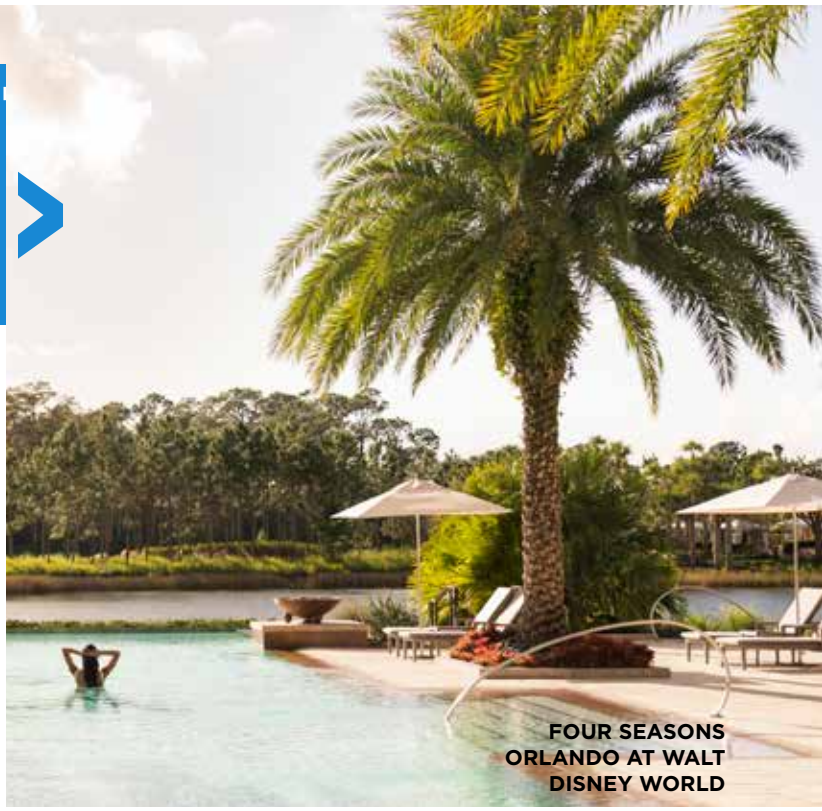
SCAN TO LEARN MORE

# FOUR SEASON ORLANDO AT WALT DISNEY WORLD

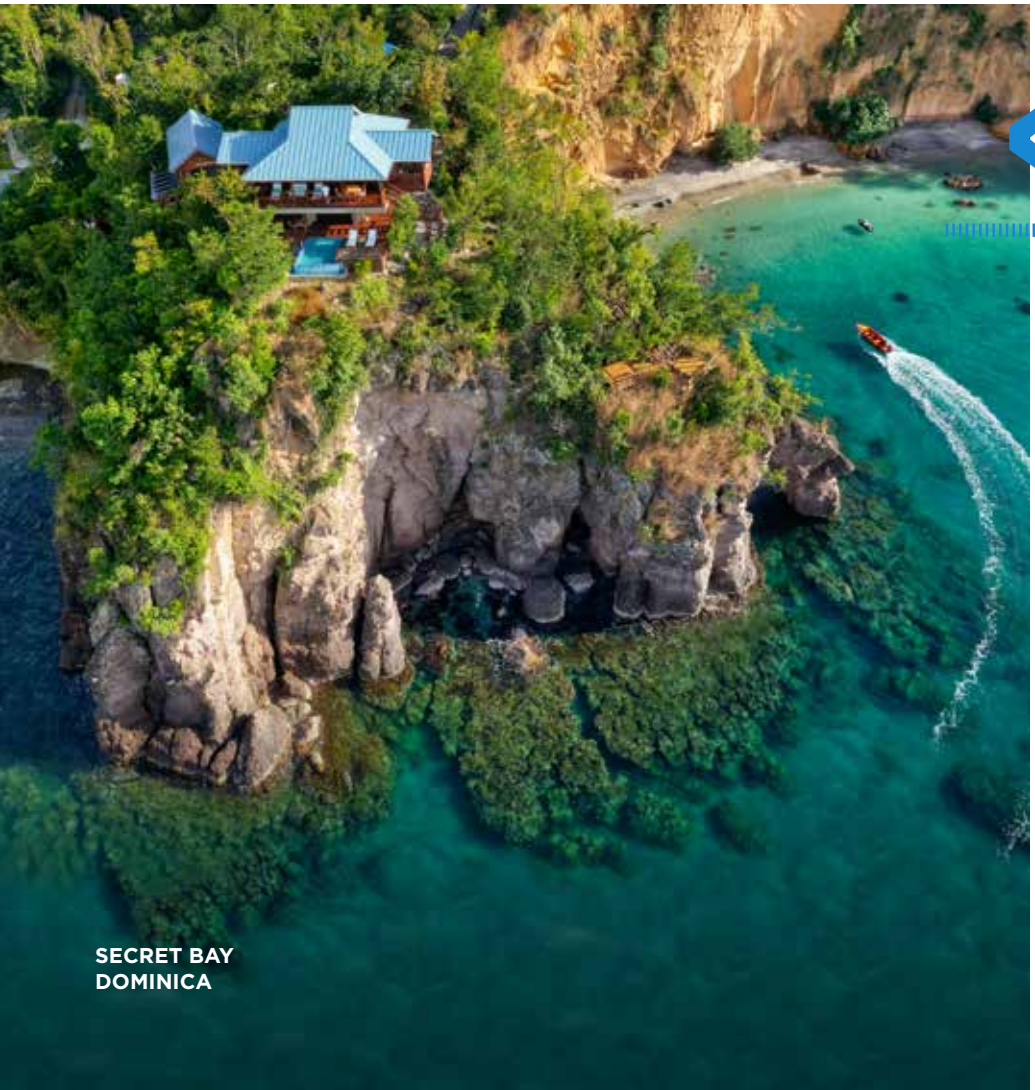
## ORLANDO, FLORIDA

Discover an elevated escape with the perfect balance of fun and relaxation at our AAA Five Diamond, luxury Orlando Resort. Splash around with the family at Explorer Island water park, or unwind beneath swaying palms at Oasis adult-only pool while we entertain your young ones at our complimentary kids camp. Treat yourself to a soothing, post-park massage at The Spa, then toast to the nightly Walt Disney World® fireworks views over dinner at our Michelin-starred rooftop steakhouse Capa.

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FOUR SEASONS ORLANDO AT WALT DISNEY WORLD



SECRET BAY DOMINICA

# SECRET BAY

## DOMINICA

Spectacularly sited on a clifftop promontory where the rainforest meets the sea on Dominica, the "Nature Island" of the Caribbean, Secret Bay is among the leading boutique resorts in the world and an acclaimed Relais & Châteaux property. The secluded six-star, all-villa resort consists of elegantly appointed, residential-style villas, each with a private plunge pool and dedicated villa host, on-call concierge, chefs and guides, access to a secret beach and transformative experiences curated specifically for each guest.

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MDescapes

## GARZA BLANCA
PUERTO VALLARTA

All Inclusive Family Resort in Puerto Vallarta. Experience the best all-inclusive resort in Puerto Vallarta, where first-class amenities invite you to relax by infinity pools, indulge in gourmet dining, and rejuvenate at a world-class spa embraced by jungle and ocean views. Garza Blanca Puerto Vallarta combines breathtaking natural beauty, exceptional service, and upscale comfort for an unforgettable luxury family vacation.

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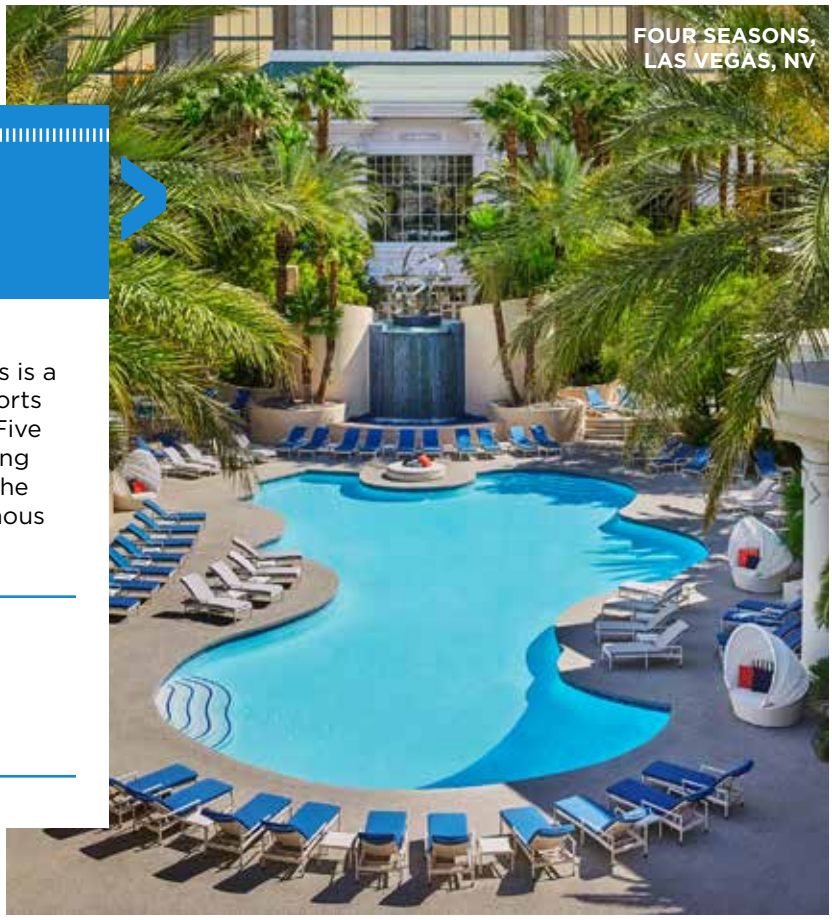

GARZA BLANCA
PUERTO VALLARTA


FOUR SEASONS
NAPA VALLEY

## FOUR SEASONS
NAPA VALLEY

Welcome to Five-Star Luxury in California Wine Country. In the food and wine capital of North America, Four Seasons welcomes you to a bespoke luxury resort in Napa Valley, the heart of California wine country. Our Forbes Five-Star Hotel in Calistoga is set within its own world-class vineyard. Discover innovative and seasonal cuisine at Michelin-starred Auro, holistic spa rituals at Spa Talisa and thoughtfully personalized Four Seasons service. Raise a glass to all the best in life as you soak in magnificent views of Napa Valley.

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FOUR SEASONS, LAS VEGAS, NV

## FOUR SEASONS
LAS VEGAS, NEVADA

As one of the only non-gaming and non-smoking hotels on The Strip, Four Seasons Hotel Las Vegas is a unique oasis in the heart of the action-packed sports and entertainment capital of the world. Offering Five Diamond luxury accommodations, acclaimed dining and a Forbes Five-Star spa, Four Seasons offers the best of both worlds: a resort retreat amid the famous energy of Las Vegas.

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FOUR SEASONS NASHVILLE

## FOUR SEASONS
NASHVILLE, TENNESSEE

Welcome to Four Seasons Hotel Nashville, a luxury hotel located in the heart of downtown's vibrant SoBro neighborhood. This new social hub is just steps away from the city's iconic music, sports, and entertainment venues. Experience the rhythm of our lively restaurants and event spaces, the tranquility of our Spa, and the stunning views from our rooftop pool overlooking the Cumberland River and Riverfront Park. With the unmatched service of Four Seasons and warm Southern hospitality, we'll inspire an authentic experience of Music City.

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## FOUR SEASONS GRESHAM PALACE
BUDAPEST

Located in the heart of Budapest, our luxury art nouveau palace Hotel – the only Forbes Five-Star hotel in Hungary – embodies the spirit of Budapest's Golden Era glam. From the moment you enter the iconic wrought iron peacock gates, pass through the lobby adorned with more than two million mosaic tiles illuminated with its striking chandelier, and let inspiration wash over you. Outside, views of the Danube and the picturesque Buda skyline stand before you. Spend the day exploring the sights, recharge in our Spa that harnesses the city's heritage in wellness, then enjoy an innovative cocktail at our lobby bar MÚZSA.

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# Early Detection,

# Rapid Diagnosis,

# Better Outcomes




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