



Child & Teen Checkups (C&TC) FACT Sheet

For Primary Care Providers

Anticipatory Guidance

13 - 21 years

C&TC Requirements:	Qualified Personnel	Documentation
<p>Anticipatory Guidance and Health Education concerning the adolescent’s health must be provided as a part of every C&TC screening. The physical, developmental, mental health and other C&TC components give the initial context for providing health education at the C&TC screening. The dental screening also provides an additional opportunity for anticipatory guidance and health education.</p> <p>Anticipatory guidance is to assist the adolescent, parent or guardian in understanding expected growth and development and to give the adolescent, parent or guardian age-appropriate information about the benefits of healthy lifestyles and practices that promote injury and disease prevention. Health questions and concerns of the child, parent or guardian must be addressed.</p>	<p>Physician</p> <p>Nurse Practitioner</p> <p>Physician Assistant</p> <p>or R.N. with adequate training</p>	<p>Show documentation that age-appropriate anticipatory guidance and health education were given.</p> <p>Consider using:</p> <ul style="list-style-type: none"> ▪ a list of age-appropriate anticipatory guidance topics that could be checked off or circled for quick documentation. Allow space for a brief note. ▪ an age-appropriate anticipatory check off guidance box and allow space to write in discussion topics or a box to check for “see dictation notes.”

Facts regarding adolescent risk behaviors

Because of the rapid physical and behavioral changes that occur during adolescence, annual visits to screen for health risk behaviors and to provide health guidance is recommended (see Resources for screening tools). Due to the sensitive nature of information shared by the adolescent during the clinic visit, confidentiality should be maintained [1].

The mortality rate is an important indicator for the health and well-being of a population. According to the Minnesota Center for Health Statistics, for young adolescents, ages 10 to 14, the leading causes of death are injury, suicide, and cancer. For adolescents 15 to 19, the three leading causes of mortality are unintentional injury (primarily motor vehicle injuries), suicide, and homicide.

The risk of motor vehicle crashes is higher among 16- to 19-year-olds than among any other age group [2].

In a national survey, 28.5% of students indicated they rode in a car or other vehicle driven by someone who had been drinking alcohol one or more times during the past 30 days [3]. According to the Minnesota Student Survey, twenty four percent of Minnesota's high school seniors drove a motor vehicle after using alcohol or drugs one or more times in the past year and over a third of them rode with friends who had used substances [10].

Binge drinking, drinking five or more drinks in a row, has declined by 2.7 percentage points for Minnesota's 9th graders to 12.6%, while Minnesota's 12th graders have seen a slight decline from 32.0% (2001) to 29% (2007) [10].

Teen sexual activity has declined since 1992. However, the decline slowed between 2001 and 2004 and rose slightly in 2007 among 12th grader males and females. In 2007, 48% of 12th graders and 19% of 9th graders have ever had sexual intercourse, compared to 46% of 12th graders and 20% of 9th graders in 2004 [10].

Since 1990, the overall teen pregnancy and birth rates have decreased significantly in Minnesota. However, pregnancy and birth rates are disproportionately high for populations of color in Minnesota. [4].

Although teen pregnancy and birth *rates* are high among Minnesota populations of color, the greatest *total number* of teen births is still to White females [4].

Both chlamydia and gonorrhea have increased steadily since the mid 90's. In fact, chlamydia is the most commonly reported communicable disease in Minnesota. Adolescents and young adults accounted for 69% of chlamydia and 56% of gonorrhea cases reported in 2006 [11].

According to the 2007 Minnesota Student Survey, nearly twelve percent of 12th grade students and 14 percent of ninth graders reporting feeling sad all or most of the time in the past month. Females at every grade level report higher rates of frequent sadness than males, remaining steady over time [10].

Firearms in the home, regardless of whether they are kept unloaded or stored locked, are associated with a higher risk of **completed** adolescent suicide [6]. In fact, most of the completed adolescent suicides in Minnesota were by firearm [15].

Ingestion of pills is the most common reported method of **attempted** suicide among adolescents in the United States [6], as well as in Minnesota [15].

Many more males than females (aged 12-19 years) are victims of intentional injury (homicide and suicide) with approximately 83% of these deaths occurring to males. The rates for males are more than 4 times greater than they are for females [5].

Few students (18%) eat 5 or more servings of fruits and vegetables daily. This has essentially stayed the same since 1998, the first year this question was asked on the Minnesota Student Survey [10]

Physical activity for 30 minutes a day at least five days per week has stayed level for Minnesota students. The percentage of 9th graders who were physically active in 2004 was 55% and the percentage of 12th graders was 41% [10].

According to the American Academy of Pediatrics (AAP), bicycle helmets are effective in preventing the occurrence of up to 88% of serious brain injuries [7]. However, in a national survey of adolescents who rode a bicycle in 2005, 83.4% rarely or never wore a helmet [3].

Advice for Health Care Providers [6]

The adolescent years are generally healthy years. Yet, since all of the health risks mentioned above are preventable, health care providers working with adolescents have a unique opportunity to provide needed guidance, and help shape positive health behaviors that will help them transition into healthy adults.

Unlike with younger children, the focus for anticipatory guidance should shift from the parent to the adolescent. While working with parents is also essential, it is important to build autonomy in the adolescent patient [14]. Similarly, assuring confidentiality is crucial to working with this age group. Adolescents may delay medical care if privacy is not assured [12].

Addressing risk factors should be in balance with a strengths-, or asset-, based approach [13]. According to Duncan et al (2007), “the goals of a strength-based approach are to 1) raise adolescents’ awareness of their developing strengths and the role they can play in their own health and well-being and 2) motivate and assist adolescents in taking on this responsibility [13].” This doesn’t have to be an additional item covered during the visit, but instead a new way of looking at anticipatory guidance that builds in opportunities to find strengths as well as risks. Ideally, this opens up communication so that the health care provider is seen as a trusted adult who cares about the whole youth [13].

Have a list of relevant local or state telephone numbers of referral resources easily available in the office.

Professional Recommendations:

- American Academy of Pediatrics/ Bright Futures - Appropriate discussion and counseling should be an integral part of each visit for care per the *AAP Guidelines for Health Supervision III (1998)*.
- Age-specific safety counseling should be provided as a part of routine well-child care as recommended by all major authorities including American Academy of Pediatrics, Bright Futures, American Academy of Family Physicians, US Preventive Services Task Force, and the Canadian Task Force on the Periodic Health Examination [8].
- American Academy of Pediatrics Committee on Genetics - endorses the US Public Health Service (USPHS) recommendation that all women capable of becoming pregnant consume 400 µg of folic acid daily to prevent neural tube defects (NTDs) [9].

- American Medical Association – *Guidelines for Adolescent Preventive Services (GAPS)*. Primary care physicians and other health providers must respond by making preventive services a greater component of their clinical practice for adolescents. From ages 11 to 21, all adolescents should have an annual preventive services visit [1].
- Consent and Confidentiality: Providing Medical and Mental Health Services to Minors in Minnesota. A legal guideline for professionals.
(<http://www.hcmc.org/depts/documents/ConsentConfidBr.pdf>)

Resources: (Accessed December 4, 2007)

Hagan JF, Shaw JS, Duncan PM, eds. 2008. *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents*, Third Edition, Elk Grove Village, IL: American Academy of Pediatrics. [Online]: <http://www.brightfutures.aap.org>.

Mayer R, Anastasi JM, Clark EM. 2006. *What to Expect & When to Seek Help: A Bright Futures Tool to Promote Social and Emotional Development in Adolescence*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, in collaboration with the National Center for Education in Maternal and Child Health. [Online]: <http://www.brightfutures.org/tools/index.html>.

Bright Futures *Family Tip Sheets*. [Online]: <http://www.brightfutures.org/TipSheets/index.html>.

Minnesota Department of Health (MDH), Maternal and Child Health Section. For questions, training, or additional information, contact the C&TC Training Coordinator at (651) 201-3735. [Online]: <http://www.health.state.mn.us/divs/fh/mch/candtc.html>

Minnesota Department of Human Services C&TC Documentation Forms, [Online] http://www.dhs.state.mn.us/id_028848 Criteria Guidelines for C&TC Provider Documentation (2006), C&TC FACT Sheets [Online]: <http://www.dhs.state.mn.us/provider/ctc>

The Health Resources and Services Administration. *Stop Bullying Now!*. [Online]: <http://stopbullyingnow.hrsa.gov/adult/indexAdult.asp?Area=preventionontips>.

American Medical Association's *Guidelines for Adolescent Preventive Services (GAPS)* Questionnaires. [Online]: <http://www.ama-assn.org/ama/pub/category/1980.html>.

Minnesota State High School League Forms and Publications (Physical Exam and Doctor's Approval to Resume Participation in Interscholastic Activities forms) [Online]: <http://www.mshsl.org/mshsl/publications.asp?catid=3>.

Positive Parenting/Parenting Tips. [Online]: <http://www.positiveparenting.com/resources/resources.html>.

Minnesota Education Now and Babies Later (MN ENABL) 2003. *SAY NOT YET! TO SEX*. [Online]: <http://www.saynotyet.com/index.htm>.



Bicycle Helmet Safety Institute (includes helmets for various activities) 2007. [Online]: <http://www.helmets.org/other.htm>.

Pediatric Symptom Checklist (PSC). Parent questionnaire. [Online]: http://www.massgeneral.org/allpsych/PediatricSymptomChecklist/psc_english.PDF.

Pediatric Symptom Checklist (PSC). Youth self report. [Online]: http://www.massgeneral.org/allpsych/PediatricSymptomChecklist/psc_english_Y.PDF.

Adolescent Health Care Resources. MDH. Screening for teen health risks. [Online]: <http://www.health.state.mn.us/youth/providers/screening.html>.

2007 Minnesota Student Survey data. Trend report, statewide and county tables. [Online]: <http://health.state.mn.us/divs/chs/mss/>

References: (Accessed December 4, 2007)

1. American Medical Association. Guidelines for Adolescent Preventive Services (GAPS). [Online] <http://www.ama-assn.org/ama/upload/mm/39/gapsmono.pdf>.
2. Centers for Disease Control and Prevention (CDC), Injury Center. *Teen drivers: Fact sheet*. [Online]: <http://www.cdc.gov/ncipc/factsheets/teenmvh.htm>.
3. Youth Risk Behavior Survey. 2005. Youth online: Comprehensive results. Unintentional injuries and violence. [Online]: <http://apps.nccd.cdc.gov/yrbss/SelQuestyear.asp?cat=1&desc=Unintentional%20Injuries%20and%20Violence&loc=XX>.
4. Minnesota State Adolescent Sexual Health Report. (2007). Minnesota Organization on Adolescent Pregnancy, Prevention, and Parenting (MOAPPP). [Online]: http://www.moapp.org/resources/adolescent_reports.html.
5. Center for Health Statistics. Minnesota Department of Health (MDH). Intentional injury causes of death by gender for ages 12-19, Minnesota 2001-2005. Minnesota Vital Signs. (2007). 3 (3): 4. [Online]: <http://www.health.state.mn.us/divs/chs/vitalsigns/082007adlscdths.pdf>.
6. Shain BN and the Committee on Adolescence (2007). Suicide and suicide attempts in adolescence. *PEDIATRICS* 120 (3): 669-676. [Online] <http://pediatrics.aappublications.org/cgi/content/full/120/3/669>.
7. American Academy of Pediatrics. 2001 (Reaffirmed February 2007). Policy Statement, Committee on Injury and Poison Prevention: Bicycle helmets. [Online]: <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/4/1030>.

8. Agency for Healthcare Research and Quality. (1998). Clinician's Handbook of Preventive Services (2nd ed.) McLean, VA: International Medical Publishing. [Online]: <http://www.ahrq.gov/clinic/ppiphand.htm>.
9. American Academy of Pediatrics Committee on Genetics, Policy Statement. 1999 (Reaffirmed January, 2007). Folic acid for the prevention of neural tube defects. PEDIATRICS 104 (2): 325-327. [Online] http://pediatrics.aappublications.org/cgi/content/abstract/104/2/325?ijkey=461b92b91f83bd7e636004551d05aaf27d2948c2&keytype=tf_ipsecsha.
10. Minnesota Student Survey 1992-2007 Trends: Behaviors, attitudes and perceptions of Minnesota's 6th, 9th and 12th graders, Minnesota Departments of Education, Health, Human Services, Public Safety and Corrections
11. 2006 Minnesota Sexually Transmitted Disease Statistics, Minnesota Department of Health, STD and HIV Section
12. Cheng TL, Savageau JA, Sattler AL, et al (1993) Confidentiality in health care: A survey of knowledge, perceptions, and attitudes among high school students. JAMA 269: 1404-14078,
13. Duncan PM, Garcia AC, Frankowski BL, Carey PA, Kallock EA, Dixon, RD, Shaw JS (2007) Inspiring healthy adolescent choices: A rationale for and guidance to strength promotion in primary care. Journal of Adolescent Health 41: 525-535.
14. Reif C, Warford A (2006) Office practice of adolescent medicine. Primary Care Clinics in Office Practice 33: 269-284.
15. Minnesota Department of Health, Injury and Violence Prevention Unit, December 2007.