

Child and Adolescent Well Visits

VISITS TO A PRIMARY CARE PROVIDER TO MONITOR DEVELOPMENTAL, MENTAL, AND PHYSICAL WELL-BEING

Why It's Important

Well visits for children and adolescents foster healthy development by focusing on physical, developmental, social, and emotional well-being, along with academic competence, violence and injury prevention, vaccinations, and blood lead level and anemia screening.¹ During these visits, the primary care provider checks a child's physical, mental, developmental, and emotional well-being using established screening methods. Well visits allow for early identification and diagnosis of disability or delay, which may decrease the emotional and financial impacts of these disabilities or delays in the future. Adolescent well visits promote healthy habits into adulthood and provide intervention services as needed to address substance use, mental health, and reproductive health. Adolescents have a considerably lower rate for well visits than younger children and older adults with only 34 percent of Minnesota teenagers ages 15 to 18 participating in well-care visit.^{2,3} Those with a family income below the federal poverty level and adolescents who are uninsured are least likely to have a usual care facility to prevent illness.³

Figure 1. Children in Minnesota with Emotional and Developmental Well-Being



Challenges to emotional and developmental well-being affect 1 in 5 children in Minnesota.²

Researchers found that infants and toddlers from households with low income who received early intervention services were more likely to catch up to their peers without developmental delay or disability compared to children from households with low-income who were suspected to have a delay or disability, but did not receive services.⁷ Providing adequate accessibility and educational resources to low income children is crucial for increasing the rate of these children who receive Child and Teen Checkups and thus, improving their health outcomes.

*“Well-checks and vaccinations should be a right for all children.” – Needs Assessment
Discovery Survey Participant*

Focus on Health Equity

Access to preventive care services for all is key to decreasing health disparities and improving quality of life. Those who receive health insurance have a higher rate of well-child visits than those who are uninsured. In 2017, about 50,000 children in Minnesota were uninsured. In Minnesota, American Indians are more than four times as likely to be uninsured than non-Hispanic whites. Hispanics and African Americans/blacks are over three times as likely to be uninsured than non-Hispanic whites.⁵ Additionally, those with lower incomes are less likely to have health insurance.⁵

Parental education is a significant predictor of screening. Children who have parents with a higher educational level are more likely to receive well-child check-ups.⁶ In Minnesota, the percentage of children who visited a health care professional to receive a preventive check-up in the past year was 10 percent higher for children with parents who have obtained a college degree than for children with parents who completed some college or technical school and 20 percent higher than parents whose highest level of education was high school graduate or GED.⁷

The 2016 Minnesota Student Survey found that the proportion of students who reported visiting a doctor within the past year was highest among students who identified as non-Hispanic white (66.2%). Students who identified as Asian/Pacific Islanders were least likely to report visiting a doctor within the last year (59.5%). The Hmong population, specifically, had the lowest ratio of doctor’s visits during the last year (51.2%).⁷

Child and Teen Checkups

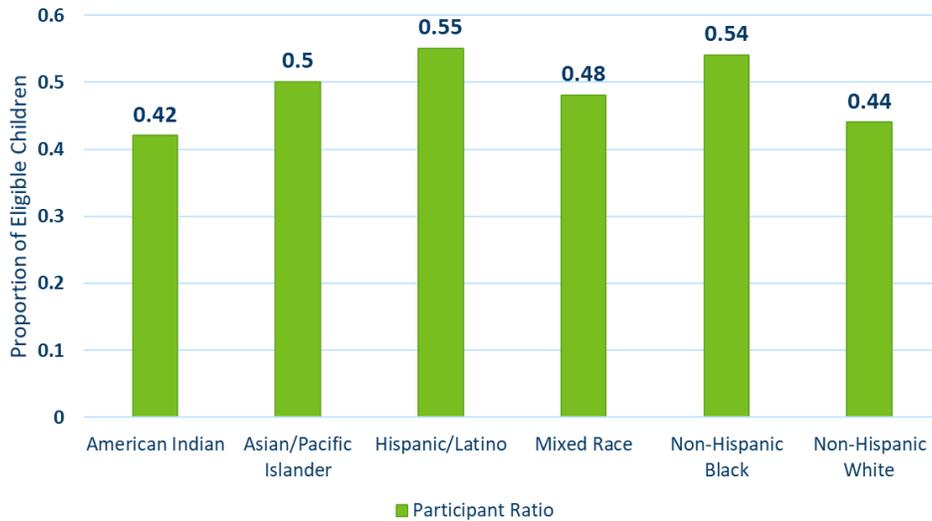
In Minnesota, 652,000 children and adolescents have eligibility to access well visits through Minnesota’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, called Child and Teen Checkups. The Child and Teen Checkups participation ratio or ratio of children who were eligible to receive Child and Teen Checkups to those who actually received Child and Teen Checkups in Minnesota in federal fiscal year (FFY) 2018 was 0.51.

The lowest participation rates in the state are in tribal and rural counties. While almost half of people living in Minnesota live in rural areas, only one sixth of the doctors in Minnesota practice there.⁸ Urban areas have one physician for every 277 people compared to large rural areas that have one physician for every 653 people. Even fewer physicians are accessible in small rural areas.⁴ The rate of Child and Teen Checkups differs in urban areas, rural areas, and among American Indian tribes. The participation ratio in the 7 county metro area is 0.56. The participation ratio in greater Minnesota is 0.44. Decreased accessibility to healthcare providers adds on to the disparities seen among children and teenagers who reside in rural areas compared to those in urban areas.

The participation ratio also varies depending on race/ethnicity; it was highest among the Hispanic/Latino (0.55) and non-Hispanic black (0.54) population.⁴ These results are promising for improving the health equity of minority communities in Minnesota. The participation ratio was lowest, however, among the American Indian (0.42) and Non-Hispanic White children (0.44) population (see Figure 2).⁴

CHILD AND ADOLESCENT WELL VISITS

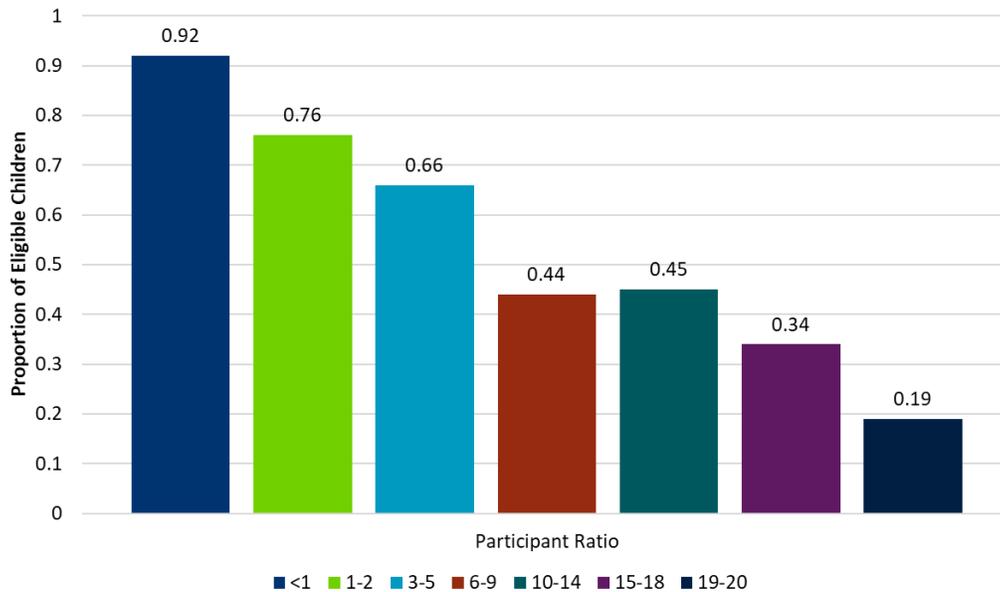
Figure 2. Participation Ratio of Medicaid-Eligible Children (ages 0 -21) Living in Minnesota Completing Child and Teen Checkups by Race/Ethnicity, FFY 2018



Source: Minnesota Health Care Programs (MHCP) Data

As children age into adolescence, rates of well visits drop (see Figure 3). As adolescents age, they could lose Medicaid coverage when they turn 18 if they are no longer income eligible, therefore creating an additional barrier to completing well visits with a primary care provider.

Figure 3. Participation Rate of Medicaid-Eligible Children Living in Minnesota Completing Child & Teen Checkups by Age, FFY 2018



Source: Minnesota Health Care Programs (MHCP) Data

Additional Considerations

Vaccination Rates

According to the National Immunization Survey, 73.8 percent of children ages 19 through 35 months living in Minnesota have completed the recommended childhood vaccine series- a drastic increase from just 41.9 percent in 2010. As of 2018, only 20.3 percent of adolescents have completed the recommended adolescent series. It is recommended that adolescents, both male and female, receive at least one dose of the human papillomavirus (HPV) vaccine. Despite the overall adherence to the recommended adolescent vaccination series, as of 2016 roughly 60 percent of Minnesota adolescents had received at least one dose of the HPV vaccine.

Blood Lead Level Testing Rates

Exposure to lead during childhood can be detrimental to development. Elevated blood lead levels are associated with learning and behavioral problems; children who are younger are most at risk as their brains are still developing. Additionally, children enrolled in Medicaid have double the risk of having an elevated blood lead level during childhood.⁹ Rates of children in Minnesota with elevated blood lead levels has been declining in the past decades, but disparities exist in which children receive this type of screening. In 2018, 43,656 children living in Minnesota received blood lead level testing through the Child and Teen Checkup program but children of color were less likely to receive a screen than white children.³

Developmental and Mental Health Screenings

Of children and adolescents ages birth to five years enrolled in Minnesota Health Care Programs who received at least one Child and Teen Checkups visit in 2017, only 34 percent received a developmental screening. Among those birth through 20 years, only 22.5 percent received a social-emotional or mental health screening. American Indian children and adolescents were the least likely to receive either type of screening. The rate of mental health screening has been increasing for all children and adolescents living in Minnesota. The rate of developmental screening between 0 and 60 months of age for children of all races declined from 2014-2016 but are starting to increase again. Any decline in developmental screening is concerning for continued and deepening disparities in access to early childhood educational interventions to identify and address learning challenges.

Important Note on Equity and Intersectionality

The Minnesota Department of Health's Title V Needs Assessment team acknowledges that structural (social, economic, political and environmental) inequities can result in poor health outcomes across generations. They have a greater influence on health outcomes than individual choices or a person's ability to access health care, and not all communities are impacted in the same way.

All people living in Minnesota benefit when we reduce health disparities.

We also acknowledge that the topic addressed in this data story does not exist in isolation— which is important to remember as we do needs assessments and as we start thinking about how we approach solutions. In addition to the needs themselves being intersectional, there are also intersecting processes and systems through which power and inequity are produced, reproduced, and actively resisted.

Citations

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Child and Family Health Division
Title V Maternal and Child Health Needs Assessment
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-3589
health.cfhcommunications@state.mn.us
www.health.state.mn.us



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