

Section 4 Adolescent Preventive Health

F. HEALTH EDUCATION AND ANTICIPATORY GUIDANCE

Provide health education and anticipatory guidance at each preventive visit and document in the patient record. The education should focus on both adolescents and parents and it should be integrated throughout the encounter. Anticipatory guidance for the parents or guardians is essential, given the many rapid changes of adolescence. It may be an opportunity for parents to voice their concerns about the adolescent's emotional or physical well-being. It provides a vehicle for parents to establish a relationship with the provider, and it may improve their parenting skills. Parents frequently have additional questions, and providers will need to reinforce their health guidance and clarify their instructions. The adolescent patient should also participate in this experience, so that he/she clearly accepts the responsibility for good health outcomes.

Present health education and anticipatory guidance in a manner that will:

- Assist the family in understanding what to expect in terms of the adolescent's development
- Provide information about the benefits of healthy lifestyles and practices
- Promote the prevention of diseases and injuries
- Provide support to adolescents, as they become responsible for their health and lifestyle choices

Although the adolescent spends less time under the direct supervision of the parent, adults should be reminded of the need to stay involved with their teenagers. Effective parenting requires adults to set limits for their children and to provide a nurturing and supportive environment that promotes healthy lifestyles. The provider needs to remind parents about successful strategies to improve the health status of their child. Open lines of communication are necessary if these goals are to be achieved. Intentional and unintentional injuries are the principal causes of morbidity and mortality in adolescents. It is essential to evaluate the extent to which adolescents have experienced

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injuries. Additionally, the provider needs to determine what measures have been taken to reduce injury.

Age-specific information is included on each of the *Healthy Kids Encounter Forms* (Refer to Section 7, Appendix I). The focus of adolescent health education and anticipatory guidance should be on the adolescent's increasing responsibility in decision-making (Refer to Section 3, *Age-Specific Health Education*).

Adolescent Sexuality/Reproductive Health

Assess what the adolescent knows about the reproductive process. Adolescents will have a broad range of understanding regarding pubertal development and the reproductive process. Discussions of these issues should be structured to meet the needs of the patient, and they may need to be simplified for the young adolescent patient. Provide guidance based on the level of maturity and sexual activity of the individual, not on chronological age. Puberty for girls may begin as early as 8 years of age. Menstruation begins between 10 and 14 years of age. In boys, puberty usually begins about two years later than in girls. Address the risks of pregnancy and sexually transmitted diseases, including HIV, with both females and males.

Adolescents should also be given the message that force and coercion have no place in sexual relationships and may be illegal. Informational materials and referrals to community resources, including law enforcement, that deal with domestic and sexual violence should be readily available. Information is available from the following resources:

- *Maryland Network Against Domestic Violence (MNADV)*¹ at **1-800-MDHELPS**
- *Maryland Coalition Against Sexual Assault (MCASA)*² at **301-328-7023**

¹ See <http://mnadv.org/>

² See <http://www.mcasa.org/>

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- National Teen Dating Abuse at **1-866-331-9474** or online chat at www.loveisrespect.org
- *National Sexual Assault Hotline* – **1-800-656-HOPE**

For information about local domestic violence organizations offering counseling and assistance to victims of domestic violence in finding safe home and shelter, use the *Local Domestic Violence Directory* (Refer to Section 8).

Contraceptive Options

In order for the adolescent to consent to any contraception method, explain the benefits and/or risks of each method. In general, adolescents initiate sexual intercourse using no contraception, progress to methods available from pharmacies, and finally, use methods prescribed by a physician. Advise specifically against the use of withdrawal and douching as methods of contraception. Similarly, discourage unprotected extra-genital sex.

Methods of contraception currently available to adolescents:

- **Abstinence** – This is the preferred contraceptive method for use by adolescents. Support and encourage them in this decision, as it is the most effective way to prevent pregnancy, STIs and HIV. However, existing data suggest that, over time, perfect adherence to abstinence is low. Therefore, do not rely on abstinence counseling alone, but provide access to comprehensive sexual health information to all adolescents.
- **Progestin Implants** – Implants (Implanon and Nexplanon) are highly effective with failure rates of less than 1%. They may remain in place for 3 years. A physician who has completed the requisite training inserts the implant into the inside of the upper arm. A common reason for their discontinuity is unpredictable bleeding and spotting.
- **Intrauterine Device (IUD)** – IUDs inserted into the uterus also provide long-acting reversible contraception. Despite the low but increasing use of IUDs in the U.S.A., they are used extensively worldwide because of their safety and effectiveness

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(failure rates of less than 1%) The disadvantages of IUDs are increased risk of expulsion for adolescents and reported moderate to severe pain with insertion. If the Primary Care Provider (PCP) believes that this method is an option for a young patient, the patient should be referred to a gynecologist for consultation.

- **Depo-Provera** –This is an injectable, progestin-only contraceptive. It is effective for 13 weeks and well tolerated by most women who have no contraindications to its use. Depo-Provera is a favored method used by women who wish to defer child bearing for an extended period of time. In the first year of use, its failure rates are 6%. In addition, this contraceptive is easy to use and is considered to improve dysmenorrhea and protect against iron deficiency anemia and endometrial cancer. The major disadvantages of Depo-Provera include the need for an injection every 13 weeks and the menstrual cycle irregularities present for nearly all patients initially. Other possible adverse effects include headache, mastalgia, hair loss, and change in libido and weight gain. This contraceptive also causes reduction in bone mineral density. All patients should be counseled about measures promoting skeletal health, such as daily intake of 1300 mg of calcium and 600 IU of vitamin D and regular weight-bearing exercise.
- **Combined Oral Contraceptive Pills (COC)** – COCs are the most popular method of hormonal contraception for adolescents available with prescription. COCs all contain a progestin and an estrogen. The Centers for Disease Control (CDC) recommends prescribing them up to 1 year at a time to healthy non-pregnant females. Typical use failure rates are 9% in adults and may be higher in adolescents. Common adverse effects of COCs include irregular bleeding, headache, and nausea. The most serious side effect associated with their use is the increased risk of blood clots, which increases from 1 per 10 000 to 3 to 4 per 10 000 woman-years during COC use. Observational data indicate that COC use does not increase the risk of infertility or breast cancer. Their use for more than 4 years also provides significant protection against endometrial and ovarian cancers.

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- **Contraceptive Vaginal Ring** – The vaginal ring releases a combination of estrogen and progestin and therefore has the same eligibility criteria for use as COCs. The ring is inserted in the vagina and stays in place for 3 weeks, with removal for 1 week to induce withdrawal bleeding, followed by insertion of a new ring. The ring has the same efficacy, risks and benefits as other combined COCs, but provides the simplest regimen, especially for women that prefer extended use, because it contains sufficient medication to be used for up to 35 days. Adverse effects are also similar to those of COCs, with the additional vaginal symptoms of discharge, discomfort, and expulsion.
- **Transdermal Contraceptive Patch** – The contraceptive patch (containing estrogen and progestin) is placed on the abdomen, upper torso, upper outer arm, or buttocks using 1 patch for each of 3 weeks in a row, followed by 1 week off the patch, during which a withdrawal bleed occurs. The failure rates are similar to those of COCs at 9%. The patch has comparable efficacy, benefits, and side effects as other COCs. Additional adverse effects include dislodged patches, and skin effects, such as hyperpigmentation, contact dermatitis, and other irritation. The FDA has identified increased estrogen exposure (1.6 times higher than with a low-dose COC) and potential increased risk of venous thromboembolism with the patch. The risk of pregnancy with correct use of the patch is slightly higher for women who weigh more than 198 pounds.
- **Progestin-Only Pills** – The progestin-only pills (also known as “mini-pills”) have significantly higher failure rates than those of other combined hormonal and progestin-only methods due to the requirement for very stringent adherence. However, they provide an additional option for patients who have safety concerns about estrogen use.
- **Male Condoms** – This is the most effective contraceptive method for the prevention of STIs (latex condoms). It is also the most common contraceptive method used by adolescents. However, condom use requires commitment at every sex act, and is influenced by individual, relationship, and broader social factors. The failure rates are 18% for all users, and can be

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higher among adolescents. The high failure rate coupled with the condom's high STI protection, has led to the recommendation for dual contraception: condoms plus a highly effective hormonal or other long-acting method. Instruct all sexually active adolescents in the use of condoms.

- **Emergency contraception** – This method is used after having unprotected intercourse. Adolescents may elect to use this method following sexual assault, or after contraceptive failure (e.g., when the condom breaks). It is available as oral levonorgestrel; an oral progesterone receptor modulator ulipristal acetate (Ella); high-dose combined estrogen-progestin oral contraceptive pills (Yuzpe regimen); and placement of copper IUD. Levonorgestrel EC is preferred to the Yuzpe regimen, because of the superior adverse effect profile and effectiveness. Levonorgestrel is available either as 2 pills or as 1 pill (Plan B One-Step). Plan B One-Step is approved by the FDA as a nonprescription product for all women of childbearing potential. Generic versions are approved as a nonprescription product for women 17 years of age older; however, proof of age is not required to purchase them. EC should be prescribed or recommended in advance for use for up to 5 days after an event or unprotected intercourse. More details on EC mechanisms and use can be found in the [AAP Policy Statement on Emergency Contraception](#).³ For additional assistance, contact the **Emergency Contraception Hotline at 1-800-584-9911**, at the *Emergency Contraception-Princeton* at <http://ec.princeton.edu/>, the LHD Family Planning Clinic, or refer the patient to the gynecologist for immediate attention.
- **Withdrawal** – It has limited effectiveness (22% failure rate among all users) and lack of STI protection. Pediatricians should encourage adolescents to adopt methods that are more effective.

³ See American Academy of Pediatrics (AAP) (2012). Policy Statement: Emergency Contraception. *Pediatrics*, 130 (6). 1174-1182. Retrieved on 12/08/14, from <http://pediatrics.aappublications.org/content/130/6/1174.full.pdf+html>.

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- **Other Methods** – The female condom, periodic abstinence, vaginal spermicides, the cervical cap, and the diaphragm are methods less commonly used by adolescents. .

For more guidance, refer to [2014 AAP Policy Statement on Contraception for Adolescents](#).⁴

⁴ See AAP (2014). Policy Statement: Contraception for Adolescents. *Pediatrics*.134 (4). Retrieved on 12/08/14, from <http://pediatrics.aappublications.org/content/134/4/e1244.full.pdf+html?sid=fefca3fd-6ad5-42c1-a86f-301af422ae12>

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Dental Care

For children and adolescents the dental administrator for the dental Medicaid, *Maryland Healthy Smiles Program*,⁵ *Scion Dental, Inc.*⁶, at **1-888-696-9596** will assist in locating appropriate dental care within reasonable distance from the enrollees' residence to ensure adequate access to oral health care services. The *Maryland Healthy Smiles Dental Program Handbook* may be accessed online⁷. Providers may contact the *Office of Oral Health*⁸ at **410-767-5300** to assist children not enrolled in the Maryland Healthy Smiles Program and request the *Oral Resource List Booklet*.⁹ Parents or caregivers can self-refer to a dentist, without a referral from the PCP.

Provide oral health education, counseling, and disease prevention information. Emphasize the need to make and keep dental appointments, stressing self-responsibility, at each visit to parents or caregivers and adolescents.

Scheduling the Return Preventive Care Visit

Educate the adolescent and the family regarding the need to have annual preventive care visits. Document the education and the next scheduled preventive visit in the medical record. When the adolescent presents for an initial visit, a school or sports physical, or an employment physical, all components of the well child visit have to be completed. If the last preventive visit was more than a year ago, and the adolescent presents for a "sick" or problem oriented visit, make every effort to conduct a preventive care visit.

⁵ See <http://phpa.dhmf.maryland.gov/oralhealth/Pages/healthy-smiles.aspx>

⁶ See provider.MDhealthysmiles.com.

⁷ To view and print a copy of the handbook, follow the link <http://phpa.dhmf.maryland.gov/oralhealth/Documents/MemberHandbook.pdf>.

⁸ See <http://phpa.dhmf.maryland.gov/oralhealth/Pages/mission.aspx>.

⁹ For an electronic copy of the guide, follow the link <http://phpa.dhmf.maryland.gov/oralhealth/Documents/OralHealthResourceGuide.pdf>