Adolescent & Young Adult Health
National Resource Center

Evidence-based Clinical Preventive Services for Adolescents and Young Adults

✓ Indicates recommendations* of the U.S. Preventive Services Task Force (USPSTF).

ADOLESCENTS

Substance Use
✓ Tobacco education and brief counseling

Reproductive Health
✓ Same as Reproductive Health for Young Adults [except for HIV and cervical cancer screening]

✓ Screening for HIV [<15 at increased risk]

Mental Health
✓ Screening for depression [everyone aged 12-18 when there are adequate systems in place to ensure accurate diagnosis, effective treatment and follow-up]

Nutrition and Exercise
✓ Obesity/BMI screening and referral†

Immunizations
✓ CDC recommended immunizations

Safety and Violence
✓ Intimate partner violence - screen women of childbearing age, refer those at risk to relevant services

In addition to the USPSTF recommendations, there is promising research in a number of other areas suggesting that preventative screening may result in adolescent behavior change.

For example, studies support the effectiveness of screening and brief counseling in primary care for alcohol and illicit drug use (Harris 2011; Walker 2002), helmet use (Ozer 2011; Stevens 2002), healthy diet (Walker 2002), suicide risk (Wintersteen 2010), chlamydia in boys (Tebb 2005), and physical activity (Walker 2002; Ortega-Sanchez 2004).

Other services recommended for adolescents between 11 and 21 years in Bright Futures Guidelines** include: Screening and counseling for alcohol and illicit drugs; chlamydia and gonorrhea screening in males, birth control use screening, suicide screening, cholesterol level, healthy diet, physical activity counseling, family/partner violence, fighting, helmets, seat belts, alcohol while driving, guns, and bullying.

YOUNG ADULTS

Substance Use
✓ Alcohol screening and counseling

✓ Tobacco screening and cessation help

Reproductive Health
✓ Screening for HIV [everyone aged 15 to 65]

✓ Screening for syphilis [anyone at increased risk]†

✓ Screening for chlamydia and gonorrhea [sexually active women age 24 years and younger]

✓ Intensive behavioral counseling for all who are at increased risk for STIs [sexually transmitted infections]

✓ Cervical cancer screening [≥21]

Mental Health
✓ Screening for depression [when there are adequate systems in place to ensure accurate diagnosis, effective treatment and follow-up]

Nutrition and Exercise
✓ Lipid disorder [≥20 with increased risk for coronary artery disease]†

✓ Obesity/BMI screening and referral†

✓ Hypertension [≥18]

✓ Healthy diet [anyone who is obese/overweight and has additional risk factors]

Immunizations
✓ CDC recommended immunizations

Safety and Violence
✓ Intimate partner violence - screen women of childbearing age, refer those at risk to relevant services

* Recommendation has an A or B grade.

**Bright Futures Guidelines are expected to be updated in 2016

† USPSTF topic update in progress

Resources

U.S. Preventive Services Task Force: http://www.uspreventiveservicestaskforce.org/

Hagan JF, Shaw JS, Duncan PM, Eds. **Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents**, Third Edition, Elk Grove Village, IL: American Academy of Pediatrics, 2008. (Fourth Edition in review – expected publication date – 2016.

National Adolescent and Young Adult Health Information Center's **Summary of Recommended Guidelines for Clinical Preventive Services for Young Adults ages 18-26**, nahic@ucsf.edu. Accessed March 7, 2016.

Centers for Disease Control and Prevention, Vaccine **Recommendations of the ACIP** (Advisory Committee for Immunization Practices): www.cdc.gov/vaccines/hcp/acip-recs/index.htm, Accessed March 7, 2016.

NRC (National Research Council) and IOM (Institute of Medicine), 2009. **Adolescent Health Services: Missing Opportunities**. Washington, D.C.: The National Academies Press.

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Works Cited

Harris, S., Csemy, L., Sherritt, L., Starostova, O., et al. (2012). Computer-Facilitated Substance Use Screening and Brief Advice for Teens in Primary Care: An International Trial. *Pediatrics*, 129(6), 1072-1082.

Ortega-Sanchez, R., Jimenez-Mena, C., Cordoba-Garcia, R., Muñoz-Lopez, J., Garcia-Machado, M., & Vilaseca-Canals, J. (2004). The effect of office-based physician's advice on adolescent exercise behavior. *Prev Med*, 38(2), 219-226.

Ozer, E., Adams, S., Orrell-Valente, J., et al. (2011). Does Delivering Preventive Services in Primary Care Reduce Adolescent Risky Behavior? *J Adolesc Health,* 49(5), 476-482.

Stevens, M., Olson, A., Gaffney, C., Tosteson, T., Mott, L., & Starr, P. (2002). A Pediatric, Practice-Based, Randomized Trial of Drinking and Smoking Prevention and Bicycle Helmet, Gun, and Seatbelt Safety Promotion. *Pediatrics*, 109(3), 490-497.

Tebb, K., Pantell, R., Wibbelsman, C., et al. (2005). Screening Sexually Active Adolescents for Chlamydia trachomatis: What About the Boys? *Am J Public Health*, 95(10), 1806–1810-1806–1810.

Walker, Z., Joy Townsend, J., Oakley, L., et al. (2002). Health promotion for adolescents in primary care: Randomized controlled trial. *BMJ*, 325(7363), 524-524.

Wintersteen, M. (2010). Standardized screening for suicidal adolescents in primary care. *Pediatrics*, 125(5), 938-9.

Adolescent & Young Adult Health
National Resource Center

Funded by MCHB, the AYAH-NRC is focused solely on the unique health and development needs of adolescents and young adults.

Inspired by and aligned with Title V transformation strategies, the AYAH-NRC will collaborate with the MCH community to integrate public health and health care delivery systems.

AYAH-NRC partners include:

- University of California/San Francisco **(lead)**
- Association of Maternal and Child Health Programs
- University of Minnesota/State Adolescent Health Resource Center
- University of Vermont/National Improvement Projects Network

For more information about the Center, contact Ms. Jane Park -- Jane.Park@UCSF.edu or visit our website nahic.ucsf.edu/resources/resource_center/

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★
Hearing		●[8]	●[9] →			★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←		●[10]	→	←	●	→	←		●	→
DEVELOPMENTAL/BEHAVIORAL HEALTH																															
Developmental Screening[11]								●			●		●																		
Autism Spectrum Disorder Screening[12]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																					★	★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																						●	●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																								
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																															
Newborn Blood		●[19]	●[20] →																												
Newborn Bilirubin[21]		●																													
Critical Congenital Heart Defect[22]		●																													
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	● →	★	★	★	★	★	←			●	→	
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	←		● →		★	★	★
Cervical Dysplasia[31]																															●
ORAL HEALTH[32]							●[33]	●[33]	★		★	★	★	★	★	★	★														
Fluoride Varnish[34]							←				●			→																	
Fluoride Supplementation[35]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ← ● → = range during which a service may be provided

(continued)

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. See "Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0–3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
25. For children at risk of lead exposure, see "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (https://www.nhlbi.nih.gov/health-topics/integrated-guidelines-for-cardiovascular-health-and-risk-reduction-in-children-and-adolescents).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases.*
30. Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/RiskAssessmentTool) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
33. Perform a risk assessment (https://www.aap.org/RiskAssessmentTool). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
34. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).
35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care

(Periodicity Schedule)

This schedule reflects changes approved in February 2017 and published in April 2017.
For updates, visit www.aap.org/periodicityschedule.
For further information, see the *Bright Futures Guidelines*, 4th Edition, *Evidence and Rationale chapter* (https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Evidence_Rationale.pdf).

CHANGES MADE IN FEBRUARY 2017

HEARING

- Timing and follow-up of the screening recommendations for hearing during the infancy visits have been delineated. Adolescent risk assessment has changed to screening once during each time period.
- Footnote 8 has been updated to read as follows: "Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per 'Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs' (http://pediatrics.aappublications.org/content/120/4/898.full)."
- Footnote 9 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."
- Footnote 10 has been added to read as follows: "Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See 'The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies' (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext)."

PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

- Footnote 13 has been added to read as follows: "This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (http://pediatrics.aappublications.org/content/135/2/384) and 'Poverty and Child Health in the United States' (http://pediatrics.aappublications.org/content/137/4/e20160339)."

TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT

- The header was updated to be consistent with recommendations.

DEPRESSION SCREENING

- Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

MATERNAL DEPRESSION SCREENING

- Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.
- Footnote 16 was added to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice' (http://pediatrics.aappublications.org/content/126/5/1032)."

NEWBORN BLOOD

- Timing and follow-up of the newborn blood screening recommendations have been delineated.
- Footnote 19 has been updated to read as follows: "Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs."
- Footnote 20 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."

NEWBORN BILIRUBIN

- Screening for bilirubin concentration at the newborn visit has been added.
- Footnote 21 has been added to read as follows: "Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See 'Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications' (http://pediatrics.aappublications.org/content/124/4/1193)."

DYSLIPIDEMIA

- Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS

- Footnote 29 has been updated to read as follows: "Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*."

HIV

- A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.
- Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
- Footnote 30 has been added to read as follows: "Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually."

ORAL HEALTH

- Assessing for a dental home has been updated to occur at the 12-month and 18-month through 6-year visits. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.
- Footnote 32 has been updated to read as follows: "Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/RiskAssessmentTool) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 33 has been updated to read as follows: "Perform a risk assessment (https://www.aap.org/RiskAssessmentTool). See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 35 has been added to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (http://pediatrics.aappublications.org/content/134/3/626)."

Summary of Recommended Guidelines for Clinical Preventive Services for Adolescents up to Age 18

UCSF Division of Adolescent and Young Adult Medicine

NAHIC

Guidelines as of 11/2017, subject to change.

	Preventive Services	All (√)	At Risk (+)	Screening Test/ Procedure and Other Notes
	Nutrition/exercise/obesity			
☐	Hypertension/Blood Pressure	√		√ Bright Futures, USPSTF insufficient evidence
☐	**Obesity/BMI**	√		**Screen ≥6 years; offer/refer to appropriate intervention**
☐	Cholesterol level		+	√ Bright Futures, USPSTF insufficient evidence
☐	Healthy diet		+	√ Bright Futures
☐	Dyslipidemia	√		√ Bright Futures recommends one screening between ages 9-11 & 17-21, *USPSTF insufficient evidence*
	Substance Use			
☐	Alcohol (screening and counseling)†	√		√ Bright Futures, USPSTF insufficient evidence
☐	**Tobacco screening†**	√		**Provide interventions (education, brief counseling)**
☐	Illicit Drugs (screening and counseling)	√		√ Bright Futures* and ACOG**, USPSTF insufficient evidence
	Mental Health/Depression			
☐	**Depression (screening and treatment)**	√		**Screen for MDD ≥ age 12, w/ adequate systems in place**
☐	Suicide Screening	√		√ Bright Futures and ACOG, USPSTF insufficient evidence
	Safety/Violence			
☐	**Family/partner violence**	√		**Screen women of childbearing age**
☐	Fighting	√		√ Bright Futures and ACOG
☐	Helmets	√		√ Bright Futures and ACOG
☐	Seat belts	√		√ Bright Futures and ACOG
☐	Guns	√		√ Bright Futures and ACOG
☐	Bullying	√		√ Bright Futures only
	Reproductive Health			
☐	**HIV†**	√	+	**Bright Futures and USPSTF recommend one screening between ages 15-18, and annually for those at increased risk**
☐	**STI (screening and counseling)**		+	**High-Intensity Counseling Interventions**
☐	**Syphilis**		+	**VDRL**
☐	**Gonorrhea (females)**		+	**NAATs; test if ≤24 and sexually active**
☐	**Chlamydia (female)**		+	**NAATs; test if ≤24 and sexually active**
☐	Chlamydia & Gonorrhea (male)		+	√ Bright Futures only
☐	Birth Control Methods	√	+	√ ACOG, + Bright Futures
☐	Pregnancy		+	+ Bright Futures
	Cancer Screening			
☐	**Cervical Cancer**		+	**USPSTF recommends against screening ≤21**
☐	**Skin Cancer (counseling)†**		+	**Counsel those with fair skin ages 10-24 about reducing UV exposure**
☐	**BRCA-Related Cancer**		+	**Family Hx of breast, ovarian, tubal, or peritoneal cancer**
	Infectious Diseases including CDC Immunization Recommendations			
☐	**Td/Tdap**	√		**Td booster every 10 years**
☐	**Human papillomavirus**	√		**9vHPV vaccine for males and females up to age 26; 3 lifetime doses**
☐	**Varicella** (LIVE VACCINE)	√ ***		**2 lifetime doses at least 4 weeks apart** ***See below
☐	**Measles, mumps, rubella**	√		**1 or 2 lifetime doses**
☐	**Influenza**	√		**1 dose annually**
☐	**Pneumococcal**		+	**PCV13: 1 lifetime dose | PPSV23: 1-2 lifetime doses**
☐	**Hepatitis A**	√		**2 or 3 lifetime doses**
☐	**Hepatitis B**	√		**3 lifetime doses**
☐	**Meningococcal Quadrivalent**	√		**2 lifetime doses**
☐	**Serogroup B Meningococcal**		+	**Men B vaccine (2 or 3-dose series) to those 16-23 years old**
☐	**Hepatitis C Screening**		+	**Anti–HCV antibody testing, polymerase chain reaction testing**

Bold = US Preventive Services Task Force (USPSTF) A or B Recommendation or CDC recommendations for immunizations.

Current evidence is insufficient to assess the balance of benefits and harms of service.

√ = All adolescents + = Adolescents at risk

For more information, please view the appendix, and visit the official website.

* Bright Futures: recommendations are for annual visits, up to age 21.

** American Congress of Obstetricians and Gynecologists (ACOG) recommendations, up to age 26.

*** The varicella vaccine should **NOT** be given to patients with these contraindications.

† USPSTF update in progress.

Cite as: National Adolescent and Young Adult Health Information Center (2017). Summary of Recommended Guidelines for Clinical Preventive Services for Adolescents up to Age 18. San Francisco, CA: National Adoelscent and Young Adult Health Information Center, University of California, San Francisco. Retrieved from: http://nahic.ucsf.edu/resource_center/adolescent-guidelines/.

Recommended Guidelines for Clinical Preventive Services for Young Adults ages 18-25: Risk Factors and Recommended Screening Tests

UCSF Division of Adolescent and Young Adult Medicine

Guidelines as of 11/2017, subject to change.

The United States Preventive Services Task Force (USPSTF) conducts scientific evidence reviews of a broad range of clinical preventive health care services and develops recommendations for primary care clinicians and health systems. These reviews are conducted periodically and published in the form of Recommendation Statements. This document serves as a broad overview of the relevant recommendations for the 18-25 age group and is not meant to be all encompassing. There may be special considerations for certain subpopulations within the young adult age group, such as pregnant women. For information on screening, please visit the USPSTF website. For information on immunizations, please visit the CDC website.

Area	Recommendation	Risk Factors (defined by USPSTF unless otherwise noted)	USPSTF Recommended Screening Tests
Nutrition, Exercise, Obesity	Hypertension/ High Blood Pressure Website: http://www.uspreventiveservicestaskforce.org/uspstf07/hbp/hbprs.pdf Updated 10/2015	Persons at increased risk include • Those who have high-normal blood pressure (130 to 139/85 to 89 mm Hg) • Those who are overweight or obese • African Americans	Office measurement of blood pressure is most commonly done with a **sphygmomanometer**. The USPSTF recommends confirmation outside of the clinical setting before a diagnosis of hypertension is made and treatment is started. Confirmation may be done by using HBPM or ABPM. Because blood pressure is a continuous value with natural variations throughout the day, repeated measurements over time are generally more accurate in establishing a diagnosis of hypertension. The USPSTF did not find evidence for a single gold standard protocol for HBPM or ABPM.
Nutrition, Exercise, Obesity	Obesity/BMI Website: http://www.uspreventiveservicestaskforce.org/uspstf11/obeseadult/obesers.pdf Updated 09/2012		**BMI is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared.** Persons with a BMI between 25 and 29.9 are overweight and those with a BMI of 30 and above are obese. There are 3 classes of obesity: class I (BMI 30-34.9), class II (BMI 35-39.9), and class III (BMI 40 and above).

Area	Recommendation	Risk Factors	USPSTF Recommended Screening Tests
Nutrition, Exercise, Obesity	Healthy diet Website: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd Updated 08/2014	• Hyperlipidemia • Other known risk factors for cardiovascular and diet-related chronic disease	Intensive behavioral counseling interventions have moderate benefits for CVD risk in overweight or obese adults who are at increased risk for CVD, including decreases in blood pressure, lipid and fasting glucose levels, and body mass index (BMI) and increases in levels of physical activity. The reduction in glucose levels was large enough to decrease the incidence of a diabetes diagnosis. This recommendation applies to adults aged 18 years or older in primary care settings who are overweight or obese and have known CVD risk factors (hypertension, dyslipidemia, impaired fasting glucose, or the metabolic syndrome). In the studies reviewed by the USPSTF, the vast majority of participants had a BMI greater than 25 kg/m2
Substance Use	Alcohol: Screening and Counseling Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care Updated 05/2013	Risky use of alcohol is defined by the NIAAA and USDA as: • More than 7 drinks per week or more than 3 drinks per day for women. • More than 14 drinks per week or 4 drinks per day for men.	Numerous screening instruments can detect alcohol misuse in adults with acceptable sensitivity and specificity. The USPSTF prefers the following tools for alcohol misuse screening in the primary care setting: **NIAAA single-question screening**, such as asking, "How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day?" The **Alcohol Use Disorders Identification Test (AUDIT)** is the most studied screening tool for detecting the full spectrum of alcohol-related problems in primary care settings. Also available is the abbreviated AUDIT- Consumption test, or **AUDIT-C.**

Area	Recommendation	Risk Factors	USPSTF Recommended Screening Tests
Substance Use	Tobacco: Screening and Counseling for non-pregnant adults Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1 Updated 09/2015	According to the 2012–2013 National Adult Tobacco Survey, smoking prevalence is higher in the following groups: • Men • Adults aged 25 to 44 years • Persons with a race or ethnicity category of "other, non-Hispanic" • Persons with a GED (vs. graduate-level education • Persons with an annual household income of less than $20,000 • Persons who are lesbian, gay, bisexual, or transgender. • Higher rates of smoking have been found in persons with mental health condition	The **"5-A" framework** provides a useful counseling strategy: 1. Ask about tobacco use. 2. Advise to quit through clear personalized messages. 3. Assess willingness to quit. 4. Assist to quit. 5. Arrange follow-up and support. Both intervention types (pharmacotherapy and behavioral interventions) are effective and recommended; combinations of interventions are most effective, and all should be offered. The best and most effective combinations are those that are acceptable to and feasible for an individual patient; clinicians should consider the patient's specific medical history and preferences and offer and provide the combination that works best for the patient.
Substance Use	Tobacco: Screening and Counseling for Pregnant Women Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1 Updated 09/2015		Because many pregnant women who smoke do not report it, using multiple-choice screening questions to assess smoking status in this group may improve disclosure. The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco. The USPSTF found convincing evidence that behavioral interventions substantially improve achievement of tobacco smoking abstinence in pregnant women, increase infant birthweight, and reduce risk for preterm birth.

			The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women.
Area	**Recommendation**	**Risk Factors**	**USPSTF Recommended Screening Tests**
Mental Health	Depression Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1 Updated 01/2016	• The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. • A number of factors are associated with an increased risk of depression ○ Women, young and middle-aged adults, and nonwhite persons have higher rates of depression than their counterparts, as do persons who are undereducated, previously married, or unemployed. ○ Other groups who are at increased risk of developing depression include persons with chronic illnesses (eg, cancer or cardiovascular disease), other mental health disorders (including substance misuse), or a family history of psychiatric disorders. • Among older adults, risk factors for depression include disability and poor health status related to medical illness, complicated grief, chronic sleep disturbance, loneliness, and a history of depression • Risk factors for depression during pregnancy and postpartum include poor self-esteem, child-care stress, prenatal	Commonly used depression screening instruments include the Patient Health Questionnaire (PHQ) in various forms and the Hospital Anxiety and Depression Scales in adults, the Geriatric Depression Scale in older adults, and the Edinburgh Postnatal Depression Scale (EPDS) in postpartum and pregnant women. All positive screening results should lead to additional assessment that considers severity of depression and comorbid psychological problems (eg, anxiety, panic attacks, or substance abuse), alternate diagnoses, and medical conditions. Effective treatment of depression in adults generally includes antidepressants or specific psychotherapy approaches (eg, CBT or brief psychosocial counseling), alone or in combination. Given the potential harms to the fetus and newborn child from certain pharmacologic agents, clinicians are encouraged to consider CBT or other evidence-based counseling interventions when managing depression in pregnant or breastfeeding women.

		anxiety, life stress, decreased social support, single/unpartnered relationship status, history of depression, difficult infant temperament, previous postpartum depression, lower socioeconomic status, and unintended pregnancy.	
Area	**Recommendation**	**Risk Factors**	**USPSTF Recommended Screening Tests**
Reproductive Health	HIV Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening Updated 04/2013	• Men who have sex with men and active injection drug users are at high risk for new HIV infection. • Those who have acquired or request testing for other sexually transmitted infections. Behavioral risk factors for HIV infection include: • Having unprotected vaginal or anal intercourse • Having sexual partners who are HIV-infected, bisexual, or injection drug users • Exchanging sex for drugs or money The USPSTF recognizes that the above categories are not mutually exclusive, the degree of sexual risk is on a continuum, and individuals may not be aware of their sexual partners' risk factors for HIV infection.	The standard test for diagnosing HIV infection is the **repeatedly reactive enzyme immunoassay**, followed by **confirmatory western blot or immunofluorescent assay**. Conventional HIV test results are available within 1 to 2 days from most commercial laboratories. **Rapid HIV antibody testing** is also highly accurate, may use either blood or oral fluid specimens, and can be performed in 5 to 40 minutes, and when offered at the point of care, is useful for screening high-risk patients who do not receive regular medical care (e.g., those seen in emergency departments), as well as women with unknown HIV status who present in active labor. Initial positive results require confirmation with conventional methods. Other U.S. Food and Drug Administration–approved tests for detection and confirmation of HIV infection include combination tests (for p24 antigen and HIV antibodies) and qualitative HIV-1 RNA.

Area	Recommendation	Risk Factors	USPSTF Recommended Screening Tests
Reproductive Health	STI: Behavioral Counseling Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/sexually-transmitted-infections-behavioral-counseling1 Updated 09/2014	• All sexually active adolescents are at increased risk for STIs and should be counseled. • Other risk groups that have been included in counseling studies include adults with current STIs or other infections within the past year, adults who have multiple sex partners, and adults who do not consistently use condoms. Clinicians should be aware of populations with a particularly high prevalence of STIs such as: • All African Americans have the highest STI prevalence of any racial/ethnic group, and STI prevalence is higher in American Indians, Alaska Natives, and Latinos than in white persons. Increased STI prevalence rates are also found in: • Men who have sex with men (MSM) • Persons with low incomes living in urban settings • Current or former inmates • Military recruits • Persons who exchange sex for money or drugs • Persons with mental illness or a disability • Current or former intravenous drug users • Persons with a history of sexual abuse • Patients at public STI clinics	Interventions ranging in intensity from 30 minutes to 2 or more hours of contact time are beneficial. Evidence of benefit increases with intervention intensity. High-intensity counseling interventions (defined in the review as contact time of ≥2 hours) were the most effective. Interventions can be delivered by primary care clinicians or through referral to trained behavioral counselors. Most successful approaches provided basic information about STIs and STI transmission; assessed the person's risk for transmission; and provided training in pertinent skills, such as condom use, communication about safe sex, problem solving, and goal setting. Many successful interventions used a targeted approach to the age, sex, and ethnicity of the participants and also aimed to increase motivation or commitment to safe sex practices. Intervention methods included face-to-face counseling, videos, written materials, and telephone support.

Reproductive Health	Syphilis Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/syphilis-infection-in-nonpregnant-adults-and-adolescents Updated 06/2016	• Men who have sex with men • Sex work • Exchange of sex for drugs • Incarceration • Men and women with HIV • Men younger than 29	Screening for syphilis infection is a two-step process that involves an initial nontreponemal test (**Venereal Disease Research Laboratory or Rapid Plasma Reagin**), followed by a confirmatory treponemal test **FTA-ABS (fluorescent treponemal antibody absorbed) or TP-PA (T. pallidum particle agglutination**).
Area	**Recommendation**	**Risk Factors**	**USPSTF Recommended Screening Tests**
Reproductive Health	Gonorrhea and Chlamydial Infection Website: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening Updated 09/2014	Those with the highest chlamydial and gonococcal infection rates occur in women aged 20 to 24 years, followed by females aged 15 to 19 years. Chlamydial infections are 10 times more prevalent than gonococcal infections in young adult women. Among men, infection rates are highest in those aged 20 to 24 years. Other risk factors for infection include having: • a new sex partner • more than 1 sex intimate • a sex partner with concurrent partners • a sex partner who has an STI • inconsistent condom use among persons who are not in mutually monogamous relationships • previous or coexisting STI exchanging sex for money or drugs	*Chlamydia trachomatis* and *Neisseria gonorrhoeae* infections should be diagnosed by using nucleic acid amplification tests (NAATs) because their sensitivity and specificity are high and they are approved by the U.S. Food and Drug Administration for use on urogenital sites, including male and female urine, as well as clinician-collected endocervical, vaginal, and male urethral specimens. Most NAATs that are approved for use on vaginal swabs are also approved for use on self-collected vaginal specimens in clinical settings. Rectal and pharyngeal swabs can be collected from persons who engage in receptive anal intercourse and oral sex, although these collection sites have not been approved by the U.S. Food and Drug Administration.

Area	Recommendation	Risk Factors	USPSTF Recommended Screening Tests
Reproductive Health	Hepatitis C Website: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-c-screening Updated 06/2013	The most important risk factor for HCV infection is past or current injection drug use. Another established risk factor for HCV infection is receipt of a blood transfusion before 1992. Additional risk factors include: • long-term hemodialysis • being born to an HCV-infected mother • incarceration • intranasal drug use • getting an unregulated tattoo • other percutaneous exposures (such as in health care workers or from having surgery before the implementation of universal precautions).	Anti–HCV antibody testing followed by polymerase chain reaction testing for viremia is accurate for identifying patients with chronic HCV infection. Various noninvasive tests with good diagnostic accuracy are possible alternatives to liver biopsy for diagnosing fibrosis or cirrhosis.
Reproductive Health	Folic Acid Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/folic-acid-for-the-prevention-of-neural-tube-defects-preventive-medication Updated 01/2017	Although all women of childbearing age are at risk of having a pregnancy affected by neural tube defects and should take folic acid supplementation, some factors increase their risk. Additional risk factors include: • Personal or family history of neural tube defects • Use of antiseizure medication • Maternal diabetes • Obesity • Mutations in folate-related enzymes	The current statement recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.

Area	Recommendation	Risk Factors	USPSTF Recommended Screening Tests
Cancer Screening	Cervical Cancer Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening Updated 03/2012	• All women who have a cervix, regardless of sexual history • Women with HPV infection • HIV infection • Compromised immune system • In-utero exposure to diethylstilbestrol • Previous treatment of a high-grade precancerous lesion or cervical cancer	Current evidence indicates that there are no clinically important differences between liquid-based cytology and conventional cytology. Women who have had a hysterectomy with removal of the cervix and who do not have a history of a high- grade precancerous lesion or cervical cancer are not at risk for cervical cancer and **should not be screened.** Women who had their cervix removed during surgery for ovarian or endometrial cancer are not at high risk for cervical cancer and **would not benefit from screening.**
Cancer Screening	Testicular Cancer Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/testicular-cancer-screening Updated 04/2011		The United States Preventive Services Task Force recommends **against** screening for testicular cancer in adult males.

Area	Recommendation	Risk Factors	USPSTF Recommended Screening Tests
Safety/Violence	Family/Partner Violence Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening Updated 01/2013	Women of child-bearing age are most at risk, however all women are at potential risk for abuse Factors that elevate risk include: • young age • substance abuse • marital difficulties • economic hardships	Several screening instruments can be used to screen women for IPV. Those with the highest levels of sensitivity and specificity for identifying IPV are Hurt, Insult, Threaten, Scream (HITS) (English and Spanish versions); Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT); Slapped, Threatened, and Throw (STaT); Humiliation, Afraid, Rape, Kick (HARK); Modified Childhood Trauma Questionnaire– Short Form (CTQ-SF); and Woman Abuse Screen Tool (WAST). The HITS instrument includes 4 questions, can be used in a primary care setting, and is available in both English and Spanish. It can be self- or clinician- administered. HARK is a self-administered 4-item instrument. STaT is a 3-item self-report instrument that was tested in an emergency department setting.

Area		
Infectious Diseases, including CDC Recommended Immunizations	Below is a list of vaccinations relevant to the young adult age group, which the CDC regularly updates. The most current CDC immunizations page can be viewed here.	
	Td/Tdap	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/tdap.pdf
	Human Papillomavirus	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hpv-gardasil-9.pdf
	Varicella	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/varicella.pdf
	Measles, mumps, rubella	MMR Website: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mmr.pdf MMRV Website: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mmrv.pdf
	Influenza	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf
	Pneumococcal (polysaccharide)	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/ppv.pdf
	Hepatitis A	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-a.pdf
	Hepatitis B	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf
	Hepatitis C	http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-c-screening
	Serogroup B Meningococcal (MenB):	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening-serogroup.pdf
	Quadrivalent Meningococcal	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.pdf

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BARRIERS to adolescent risk screening

Completing a confidential screening for high-risk behaviors in adolescents can be a challenge for health care providers. Teens are unlikely to bring up risky behaviors on their own, especially if they think the information might not be kept confidential. Conversations about risky behaviors can be difficult for providers to navigate with adolescents and parents, and providers may not believe adolescent patients will be honest with them. Time with each patient may be limited, and providers may find it hard to imagine fitting in one more assessment.

STRATEGIES for adolescent risk screening

Use a standardized risk screening tool for high-risk behaviors.

- Using a screening tool allows risky behaviors to be reviewed before talking with teens so that the provider can gather resources. It can help start the conversation, and, while still screening for multiple risks, allows the discussion and counseling to be focused on the issues most affecting that teen.
- Administration and interpretation of a health risk assessment tool is reimbursable by some insurance companies.
- With a standardized, validated tool, individual changes can be measured over time and risk trends in a clinic population identified.
- The Rapid Assessment for Adolescent Preventive Services (RAAPS[1]) is one risk screening tool recommended by the Society for Adolescent Health and Medicine.
- Other risk screening tool options include GAPS[2] and Bright Futures[3].
- Best practice is to use an electronic version, as teens prefer to communicate through and respond more honestly when using technology.
- If a clinic cannot use an electronic version due to cost, workflow, or lack of computers or tablets for patients to use, risk assessments can be done on paper instead.

Create a workflow that ensures risk screening is done confidentially at least once a year.

- Build risk screening into the well visit workflow for patients age 12 to 21. (See sample workflows on page 3.)
- Patients should complete the risk screening form privately, while no one is around.
- Risk screenings should **NOT** be completed while sitting with a parent in the waiting room; giving adolescents their own clipboard is not enough to make them comfortable sharing sensitive information.
- Explain confidentiality laws and/or provide a handout when giving instructions for completing the risk screening so the teen can feel comfortable answering the questions honestly.
- Consider scheduling slightly longer visits with adolescents when possible so they have time to get answers to their questions.
- AHI developed an infographic[4] on confidential risk screening than can be posted or shared with colleagues, parents, and patients.

Help parents feel like partners in the process.

- Send letters home to families before well child visits explaining the following:
  - Allowing teens to use their voice & share their views of their health is an important developmental step.
  - Confidential time alone with teens is standard.
  - Teens will complete a health survey on their own to give them a chance to independently express their views on their health.
  - See sample letter on page 4.
- Provide adolescents and parents handouts at check in so that parents know to expect that confidential time will be spent with their child and both parties know about minor healthcare rights.
- Consider using a questionnaire for parents in addition to an adolescent questionnaire.
  - A parent questionnaire can get important information from parents to supplement information provided by the adolescent patient and provide parents with a task to focus on while their adolescent completes the risk assessment tool.
  - The Children's Clinic created this parent questionnaire[5] to accompany their adolescent questionnaire[6].
  - Encourage open communication between teens and parents after completion of the questionnaires.

Make sure all providers and staff members know confidentiality laws and limitations.

- Setting clear expectations minimizes confusion for families, improves communication with adolescents, and decreases teens' uncertainty about what can and cannot be managed confidentially.
- Have front desk staff systematically confirm the preferred method for communicating with each adolescent patient.
- Consider allowing adolescents to choose a password to confirm that providers/staff are talking with the right person when they call to discuss results.
- Be sure adolescents understand that if they use private insurance, and Explanation of Benefits (EOB) will be sent home to their parents, detailing services received even if services were requested confidentially.
- Keep lists of clinics where patients can receive confidential care on a free or sliding scale, like school-based health centers, Planned Parenthood, and local health departments.
- Establish connections with local pharmacies to ensure adolescents' confidentiality will be respected there; ask the pharmacist to call the clinician (not the parents) with questions about teens' prescriptions.

Make staff aware of at-risk populations and how they can respond.

- Some adolescents, including those in foster care, homeless shelters, juvenile detention centers, and substance abuse programs have higher rates of risk-taking than other adolescents.
- Develop protocols for risk intervention and referral, particularly for patients disclosing self-harm, suicidal ideation, or abuse, keeping in mind your state's confidentiality and mandatory reporting laws. Refer to these policies and procedures used by the University of Michigan Health System Regional Alliance for Healthy Schools as examples for suicide[7], psychiatric crises[8], child abuse[9], and domestic abuse[10] situations that may arise.

ADDITIONAL RECOMMENDATIONS

- Use the Parent Handout, Teen Handout, and Poster on confidentiality rights to inform families of the laws and your practices. These resources for sites in the state of Michigan can be found here.[11] Materials for other states may be available upon request.

SAMPLE WORKFLOWS FOR CONFIDENTIAL RISK SCREENING

Workflow 1:

1. Front desk staff gives the parent/guardian a letter explaining confidential time with adolescent patients.
2. MA calls patient and explains to parent/guardian "I'm going to take your child back to get their vital signs and have them complete a brief health survey, and then I'll bring you to the room before the provider comes to see them."
    a. MA can explain that "We give teens a chance to share their own views on their health, and that's why we have them complete the health survey on their own." If there is parent push-back, MA rooms the patient without doing risk screening, and the provider can address the issue.
3. MA rooms the patient, has them complete the risk screening, and brings the results to the provider for review. MA then gets the parent/guardian from the waiting room.
4. Provider meets with the parent/guardian and patient then asks the parent/guardian to step out at the end of the visit for confidential time. Provider then reviews risk screening with the patient.

Limitations of this workflow: Parent is asked to not be present twice and has to go back and forth between the waiting room and patient room.

Workflow 2:

1. Front desk staff gives the parent/guardian a letter explaining confidential time with adolescent patients.
2. Front desk staff or MA brings the patient to an area in waiting room with a privacy screen to complete their risk screening. Staff instructs the patient to return the risk screening directly to the front desk staff when they are finished (if on paper) or submit electronically (if on a computer or tablet).
3. When risk screening is completed, provider receives it for review (either from staff or electronically).
4. MA calls the patient and parent/guardian back, and the provider meets with both together.
5. Provider then asks the parent/guardian to step out for confidential time with the patient, then reviews the risk screening with the patient alone.
6. MA brings the parent/guardian in from the waiting room for the remainder of the visit.

Limitations of this workflow: May be hard to create a truly private space in the waiting room and for the patient to successfully hand a paper form directly back to the front desk.

SAMPLE PARENT LETTER

Dear Parent /Guardian:

Adolescence is a time of transition from childhood to adulthood. We want to help prepare your teen to be an active participant in their medical care. A normal developmental step in this process is allowing your teen to share their views of health in their own voice. We have two standard practices to give them this chance to express their views: your teen will complete a health survey on their own, and we will talk to your teen independently for part of their visit. Since this can be a difficult time of life, we will be taking some time to talk to them in private concerning issues that you or your teen may not necessarily be comfortable discussing with each other.

Some of the topics that we will be talking about will include:

- Healthy eating and sleeping habits
- Friends and relationships
- Emotions and mood
- Sexuality
- Drugs and alcohol

We will address all these subjects in an age- and maturity-appropriate manner.

In order for these discussions to be as open and helpful as possible, we will assure your teenager that our discussions will be confidential. If there is a concern about your teen doing harm to themselves or someone else, we will inform you. On issues of sexually transmitted diseases, birth control, pregnancy, and drug use, we will encourage your teen to share this information with you.

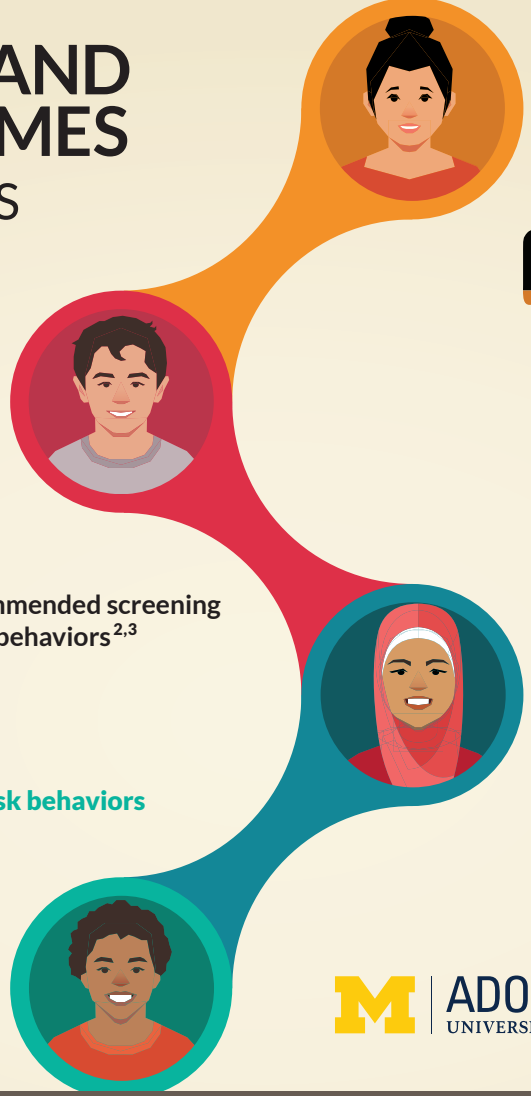
If there are any particular issues that you would like us to address with your teen, please let us know. Also, let us know if you would like to talk to us privately about concerns you have about your teen or strategies to discuss sensitive topics with them. We want to do our very best to be your ally in helping your child grow up to be healthy and happy.

Sincerely,

[provider name or health center name]

[1] http://www.possibilitiesforchange.com/raaps/
[2] https://www.uvpediatrics.com/health-topics/stage/#GAPS
[3] https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/adolescence-tools.aspx
[4] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/02/riskscreeninginfographic.pdf
[5] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/06/adolescent-parent-questionnaire-tcc.pdf
[6] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/06/adolescent-questionnaire-tcc.pdf
[7] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/02/policy-2-5-suicide-assessment.pdf
[8] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/02/psych-emergencies-policy-procedure-draft.docx
[9] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/06/rahs-procedure-for-reporting-child-abuse-2.pdf
[10] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/06/rahs-procedure-for-reporting-domestic-abuse.pdf
[11] http://www.umhs-adolescenthealth.org/improving-care/health-center-materials/

IDENTIFYING RISKS AND IMPROVING OUTCOMES
FOR ADOLESCENT PATIENTS



High-Risk Behaviors

High-risk behaviors are the **primary causes of morbidity and mortality** in adolescent patients (ages 12 to 21):[1]

- **» Substance abuse**
- **» Unsafe sexual activity**
- **» Interpersonal violence**
- **» Suicide**

of adolescents receive recommended screening and counseling for high-risk behaviors[2,3]

Why Confidentiality Matters

- Adolescents are **more likely to discuss high-risk behaviors** if they believe their care is confidential.[2,4,5]
- Adolescents **answer confidential screenings more honestly**.[6]
- State and national **laws allow minors to receive confidential care** related to sexual health, mental health, and substance abuse.

Barriers to Confidential Care

There is **low knowledge about minor consent laws.**[7,8,9]

Less than half of adolescents receive a yearly well or preventative exam. **Most do not spend any time alone with their provider** during that visit.[10]

Providers have noted a **lack of expertise, insurance issues,** and **concerns about medical records**.[11]

Advantages of Screening Tools

- Screening tools **provide a comprehensive picture** of the patient.
- They **increase efficiency and effectiveness of care**, allowing physicians to tailor their conversations with patients.
- When paired with effective counseling and intervention, **they can make a significant impact on adolescent high-risk behaviors.**[12]

ADOLESCENT HEALTH INITIATIVE
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

Example of a Confidential Work Flow

1. At check-in, front desk staff gives parent/guardian and patient a letter about confidential time with adolescent patients.
2. Medical Assistant (MA) calls patient, explains to parent/guardian, "I'll be bringing your child back to get their vital signs and have them complete a brief health survey. Then I'll bring you to the room."
3. MA places patient in an exam room, has them complete the screening tool, brings the results to the provider to review, and then brings back parent/guardian.
4. Provider meets with parent/guardian and patient, and then asks the parent/guardian to step out for confidential time. Provider then discusses the risk screen confidentially with the patient.

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