Providing Anticipatory Guidance to Children and Adolescents

Stephen W. North

Anticipatory guidance, a component of Bright Futures, refers to communicating with patients and caregivers to identify and provide information most needed. Providing reliable, appropriate, and culturally competent anticipatory guidance to children, adolescents, and their families at every visit is one of the most essential roles of a primary care provider.

Determining the right information for a specific patient can be quite challenging for a physician, given the large amount of information recommended by multiple agencies and various guidelines including those provided by Bright Futures [1]. Finding the best approach to providing anticipatory guidance for a patient and his or her family in a manner that respects their experience and knowledge is part of the art of medicine. It is not a skill learned quickly in an afternoon at a continuing medical education workshop.

In my own practice, at every visit I ask every child and adolescent how they are doing in school. The most frequent response is "good," with "fine" coming in a close second. I could easily write "good" in the note and move on. Because I know that school performance, and more important, changes in school performance and involvement, are markers for multiple health issues, I always follow up with the question "And what does 'good' mean in your family?" The question almost always opens up the conversation with both the patient and the family, allowing me to better understand the daily activities of the patient and to tailor anticipatory guidance to his or her specific needs.

There are 2 essential steps in providing effective anticipatory guidance: talking with and listening to patients and families and taking the time to provide them with the information they need. Determining the needs of the patient and the family through questionnaires that they fill out before seeing you can be helpful. However, building the doctor-patient-family relationship through conversation is essential [2]. Conversations are based on open-ended questions. Too often, physicians instead want to move through a script for each visit. A direct observational study of 483 well-child visits with 52 providers using the Bright Futures guidelines demonstrated that fewer than half (38.9%) of the visits began with open-ended questions, and a quarter did not include any open-ended questions [3]. Although guidelines and questionnaires are of benefit, it is essential to view the well-child check as a conversation about the health of the family rather than as a checklist *(Do you wear seatbelts? Do you eat vegetables 5 times a day?)* that needs to be completed before a patient can get his shots, a sticker, and a camp form.

The amount of time the physician spends with the patient is the greatest indicator of the quality of the anticipatory guidance provided during that visit. In a study of well-child checks for children aged 4-35 months [4], only 20.3% of parents reported spending more than 20 minutes with the physician. Longer visits increased the likelihood that a patient would receive developmental screening, that the parents would feel they had had enough time to ask the necessary questions, and that parents would recommend the doctor to other parents. Almost all providers feel pressure to see more patients in less time. In the setting of the traditional well-child check, we must work to take the time with our patients to answer their questions with high-quality information that can potentially reduce the frequency of office visits and improve health.

The Bright Futures guidelines specifically mention that they are "intended to be used selectively to invite discussion, gather information, address the needs and concerns of the family, and build partnership" [1]. I live in a rural mountain community where families frequently hunt together and ride four-wheelers. If I chose to follow the guidelines verbatim, I would make strong statements to almost every family I see stating that these activities are unsafe and should be avoided. Instead, I find it much more productive to ask patients what color their helmets are and where their guns are kept in their homes. It is important for providers to recognize that there is a bias inherent in any set of guidelines and that following them to the letter could be detrimental to relationships with families and patients.

Recognizing that the family—however it is defined for that particular patient—is the center of the medical decision-making process for children and adolescents is essential for improving acceptance of anticipatory guidance. It is

Electronically published February 8, 2013.

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N C Med J. 2013;74(1):53-56.
0029-2559/2013/74110

Safe Kids North Carolina

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Every year in North Carolina, approximately 200 children die from unintentional injuries, according to the North Carolina State Center for Health Statistics [1]. Through education and outreach, Safe Kids North Carolina works to prevent these injuries, which are the leading killer of children aged 14 years and younger. The organization focuses on a wide variety of risk areas, including child passenger safety, burn prevention, prevention of falls, pedestrian safety, poisoning prevention, water safety, and more.

Safe Kids North Carolina, which is housed within and staffed by the North Carolina Department of Insurance, helps spread important messages about injury prevention through a network of volunteers across the state. Currently, there are 38 local Safe Kids coalitions covering 67 counties in North Carolina. Because of partnerships with these local Safe Kids coalitions and other child safety advocates, Safe Kids North Carolina has been able to deliver comprehensive injury prevention programs to communities statewide.

According to the North Carolina Division of Public Health, motor vehicle–related injuries continue to be the leading cause of death and the second leading cause of hospitalizations. Safe Kids is working to improve child passenger safety by educating people about the proper use of child safety seats and restraints. Through the leadership of Safe Kids North Carolina and the Governor's Highway Safety Program, there are now more than 130 permanent checking stations where parents and caregivers can go to learn how to choose an appropriate child safety seat for their child and how to use it properly. Each checking station is staffed by a technician who has been certified in child passenger safety. Leaders in the fire service are common partners in this effort, offering their fire stations for use as checking stations and allowing their firefighters to receive the training to become certified safety seat technicians. Additionally, Safe Kids North Carolina aims to make child safety seats widely available to the public by implementing the Buckle Up Kids program in communities around the state. Active in 83 North Carolina counties, Buckle Up Kids provides qualifying families with a limited number of low-cost child restraints and education about how to use them.

Safe Kids North Carolina has also emerged as a statewide leader in preventing unintentional poisonings through its Operation Medicine Drop events. With the goal of keeping medications out of the hands of children, Safe Kids North Carolina engaged partners such as the US Drug Enforcement Administration, the State Bureau of Investigation, and North Carolina Riverkeepers to coordinate events across the state to which people can bring unneeded or expired medications for safe, secure disposal. The group of stakeholders involved in Operation Medicine Drop continues to grow and now includes substance abuse prevention groups, law enforcement, and environmental protection advocates, who see a shared benefit in the safe disposal of medications. Since its inception in 2010, Operation Medicine Drop has grown exponentially, and to date, the initiative has collected and destroyed more than 30 million doses of medications through hundreds of drug take-back events held each year.

In addition to bringing safety programs directly into our communities, Safe Kids North Carolina has a strong relationship with media outlets throughout the state to promote childhood safety initiatives. Safe Kids staff members are regular guests on television and radio shows, and every year they hold press conferences and media events about fire prevention, water safety, and the dangers of hot cars. Safe Kids North Carolina has also embraced social media and online outreach as ways of communicating safety messages on a round-the-clock basis.

The vast majority of childhood injuries and deaths are preventable. Through the efforts described here and many others, Safe Kids North Carolina is a proactive force in protecting our state's most valuable resource—our children—and helping to establish lifelong safety habits in North Carolina's families. NCMJ

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Acknowledgment

Potential conflicts of interest. W.G. has no relevant conflicts of interest.

References

1. State Center for Health Statistics, Division of Public Health, North Carolina Department of Health and Human Services. 2011 Child Deaths in North Carolina, Trend in Rate of Child Deaths 1991-2011, Ages Birth Through 17 Years. http://www.schs.state.nc.us/schs/deaths/child/CFinNC2011.pdf. Accessed December 19, 2012.

Electronically published February 8, 2013.

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N C Med J. 2013:74(1):54.
0029-2559/2013/47111

important to begin the visit with an open-ended question designed to find out what concerns the parents and child have and to use the information contained in their answers to gauge their level of knowledge. A 2011 study found that in pediatric practices that offer family-centered care, parents are more receptive to anticipatory guidance, and pediatric patients have fewer unmet needs for health services [5].

The asynchronous developmental progress seen in adolescents poses another challenge to providers. Although adolescents all follow the same developmental pathway, each

progresses through these developmental stages in his or her own way. Bright Futures materials recommend 37 possible points to bring up with early adolescents and discuss during a particular well-child visit. Two 13-year-old boys in the 8th grade at the same school may need completely different types of information based on their activities, family situation, religious beliefs, and psychosocial context. In order for adolescents to remember the anticipatory guidance that is provided, the physician needs to make sure that it is relevant to the patient's life at that point. Focusing on eating better and exercising more will not resonate with a patient if the only thing he worries about each day is being bullied on the bus on the way home because he hasn't started to grow facial hair.

A unique challenge in working with adolescents is that they rarely come for preventive health visits. An analysis of data from the 2001-2004 Medical Expenditure Panel Survey demonstrated that only 38% of adolescents had had a preventive care visit in the previous 12 months [6]. Furthermore, being from a low-income community or being uninsured increased the risk of not receiving preventive health services. It could be argued that those populations are in greatest need of anticipatory guidance. Infrequency of visits, especially by higher-risk patients, makes it essential that risk assessment and anticipatory guidance be incorporated into all adolescent visits.

Using a consistent framework for blending open-ended questions into a conversation can be very helpful in identifying topics that need additional attention. The HEADS mnemonic (H, home environment; E, education, ethnicity, and employment; A, activities with peers, anxiety, and appetite; D, drugs [and alcohol and tobacco], depression, and delusions; S, suicide, safety, and sexuality) is an excellent and widely used risk-assessment tool that can help providers remember the topics that should be covered [7]. In order to provide relevant and meaningful anticipatory guidance to all adolescents, it is important to understand how they perceive themselves in their social context and to follow up on answers that are somewhat vague. Incorporating the HEADS mnemonic into an electronic health record template allows a provider to quickly include it in all adolescent visits.

The conversation that opens an adolescent preventive visit can be challenging to negotiate because of the complex biopsychosocial changes happening in the patient's life. Employing a strengths-based interview style—that is, focusing on exploring and discovering the patient's strengths and resources—can help create an environment in which both the parent and the patient feel more comfortable and subsequently provide more detailed information. Keep in mind that the information gathered is just as important for the patient's long-term health as is that information obtained when you auscultate the heart.

There are issues that adolescents may be less willing to talk about in front of their parents, but that need to be addressed. It is essential for the provider to create an environment in which the parents can discuss any specific concerns they have and then leave the office, giving the patient some time alone with the physician to discuss private or confidential matters. Placing this in the context of supporting the adolescent's normal development and helping him or her become comfortable talking to a physician directly often helps offset any parental concerns. It is important to review what confidentiality means with the parents and the adolescent before asking the parents to leave the room. Wrapping up the visit with all parties present and sharing the majority of the anticipatory guidance with parent and teen reinforces the importance of the family in the overall health of the adolescent.

Even with the best guidelines and a conversational framework, we as providers often fail to address essential topics during adolescent visits. It is recommended that violence prevention be discussed at two-thirds of all adolescent visits. However, the physicians in the observational study of well-child visits referred to above [3] mentioned violence prevention in fewer than 1% of visits. Additionally, physicians often fail to provide needed anticipatory guidance around the transitions in health care that adolescents will experience—specifically, changes in health insurance status and transitions in care [8]. This raises the question of whether we as physicians tend to focus on those topics that we are more comfortable discussing and to avoid other topics despite their importance. How do we work to improve our comfort level with the potentially more important topics?

Providing patients and parents with information to take home is important. However, I find that our office's traditional handouts are frequently left in the exam room or are never taken from the front desk. To be more effective in delivering preventive health information to patients, we need to explore new communication methods. Parents who received baby books with stories containing positive health messages [9] or DVDs containing newborn anticipatory guidance [10] were found to have retained more knowledge of the specifically targeted topics [9, 10] and to feel more confident in caring for their child [10] than did those who received no books [9], noneducational books [9], or traditional paper handouts [10]. The informational handouts physicians provide are often filled with too much information. The handouts for adolescents that are used in the Bright Futures guidelines contain 37 bullet points, and in my experience, they are not an effective means of reaching this high-risk population. To effectively reach both parents and adolescents, we must make use of social media, text messaging, and videos to reinforce and expand the anticipatory guidance we provide in the office.

Asking open-ended questions and learning about the family are essential components of comprehensive preventive health care that provides appropriate anticipatory guidance. The challenge comes in making the time to do so during office visits, given the typical daily schedules of primary care physicians. Although it is not financially rewarding to do so, I find it necessary to take a minimum of 30 minutes for each

well-child check, and I take 45 minutes for adolescent well visits (which often get labeled as "sports physicals").

As our state and country move toward a prevention model for health care, it is essential to improve the reimbursement for well-child checks. Unfortunately, measures of the quality and effectiveness of the anticipatory guidance provided during office visits have not been included in the 2014 Pediatric Recommended Core Measures listed by the Center for Medicare and Medicaid Services [11]. Because reimbursement is being guided more frequently by these and similar measures, it is essential that effective patient education be included. To achieve this, health care providers and public health officials must advocate for changes in these measures and for reimbursement policies that recognize the importance of physician-led health education. Providers need to be supported in taking the time necessary to provide quality care to patients and their families. NCMJ

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Acknowledgement

Potential conflicts of interest. S.W.N. has no relevant conflicts of interest.

References

1. Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008.
2. Rosenthal MS. A piece of my mind. Anticipatory guidance. JAMA. 2010;304(13):1421–1422.
3. Norlin C, Crawford MA, Bell CT, Sheng X, Stein MT. Delivery of well-child care: a look inside the door. Acad Pediatr. 2011;11(1):18–26.
4. Halfon N, Stevens GD, Larson K, Olson LM. Duration of a well-child visit: association with content, family-centeredness, and satisfaction. Pediatrics. 2011;128(4):657–664.
5. Kuo DZ, Frick KD, Minkovitz CS. Association of family-centered care with improved anticipatory guidance delivery and reduced unmet needs in child health care. Matern Child Health J. 2011;15(8):1228–1237.
6. Irwin CE Jr, Adams SH, Park MJ, Newacheck PW. Preventive care for adolescents: few get visits and fewer get services. Pediatrics. 2009;123(4):e565–e572.
7. Goldenring JM, Rosen DS. Getting into adolescent heads: an essential update. Contemp Pediatrics. 2004;21(1):64–90.
8. Sawicki GS, Whitworth R, Gunn L, Butterfield R, Lukens-Bull K, Wood D. Receipt of health care transition counseling in the national survey of adult transition and health. Pediatrics. 2011;128(3):e521–e529.
9. Reich SM, Bickman L, Saville BR, Alvarez J. The effectiveness of baby books for providing pediatric anticipatory guidance to new mothers. Pediatrics. 2010;125(5):997–1002.
10. Paradis HA, Conn KM, Gewirtz JR, Halterman JS. Innovative delivery of newborn anticipatory guidance: a randomized, controlled trial incorporating media-based learning into primary care. Acad Pediatr. 2011;11(1):27–33.
11. Centers for Medicare and Medicaid Services. 2014 Clinical Quality Measures (CQMs) Pediatric Recommended Core Measures. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_CQM_PrediatricRecommended_CoreSetTable.pdf. Accessed November 19, 2012.