All Ideas for Closing Performance Gaps

Key Activity: Elicit and Address Patient/Family Concerns

Rationale: Bright Futures believes that for a health supervision visit to be successful, the needs and agenda of the family must be addressed. The first priority of any Bright Futures health supervision visit is to attend to the concerns of the parent and/or the patient.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: ***Practice does not actively elicit and document that patient/parent concerns were addressed and resources provided during health supervision visits.***		
The practice does not have systematic process for eliciting family issues and needs.	1. Implement the use of Bright Futures documentation forms found in the Bright Futures Tool and Resource Kit. 2. Discuss with your office staff the challenge of balancing recommended anticipatory guidance and preventive services with addressing family issues and needs. 3. Consider reviewing and/or developing a brief template that outlines questions to ask patients/parents about their concerns. Investigate the Bright Futures Tool and Resource Kit for templates that can be used and modified for your practice. 4. Focus on a particular group of patients as you adopt new strategies for eliciting parental concerns. Start with a small, focused population when testing new approaches, such as newborns, because parents may have similar concerns. 5. Review and discuss with the parent what she or he is doing well and any concerns identified by office staff or through the questionnaire. 6. Ask the office scheduler to inquire if a parent has concerns at the time an appointment is made and note concerns in the patient's medical record. 7. Ask a nurse or medical assistant (MA) to place the completed form with the chart or, if using an electronic health record (EHR), ask the MA to optically scan the completed questionnaire or enter the information into the EHR. 8. Customize your EHR to include a Parental Concerns prompt that provides space to type or write in information regarding needs of the parent/patient. The prompt may even link to the questionnaire used to elicit information, or the questionnaire may be optically scanned into the EHR.	Schedule training for all office staff to review proper use of the new templates.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	9. Prioritize topics of concern to address during the visit and topics for which you will refer to outside resources. 10. Consider what new resources or referrals your practice may need. 11. Identify new community resources or referrals for issues that are best handled outside the office. Gathering data about the most common concerns of your patients may help you decide which referrals and community resources are the most likely to be needed and used by your patients.	
The professional agenda and patient/parent agenda differ.	1. Rely on your clinical judgment to balance the needs of the family with your recommendations and goals for the visit. 2. Develop a policy for office staff that outlines questions to ask patients/parents about concerns at the time an office visit is scheduled and/or during a reminder call, *and* note the concerns on the patient chart. Incorporate Bright Futures previsit questionnaires into your office routine. • Infancy Visit Tools • Early Childhood Tools 3. Provide Bright Futures previsit questionnaires for the patient/parent to complete in the waiting room or exam room before the visit.	Schedule a brainstorming session with office staff to generate suggestions that address how: ○ To change the culture of the practice with the team ○ Other practices handle parental concerns ○ To implement Bright Futures suggestions
Parental concerns from previous visits were not documented in the chart or EHR.	1. Review the patient's medical record to determine if concerns were raised and addressed during previous visit(s). 2. If using a paper-based system, attach a list of concerns to the front of the chart, discuss the concerns with the parent, and check off as each concern is addressed. 3. In an EHR system, click on the "previous" tab to review concerns from previous visits. 4. As parent/patient concerns are tracked longitudinally, the primary care professional should discuss improvements, additional referrals, or compliance with a referral if made during a previous visit.	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Follow-up visits and/or counseling may not be covered without the correct International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-10-CM) code.	1. Become familiar with coding requirements for counseling during health supervision visits. Ensure that appropriate documentation is made for billing codes. The *Coding for Pediatrics 2016, 21st Edition* and *Bright Futures and Preventive Medicine Coding Fact Sheet* provide answers to coding questions. 2. Communicate coding requirements to the office staff and billing group. 3. Develop a practicewide policy that outlines how to code correctly for counseling during a health supervision visit.	

Key Activity: Perform Developmental Screening and Autism Screening and Follow-up

Rationale: Early identification of children with development delay is critical for diagnosing and providing early therapeutic interventions. The pediatric provider, with parental report and continuous surveillance, and structured screening during health supervision visits, can identify children with special health care needs (eg, developmental concerns).

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: *Age-appropriate developmental screening is not routinely performed.*		
The practice is not familiar with Bright Futures developmental surveillance and standardized developmental screening.	1. Understand the basis of Structured Developmental Screening. 2. Implement the use of Bright Futures tips for organizing your office practice. 3. Define developmental surveillance as the process of recognizing children who may be at risk of developmental delays. o There are 6 recommended components of developmental surveillance to consider: 1. Elicit and attend to the parents' concerns about their child's development. Review the developmental milestones reported by the parent in the Previsit Questionnaire (see example of 18-month visit). 2. Document and maintain a developmental history. Use the age-appropriate Bright Futures Documentation forms to document all aspects of the health supervision visit (see example of 18-month visit). 3. Make accurate observations of the child. 4. Identify risk and protective factors. 5. Maintain an accurate record by documenting the process and findings.	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	Lastly share opinions and findings with other professionals, especially when concerns arise. 4. Define developmental screening as the use of a named developmental screening tool with appropriate sensitivity and specificity. ○ Formal developmental screening is recommended at age-specific visits: ▪ 9 Months ▪ 18 Months ▪ 24 Months ▪ 2.5 Years	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
The practice lacks a clinician champion.	1. Identify a champion (possibly a nurse or doctor; leadership skills are needed). 2. Boston's Children's Hospital *Developmental Screening Tool Kit: for Primary Care Providers* does a good job addressing these barriers. Available at: http://www.childrenshospital.org/developmental-screening.	
The practice does not have an organized approach to conduct developmental surveillance and standardized developmental screening.	1. Review various studies, policy statements, and toolkits, including online options. 2. Develop and implement a practicewide developmental screening policy. For more information, see the following: • The Bright Futures Training Intervention Project produced resources that illustrate how to develop a plan that will result in a comprehensive system to support prevention and development screening for young children. • Boston's Children's Hospital *Developmental Screening Tool Kit: for Primary Care Providers* addresses these barriers. Available at: http://www.childrenshospital.org/developmental-screening. Resources include: ○ How to Implement ○ Sample Practice Flow ○ Pointers from Practice • The Centers for Disease Control and Prevention (CDC) offers resources for primary care practice such as: ○ List of developmental screening tools ○ Pediatric Developmental Screening Flowchart ○ Pediatric Staff Roles 3. Ask parents to complete screening tools and/or questionnaires in the waiting room before the health supervision visit. 4. Ask patients to log on to an electronic health record site or patient portal (if practice has access) to complete several tools for developmental assessment. 5. Log on to online screening services to complete screening tools.	Review these resources: • http://www.childrenshospital.org/developmental-screening • http://www.cdc.gov/ncbddd/childdevelopment/screening-hcp.html

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
The practice is unsure about which structured developmental surveillance and developmental screening tools to use.	1. Review the Bright Futures Training Intervention Project, organized approach for performing developmental surveillance, and the age-specific priorities and screening tables for each recommended health supervision visit. 2. Review the 2006 AAP policy statement references the developmental screening tools appropriate for primary care. AAP also developed a tool set, Selecting Developmental Surveillance and Screening Tools. 3. Review the Commonwealth Fund's Healthy Development Learning Collaborative, which is made up of practices that consistently implemented the Parents' Evaluation of Development Status (PEDS) or the Ages and Stages Questionnaire (ASQ) for structured developmental screening.	
Screening tools are not administered (or used as intended), and interpretation of results is not consistent.	1. Develop a practice workflow diagram for use when determining how the new screening tools will be implemented. The following is an example of workflow diagrams that may be implemented in your office. • Boston Children's Hospital has a short vignette of a sample practice flow algorithm for administering, evaluating, and documenting developmental screening tools. Available at: http://www.childrenshospital.org/autism-screening/how-to-implement/sample-practice-flow. 2. Review the workflow with office staff and physicians. Identify gaps in the workflow. 3. Instruct medical staff to refer to instructions for specific tools.	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
The practice does not seek feedback regarding patient/parent experience with various tools.	1. Seek input from patients, families, and staff about their experiences with your new system. See the Eliciting Parental Strengths and Needs tip sheet for a list of questions useful in gathering feedback.	
The practice does not provide referral/intervention services.	1. Review local early intervention programs that are the central referral source for developmental concerns within the community. 2. Review the Academy's clinical report, Early Intervention, IDEA Part C Services, and the Medical Home: Collaboration for Best Practice and Best Outcomes. 3. Consider using a referral form for early intervention services developed by AAP and the US Department of Education Office of Special Education Programs. Check with referral sources to see if a form is available, and if not, collaborate on creating one. 4. Provide local school district information for parents who want to request an evaluation if there is a developmental concern. These programs differ by state; click here to see a list of all the Section 619 state coordinators. 5. In some cases, referral to pediatric subspecialists such as neurodevelopmental pediatricians, developmental and behavioral pediatricians, and child neurologists is appropriate for additional developmental diagnostic evaluations. For additional information, review the Act Early on Developmental Concerns: Partnering with Early Intervention presentation. 6. Delegate an office champion to follow up with referrals and intervention services. Update the referral and intervention services list regularly. Make sure you assign a backup person. 7. Provide and discuss the Bright Futures Patient/Parent Education handouts while still in exam room. 8. Consider cross-training of staff on implementation (eg, inviting referral sources to come to clinics and talk about their services and establish communication mechanisms during a staff in-service). 9. Have a list of referral resources posted on the wall of exam rooms. 10. Have referral algorithms posted to help guide clinicians into next steps.	Review *Developmental Screening Tool Kit: for Primary Care Providers How do we Handle Referrals?* Boston's Children's Hospital Web site, available at: http://www.childrenshospital.org/autism-screening/billing-referring.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Cultural or linguistic barriers exist when discussing social developmental issues with patients/parents.	1. Provide a tool that has been translated and validated in multiple languages for practice population, such as the following: • PEDS: English, Spanish, Vietnamese • ASQ-3: English and Spanish • ASQ-SE: English, Spanish, and Norwegian 2. Provide cultural competence resources and training. 3. Read the screening tool aloud or use a telephone language line for parents who may have difficulty because of cultural, linguistic, and reading-level considerations. 4. Consider engaging a translation service such as languageline.com/.	
The practice is not reimbursed for time to administer and interpret developmental screening and surveillance tools	1. Code correctly. • Refer to the Academy's Achieving Bright Futures, with links to every encounter and how to code for the related services. • Review the AAP's Practice Management Online Web site for additional resources. • Contact the Academy's Private Payer Advocacy staff.	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: *Age-appropriate, autism-specific screening is not routinely performed.*		
The practice is not familiar with the prevalence of autism and autism-specific screening policies.	1. Review the AAP news release, Autism Prevalence on the Rise: 1 in 68 Children Diagnosed With Autism Spectrum Disorder and the AAP news article, Autism prevalence now 1 in 68, varies by sex, race/ethnic group. 2. Review the following AAP policies and articles: • Identification and Evaluation of Children With Autism Spectrum Disorders *Pediatrics*, November 2007, Reaffirmed August 2014 (Clinical Report) • Management of Children With Autism Spectrum Disorders *Pediatrics*, November 2007, Reaffirmed August 2014 (Clinical Report) • Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening *Pediatrics,* July 2006, Reaffirmed August 2014 (Policy Statement) 3. The Council on Children with Disabilities (COCWD) serves as the main point of contact for the Academy on ASD issues. The COCWD is dedicated to helping the Academy ensure that accurate, comprehensive information about autism spectrum disorder (ASD) is available and communicated to pediatricians, parents, and the public. 4. Review the AAP/CDC: Learn the Signs. Act Early: Autism Case Training. The CDC's AAP-endorsed curriculum is designed to educate future pediatricians on identifying, diagnosing, and managing autism spectrum disorders through case-based scenarios.	
The practice does not have an organized approach to conduct autism-specific screening.	1. Follow the process outlined above to develop and implement a practice-wide developmental screening policy.	
The practice is not familiar with current autism-specific screening recommendations.	2. Per the AAP/Bright Futures Recommendations for Preventive Pediatric Health Care (periodicity schedule), autism-specific screening should be performed at the 18- and 24-month health supervision visits. • If the autism screening is missed at 24 months, complete it at the 30-month visit.	
The practice is unsure about which validated autism screening tools to use	1. Become familiar with the Modified Checklist for Autism in Toddlers, Revised, With Follow-up (M-CHAT-R/F), a validated autism spectrum screening tool. 2. Complete the M-CHAT-R/F follow-up interview. Without this, the sensitivity and specificity drop significantly.	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: ***No follow-up plan is provided for positive screening results (developmental and autism concerns).***		
There is no process in place for follow-up of positive screening results (developmental and autism concerns)	1. Explain findings in a way that is optimistic, clear, and encourages families to seek recommended services. Provide written information on potential services. 2. Ideally, every family who is referred or who needs developmental behavioral promotion for specific concerns, should receive a summary report to take home. 3. Make sure and send referral letters to relevant services and consider making appointments for families, as this greatly improves the chance they will follow up. 4. Consider using the referral form for early intervention services developed by the AAP and the US Department of Education Office of Special Education Programs. 5. If available, participate in statewide monitoring and service coordination initiatives such as Help Me Grow, ABCD, or practice-based programs such as Healthy Steps. These projects provide assistance with referrals and referral monitoring. 6. If a national program is not available, reach out to nonmedical services to ensure they will send results to you. Consider inviting regional IDEA staff to meet with your practice. 7. Update longitudinal documentation. All medical charts should include a problem checklist, which also can show what needs additional attention and follow-up. This can be included in the EHR and include alerts to yourself and staff about the need to check on referrals.	

Key Activity: Elicit and Discuss Family Strengths

Rationale: Bright Futures encourages health care providers to recognize the importance of a family's strengths in caring for their children. By identifying strengths in each visit, there is a natural progression of the health supervision visit from a disease detection model toward a strength-based approach of health promotion and disease prevention. Each health supervision visit is a critical opportunity for enhancing the family's strengths and assets.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap*: Practice does not actively elicit and document family strengths during health supervision visits.*		
Health care providers are traditionally trained to use a risk-based diagnostic frame of reference rather than a positive parenting/positive youth development model.	1. Choose an interdisciplinary team to champion this activity within the practice because there is a role for everyone in this key clinical activity—even though the documentation in the chart will probably come from the health care professional (HCP). 2. Define and discuss a strength-based approach with medical home staff. 3. Ask each medical home team member to think about what they are doing already to identify strengths, suggest these strategies to parents, and ask for their thoughts on changes that could to be made for their health (when appropriate) before the next meeting. Also, ask the parents to observe what others are doing. 4. At the second meeting, ask staff to share what they identified. Be ready to share examples from the course and remind them of the protective factors from Strengthening Families, CDC, and Connected Kids • This discussion will determine if it is time for more education about the rationale for and examples of the use of a strength-based approach, or whether it is appropriate to choose a systematic process for eliciting family strengths. • Often, what the HCP and staff already have identified fit with the suggestions from the literature. 5. Use a strength-based approach to build relationships with the family and child. Suggested tools proven to be helpful are: • Bright Futures parent educational handouts • Connected Kids Social Connections worksheet to assess family social capital • Connected Kids People Who Care About worksheet to assess social capital	Schedule training for all office staff to review proper use of the new templates. In several smaller practices, the team found that an interim step was helpful. They organized an activity where team members commented on strengths they appreciated about each other. Almost everyone found it a positive experience and did not need any more convincing about the power of this approach.
Health care provider does not have systematic process for eliciting family strengths and needs.	1. Decide on strength categories to watch for—commenting on issues that come up during the history and observation. Identify one or more universal areas (ie, a social connections and support) that you will look for in each family. 2. Develop and implement a standard set of questions or a checklist to help reveal the presence of or need to work on specific family strengths. 3. Develop a systematic approach as to how strengths will be identified—for example, through questionnaire, interview, or both.	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	4. Implement use of Bright Futures documentation forms found in the Bright Futures Tool and Resource Kit. 5. Determine if a nurse or health assistant will have a role in this identification process.	
Health care provider is unaware of how to develop a collaborative approach with patients/parents.	1. Focus on a particular group of patients when adopting new strategies to incorporate the strength-based approach. • Start small with a focused population such as newborns or preschool-aged children when testing new approaches. • Expand the focus once the new system is in place to address other ages. • Discuss the challenge of balancing recommended anticipatory guidance and preventive services and addressing family and child strengths with your office staff. 2. Gather information about frameworks and other approaches for implementing a strength-based approach. Frameworks and approaches to consider are: • Frameworks: Connected Kids, Strengthening Families, CDC • Approaches: Shared decision-making, motivational interviewing, FRAMES	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Health care provider is unaware of available community resources for families.	1. Assess family support. Consider using a tool such as Bright Futures previsit questionnaire or the Social Connections worksheet from Connected Kids. If you already have a questionnaire for parents, consider adding new strengths/protective factors from Bright Futures materials. 2. Support parents in becoming more connected by using the Connected Kids brochure, Connecting With Your Community. 3. Investigate community resources as another means to develop and encourage youth development and building a family's and child's strengths. 4. Acquire or develop and maintain a community resource guide using the Connected Kids or Bright Futures materials	

Key Activity: Perform Age Appropriate Risk Assessment and Medical Screening

Rationale: Determining disease and assessing medical risk are some of the primary functions a provider performs every day. Comprehensive risk assessment and medical screening are integral parts of every health supervision visit and a prerequisite for additional medical treatment and anticipatory guidance. One component of disease detection and risk assessment is medical screening.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: ***Age-appropriate risk assessment and medical screenings are not performed consistently at all health supervision visits.***		
The practice does not have a system in place to perform, interpret, and document that age-appropriate risk assessment and medical screenings are performed at all health supervision visits ages birth to 4 years.	• Familiarize your practice with the Bright Futures Preventive Services Prompting Systems. • Use the Bright Futures Presentation and Handouts Materials. • Implement and use Bright Futures Preventive Services Prompting Sheet (Birth–4 years) to remind you what risk assessment and screenings are needed at each health supervision visit. • Consider converting preventive services prompting sheets for EMR use. For help with how to incorporate forms into an EMR System, contact aapsales@aap.org • Have the parent/guardian complete questionnaires online or on a tablet in your office and have it populate your EMR, if possible. Alternatively, have the parent/guardian	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	complete questionnaires in the waiting area, and look for positives before the health care professional sees the patient. • Review the Bright Futures Tool and Resource Kit for risk screening questionnaires that can streamline your practice's approach to medical screening and risk assessments. • To improve documentation, use the Bright Futures visit documentation forms available for every health supervision visit. Each form has a designated area to record and document risk assessment and medical screening.	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
The practice does not use open-source (nonproprietary), validated risk assessment and medical screening tools.	1. Review your practice's current previsit questionnaire and compare it with the Bright Futures previsit and medical screening questionnaires to determine if additional information should to be added to your existing questionnaires. The Bright Futures Tool and Resource Kit has previsit questionnaires and medical screening questionnaires for every health supervision age. • Infancy Visit Tools (Prenatal to 11 months) • Early Childhood Tools (1 to 4 years) 2. Review the measurements section of the Bright Futures visit documentation forms, which also provides a systematic way to record important medical screening and results (eg, blood pressure, weight, body mass index, laboratory results) outside of established normal ranges. • Infancy Visit Tools (Prenatal to 11 months) • Early Childhood Tools (1 to 4 years) 3. Ask nurses and/or medical assistants to read questions to parents/families who are unable to read so the provider can be prepared to do selective screening. Use the Spanish versions, when appropriate.	
Gap: *The patient's measurements (weight for length for patient's under 2 years of age/BMI measured for patient 2 years of age or older) are not taken and plotted on the percentile curve at all health supervision visits consistently.*		
Clinicians and/or staff do not recognize the importance of accurately and consistently measuring and documenting patients' growth measurements.	1. Review the guidelines and recommendations that outline clinician responsibilities for accurate and reliable growth measurements for pediatric patients: • Bright Futures/AAP Periodicity Schedule • Optimizing Linear Growth Measurement in Children available at: http://www.jpedhc.org/article/S0891-5245(14)00002-9/abstract	• Discuss with staff the importance of reliable growth measurement for clinical decision-making and intervention to: ○ Detect growth abnormalities. ○ Detect abnormalities in nutritional status. ○ Detect diseases that affect growth. ○ Track the effects of medical or nutritional intervention.
The provider does not always recognize abnormal measures (eg, blood pressure, weight, body mass index) outside of established normal ranges.	1. Use updated tables of normal ranges for blood pressure, weight, and other measures for each age group. 2. Develop or use computer tools programmed to automatically flag abnormal measures in the EHR, if your office is computerized.	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	3. Scan completed forms into your EHR system. In a noncomputerized office, an abnormal measure may be flagged manually on a chart or in an office log.	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?

The practice does not have a systematic approach for measuring and documenting patients' growth.	1. Establish clear office procedures for obtaining and plotting growth measurements. Consider the following:
	• Meet with staff to gather information and ideas about establishing an officewide procedure for measuring and documenting patient growth.
	• Identify roles and responsibilities for measurement and plotting growth.
	• Develop a visit flow for obtaining and recording growth measurements that considers the patient/family, physician, and staff members' time, office efficiency, equipment, and backup contingencies.
	• Use AAP-recommended tools for documenting growth:
	  ○ WHO Growth Charts for Children 0–2 Years of Age
	  ○ CDC Growth Charts for Children 2 Years of Age and Above (available in English, French, and Spanish)
	• Train staff and provide cross-training:
	  ○ To take and record measurements accurately
	  ○ To follow established visit flow
	• Include checks and balances in office procedures to ensure that:
	  ○ All growth measurements are documented
	  ○ The clinician reviews the growth chart at each visit
	  ○ The growth summary is shared with the patient and family
	• Identify a single, preferred location for all measurement equipment and materials.
	• Document the schedule and procedure for calibrating and maintaining equipment. Use a calibration log for measurement equipment.
	
	2. Periodically audit office procedures to ensure they are effective and that staff members follow them consistently and correctly.
		• Consult with other practices about their office procedures for growth measurement, documentation, and family discussions; adapt them for your practice.
		• Stress with staff the importance of documentation as a necessary component of high-quality care. Help them recognize that actions that are not documented are considered not done.
		• Consider the online training course, Using the WHO Growth Charts to Assess Growth in the United States Among Children Ages Birth to 2 Years.
		
		This online training course was developed by the CDC to train health care providers and others who measure and assess child growth on how to use the World Health Organization (WHO) growth standards to assess growth among infants and children ages birth to 2 years.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: ***No follow-up plan is provided for when risks or medical concerns are identified.***		
Practice does not have an organized process for follow-up of abnormal screens.	1. Identify and reflect on the child's strengths. • If developmental concerns are identified in children up to 8 years of age (via the PEDS), consider following the AAP Developmental Screening algorithm. • If mental health concerns are identified, the AAP Task Force on Mental Health algorithm may be followed to determine next steps. 2. Offer suggestions for augmenting strength areas that may be lacking or deficient. Point out the patient's existing strengths to provide a hopeful foundation upon which such suggestions can be offered. 3. Use discussion of strengths as a way to engage the patient in discussing needed behavioral changes. 4. Providers can encourage patients to utilize their strengths in discussions about behavioral change by incorporating principles of shared decision-making or motivational interviewing.	
Practice does not have a seamless approach for referrals for specialized services as indicated and/or close follow-up care.	The primary care practitioner can coordinate the specialty services and provide integrated oversight of the patient's progress. 1. Create a regularly updated list of community-based referral programs with contact numbers (eg, WIC, The United Way, and public health departments, and Providers/Practitioners). • Assign an office champion to keep lists updated on an ongoing basis and to systematically call each number on the list (possibly during slow times) to ensure sure they are still operational. 2. Implement use of Bright Futures Community Resources tools: • Bright Futures: Community Resources List (pg. 8) and Community Resources Check Sheet (pg. 7) 3. Use the Community Pediatrics Self-Assessment tool to determine where your practice is in relation to community pediatrics activities. 4. Link to community and tools on the AAP Council on Community Pediatrics Web site.	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Practices are unaware that reimbursement may be available for full range of screenings/follow-up and/or how to apply for it.	1. Code correctly. • Refer to the AAP's *Achieving Bright Futures,* which links to every encounter and how to code for the related services. • Refer to the AAP's Bright Futures and Preventive Medicine coding fact sheet. 2. Review the AAP's Practice Management Online Web site for additional resources. 3. Contact the AAP's Private Payer Advocacy Advisory Committee.	

Key Activity: Perform Maternal Depression Screening and Follow-up

Rationale: Health care providers can improve maternal well-being and family functioning through identification of maternal depression, facilitating referrals, and following up the mother's and the dyad's treatment in the community (Heneghan et al, 2007). Early detection of maternal depression and referral can improve health outcomes for parents and families and, most importantly, the child.

Potential Barriers	Suggested Ideas for Change
Gap: ***Maternal depression screening not routinely performed.***	

Potential Barriers	Suggested Ideas for Change
Health care provider/practice does not routinely screen for maternal depression during each health supervision visit.	1. Prepare your practice to implement maternal depression screening: a. Engage your group: Identify champions, and motivate and educate the staff. b. Develop a practice approach: Choose a screening tool, explore available resources, network with colleagues, and establish a triage and referral mechanism. c. Develop an office system: Train your staff, develop a system to distribute and record screeners, select monitors, and change your office environment. For more information on developing an office system, see: • Olson A, Gaffney C. *Parental Depression Screening for Pediatric Clinicians: An Implementation Manual*. The Commonwealth Fund. April 2007. • Earls M. The Committee on Psychosocial Aspects of Child and Family Health. Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. *Pediatrics.* 2010 Nov:126(5):1032–1039. 2. Develop a practicewide systematic approach to screening new mothers for maternal depression. The following process is efficient, effective, and proven: a. Assess well-being of the mother at the recommended health supervision visit(s): 1 week, 1 month, 2 months, 4 months, and 6 months. b. Discuss the impact of the mother's well-being on the child. c. If you have concerns, arrange a follow-up visit, phone call, or text message. d. If maternal depression or substance abuse is present, refer the mother to her adult primary care provider, mental health clinician, or community support. e. If suicidality or psychosis is a concern, refer to crisis/emergency services immediately. Have an office Policy and Procedure for referring mothers to emergency services. f. Refer to the dyad if there is concern with the mother-child relationship/attachment. g. Refer the infant for Part C Early Intervention Services if socioemotional development is impacted. h. Provide information, support, and access to relevant community resources.

Potential Barriers	Suggested Ideas for Change
The practice does not use a standardized maternal screening tool.	1. Choose and use a standardized maternal depression screening tool. Standardized screening tools include the following: a. Edinburgh Postnatal Depression Scale (EPDS): The EPDS has 10 multiple choice questions and is completed by the mother. A score of 10 or greater indicates possible depression; a score of 20 or greater requires immediate referral for emergency mental health services. b. Patient Health Questionnaire (PHQ-2 and PHQ-9) (Detailed scoring information can be found here.): ○ If the PHQ-2 symptom screen for depressed mood or anhedonia is positive, then check the PHQ-9 symptom checklist and use clinical judgment regarding management. ○ If the score is 0–4 (minimal severity), no treatment is recommended. If the score is 5–9 (mild) or 10–14 (moderate), supportive self-care, monitoring, and follow-up is recommended. ○ If the score is 15 to 19 (moderately severe) or 20 or more (severe), a referral is needed. ○ For scores above 10, all infants should have follow-up screening of their socioemotional development. ○ If the mother is suicidal, an urgent referral is needed. All health care professionals should have a Suicide Protocol for the office in place (see an example from Family Practice Management). c. The Survey of Well-being of Young Children (SWYC) includes questions about depression, as well as other psychosocial risk factors. If depression questions indicate risk, follow up with the EPDS or PHQ-9 screening tool. ○ The Survey of Well-being of Young Children for Massachusetts (SWYC/MA) for Postpartum Depression tool has embedded EPDS questions into the 2- , 4- , and 6-month forms. 2. Assess new mothers for maternal depression at recommended health supervision visit(s): 1 week, 1 month, 2 months, 4 months, and 6 months. 3. Standardize documentation when recording outcomes of the formal screening process, providing education or counseling to the mother, assessing safety issues, advising referrals and for refusals, and any follow- up. For example, you may develop a way to track depression screening results in the EMR. Close follow-up of mothers in the office and tracking of referrals is critical.

Potential Barriers	Suggested Ideas for Change
The health care provider does not have adequate time to treat mental health problems.	1. Understand the Academy's Mental Health Competencies for Pediatric Primary Care and how to use a common-factors approach. 2. Be prepared to discuss maternal depression at one or more health supervision visits during the first year of the child's life. The screening/discussion process can be brief if the tool is administered before the visit. For example: • Mail the tool before the visit. • Train front office or nursing staff to administer the tool before the visit (in the waiting room or the examination room). 3. Complete the screening discussion, which should include the following: • Response to concerns. • Arrangement of follow-up for mom and the dyad. 4. Counsel and refer mothers with positive screening results. • Develop a process to refer parents with a positive screening result to primary care, obstetric, or mental health specialist. • Discussion of screening results can be completed in 5 or 10 minutes (Olson et al, 2006).

Potential Barriers	Suggested Ideas for Change
The health care provider/practice is not trained to treat maternal depression.	1. Utilize AAP Mental Health Initiatives (including the primary care tools available in the Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit) to assess practice readiness and to do practice workflow planning. 2. Develop relationships with community mental health providers (for mom and infant mental health providers) and establish referral processes prior to beginning a screening program (strategies could include a lunch-and-learn at the practice or a community "mixer"). 3. Consider gathering information about local and national mental health resources to provide to mothers and potentially collaborate directly with their mental health providers. • Create data-sharing agreements with referral sources for certain information that impacts the health of the child and mother. • Identify support systems in the community for the mother, including home visiting programs, church programs, and support groups. 4. Create a supportive office environment (eg, displaying posters and educational brochures, and offering help and comfort for depressed mothers). 5. Develop a system for appropriate documentation in the child's medical record regarding maternal screening: • Refer the mother to her primary care provider, obstetrician (6-week visit), or a mental health provider for follow-up, treatment, or referral. • Document in the child's medical record that a screening for postpartum depression took place and, if necessary, that a referral was made. However, what takes place when the mother seeks care after such a referral is part of the mother's record, not the child's record. • Schedule a follow-up visit in one month to track mom's referral and to assess infant socioemotional development and attachment. 6. Attend continuing medical education courses about toxic stress and early brain development, resiliency factors for families, evidence-based treatments for the mother (parent)-infant dyad, as well as evaluation and management of depression, alcohol, and other drug abuse and other mental health issues. 7. Research hospital pediatric departments that work closely with psychiatry departments to learn if workshops or grand rounds designed specifically for pediatric providers are available.

Potential Barriers	Suggested Ideas for Change
The practice does not have a systematic referral and/or follow-up process in place for maternal depression.	1. Monitor the child for the behavioral impact of familial depression, utilizing an appropriate socioemotional screening tool such as the ASQ-SE-2. 2. Screen before the visit to address issues, and make a referral (referrals may include for mom, evidence-based treatment for the dyad, or Part C Early Intervention Services). 3. Develop a systematic approach to track follow-up and referral for maternal depression. 4. Visit the Mental Health Initiatives: Primary Care Tools page on the AAP Web site for additional resources.
The health care provider is not reimbursed for time and effort to evaluate and manage maternal postpartum depression.	Bill and code for maternal screening using H1000 and CPT code 99420, administration and interpretation of health risk assessment instrument (eg, health hazard appraisal). • Refer to the Bright Futures and Preventive Medicine coding fact sheet.

Key Activity: Perform Oral Health Risk Assessment

Rationale: In the United States, dental caries (tooth decay) is the most common chronic disease affecting children. Experts agree that early childhood caries may have a long-term effect because caries in primary teeth is a leading risk factor for caries in permanent teeth.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: ***Oral health risk assessment is not routinely performed by health care professional.***		
The pediatrician is unaware of how to assess a child's risk for caries.	1. Use tools developed for caries risk assessment available through professional groups; see Children's Oral Health on the AAP Web site. 2. Refer to www.smilesforlifeoralhealth.org to learn how to assess a child's risk for caries. 3. Invite local expert, (eg, AAP Chapter Oral Health Advocate [COHA]) to the office to provide training on oral health risk assessment. 4. Develop a practice dental champion who can support dental activities.	Develop standardized practice office training for all staff on caries risk assessment.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
The pediatrician is having difficulty incorporating caries risk assessment into care delivery.	1. Incorporate risk assessment into charting/EHRs. 2. Develop standard workflow to incorporate oral health risk assessment into health supervision visits, eg, utilize staff to complete portions of risk assessment. 3. Utilize a parent-completed risk assessment tool prior to visit. 4. Use the frequency of health supervision visits as an opportunity to assess caries risk, and provide anticipatory guidance and recommendations regarding proper dental care for this young age group.	Conduct practice process meetings to identify specific barriers. Develop quality improvement metric to track documentation of oral health risk assessment. Consider a Plan/Do/Study/Act activity to strategize on incorporating processes.
The pediatrician is unaware of importance of optimal oral health and how to prevent caries.	1. Review Smiles for Life curriculum at www.smilesforlifeoralhealth.org. 2. Review Protecting All Children's Teeth: A Pediatric Oral Health Training Program on the AAP Web site. 3. Review the Academy's Policy Statement on Preventative Oral Health Intervention for Pediatricians. 4. Review the Academy's Policy Statement on Maintaining and Improving the Oral Health of Young Children.	Hold staff-side Smiles for Life lunch-and-learns. Develop a practice dental champion. Host a local expert to provide grand rounds/lunch-and-learns.
The parent is unaware of importance of optimal oral health and how to prevent caries.	1. Provide education and anticipatory guidance to parents regarding the importance of and longevity of primary teeth and how to prevent caries. Materials that are helpful include: ▪ AAP Pediatric Guide to Oral Health Flip Chart and Reference Guide ▪ Brushing Up on Oral Health: Never Too Early to Start ▪ A Guide to Children's Dental Health Brochure ▪ Oral Health Picture Handout for Families in English and Spanish ▪ Bright Futures Oral Health Toolbox ▪ California Dental Association Oral Health Fact Sheets (multiple languages) ▪ Cavity Free at Three Patient Education Materials ▪ Oral Health Special Needs Fact Sheets for Professionals and Caregivers ▪ Oral Health Care During Pregnancy: A National Consensus Statement	Use the AAP flip chart in discussion with parent about oral health.
Gap: ***Patient/parent has limited access to pediatric dental services.***		

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
The patient has limited access to a dental home: • Lack of pediatric dentists • Lack of general dentists willing to see children younger than 3 years • Lack of dentists willing to accept insurance coverage for child	1. Develop a relationship with your dental community by contacting local dentists. 2. Develop relationships with university dental schools, if available, in your area. 3. Integrate a dental hygienist in the pediatric office for preventive dental services and to facilitate relationships with the dental home. 4. Refer children to midlevel dental professionals, eg, dental hygienist. 5. Consult with Medicaid in your state for list of dental professionals willing to see children with Medicaid coverage. 6. Obtain local funding to improve access to dental services in your community. 7. Investigate Area Health Education Consortium for health education programs and dentist recruitment and retention activities. 8. Develop a relationship with your AAP COHA. These advocates are pediatricians trained to provide training to their state colleagues on how to incorporate oral health into the medical home, advocate for children's oral health issues, serve as access points, and build relationships with dental colleagues and societies. Find a roster here.	Post information on your chapter Web site about dentists who will see children ages 0–4 years. Consider partnering with your local dental society to offer 0- to 4-year-old oral health training to both general dentists and primary care professionals. Take a dentist to lunch.
The patient/parent does not have dental insurance.	1. Advocate for dental insurance for all families through your state AAP chapter and/or state oral health coalitions. 2. Utilize state/national Affordable Care Act (ACA) resources to learn of eligibility for dental insurances.	Encourage parent/caregivers to establish a dental home, which will result in a higher chance that the child will have dental home too.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: *Health care professional has limited knowledge of fluoridation requirements for dental care.*		
Health care professional is unaware of fluoride levels in local water supplies.	1. Refer to the Campaign for Dental Health to learn about community water fluoridation in your community. 2. Educate yourself and your practice about the current controversies regarding water fluoridation at ilikemyteeth.org. 3. Develop a list of fluoride levels in water supplies where patient population resides. ▪ Call the city water or public health department to ascertain if the water supply is fluoridated. ▪ Provide appropriate fluoride systemic supplementation per CDC recommendations and USPSTF recommendations. 3. Educate parents about proper levels of fluoride in their water supply. 4. Encourage parents to call the city water or public health department to determine if their community water is fluoridated. 5. Educate parents with a private well about the benefits of therapeutic levels of fluoride in their water supply. ▪ Instruct parents to have well water tested for fluoride every 5 years and to call your office/forward a copy of the test results to your office. ▪ Provide family testing kits for fluoride content, and address a results envelope to your office. 6. Educate parents about the importance for follow-up of fluoride water testing for their children. 7. Educate parents that, in general, tap water is healthy and that bottled water may not contain the needed fluoride for their children's teeth.	Become a member of the AAP Section of Oral Health to keep up to date on the most recent resources for water fluoridation. Collaborate with your local oral health coalition to learn more about community water fluoridation in your municipality/state. Collaborate with your local health department to keep up to date regarding changes in your community's water fluoridation.
The health care professional is having difficulty assessing child's overall fluoride intake.	1. Refer to the AAP clinical report, Fluoride Use in Caries Prevention in the Primary Care Setting. 2. Consider all of the sources of water the child gets throughout the day. 3. Assess the use of other sources of fluoride including fluoridated toothpastes, fluoride rinses, and fluoride received at a medical or dental visit.	Contact your local COHA or dental expert for help.
The health care professional is unaware of how to order and apply fluoride varnish.	1. Utilize existing resources, eg, Smiles for Life and From the First Tooth, to learn how to apply fluoride varnish. 2. View videos to learn how to apply fluoride varnish at Smiles for Life and From the First Tooth. 3. Consult peers/COHAs/dental professionals regarding how to order supplies. 4. Work with local business to develop oral health kits that include toothbrushes, toothpaste, fluoride varnish, and educational materials.	Include business office staff in making decisions about ordering supplies.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: ***The pediatrician is not getting reimbursed for oral health services.***		
The pediatrician is not reimbursed for providing preventive oral health services, including fluoride varnish.	1. If the state does not reimburse, become active in the state AAP chapter. 2. Develop a relationship with your AAP COHA. 3. Utilize CPT code 99188 for fluoride varnish application. 4. Investigate who in your state can legally apply fluoride varnish, because some states only allow pediatricians to apply the varnish while others allow RNs or MAs to do so.	A CPT code 99188 is now available for fluoride varnish application. Currently, CDT Dental Procedure Codes are used and reimbursed by Medicaid in some states.

Key Activity: Provide Anticipatory Guidance

Rationale: Anticipatory guidance is specific, preventive information given to patients/parents to improve the well-being of pediatric patients by reducing injuries and meeting basic needs (eg, nutrition, sleep patterns, behavior issues), which ultimately promotes healthy coping and an understanding of normal child and adolescent development. The process to provide anticipatory guidance is similar across all age groups.

Bright Futures Guidelines recommend anticipatory guidance topics for various age groups, including infancy and early childhood, which standardizes how health care professionals determine which topics to discuss at each visit. The process uses Bright Futures "Priorities for the Visit" for each health supervision visit.

Bright Futures guidelines recommend 5 priorities for each visit, which provides a systematic approach for providing anticipatory guidance for the 15 recommended health supervision visits from infancy through early childhood.

Potential Barriers	Suggested Ideas for Change
Gap***: Bright Futures Priorities (Anticipatory Guidance) are not discussed or materials are not provided.***	
The practice does not have a system for providing anticipatory guidance during a health supervision visit.	1. Develop a systematic, practice-wide approach to provide anticipatory guidance at every health supervision visit. 2. Establish an office team to create and/or select Bright Futures content, and then design the system where handouts are attached to the child's chart prior to the visit.

Potential Barriers	Suggested Ideas for Change
The health care professional does not routinely document that anticipatory guidance was provided during a health supervision visit.	1. After each health supervision visit, document in the patient's medical record that anticipatory guidance was provided. 2. Use appropriate Bright Futures Visit Documentation forms in the Bright Futures Tool and Resource Kit to document anticipatory guidance discussion. 3. Incorporate anticipatory guidance documentation into your electronic health record system.
The health care professional is not familiar with Bright Futures priorities for offering age-appropriate anticipatory guidance.	1. Review your documentation system (paper/electronic) to ascertain whether the prompts include the Bright Futures Priorities for the Visit. Use or adapt age-appropriate Bright Futures Visit Documentation Forms, which provide reminders and facilitate documentation of the 5 anticipatory guidance priority areas for each age group. 2. Provide a Bright Futures Patient/Parent Educational Handout that covers all necessary content, available in the Bright Futures Tool and Resource Kit. 3. Consider adding complementary materials to the Bright Futures resources such as: • HealthyChildren.org • Reach Out and Read (ROR) • Connected Kids (CK) • Healthy Steps 4. Laminate Bright Futures resources for use in each examination room.

Potential Barriers	Suggested Ideas for Change
The health care professional and parent/patient do not share the same agenda for a health supervision visit.	1. Create a shared agenda when providing anticipatory guidance: • Ask about parental concerns at the time the appointment is scheduled. • Use the Bright Futures Previsit Questionnaire and Supplemental Questionnaire (available in the Bright Futures Tool and Resource Kit) to focus on areas of parental concern and/or topics needing counseling that align with the 5 priorities. • Provide a Bright Futures Patient/Parent Educational Handout following a health supervision visit. • Standardize handouts for appropriate ages and development. • Make common topics of interest available in waiting room or on office Web site for readily available access to reputable materials related to concerns expressed. 2. Note in patients' medical record that an opportunity was given to discuss concerns and whether concerns were expressed. • Direct the medical assistant to list parent concerns in the child's history. • Create a prompt that concerns were addressed in the EMR or a check-off in the paper record. 3. Review resources for additional information about common parental concerns and how to address them. See suggestions in the Resources section of the course. 4. Address patient education regarding additional sources of information and education, for example, the library, Web sites, and community resources.
Practice does not have standardized anticipatory guidance handouts available.	1. Use the age-appropriate anticipatory guidance Bright Futures Patient/Parent Educational Handout. 2. Review Clinical Practice tip sheets and your practices' materials to determine gaps.
The health care professional does not have time to provide anticipatory guidance at each health supervision visit.	1. Develop a practice policy that addresses using previsit questionnaires to screen for high-priority issues/topics to be discussed during each health supervision visit. 2. Allow additional time during health supervision visit to discuss patient/parental issues/concerns. 3. Schedule a follow-up appointment with the health care professional if and when more in-depth anticipatory guidance is needed. 4. Develop a system to ensure that professional time taken to provide anticipatory guidance is appropriately billed.

Potential Barriers	Suggested Ideas for Change
The practice does not have a system to effectively track anticipatory guidance longitudinally.	Develop a system to document that anticipatory guidance and appropriate handouts were provided. • Begin with 1 or 2 partners in your practice to test the process, then reevaluate, make necessary changes, and gradually incorporate it into a practicewide policy. • Start incrementally by selecting a single topic that can be addressed in a developmentally appropriate way from infancy through early childhood. • Consider motor vehicle and passenger safety because it is a component element of the priorities for every recommended visit. • Document that anticipatory guidance was given and/or a brochure was explained and given to patient/parent. • Use the Bright Futures Visit Documentation forms (or a similar standardized documentation form) to document topics that warrant follow-up discussion at the next health supervision visit and to document that follow-up discussion occurred.
Health care professional and/or patient/parent have cultural and/or language barriers.	1. Provide training for health care professionals and office staff that promotes culturally effective or culturally competent care, and avoids stereotyping patients and families. 2. Review questionnaires and handouts to determine if they are written at an appropriate reading level for your patient population. 3. Instruct the office staff to ask every patient/parent who completes a form in the office if she or he needs help. 4. Place an alert in the chart if the caregiver needs assistance with reading or writing, and develop an office policy on how best to assist him or her. 5. Identify an interpreter who is available to work with the patient and/or family during the visit. Add an alert to the patient's medical record in the special needs section that indicates an interpreter is necessary. Avoid using children and adolescents as interpreters for their families. 6. Refer patient/parent to Web sites and other sources for additional information to address their concerns.