Potential Barriers and Suggested Ideas for Change

Key Activity: **Referral**
Rationale: Most pediatric patients with uncomplicated gastroesophageal reflux (GER) can be managed by their primary care provider (PCP). Understanding when to refer pediatric patients with gastroesophageal reflux disease (GERD) to a gastroenterologist helps eliminate unnecessary referrals.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Appropriate referral to a gastroenterologist is not always performed for patients with persistent clinically evident reflux.		
Criteria for primary care practice referring patients with GERD or GERD masqueraders are not well understood.	Review the following for information regarding 'red flags' that might suggest GERD or an alternative diagnosis: ✓ 2018 NASPGHAN Guidelines ✓ 2009 A Global, Evidence-based Consensus on the Definition of Gastroesophageal Reflux Disease (See *Education* in the Clinical Guide.) ✓ 2013 AAP Clinical Report: Gastroesophageal Reflux: Management Guidance for the Pediatrician Consider referral to a pediatric gastroenterologist or other pediatric subspecialist ***when***: ⇨ Onset of GER symptoms first occurs after 6 months of age or when symptoms persist beyond 12 months. This raises the possibility the symptoms are not due to benign GER of infancy and alternative diagnoses and/or therapy need to be considered. ⇨ The presumed GERD signs and symptoms have not resolved or significantly improved after nonpharmacological lifestyle changes in an infant, and/or after 4 to 8 weeks of PPI pharmacological therapy with an older child or adolescent. ⇨ The patient has a significant complication of GERD. Complications might include anemia, hematemesis, persistent nighttime awakening due to heartburn, noncardiac chest pain, regurgitation, and failure to thrive, as well as severe respiratory or upper airway (ie, otolaryngological) symptoms. ⇨ The primary care physician believes the diagnosis is something other than reflux, based on 'red flag' symptoms or lack of improvement. ⇨ The infant or child displays alarm signs or symptoms suggesting an underlying gastrointestinal disease (see Table 3). ⇨ Patients cannot be permanently weaned from pharmacological	Conduct an in-service program for all medical staff to review the 2018 NASPGHAN Guidelines, eg, Grand Rounds, lunch symposium, webinars. After reviewing the 2018 NASPGHAN Guidelines discuss with your team how to distinguish between a true GERD diagnosis and what might be a GERD masquerader.

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	treatment within 6–12 months. Consult local gastroenterologists for guidance on what they would consider an appropriate referral.	
Subspecialty practice does not have consensus among all providers as to what is and is not an appropriate referral to the pediatric gastroenterologist.	All providers of subspecialty practice should review all current guidelines and set standards for: ✓ The criteria of symptoms and signs that would support evaluating and continued care of the patient ✓ Agreement on what situations would warrant sending the patient back to the referring physician Reach out to local referring physicians to discuss what they should be looking for when referring a patient for evaluation of GERD. Provide training for all medical staff (such as using the content provided in EQIPP) about appropriate criteria for referral to a gastroenterologist.	Routinely meet with all providers of the practice and review/discuss recent cases of GERD referrals and outcomes of such referrals.
Gap: Trial of acid-suppressant medication is not routinely recommended before referral to a subspecialist for patients 1 year of age or older.		
The practice does not have a protocol to address when empiric treatment is appropriate for patients with GERD before referral to a specialist.	Review 2018 NASPGHAN Guidelines for information about when to use acid-suppressant therapy before referral to a gastroenterologist: • **In patients 1 year of age or older**, an empiric trial of acid suppression should be initiated or continued prior to referral to a subspecialist. • **In patients under 1 year of age**, acid suppression should not be started for patients before referral to a gastroenterologist, unless one is not available. Determine if there is reasonable access to a pediatric gastroenterologist for your patients. Develop a practice protocol not to use empiric treatment and instead refer to a pediatric gastroenterologist. If a gastroenterologist is not available, then develop a protocol for empiric treatment before referring patients with reflux.	• Educate health care providers about the unnecessary use of acid-suppressant therapy with infants under 1 year of age before referral. • Discuss inappropriate use of acid suppression therapy and PPIs when still in the pediatrician's office.
Gap: The primary healthcare physician (PHP) and other pertinent information is not sent with the referral or obtained by the subspecialist.		
The primary care practice does not have a process to ensure that all pertinent information accompanies the referral.	Create a checklist to add to referral forms that include the following to assure all pertinent information is sent to the subspecialist: ☐ History ☐ Physical examination	

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	☐ Growth charts ☐ Any nonpharmacological lifestyle changes attempted ☐ Dietary, formula (if applicable) changes attempted ☐ Medications, if any ☐ Laboratory results, if any ☐ Imaging results, if any ☐ Summary of case (ie, impression of concern) ☐ Any psychosocial concerns ☐ Contact information for the referring physician ☐ Contact information for the patient/family Contact local gastroenterologists to inquire what information they would like to have sent along with the referral.	
The subspecialty practice does not have a process in place to confirm or obtain all pertinent information from the referring physician.	Contact local physicians that refer to the subspecialty practice and send them a checklist of items that should accompany the referral. At the time of a new patient referral appointment, have front-office staff get the name and contact information for the referring physician so they can be contacted for the medical records. One day prior to patient referral appointments, have office staff confirm all information has been received.	
Patients/caregivers make appointments without referral or copies of medical information.	Create a process for front office staff to confirm the following when making appointments for GERD evaluation: ✓ Ask if the patient is being referred by a physician: • If referred by a physician, get the name and contact information of the referring physician. Call the referring physician to make sure the information from the above checklist will accompany the referral. • If not referred by a physician, get the patient's primary care physician's information and a signed request for medical records.	