Potential Barriers and Suggested Ideas for Change

Key Activity: Assess Social Health and Well-being

Rationale: Research shows positive childhood experiences through safe, stable, and nurturing relationships (SSNRs) are essential vital signs of early childhood health. SSNRs are biological necessities with the power to mitigate lifelong health impacts of childhood adversity and toxic stress. A new pediatric framework called early relational health puts child-family relationships first when assessing patient and family health and well-being. It includes assessment, discussion, and support to address needs related to family strengths and protective factors and unmet psychosocial needs of the patient and family.

Pediatric practices can maximize opportunities to build SSNRs and support patient and family health and well-being by engaging in family-centered discussion to assess strengths and protective factors and unmet social needs using the following approach:

- Elicit/discuss the interests and concerns of the family.
- Assess/discuss family strengths.
- Screen for perinatal depression of caregiver using a validated tool.
- Assess/discuss the social drivers of health (SDOH) that emerge from the family's and community's circumstances, and which affect health in positive and negative ways.
- Screen for social-emotional developmental using a validated tool.
- Acknowledge and validate family responses.

The next key clinical activity (KCA) focuses on the collaborative partnership with the family to address the above items identified during the visit.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Practice preparation not complete (pertains to all measures in this KCA)		
The practice setting requires capacity building to better understand the importance of early relational health and to prepare to increase rates of early childhood screening, counseling, referral, and follow-up for, perinatal depression, SDOH, and social-emotional development.	• Create a team, identify a champion, obtain leadership, and practice-wide buy-in concerning social health and early childhood well-being practice improvements. ✔ Ensure staff resources are allocated to quality improvement efforts. ✔ Establish regular team meetings to plan small tests of change, review chart data, and use Plan, Do, Study, Act (PDSA) cycles for improvement. ✔ Build relationships with community partners. ✔ Recruit and engage a family advisor. Develop clear expectations and responsibilities for family advisor contributions (eg, job description, task list, establish meeting expectations, discuss compensation). ✔ Implement a process to communicate project updates to entire practice, including senior leadership.	• Review resources on early relational health and share with staff: ✔ ASHEW videos: Early Relational Health Part 1 and Part 2 ✔ AAP technical report, The Lifelong Effects of Early Childhood Adversity and Toxic Stress ✔ The webinar, Promoting Relational Health: Implementing a Public Health

	• Use the following materials to guide your implementation efforts and share with staff, ensuring all are trained in their use: ✔ Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health ✔ The Impact of Racism on Child and Adolescent Health ✔ AAP 2019 Mental Health Competencies for Pediatric Practice ✔ *Bright Futures Guidelines*, 4th Edition, core materials including the health promotion theme of Promoting Family Support • Use the Getting Started: Implementing a Screening Process worksheet available in Word or pdf format to plan your practice's process for early childhood screening and assessment. • Use knowledge from the Bright Futures implementation tip sheet, *Tips to Link Your Practice to Community Resources* to build relationships with community partners. • Recognize What Families Say Matters in a Social-Emotional Health System. • Review strength-based-approach materials and make changes to visit processes to promote a strength-based approach to healthcare. Refine ideas through PDSA cycles and incorporate the best changes into your practice's processes. • Use knowledge from the following to create positive visit experiences for families and ensure your practice is a welcoming, stigma-free, culturally inclusive environment: ✔ AAP 2019 The Impact of Racism on Child and Adolescent Health policy statement ✔ Presentation: Fostering a Welcoming Office Environment • Review previsit planning processes. Consider assigning 1 staff member as the complex care coordinator to schedule, identify needs, and prepare for the visit. When available, integrate behavioral health, social worker, and/or family navigator to manage this work and allow the health care team to perform other tasks.	Approach in Primary Care, led by Andrew Garner, MD, PhD, FAAP (Scroll down for link.) • Review resources on family advisor engagement and share with staff: ✔ AMA Johns Hopkins Family Advisor Recruitment ✔ The Value of Family Advisors as Coleaders in Pediatric Quality Improvement Efforts: A Qualitative Theme Analysis ✔ Family Engagement in Systems Assessment Toolkit • Review resources on family strengths concepts and share with staff: ✔ HOPE: Healthy Outcomes from Positive Experiences resource library ✔ Brain architecture resources from the Harvard University Center on Developing Child • Work with the social health and wellness team to test, implement, and refine ideas to improve team communication and processes related to

	• Establish regular huddles as a part of complex care management, allowing care teams to work and problem solve together to improve care. Provide training/education support as needed.	early relational health through PDSA cycles.
Social needs documentation requires further improvement to standardize and/or meet patients' needs.	• Review documentation practices and develop clear protocols for documenting patient charts with all family discussions and care coordination. Standardize processes and documentation of the screening and assessment outcomes, counseling, referrals, visit plan, follow-up, etc. Consider these strategies: ✔ Make check boxes on patient charts for age-appropriate screenings and risk assessments. ✔ Customize the EHR to include prompts. ✔ Post documentation reminders in prominent places. ✔ Utilize Z codes for identified needs/secondary diagnoses when social driver assessments show risks. • Use knowledge from the ASHEW resource, Documenting Early Relational Health in Patient Charts for documentation tips.	• Discuss documentation issues in a staff meeting and brainstorm ways to improve. Work with the social health and wellness team to test, implement, and refine ideas to improve documentation through PDSA cycles.
Gap: Family interests/concerns are not elicited/addressed.		
The practice setting requires further improvement to create and standardize processes to elicit, document, and discuss family interests and concerns.	Consider ways to elicit family interests and concerns: **Develop custom scripts/prompts.** • Use family-centered communication and evidence-based approaches during discussions and interventions. • Ask about interests and concerns on the phone when the visit is scheduled and note them in the medical record. • Encourage families to learn about what to expect from milestone visits and typical child development for the age. Share resources such as the following (available in English and Spanish): ✔ Milestones Matter: 10 to Watch for by Age 5 ✔ *Bright Futures* tip sheet, *The Well-Child Visit: Why Go and What to Expect* ✔ CDC: Learn the Signs Act Early family resources	• Make the Bright Futures family tip sheet, *The Well-Child Visit: Why Go and What to Expect,* available to families. Consider displaying it in the waiting room, in exam rooms, or on the practice portal. • Review the practice's documentation practices to ensure that all family discussions are

	• Engage in family-centered discussion at the start of each visit. Specifically ask about the family's interests and concerns. ✔ Acknowledge and validate them. ✔ Review topics from previous visits to discuss progress or worsening conditions, ensuring all interests and concerns are addressed over time. ✔ Inquire about new interests and concerns during the visit by asking, *What would you like to talk about today? What interests or concerns you about your child or family's living situation?* **Standardize EHR documentation and workflow.** • Customize EHR prompts to ask about family interests and concerns. Include space to enter the information. Develop ways to learn from families about their experience of care (eg, face-to-face inquiries, focus group discussions, use of a family survey tool) to improve patient/family satisfaction and/or quality of care. • Ask at the end of the patient visit, *What questions do you have?* • Determine with your team where to document the discussion in the patient's chart (eg, social or family history). • Address identified needs, interests, or concerns through a primary care intervention when possible by providing support and monitoring. This includes discussion and education, developing the visit assessment and plan that includes shared decision-making regarding next steps, coordinating care with clinical and community partnerships, monitoring progress, and following through on referrals, if indicated. (See the next KCA, Address Identified Needs for more information on this topic.)	documented in the medical record. Consider the suggestions in row 2 of this grid to improve documentation habits.
Gap: Family strengths are not assessed/discussed.		
The practice setting requires further improvement to create and standardize processes, document, and discuss family strengths.	• Share key points with staff about the benefits of a strength-based approach to support healthy child development and lifelong health :	• Apply knowledge from resources to strengthen your practice's strength-based

	✔ Early relational health, family-centered care, and strength-based approaches support families by building on their strengths to buffer against adversity from SDOH. ✔ The necessity of a change in thinking from disease to assets and strengths, on what the patient/family does well, and how to help them do even better. • Review resources such as the ones below to create a custom script and EHR prompt to test using new approaches: ✔ American Academy of Pediatrics (AAP) Identifying Risks, Strengths, and Protective Factors ✔ AAP and Zero To Three Early Brain Child Development: The First 1,000 Days ✔ New Mexico Three Questions ✔ Center for the Study of Social Policy (CSSP) Strengthening Families Action Sheets ✔ Healthy Outcomes and Positive Experiences (HOPE) 4 Building Blocks of HOPE • Gather educational materials, community resources and referral information relevant to your patient population and have the materials readily available to discuss during the visit. • Document the discussion in the patient's chart, perhaps in the history with updates of family psychosocial history, SDOH. See the ASHEW resource, Documenting Early Relational Health in Patient Charts, for tips on documenting family strengths and risks in patient charts. • Address identified needs, interests, or concerns through a primary care intervention when possible by providing support and monitoring. This includes discussion and education, developing the visit assessment and plan that includes shared decision-making regarding next steps, coordinating care with clinical and community partnerships, monitoring progress, and following through on referrals, if indicated. (See the next KCA, Address Identified Needs for more information on this topic.)	approach and share with staff: ✔ Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample ✔ Fostering Resilience, The 7 Cs: The Essential Building Blocks of Resilience ✔ *Bright Futures* Eliciting Parent Strengths Tip Sheet ✔ Motivational interviewing ✔ Shared Decision Making ✔ Common Factors Approach (HEL^{2}P^3) ✔ Video using a strength-based approach in 9-month and 2-year visit • Review the practice's documentation practices to ensure all family discussions are documented in the medical record. Consider the suggestions in row 2 of this grid to improve documentation habits.

Gap: Perinatal depression screening is not completed using a validated tool at recommended well child visits.		
Pediatricians and their healthcare teams require capacity building to implement a perinatal depression screening process.	• Use knowledge that perinatal depression includes the spectrum of depressive and anxiety symptoms occurring during pregnancy and for mothers and other caregivers after childbirth for quality improvement purposes. • Follow AAP recommendations for perinatal depression screening: ✔ *Bright Futures Guidelines*, 4th Edition, recommends perinatal depressions screening at the 1- , 2- , 4- , and 6-month visits. ✔ AAP policy *Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice* • View the CME webinar, The Why and How of Perinatal Depression Screening on the Clinical Education Opportunities on Social Determinants of Health webpage, an AAP STAR Center resource. • View and use with all staff the AAP Perinatal Depression Curriculum, free to anyone. Click here to access the curriculum. Once a user account is created and you are logged in, click on the Training, Learning, and Resource page, then Training Curricula. • Use the Community Care of North Carolina Maternal Depression Tools to prepare to identify perinatal depression at well child checks between the 1st and 6th months of the child's life. • Utilize physician training resources, practice tools, and resources to promote healthy mental development available from the AAP Mental Health Initiatives. • Develop relationships with community mental health providers and other support systems to assist your efforts and to provide appropriate linkages to the caregiver. • Develop relationships with community providers of dyadic therapies (eg, Child-Parent Psychotherapy [CPP], Attachment and Biobehavioral Catch-up [ABC], and Circle of Security).	✔ Visit the Mental Health Initiatives: Primary Care Tools webpage for information and guidance on how pediatric healthcare professionals can support the healthy mental development of patients/families. ✔ Use information from the Bright Futures implementation tip sheet, *Tips to Link Your Practice to Community Resources*. ✔ Attend ASHEW RoundTable to connect with peers and experts to learn and share with each other. ✔ Participate in related continuing medical education courses such as the following: ✔ Screeningtime.org ✔ Postpartum Support International ✔ Circles of Security
The practice setting requires further improvement to	• Review the following validated perinatal depression screening tools and select one to test/implement:	✔ Consult with other practices in your area about which screening

implement a standardized perinatal depression screening tool at all recommended visits.	✔ Edinburgh Postnatal Depression Scale (EPDS) (NOTE: Contact the Royal College of Psychiatrists at permissions@rcpsych.ac.uk to request permission to use; Rights and Permissions Manager: Lucy Alexander.) ✔ Patient Health Questionnaire (2-item) (PHQ-2) ✔ Patient Health Questionnaire (9-item) (PHQ-9) ✔ The Survey of Well-being of Young Children (SWYC) includes the Edinburgh Postnatal Depression Scale in the 2- , 4- , and 6-month visits and the PHQ-2 in the other visit forms. • See the STAR Center Screening Tool Finder for more information about each tool.	tool might work best for your patient population.
***Gap:* Perinatal depression screening results are not discussed.**		
The practice setting requires further improvement to standardize perinatal depression screening, documentation, and discussion of results into the office workflow.	• Determine when and how the screen fits the practice's workflow. Here are some considerations: ✔ Mail the screening tool before the visit or use patient portal. ✔ Train front office or nursing staff to introduce and provide the screen before the visit (in the waiting room or the examination room). ✔ Document the results in the patient's chart. Standardize where results and discussion of results are documented (perhaps in the history with updates of family psychosocial history, SDOH). ✔ Assure that the provider can review the screening results prior to entering the exam room. ✔ Prepare to handle acute/urgent results (maternal suicidality or psychosis). For information how to manage high-risk situations and referrals, see the AAP 2019 Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice policy statement and technical report. ✔ Prepare to discuss all screening results with the caregiver and consider how you will: – Acknowledge and validate family experiences. – Promote the strength of the mother-infant relationship. – Encourage and reassure breastfeeding (may be protective). – Encourage understanding of and responding to the infant's cues.	• Seek staff and caregiver feedback on the screening and discussion process and refine using PDSA cycles. • Review the practice's documentation practices to ensure that all family discussions are documented in the medical record. Consider the suggestions in row 2 of this grid to improve documentation habits. • Apply information from AAP CURES ACT Quick Talks to your practice:

	– Encourage routines for predictability, sleep, diet, exercise, and stress relief. – Promote realistic expectations and prioritize needs when planning together. – Encourage social connections. ● Prepare to offer parents/caregivers in **low-risk situations** office-based interventions. Components of office-based interventions can include such things as: ✔ Explanation and open dialogue to help reduce stigma, normalize the stress faced by new families, and ultimately, foster early identification of those who may need additional resources ("demystification") ✔ Communication about the potential impact on the infant and need for infant screenings and surveillance ✔ Initial and ongoing support, which includes providing validation and empathy for the mother's experiences and identifying community resources to promote family wellness ✔ Reinforcement, when necessary, through referrals to evidence-based treatment programs (eg, to a mental health provider or lactation support) ● Address identified needs, interests, or concerns through a primary care intervention when possible by providing support and monitoring. This includes discussion and education, developing a visit assessment and plan that includes shared decision-making regarding next steps, coordinating care with clinical and community partnerships, monitoring progress, and following through on referrals, if indicated. (See the next KCA, Address Identified Needs for more information on this topic.)	✔ Managing Maternal Health Information ✔ Preventing Harm Exception
The practice setting requires further improvement to receive payment for perinatal depression screening,	● Use information from the STAR Center CME webinar, The Why and How of Perinatal Depression Screening, includes a section on billing and coding. (Scroll down for link to webinar.) ● View the ASHEW RoundTable recording on perinatal depression coding and billing. (Access Passcode is **v+869!Dw**.)	✔ Review the CMS guidance that outlines how and why states should include perinatal depression screening.

discussion, referral, and follow-up.	• Use CPT code 96161 for perinatal depression screening (eg, caregiver-focused health risk assessment). ✔ If a social-emotional screen of patient is performed as a follow-up, use code 96127. ✔ If there are concerns about the dyad relationship, the code Z62.820, Relationship Specific Disorder or Infancy/Early Childhood, (published in the DC: 0-5 - Diagnostic Classification for 0- to 5-year-olds, 2016) can be used as secondary to the well-visit code. ✔ If attachment problems meet the DC:0-5 criteria for Reactive Attachment Disorder, use code F94.2. ✔ Use updated time-based coding for complex needs visits, see: 2021 Office-based E/M changes affect time-based reporting, prolonged services.	✔ See the *Coding for Pediatric Preventive Care* booklet for more reimbursement information. ✔ Contact screening@aap.org for additional technical assistance.
Gap: Practice-standardized social drivers of health are not assessed/results discussed at every visit.		
Pediatricians and their healthcare teams need additional knowledge to implement risk assessments for SDOH.	• Use knowledge that SDOH (protective and risk factors) influence health outcomes for quality improvement purposes. • Follow *Bright Futures* Guidelines and the following AAP policy recommendations to prepare to assess and discuss SDOH and related adversity at every visit: ✔ AAP 2021 Preventing Childhood Toxic Stress: Partnering with Families and Communities to Promote Relational Health policy statement ✔ AAP 2019 Impact of Racism on Child and Adolescent Health policy statement ✔ AAP 2021 Trauma-Informed Care clinical report	• Discuss the connection between social drivers of health and health outcomes in a staff meeting. Get agreement on a protocol to use to assess social drivers and discuss results with families. Refine and adjust the protocol using PDSA cycles.
e practice setting requires further improvement to standardize questions to assess SDOH.	• Review available SDOH assessments and select one to test/implement from the STAR Center Screening Tool Finder (eg, Health Leads, SEEK).	• Use STAR Center materials to communicate with families about why

	• Use information from the STAR Center presentation, The Why and How of Asking SDOH Questions, to learn about possible assessment questions and tools . • Identify common SDOH within your patient population and choose risk assessment questions that fit your patient population. Since no validated SDOH tool exists, only validated questions, it is appropriate to ask practice-standardized questions rather than use a tool for risk assessment if that fits your patients and practice needs. Also consider a standardized, respectful, culturally appropriate message about the reason for the screening.	screening is important: ✔ STAR Center Communicating with Families Screening Resources ✔ Video, Screening Matters: A Family Perspective
e practice setting has not incorporated SDOH risk assessment, documentation, and discussion of results into the office workflow.	• Determine how the SDOH risk assessment fits the practice's workflow using the Getting Started: Implementing a Screening Process worksheet available in Word or pdf format. Here are some additional considerations: ✔ Administer the assessment previsit via a patient portal or mail. ✔ Train front office or nursing staff to introduce and provide the screen before the visit (in the waiting room or the examination room). ✔ Document the results in the patient's chart. Standardize where results and discussion of results are documented (perhaps in the history with updates of family psychosocial history, SDOH). ✔ Assure that the provider can review the results prior to entering exam room. • Engage families in conversations about the SDOH assessment and results using family-centered communication techniques that invite discussion and evidence-based practice approaches to acknowledge and validate experiences during interventions. (Click for examples.) As you discuss results with the caregiver, consider how you will: ✔ Promote the SSNR strengths of patient and caregiver, family, and community relationships. ✔ Encourage family routines for sleep, eating, physical activity, and relaxation.	• Practice role -playing conversations with patients tailored to assessing risks of SDOH, using resources such as the following: ✔ STAR Center Simulations (login to receive MOC Part 2/CME) ✔ ASHEW role-play tool and slides ✔ Pediatric CARE Podcast: Family-centered counseling techniques ✔ Pediatric CARE Podcast: Protective Factors and Positive Childhood Experiences • Review the documentation practices to ensure that all family discussions are documented in the

	✔ Promote realistic expectations and prioritize needs when planning together. ✔ Encourage social connections. • Address identified needs, interests, or concerns through a primary care intervention when possible by providing support and monitoring. This includes discussion and education, developing a visit assessment and plan that includes shared decision-making regarding next steps, coordinating care with clinical and community partnerships, monitoring progress, and following through on referrals, if indicated. (See the next KCA, Address Identified Needs for more information on this topic.)	medical record. Consider the suggestions in row 2 of this grid to improve documentation habits. • Apply information from AAP CURES ACT Quick Talks to your practice: ✔ What is information blocking and why is it restricted? ✔ Proactive sharing/anticipatory guidance for results ✔ Empowering patients through written notes ✔ Best practices for patient-centered notes
The practice requires further improvement to receive payment for risk assessment of SDOH, discussion, referral, and follow-up.	• Use CPT code 96160 for health risk screening. If using a screen that includes a caregiver assessment, also use 96161. • See the list of common early childhood SDOH Z codes. • Use updated time-based coding for complex needs visits, see: 2021 Office-based E/M changes affect time-based reporting, prolonged services.	• See the *Coding for Pediatric Preventive Care* booklet for more payment information. • Contact screening@aap.org for additional technical assistance.
Gap: Age-appropriate social-emotional development screening using a validated tool is not completed at every visit.		

Pediatricians and their health care teams require capacity building to implement age-appropriate social-emotional development screening in the practice.	• Use knowledge such as the following for quality improvement purposes: ✔ Social-emotional child development such as communication, autonomy, affect, and interaction with people is critical to the child's healthy development and future success. ✔ The earlier a development risk is recognized and an intervention begins, the better the child's chance of substantial improvement. ✔ Risk surveillance and screening do not establish a diagnosis but can help determine appropriate frequency for monitoring, counseling, and interventions. • Review the ASHEW webinar led by Mary Margaret Gleason on Social-Emotional Screening, which describes the protective and risk factors that influence social-emotional health; demonstrates how to engage caregivers in screening conversations; and explains how to implement screening, intervention, referral, and follow-up processes in pediatric practices. • Follow *Bright Futures* Guidelines and the following materials to prepare to conduct age-appropriate social-emotional development screenings using validated tools at recommended visits: ✔ AAP policy statement, Promoting Optimal Development: Screening for Behavioral and Emotional Problems ✔ *Bright Futures Guidelines*: Promoting Healthy Development chapter	• Review related training, resources, and literature: ✔ PediaLink curriculum, Milestones Matter: Don't Underestimate Developmental Surveillance ✔ Review the resources on the AAP Developmental Surveillance and Screening webpages. ✔ Article by Douglas Russell and Mary Margaret Gleason, Starting Early: Promoting Emotional and Behavioral Well-Being in Infant and Toddler Well-Child Care
The practice setting needs further improvement to standardize age-appropriate social-emotional development screening tools at every visit.	• Select validated screening tools to test/implement via the AAP STAR Center Screening Tool Finder ✔ Survey of Well-being of Young Children (SWYC) age-specific forms for every age on the Periodicity schedule ✔ Ages and Stages Questionnaire: Social-emotional, Second Edition (ASQ:SE-2) ✔ Brief Infant Toddler Social-Emotional Assessment (BITSEA) ✔ Early Childhood Comprehensive Assessment (ECSA) • Use information from Mary Margaret Gleason's article on screening, Recognizing Young Children in Need of Mental Health Assessment:	• Consult with other practices in your area about which screening tools might work best for your patient population.

	Development and Preliminary Validity of the Early Childhood Screening Assessment	
Gap: Social-emotional development screening results are not discussed.		
The practice setting needs further improvement to establish an office workflow for screening, documenting, and discussing results.	• Determine how the social-emotional development screening fits the practice's workflow using the Getting Started: Implementing a Screening Process worksheet available in Word or pdf format. Here are some additional considerations: ✔ Mail the screening tool before the visit or use a patient portal. ✔ Train front office or nursing staff to introduce and provide the screen before the visit (in the waiting room or the examination room). ✔ Document the results in the patient's chart. Standardize where results and discussion of results are documented (perhaps in the history with updates of family psychosocial history, SDOH). ✔ Ensure that the provider can review the results prior to entering exam room. • Engage families in conversations about social-emotional development screenings and results using family-centered communication techniques that invite discussion and evidence-based practice approaches to acknowledge and validate experiences during interventions. (Click for examples.) As you discuss results, consider how you will: ✔ Promote the SSNR strengths of patient and caregiver, family, and community relationships. ✔ Encourage routines for predictability, sleep, diet, exercise, and stress relief. ✔ Encourage social connections. ✔ Promote realistic expectations and prioritize needs when planning together. • Address identified needs, interests, or concerns through a primary care intervention when possible by providing support and	• Review the practice's documentation practices to ensure that all family discussions are documented in the medical record. Consider the suggestions in row 2 of this grid to improve documentation habits. • Apply information from AAP CURES ACT Quick Talks to your practice: ✔ What is information blocking and why is it restricted? ✔ Proactive sharing/anticipatory guidance for results ✔ Empowering patients through written notes ✔ Best practices for patient-centered notes

	monitoring. This includes discussion and education, developing a visit assessment and plan that includes shared decision-making regarding next steps, coordinating care with clinical and community partnerships, monitoring progress, and following through on referrals, if indicated. (See the next KCA, Address Identified Needs, for more information on this topic.)	
The practice setting requires further improvement to receive payment for social-emotional development screening, discussion, referral, and follow-up.	• Use CPT code 96127 for health risk screening. • Utilize Z codes for Infant and Early Childhood Mental Health (IECMH). • Utilize the DC:0-5 for appropriate criteria and coding for IECMH. ✔ If there are concerns about the dyad relationship, the code Z62.820, Relationship Specific Disorder or Infancy/Early Childhood, (published in the DC: 0-5 - Diagnostic Classification for 0- to 5-year-olds, 2016) can be used as secondary to the well-visit code. ✔ If there are attachment concerns that meet the DC:0-5 criteria for Reactive Attachment Disorder, use code F94.2. ✔ Use updated time-based coding for complex needs visits, see: 2021 Office-based E/M changes affect time-based reporting, prolonged services	• See the *Coding for Pediatric Preventive Care* booklet for reimbursement information. • Contact screening@aap.org for additional technical assistance.

Appendix

Family

It is important for pediatric offices to expand their definition of family in order to attend to the whole child and honor their family experiences.

The Family: A Description

We all come from families.

Families are big, small, extended, nuclear, multi-generational, with one parent, two parents, and grandparents.

We live under one roof or many.

A family can be as temporary as a few weeks, as permanent as forever.

We become part of a family by birth, adoption, marriage, or from a desire for mutual support.

As family members, we nurture, protect, and influence each other.

Families are dynamic and are cultures unto themselves, with different values and unique ways of realizing dreams.

Together, our families become the source of our rich cultural heritage and spiritual diversity.

Each family has strengths and qualities that flow from individual members and from the family as a unit.

Our families create neighborhoods, communities, states, and nations.

Developed and adopted by the Young Children's Continuum of the New Mexico State Legislature
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Family Advisor

Parents and other family members have experiences, perspectives, and expertise to offer, teach, and share. They can pose questions, provide feedback, suggest ideas, or propose solutions.

Why might a practice engage a family advisor? Pediatricians often talk with their patients about social drivers of health, infant and child mental health, and other complex and chronic healthcare needs. These conversations can be sensitive and raise questions around confidentiality, community referral services, health equity, and more. Family advisors can help practices address the best way these questions can be posed to families and develop solutions together. Their experiences and expertise make them the perfect partners to bridge the gap between community and clinical services. Family advisors should be compensated for their time, expertise, and contributions to practice improvements.

Value of Engaging Family Advisors for Practices and Patients
The relationship between families and their pediatrician is critical. These relationships can make a lifelong difference in child and family health. Meaningful patient and family engagement can help:

- Patients and families feel heard, understood, and respected.
- Improve patient outcomes and lower healthcare costs.
- Strengthen the family's relationship with the clinical team and further embed the patient in the medical home.
- Promotes family engagement and partnership for improved patient outcomes.
- Show that the practice cares for the whole family and values their lived experiences.

Family Advisors can support practices to:

- Examine, reach, and maintain practice's mission, vision, and value statements.
- Be culturally responsive to the needs of the children and families served.
- Support families to address concerns related to child health.
- Address the unique needs of children with complex care needs and their families.
- Improve and bridge communication between parents and providers.
- Help identify and remove barriers to service.
- Serve as a connection between families and clinical and community providers.
- Identify practice changes that improve patient facing policies and procedures.

Early Relational Health

Research shows positive childhood experiences through safe, stable, and nurturing relationships (SSNRs) are essential vital signs of early childhood health. SSNRs are biological necessities with the power to mitigate lifelong health impacts of childhood adversity and toxic stress.

A new pediatric framework called early relational health puts child-family relationships first when assessing patient and family health and well-being. Early relational health addresses the complex interpersonal interactions between young children and their parents, family, and caregivers that can have positive impact on the child's healthy development and well-being. It includes assessment, discussion, and support to address needs related to family strengths and protective factors, and unmet psychosocial needs of the patient and family.

SSNRs

Safe, stable, and nurturing relationships (SSNRs) are essential vital signs of early childhood health. SSNRs are biological necessities with the power to mitigate lifelong health impacts of childhood adversity and toxic stress.

Family Strengths

Engage families with an intentional, productive, and constructive approach in the context of their support systems, programs, and communities. Recognize, utilize, and enhance families' strengths and promote positive outcomes by providing opportunities, fostering positive relationships, and providing support to build families' unique strengths and protective factors.

It is important to recognize the many types of family strengths, including: adaptability, cohesion, humor, willingness to try, and networks of support. Strengths can be found in all areas of family life, including family interests and activities; extended family and friends; religious, spiritual, or cultural beliefs; family values and rules; employment and education; emotional or psychological well-being; physical health and nutrition; shelter and safety; income or money; and family interaction.

Protective Factors

The following factors are from Strengthening Families™ Protective Factors Framework:

- **Parental resilience**: Managing stress and functioning well when faced with challenges, adversity, and trauma
- **Social connections**: Positive relationships that provide emotional, informational, instrumental, and spiritual support
- **Knowledge of parenting and child development**: Understanding child development and parenting strategies that support physical, cognitive, language, and social and emotional development
- **Concrete support in times of need**: Access to concrete support and services that address a family's needs and help minimize stress caused by challenges
- **Social and emotional competence of children**: Family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships

See Protective Factors Framework from the Center for the Study of Social Policy and HOPE: Healthy Outcomes from Positive Experiences. Pediatricians often combine this topic with early literacy promotion when discussing with families and offer books that foster family strengths.

Strength-based Approach

The strength-based approach uses an asset-based language. Empowered caregivers are experts on their family and paretners in their child's healthy development. Family strengths buffer against adversity, build resilience, and improve lifelong health. They should be discussed and commended at every visit. Strengths include positive relationships and routines that foster healthy sleeping, eating, physical, development, mental health, and cultural pride.

See Identifying Risks, Strengths, and Protective Factors for Children and Families: A Resource for Clinicians Conducting Developmental Surveillance and AAP and CSSP Promoting Children's Health and Resiliency: A Strenghtening Families Approach.

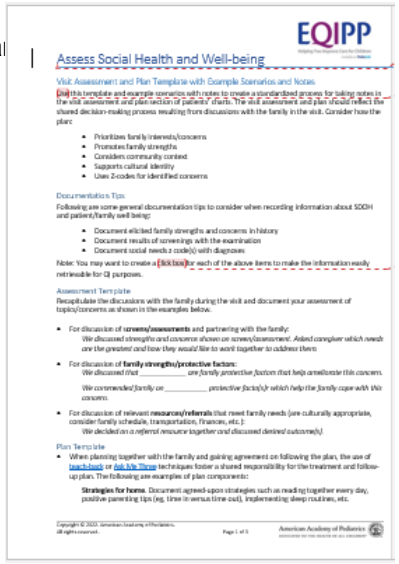
Practice-standardized

A consistent set of questions and processes selected by the practice that aligns with the needs of the patient population.

Visit Assessment and Plan

To be effective, the visit assessment and plan should include all discussions that took place during the visit and represent a shar developed in partnership with the family. The visit assessment and plan should:

- Prioritize family interests/concerns.
- Consider family strengths/protective factors.
- Validate concerns.
- Partner with the family to find resources/referrals that meet the family's needs (be culturally appropriate, meet the family's schedule, consider transportation, etc).
- Use Z-codes for identified concerns.


EQIPP

Assess Social Health and Well-being

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Following are some general documentation tips to consider when recording information about SDOH and patient/family well-being:

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Note: You may want to create a checkbox for each of the above items to make the information easily retrievable for QI purposes.

Assessment Template

Recapitulate the discussions with the family during the visit and document your assessment of topics/concerns as shown in the examples below.

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  We discussed strengths and concerns shown on screen/assessment. Asked caregiver which needs are the greatest and how they would like to work together to address them.
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  We discussed that _____ are family protective factors that help ameliorate this concern.
  We commended family on _____ protective factor(s) which help the family cope with this concern.
- For discussion of relevant **resources/referrals** that meet family needs (are culturally appropriate, consider family schedule, transportation, finances, etc.):
  We decided on a referral resource together and discussed desired outcome(s).

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- When planning together with the family and gaining agreement on following the plan, the use of teach-back or Ask Me Three techniques foster a shared responsibility for the treatment and follow-up plan. The following are examples of plan components:

  Strategies for home. Document agreed-upon strategies such as reading together every day, positive parenting tips (eg, time in versus time-out), implementing sleep routines, etc.

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Z codes

Use Z codes for identified needs/secondary diagnoses when social driver assessments show risks. Such identification can be used for billing, referral, and tracking purposes. See the list of common early childhood SDOH Z codes.

Potential Barriers and Suggested Ideas for Change

Key Activity: Address Identified Needs

Rationale: Identified needs/interests/concerns related to the social health and well-being of the child and family require addressment. This can be accomplished through counseling and conversations with the family, developing a shared plan with the family regarding next steps, referrals to clinical and community partnerships as appropriate, and following through on referrals.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Practice preparation not complete (pertains to all measures in this KCA)		
The practice setting requires some capacity building to prepare for addressing family/child social-emotional needs, interests, and concerns identified through family discussions, risk assessments, and screenings. Addressing results includes in partnership and discussion with the family: • The prioritization of interests, concerns, and needs • The development of a plan to meet those interests/concerns/needs • Follow-up with the family	• Use the following materials to guide the practice's preparation efforts and share with staff: • Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health • The Impact of Racism on Child and Adolescent Health • AAP 2019 Mental Health Competencies for Pediatric Practice • Algorithm: Mental Health Care in Pediatric Practice • The *Bright Futures Guidelines*, 4th Edition, core materials including the health promotion theme of Promoting Family Support and age-specific visit priorities. • Use knowledge about the benefits of a strength-based approach to support healthy child development and lifelong health share key points with staff: • That early relational health, family-centered care, and whole child approaches support families by building on their strengths. • A change in thinking from disease to assets and strengths, on what the patient/family does well and how to help them do even better is essential.	• Review resources on family strengths concepts and share with staff: • Positive Experiences • Center on Developing Child • Create a team that includes family advisor(s), identify a champion, obtain leadership and practice-wide buy-in concerning social health and early childhood well-being practice improvements. • Plan, test, refine, and tests of change through Plan, Do, Study, Act (PDSA) cycles. • Review documentation practices to ensure all family discussions, including those concerning supporting informational messages/materials are documented in the chart.

	● Use knowledge from the Identifying Strengths, Risks, and Protective Factors Resource Guide to strengthen protective factors in families and children and share knowledge with staff. ● Use knowledge about family-centered communication techniques and evidence-based approaches that invite discussion and engage families in their healthcare decision making. Share these techniques and approaches with staff. (Click for examples.) ● Apply knowledge from What Families Say Matters in a Social-emotional Health System to your practice setting. ● Begin a simple registry for population management using these resources: ● ASHEW Referral Tracking Tool (EXCEL worksheet) used to identify, flag, and track patients/ families with identified complex needs to ensure referrals are followed up with families. ● ASHEW Complex Needs Planning Worksheet used to plan a complex needs registry, and implement quality improvement (QI) strategies for supporting patients/families. Review resources on family engagement and share with staff. ● Engaging families in the visit: ● Family Perspective Webinar From AAP CA-1 Chapter ● Family Perspective Slides ● Fostering Welcoming Environment ● National Center Medical Home Implementation. Video: Changing Relationships How to Foster Effective Communication With Patients and Families ● Engaging family leaders as advisors to the practice: ● Family Advisor Job Description ● AMA and Johns Hopkins Family Advisor Recruitment Toolkit	

	• Assessing practice strengths and needs for family engagement: • Family Engagement in Systems Assessment Tool (FESAT) Note: must complete a pop-up with your e-mail to access so they can report to their funder who is using the tool. To be used as a discussion and planning guide.	
Gap: An explanation of how to use supporting informational materials (if provided) was not completed.		

The practice may provide supporting informational materials appropriate to the family's interests, concerns, identified needs, or positive screens/assessments, but not discuss them or fail to document such discussions.	ıize the following:
	  • Supporting information materials can include handouts, Web site links, patient portal, pamphlets, etc.
	  • The conversation should include how to use the materials to address the family's interests, concerns, identified needs, or positive screens/assessments.
	  • Some families may experience barriers to health literacy, which may require additional support to improve health outcomes. All families can benefit from the use of plain language and clear communication practices. Consider these tips:
	• Create a safe environment by fostering an atmosphere in which questions are welcomed and cultural preferences are elicited and considered in care planning.
	• Avoid assuming that families understand the medical issue or next steps to address it. Also avoid checking for understanding with a yes/no question, *"Do you understand?"* Families may be embarrassed to admit that they do not. It is better to ask families to put the information in their own words to make sure they understand. Ask them to describe back to you: *What is the problem? What do I need to do? Why is it important?*
		• Consider creating a centralized information area in the waiting area and in exam rooms devoted to social-emotional health educational topics geared for your patient population. Materials should be geared for the language, literacy level, and culture of the patient/family.

	• Create written materials in a patient-friendly manner. Use simple words, short sentences, bullet format, pictures wherever possible, and lots of white space. Avoid medical jargon and unnecessary information. Concentrate on what the patient should do. • Use interpretation services for families that experience language barriers. • Check for understanding using methods such as teach-back or Ask Me Three. • A check-back with the family to determine if the materials are meeting the family's needs or if additional counseling and/or materials are needed is recommended.	
The practice needs additional resources on social needs topics to discuss and support needs with families.	• Gather/develop supporting informational messages and resources on social-emotional topics to discuss and share with families. Materials should be geared for the language, literacy level, and culture of the patient/family. Note that it is not enough to provide handouts, recommend Web sites, or direct families to the patient portal. Supporting informational messages should be communicated to families face-to-face and their understanding assured. For information on **having effective family conversations**, see: • AAP STAR Center Screening Time Course learning module with conversation simulations (login required) • Use knowledge about family-centered communication techniques and evidence-based approaches that invite discussion and engage families in their healthcare decision making. Share these techniques and approaches with staff. (Click for examples.) • AAP Mental Health Motivational Interviewing	mentation is an issue: • Discuss documentation problems in a staff meeting and brainstorm ways to improve them. • Work with the social health and wellness team to test, implement, and refine ideas to improve documentation through Plan, Do, Study, Act (PDSA) cycles.

- Role Play SDOH Conversations(Video coming soon)
- ScreeningtTime.org CME and Simulations Note: must be logged into AAP.org to complete MOC; do not have to be AAP member to create login and receive MOC.
- Family-centered Care Pediatric CARE Podcast
- Pediatric CARE Podcast: Protective Factors and Positive Childhood Experiences
- Common Factors Approach (HEL^{2}P^{3})
- Common Elements Handout
- AAP Interim Guidance on supporting the emotional and behavioral needs of children, adolescents, and families during the COVID-19 pandemic

For information on **family strengths**, see:

- CSSP Strengthening Families
- CSSP Strengthening Families Action Sheets
- AAP Early Brain and Child Development: The First 1,000 Days
- Bright Futures Eliciting Parent Strengths Tip Sheet
- Bright Futures PreSip2/UVM Eliciting Parent Strengths 18 and 24 months
- Family-Centered Approaches Webinar Slides
- Common Factors Approach (HEL^{2}P^{3})
- Eliciting Family Strengths Scripts

perinatal depression, see:

- Maternal Depression Screening Conversation Tip Sheet
- Centers for Disease Control and Prevention
- Resources on STAR Center Web site

- Community Care North Carolina Perinatal Depression Getting Started
- Perinatal depression resources on STAR Center Web site

- **social drivers of health**, see:
  - Unite Us
  - FindHelp.org
  - United Way 211
  - AAP and Food Research & Action Center (FRAC) Screen and Intervene: A Toolkit for Pediatricians to Address Food Insecurity
  - Social drivers of health resources on the STAR Center Web site

- **trauma informed care**, see:
  - Child Trends Trauma Informed Care

- **medical-legal partnership**, see:
  - National Center for Medical Legal Partnership.org
  - Directory of medical-legal partnerships (MLPs) by state
  - Customizable Tool: Screening for MLP legal needs in health care settings

- **child welfare**, see:
  - AAP Healthy Foster Care America
  - AAP Abuse and Neglect
  - National Child Traumatic Stress Network (NCTSN) Child Welfare Trauma Toolkit
  - NCTSN Pediatric Medical Traumatic Stress Toolkit Health Care Providers

	For **social-emotional development**, see: • AAP Interim Guidance on Supporting Emotional and Behavioral Needs of Children, Adolescents, and Families During COVID-19 Pandemic • Tulane Early Childhood Collaborative – Managing Difficult Behaviors • Circle of Security International • Relationships: Circles of Security and Attachment Vitamins • National Child Traumatic Stress Network (NCTSN) general Web site and Attachment and Biobehavioral Catch Up (ABC) and Child-Parent Psychotherapy (Child First) • Tulane Early Childhood Collaborative (LA_TECC) parent resources • Zero To Three For **dyadic therapies** involving treatment delivered to a parent/family and child simultaneously, see: • Parent Child Interaction Therapies • Triple_P Parenting.com and associated parent Web site • Provider locator: Child Parent Psychotherapy For **anti-racism**, see: • From Health Leads.org, webinar series: Moving From Antiracism Intention To Action , Beyond Do No Harm: Elevating BIPOC Voices In SDOH Interventions and Bringing Light & Heat: A Health Equity Guide For Healthcare Transformation And Accountability • Continuum on Becoming an Anti-Racist Organization • AAFP EveryONE Project Toolkit promotes diversity and addresses SDOH to advance health equity in all communities • Raceconscious.org	

	• Embracerace.org	
Gap: Follow-up plans are not established for positive screens/assessments or identified interests/concerns, including a referral if indicated.		
The practice setting does not have systematic processes in place to document and follow up on identified social health interests/concerns or positive screens/assessments. This includes: • Resource/referral follow-up plans documented in a standardized way that enables chart review and data collection/reporting. • Consent to release information to/from referral source. • Routine follow-up with patients and community partners to make sure families have connected to recommended resources, have received the intervention, and the practice has received a report on health outcomes.	• Recognize the importance of developing and sustaining relationships with relevant community partners. See: • Use information from The Social Determinants of Health Academy presentation, Reducing Health Disparities Through Community Partnerships slides 22–33. • Establish relationships with local/state family organizations who work with families for support, information, referral, and help with systems navigation. • Include peer support linkages. Families often benefit from social, emotional, and informational support from other parents/caregivers. Peer support helps families gain confidence, improve health literacy, and reduce the sense of isolation families may feel. • Recognize the value of family advisors to help identify relevant community partners and to assist in your practice's quality improvement efforts. • Develop processes that include a warm hand-off to the referring partner. Warm handoffs can help avoid communication issues and engage families by encouraging them to ask questions and to clarify or correct the information exchanged. Warm hand-offs help build relationships by communicating care and concern. When needed, use a release of information like this example. • Define how to document outcomes of screening/assessments, follow-up plans, and referrals. For best results in your quality improvement interventions, consider how you will be able to collect/retrieve data for these activities so your quality improvement	e information from the following resources to generate discussions in team meetings about how to best identify the patient's risk and document, track, and follow up: • Risk Stratification Tool • CAHMI Risk Stratification Tool • Referral and Tracking Discussion Questions

	efforts can be reported. See the following resources:
	• Getting Started: Implementing a Screening Process worksheet, which can be downloaded in Word or pdf format
	• Identifying and Supporting Families with Complex Needs PowerPoint presentation that includes a worksheet to track positive screens, referrals, and follow-up.
	• ASHEW Complex Needs Planning Worksheet
	• Use Z codes to identify patients. See the following resources:
	  • AAP Z SDOH Codes list
	  • Infant and Early Childhood Mental Health Z Codes
	  • Use an EHR flag or other reminder/recall or system to track positive screens, referrals, and follow-up. Consider using/adapting the ASHEW Referral Tracking Sheet to fit your practice's needs.
	  • Allow adequate staff time and resources to perform necessary documentation and follow-up tasks.
	  • Use time-based billing for patients with complex needs, see 2021 Office-based E/M changes affect time-based reporting, prolonged services.
	  • Make an attempt to follow up on the status of the referral (if indicated) within 30 days to ensure the family is accessing support (ie, phone call to family or referral clinician, community resource, etc).	

The visit assessment and plan* are not comprehensive of all family discussions, identified needs, and next steps		
The practice setting does not have systematic processes in place for developing and documenting the visit	• Use knowledge about family-centered communication techniques and evidence-based approaches that invite discussion about the plan and help develop next steps.	• Develop ways to learn from families about their experience of care (eg, face-to-face inquiries, focus group

assessment and plan with input from the family.	Share these techniques and approaches with staff. (Click for examples.) ● Recognize that the visit assessment and plan should reflect: ● Priorities of the family interests/concerns ● Promotion of family strengths ● Consideration of the community context ● Support of cultural identity ● Inclusion of next steps for positive screenings and assessments ● Use of Z codes for secondary diagnoses/identified concerns ● View an example Visit Assessment and Plan Template With Scenarios	discussions, use of a family survey tool) for purposes of improving patient/family satisfaction and/or quality of care. ● Review shared-decision making practices with staff. ● Consider what suggestions the QI team can make to ensure complete addressment of all family discussions and shared decision making in the visit assessment and plan. Refine ideas through PDSA cycles.
Gap: Referrals to clinical and community partnerships are not established when indicated and/or are not followed through to completion.		
The practice setting requires some capacity building to prepare for referrals for social-emotional development concerns.	● Recognize that physician support and validation are powerful and can have influence in whether the family seeks help and care. Also recall from What Families Say Matters in a Social-emotional Health System that families need services and service providers that are caring, engaging, and personalized. Ongoing physician involvement and support during the referral process are essential. ● Establish relationships with relevant community services to which you can refer patients/families. ● For **perinatal depression**, establish linkages to resources such as obstetric, lactation consultant, mental health specialist for the caregiver, IECMH clinicians who provide dyadic therapy, etc. ● For **social drivers of health** needs, establish linkages to resources such as local food bank,	● Consult with other practices in your area about referral resources for your patient population. ● See the Bright Futures implementation tip sheet, *Tips to Link Your Practice to Community Resources*. ● Review relevant literature and share with staff, including A Road Map to Address the Social Determinants of Health Through Community Collaboration, which includes a road map that links risk assessment to community-based interventions using Maslow's Hierarchy of Needs. ● Consider what checks and balances the QI team can make to ensure complete follow-through on

	Head Start, home visiting, Legal Aid (Medical Legal Partnership), etc. • For **social-emotional development** needs, establishing linkages with IECMH clinicians (including Child First), pediatric subspecialists such as, developmental and behavioral pediatricians, child psychiatrists. In other cases, school and community services such as Head Start (and Early Head Start), home visiting, Part C, early intervention services, physical, occupational or speech therapists, etc. may be needed. • Be prepared with crisis/emergency resources in the area for situations such as when thoughts of self-harm or harm to others develop or when depression symptoms worsen. • Use/adapt the AAP Family Friendly Referral Guide, a customizable handout to give to families whose child has a developmental concern. Practices can customize the handout with information about local referral resources.	referrals. Refine ideas through PDSA cycles.
The practice setting has not incorporated an effective referral process into the office workflow.	• Work with the QI team to plan how your practice will close the referral loop, eg, track referrals, follow-up, and patient outcomes. Consider how to obtain consent for bidirectional communication and how to establish feedback loops with referral partners. Review roles and responsibilities of staff. Standardize documentation processes. • Develop processes that include a warm hand-off to the referring provider. Warm handoffs can help avoid communication issues and engage families by encouraging them to ask questions and to clarify or correct the information exchanged. Warm	• See the Bright Futures implementation tip sheet, *Tips to Link Your Practice to Community Resources*.

	hand-offs help build relationships by communicating care and concern. • Provide families with full contact information, help making the appointment, or securing transportation as needed. Having the practice referral coordinator make the referral appointment together with the family before they leave the clinic is highly recommended. • Arrange a follow-up phone call in a few days to support and encourage follow-through. Having the referral coordinator call the family to remind them of the referral appointment a day or 2 in advance is highly recommended. • Provide resources for community support. • Use a reminder/recall or tickler system to ensure that referral appointments occur in a timely manner. Use/adapt the ASHEW Referral Tracking Sheet to fit your practice's needs.	
Families experience barriers that prevent follow-up on recommended services.	• Attempt to understand the reason the family did not keep the appointment: • Was the plan developed through a shared decision-making process? • Was a warm hand-off provided in which you communicated your care and concern by entrusting the family's needs and care into other, specialized hands? Was the family engaged in the process? • Does the family understand the benefit of the recommended service? • Does the family have other, more pressing needs that need to be addressed first? Some needs (hunger, for example) simply take precedence over others.	• Discuss follow-up compliance problems in a staff meeting and brainstorm ways to improve them. Plan, test, refine and implement ideas for change through Plan, Do, Study, Act (PDSA) cycles.

	• Are there barriers to access to care such as lack of transportation, need for childcare, inability to take time from work, language barriers? • Was an appointment reminder call made/received? Telephone reminders have been proven to improve compliance. • Was a check-back appointment made to the medical home to ensure consistent evaluation of progress? • Are community support services available? Were they recommended?	

Appendix

Family

It is important for pediatric offices to expand their definition of family in order to attend to the whole child and honor their family experiences.

Family Advisor

Parents and other family members have experiences, perspectives, and expertise to offer, teach, and share. They can pose questions, provide feedback, suggest ideas, or propose solutions.

Why might a practice engage a family advisor? Pediatricians often talk with their patients about social drivers of health, infant and child mental health, and other complex and chronic healthcare needs. These conversations can be sensitive and raise questions around confidentiality, community referral services, health equity, and more. Family advisors can help practices address the best way these questions can be posed to families and develop solutions together. Their experiences and expertise make them the perfect partners to bridge the gap between community and clinical services. Family advisors should be compensated for their time, expertise, and contributions to practice improvements.

Value of Engaging Family Advisors for Practices and Patients
The relationship between families and their pediatrician is critical. These relationships can make a lifelong difference in child and family health. Meaningful patient and family engagement can help:

- Patients and families feel heard, understood, and respected.
- Improve patient outcomes and lower healthcare costs.
- Strengthen the family's relationship with the clinical team and further embed the patient in the medical home.
- Promotes family engagement and partnership for improved patient outcomes.
- Show that the practice cares for the whole family and values their lived experiences.

Family Advisors can support practices to:

- Examine, reach, and maintain practice's mission, vision, and value statements.
- Be culturally responsive to the needs of the children and families served.
- Support families to address concerns related to child health.
- Address the unique needs of children with complex care needs and their families.
- Improve and bridge communication between parents and providers.
- Help identify and remove barriers to service.
- Serve as a connection between families and clinical and community providers.
- Identify practice changes that improve patient facing policies and procedures.

Family Strengths

Engage families with an intentional, productive, and constructive approach in the context of their support systems, programs, and communities. Recognize, utilize, and enhance families' strengths and promote positive outcomes by providing opportunities, fostering positive relationships, and providing support to build families' unique strengths and protective factors.

It is important to recognize the many types of family strengths, including: adaptability, cohesion, humor, willingness to try, and networks of support. Strengths can be found in all areas of family life, including family interests and activities; extended family and friends; religious, spiritual, or cultural beliefs; family values and rules; employment and education; emotional or psychological well-being; physical health and nutrition; shelter and safety; income or money; and family interaction.

Protective Factors

The following factors are from Strengthening Families™ Protective Factors Framework:

- **Parental resilience**: Managing stress and functioning well when faced with challenges, adversity, and trauma
- **Social connections**: Positive relationships that provide emotional, informational, instrumental, and spiritual support
- **Knowledge of parenting and child development**: Understanding child development and parenting strategies that support physical, cognitive, language, and social and emotional development
- **Concrete support in times of need**: Access to concrete support and services that address a family's needs and help minimize stress caused by challenges
- **Social and emotional competence of children**: Family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships

See Protective Factors Framework from the Center for the Study of Social Policy and HOPE: Healthy Outcomes from Positive Experiences. Pediatricians often combine this topic with early literacy promotion when discussing with families and offer books that foster family strengths.

Strength-based Approach

The strength-based approach uses an asset-based language. Empowered caregivers are experts on their family and paretners in their child's healthy development. Family strengths buffer against adversity, build resilience, and improve lifelong health. They should be discussed and commended at every visit. Strengths include positive relationships and routines that foster healthy sleeping, eating, physical, development, mental health, and cultural pride.

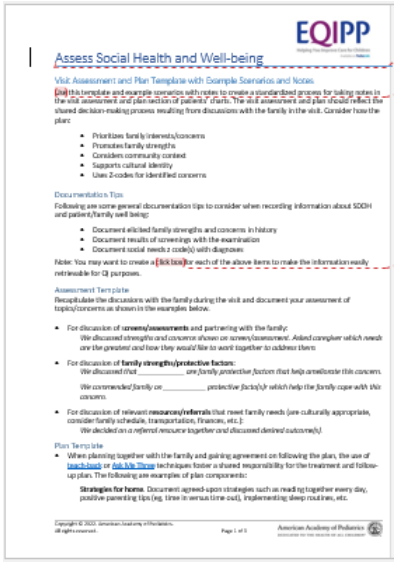
See Identifying Risks, Strengths, and Protective Factors for Children and Families: A Resource for Clinicians Conducting Developmental Surveillance and AAP and CSSP Promoting Children's Health and Resiliency: A Strenghtening Families Approach.

Bright Futures Guidelines, 4th Edition, Core Materials Visit Assessment and Plan

To be effective, the visit assessment and plan should include all discussions that took place during the visit and represent a shared decision-making process developed in partnership with the family. The visit assessment and plan should:

- Prioritize family interests/concerns.

Social Health and Early Childhood Well-being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  We commended family on _____ protective factor/s which help the family cope with this concern.
- For discussion of relevant **resources/referrals** that meet family needs (are culturally appropriate, consider family schedule, transportation, finances, etc.):
  We decided on a referral/resource together and discussed desired outcome/s.

Plan Template

- When planning together with the family and gaining agreement on following the plan, the use of teach-back or Ask Me Three techniques foster a shared responsibility for the treatment and follow-up plan. The following are examples of plan components:

  Strategies for home. Document agreed-upon strategies such as reading together every day, positive parenting tips (eg, time in versus time-out), implementing sleep routines, etc.

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- Consider family strengths/protective factors.
- Validate concerns.
- Partner with the family to find resources/referrals that meet the family's needs (be culturally appropriate, meet the family's schedule, consider transportation, etc).
- Use Z-codes for identified concerns.

▸ View the example **Visit Assessment and Plan Template With Scenarios,** which can be used/adapted to standardize note taking in the visit assessment and plan section of patients' charts.

***Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 4th Edition**

- *Bright Futures Guidelines*, 4th Edition, Pocket Guide
- *Bright Futures Tool and Resource Kit*, 2nd Edition

Bright Futures/AAP *Recommendations for Preventive Pediatric Health Care* (Periodicity Schedule)