Social Health and Early Childhood Well-Being

Practice Survey

EQIPP
Helping You Improve Care for Children
Available on PediaLink

What You Can Learn From the Practice Survey

Important factors such as the people, processes, resources, and culture of your practice will shape your ability to make quality improvement strides in the identification and intervention of social needs of early childhood patients and their families. You may answer the following questions individually or for your practice. Use the results of the survey and the information in this EQIPP course to guide your improvement efforts. Consider taking the survey again after making practice improvements to assess your progress.

Have you/Has your practice:	Yes	No	In Progress
1. Become familiar with the AAP endorsed guidelines, policy statements, technical reports, and recommendations for addressing social health and early childhood wellness, including the following? • Policies to reduce impacts of adversity and foster resilience through therapeutic relationships: ✓ AAP 2021 Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health policy statement ✓ AAP 2021 Trauma-informed Care clinical report • Bright Futures/AAP *Recommendations for Preventive Pediatric Health Care* (Periodicity Schedule) • AAP 2019 Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice policy statement and technical report • Promoting Optimal Development: Screening for Behavioral and Emotional Problems • Policies requisite for providing mental health care and guidance to patients/families: ✓ AAP 2019 Mental Health Competencies for Pediatric Practice policy statement ✓ AAP 2019 Achieving the Pediatric Mental Health Competencies policy • Policies requisite for providing equitable care and guidance to families: ✓ AAP 2019 The Impact of Racism on Child and Adolescent Health policy statement ✓ AAP 2016 Poverty and Child Health in the United States policy statement			
2. Obtained buy-in from leadership in the position of approving practice/organizational changes such as making social health and wellness a priority, allocating dedicated staff time to champion quality improvement efforts, strengthening community partner relationships, approving EHR enhancements, etc?			
3. Obtained buy-in from all practice physicians and staff that includes practice-wide participation in quality improvement efforts? This includes establishing a social health and wellness champion or team to spread awareness and help guide, monitor, and amend processes as a result of quality improvement Plan-Do-Study-Act (PDSA) cycles.			
4. Established a social health and wellness champion or team to lead practice-wide improvements? The champion or team can help guide, monitor, and amend processes through PDSA cycles.			
5. Taken steps to ensure families will have positive office visit experiences by ensuring that your practice is a welcoming, stigma-free, culturally inclusive environment?			
6. Developed a plan to introduce and discuss your practice's privacy policy to families?			
7. Engaged staff in educational activities that support positive social interventions that affect lifelong health and wellness?			

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Have you/Has your practice:	Yes	No	In Progress
• Family-centered counseling – Motivational interviewing, Common Factors, Common Elements, shared decision making, trauma-informed care, strength-based approaches • Equity – history of racism in United States, impacts on health, bias in communication, microaggressions, principles of health equity, cultural humility and safety, cultural pride building			
8. Arranged formal or informal feedback loops with patients and families to learn about their experience of care (eg, face-to-face inquiries, focus group discussions, use of a family survey tool) for purposes of improving patient experience, safety, and quality of care?			
9. Engaged families as formal partners in your practice's quality improvement efforts and system changes (eg, include a family advisor on the QI team)?			
10. Selected validated screening and assessment tools (or created practice-standardized approaches when validated tools are not available) to do the following: ☐ Elicit the interests and concerns of the family. ☐ Assess family strengths. ☐ Screen for perinatal depression of the caregiver. ☐ Assess the social drivers of health that emerge from family and community circumstances, and which affect health in positive and negative ways. ☐ Screen for social-emotional development. Ensured staff are trained in the use of selected tools and know how to interpret results?			
11. Identified social health and wellness informational support messages and materials that address screening/assessment results and family interests and concerns? Messages should consider the language, literacy level, and culture of the patient population.			
12. Hired staff members who speak the language/dialect common to the community and/or utilized language interpreter services?			
13. Developed a process to identify children with complex needs based on psychosocial risk and flag patient charts accordingly? Recognize that social drivers of health may require additional support and services.			
14. Created and maintained an up-to-date community resource list with contact information of sources specializing in the social health concerns of young patients and their families?			
15. Identified how the visit assessment and plan will be documented in the medical record? The plan should support the shared decision-making process and discussions with the family. Consider how the plan: • Prioritizes family interests/concerns • Promotes family strengths • Considers community context • Supports cultural identity • Identifies next steps for needs identified from screenings and assessments • Addresses family confidentiality • Uses Z-codes for identified concerns			
16. Designed an effective referral and follow-up workflow? Consider how the flow: ☐ Has clearly defined staff roles and responsibilities in the referral and follow-up processes. ☐ Includes a warm hand-off from one team member to the next in front of the patient/family. This helps prevent communication breakdown by including the			

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Have you/Has your practice:	Yes	No	In Progress
family in discussions about the clinical needs, current status, and plan of care, and enables the family to correct or clarify information. ☐ Includes a warm referral process from primary care to mental health professionals, community resources, etc. (A warm referral process includes direct contact with the referring team or individual.) ☐ Obtains consent for exchange of information as needed and discusses necessary information exchanges with referring services and the family. ☐ Uses a reminder/recall tracking system and EHR tracking alerts to ensure follow-through occurs on a timely basis. ☐ Includes a checkback with the family within 30 days to ensure families' needs are being met			
17. Determined how to code for visits concerning issues related to social health and early childhood well-being? Coding processes should consider complex psychosocial needs and the use of Z-codes (as secondary diagnosis code) for complex diagnoses.			

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Appendix

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.

PDSA* Cycles: Testing Processes to Assess and Address the Social Health and Well-being of Children and Families in Your Practice

Consider the practice-wide changes recommended to prepare the practice for implementation presented in the Practice Survey.	
PDSA Cycle: Start with a single process and rapidly test a change – by planning it, trying it, observing the results, and acting on what is learned.	
Plan	Plan the small test of change: ✓ Describe the test. ✓ List the tasks necessary to complete the test. ✓ Consider: What is the workflow? Who is involved? What materials (eg, screening tools, brochures) are needed and how will they be accessed? ✓ What do you predict will happen?
Do	Pilot the test of change you have laid out. Collect data. Describe observations.

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Study	What did you learn? Analyze data and observational feedback from from staff. How do your results compare with your prediction? What worked? What did not work? Use the information gathered to help refine and improve your process.
Act	Determine how to proceed with this test of change. Adapt – Improve the change and continue testing. Adopt – Select changes to implement on a larger scale. Abandon – Discard this change and try a different change.
Use successive PDSA cycles to refine and improve your process. The value of the PDSA cycle is the continuous search for improvement. Once a process is working well, standardize improvements and begin to use them regularly. Consider formalizing the process as an office policy/procedure document. Choose a different process or procedure and use PDSA cycles to test and refine as above.	

*PDSA Cycle is part of the Model of Improvement developed by the Institute for Healthcare Improvement. Cambridge, Massachusetts, US.

Common Elements

The common elements approach identifies evidence-based practices (EBPs) for a specific problem area (eg, parent training, disruptive behavior disorders, trauma, depression, anxiety, etc). Click here for a summary of Common Elements of Evidence-based Practice Amenable to Pediatric Primary Care: Indications And Sources.

Common Factors

Common Factors are family-centered techniques that use common skills present in multiple evidence-based interventions, which can be used to validate concerns and connect with families. They can be remembered by the mnemonic HEL^{2}P^3:

Hope
Empathy
L^2 Language, Loyalty
P^3 Permission, Partnership, Plan

See the Common Factors Approach: (HEL^{2}P^3) to Build a Better Alliance.