Potential Barriers and Suggested Ideas for Change

Key Activity: Patient and Family Engagement

Rationale: Effective health supervision visits support healthy child development and foster active partnership in the child's health care that respects patient and family values, culture, and confidentiality. The practice promotes desired social, developmental, mental health, and physical health outcomes of infants, children, and adolescents by engaging patients/families in the following ways:

- Elicit and address the interests and concerns of the patient/family.
- Learn from and build on the strengths of the patient/family.
- Assess and address social determinants (drivers) of health that emerge from the family's and community's circumstances, and which affect health in positive and negative ways.
- Anticipate emerging issues that the patient/family may face and provide guidance and education.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
The practice setting is unfamiliar with the *Bright Futures Guidelines*, 4th Edition materials and/or does not adhere to the Bright Futures/AAP Periodicity Schedule. The practice setting concentrates on preventive care activities and services during well child visits and places less emphasis on patient/family interests/concerns, culture, beliefs, strengths, and social determinants (drivers) of health.	familiar with: • *Bright Futures Guidelines*, 4th Edition core materials and pay particular attention to the health promotion theme of Promoting Family Support. Share the materials with staff and ensure all are trained in their use: • *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) • *Bright Futures Guidelines*, 4th Edition: Priorities and Screening Tables • Policies related to effective family partnerships: ✓ AAP 2012 Patient- and Family-Centered Care and the Pediatrician's Role policy statement policy statement, reaffirmed 2018 ✓ AAP 2021 Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health policy statement ✓ AAP 2021 Trauma-Informed Care clinical report • Policies related to providing mental health care and guidance to patients/families: ✓ AAP 2019 Mental Health Competencies for Pediatric Practice policy statement	• Review and share with staff: ✓ The tip sheet, *Practical Tips for Implementing Bright Futures in Clinical Practice* ✓ The Bright Futures Toolkit Overview demo ✓ The Bright Futures User Guide and Instructions for Toolkit Implementation • Review how to use the BF Toolkit video presentation. Explore the latest Bright Futures approach, tools, resources, and news at: https://brightfutures.aap.org/

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	✓ AAP 2019 Achieving the Pediatric Mental Health Competencies technical report • Policies related to providing equitable and culturally effective care and guidance to patients/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 ✓ AAP 2013 Enhancing Pediatric Workforce Diversity and Providing Culturally Effective Pediatric Care: Implications for Practice, Education, and Policy Making policy statement ✓ AAP 2019 Providing Care for Children in Immigrant Families policy statement ✓ National Center for Medical Home Implementation fact sheet, Strategies to Enhance Care for Hispanic Children, Youth, and Families ✓ National Center for Cultural Competence at Georgetown University, Conscious & Unconscious Biases in Health Care, available at: https://nccc.georgetown.edu/bias/	
The practice setting requires some capacity building to support increasing rates of screening, counseling, referral, and follow-up of recommended services to improve patient safety and care.	• Develop and train a Bright Futures implementation team that includes family advisor member(s) to lead practice-wide improvements concerning Bright Futures implementation. This team can help guide, monitor, and make changes to health supervision visit processes to improve care. • Establish patient- and family-centered care coordination practices that include: ✓ Warm hand-offs in the referral process **from one team member to the next** and from **primary care to specialty care**. This process helps prevent communication breakdown by partnering with the family in what is being discussed about the clinical problem, current status, and plan of care. ✓ Ways to help families navigate effectively across health care entities with clear accountability and responsibility among all parties. ✓ Reminder and recall interventions to ensure that recommended referrals, tests, and follow-up appointments are completed on a timely basis.	• Review resources on family advisor engagement: ✓ ASHEW family advisor resources: Family Advisor Job Description, Family Perspective Webinar from AAP CA-1 Chapter, and Family Perspective Slides ✓ AMA Johns Hopkins Family Advisor Recruitment, available at: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/iho-bp-patient-and-family-advisor-recruitment-guide_0.pdf ✓ The Value of Family Advisors as Coleaders in Pediatric

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
		Quality Improvement Efforts: A Qualitative Theme Analysis, available at: https://pubmed.ncbi.nlm.nih.gov/33457634/ ✓ Family Engagement in Systems Assessment Toolkit
Activities and services recommended by Bright Futures and identified on the current Bright Futures/AAP Periodicity Schedule are provided but not documented.	• Review documentation practices and develop clear practice setting protocols for documenting all preventive care activities/services and follow-up in patient charts. Standardize the way the practice records outcomes of the screening and risk assessment processes, provides education or counseling, referrals, follow-up, and declination of services. ✓ Consider making check boxes on patient charts for age-appropriate screenings and risk assessments. ✓ Customize EHR to include prompts. ✓ Post documentation reminders in prominent places. ✓ Ensure patient and family privacy in all documentation practices. (See resources on the Society for Adolescent Health and Medicine (SAHM) webpage, Confidentiality Resources For Adolescents, Young Adults, and Parents for more information, this is available at: https://www.adolescenthealth.org/Resources/Clinical-Care-Resources/Confidentiality/Confidentiality/Confidentiality-Resources-For-Adolesc.aspx. • Consider using the Bright Futures Visit Documentation Forms to record assessments, discussions, and interventions that are agreed upon by the patient and family.	• Discuss documentation issues in a staff meeting and brainstorm ways to improve them. • Work with the Bright Futures implementation team to test, refine, and implement the best ideas through Plan, Do, Study, Act (PDSA) cycles.
Gap: Patient/family interests and concerns are not elicited and addressed.		
The practice setting is unfamiliar with a strength-based approach and uses more of a risk-based diagnostic approach to health care.	• Become familiar with the *Bright Futures Guidelines,* 4th Edition core materials described in row 1 of this grid. Pay particular attention to the health promotion theme of Promoting Family Support and understanding and promoting patient/family strengths. • Review materials from the Center for the Study of Social Policies and share with staff, including Strengthening Families™: An Overview, About Strengthening Families™ and the Protective Factors Framework and other	• Consider changes to health supervision visit processes to promote a strength-based approach to healthcare. Refine ideas through Plan, Do, Study, Act (PDSA) cycles.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	resources available at: https://cssp.org/our-work/project/strengthening-families/. ● Watch the video on implementing a strength-based approach during Bright Futures health supervision visits and share with staff. ● Review Healthy Outcomes and Positive Experiences (HOPE) 4 Building Blocks of HOPE and other resources to help talk about the positive experiences that support children's growth and development into healthy, resilient adults available at: positiveexperience.org.	
The practice setting does not have a systematic process for eliciting patient/family concerns.	Consider these ways to elicit patient/family interests and concerns: ● Consider ways to ensure that your practice is a welcoming, stigma-free, culturally inclusive environment. ● Address language barriers in your patient population. Determine ways to support families that do not speak English primarily. ● Ask about interests and concerns on the phone when the visit is scheduled and note them in the medical record. ● Use a previsit questionnaire that specifically asks about patient/family interests and concerns such as these in the *Bright Futures Tool Resource Kit*, 2nd Edition, available for review and reference here. Questions centered around the visit priorities are included on the questionnaire. ● Send the previsit questionnaire in advance of the visit. ● Have the patient/family complete the questionnaire in the waiting room before the visit. ● Ask about interests and concerns through face-to-face communication during the visit. Ask, *What would you like to talk about today?* ● Encourage families to visit the Bright Futures Well-Child Visits: Parent and Patient Education webpage to learn about what to expect from each milestone visit and typical child development for that age. ● Customize the EHR to include a prompt to ask about patient/family interests and concerns. Include space to type or write in information. ● Employ communication techniques such as the following: ✓ Those noted on the AAP Communicating with Families webpage, which includes information about using a strength-based approach, employing motivational interviewing techniques, and communicating in plain language. ✓ Common Factors Approach (HEL^{2}P^3)	● Brainstorm ways to elicit patient/family interests and concerns in a staff meeting. Use the Tips to Elicit Patient/Family Interests and Concerns handout created in this EQIPP to springboard discussion. ● Make the Bright Futures family tip sheet, *The Well-Child Visit: Why Go and What to Expect* available to families. Consider displaying in the waiting room, exam rooms, or practice portal. ● 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) for purposes of improving patient/family satisfaction and/or quality of care.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	✓ Strengths and Difficulties Questionnaire (SDQ) ● Use knowledge from the following to improve cultural competence: ✓ AAP 2019 The Impact of Racism on Child and Adolescent Health policy statement ✓ AAP 2019 Providing Care for Children in Immigrant Families policy statement ✓ National Center for Medical Home Implementation fact sheet, Strategies to Enhance Care for Hispanic Children, Youth, and Families ✓ AAP 2013 Enhancing Pediatric Workforce Diversity and Providing Culturally Effective Pediatric Care: Implications for Practice, Education, and Policy Making policy statement ✓ National Resource Center for Patient/family-centered Medical Home: Enhancing Cultural Competence in Pediatric Medical Homes ✓ A Pediatrician's Guide to an LGBTQ+ Friendly Practice, which includes recommendations for creating a welcoming atmosphere and positive experience; ways to improve office systems; sample office form for teens; and communication best practices and examples. ✓ National Center for Cultural Competence at Georgetown University: Conscious & Unconscious Biases in Health Care ● Review interests and concerns from previous visits to discuss progress or worsening conditions and ensure all are addressed over time. ● Have the front desk ask at patient check out, *Did we address all your concerns today?*	
Gap: Age-appropriate patient/family strengths are not assessed, and feedback not integrated into the patient/family discussion.		
The practice setting does not have a systematic process for assessing, discussing, and documenting patient/family strengths in culturally effective ways.	● Recognize that supporting families successfully requires understanding and building on the strengths of families. This requires a shift to what the patient/family does well and how to help them do even better. This helps support healthy child development—achieving autonomy, competence, self-efficacy, and the ability to form healthy relationships. ● Identify necessary screenings and risk assessments in the Bright Futures/AAP *Recommendations for Preventive Pediatric Health Care* (Periodicity Schedule) for a child of the visit age.	● Discuss the benefits of a strength-based approach to healthcare in a staff meeting. Get agreement on a protocol to achieve this approach. Identify issues and adjust the protocol.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Identify related screening tools to use designed to maximize communication about the needs and strengths of families: ✓ FAST ✓ CANS ✓ Common Factors Approach (HEL^{2}P^3) ✓ Strengths and Difficulties Questionnaire • Consider common strengths and weaknesses within your patient population. Prepare anticipatory guidance message points, educational materials, community resources and referral information in advance so they are readily available during the visit. • Make it a practice to verify that patient/family strengths are discussed at the conclusion of the visit. Consider posting a reminder in a prominent place.	• Review literature on family strengths and connections such as the following: ✓ HOPE: Healthy Outcomes from Positive Experiences ✓ Strengthening Families™ Protective Factors Framework ✓ Youth Thrive ✓ Fostering Resilience, The 7 Cs: The Essential Building Blocks of Resilience • Consider taking the Georgetown course on Conscious and Unconscious Bias, available at: https://nccc.georgetown.edu/bias. • Review the ideas presented in Row 2 of this grid to improve documentation.
Gap: Practice-standardized social determinants (drivers) of health assessment not completed by the patient/family and/or a plan established, or referral recommended, if indicated, to address identified need.		
The practice setting does not have a systematic process for assessing, addressing, and documenting social determinants (drivers) of health.	• Recognize that children cared for with safe, predictable routines and by nurturing and responsive adults gain protection from risks to health and help to support well-being. It is important to engage families with an intentional, constructive approach to healthcare that takes into consideration the family's support systems, programs, and communities. Also realize: ✓ Consider family circumstances such as education, income level, and environment when providing care. ✓ Identify key protective factors that promote well-being and help parents find resources, supports, or coping strategies that allow them to parent effectively, even under stress.	• Discuss how social determinants (drivers) can impact health outcomes in a staff meeting. Get agreement on a protocol to use to assess, address, and document social determinants (drivers) during health supervision visits. Identify issues and adjust the protocol. • Review literature on social determinants (drivers) of health such as the following:

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Be prepared to complete all screenings and risk assessments identified in the Bright Futures/AAP *Recommendations for Preventive Pediatric Health Care* (Periodicity Schedule) for a child of the visit age. • Identify related screening tools to use for risks such as prenatal alcohol exposure, parental depression, food insecurity, and adverse family experiences. These screens are included in selected visits according to age of the child and timing of risk. ✓ Social determinants (drivers) of health questions are found in the Anticipatory Guidance section of the visits and included in the Bright Futures Previsit Questionnaires. ✓ Also review Links to Commonly Used Screening Instruments and Tools on the AAP Toolkits webpage (requires subscription) and the STAR Center Screening Resource Library. • Identify common social determinants (drivers) of health within your patient population and prepare anticipatory guidance message points, educational materials, community resources and referral information in advance so they are readily available during the visit. • Review federal, state, and local resources such as the following: ✓ National helplines (eg, 2-1-1) ✓ Other free resources (eg, Cap4Kids, findhelp.org ✓ Screen and Intervene: A Toolkit for Pediatricians to Address Food Insecurity • Make it a practice to verify that identified social determinants (drivers) are addressed or a plan put in place to address them at the conclusion of the visit. Consider making a check box on the patient chart for this purpose. • Consider using ICD-10-CM Z codes to capture SDOH data. The 2022 *Coding for Pediatric Preventive Care* includes codes for SDOH diagnoses/concerns, which can be used to report/track SDOH concerns. Also see: the CMS infographic on Using Z Codes. • Review documentation practices and develop a clear practice protocol for documenting results of patient/family discussions patient charts	✓ *Bright Futures Guidelines*: Promoting Lifelong Health for Families and Communities ✓ Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health ✓ Healthy People 2030 Social Determinants of Health ✓ Child and Adolescent Health Measurement Initiative (CAHMI). Report of the Social Determinants of Health Technical Working Group, Maternal and Child Health Measurement Research Network (MCHMRN); type **social determinants** in the search box ✓ Responding to Aces With HOPE: Health Outcomes From Positive Experiences, available at: https://www.academicpedsjnl.net/article/S1876-2859(17)30107-9/fulltext ✓ Center on the Developing Child: The Brain Architects, available at: https://devhcdc.wpengine.com/resources/the-brain-architects-connecting-health-learning-part-i-the-science/ • A reminder/recall or tickler system to ensure that referral appointments and/or treatment occurs in a timely manner.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
		• Consider what checks and balances the Bright Futures implementation team can make to ensure a complete addressment of social determinants (drivers) occurs at health supervision visits. Refine ideas through Plan, Do, Study, Act (PDSA) cycles. • Review the ideas presented in Row 2 of this grid to improve documentation concerning social determinants (drivers) discussions/ addressment.
Gap: Age-appropriate Bright Futures priorities (anticipatory guidance) are not discussed at all health supervision visits.		
The practice setting provides reactive anticipatory guidance as needs arise but does not provide proactive counseling that align with Bright Futures visit priorities specific to the visit age.	• Recognize that for each health supervision visit, anticipatory guidance is proactive counseling that is specific to the age of the child and is organized by the visit priorities. These priorities provide a systematic approach to the emerging issues that patients and families face – for example, information about the benefits of a healthy lifestyle and practices that promote injury and disease prevention within the context of the culture and values of the family. For guidance to be effective and adopted by the family, it must be: ✓ Timely (delivered at the right age) ✓ Appropriate to the child and family in their beliefs, community, and culture • Use the Anticipatory Guidance sections of the *Bright Futures Guidelines* for the visit age, which suggests *how* to provide guidance. Sample questions and suggested talking points can be used and adapted to the individual patient.	✓ Consider the ideas presented in Row 2 of this grid to improve documentation of anticipatory guidance discussions. ✓ Work with the Bright Futures implementation team to test, refine, and implement ideas for improved anticipatory guidance delivery through Plan, Do, Study, Act (PDSA) cycles.

Appendix

Family

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

June 20, 1990

Family Advisor

The Practice Family Advisor role will provide the parent/caregiver perspective to quality improvement efforts to the practice. This advisor is a father, mother, guardian, or family member typically with personal experience with difficulty accessing health care and/or insurance coverage and has used or currently uses community resources/services. This advisor has a strong interest in improving services for children, particularly those with limited resources, and has a belief that collaboration with pediatricians and other professionals is essential to quality child health care. Family advocacy experience is recommended but not required. This advisor will devote consistent time to the quality improvement project (approximately 1-2 hours a week). It is recommended that this be a paid position.

Roles and responsibilities will include:

- Shares experiences utilizing community resources and assists in developing appropriate recommendations that are meaningful for families
- Attends and participates in team meetings
- Actively participates on periodic conference calls to provide family perspective
- Reviews provided materials in advance of meetings
- Other: _____

Key Protective Factors

The following 5 factors from The Strengthening Families Approach and Protective Factors Framework™: A Pathway to Healthy Development and Well-Being include:

- 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, 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

For more information and resources, see:

- Protective Factors Framework from the Center for the Study of Social Policy (CSSP)
- Four Ways to Assess Positive Childhood Experiences from Healthy Outcomes from Positive Experiences (HOPE)
- Promoting Children's Health and Resiliency: A Strengthening Families Approach from the CSSP and AAP

Bright Futures Visit Priorities

Bright Futures recommendations include proactive counseling or anticipatory guidance for families organized by the 5 priorities or most important topics for a child of the visit age. These 5 priorities are in addition to addressing the needs and agenda of the family. See each visit age in the *Bright Futures Guidelines*, 4th Edition and Pocket Guide to review the priorities for that age.

PDSA* Cycles: Implementing Bright Futures Processes in Your Practice

Consider the practice-wide changes needed to implement *Bright Futures Guidelines* and incorporate *Bright Futures* core tools in health supervision visits.	
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 process: What is the workflow? Who is involved? What materials (eg, screening tools, brochures) are needed and how will they be accessed?
Do	Pilot the process you have laid out.
Study	Gather feedback from staff. What worked? What did not work? Use the information gathered to help refine and improve your process.
Act	If needed, redesign your process and test again. Implement changes that resulted in success.
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.

Potential Barriers and Suggested Ideas for Change

Key Activity: **Preventive Care Activities and Services**

Rationale: The health supervision visit allows for the comprehensive assessment of a child, the opportunity to promote health, and for further evaluation if abnormalities are detected. Preventive care activities and services recommended in the *Bright Futures Guidelines*, 4th Edition, and the Bright Futures/AAP Periodicity Schedule can help detect or prevent serious diseases and medical problems in partnership with children and families, using the Periodicity Schedule to deliver age-appropriate screenings, procedures, and services, based on the child's development stage and recognized standards of medical and dental practice, promoting optimal health.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?

The practice setting is unfamiliar with the *Bright Futures Guidelines*, 4th Edition, materials and/or does not apply adherence to the Bright Futures/AAP Periodicity Schedule.	• Become familiar with the *Bright Futures Guidelines*, 4th Edition, core materials. Share the materials with staff and ensure all are trained in their use:
	  • *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)
	  • *Bright Futures Guidelines*, 4th Edition: Priorities and Screening Tables
	• Become familiar with the 2012 AAP policy statement that defines what is meant by patient- and family-centered care, Patient- and Family-Centered Care and the Pediatrician's Role.
	• Be familiar with 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
	• Consider developing a Bright Futures implementation team that includes family advisor member(s) to lead practice-wide improvements concerning Bright Futures implementation. This team can help guide, monitor, and make changes to health supervision visit processes to improve care.
		• Review and share with staff:
		  • The tip sheet, *Practical Tips for Implementing Bright Futures in Clinical Practice*
		  • The Bright Futures Toolkit Overview demo
		  • The Bright Futures User Guide and Instructions for Toolkit Implementation
		• Review resources on family advisor engagement:
		  • ASHEW family advisor resources: Family Advisor Job Description, Family Perspective Webinar from AAP CA-1 Chapter, and Family Perspective Slides
		  • AMA Johns Hopkins Family Advisor Recruitment
		  • The Value of Family Advisors as Coleaders in Pediatric Quality

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
		Improvement Efforts: A Qualitative Theme Analysis • Family Voices Family Engagement in Systems Assessment Toolkit

Preventive care activities and services recommended by Bright Futures and identified on the Bright Futures/AAP Periodicity Schedule are provided but not documented.	• Review documentation practices and develop clear practice setting protocols for documenting all preventive care activities/services and follow-up in patient charts. Standardize the way the practice records outcomes of the screening and risk assessment processes, provides education or counseling, referrals, refusals, and follow-up.
	  • Consider making check boxes on patient charts for age-appropriate screenings and risk assessments.
	  • Customize the EHR to include prompts.
	  • Post documentation reminders in prominent places.
	• Consider using the Bright Futures Visit Documentation Forms to record physical examination findings, assessments, and interventions that are agreed upon by the patient and family.
		• Discuss documentation issues in a staff meeting and brainstorm ways to improve them.
		• Work with the Bright Futures implementation team to test, refine, and implement the best ideas through Plan, Do, Study, Act (PDSA) cycles.

Gap: Perinatal depression screening is not completed at recommended visits following birth.		

Pediatric healthcare professionals are unclear about their responsibility for perinatal depression screening, or they feel that it is outside the scope of pediatric care.	• Be familiar with the *Bright Futures Guidelines*, 4th Edition, core materials listed in Row 1 of this grid and the 2019 AAP policy statement, *Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice*, which describes:
	  • The impact of the parental/primary caregivers' well-being on the child
	  • The pediatric healthcare professional's responsibility to assess the well-being of the parents and other primary caregivers at the recommended health supervision visits: 1 month, 2 months, 4 months, and 6 months, and to continue to watch for emerging concerns after this time
	  • The need to act when the screening result is positive:
	  • Provide a brief intervention to the mother/caregiver to:
	  ○ Promote the strength of the mother-infant relationship.
		• Visit the Mental Health Initiatives Web page for information and guidance on how pediatric healthcare professionals can support the healthy mental development of patients/families.
		• Review with staff the 2019 AAP policy statement, *Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice*.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	○ Encourage the mother and reassure her regarding any concerns about breastfeeding. ○ Encourage understanding and responding to the infant's cues. ○ Encourage reading and talking to the infant. ○ Encourage routines for predictability and security, sleep, diet, exercise, and stress relief. ○ Promote realistic expectations and prioritizing important things. ○ Encourage social connections. • If concerns for perinatal depression or substance use are present, refer the parents/primary caregiver to the adult primary care professional, mental health clinician, or community support. • If suicidality or psychosis is a concern, refer to crisis/emergency services immediately. Have an office Policy and Procedure for referring to emergency services. • Refer to the dyad if there are concerns for perinatal depression, because untreated perinatal depression can impact mother and infant relationship/attachment, or if there are other concerns with parents'/primary caregivers' health that is a risk for the dyad relationship. • Perform social-emotional screening of the infant with appropriate screening tools when there are concerns based on the perinatal depression screen. For more information, see 2015 AAP clinical report, *Promoting Optimal Development: Screening for Behavioral and Emotional Problems*. • Refer the infant for Part C Early Intervention Services if there are concerns for social-emotional development. • Provide encouragement and support by offering information about self-care strategies, stressing the need for social support, and offering relevant community resources. • Consider using the Common Factors (HEL^{2}P^3) approach when addressing mental health problems: **H**ope **E**mpathy **L**^{2} Language, Loyalty **P**^{3} Permission, Partnership, Plan	• See the STAR Center webinar, The Why and How of Perinatal Depression Screening. • See the Bright Futures implementation tip sheet, *Tips to Link Your Practice to Community Resources.* • See the Community Care of North Carolina Maternal Depression Resource Guide.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?

Pediatric healthcare professionals are not trained to perform perinatal depression screening.	• Utilize physician training resources, practice tools, and family resources to promote healthy mental development and address concerns of patients/families available from the AAP Mental Health Initiatives.
	• Develop relationships with community mental health providers and other support systems to assist your efforts and those of the mother.
	• Choose a screening tool, explore available resources such as those available in the AAP STAR Center Resource Library, network with colleagues, and establish a triage and referral mechanism.
	• Partner with state perinatal mental health consultation services (for example, Massachusetts MCPAP for MOMS) and HRSA Maternal & Child Health telehealth access programs for some states available at: https://mchb.hrsa.gov/maternal-child-health-initiatives/mental-behavioral-health/mdrbd.
		• Participate in related continuing medical education courses such as the following:
		  • Clinical education opportunities on social determinants (drivers) of health, including perinatal depression available on the AAP STAR Center
		  • Postpartum Support International
		  • PediaLink Perinatal Depression Curriculum (found in the Teaching & Learning Resource Center section)

The practice setting does not use a standardized screening tool for perinatal depression and/or has established practice-wide processes for screening.	• Consider the following commonly used standardized perinatal depression screening tools:
	  • Edinburgh Postnatal Depression Scale (EPDS)
	  • Patient Health Questionnaire (PHQ-2 followed by PHQ-9) if positive
	  • Survey of Well-being of Young Children (SWYC)
	• Ask about a history of perinatal depression during this pregnancy or prior pregnancies during the first visit. Prepare to discuss screening for perinatal depression at health supervision visits between the 1st and 6th months of the child's life. The screening/discussion process can be brief if the tool is administered before the visit. For example:
	  • Send the screening tool before the visit by mail or patient portal.
	  • Train front office or nursing staff to give the screening tool to the mother to complete before the visit (in the waiting room or the examination room).
	• Make other necessary practice preparations for perinatal screening, including:
	  • How you will ideally inform partners in the community (ie, prenatal providers, mental health providers) before you begin screening for
		• Consult with other practices in your area about which screening tool might work best for your patient population.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	perinatal depression and before you start to refer patients so that mutually agreed upon processes for urgent and nonurgent concerns are put into place for communication and information sharing • Whom you might select within the practice to be the designated referral person to keep up contact information and the processes to use for urgent and nonurgent referrals (see below) • The need to locate community mental health resources, perhaps by using the Postpartum Support International Online directory at https://psidirectory.com/ • Prepare for **urgent/emergent** referrals and immediate actions by establishing relationships and developing clear processes. • In cases of suicidality, have clearly designated contact information available 24/7 (question 10 on EPDS is positive or PHQ-9 indicates suicidality): • Local emergency number • National Suicide Prevention Hotline at 1-800-273-TALK (8255)) and En Español: 1-888-628-9454 • 24/7 Crisis Text Line: Text "HOME" to 741-741 • 988 hotline in states who have implemented this number with resources for suicidal ideation • In cases where the mother expresses concern about her or her infant's safety or if the healthcare professional is concerned that the mother is homicidal, severely depressed, manic, or psychotic, use one or more of the resources listed above. • The mother should only leave with her support person or under the care of the community resource you have designated, such as mental health crisis services or emergency medical services. • Prepare for **nonurgent** referrals by establishing relationships and developing clear processes. • With community partners you plan to make referrals to assess perinatal depression, including primary care providers, obstetric, and mental health providers for the mother, mother and infant dyad and infant (for targeted	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	promotion of social emotional development), and lactation support for breastfeeding mothers. • If the mother does not have insurance more than 60 days postpartum, the infant's Medicaid or other insurance can be used to bill for mental health services for the infant/mother dyad. • Check in with mom to see if she has gone to the referral and how she is doing with her depressive symptoms. • Schedule a follow-up appointment in the office.	
The practice setting has concerns about payment.	• Use CPT code 96161 for perinatal depression screening (eg, caregiver-focused health risk assessment). • Consult the AAP Practice Management Coding and Valuation Web page for coding resources, including topical fact sheets and link to the Coding Hotline. Also consult the AAP Chapter for coding assistance. • Review the CMS guidance that outlines how and why states should include perinatal depression screening in health supervision visits.	• See the *Coding for Pediatric Preventive Care* booklet for more payment information.
Gap: No plan documented to address perinatal depression.		
The practice setting does not have a systematic referral and/or follow-up process in place for perinatal depression.	• Establish relationships and develop processes to refer parents with positive screening results and urgent and nonurgent needs as appropriate and as previously described above. • Consider these additional tips for improved follow-through: • Demystify and address stigma about perinatal depression and the importance of early assessment to identify, treat, and support to reduce impact on the infant and parental/primary caregivers. • Provide contact information, help making the appointment, or securing transportation as needed. • Provide supportive, nonjudgmental education about depression verbally; consider supplementing the message with family-focused resources such as	• Recognize the importance of physician involvement in the ongoing assessment, support, and intervention of the mother as well as the infant-parent relationship. • Use a reminder/recall or tickler system to ensure that referral appointments occur in a timely manner. • See the Bright Futures implementation tip sheet, *Tips to Link Your Practice to Community Resources*.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	from the Centers for Disease Control and Prevention and Postpartum Support International. • Provide resources for community support/care management. • Inform families about emergency resources in the area if depression symptoms worsen or thoughts of self-harm or harm of others develops. For people in crisis, be prepared to provide the local emergency number or the National Suicide Prevention Hotline at 1-800-273-TALK (8255). Many states are beginning to use a 988 hotline as their local resource. Families may also visit Vibrant Emotional Health's Safe Space for digital resources. • Recognize that your support and validation is powerful and can have influence in whether the mother will seek help and care for herself. • Arrange a follow-up phone call in a few hours or days to support and encourage follow-through.	• Review the ideas presented in Row 2 of this grid to improve documentation.
Gap: Developmental screening and age-appropriate surveillance screening not completed and documented.		

While developmental screening and surveillance is relatively clear for young children (assessment of motor, social, and language skills), the practice setting does not have a system in place to perform developmental surveillance for school-age and adolescent patients.	• Review the *Bright Futures Guidelines*, 4th Edition, core materials listed in Row 1 of this grid and the 2020 AAP clinical report, *Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening*, which describe the health supervision visit priorities that address healthy development.
	• Be prepared to discuss developmental screening results at the 9-, 18-, and 30-month health supervision visits. The screening/discussion process can be brief if the screening tool is given to the parent to complete before the visit. For example:
	  • Mail the screening tool before the visit.
	  • Train front office or nursing staff to give the screening tool for the parent to complete before the visit (in the waiting room or the examination room).
	• Consider the following commonly used standardized screening tools:
	  • Survey of Well-being of Young Children (SWYC) Developmental Milestones
	  • Ages and Stages Questionnaire: Third Edition (ASQ-3)
	  • Parents' Evaluation of Developmental Status (PEDS)
		• Review the *Bright Futures Guidelines*: Promoting Healthy Development chapter.
		• Review the PediaLink course, Milestones Matter: Don't Underestimate Developmental Surveillance.
		• Help children and adolescents understand their own development, healthcare needs, and issues by providing resources such as those provided on the Bright Futures Resources for Children and Teens Web page.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Parents' Evaluation of Developmental Status: Developmental Milestones (PEDS:DM) • Others available from the AAP STAR Center Resource Library, which focuses primarily on early childhood screening • Ask developmental surveillance questions directly during the health supervision visit or consider using the previsit questionnaires from the *Bright Futures Tool and Resource Kit*, which includes surveillance questions concerning healthy development (eg, developmental milestones). • Use and share the CDC: Learn the Signs. Act Early. Developmental Surveillance Resources for Healthcare Providers materials appropriate for the age of the child (updated in February 2022 to include the 15- and 30-month age checklists). • Promote use of the CDC's Milestones Tracker App. patients with possible mental health or behavioral problems, consider: • The use of the Pediatric Symptom Checklist (PSC), the Survey of Well-being of Young Children (SWYC), which includes the Baby/Preschool Pediatric Symptom Checklist, or the Strengths & Difficulties Questionnaires (SDQ) • The use of other developmental surveillance questionnaires for school-age children and adolescents, such as HEEADSSS or PEDS and PEDS: DM (children up to age 8), for example • Resources such as Help Me Grow (if available in your area) and early intervention Part B services • Decide on and incorporate EHR prompts for developmental surveillance for age-appropriate health supervision visits. • Consider flagging charts of patients who are overdue for developmental screening or surveillance, especially those with missed health supervision visits.	• Review the resources on the AAP Developmental Surveillance and Screening Web pages. • Take the AAP PediaLink course, *Innovative Strategies for Improving Developmental Surveillance and Screening*.
Gap: No plan documented and/or feedback not integrated into the family discussion.		
The practice setting does not have an organized process for	• Consider the 2020 AAP clinical report and algorithm, *Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders*	• Use a reminder/recall or tickler system to ensure that referral

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
follow-up of positive screens or surveillance concerns.	*Through Developmental Surveillance and Screening*, which illustrates increasing developmental concern as a process. If mental health concerns are identified, the AAP Mental Health Toolkit's Mental Health algorithm may be followed to determine next steps. • Identify and reflect on the child's/adolescent's strengths. Rather than jumping in to offer suggestions for areas that may be lacking or deficient, use principles of shared decision-making and motivational interviewing to encourage patients to take ownership of changes. Provide individualized anticipatory guidance and education as appropriate. • Share CDC materials How to Get Help for Your Child tip sheet when there are concerns and materials from Learn the Signs. Act Early. • Establish linkages to local community resources or specialists to which you can refer patients/families. In some cases, referral to pediatric subspecialists such as neurodevelopmental pediatricians, developmental-behavioral pediatricians, child neurologists, or child psychiatrists may be appropriate. In other cases, early intervention (Part C for children 0–3 years; Part B for children 3–5 years), child care, school, and community services may be needed. If not eligible for early intervention services, refer for physical therapy, occupational therapy, and/or speech and language therapy, as indicated.	appointments and treatment occurs in a timely manner. • Use teach-back techniques to assess patient and family understanding. • Review the ideas presented in Row 2 of this grid to improve documentation.
Gap: Growth or BMI is not measured and plotted on appropriate percentile curves. (Weight-for-length and head circumference <2 years/Body mass index [BMI] >2 years; for premature infants, plot by adjusted age until age 2.)		

Pediatric healthcare professionals and staff do not recognize the importance of accurately and consistently measuring, documenting, and monitoring patients' growth over time.	• Review the *Bright Futures Guidelines*, 4th Edition, core materials listed in Row 1 of this grid and the 2015 AA ***Growth or BMI is not measured and plotted on appropriate percentile curves*** per the clinical report, *The Role of the Pediatrician in Primary Prevention of Obesity*, which describe the importance of clinical responsibilities for accurate and reliable growth measurements plotted longitudinally.
	  • Plot length, height, weight, and head circumference in children younger than 2 years. For premature infants, plot by adjusted age until age 2. (Head
		• Review relevant policy, resources, and literature:
		  • The *Bright Futures Guidelines*: Promoting Healthy Weight chapter
		  • AAP: Institute for Healthy Childhood Weight Web page
		  • The 2017 USPSTF recommendation statement,

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	circumference and weight-for-length are measured in this EQIPP course using WHO Growth Charts for Children 0–2 Years of Age.) • Plot stature, weight, and body mass index (BMI) for children 2 years of age and older. (BMI is measured in this EQIPP course using CDC Growth Charts for Children 2 Years of Age and Above.) • Pubertal (Tanner) stages should be assessed at all ages. • Discuss with staff the importance of reliable growth measurements to reassure patients and families of adequate growth and to use for clinical decision-making and intervention to: • Detect growth abnormalities or trends that indicate concerns or risks. • Detect abnormalities in nutritional status. • Detect diseases that affect growth. • Track the effects of medical or nutritional intervention.	*Obesity in Children and Adolescents: Screening.* • The 2015 AAP clinical report, *The Role of the Pediatrician in Primary Prevention of Obesity* • 2021 AAP clinical report, *Identification and Management of Eating Disorders in Children and Adolescents*
The practice setting does not have a systematic approach for obtaining and documenting patients' growth.	• Use AAP-recommended tools for documenting growth measurements: • WHO Growth Charts for Children 0–23 Months of Age • CDC Growth Charts for Children 2 Years of Age and Above These tools are also available in the appendix of the *Bright Futures Guidelines*. **Note**: For premature infants, plot by adjusted age until age 2. • Develop a visit flow for obtaining and recording growth measurements at every health supervision visit. The flow should consider the patient and family, pediatric healthcare professional, and staff members' time, office efficiency, equipment, and backup contingencies. • Consider using Bright Futures Visit Documentation Forms for a place to record measurements and to remind staff to record growth information. • Scan completed growth charts and documentation forms into your EHR system. Alternatively, flag concerns manually on a chart or in an office log.	• Share with staff the online training course, Growth Chart Training: Using the WHO Growth Charts. • Complete the AAP course, EQIPP: Growth – Addressing Concerns and Management.
The practice setting does not have an organized process for follow-up of growth concerns	• Develop checks and balances to ensure all are trained to take and record measurements accurately and that the pediatric healthcare professional reviews growth information with the patient and family.	• Consider the ideas presented in Row 2 of this grid for documentation ideas if growth is measured and

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?

or does not place appropriate importance on the issue.	• Plot measurements to monitor growth over time. The AAP and CDC recommend:
	  • WHO Growth Charts for Children 0–2 Years of Age
	  • CDC Growth Charts for Children 2 Years of Age and Above
	These tools are also available in the appendix of the *Bright Futures Guidelines*. **Note**: For premature infants, plot by adjusted age until age 2.
	• Recognize that deviations from normal growth percentiles require further investigation and/or anticipatory guidance.
	• Establish linkages to local community resources or specialists to which you can refer patients/families with growth and healthy weight issues as needed.
	• Stress the importance of maintaining a healthy weight for overall health and well-being that transcends to good health in adulthood. Become familiar with and share with staff:
	  • *Bright Futures Guidelines* chapter, Promoting Healthy Weight
	  • 2015 AAP clinical report, *The Role of the Pediatrician in Primary Prevention of Obesity*
	  • 2017 USPSTF recommendation statement, *Obesity in Children and Adolescents: Screening*
	  • AAP Institute for Healthy Childhood Weight Algorithm for the Assessment and Management of Childhood Obesity in Patients 2 Years and Older
		guidance provided but not documented in the medical record.
		• Review the patient/family education resources concerning growth issues available from the Pediatric Endocrine Society.

Gap: Immunization status is not verified at all health supervision visits		
The practice setting does not have an organized process for ensuring that patients are up to date on immunizations or does not place appropriate importance on the issue.	• Assessing the completeness of recommended and required age-appropriate immunizations is a key element of preventive health services. Review the *Bright Futures Guidelines*, 4th Edition. core materials listed in Row 1 of this grid, which describe the importance of and clinical responsibilities for ensuring up-to-date immunization status for all patients. • Recognize that immunizations are the safest and most effective tools for protecting children from various potentially serious childhood diseases. • Be up-to-date about the latest vaccination recommendations. Use the current Immunization Schedule, as recommended by the Advisory Committee on	• Explore resources for pediatric healthcare professionals and patients/families on the AAP Immunizations Web page. Also review the AAP clinical report, The Need to Optimize Adolescent Immunization • Consider the ideas presented in Row 2 of this grid for ideas if

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC), AAP, American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American College of Nurse-Midwives (ACNM), American Academy of Physician Assistants (AAPA), and National Association of Pediatric Nurse Practitioners (NAPNAP). • Train office staff to routinely assess vaccination needs of patients and encourage discussions about vaccine hesitancy and addressing misinformation. • Audit vaccination rates for your practice setting and for individual professionals.	immunization documentation is an issue.
Gap: Missed vaccines are not administered during the health supervision visit and/or an immunization follow-up plan are not documented.		
The practice setting misses immunization opportunities.	• Explore the reasons why patients in your practice setting are not up to date on their vaccines. Is it missed health supervision appointments? Lack of knowledge or misinformation? Limited hours in the practice setting for immunizations? Lack of insurance or ability to pay? Parents' vaccine hesitancy? Life struggles in the parents' lives such as transportation or missing work? Fear of needles by the child or parent? It is essential to identify the barriers before attempting to implement solutions. Help families connect with services in the community using the resource locator from Prevent Child Abuse. • Make it a practice to use *all* clinical encounters, including visits for mild illness, to provide needed immunizations. • Provide a range of clinic times when immunizations can be administered. Ensure there is limited wait time to obtain the immunization. • Put reminder/recall systems in place (ie, generally available within state immunization registries) for missed health supervision appointments and missed immunizations. • Train office staff to routinely assess vaccination needs of patients and encourage compliance. • Use the state immunization registry to determine the immunization needs of patients.	• Work with the Bright Futures implementation team to test, refine, and implement the best ideas through Plan, Do, Study, Act (PDSA) cycles. • Explore resources for pediatric healthcare professionals and patients/families on the AAP Immunizations Web page. • Consider the ideas presented in Row 2 of this grid for ideas if immunization documentation is an issue. • Use AAP, Healthychildren.org, and CDC family-focused immunization resources to encourage immunizations.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Use the CDC Epidemiology and Prevention of Vaccine-Preventable Diseases (The Pink Book: Course Textbook) as a resource. • Appendices include vaccine excipient summaries, vaccine-preventable disease terms in multiple languages, vaccine safety monitoring etc, at: https://www.cdc.gov/vaccines/pubs/pinkbook/appendix/index.html. • Make every effort to reduce patients' out-of-pocket costs for immunizations.	
Gap: Oral health risk assessment is not completed at recommended health supervision visits.		

Pediatric healthcare professionals are not taking responsibility for incorporating oral health care into their practice.	• Realize that, according to the *Bright Futures Guidelines*, the 2021 USPSTF recommendations, the AAP policy statement from the Section on Oral Health, *Maintaining and Improving the Oral Health of Young Children* (reaffirmed January 2019), and the 2020 AAP clinical report, *Fluoride Use in Caries Prevention in the Primary Care Setting*, the following activities done by pediatric primary healthcare professionals in their offices, can significantly reduce the amount of decay in children's teeth:
	  • Recommend the establishment of the dental home by age 1 and routine visits thereafter.
	  • Perform an oral health risk assessment including examination of the teeth and gums. An oral health risk assessment evaluates and documents caries risk, protective factors, clinical findings, and an assessment plan.
	  • Provide oral health anticipatory guidance.
	  • Apply fluoride varnish.
	• Recognize that optimal oral health requires collaboration between the offices of the pediatric primary health care and dental professionals to provide the patient and family with consistent and continuing preventive oral healthcare. To accomplish this, the pediatric practice setting needs to establish interprofessional relationships with dental partners, help families build partnerships with dental professionals, facilitate and track dental referrals, and regularly update a dental resource guide.
	• Be aware of clinical responsibilities for the pediatric medical home to perform oral health risk assessments:
		• Review the *Bright Futures Guidelines*, 4th Edition, core materials listed in Row 1 of this grid, which describe the pediatric oral healthcare responsibilities. Pay particular attention to the chapter, Promoting Oral Health.
		• Use the AAP Oral Health Prevention Primer to achieve optimal oral health for patients and families.
		• Consult the *How and When Do I Provide an Oral Exam and Risk Assessment?* and *How Should I Set Up My Practice To Include Oral Health?* tabs on the AAP Oral Health Practice Tools Web page.
		• See Smiles For Life for staff training and implementation tools.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• At the 6- and 9-month visits, pediatric healthcare professionals should universally screen children using the Oral Health Assessment Tool (also available in Spanish.) Every effort should be made to help the family establish a dental home for the child by 12 months. • At the 12- and 18-month, 2-, 2½-, 3-, 4-, 5-, and 6-year visits, a risk assessment should be completed if not previously done, previous assessments should be updated, and assessments should continue if a dental home has not been established, as recommended in the Bright Futures/AAP Periodicity Schedule.	
Families do not prioritize establishing a dental home, or they face barriers to access a dental home such as insurance limitations.	• Offer education and guidance on the establishment of a dental home in the form of posters or handouts—find these on the *How Do I Help Children To Find a Dental Home?* and *How can I Educate Families* tabs on the AAP Oral Health Practice Tools Web page. • Explain to families that childhood caries can lead to dental pain, worsening disease that requires more intensive and expensive treatments, tooth loss and lost school days—requiring children to require general anesthesia for restoration of decay and/or families to stay home to care for their child and incur expensive dental restorations, which can lead to higher costs. • Provide education and resource assistance as needed, including the AAP *Brush, Book, Bed* program and Healthy Smile Brochures for Parents on the National Maternal and Child Oral Health Web page.	• Investigate families' barriers to seeking regular dental care. Provide education and resource assistance as needed, including the AAP *Brush, Book, Bed* program. • Find dentists in your community who accept young children and various insurances, including public insurance for families who do not speak English as their primary language and for children with special needs. • Share with families of children with special needs this Dental Home Checklist from North Carolina in English and Spanish to help them find the right dental home. • Integrate a dental provider into your practice, such as dental hygienist or advocate for existing dental providers in your community to see young children.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
The practice setting lacks a protocol to refer patients to a dental home and ensure that the visit is attended.	• Select an oral health practice champion within the practice and designate support staff responsible for oral health awareness, referrals, communication with the dental home, follow-up, etc. • Meet with your state's chapter oral health advocate to help implement oral health workflows into your practice. • Automate the referral in the EMR and include a list of dental health professionals who see children and adolescents of all ages, accept Medicaid, and offers services in Spanish and for children with special healthcare needs. Include a tickler or reminder/recall prompt in the EMR to ensure follow-up occurs.	• Equip families with the resource, *Questions to Ask When Calling a Dental Provider* on the AAP Oral Health Practice Tools Web page. • Share with families of children with special needs this Dental Home Checklist from NC in English and Spanish to help them find the right dental home. • Use teach-back techniques to assess patient and family understanding. • Review the ideas presented in Row 2 of this grid to improve documentation.
Gap: Fluoride varnish is not applied in the pediatric office (unless no teeth have erupted, service declined by the family, or services provided by the patient's dental home).		

The practice setting does not consider fluoride varnish application to be their responsibility. Reasons may include:
• A perception that applying fluoride varnish in the office would be burdensome or time-consuming
• Lack of training
• Concerns about payment
	• Review *Bright Futures Guidelines* recommendations for fluoride varnish application and the following:
	  • AAP policy statement from the Section on Oral Health, *Maintaining and Improving the Oral Health of Young Children* (reaffirmed January 2019)
	  • AAP 2020 clinical report, Fluoride Use in Caries Prevention in the Primary Care Setting
	  • 2021 USPSTF recommendations
	• Educate staff that preventive oral health is a responsibility of primary care and includes applying fluoride varnish. Share resources such as *How Much Fluoride Do My Patients Need?* and *What Do I Need To Apply Fluoride Varnish in My Office?* on the AAP Oral Health Practice Tools Web page.
	• Review training materials on fluoride varnish and its application, including:
	  • YouTube Video, Fluoride Varnish Application by NYCHealth
	  • Into the Mouth of Babes
		• Review resources and share with staff:
		  • Ways to set up your practice to include oral health using tools from the Oral Health Practice Tools Web page.
		  • Oral Health Prevention Primer from Ilikemyteeth.org
		• Remind staff about the impact poor oral health has on the child, family, and society, including increasing disease burden, poor school performance/learning, pain, lost days in school, and possible increased severity or risk of

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
• Family hesitancy regarding fluoride, either debating or refusing its use	• Smiles for Life Fluoride Varnish and Counseling Course • Chapter Oral Health Advocate (COHA) for training at your institution, practice, or AAP chapter meeting. • Prepare the office for routine fluoride application with educational handouts and fluoride varnish supplies at the ready beginning at the 6-month visit. • Prepare to discuss specific family concerns about fluoride, either debating or refusing its use. Be sure to uncover the families' specific concerns with empathy and then address them, emphasizing the importance and proven benefits of fluoride and sharing reliable education materials to share with families about the benefits of fluoride. • Realize that payment for fluoride varnish can provide significant additional revenue to the practice while improving the health of patients. Costs for applying the varnish are less than $2 in supplies plus your time to apply it. (See payment information on the AAP Section on Oral Health Web page.) • Recognize that fluoride varnish application is a Bright Futures recommendation for pediatric preventive care and, therefore, is not optional.	complications with SARS-CoV-2 infections (*British Dental Journal*, 2020). • Gather education materials to display in your office and share with families such as: • Posters: Healthy Teeth Healthy Children *What is Fluoride Varnish?* available in English or Spanish, or the Smiles for Life Child Fluoride Varnish Posters • Videos: Fluoride: An easy way to protect your teeth (Spanish: Los beneficios de agua del grifo) • Handouts: Fluoride for Children: FAQs from healthychildren.org • Baby Oral Health Program
Gap: Autism spectrum disorder-specific screening is not completed at the 2-year health supervision visit.		
General developmental screening is performed as recommended, but standardized autism spectrum disorder-specific screening is not performed routinely at 18 and 24 months. Rather, ASD-specific screening is only performed when signs and symptoms indicate a need for screening.	• Recognize that early identification of autism spectrum disorder (ASD) is critical. The prognosis for children with ASD can be greatly improved with evidence-based behavior modifications and other interventions known to improve function. • Review the *Bright Futures Guidelines*, 4th Edition, core materials listed in Row 1 of this grid, which outline the recommendation for universal screening for ASD at the 18-month and 24-month visits. Also review the following 2020 AAP clinical reports: • *Identification, Evaluation, and Management of Children With Autism Spectrum Disorder* • *Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening*	• Become familiar with clinician resources on ASD, including: • The PediaLink course, *Identifying and Caring for Children with Autism Spectrum Disorder: A Course for Pediatric Clinicians* • The AAP Toolkit, *Caring for Children With Autism Spectrum Disorder: A Practical Resource Toolkit for Clinicians* (accessible with a Pediatric Care Online subscription)

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?

The practice setting does not use a validated autism spectrum disorder screening tool.	• Consider the following commonly used standardized screening tools:
	  • Modified Checklist for Autism in Toddlers, Revised, With Follow-up (M-CHAT-R/F), a validated autism spectrum disorder screening tool. Be sure to complete the M-CHAT-R/F follow-up interview to gain clarity on at-risk responses. Without this, the sensitivity and specificity drop significantly.
	  • Survey of Well-being of Young Children (SWYC), which includes the Parents Observation of Social Interaction (POSI).
	• Be prepared to refer a child for further diagnostic evaluation and early intervention services if at high risk for ASD. When a diagnosis of autism is being ruled out, a hearing evaluation may be ordered to confirm that speech and language delay is not caused by a hearing problem.
		• View the CDC Pediatric Developmental Screening Flowchart for an example of how screening activities might flow in your practice.

The practice setting 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.	• Review the *Bright Futures Guidelines*, 4th Edition, core materials listed in Row 1 of this grid, which describe clinical responsibilities to complete an age-appropriate risk assessment at every health supervision visit. If the risk assessment is positive, additional screens, tests, or referrals should be ordered as early as possible. • Implement and use Bright Futures Preventive Services Prompting Sheets (Infancy & Early Childhood; Middle Childhood & Adolescence) and Medical Screening Reference Tables for the risk assessments and screenings needed at each health supervision visit. Consider converting preventive services prompting sheet information for EMR use. • Review resources in the *Bright Futures Tool and Resource Kit*, 2nd Edition for questionnaires that can streamline your practice's approach to risk assessments and medical screenings. The *Toolkit* has previsit and medical screening questionnaires for every health supervision age.	• Consider having the patient/parent/guardian complete questionnaires online or on a tablet in your office and populate the information into your EMR, if possible. Alternatively, have the patient/family complete questionnaires in the waiting area, and delegate an appropriate staff member to look for positives before the patient is seen.
Gap: No plan documented when autism spectrum disorder-specific screening results are positive.		
The practice setting does not have appropriate checks and balances in place to ensure	• Review the *Bright Futures Guidelines*, 4th Edition, core materials listed in Row 1 of this grid, which describe clinical responsibilities to follow up as early as possible whenever a risk assessment is positive. In particular, the Bright Futures Medical Screening Reference Tables include associated medical history risk factors,	• Discuss with staff the ramifications if medical screening does not take place. Get staff input on communication breakdowns and

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?

appropriate follow-through occurs.	questions to ask to determine if the child is at risk for a specific condition, and the actions to take if the risk assessment is positive.
	• Discuss with staff the importance of having all next steps, discussions with the patient/family, educational materials provided, referrals, community linkages and recommended services, and other details of the follow-up plan documented in the medical record. Use checks and balances to ensure appropriate follow-through are essential.
	• Consider using the Bright Futures Visit Documentation Forms, which include a designated area to record and document risk assessments and medical screenings. Other ideas to improve documentation are presented in Row 2 of this grid.
	• Document follow-up for medical screening while in the exam room, which serves two purposes: to schedule follow-up and to reaffirm the follow-up plan with the patient/family.
	• Identify potential barriers to access linkages (finances, language, transportation, lack of understanding or motivation for change, stigma, etc) and jointly:
	  • Employ shared decision making to address barriers.
	  • Involve a care coordinator, social worker, parent navigator, community health worker, or staff member to assist families find resources.
	  • Employ alternate modalities of following up, such as virtual visits or phone calls.
	  • Identify and develop relationships with community advocates to whom you may refer patients.
		ideas for checks and balances that could be put in place to ensure appropriate follow-through occurs.
		• Employ teach-back or Ask Me Three techniques with patients/families so that when a follow-up plan is communicated, the family repeats the plan back. This fosters a shared responsibility for the treatment and follow-up plan.
		• Delegate the responsibility for reviewing the completed Bright Futures Visit Documentation Forms and scheduling medical screening follow-up to a specific staff member.

Gap: Age-appropriate practice-standardized behavioral-social-emotional screening is not completed.		
Pediatric healthcare professionals do not feel equipped to identify behavioral-social-emotional problems or feel the screening is outside the scope of primary care.	• Review the *Bright Futures Guidelines*, 4th Edition, core materials listed in Row 1 of this grid and the 2015 AAP clinical report, *Promoting Optimal Development: Screening for Behavioral and Emotional Problems*, which describe clinical responsibilities to perform age-appropriate psychosocial/behavioral assessments at all health supervision visits.	• Review the 2015 AAP clinical report, *Promoting Optimal Development: Screening for Behavioral and Emotional Problems* with appropriate staff.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?

	• Apply the AAP Practice Readiness Inventory to evaluate your practice setting to determine the strength of your organization's readiness to provide essential mental health service.
	• Recognize the importance of standardized screening tools to predict the risk of a psychosocial/behavioral disorder but not make the diagnosis. Consider the following commonly used standardized tools:
	  • Pediatric Symptom Checklist (PSC)
	  • Strengths & Difficulties Questionnaires (SDQ)
	  • Survey of Well-being of Young Children (SWYC): BPSC and PPSC
	  • Ages and Stages Questionnaire: Social-Emotional, Second Edition (ASQ:SE-2)
		• Review the 2019 AAP policy statement, *Mental Health Competencies for Pediatric Practice*.
		• Review the *Bright Futures Guidelines*: Promoting Mental Health chapter.
		• Watch the AAP Pediatric Mental Health Minute Series.
		• View resources available on the AAP Mental Health Initiatives Web page.

Gap: No plan documented when behavioral-social-emotional screen is positive.		
The practice setting does not have linkages to local community resources or specialists.	• Review the Bright Futures implementation tip sheet, *Tips to Link Your Practice to Community Resources*. • Create and maintain a list of community-based referral programs (eg, Cap4Kids or 2-1-1 and Help Me Grow, if available in your area) to share with patients/families. Identify contacts within these agencies for information exchange and support for referred patients. • Utilize the Infant & Early Childhood Mental Health Consultation resources to identify state mental health professionals serving young children and other mental health resources for older children and adolescents. • Prioritize a warm handoff.	• Review the ideas presented in Row 2 of this grid to improve documentation. • Evaluate whether the referral organization is meeting culturally appropriate patient/family needs. Seek feedback from the organization about the status of the referral as well as feedback from families that have used the services. • Review the PediaLink course, *Bright Futures - Building Positive Parenting Skills Across Ages*
Patients/families lack access to care.	• Consider the reasons families in your practice population lack access to care and identify ways you might respond to them; for example, addressing illiteracy and low health literacy, stigma, cultural values or beliefs, identifying low cost or free resources, expanding care offerings in your practice setting, socializing patients to mental healthcare delivery, etc.	• Use a strength-based approach to elicit and build upon patients/families strengths and protective factors.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Encourage patient accountability for mental healthcare delivery through active listening, education, and shared-decision making. • Become an advocate in your community and in the nation to improve healthcare access and coverage, especially for vulnerable patient populations.	• Use the Common Factors Approach to help to build a therapeutic alliance between patient/family and pediatric healthcare professionals. • Review a list of and build relationships with key mental health specialty services and possible community resources that provide them.
Gap: Appropriate lipid screening not completed at least once for patient between ages 9–11 years.		
Pediatric healthcare professionals do not recognize the need for universal lipid screening at recommended ages; rather, they only conduct lipid screening for patients with elevated BMIs or with a family history of heart disease or high cholesterol.	• Review the *Bright Futures Guidelines*, 4th Edition, core materials listed in Row 1 of this grid and the 2012 summary report, *National Heart, Lung, and Blood Institute. Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents*, which describe clinician responsibilities to perform universal lipid screening to identify children with familial hyperlipidemias and lipid abnormalities that require lifestyle modification: • Complete at least 1 nonfasting lipid screening for children between 9 and 11 years of age with no risk factors. • Complete a fasting lipid profile screening for children between 9 and 11 years of age with borderline/high cholesterol or known risk factors. • Complete at least 1 nonfasting lipid screening for young adults 17 to 21 years of age with no risk factors. • Avoid screening during puberty (approximately 12–16 years of age), as TC and LDL cholesterol levels decrease as much as 10% to 20% during that time.	• Review the 2008 AAP clinical report, *Lipid Screening and Cardiovascular Health in Childhood.*
Gap: No plan documented when lipid screening results are positive.		
The practice setting does not have a system in place to perform, interpret, and	• Ensure that pediatric healthcare professionals and appropriate staff recognize the markers for a positive screen and put an appropriate treatment plan in place. the following table and points below it to guide interpretation of results:	• Review the ideas presented in Row 2 of this grid to improve documentation.

<table>
<tr><th>Potential Barriers</th><th>Suggested Ideas for Change</th><th>Still Not Seeing Results?</th></tr>
<tr><td>document that medical screenings are completed.</td><td>
<table>
<tr><th>Lipid</th><th colspan="3">CUTOFF LEVEL CATEGORY, mg/dL (mmol/L)</th></tr>
<tr><td></td><td>Acceptable</td><td>Borderline</td><td>High/Low</td></tr>
<tr><td>Total cholesterol</td><td><170 (<4.4)</td><td>170–199 (4.4–5.1)</td><td>≥200 (≥5.2</td></tr>
<tr><td>LDL-C</td><td><110 (<2.8)</td><td>110–129 (2.8–3.3)</td><td>≥130 (≥3.4)</td></tr>
<tr><td>non-LDL-C</td><td><120 (<3.1)</td><td>120–144 (3.1–3.7)</td><td>≥145 (≥3.8)</td></tr>
<tr><td colspan="4">Triglycerides</td></tr>
<tr><td>Age 0–9y</td><td><75 (<0.85)</td><td>75–99 (0.85–1.12)</td><td>≥100 (≥1.13)</td></tr>
<tr><td>Age 10–19y</td><td><90 (<1.02)</td><td>90–129 (1.02–1.46)</td><td>≥130 (≥1.47)</td></tr>
<tr><td>HDL-C</td><td>>45 (>1.2)</td><td>40–45 (1.0–1.2)</td><td><40 (<1.0)</td></tr>
</table>
Source: Hyperlipidemia. Pediatr Rev. 2020;41(8):393–402

Non-HDL cholesterol should be less than 145, and HDL should be above 40.
If the child’s cholesterol levels are high or borderline, the patient/family should be encouraged to manage the levels through diet and exercise modifications. If available, families should be referred to a nutritionist. The IHCW algorithm may help guide follow-up.
If diet and exercise do not help, additional pharmacologic management may be necessary.
If levels are extremely high, the child should see a pediatric cardiologist.

</td><td>

Review the Healthychildren.org and CDC family-friendly resources related to lipid screening and cholesterol levels.

</td></tr>
<tr><td colspan="3">Gap: Substance use screening not completed for patients aged 12 years and above at the most recent health supervision visit or another health visit within the past year.</td></tr>
</table>

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?

Pediatric healthcare professionals and/or staff do not routinely screen for substance use beginning at age 11 years, perhaps because:
• They do not recognize the importance of universal and systematic substance use screening.
• They do not feel comfortable doing the screening.
	• Recognize the clinical responsibilities to universally and systematically screen for tobacco/nicotine (including vaping), alcohol, or drug use for patients beginning at age 11 years. For younger patients, ask if the child is exposed to substance use in the home or spends time with anyone who does. Apply knowledge from the following:
	  • *Bright Futures Guidelines*, 4th Edition, core materials listed in Row 1 of this grid.
	  • 2016 AAP clinical report, *Substance Use Screening, Brief Intervention, and Referral to Treatment*. Be aware that data have shown that relying on clinical impressions alone can result in the underestimation of substance use or failure to detect substance use disorders.
	• Recognize that neurodevelopment changes during adolescence confer vulnerability to addictions. Also, the age at first substance use is inversely correlated with the lifetime incidence of developing a substance use disorder.
	• Select and implement a standardized substance use screening tool to guide assessment for substance use-related problems. Screening should occur annually at a minimum and as concerns arise for all patients between the ages of 11 and 21 years. The screening tool should identify substance use frequency and risk level.
	• Review the AAP E-cigarette Curriculum that focuses on addressing youth E-cigarette prevention and cessation based on current evidence and best practices.
		• Conduct lunch-and-learn sessions with staff to highlight:
		  • Data about the increasing concerns of substance use by children and adolescents in the United States, including prevalence and mortality rates
		  • Patient and family member stories, which offer valuable insights that go beyond statistics and outcomes to inspire, humanize, and compel action
		• Complete the AAP course, EQIPP: Substance Use – Screening, Brief Intervention, Referral to Treatment.
		• See the Substance Abuse and Mental Health Services Administration (SAMHSA) Web site for SBIRT information and resources.

The practice setting does not have appropriate adolescent confidentiality and privacy practices in place.	• Apply knowledge from the Adolescent Confidentiality and Privacy information and resources provided in this EQIPP course, including Sample Confidentiality Statement and Customizable Confidentiality Letters. Be sure to introduce to patients/families in early adolescence and explain limits to confidentiality (eg, threat to self or others) in which confidentiality may be broken.	• Post signs or posters to make patients/families aware that your practice setting is equipped to discuss and manage substance use concerns in a confidential manner. Find an example on the AAP Adolescent Health Care Campaign Toolkit.
Gap: A follow-up discussion about substance use does not occur. *(Note: This includes education and positive reinforcement for patients who do not use substances and education and referral to treatment for patients who do.)*		

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?

Discussions about substance use only occur when the assessment is positive.	• Review the clinical responsibilities to provide a brief intervention following ***all*** tobacco/nicotine, alcohol, and drug use screening outlined in the *Bright Futures Guidelines and* 2016 AAP clinical report, *Substance Use Screening, Brief Intervention, and Referral to Treatment*. The brief intervention includes:
	  ◦ Positive reinforcement for patients who do not use substances
	  ◦ Education and referral to treatment for patients who do
	• View the Mental Health Initiatives video, which focuses on using brief intervention to address substance use. Motivational interviewing strengthens the individual's personal motivation to change by drawing the individual's meaning, importance, and capacity for change.
	• Be aware that substance use may change over time. Positive reinforcement for patients who do not use substances is an encouragement to delay initiation.
	• Ensure that your practice setting has substance use referral resources that are culturally and linguistically appropriate and are readily available for patients who need them. Patients with reported moderate to severe substance use who have indicated an inability to generate and commit to behavior change goals and/or have significant psychiatric or medical comorbidities should ideally receive more intensive, specialized evaluation and care.
	• Evaluate your EMR to be sure it is set up to accommodate SBIRT documentation for **all** the following:
	  ◦ Screening result, including abstinence or frequency and risk level
	  ◦ Brief intervention conversation that ensued
	  ◦ Educational materials provided
	  ◦ Behavior change goals if set
	  ◦ Follow-up plan
	  ◦ Recall/reminder alerts to verify those referred have established care or follow-up
		• Audit substance use screening documentation periodically. Brainstorm reasons for lack of documentation with staff and strategize ways to overcome them. Consider the ideas presented in Row 2 of this grid to improve documentation.
		• Use the AAP Vaping and Smoking Prevention Campaign Toolkit.
		• The SAMHSA Web site maintains a comprehensive substance use treatment physician listing and treatment facility locator. Also check state and county Department of Human Services Web sites.
		• Direct patients/families to review materials available on the Partnership for Drug-Free Kids Web site.
		• Use the Common Factors Approach to help to build a therapeutic alliance between patient/family and pediatric healthcare professionals.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Adolescent depression and suicide risk screening not completed at the most recent 12-, 16-m or 17-year health supervision visit or another health visit within the last year.		

Pediatric healthcare professionals are unaware of their responsibility for universal adolescent depression screening, which includes suicide risk screening, or do not feel equipped to conduct and respond to screening results.	• Recognize that adolescent depression is associated with negative academic, social, and health outcomes, including depression in adulthood, substance use, early pregnancy and parenthood, higher medical expenses, and increased suicide risk.
	• Be familiar with the clinical responsibilities to screen for adolescent depression and suicide risk universally and systematically for patients 12 to 21 years of age, as outlined in the *Bright Futures Guidelines*, 4th Edition, core materials listed in Row 1 of this grid. Pay particular attention to these sections:
	  • Adolescent Visits—11 to 21 Years
	  • Promoting Mental Health
	• Consult the following clinical resources for additional information and guidance:
	  • AAP Guidelines for Adolescent Depression in Primary Care (GLAD-PC): I. Identification, Assessment, and Initial Management
	  • AAP Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management
	• Adopt standardized depression and suicide risk screening tools to determine if patients are at risk for depression or suicidal ideation. **Be aware that screening for depression only is not sufficient to identify suicide risk.**
	Commonly used depression screening tools include:
	  • Patient Health Questionnaire (PHQ-2*; PHQ-9: Modified for Adolescents)
	  • Kutcher Adolescent Depression Scale (KADS-6)
	*Does not include suicide risk questions.
	• Because suicidal ideation very often occurs for reasons other than depression, add a specific suicidality screener, such as the Ask Suicide-Screening Questions (ASQ) to simultaneously screen for both depression and suicide risk at all health supervision visits for all adolescent patients beginning at age 12.
		• Invite guest speakers (patient, parent, or mental health professional) to talk about the importance of depression screening, management of depression, and suicide risk in adolescents in culturally appropriate ways.
		• Review the AAP articles:
		  • *Mental Health Competencies for Pediatric Practice* (2019)
		  • *Achieving the Pediatric Mental Health Competencies* (2019)
		  • *Suicide and Suicide Attempts in Adolescents* (2016)
		• Review the *Bright Futures Guidelines*: Promoting Mental Health chapter.
		• Watch the AAP Pediatric Mental Health Minute Series. Scroll to locate the one on Adolescent Depression.
		• Integrate the AAP Residency Curriculum: Mental Health Education Resources.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• The *Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit* includes copies of the PHQ-A (in multiple languages). • The National Institute of Mental Health houses copies of the ASQ (in multiple languages). A more detailed compilation of mental health tools for use with pediatric patients from the Mental Health Practice Tools is available here. Also see the AAP *Blueprint for Youth Suicide Prevention*.	
Gap: Plan not documented when the adolescent depression and suicide risk screening results are positive.		

The pediatric healthcare professional is not comfortable discussing mental health concerns.
 	
ents/families are resistant to discussing/accepting that the adolescent is depressed.
	• Review resources and information provided in the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit.
	• Recognize that, depending on the severity of the concern and the pediatric healthcare professional's expertise, concerns can be addressed through in-office interventions, comanaged care, or referral to a mental health professional. Suicide risk and the presence of firearms in the home also must be considered.
	• Provide guidance and education using resources such as:
	  • AAP Mental Health and Teens: Watch for Danger Signs
	  • AAP Suicide Prevention Campaign Toolkit
	  • American Academy of Child and Adolescent Psychiatry (AACAP) Facts for Families: Depression in Children and Teens
	  • ASQ Suicide Screening Questions Toolkit
	  • AAP Point of Care Solutions: Depression in Children and Adolescents: Treatment (Requires subscription)
	  • AAP Point of Care Solutions: Depression in Children and Adolescents: Types and Signs (Requires subscription)
	• Create a Mental Health or Adolescent portal on your practice setting's Web site with educational resources, including information on your practice's approach to mental health concerns and where and how to get help.
		• Include materials on the practice's Web site and within the practice to normalize talking about mental health and addressing stigma.
		• Appoint an office adolescent or mental health champion to educate patients and families about mental health issues in culturally appropriate ways and to facilitate referrals and follow-up.
		• Research resources on adolescent depression and make available to patients/families. One such example is the NIMH brochure, Teen Depression: More Than Just Moodiness.
		• Use the Common Factors Approach to help to build a therapeutic alliance.
		• Use Bright Futures Visit Documentation Forms, which remind pediatric healthcare

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Apply principles of shared decision-making and motivational interviewing in discussions to encourage patients to take ownership of possible change. • Refer patients to community mental health providers with experience and tools to provide needed services. Provide oversight of patient progress.	professionals/staff to document depression screening, results, family discussions, resources, and referrals. Consider additional ideas presented in Row 2 of this grid to improve documentation.
Gap: Universal HIV screening is not completed at least once at a health supervision visit for patients between 15–17 years of age. (Screening should occur more often if risk factors are present.)		

Pediatric healthcare professionals and staff provide HIV screening only when risk factors are present.	• Review the following AAP policies and recommendations concerning clinical responsibilities for universal HIV screening at least once between the ages of 15 and 18 years regardless of risk factors:
	  • *Bright Futures Guidelines*, 4th Edition, core materials listed in Row 1 of this grid
	  • AAP 2021 clinical report, *Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis*.
	  • USPSTF recommendations on HIV screening
	  • AAP 2021–2024 *Red Book** topics:
	  • In Section 3, Human Immunodeficiency Virus Infection
	  • In Section 2, Sexually Transmitted Infections
	*Note: *Red Book* is an AAP member benefit. Nonmembers may view the PDF version.
		• Recognize and discuss with staff the important role pediatric healthcare professionals play in preventing and controlling HIV infection by promoting risk-reduction counseling, screening, and diagnostic testing for HIV, understanding PEP and PrEP indications and offering to youth at risk of exposure, and providing treatment for those infected.
		• Create adolescent-friendly waiting or exam rooms with sexual health information materials, posted adolescent confidentiality and privacy practices, and rainbow flags on wall.

Gap: No plan documented when HIV screening results are positive.		
Pediatric healthcare professionals/staff are not comfortable discussing conditions that may have been sexually transmitted.	• Introduce your adolescent confidentiality and privacy practices to patients and families in early adolescence to make all parties comfortable with discussing adolescent development and emerging health issues, including HIV. • Prepare to have candid, confidential discussions with adolescents on sexual activity.	• Appoint an adolescent office champion to provide education and share resources with patients/families about adolescent health issues, including HIV.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?

Patients/families are resistant to discussing/accepting that they are at risk of a condition that has likely been sexually transmitted.	• Review the CDC video resource: The 6P's: A New Approach To Sexual History Taking.
	• Recognize that open discussions about sexual development, sexual desire, sexual identity, and sexual behavior should begin in early adolescence. It is important to share information, listen and respond to the adolescent's concerns, respect privacy, provide education and anticipatory guidance, and make sexuality part of a routine, continuing conversation. Such actions help establish trust and pave the way for the development of a shared partnership in care.
	• Select educational materials and online resources to share with patients/families so they can learn about HIV and understand how it is prevented, transmitted, tested, and treated:
	  • From the CDC, HIV basics
	  • From HIV.gov, HIV Pre-Exposure Prophylaxis materials
	  • From Healthychildren.org, HIV and AIDS
		• Create an adolescent portal on your practice setting's Web site and encourage communication about sexual health, HIV and STIs with pertinent educational resources including information on your practice's confidentiality and privacy practices.
		• Use teach-back techniques to assess patient/family understanding.
		• Consider the ideas presented in Row 2 of this grid to improve documentation, as needed.

Gap: Chlamydia screening is not completed annually for patients who are: • ***Female and sexually active*** • ***Male, sexually active, and at increased risk***		

Pediatric healthcare professionals are reluctant to discuss sexual activity with adolescent patients. They do not ask if the patient is sexually active.
 	
Patients are resistant to discuss their sexual activity.
	• Review the *Bright Futures Guidelines*, 4th Edition, core materials listed in Row 1 of this grid, which describe clinical responsibilities to perform chlamydia screening annually for the following:
	  • Females who are sexually active, even if no symptoms are present or barrier contraception is reported.
	  • Males who are sexually active and at increased risk. According to the AAP 2021 -2024 *Red Book*: Chlamydia trachomatis section, risk factors include settings with high prevalence rates (eg, correctional facilities, national job training programs, military recruits, STI clinics, high school clinics, adolescent clinics); sex with another male; multiple or anonymous sex partners; sex in conjunction with illicit drug use; or sex with partners who participate in these activities.
		iew and share with staff:
		• USPSTF recommendations on chlamydia and gonorrhea screening
		• AAP 2016 clinical report, *Sexuality Education for Children and Adolescents*
		• AAP 2017 clinical report, *Sexual and Reproductive Health Care Services in the Pediatric Setting*
		• Why Screen for Chlamydia? An Implementation Guide for Health

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	review these topics in the AAP 2021–2024 *Red Book*: • In Section 3, Chlamydia Trachomatis • In Section 2, Sexually Transmitted Infections • Recognize that sexuality-related issues are an important component of adolescent health care. Chlamydia infection is the most commonly report sexually transmitted infection (STI) in the United States and many of those infected are asymptomatic. Asymptomatic infected males can transmit chlamydia to female partners. Chlamydia is the leading preventable cause of infertility in the United States. Treating chlamydia-infected females: • Reduces pelvic inflammatory disease • Reduces infertility, ectopic pregnancy, and chronic pelvic pain • Prevents complications in newborns Identifying and treating chlamydia in males who have sex with males can help to prevent HIV infection and identify patients who can benefit from PrEP. • Review Sexual Health and Your Patients: A Provider's Guide for information on taking a sexual history and discussing sex with patients. • Introduce adolescent confidentiality and privacy practices to patients and their family in early adolescence to ensure all parties are comfortable discussing adolescent development and emerging health issues, including sexually transmitted infections (STIs). • Prepare to have candid, confidential discussions with adolescents on sexual activity. • Recognize that open discussions about sexual development, sexual desire, sexual identity, and sexual behavior should begin in early adolescence. It is important to share information, listen and respond to the adolescent's concerns, respect privacy, provide education and anticipatory guidance, and make sexuality part of a routine, continuing conversation. Such actions help establish trust and pave the way for the development of a shared partnership in care. • Select and share educational materials and online resources with adolescents so they can learn about STIs and understand how they are prevented, transmitted, tested, and treated:	Care Providers from the National Chlamydia Coalition • AAP 2016 policy statement, *Achieving Quality Health Services for Adolescents*. • The *Bright Futures Guidelines*: Promoting Healthy Sexual Development and Sexuality chapter • Healthy Children.org Sexually Transmitted Infections Web site • Centers for Disease Control and Prevention (CDC): surveillance data, treatment guidelines, informational brochures, informational fact sheets, infographics, training, STD clinical slides, STD picture cards and more at www.cdc.gov/std. • CDC STI Treatment Guidelines adolescent special populations section and chlamydia section: screening strategies, including 3 site testing and opt out screening. • Brainstorm ways to make your office environment adolescent friendly so adolescents feel comfortable and your practice approachable. • View the Community Care of North Carolina Engaging Adolescent video series. • Create an adolescent portal on your practice setting's Web site with

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• CDC Sexually Transmitted Diseases – Adolescents and Young Adults • AAP Adolescent Sexual Health • Healthychildren.org – Sexually Transmitted Infections • Expedited Partner Therapy (EPT) • Advocates for Youth Adolescent Reproductive and Sexual Health Education Program (ARSHEP)	pertinent adolescent educational resources including information on your adolescent confidentiality and privacy practices. • Create adolescent-friendly waiting or exam rooms with sexual health information materials, posted adolescent confidentiality and privacy practices, and rainbow flags on wall.

The practice setting lacks a process for obtaining a gender neutral or nonbinary sexual history from adolescent patients.	• Use or develop a patient-only questionnaire such as the following that specifically asks appropriate questions about sexual activity:
	  • Adolescent Bright Futures Previsit Questionnaires (Risk Assessment section)
	  • AAP Adolescent Sexual Health
	  • HEEADSS for Adolescents interview instrument to facilitate question-and-answer sessions to find out about issues in adolescents' lives, including sexual activity
	  • SSHADESS screening questions
	  • **Note**: According to the 2021 STI Treatment Guidelines, "providers might consider opt-out chlamydia and gonorrhea screening (ie, the patient is notified that testing will be performed unless the patient declines, regardless of reported sexual activity) for adolescent and young adult females during clinical encounters. Cost-effectiveness analyses indicate that opt-out chlamydia screening among adolescent and young adult females might substantially increase screening, be cost-saving, and identify infections among patients who do not disclose sexual behavior."
	• Employ principles of shared decision-making and motivational interviewing to encourage adolescents to take ownership of changes. Provide individualized anticipatory guidance and education as appropriate.
	• Routinely ask about sexual behavior and document in the EHR.
		• Review these professional resources to gain familiarity with obtaining a sexual history from adolescents:
		  • CDC presentation, A Guide to Taking a Sexual History
		  • AAP PediaLink Adolescent Sexual Health Curriculum Series

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Collect urine specimen with vitals at every visit and decide whether to send for testing during visit.	
Gap: No plan documented when chlamydia screening results are positive.		

The practice setting lacks a process for delivering test results to patients.	• Establish a systematic way to confidentially deliver and discuss test results and next steps with adolescents. For example:
	  • Ask for the patient's cell number and the best time to call.
	  • Have the patient call the office at a designated time when staff is available to discuss results.
	  • Offer expedited partner therapy to all patients testing positive.
	  • Consult local or state health department to understand confidential reporting requirements and appropriate treatment and follow-up, including state EPT laws.
	  • Schedule a test of reinfection within 3 months.
	• Provide education, resources, and a treatment plan for patients who test positive. Put checks and balances in place to ensure appropriate follow-through.
		• Use teach-back techniques to assess patient/family understanding.
		• Consider the ideas presented in Row 2 of this grid to improve documentation, as needed.

Appendix

Family

PDSA* Cycles: Implementing Bright Futures Processes in Your Practice

Consider the practice-wide changes needed to implement *Bright Futures Guidelines* and incorporate *Bright Futures* core tools in health supervision visits.	
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 process: What is the workflow? Who is involved? What materials (eg, screening tools, brochures) are needed and how will they be accessed?
Do	Pilot the process you have laid out.
Study	Gather feedback from staff. What worked? What did not work? Use the information gathered to help refine and improve your process.
Act	If needed, redesign your process and test again. Implement changes that resulted in success.
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.

Key Protective Factors

The following 5 factors from The Strengthening Families Approach and Protective Factors Framework™: A Pathway to Healthy Development and Well-Being include:

- 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, 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

For more information and resources, see:

- Protective Factors Framework from the Center for the Study of Social Policy (CSSP)
- Four Ways to Assess Positive Childhood Experiences from Healthy Outcomes from Positive Experiences (HOPE).
- Promoting Children's Health and Resiliency: A Strengthening Families Approach from the CSSP and AAP

Adolescent Confidentiality and Privacy Practices

The *Bright Futures Guidelines*, 4th Edition, recommend that adolescents start having confidential, one-on-one time with their pediatric health care professional during early adolescence. This information is excerpted from the Adolescent Health Consortium's Investing in Adolescent and Young Adult Health report (as part of the AAP Adolescent Health Care Campaign Toolkit, which includes strategies to create an adolescent supportive practice and professional and family-focused resources).

- Confidentiality refers to the idea that discussions between an adolescent or young adult patient and their pediatric healthcare professionals are kept private, and not shared with the patient's parents or other third parties without the permission of the patient. (See State Laws and Exceptions to Confidentiality below.)
- The benefits of adolescent confidential health care include fostering health, encouraging independence, building therapeutic relationships, and discussing critical and sensitive health topics (eg, sexual/reproductive health, substance use, mental/emotional well-being, risk-taking behaviors). Adolescent patients are more likely to disclose health information if they trust their pediatric healthcare professionals. Trust-based relationships can lead to better interactions and higher-quality health visits.

- Pediatric healthcare professionals should recognize parents as a critical partner in fostering adolescent health and provide appropriate guidance to navigate health questions and concerns.
- In early adolescence, pediatric healthcare professionals should introduce their privacy policy and confidentiality practices to adolescents and their families, including situations in which confidentiality may be broken (eg, threat to self or others, abuse/neglect, reportable diagnosis [only to the health department]). Inform families that health supervision visits for adolescents will include one-on-one time to speak with the adolescent during the health supervision visit. Confidential topics include discussions about sexual/reproductive health, substance use, mental/emotional well-being, risk-taking behavior, and anything else of concern to the specific adolescent.

State Laws
Pediatric healthcare professionals should adhere to state's laws concerning confidentiality and consent, including ways in which confidentiality can be compromised (eg, record keeping, billing statements, insurance)**.** Pediatric healthcare professionals and medical institutions need to establish systems to protect adolescent confidentiality in the medical record and limit sharing of confidential information.

Exceptions to Confidentiality
Pediatric healthcare professionals should adhere to exceptions to confidentiality, eg, imminent danger/abuse, self-harm, or reportable sexually transmitted infection diagnosis (to the health department). The University of Michigan's Adolescent Health Initiative offers training videos around confidentiality laws.

Also see:
- Additional adolescent confidentiality information and resources presented in this EQIPP course:
  - Confidential Discussions With Adolescents on Sexual Activity
  - Sample Confidentiality Statement and Customizable Confidentiality Letters
  - Adolescent Confidentiality and Privacy
- The 2020 Society for Adolescent Health and Medicine statement, *The 21st Century Cures Act & Adolescent Confidentiality* to develop confidentiality practices

Confidential Discussions with Adolescents on Sexual Activity

Regarding discussions on sexual activity, the 2021 CDC Sexually Transmitted Infections Treatment Guidelines and 2021 USPSTF recommendations include:
- Pediatric healthcare professionals should confidentially ask all adolescents whether they have ever had sexual intercourse, are currently sexually active, or are planning to become sexually active in the future. Professionals should ask about gender identity and sexual orientation.
- Professionals should define the terms "sexual intercourse," "gender identity," "sexual orientation," and "sexually active," because these terms can have different meanings for adolescents. It is important that adolescents and young adults are educated to recognize that noncoital practices (oral/genital contact, anal intercourse, and hand/genital contact), as well as vaginal intercourse, put them at risk of STIs.

Also see:
- Additional adolescent confidentiality information and resources presented in this EQIPP course:
  - Confidential Discussions With Adolescents on Sexual Activity
  - Sample Confidentiality Statement and Customizable Confidentiality Letters
  - Adolescent Confidentiality and Privacy

- The 2020 Society for Adolescent Health and Medicine statement, *The 21st Century Cures Act & Adolescent Confidentiality* to develop confidentiality practices
- 2018 AAP Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents policy statement
- AAP Web page, including how to support special adolescent populations

Sample Confidentiality Statement and Customizable Confidentiality Letters

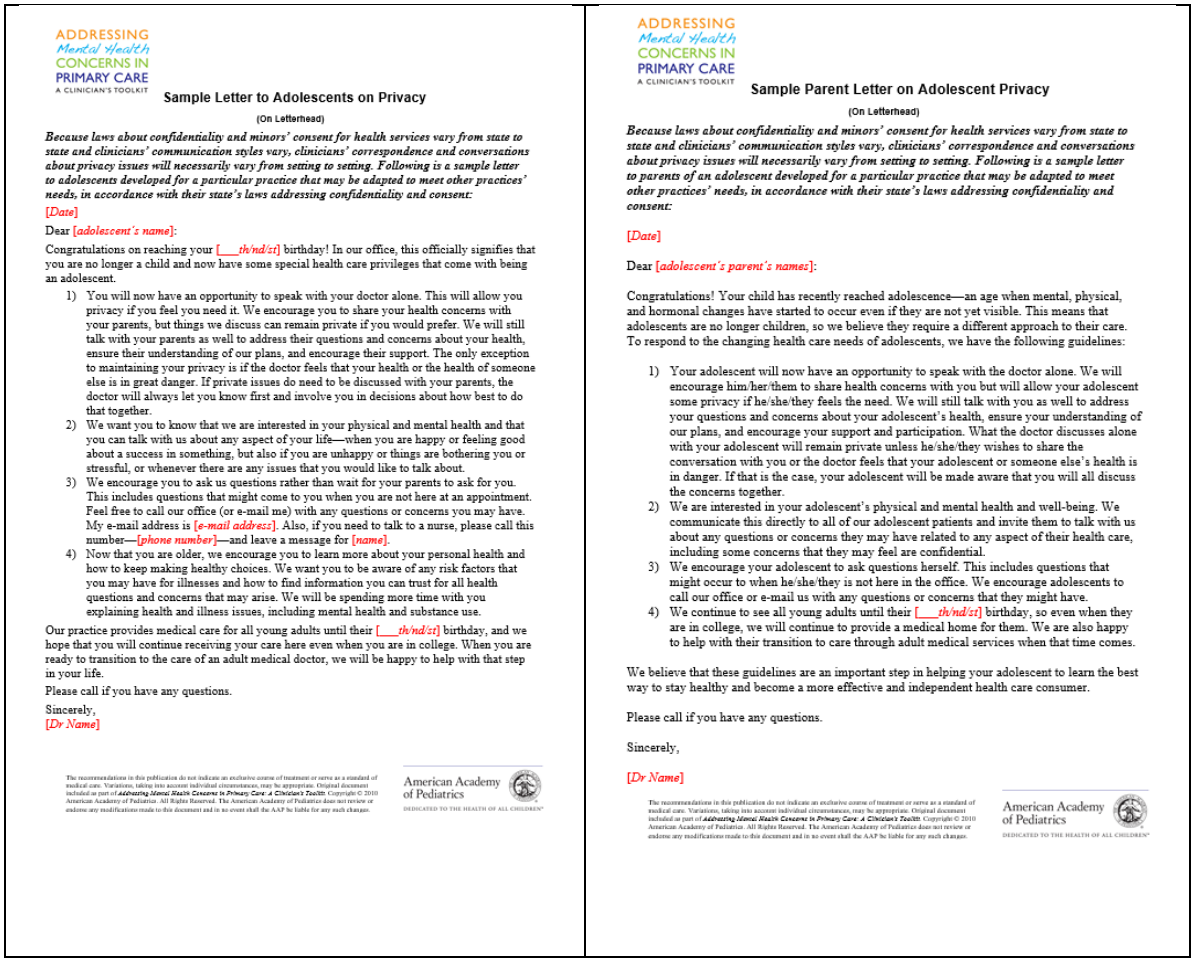
Sample Confidentiality Statement

The *Bright Futures Guidelines*, 4th Edition, includes a sample confidentiality statement: *"Our discussions with you are private. We hope you will feel free to talk openly with us about yourself and your health. Information is not shared with other people without your permission unless we are concerned that someone is in danger."* Author: Jack Mayer, MD, MPH, Rainbow Pediatrics, Middlebury, VT.

Customizable Confidentiality Letters

Following are example confidentiality letters for adolescents and parents from the AAP Mental Health Toolkit that can be customized for your practice.

Bright Futures – Infancy to Adolescence



ADDRESSING Mental Health CONCERNS IN PRIMARY CARE
A CLINICIAN'S TOOLKIT

Sample Letter to Adolescents on Privacy

(On Letterhead)

Because laws about confidentiality and minors' consent for health services vary from state to state and clinicians' communication styles vary, clinicians' correspondence and conversations about privacy issues will necessarily vary from setting to setting. Following is a sample letter to adolescents developed for a particular practice that may be adapted to meet other practices' needs, in accordance with their state's laws addressing confidentiality and consent:

[Date]

Dear *[adolescent's name]*:

Congratulations on reaching your *[___th/nd/st]* birthday! In our office, this officially signifies that you are no longer a child and now have some special health care privileges that come with being an adolescent.

1) You will now have an opportunity to speak with your doctor alone. This will allow you privacy if you feel you need it. We encourage you to share your health concerns with your parents, but things we discuss can remain private if you would prefer. We will still talk with your parents as well to address their questions and concerns about your health, ensure their understanding of our plans, and encourage their support. The only exception to maintaining your privacy is if the doctor feels that your health or the health of someone else is in great danger. If private issues do need to be discussed with your parents, the doctor will always let you know first and involve you in decisions about how best to do that together.
2) We want you to know that we are interested in your physical and mental health and that you can talk with us about any aspect of your life—when you are happy or feeling good about a success in something, but also if you are unhappy or things are bothering you or stressful, or whenever there are any issues that you would like to talk about.
3) We encourage you to ask us questions rather than wait for your parents to ask for you. This includes questions that might come to you when you are not here at an appointment. Feel free to call our office (or e-mail me) with any questions or concerns you may have. My e-mail address is *[e-mail address]*. Also, if you need to talk to a nurse, please call this number—*[phone number]*—and leave a message for *[name]*.
4) Now that you are older, we encourage you to learn more about your personal health and how to keep making healthy choices. We want you to be aware of any risk factors that you may have for illnesses and how to find information you can trust for all health questions and concerns that may arise. We will be spending more time with you explaining health and illness issues, including mental health and substance use.

Our practice provides medical care for all young adults until their *[___th/nd/st]* birthday, and we hope that you will continue receiving your care here even when you are in college. When you are ready to transition to the care of an adult medical doctor, we will be happy to help with that step in your life.

Please call if you have any questions.

Sincerely,
[Dr Name]

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

ADDRESSING Mental Health CONCERNS IN PRIMARY CARE
A CLINICIAN'S TOOLKIT

Sample Parent Letter on Adolescent Privacy

(On Letterhead)

Because laws about confidentiality and minors' consent for health services vary from state to state and clinicians' communication styles vary, clinicians' correspondence and conversations about privacy issues will necessarily vary from setting to setting. Following is a sample letter to parents of an adolescent developed for a particular practice that may be adapted to meet other practices' needs, in accordance with their state's laws addressing confidentiality and consent:

[Date]

Dear *[adolescent's parent's names]*:

Congratulations! Your child has recently reached adolescence—an age when mental, physical, and hormonal changes have started to occur even if they are not yet visible. This means that adolescents are no longer children, so we believe they require a different approach to their care. To respond to the changing health care needs of adolescents, we have the following guidelines:

1) Your adolescent will now have an opportunity to speak with the doctor alone. We will encourage him/her/them to share health concerns with you but will allow your adolescent some privacy if he/she/they feels the need. We will still talk with you as well to address your questions and concerns about your adolescent's health, ensure your understanding of our plans, and encourage your support and participation. What the doctor discusses alone with your adolescent will remain private unless he/she/they wishes to share the conversation with you or the doctor feels that your adolescent or someone else's health is in danger. If that is the case, your adolescent will be made aware that you will all discuss the concerns together.
2) We are interested in your adolescent's physical and mental health and well-being. We communicate this directly to all of our adolescent patients and invite them to talk with us about any questions or concerns they may have related to any aspect of their health care, including some concerns that they may feel are confidential.
3) We encourage your adolescent to ask questions herself. This includes questions that might occur to when he/she/they is not here in the office. We encourage adolescents to call our office or e-mail us with any questions or concerns that they might have.
4) We continue to see all young adults until their *[___th/nd/st]* birthday, so even when they are in college, we will continue to provide a medical home for them. We are also happy to help with their transition to care through adult medical services when that time comes.

We believe that these guidelines are an important step in helping your adolescent to learn the best way to stay healthy and become a more effective and independent health care consumer.

Please call if you have any questions.

Sincerely,

[Dr Name]

American Academy of Pediatrics
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To customize the letters for use in your practice:

- Sample Letter to Adolescents
- Sample Letter to Parents

Standardized Substance Use Screening and Assessment Tools

The substance use screening tool should be developmentally appropriate, valid, and reliable, and practical for use in a busy medical office. The best screening tools contain the lowest number of succinct, validated questions that can elicit accurate and reliable responses. At a minimum, the screening tool combined with clinical judgment and additional assessments as needed should help identify the patient's frequency of substance use and risk level.

The following are commonly used substance use screening/assessment tools:

- Screening to Brief Intervention (S2BI)
- Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)
- Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT)

Each tool provides an interpretation of screening results. See Interpreting Substance Use Screens for interpretation of S2BI and CRAFFT.

Interpreting Substance Use Screens

Interpreting S2BI

Substance Use Disorder (SUD)	S2BI Score	Brief Intervention Goals
None (No past-year use)	No use of any substance	Positive reinforcement and encouragement to delay initiation.
None (Past-year use without a SUD)	Once or twice use of any substance	Brief advice to encourage cessation.
Mild-Moderate SUD	Monthly use of any substance	Brief motivational intervention to encourage cessation or reduce use.
Severe SUD	Weekly or greater use of any substance	Brief motivational intervention to reduce use or risky behaviors AND accept referral to treatment. Adolescents with nicotine, alcohol or opioid addiction may also benefit from medications.

Interpreting CRAFFT

Explore **Yes** responses with the patient to reveal the extent of substance use-related problems and inform the brief intervention.