Ideas for Closing Performance Gaps

Key Activity: Elicit and Address Patient/Family Concerns

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

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Practice does not actively or effectively elicit and document that patient/family concerns were addressed and resources were provided during health supervision visits.		
The practitioner does not have systematic process for eliciting family strengths and needs.	1. Pilot the use of Bright Futures documentation forms found in the Bright Futures Tool and Resource Kit on a limited basis. • Adjust the use so the forms fit in the needs of your practice and patients' needs. • Ask teens and families on the Family Advisory Committees to review the forms. Discuss ways to pilot/implement the forms in the office setting. 2. Use other standardized questionnaires such as mental health surveys, screens for family substance abuse, social isolation, family hunger, and family mental health issues to identify needs. 3. Discuss with your staff the challenge of balancing recommended anticipatory guidance and preventive services with addressing family strengths and needs. Include a discussion of confidentiality policies and how you will address the needs of teens and parents/caregivers. 4. Consider reviewing and/or developing a brief template that outlines questions to ask patients/parents about their concerns. • Investigate the Bright Futures Tool and Resource Kit for questions that can be incorporated into your EMR or patient portal. 5. Focus on a particular group of patients as you adopt new strategies for eliciting parental concerns. • Start with a small, focused population when testing new approaches, such as new patients, because parents may have similar concerns. • Identify a key clinician with an interest in well-youth improvement and ask them to pilot a change on a limited number of patients before making the change officewide.	Try suggested strategies on a small scale first, with a single practitioner and a limited number of patients. Recruit teens and families on Family Advisory Committees to review forms, help design policy, and plan implementation. Survey patient satisfaction and scheduler satisfaction of a new role for this staff member. Provide memory ticklers and signs next to the scale or nurse's station, or drop-down boxes in the computer to remind nurse or MA to get forms completed.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Work with a quality improvement coach to map the office workflow around youth visits including scheduling appointments and delivering care. 6. Ask the scheduler to ask if a parent has concerns at the time an appointment is made and note concerns in the patient's medical record. • Pilot the process first on a few patients before taking it officewide. • After a successful pilot, schedule training for all office staff to review proper use of the new templates. 7. Pilot a process in which the nurse or medical assistant (MA) places the completed forms with the chart, or, if using an electronic health record (EHR), ask the MA to optically scan the completed questionnaire or enter the information into the EHR. • It is also possible to add a Family/Patient Concerns prompt to the EHR that can be clicked during the examination. 8. Review and discuss with the youth/adolescent and/or parent/caregiver what she or he is doing well and any concerns identified by office staff or through the questionnaire. 9. Customize your EHR to include a Family/Patient Concerns prompt that provides space to type or write in information regarding needs of the parent/caregiver and youth/teen. The prompt may even link to the questionnaire used to elicit information, or the questionnaire may be optically scanned into the EHR. 10. Determine topics of concern you will address during the visit and topics for which you will refer to outside resources. 11. Consider what new resources or referrals your practice may need. 12. Identify new community resources or referrals for issues that are best handled outside the office. • Gathering data about the most common concerns of your patients may help you decide which referrals and community resources are the most likely to be needed and used by your patients. (Refer to the Bright Futures *Community Resources Tip Sheet.*) • Ask youth/adolescents about possible community resources with which they are familiar and using. • Identify options for using social media to educate teens. • Keep a ready resource of commonly used referral resources in the community.	Consider where the prompt is placed in the chart and if it is noticed by the intended user. Be flexible, especially in situations in which you cannot identify satisfactory outside resources. Your empathy and hope for patients may be better than no care at all. For those families with significant concerns or who appear to have substantial adverse circumstances interfering with their ability to provide optimal development, consider partnering with other resources for family support. Consider hosting meet-and-greet sessions with outside community resources to establish a better understanding of services and a personal contact. Schedule training for all office staff to review proper use of the new templates.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	13. Ask youth/adolescents about possible social media options for education. 14. As success builds with your pilot approaches, consider taking the improvement officewide with appropriate preparation.	
Heath care professional agenda and patient/family agenda differ.	1. Rely on your clinical judgment to balance the needs of the family with your recommendations and goals for the visit. 2. Develop a policy for office staff that outlines questions to ask patients/parents about concerns at the time an office visit is scheduled and/or during a reminder call, *and* note the concerns on the patient chart. Incorporate Bright Futures previsit questionnaires (both for patient and parent) into your office routine. 3. Provide Bright Futures previsit questionnaires for the patient and family to complete in the waiting room or exam room before the visit.	Schedule a brainstorming session with office staff to generate suggestions that address how: ○ To change the culture of the practice with the team. ○ To rebalance the duties of the team so each member is utilized effectively ○ Other practices handle parental concerns. ○ To Implement Bright Futures suggestions.
Family concerns from previous visits were not documented in the chart or EHR.	1. Rely on your clinical judgment to balance the needs of the family with your recommendations and goals for the visit. 2. Develop a policy for office staff that outlines questions to ask patients/parents about concerns at the time an office visit is scheduled and/or during a reminder call, *and* note the concerns on the patient chart. Incorporate Bright Futures previsit questionnaires into your office routine. 3. Provide Bright Futures previsit questionnaires for the family to complete in the waiting room or exam room before the visit.	Get feedback from families formally or informally as to ways they think their concerns could be more effectively addressed. Parent partners on the office QI team can be especially valuable in this situation.
Follow-up visits and/or counseling may not be covered without the correct International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code.	1. Become familiar with coding requirements for counseling during health supervision visits. Ensure that appropriate documentation is made for billing codes. 2. Communicate coding requirements to the office staff and billing group. 3. Develop a practicewide policy that outlines how to code correctly for counseling during a health supervision visit.	Identify a specific clinician in the practice with an interest in coding who can work with office staff in optimizing code results.

Key Activity: Perform Developmental Surveillance/Identification of Patient Strengths

Rationale: While developmental surveillance is relatively clear for young children (assessment of motor, social, and language skills), the details of promoting healthy development for school-aged children and adolescents is less well defined. In the 3rd edition of the *Bright Futures Guidelines*, the visit priorities address healthy development, and the Association of Maternal and Child Health Programs framework was adopted as a guide. This strength-based framework provides a platform to accentuate what is going right for a child, and has a positive focus to health promotion and disease prevention. In addition, the concept of using a strength-based approach with children, adolescents, and families was recommended in all editions of Bright Futures.[1]

[1]Tanski S, Garfunkel LC, Duncan PM, Weitzman M (eds.). *Performing Preventive Services: A Bright Futures Handbook*. Elk Grove Village, IL: American Academy of Pediatrics. 2010; pg. 9.

Potential Barriers	Suggested Ideas for Change
Gap: *Age appropriate developmental screening is not routinely performed.*	
The practice is not familiar with Bright Futures developmental surveillance recommendations for patients 5 to 21 years of age.	1. Review the following sections of The Bright Futures Guidelines: • Middle Childhood: 5 to 10 years • Adolescence: 11 to 21 years 2. Become familiar with developmental milestone periods for middle childhood and adolescence. Surveillance of Development milestones are outlined in the Bright Futures Pocket Guide: • 7- and 8-year visit • 9- and 10-year visit • 11- to 21-year (adolescent) visits

Potential Barriers	Suggested Ideas for Change
The practice does not have a system in place to perform, interpret, follow up, and document developmental surveillance for school age and adolescent patients.	1. Designate an office champion who is responsible for spearheading development and implementation of a systematic approach to developmental surveillance. 2. Form an improvement team and define developmental surveillance for your office: • Focus on a particular group of patients when adopting new strategies to assess development in middle childhood and adolescence. • Start with a small and focused population, such as children entering middle school or a particular age group of adolescents (eg, early adolescents – 11–14 years) when testing new approaches. • Then, expand the focus to include other ages of middle childhood and adolescence. • Parent- and adolescent-completed questionnaires offer ease and flexibility of administration, and can be used to assess a broad range of skills and developmental issues. • Incorporate EHR prompts for developmental surveillance during appropriate office visits. • Questions can be asked during the visit itself as well. It is helpful for the medical home staff and health care providers to agree on what the major components of surveillance should be. Staff can begin addressing issues during their time with the young person and family and can also help identify adolescent and family strengths. • Ensure that your practice consistently addresses developmental tasks during health supervision visits in middle childhood and adolescence. 3. If possible, utilize EHR-based flags/prompts to remind health care providers to consider performing overdue developmental surveillance in all types of visits in order to minimize missed opportunities. 4. If your practice does not use an EHR, use paper notes to flag charts of patients presenting for healthcare visits who are overdue for developmental surveillance.

Adolescents have a lower rate of health supervision visits.	1. Utilize a reminder recall system:
	• Define a recall/reminder system for your practice.
	• Determine what services and/or criteria for tracking will be the focus of your reminder/recall system.
	  ○ Consider using the measures of this course to streamline office health supervision data collection.
	  ○ Determine which group of patients to target with the new system. For example, target patients who are behind on services (most effective approach), or send reminders to an entire age group (less effective approach).
	• Determine the number of patients who are overdue for health supervision visits to estimate and prepare for a potential increased volume/workload.
	  ○ Discuss with scheduling and billing staff for suggestions.
	  ○ Use visit reports/EHR tracking or a practice management system.
	
	2. Delegate an office champion to manage the recall/reminder system.
	
	3. When adolescent patients are seen for sick visits, remind them and their parent/guardian of the importance of health supervision visits through age 21 years.

Potential Barriers	Suggested Ideas for Change
The practice is unsure about which developmental surveillance questionnaire to use for middle childhood and adolescence.	1. Consider using a concise template to obtain information quickly and efficiently. 2. The Bright Futures previsit questionnaires include questions for parents of 7- to 10-year-old children and youth ages 11 to 21 years. These questions could be added to questionnaires already in use with these age groups. 3. Discuss with office staff the use of developmental surveillance questionnaires coupled with strength-based approaches during health supervision visits. 4. Review various surveillance questionnaires and choose the one that is most popular within your practice, or use them to create a composite customized questionnaire. An example is the HEEADSSS assessment with additional strengths questions (see Bright futures documentation form) that is used for adolescent surveillance during the psychosocial interview. 5. If appropriate, incorporate documentation of questionnaire responses or overall assessments in EHR documentation.
Health care providers and/or patients/parents have cultural and/or language barriers.	1. Provide training for office staff that addresses cultural and language differences *commonly* faced in caring for the cultural groups represented in your patient population. • Of note, the conceptualization of which characteristics constitute strengths may be different for families with different cultural backgrounds, and different cultures may be more or less permissive of self-identifying strengths, which may be misunderstood as inappropriate self-promotion. 2. Instruct the office staff to check with patients/parents to ensure that they understand how to complete the tool and to answer any questions that they may have. • Read the questions to parents or adolescent who may have difficulty using the tool due to cultural, linguistic, or literacy considerations. 3. Stock developmental surveillance forms in the various languages that are most represented in your patient population**.** Bright Futures previsit questionnaires are available in English and Spanish.

Potential Barriers	Suggested Ideas for Change
Gap: No follow-up plan provided for positive screening results.	
The practice does not have an organized process for follow-up of positive screens.	1. Identify and reflect on the child's/adolescent's strengths. 2. Offer suggestions for augmenting strength areas that may be lacking or deficient. Point out the patient's existing strengths to provide a hopeful foundation upon which such suggestions can be offered. 3. Use discussion of strengths as a way to engage the patient in discussing needed behavioral changes. 4. Health care providers can encourage patients to utilize their strengths in discussions about behavioral change by incorporating principles of shared decision-making or motivational interviewing. If developmental concerns are identified in children up to 8 years old (via the PEDS), consider following the AAP Developmental Screening algorithm. If mental health concerns are identified, the AAP Task Force on Mental Health algorithm may be followed to determine next steps.
The practice does not have a seamless approach for referrals for specialized services as indicated and close follow-up care.	1. Review the Pediatrician's Role in Community Pediatrics. 2. Contact your local health department and school district to determine what services are available to your patients. 3. The health care provider can coordinate the specialty services and provide integrated oversight of the patient's progress. 4. Coordinate the specialty services and provide integrated oversight of the patient's progress.
Practice does not have linkages to local community resources or specialists.	1. Implement use of Bright Futures Community Resources tools: • Bright Futures: Community Resources Tip Sheet • Bright Futures: Community Resources Check Sheet (pg. 7) 2. Use the Community Pediatrics Self-Assessment tool to determine where your practice is in relation to community pediatrics activities. 3. Create a regularly updated list of community-based referral programs with contact numbers. • Community resources fall into 2 categories: agencies and providers/practitioners. 4. Assign an office champion to keep lists updated on an ongoing basis and to systematically call each number on the list (possibly during slow times) to make sure they are still operational.

Key Activity: Perform Risk Assessment and Medical Screening

Rationale: Assessing medical risk and diagnosing illness are core functions of primary care clinicians. Comprehensive risk assessment and medical screening are integral parts of every health supervision visit and a prerequisite for additional medical treatment and anticipatory guidance.

One component of illness detection and risk assessment is medical screening. Some school-aged and adolescent patients do not receive annual medical screening visits, leading to missed opportunities for providing medical screening and risk assessment. Incorporating medical screening and risk assessment for all school-aged and adolescent patients can potentially identify those who are at risk for illness or who have already developed manifestations of illness so that appropriate medical treatments can be provided.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: ***Age-appropriate risk assessment and medical screenings are not performed consistently at all health supervision visits.***		
The practice does not have a system in place to perform, interpret, and document that age-appropriate risk assessment and medical screenings are performed at **all** health supervision visits.	1. Implement and use the Bright Futures Preventive Services Prompting Sheet to remind you what risk assessment and screenings are needed at each health supervision visit. 2. Use the Bright Futures Training and Implementation Materials. 3. Consider converting the preventive services prompting sheet for EHR use. For help with incorporating forms into an EHR system, contact aapsales@aap.org. 4. Ask parents/guardians to complete the parent questionnaires online or on a tablet in your office, and have it populate directly into your EHR, if possible. • If possible with your EHR system and if you already have a patient portal, consider having your adolescent patients complete an online questionnaire prior to their scheduled visit, ensuring this information is collected independently from the parent/guardian and kept confidential. 5. Review the Bright Futures Tool and Resource Kit for risk screening questionnaires that can streamline your practice's approach to medical screening and risk assessments. 6. To improve documentation, use the Bright Futures Documentation forms available for every health supervision visit. Each form has a designated area to record and document risk assessment and medical screening.	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
The practice does not have an understanding of how Bright Futures defines universal and selective screening.	1. Review the chapter, Rationale and Evidence, in the Bright Futures Guidelines to understand universal and selective screening. 2. Review the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (periodicity schedule). Note the key at the bottom that indicates what screenings are universal (ie, provided to all children at that specific visit) or selective (ie, offered only if a preceding risk assessment is positive). 3. Bright Futures summarizes the recommended risk assessments, screenings, and follow-up that should occur at each health supervision visit in the Bright Futures screening tables, as well as in the Bright Futures Pocket Guide.	
The practice does not use open-source (nonproprietary), validated risk assessment and medical screening tools.	1. Review your practice's current previsit questionnaire and compare it with the Bright Futures previsit and medical screening questionnaires to determine if additional information should to be added to your existing questionnaires. The *Bright Futures Tool and Resource Kit* has previsit and medical screening questionnaires for every health supervision age. 2. Review the measurements section of Bright Futures documentation forms, which provides a systematic way to record important medical screening and results (eg, blood pressure, weight, body mass index, laboratory results) outside of established normal ranges. 3. Ask nurses and/or medical assistants to read questions to parents/families that are unable to read so the health care provider can be prepared to do selective screening.	
Gap: *Patient's measurements (BMI) are not taken and plotted on the percentile curve at all health supervision visits consistently*		

Clinicians and/or staff do not recognize the importance of accurately and consistently measuring and documenting patients' growth measurements.	1. Review the guidelines and recommendations that outline clinician responsibilities for accurate and reliable growth measurements for pediatric patients:
	• AAP Bright Futures Recommendations for Preventive Pediatric Health Care
	
	2. Review the following for additional reading on evaluation and management:
	• Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report
	• Bright Futures: Promoting Healthy Weight
	• The USPSTF Statement on Screening, 2010
	• The NHLBI Guidelines, 2011
	• The Endocrine Society Guidelines, 2008
		• Discuss with staff the importance of reliable growth measurement for clinical decision-making and intervention to:
		  • Detect growth abnormalities.
		  • Detect abnormalities in nutritional status.
		  • Detect diseases that affect growth.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
		• Track the effects of medical or nutritional intervention.
The practice does not have a systematic approach for measuring and documenting patients' growth.	1. Establish clear office procedures for obtaining and plotting growth measurements. Consider the following: • Meet with staff to gather information and ideas about establishing an officewide procedure for measuring and documenting patient growth. • Identify roles and responsibilities for measurement and plotting growth. • Develop a visit flow for obtaining and recording growth measurements that considers the patient/families', physicians', and staff members' time, office efficiency, equipment, and backup contingencies. • Use AAP-recommended tools for documenting growth: • CDC Growth Charts for Children 2 Years of Age and Above (available in English, French, and Spanish) • Train staff and provide cross-training: ○ To take and record measurements accurately ○ To follow established visit flow • Include checks and balances in office procedures to ensure that: ○ All growth measurements are documented. ○ The clinician reviews the growth chart at each visit. ○ The growth summary is shared with the patient and family. • Identify a single, preferred location for all measurement equipment and materials. • Document the schedule and procedure for calibrating and maintaining equipment. Use a calibration log for measurement equipment. 2. Periodically audit office procedures to assure they are effective and that staff members follow them consistently and correctly.	• Consult with other practices about their office procedures for growth measurement, documentation, and family discussions; adapt them for your practice. • Stress with staff the importance of documentation as a necessary component of high-quality care. Help them recognize that actions that are not documented are considered not done. • Consider the online training course, Using the WHO Growth Charts to Assess Growth in the United States Among Children Ages Birth to 2 Years. This online training course was developed by the CDC to train health care providers and others who measure and assess child growth on how to use the World Health Organization (WHO) growth standards to assess growth among infants and children ages birth to 2 years.
Provider does not always recognize abnormal measures (eg, blood pressure, weight, body mass index) outside of established normal ranges.	1. Use updated tables of normal ranges for blood pressure, weight, and other measures for each age group. 2. Develop or use computer tools programmed to automatically flag abnormal measures in the EHR, if your office is computerized.	

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

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: *No follow-up plan provided for when risks or medical concerns are identified.*		
The practice does not have an organized process for follow-up of positive screens that require behavior screens.	5. Identify and reflect on the child's/adolescent's strengths. 6. Offer suggestions for augmenting strength areas that may be lacking or deficient. Point out the patient's existing strengths to provide a hopeful foundation upon which such suggestions can be offered. 7. Use discussion of strengths as a way to engage the patient in discussing needed behavioral changes. 8. Health care providers can encourage patients to utilize their strengths in discussions about behavioral change by incorporating principles of shared decision-making or motivational interviewing. 9. Use the Bright Futures Screening Tables, which also show the next steps that should be taken. 10. If developmental concerns are identified in children up to 8 years (via the PEDS), consider following the AAP Developmental Screening algorithm. If mental health concerns are identified, the AAP Task Force on Mental Health algorithm may be followed to determine next steps.	
The provider is not familiar with further evaluation and treatment procedures for screening measures that are outside of the normal range.	1. Create management algorithms based on consensus guidelines to facilitate initial clinical responses to abnormal screening results. 2. Review abnormal screening results within each clinical setting to derive group standards for management of common abnormal screening results.	
The provider may not be as comfortable screening for adolescent issues related to confidentiality, eg, STI/HIV and drug and alcohol screening.	1. Train staff and providers about adolescent confidentiality and consent for care, including issues related to EHR's. • AAP policy on Standards for Health Information Technology to Ensure Adolescent Privacy • Society for Adolescent Health and Medicine (SAHM) Statement 2. Set practice standards for ensuring the screening questionnaires are answered by adolescent patients independently and privately. 3. Set practice standards for how to address positive screening results related to confidential screening questions while ensuring privacy in managing the abnormal screening results.	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
The practice does not have a seamless approach for referrals for specialized services as indicated and close follow-up care.	5. Review the Pediatrician's Role in Community Pediatrics. 6. Contact your local health department and school district to determine what services are available to your patients. 7. The health care professional can coordinate the specialty services and provide integrated oversight of the patient's progress. 8. Coordinate the specialty services and provide integrated oversight of the patient's progress.	
The practice does not have linkages to local community resources or specialists.	5. Implement use of Bright Futures Community Resources tools: • Bright Futures Community Resources Tip Sheet • Bright Futures Community Resources Check Sheet (pg. 7) 6. Use the Community Pediatrics Self-Assessment tool to determine where your practice is in relation to community pediatrics activities. 7. Create a regularly updated list of community-based referral programs with contact numbers. • Community resources fall into 2 categories: agencies and providers/practitioners. 8. Assign an office champion to keep lists updated on an ongoing basis and to systematically call each number on the list (possibly during slow times) to make sure they are still operational. 9. Link to community and tools on the AAP Web site.	
The practice us unaware that payment may be available for a full range of screenings/follow-up, and/or how to apply for it.	1. Code correctly. • Refer to the AAP Bright Futures and Preventive Medicine Coding Fact Sheet that contains a comprehensive list of codes for the related services • Review the AAP's Practice Management Online Web site for additional resources. 2. Contact the AAP Private Payer Advocacy Advisory Committee.	

Key Activity: Perform Adolescent Depression Screening and Follow-up

Rationale: Adolescent depression is very common, affecting between 12% and 25% of adolescents. Lifetime prevalence of depression and dysthymia increases from 8.4% for ages 13–14 years to 15.4% for ages 17–18 years. Depression in adolescents is not always characterized by sadness, but can be seen as irritability; anger; boredom; an inability to experience pleasure; or difficulty with family relationships, school, and work. It is important to screen for depression to identify the source and assess the severity of depression. "The wide mood changes in adolescents' challenge providers to distinguish between a mental health disorder and troubling, but essentially normal behavior."

Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: *Adolescent depression screening is not routinely performed at annual health supervision visit for patients 12 to 21 years of age.*		

Health care providers and/or staff do not recognize the importance of adolescent depression screening.
 	
The practice is unaware of new AAP recommendations for adolescent depression screening between the ages of 12 to 21 years.
	• Review the following sections of the Bright Futures Guidelines with all staff:
	  ○ Adolescent Visits—11 to 21 Years
	  ○ Promoting Mental Health
	
	• Review the AAP resources:
	  ○ 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
	  ○ Mental Health Competencies for Pediatric Primary Care.
	
	• Review the US Preventive Service Task Force Clinical Summary for depression screening in children and adolescents and the AACAP Practice Parameter for the Assessment and Treatment of Children and Adolescents With Depressive Disorders.
	
	• Review the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit.
		• Discuss with all staff the importance of adolescent depression screening and stress the following:
		  ○ Suicidality is the third leading cause of death in adolescents.
		  ○ Adolescents who have major difficulties in one area of functioning often demonstrate symptoms and difficulties in other areas of daily functioning.
		  ○ Depression is present in 10% to 15% of adolescents at any given time.
		  ○ Having a parent with depression doubles to quadruples a child's risk of a depressive episode.
		  ○ Depression in adolescents is not always characterized by sadness, but can be seen as irritability; anger; boredom; an inability to experience pleasure; or difficulty with family relationships, school, and work.
		• Conduct a Lunch and Learn or similar session with fellow health care providers to ensure all providers are aware of the criteria for depression in adolescents.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Review the Bright Futures Periodicity Schedule with all staff: ○ Post a copy of the periodicity schedule on the wall in all exam rooms.	

Screening is not being routinely performed because of lack of knowledge of the screening tools available and which ones to use.
 	
The practice is not familiar with how to interpret, follow up, and document adolescent depression screening results.
	• Become familiar with the following standardized depression screening tools and determine which tools your practice will use:
	  ○ Start with a general tool, like Bright Futures Supplemental Screening Tool.
	  ○ If there is a positive response to depression questions, use a more specific tool like Patient Health Questionnaire 9 (PHQ-9) or PHQ-9 Modified for Adolescents (PHQ-A).
	  Note: *The PHQ-9: Modified for Adolescents indicates only the likelihood that an adolescent is at risk for depression or suicide; its results are not a diagnosis or a substitute for a clinical evaluation.* The Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit includes a copy of this tool.
		• Conduct educational sessions about screening and management of depression and of suicide risk in adolescents.

Screening is not performed because of lack of time in the visit.	• Develop patient tool that can be easily scored. Provide a previsit questionnaire to the adolescent prior to the visit. ○ Start with PHQ-2. If positive, follow up with PHQ-A. • Develop work flows for screening and managing patients with depression.	
Adolescent patients are not seen in the office for health supervision visits as often as younger children.	• If possible, utilize EHR-based flags/prompts to remind health care providers to perform adolescent depression screening between the ages of 12 to 21 years. • Utilize previsit questionnaires to identify mental health concerns when adolescents are in the office for sick visits. • Update and reinforce screening via the recall system.	Consider administrating brief depression screen for adolescents coming to the office for something other than health supervision visits.
The practice does not have a systematic approach for adolescent depression screening.	• Make sure depression screening tools are available in each exam room. • Integrate screening into the office flow for any adolescent visit.	

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: *Adolescent depression concerns are not discussed with the patient & family*		
The health care provider is not comfortable discussing mental health concerns with families. • Language barriers and cultural differences and attitudes toward depression impede discussions. • Parents/guardians are resistant to discussing/accepting that the adolescent is depressed. • Resources are not available (or not utilized) to guide a patient/family discussion of depression.	• Use previsit questionnaires as a way to begin a dialogue of common adolescent concerns. ✓ Bright Futures Previsit Questionnaires: – Older Child/Early Adolescent Visits—For Parents – Older Child/Younger Adolescent Visits – Early Adolescent Visits – 15- to 17-Year Visits – 18- to 21-Year Visits • Use supplemental questionnaires as a way to ask additional questions regarding the adolescent's development: ✓ Bright Futures Supplemental Questionnaires: – 11- to 14-Year—Parent – 11- to 14-Year Older Child/Younger Adolescent—Patient – Early Adolescent—Patient – 15- to 17-Year Middle Adolescent—Patient – 18- to 21-Year Late Adolescent—Patient • Use the **Common Factors** approach. • For patients and families with specific needs (eg, language, culture, LGBT populations), refer to community providers with experience and tools to provide needed services. • Designate an office champion for all adolescent issues.	• Review the Mental Health Competencies for Pediatric Primary Care. • Engage the family for assistance and support.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Routine education of depression concerns are not part of the practice's standard visit flow.	• Make discussion and/or brochure about adolescent depression routine part of visit. • Make depression education a routine part of designated well-child visits. • Provide a handout to patients and/or parents/guardians during the visit that includes a list of information resources. • Post signs or posters in waiting rooms to make patients and families aware that your practice is equipped to discuss and manage mental health concerns in a confidential manner.	• Appoint an office mental health champion to educate patients and families. • Utilize information available from HealthyChildren.org: ○ Mental Health and Teens: Watch for Danger Signs ○ Your Family's Mental Health: 10 Ways to Improve Mood Naturally • Create a Mental Health or Adolescent portal on your practice Web site with educational resources including information on your practice's approach to mental health concerns and where and how to get help.
Mental health information is communicated to the family but discussions are not documented in the medical record.	• Use the Bright Futures Documentation forms to document depression screening performed; results and family discussion/educational materials provided. ○ 11- to 14-Year (page 737-765) ○ 15- to 21-Year (page 767-821)	

Key Activity: Perform Cholesterol Screening and Follow-up

Rationale: "*Significant evidence exists that using family history of premature CVD or of cholesterol disorders as the primary factor in determining lipid screening for children misses approximately 30-60% of children with dyslipidemias, and accurate and reliable measures of family history are not available. (Grade B) In the absence of a clinical or historic marker, identification of children with lipid disorders that predispose them to accelerated atherosclerosis requires universal lipid assessment.*"
Reference: Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents. Summary report. *Pediatrics*. 2011;128(5). Accessed November 13, 2016

Potential Barriers	Suggested Ideas for Change
Gap: A nonfasting cholesterol screen is not completed for patients once between the ages of 9 and 11 years or once between the ages of 17 and 21 years.	

Potential Barriers	Suggested Ideas for Change

Practice only conducts cholesterol screening for patients with elevated BMI or a family history of heart disease or high cholesterol.	• Provide staff members with knowledge about the importance of preventing the development of cardiovascular risk factors and optimize cardiovascular health.
	  ○ See the American Heart Association's page, Children and Cholesterol.
	  ○ Provide clinical staff with training about the revised cholesterol testing guidelines.
	  ○ Review NIH Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents:
	  ▪ Chapter 9, *Lipids and Lipoproteins* recommendations; and
	  ▪ Table 9-5. Evidence-Based Recommendations for Lipid Assessment
	
	Note: Nonfasting is a quicker and more convenient test for children and adolescents in these age ranges, but ONLY if there are no risk factors. If risk factors exist, administer a fasting lipid profile. See an explanation on pages 5–7 of the Promoting Healthier Weight resource from the Vermont Department of Health.

Physicians are unfamiliar with appropriate laboratory tests for pediatric patients.	• Review with staff when to use which screening: fasting vs nonfasting
	  ○ See Chapter 9, Table 9-5. Evidence-Based Recommendations for Lipid Assessment from the NIH Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents.
	  ○ See the recommendations for when to use fasting/nonfasting screens at the end of this document.

Practice is not reimbursed appropriately for testing and follow-up services.	• Code correctly.
	  ○ Refer to the AAP Bright Futures and Preventive Medicine Coding Fact Sheet that contains a comprehensive list of codes for the related services:
	  ▪ See ICD-10-CM Code **Z13.220** Encounter for screening for lipoid disorders.
	  ○ Review the AAP Practice Management Online Web site for additional resources.
	  ○ Contact the AAP Private Payer Advocacy Advisory Committee.

Parents are reluctant to perform lab testing.	• Send the parents a letter prior to the visit to cue that the testing may need to occur. • Consider purchasing a finger-stick cholesterol machine (for nonfasting screen) to perform the screen before the family leaves. • For adolescents, consider getting other screening at the same time with the same blood draw (eg, HIV screen).
Gap: Follow-up plan not established for patients with a positive nonfasting cholesterol screen.	
Practice does not have an organized process for follow-up of positive nonfasting cholesterol screens with a fasting lipid profile.	• For computerized offices, add preset order to the EMR. ○ Add clear instructions to provide to families for fasting. See the recommendations for when to use fasting/nonfasting screens at the end of this document. • Access hospital-based clinics or large health care organizations with subspecialty services for testing and treating adult patients, which may provide an organized menu of services/processes that can be adapted for pediatric practice. • Refer the patient to a local resource (Public Health Department or health clinic) for screening and follow-up.

Potential Barriers	Suggested Ideas for Change

Staff and providers do not provide a personalized treatment plan for patients with a positive screen.	• Develop a handout with basic information about the implications of the test results, treatment goals, management, and monitoring.
	  ○ Note: Be sure that materials are appropriate for the age of the patient.
	  ○ Handout should include information on lifestyle changes, including physical activity, smoking cessation, and nutrition.

Physicians are unsure about when, and which tests, to use pharmacologic interventions for young adults.	• See the NIH Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents.

When to use fasting/nonfasting screen:

The guidelines sponsored by the National Heart, Lung and Blood Institute (NHLBI), part of the National Institutes of Health, and endorsed by the American Academy of Pediatrics (AAP) recommend that **all children be screened for high cholesterol at least once between the ages of 9 and 11 years, and again between ages 17 and 21 years.**

- A nonfasting cholesterol screen is completed for patients once between the ages of 9 and 11 years or once between the ages of 17 and 21 years.
- A follow-up plan is established for patients with a positive nonfasting cholesterol screen.

Age:	New Recommendation:
2–8 years	Obtain **fasting lipid profile only if** family history is positive (+), parent with dyslipidemia, any other RFs (+), or high-risk condition
9–11 years	Obtain **universal lipid screen** with nonfasting non-HDL = TC – HDL, or fasting lipid profile → manage per lipid algorithms as needed.
12–16 years	Obtain **fasting lipid profile if** family history newly (+), parent with dyslipidemia, any other RFs (+), or high-risk condition; manage per lipid algorithms as needed.
17–21 years	Measure **nonfasting non-HDL-C or fasting lipid profile** in all x 1 → review with patient; manage with lipid algorithms per ATP as needed. Measure BP → Review with patient. Evaluate and treat as per JNC guidelines.

Source: Table 15 from the NHLBI report: Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents

Children with special risk conditions

If there are other risk factors, prescribe a fasting lipid screen regardless of the child's age. This includes instances where you identify a risk factor that wasn't present in earlier visits.

See Tables 9-6 and 9-7 from the NHLBI Guidelines, which define risk factors.

Key Activity: Perform Chlamydia Screening and Follow-up

Rationale: Chlamydia is the most common notifiable disease in the United States. It is among the most prevalent of all STIs, and since 1994, has comprised the largest proportion of all STIs reported to CDC. During 2013–2014, rates of reported chlamydia increased 2.8% overall, but decreased 4.2% among females aged 15–19 years. However, both test positivity. The number of reported cases of *C. trachomatis* infections remain high among most age groups, racial/ethnic groups, geographic areas, and both sexes. The USPSTF strongly recommends that clinicians routinely screen all sexually active women aged 24 years or younger.

Sources: 2014 Sexually transmitted diseases surveillance: Chlamydia. CDC Web site: https://www.cdc.gov/std/stats14/chlamydia.htm
Chlamydia and gonorrhea: Screening. US Preventive Services Task Force Web site: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/chlamydia-and-gonorrhea-screening?ds=1&s=chlamydia.

Potential Barriers	Suggested Ideas for Change
Gap: The practice does not solicit and document chlamydia screenings performed on sexually active adolescents younger than 21 years of age.	
Health care providers are reluctant to discuss sexual activity with adolescent patients.	1. Implement the use of Bright Futures screening tools for adolescents. 2. Train staff and providers about adolescent confidentiality and consent for care, including issues related to EHRs. • AAP policy on Standards for Health Information Technology to Ensure Adolescent Privacy 3. Explain communication policies and confidentiality to adolescents and their parents/guardians. 4. Make your office friendly for adolescents. • Ask questions to understand your practice's approach to adolescent confidentiality. • Consider the following: ○ Develop and post a confidentiality policy. ○ Establish a practicewide policy of time spent with adolescent without their parent present. ○ Offer office hours after school or walk-in hours for adolescents. ○ Provide privacy for answering questionnaires and use of office phones and triage. ○ Place adolescent-friendly magazines and posters in each exam room. ○ Post rainbow ally stickers in each exam room to signal gay/lesbian adolescents that this is a safe place to discuss confidential issues. ○ Encourage adolescents to share information with parent or a trusted adult. ○ Offer materials in a private location where adolescents will feel comfortable taking them. ○ Make sure take-home materials will fit into an adolescent's pocket or purse. 5. Develop/implement a process for obtaining a sexual history from adolescent patients. Suggested ideas include: • Use a patient-only questionnaire such as Bright Futures Adolescent Supplemental Questionnaire. • If not using Bright Futures questionnaires, be sure what you are using asks appropriate questions about sexual activity. • Consider having adolescents answer questionnaires on a tablet or other electronic devices. • Identify a process to ask adolescents confidential questions by establishing rapport. Use a strength-based approach with adolescents. • Use the HEEADSSS psychosocial interview to address sexuality, following more expected questions about home life, eating, etc, when rapport has been established.

Potential Barriers	Suggested Ideas for Change
Health care providers are reluctant to screen and test for chlamydia.	1. Screen sexually active adolescents (females and males who meet screening criteria) annually for chlamydia during health supervision visits, even if symptoms are not present and even if the use of barrier contraception is reported. If a patient was not seen for a health supervision visit in the past year or a chlamydia test was not done, health care providers can offer the test at any visit type. 2. Determine and document every adolescent's sexual history. • Use the HEEADSSS model facilitate question-and-answer sessions with sexually active adolescents. 3. Consider practicewide changes, which may help screening be more effective. • Implement a system of reminders/alerts built into your EHR that are triggered by patient response. • Train support staff to alert the health care provider if a need for screening is determined. • Determine the test your practice will use to identify chlamydia (eg, urine or vaginal or cervical swab). o Nucleic acid amplification tests (NAATs) are the most sensitive for chlamydia in females and males. o Consider creating a standing order so that all adolescents coming for their yearly exams are asked to provide a urine sample. 4. Establish a systematic way to easily and confidentially deliver and discuss test results with adolescents. • Ask for confidential contact information for all patients at check-in. o Ask for cell phone numbers and the best times to call. • Ask patients to call the office at designated times when the office staff will be available to discuss results. If you have a larger practice, contract with other companies for patients to call in and obtain test results.
The practice does not have a consistent diagnosis, treatment, and follow-up plan for chlamydia.	1. Identify your practice's process for treating chlamydia and reporting cases of chlamydia to your local health department. 2. Determine what your practice's policy will be for partner notification. • Develop a process to work with the patient to confidentially notify the partner (some health care providers notify the partner directly). • Conduct partner notification in one of the following ways: o In person o By phone/text o By e-mail o By letter

Potential Barriers	Suggested Ideas for Change
The practice is unsure about how to code for chlamydia screening.	1. Review the codes most relevant to your practice's approach to chlamydia screening and counseling, and include them on your encounter form or billing sheet. Refer to the AAP Bright Futures and Preventive Medicine Coding Fact Sheet that contains a comprehensive list of codes for the related services 2. Review a fact sheet for medical care providers seeking more information about minors' rights to consent for reproductive health care and how to protect that confidentiality through office practices, including coding, and procedures. 3. Talk with private insurers to determine what will show up on the patient Explanation of Benefits, and determine a protocol to enact when patient confidentiality needs to be assured.
Adolescents have lower rates of health supervision visits.	1. If possible, utilize EHR-based flags/prompts to remind health care providers to consider performing overdue chlamydia screening in all types of visits. 2. Consider using a short interval questionnaire at non-health–supervision visits for adolescents who are overdue for questions about appropriate sexual activity; these questions will help determine who needs chlamydia screening.

Questions to help your practice understand its approach to adolescent confidentiality.

Adolescents tend to underutilize existing health care resources. *The issue of confidentiality has been identified by providers and adolescents as a significant access barrier to health care*. Thus, Bright Futures encourages providing confidential care to adolescents. This approach helps adolescents build a trusting relationship that promotes full disclosure of health information. Consider the following questions to understand your practice's approach to adolescent confidentiality:

- Do you have an office policy about confidential issues pertaining to adolescents and their families?
- Do you mail a copy of your confidentiality policy to parents of adolescents as they reach a certain age (11 or 12 years)?
- Do you post your confidentiality policy for parents and adolescents to see in your waiting room or exam rooms?
- Do you have a system to handle confidential information in medical records?
- Is it customary in your practice to allow adolescents and parents to talk separately with health care providers about their concerns?
- Do you educate your partners and staff regarding laws that specifically pertain to adolescents and their right to receive care without parent or guardian's consent?
    - In fact, "all 50 states and the District of Columbia explicitly allow minors to consent to STI services, although 11 states require that a minor be of a certain age (generally 12 or 14 years) before being allowed to consent." (Guttmacher Institute, Minors' Access to STI Services: State Policies in Brief.) A current listing of state policies is available for review.
- Does the atmosphere (eg, pictures, wallpaper) create a safe and comfortable environment for adolescents to discuss private concerns regarding their health?
- Do you display and/or offer educational materials about confidentiality to adolescent patients and/or patients?
- Are you and your staff careful not to discuss patient information in open environments (eg, elevators, hallways, waiting rooms)?
- Do you make sure all the doors to the examination room are closed when getting an adolescent patient's medical history or discussing anything sensitive and ensure the accompanying adult is in the waiting room or an area at a distance?
- Do you ask if your adolescent patient feels comfortable receiving messages or mail from you?

- Do you discuss the situations in which you may need to breach confidentiality?
- Do you review with staff their knowledge and feelings regarding confidentiality for adolescents?

Source: Adolescent Health Working Group

Key Activity: Provide Anticipatory Guidance

Rationale: Anticipatory guidance is specific, preventative information given to patients and families to improve the well-being of pediatric patients by reducing injuries and meeting basic needs (eg, nutrition, sleep patterns, behavior issues) which, ultimately, promotes healthy coping and an understanding of normal child and adolescent development.

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

Bright Futures guidelines recommend 5 priorities for each visit, which provides a systematic approach for providing anticipatory guidance for the 31 recommended health supervision visits from infancy through late adolescence.

Potential Barriers	Suggested Ideas for Change
Gap*: Bright Futures Priorities (Anticipatory Guidance) are not discussed or materials provided.*	
The practice does not have a system for providing anticipatory guidance during a health supervision visit.	1. Develop a systematic, practicewide approach to provide anticipatory guidance at every health supervision visit. 2. Establish an office development team to create and/or select Bright Futures content, and then design the system where handouts are attached to the patient's chart prior to the visit. 3. After deciding on the tools you will use for developmental screening, design a process to send the tools to the parent/caregiver or patient one week before the scheduled visit. When the office calls to remind the parent/caregiver or patient about the appointment, prompt the parent/caregiver or patient to bring the screening tools to the visit.
The health care professional does not routinely document that anticipatory guidance was provided during health supervision visit.	1. After each patient visit, document in the patient's medical record that anticipatory guidance was provided. 2. Use school-age and/or adolescent-appropriate Bright Futures forms in the *Bright Futures Tool and Resource Kit* to document anticipatory guidance discussion. 3. Incorporate anticipatory guidance documentation into your electronic health record system.

Potential Barriers	Suggested Ideas for Change
The health care professional is not familiar with Bright Futures priorities for offering age-appropriate anticipatory guidance.	1. Review your documentation system (paper/electronic) to ascertain whether the prompts include the Bright Futures Priorities for the Visit. Use or adapt age-appropriate Bright Futures visit documentation forms, which provide reminders and facilitate documentation of the 5 anticipatory guidance priority areas for each age group. 2. Provide a Bright Futures Patient/Parent educational handout that covers all necessary content, available in the *Bright Futures Tool and Resource Kit.* 3. Consider adding complementary materials to the Bright Futures resources, for example: • Connected Kids • Healthychildren.org • Fostering Resilience • Young Women's Health • Young Men's Health 4. Laminate Bright Futures resources for use in each examination room.
The health care professional and parent/patient do not share the same agenda for a health supervision visit.	1. Create a shared agenda when providing anticipatory guidance: • Ask about parental and patient concerns at the time the appointment is scheduled. • Use the Bright Futures previsit and supplemental questionnaires to focus on areas of parental concern and/or topics needing counseling that align with the 5 priorities. • Standardize handouts for appropriate ages and development. Consider providing Bright Futures Parent/Patient educations handouts for school-aged and adolescent patients following a health supervision visit. • Make sure reputable information about common topics of interest are available in the waiting room or on the office Web site. 2. Note in the patient's medical record that an opportunity was given to discuss concerns and whether any concerns were expressed. 3. Review resources for additional information about common parental and patient concerns and how to address them. See content suggestions. 4. Address patient education regarding additional sources of information and education, for example, the library, Web sites, and community resources.

Potential Barriers	Suggested Ideas for Change
The practice does not have standardized anticipatory guidance handouts available.	1. Use the Bright Futures Parent/Patient educational handout for school age and adolescent appropriate anticipatory guidance. 2. Review the lessons learned in the Bright Futures Training Intervention project and your practice's materials to determine gaps. 3. Use flyers and handouts on adolescent health from the Adolescent Health Working Group resources.
The health care professional does not have time to provide anticipatory guidance at each health supervision visit.	1. Develop a practice policy that addresses using previsit questionnaires to screen for high-priority issues/topics to be discussed during each health supervision visit. 2. Allow additional time during the health supervision visit to discuss patient and family issues/concerns. 3. Schedule a follow-up appointment with the health care professional or nurse if/when more in-depth anticipatory guidance is needed. 4. Consider working with health educators if available to provide health education based on previsit questionnaires. 5. Consider providing group educational visits for families and patients on those high-priority topics that are assessed to be positive (eg, how to eat healthy). 6. For adolescents, consider scheduling additional time to allow for confidential adolescent psychosocial assessments and developmentally appropriate anticipatory guidance. 7. Develop a system to ensure that provider time taken to provide anticipatory guidance is appropriately billed and/or compensated.
The practice does not have a system to effectively track anticipatory guidance longitudinally.	Develop a system to document that anticipatory guidance and appropriate handouts were provided. • Begin the process with 1 or 2 partners in your practice to test the process, then reevaluate, make necessary changes, and gradually incorporate it into a practicewide policy. • Start incrementally by selecting a single topic that can be addressed in a developmentally appropriate way from infancy through adolescence. ○ Consider motor vehicle and passenger safety because it is a component element of the priorities for every recommended visit. • Document that anticipatory guidance was given and/or a brochure was explained and given to the patient/parent. • Use the Bright Futures visit forms (or a similar standardized documentation form) to document topics that warrant follow-up discussion at the next health supervision visit, and to document that follow-up discussion occurred.

Potential Barriers	Suggested Ideas for Change
The health care professional and/or patient/parent have cultural and/or language barriers.	1. Provide training for health care professionals and office staff that promotes culturally effective or culturally competent care, and avoids stereotyping patients and families. 2. Review questionnaires and handouts to determine if they are written at an appropriate reading level for your patient population. 3. Instruct the office staff to ask every patient and parent who completes a form in the office if she or he needs help completing the form. 4. Place an alert in the chart if the family needs assistance with reading or writing, and develop an office policy on how best to assist him or her. 5. Identify an interpreter who is available to work with the patient and/or family during the visit. Add an alert to the patient's medical record in the special needs section that indicates an interpreter is necessary. Avoid using children and adolescents as interpreters for their families. 6. Refer the patient/parent to Web sites and other sources for additional information to address their concerns.
The health care professional challenges in providing anticipatory guidance to adolescents relevant to confidential issues including sexual health, alcohol, cigarette and substance use, and mental health.	• Provide staff and health care professional training to ensure confidential services to adolescents, including providing anticipatory guidance information relevant to adolescent behaviors that are considered under the scope of confidential services. • See AAP Provider Tools for Confidentiality and Minor Consent. • Work with staff and health care professionals to ensure patient information regarding anticipatory guidance related to confidential information is kept confidential and private. This includes protected content of the discussion with the adolescent, as well as previsit questionnaires that elicit sensitive adolescent issues. • The Adolescent Health Working Group provides tools and tips for professionals, an office self-assessment chart, back office policy recommendations, advice for engaging adolescents and supporting parents, and office handouts/flyers. • Develop clinic patient flow that incorporates a confidential visit with the health care professional as a part of the overall health supervision visit. • Discuss and offer handouts to families describing the importance of meeting with adolescents individually and protecting confidentiality around sensitive issues, as well as the limits of confidentiality.