Potential Barriers and Suggested Ideas for Change

Key Activity: Education, Follow-Up, and Communication

Rationale: According to experts in the field, providing education and anticipatory guidance to patients and/or their caregivers leads to better management of children with GER and GERD.[1,2]

Regarding follow-up, Nelson[2,3] (1998, 2000) followed a cohort of infants with GER (Happy Spitters) and found that for the majority, reflux is a benign condition with symptoms that resolve by age 12 months. When symptoms persist beyond 12 months without adequate treatment, infants and children with GERD are at increased risk for complications related to acid reflux including erosive esophagitis, esophageal strictures, Barrett's esophagus, vocal cord damage, growth failure, and chronic lung disease. Regular follow-up of children with GERD to ensure both optimal treatment and compliance can minimize the risk for developing complications and may also lead to early identification and treatment of any that do occur. In some cases, recommended follow-up of infants and children with GER or GERD may be with the primary healthcare provider. At other times, it may be with a subspecialist.

The other important piece of the puzzle is appropriate and regular communication. *For effective care of patients with gastroesophageal reflux disease (GERD),* bidirectional communication *is necessary between the GERD Core Team (comprised of the primary healthcare provider [PHP], subspecialist, patient, and family) and the rest of the multidisciplinary team. This exchange is particularly important with regards to the sharing of follow-up and care plans.* It is the PHP's responsibility to obtain and support the care plan and to communicate important health status changes. It is the subspecialist's responsibility to communicate essential care and management parameters.

[1]Rosen R, Vandenplas Y, Singendonk M, et al. Pediatric gastroesophageal reflux clinical practice guidelines: joint recommendations of the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition and the European Society for Pediatric Gastroenterology, Hepatology, and Nutrition. *J Pediatr Gastroenterol Nutr.* 2018;66(3):516–554. doi: 10.1097/MPG.0000000000001889

[2]Nelson SP, Chen EH, Syniar GM, Christoffel KK; Pediatric Practice Research Group. One-year follow-up of symptoms of gastroesophageal reflux during infancy. *Pediatrics*. 1998;102:e67–e69

[3]Nelson SP, Chen EH, Syniar GM, Christoffel KK; Pediatric Practice Research Group. Prevalence of symptoms of gastroesophageal reflux during childhood: a pediatric practice-based survey. *Arch Pediatr Adolesc Med.* 2000;154(2):150–154

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
Gap: Anticipatory guidance regarding pediatric gastroesophageal reflux is not provided to the family and/or patient or documented in the patient chart.		
Importance of education and anticipatory guidance when managing patients with reflux is not fully understood.	Provide information to health care team that documents the importance of education and anticipatory guidance when managing patients with GER or GERD. (See 2018 NASPGHAN Guidelines and 2013 AAP Clinical Report: Gastroesophageal Reflux: Management Guidance for the Pediatrician.) Use tools provided in *Education* and *Treatment* Clinical Guides of this course.	
Lack of appropriate, helpful information and/or materials to	Develop a protocol to provide education and anticipatory guidance to patients and caregivers of patients with GER or GERD.	Provide take-home materials (for patients/caregivers) regarding GER and

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
provide to patient/caregiver.	Provide simple, straightforward materials that can be used in educating patient/caregiver regarding GER and GERD. Take into account cultural, literacy level, and language barriers when choosing education materials for your patient population. Direct parents to the following: **GIKids.org,** which provides videos, audio, and downloadable pdf materials such as: o Parent's Take Home Guide to GERD (also recommended by AAP) o Infants Reflux Checklist o Coping Guide for Parents o Teen's Checklist for GER or GERD AAP **HealthyChildren.org** web site for these useful information topics: o GER and GERD Parent FAQs o Not All Reflux in Infants is Disease, According to AAP o Infant Vomiting o What Is a Pediatric Gastroenterologist? Ensure that the patient/caregiver is aware of nonpharmacological lifestyle changes, expectations, and when and how to follow up with health care provider. A written care plan should be created by the **Subspecialis**t, with input from the patient/family. The care plan should be specific and easy for the patient/parent/caregiver to understand. For more information see *Follow-up* and *Communication* in the Clinical Guide. Note: *It is the **generalist's** responsibility to send essential information with the initial referral, to obtain and support the care plan, and to communicate important health status changes.* *It is the **subspecialist's** responsibility to develop and share the care plan with team members and communicate important care plan updates after every visit.*	GERD from GIKids.org. Have these resources readily available in the treatment room, the waiting room, and/or with the patient's chart. Primary care practices can consider contacting local gastroenterologists to ask for sources of reliable patient education materials or informative Web sites

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
There is inadequate time to provide education and anticipatory guidance to patient/caregivers.	Use a treatment protocol that highlights specific anticipatory guidance. Put together a list of reliable Web sites and resources that can be handed to the patient/caregiver. Check the following home pages for more information: GIKids.org, NASPGHAN.org, and HealthyChildren.org. Create an information center in any small unused space of your office, and label it the *Education Center*. Designate a staff person to be your Education Champion responsible for: o Reviewing educational materials with patients/caregivers o Ensuring that the patient/caregiver understands: a. Symptoms/signs to watch for b. How and when to administer medications c. Who to contact with questions or concerns o Maintaining inventory of up-to-date patient education materials	Provide skill-building training for staff to effectively deliver relevant GER/GERD education.
There is not a standard place in the medical record to document patient education was provided.	Document in the chart of each patient with newly diagnosed GER or GERD that the GER or GERD materials were discussed and given to the patient/caregiver. During follow-up visits, reiterate key points summarized on the handout used. Create an encounter form with an area to record educational materials and discussion. A sample encounter form is provided with this course. Update EHR systems to include prompts for documentation of discussions and educational materials provided.	
Gap: A follow-up plan is not established/updated/maintained or documented in the patient's chart.		
Follow-up appointment to assess GER or GERD symptom management, either in the primary healthcare office or with the subspecialist, is not regularly scheduled or documented within a practice.	Develop a follow-up plan protocol. • Review the current follow-up scheduling process to identify gaps and areas of potential breakdown. • Examine your process for the following: o Follow-up appointment scheduling process: ▪ *What is your current process for scheduling follow-up appointments?* ▪ *How do you apply this process for patients with GER or*	Meet with the health care team to discuss how ensuring follow-up appointments to monitor GER and GERD can help keep patient care in line with the 2018 NASPGHAN Guidelines and brainstorm ways to meet the recommendations of the guidelines. Identify communication breakdown to improve

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	GERD? ▪ *Are there steps in the process that consistently fail? If so, what are they and why do they fail?* o Communication between physicians and staff when a follow-up appointment is requested and not made: ▪ *How does your practice track a follow-up appointment for GER or GERD?* ▪ *How does your practice ensure that patients appropriately follow up with either the primary health care provider or a subspecialist?* o Patient appointment reminder system: ▪ *Does your practice's reminder and recall system work as well as it should?* ▪ *Is there a process to document all follow-up recommendations and appointment referrals in the medical record?* • Identify and correct defects in the appointment reminder system. • Consider follow-up appointments via phone contact. • Implement systemwide changes (in the practice) that track patients who do not keep follow-up appointments.	bidirectional communication between referring providers and subspecialists when follow-up appointments are recommended, but not scheduled. Review and post in the office the GERD Bidirectional Communication Diagram as a reminder of effective communication
Parents or caregivers do not understand the potential for complications associated with GER and GERD.	Identify parent's level of understanding of GER and GERD in infants. ▪ Educate parents through discussion, as well as educational brochures and pamphlets, such as those available at GIKids.org. (Additional materials are listed in the Potential Barriers and Suggested Ideas for Change in the *Education* Clinical Guide of this course.) ▪ Explain and emphasize the need to monitor for bothersome symptoms or 'red-flag' signals while providing anticipatory guidance. ▪ Ask parents to verbalize understanding of the natural history of GER and GERD, including red flag warning signals. ▪ Ask parents to verbalize understanding of GERD and the potential complications associated with inadequate treatment.	Instruct parents to complete Infants Reflux Checklist and Parent's Take Home Guide to GERD. Provide GIKids Web site guidance for parental self-education on GER and GERD. Print information to use as handouts if computer access is an issue.
Primary healthcare providers and medical staff may be unaware of	Review the *Treatment* and *Referral* sections in the Clinical Guide of this course for tips on how to accomplish the following:	Meet with health care team to discuss 2018 NASPGHAN Guidelines and to establish

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
appropriate treatment duration for infants and children with GERD and/or appropriate timing for referral to a gastroenterologist.	• Educate primary healthcare providers and medical staff regarding appropriate GER and GERD treatment and referral. • Develop a practice-wide protocol that addresses the various pharmacologic treatment options and strategies for patients with GERD. (Provide officewide training once a protocol is developed.)	follow-up appointments as a mainstay of monitoring GER and GERD. Engage health care team in brainstorming about ways to meet the recommendations of the guidelines.
Gap: A written care plan developed by the subspecialist with input from the patient and family is not available. *It is the **subspecialist's** responsibility to develop and share the care plan with team members and communicate important care plan updates after every visit.*		
The importance of developing or maintaining a written care plan with input from the patient and family is not recognized.	• Review the policies and guidelines that outline clinician responsibilities for developing and maintaining patient care plans, including: ✓ The 2002 AAP Medical Home Policy Statement (reaffirmed 2008), which defines the concept of the medical home and outlines the importance of care coordination between the pediatric medical home, the specialty care team, and other providers ✓ The 2011 transition guidelines clinical report from the AAP, AAFP, and ACP, Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home ✓ The 2012 AAP clinical report, Home Care of Children and Youth with Complex Health Care Needs and Technology Dependencies, which addresses the development of an interdisciplinary and coordinated plan of care for the child with complex medical needs with technology dependencies	• Review examples of care plans that have helped in the care of patients in your practice. • Discuss with staff the importance of developing and maintaining a care plan. ✓ To improve patient care and long-term patient outcomes ✓ To determine the need for referral and treatment ✓ To monitor the effects of intervention • Identify families in your practice willing to be part of a team of staff and patient users who jointly develop a written policy for how your practice will develop and maintain care plans. • Use online resources such as national listservs to share ideas.
A ready-made care plan template to use for the patient's medical condition is not available to the subspecialist. The subspecialist is not aware of what information should be included in a care plan. A systematic approach for creating, reviewing, and updating the care plan is not in place.	• Identify elements of a complete written patient care plan and adapt for the practice's 2 or 3 most common specific conditions. (See *Follow-Up and Communication* Clinical Guide.) • Establish clear office procedures for creating and maintaining a care plan for each patient with GER and GERD. Consider the following: ✓ Meet with staff to gather information and ideas about establishing an officewide procedure for creating and maintaining care plans. ✓ Identify roles and responsibilities for documenting and maintaining information in the plan, including specific responsibilities for updating	• Consult with other practices about their office procedures for care plans and adapt them for your purposes. • Stress with staff the importance of care plan documentation as a necessary component of high-quality care. Help them recognize that actions that are not documented may not have been done.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	elements of the case plan (as identified above). ✓ Develop a visit flow for documentation and maintenance of the care plan that considers the patient/family, physician, staff members, office efficiency, equipment, and backup contingencies. ✓ Include checks and balances in office procedures to ensure that: – The clinician reviews the care plan at each visit. – All care plan elements are documented or updated. – The care plan is shared with the patient, family, and essential team members. – The benefits and possible side effects of treatment are communicated to the patient/family. – Any identified diagnostics tests have been completed, reviewed, documented, and communicated to the patient/family. – If tests are not completed, follow up to identify the reason and document the reason for noncompletion. • Periodically audit office procedures to assure their effectiveness and that staff members follow them consistently and correctly. • Standardize how and where the care plan is documented and maintained: ✓ After visit summary ✓ Care plan as a separate document ✓ EMR ✓ Other	
Patients miss follow-up visits, thereby making health supervision and care plans out of date.	• Set up a registry or other system to track patients who are not being seen regularly. Designate a staff member to reach out to patients/families that are behind with appointments. • Schedule a return appointment at the time the patient comes in for a visit. • Implement a reminder and recall system (using EMR, internal memo, or chart reminder). • Educate patients/families about the importance of ongoing health supervision visits to monitor GER/GERD and well-being. Review the recommended assessments and timeframes that support favorable	• Educate patients and families about the importance of health supervision visits and the gradual educational process of transition. • Educate patients and families about appropriate location for follow-up (ie, with the Primary Healthcare Provider [PHP]). • Ensure the PHP is appropriately obtaining and supporting care plans recommended by the subspecialist, and that there is appropriate bidirectional communication about any important health status changes.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	health outcomes. • Check to see if patients are unnecessarily receiving care from subspecialists (if you are a generalist) or unnecessarily scheduling follow-up with subspecialists rather than their primary care provider (if you are a subspecialist). • Check to see if financial or psychosocial factors play a role in visit noncompliance and consider involving social services as needed. • Consider ways to improve access to care within the practice, by providing additional evening or Saturday appointments, for example. • Consult with other care team members regarding barriers to keeping regular appointments and strategize approaches for return visits.	• Ensure the subspecialist is appropriately communicating any recommended care plans to the PHP, and that there is appropriate bidirectional communication about any important health status changes. • Adhere to a written policy of no prescription refills without adequate and appropriate general health supervision, stressing the importance of patient safety. • Engage social workers or case managers in an attempt to improve adherence to regular health supervision. Refer patients/families with psychosocial issues for counseling.
Gap: The care plan is not routinely shared with the patient/family.		
A systematic approach for sharing the care plan and reviewing the care plan with the patient/family is not in place.	• Include checks and balances in office procedures to ensure that: ✓ The clinician reviews the care plan at each visit. ✓ The care plan is shared with the patient/family. ✓ The benefits and possible side effects of treatment are communication to the patient/family.	• Consult with other practices about their office procedures for communicating and documenting patient/family discussions.
Gap: The current care plan is not obtained or important health updates are not shared on a timely basis. *It is the **generalist's** responsibility to send essential information with the initial referral, to obtain and support the care plan, and to communicate important health status changes.* *It is the **subspecialist's** responsibility to develop and share the care plan with team members and communicate important care plan updates after every visit.*		
All team members are not identified in the care plan or their contact information is incomplete or unavailable.	• Identify essential care team members and designate a staff member to update contact information in the care plan. Create processes for keeping this information up-to-date and communicated to essential stakeholders in the child's care. ✓ Help patients/families create/maintain a list of team members that supports the patient's care. Communicate to patients/families their responsibility to maintain the contact list. ✓ Verify care team members with the patient/family at every visit and update the contact list after intake appointment.	• Consult with other practices about how their care teams are documented and updated in the patient's medical record. Adapt ideas that work for other practices into your office procedures.

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	✓ Flag changes in team members when the patient notifies you.	
There is no process in the subspecialist's office for communicating the current care plan and important updates to all team members. There is no process in the PHP's office for obtaining the patient's care plan or communicating important health status changes to all team members.	• Establish clear office procedures for sharing/obtaining the care plan and important changes to all team members. Consider the following: ✓ Who (staff) is responsible for sharing/obtaining the care plan ✓ What should be included in the communication ✓ Who should be included in the communication ✓ How the patient/family will receive a copy of the current care plan ✓ The form of team communications, eg, fax the care plan to the primary care office and request verification that it was received and understood; alternatively, submit electronically to practices sharing the same EMR system and have 1 staff person in the clinic responsible for transmission of the updated plan at every encounter ✓ The frequency of communication for changes to the plan, eg, after every visit or when clinical changes occur	• Consult with other practices about how care plan changes are communicated to members of the care team. Adapt ideas that work for other practices into your office procedures. • If the practice uses an EMR, consult with EMR management to develop a method for transmitting care plan updates to appropriate team members. • If the practice uses a dictation system, consult with dictation management to develop a method for transmitting plan updates to appropriate team members.