Potential Barriers and Suggested Ideas for Change

Key Activity: Address Identified Needs

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

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

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	• Begin a simple registry for population management using these resources: ✓ ASHEW Referral Tracking Tool (EXCEL worksheet) used to identify, flag, and track patients/ families with identified complex needs to ensure referrals are followed up with families. ✓ ASHEW Complex Needs Planning Worksheet used to plan a complex needs registry, and implement quality improvement (QI) strategies for supporting patients/families. Review resources on family engagement and share with staff. ✓ Engaging families in the visit: – Family Perspective Webinar From AAP CA-1 Chapter – Family Perspective Slides – Fostering Welcoming Environment – National Center Medical Home Implementation. Video: Changing Relationships How to Foster Effective Communication With Patients and Families ✓ Engaging family leaders as advisors to the practice: – Family Advisor Job Description – AMA and Johns Hopkins Family Advisor Recruitment Toolkit ✓ Assessing practice strengths and needs for family engagement: – Family Engagement in Systems Assessment Tool (FESAT) Note: must complete a pop-up with your e-mail to access so they can report to their funder who is using the tool. To be used as a discussion and planning guide.	
Gap: An explanation of how to use supporting informational materials (if provided) was not completed.		
The practice may provide supporting informational materials appropriate to the family's interests, concerns, identified needs, or positive screens/assessments, but not discuss them or fail to document such discussions.	Recognize the following: • Supporting information materials can include handouts, Web site links, patient portal, pamphlets, etc. • The conversation should include how to use the materials to address the family's interests, concerns, identified needs, or positive screens/assessments.	• Consider creating a centralized information area in the waiting area and in exam rooms devoted to social-emotional health educational topics geared for your patient population. Materials should be geared for the language, literacy

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	• Some families may experience barriers to health literacy, which may require additional support to improve health outcomes. All families can benefit from the use of plain language and clear communication practices. Consider these tips: ✓ Create a safe environment by fostering an atmosphere in which questions are welcomed and cultural preferences are elicited and considered in care planning. ✓ Avoid assuming that families understand the medical issue or next steps to address it. Also avoid checking for understanding with a yes/no question, *"Do you understand?"* Families may be embarrassed to admit that they do not. It is better to ask families to put the information in their own words to make sure they understand. Ask them to describe back to you: *What is the problem? What do I need to do? Why is it important?* ✓ Create written materials in a patient-friendly manner. Use simple words, short sentences, bullet format, pictures wherever possible, and lots of white space. Avoid medical jargon and unnecessary information. Concentrate on what the patient should do. ✓ Use interpretation services for families that experience language barriers. ✓ Check for understanding using methods such as teach-back or Ask Me Three. • A check-back with the family to determine if the materials are meeting the family's needs or if additional counseling and/or materials are needed is recommended.	level, and culture of the patient/family.
The practice needs additional resources on social needs topics to discuss and support needs with families.	• Gather/develop supporting informational messages and resources on social-emotional topics to discuss and share with families. Materials should be geared for the language, literacy level, and culture of the patient/family. Note that it is not enough to provide handouts, recommend Web sites, or direct families to the patient portal. Supporting informational messages should be communicated to families face-to-face and their understanding assured. For information on **having effective family conversations**, see: ✓ AAP STAR Center Screening Time Course learning module with conversation simulations (login required) ✓ Use knowledge about family-centered communication techniques and evidence-based approaches that invite discussion and engage families in their healthcare decision making. Share these techniques and approaches with staff. (Click for examples.)	If documentation is an issue: • Discuss documentation problems in a staff meeting and brainstorm ways to improve them. • Work with the social health and wellness team to test, implement, and refine ideas to improve documentation through Plan, Do, Study, Act (PDSA) cycles.

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	✓ AAP Mental Health Motivational Interviewing ✓ Role Play SDOH Conversations(Video coming soon) ✓ ScreeningtTime.org CME and Simulations Note: must be logged into AAP.org to complete MOC; do not have to be AAP member to create login and receive MOC. ✓ Family-centered Care Pediatric CARE Podcast ✓ Pediatric CARE Podcast: Protective Factors and Positive Childhood Experiences ✓ Common Factors Approach (HEL^{2}P^3) ✓ Common Elements Handout ✓ AAP Interim Guidance on supporting the emotional and behavioral needs of children, adolescents, and families during the COVID-19 pandemic For information on **family strengths**, see: ✓ CSSP Strengthening Families ✓ CSSP Strengthening Families Action Sheets ✓ AAP Early Brain and Child Development: The First 1,000 Days ✓ Bright Futures Eliciting Parent Strengths Tip Sheet ✓ Bright Futures PreSip2/UVM Eliciting Parent Strengths 18 and 24 months ✓ Family-Centered Approaches Webinar Slides ✓ Common Factors Approach (HEL^{2}P^3) ✓ Eliciting Family Strengths Scripts For **perinatal depression**, see: ✓ Maternal Depression Screening Conversation Tip Sheet ✓ Centers for Disease Control and Prevention ✓ Resources on STAR Center Web site ✓ Community Care North Carolina Perinatal Depression Getting Started ✓ Perinatal depression resources on STAR Center Web site	

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	For **social drivers of health**, see: ✓ Unite Us ✓ FindHelp.org ✓ United Way 211 ✓ AAP and Food Research & Action Center (FRAC) Screen and Intervene: A Toolkit for Pediatricians to Address Food Insecurity ✓ Social drivers of health resources on the STAR Center Web site For **trauma informed care**, see: ✓ Child Trends Trauma Informed Care For **medical-legal partnership**, see: ✓ National Center for Medical Legal Partnership.org ✓ Directory of medical-legal partnerships (MLPs) by state ✓ Customizable Tool: Screening for MLP legal needs in health care settings For **child welfare**, see: ✓ AAP Healthy Foster Care America ✓ AAP Abuse and Neglect ✓ National Child Traumatic Stress Network (NCTSN) Child Welfare Trauma Toolkit ✓ NCTSN Pediatric Medical Traumatic Stress Toolkit Health Care Providers For **social-emotional development**, see: ✓ AAP Interim Guidance on Supporting Emotional and Behavioral Needs of Children, Adolescents, and Families During COVID-19 Pandemic ✓ Tulane Early Childhood Collaborative – Managing Difficult Behaviors ✓ Circle of Security International ✓ Relationships: Circles of Security and Attachment Vitamins	

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	✓ National Child Traumatic Stress Network (NCTSN) general Web site and Attachment and Biobehavioral Catch Up (ABC) and Child-Parent Psychotherapy (Child First) ✓ Tulane Early Childhood Collaborative (LA_TECC) parent resources ✓ Zero To Three For **dyadic therapies** involving treatment delivered to a parent/family and child simultaneously, see: ✓ Parent Child Interaction Therapies ✓ Triple_P Parenting.com and associated parent Web site ✓ Provider locator: Child Parent Psychotherapy For **anti-racism**, see: ✓ From Health Leads.org, webinar series: Moving From Antiracism Intention To Action, Beyond Do No Harm: Elevating BIPOC Voices In SDOH Interventions and Bringing Light & Heat: A Health Equity Guide For Healthcare Transformation And Accountability ✓ Continuum on Becoming an Anti-Racist Organization ✓ AAFP EveryONE Project Toolkit promotes diversity and addresses SDOH to advance health equity in all communities ✓ Raceconscious.org ✓ Embracerace.org	
Gap: Follow-up plans are not established for positive screens/assessments or identified interests/concerns, including a referral if indicated.		
The practice setting does not have systematic processes in place to document and follow up on identified social health interests/concerns or positive screens/assessments. This includes: • Resource/referral follow-up plans documented in a standardized way that	• Recognize the importance of developing and sustaining relationships with relevant community partners. See: ✓ Use information from The Social Determinants of Health Academy presentation, Reducing Health Disparities Through Community Partnerships slides 22–33. ✓ Establish relationships with local/state family organizations who work with families for support, information, referral, and help with systems navigation. ✓ Include peer support linkages. Families often benefit from social, emotional, and informational support from other parents/caregivers. Peer support helps	Use information from the following resources to generate discussions in team meetings about how to best identify the patient's risk and document, track, and follow up: ✓ Risk Stratification Tool ✓ CAHMI Risk Stratification Tool ✓ Referral and Tracking Discussion Questions

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enables chart review and data collection/reporting. • Consent to release information to/from referral source. • Routine follow-up with patients and community partners to make sure families have connected to recommended resources, have received the intervention, and the practice has received a report on health outcomes.	families gain confidence, improve health literacy, and reduce the sense of isolation families may feel. ✓ Recognize the value of family advisors to help identify relevant community partners and to assist in your practice's quality improvement efforts. • Develop processes that include a warm hand-off to the referring partner. Warm handoffs can help avoid communication issues and engage families by encouraging them to ask questions and to clarify or correct the information exchanged. Warm hand-offs help build relationships by communicating care and concern. When needed, use a release of information like this example. • Define how to document outcomes of screening/assessments, follow-up plans, and referrals. For best results in your quality improvement interventions, consider how you will be able to collect/retrieve data for these activities so your quality improvement efforts can be reported. See the following resources: ✓ Getting Started: Implementing a Screening Process worksheet, which can be downloaded in Word or pdf format ✓ Identifying and Supporting Families with Complex Needs PowerPoint presentation that includes a worksheet to track positive screens, referrals, and follow-up. ✓ ASHEW Complex Needs Planning Worksheet ✓ Use Z codes to identify patients. See the following resources: – AAP Z SDOH Codes list – Infant and Early Childhood Mental Health Z Codes • Use an EHR flag or other reminder/recall or system to track positive screens, referrals, and follow-up. Consider using/adapting the ASHEW Referral Tracking Sheet to fit your practice's needs. • Allow adequate staff time and resources to perform necessary documentation and follow-up tasks. • Use time-based billing for patients with complex needs, see 2021 Office-based E/M changes affect time-based reporting, prolonged services. • Make an attempt to follow up on the status of the referral (if indicated) within 30 days to ensure the family is accessing support (ie, phone call to family or referral clinician, community resource, etc).	

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

Potential Barriers	Suggested Ideas for Change	Still Not Seeing Results?
	✓ For **social-emotional development** needs, establishing linkages with IECMH clinicians (including Child First), pediatric subspecialists such as, developmental and behavioral pediatricians, child psychiatrists. In other cases, school and community services such as Head Start (and Early Head Start), home visiting, Part C, early intervention services, physical, occupational or speech therapists, etc. may be needed. • Be prepared with crisis/emergency resources in the area for situations such as when thoughts of self-harm or harm to others develop or when depression symptoms worsen. • Use/adapt the AAP Family Friendly Referral Guide, a customizable handout to give to families whose child has a developmental concern. Practices can customize the handout with information about local referral resources.	• Consider what checks and balances the QI team can make to ensure complete follow-through on referrals. Refine ideas through PDSA cycles.
The practice setting has not incorporated an effective referral process into the office workflow.	• Work with the QI team to plan how your practice will close the referral loop, eg, track referrals, follow-up, and patient outcomes. Consider how to obtain consent for bidirectional communication and how to establish feedback loops with referral partners. Review roles and responsibilities of staff. Standardize documentation processes. • Develop processes that include a warm hand-off to the referring provider. Warm handoffs can help avoid communication issues and engage families by encouraging them to ask questions and to clarify or correct the information exchanged. Warm hand-offs help build relationships by communicating care and concern. • Provide families with full contact information, help making the appointment, or securing transportation as needed. Having the practice referral coordinator make the referral appointment together with the family before they leave the clinic is highly recommended. • Arrange a follow-up phone call in a few days to support and encourage follow-through. Having the referral coordinator call the family to remind them of the referral appointment a day or 2 in advance is highly recommended. • Provide resources for community support. • Use a reminder/recall or tickler system to ensure that referral appointments occur in a timely manner. Use/adapt the ASHEW Referral Tracking Sheet to fit your practice's needs.	• 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?
Families experience barriers that prevent follow-up on recommended services.	• Attempt to understand the reason the family did not keep the appointment: ✓ Was the plan developed through a shared decision-making process? ✓ Was a warm hand-off provided in which you communicated your care and concern by entrusting the family's needs and care into other, specialized hands? Was the family engaged in the process? ✓ Does the family understand the benefit of the recommended service? ✓ Does the family have other, more pressing needs that need to be addressed first? Some needs (hunger, for example) simply take precedence over others. ✓ Are there barriers to access to care such as lack of transportation, need for childcare, inability to take time from work, language barriers? ✓ Was an appointment reminder call made/received? Telephone reminders have been proven to improve compliance. ✓ Was a check-back appointment made to the medical home to ensure consistent evaluation of progress? ✓ Are community support services available? Were they recommended?	• Discuss follow-up compliance problems in a staff meeting and brainstorm ways to improve them. Plan, test, refine and implement ideas for change through Plan, Do, Study, Act (PDSA) cycles.

Appendix

Family

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

The Family: A Description

We all come from families.

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

We live under one roof or many.

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

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

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

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

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

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

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

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

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

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

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

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

Family Advisors can support practices to:

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

Family Strengths

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

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

Protective Factors

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

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

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

Strength-based Approach

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

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

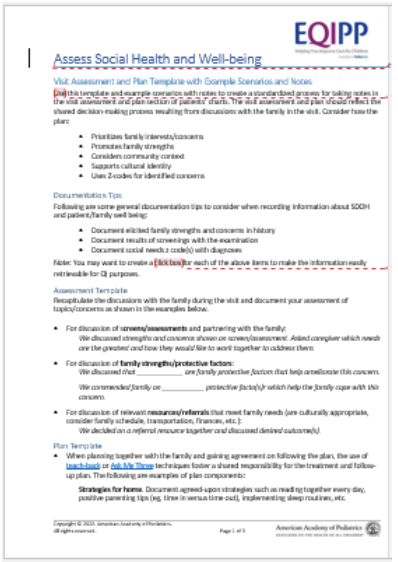
Bright Futures Guidelines, 4th Edition, Core Materials Visit Assessment and Plan

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

- Prioritize family interests/concerns.

Social Health and Early Childhood Well-being

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


EQIPP

Assess Social Health and Well-being

Visit Assessment and Plan Template with Example Scenarios and Notes

Use this template and example scenarios with notes to create a standardized process for taking notes in the visit assessment and plan section of patients' charts. The visit assessment and plan should reflect the shared decision-making process resulting from discussions with the family in the visit. Consider how the plan:

- Prioritizes family interests/concerns
- Promotes family strengths
- Considers community context
- Supports cultural identity
- Uses Z-codes for identified concerns

Documentation Tips

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

- Document elicited family strengths and concerns in history
- Document results of screenings with the examination
- Document social needs z code(s) with diagnoses

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

Assessment Template

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

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

Plan Template

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

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

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

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

- *Bright Futures Guidelines*, 4th Edition, Pocket Guide
- *Bright Futures Tool and Resource Kit,* 2nd Edition
- Bright Futures/AAP *Recommendations for Preventive Pediatric Health Care* (Periodicity Schedule)