Disclosure Statement

Colleen Kraft, MD, FAAP

- I have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this CME activity.

- I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.
Put Bright Futures into practice to promote health at the state and community levels.

Bright Futures recommendations, tools, and resources address current and emerging health promotion needs at the family, clinical practice, community, health system, public health, and policy levels.
Physician Performance Based Compensation

Primary Care Physician (PCP) Incentive Program

UnitedHealthcare appreciates the important role played by primary care physicians (PCPs) and we believe that those who provide high-quality, cost-effective care should be rewarded appropriately. Therefore, as one activity in a growing portfolio of primary care support programs, we are launching a Primary Care Physician (PCP) incentive program pilot. This program provides your practice with the opportunity to earn a bonus payment by meeting a core subset of UnitedHealthcare's traditional quality and cost-efficiency criteria. Because this is a pilot program, designed to determine the effectiveness of the incentive model, we are limiting it to select markets and a limited number of PCP practices.

PCP Incentive Program FAQ

Patient-Centered Medical Home (PCMH) Program

PCMH is one of the UnitedHealthcare value based contracting programs offered in specific markets. The PCMH program provides enhanced payments for primary care providers that implement the medical home model of care.

The UnitedHealthcare medical home model of care focuses on several key elements to help reduce medical cost, improve quality of care and to provide the patient a better experience with the provider and the provider's practice care management team. Examples of key elements include better access to care, coordination across the continuum and transitions of care, chronic case management when needed, preventative care, and medication review.

PCMH Program FAQ
The *Bright Futures Tool and Resource Kit* also contains supplementary materials:

- Additional Parent/Patient Handouts
- Developmental, behavioral, and psychosocial screening and assessment tools
- Practice management tools for preventive care
- Information on community resources
Core Tools: Integrated Format

Previsit Questionnaires

Allows healthcare provider to gather pertinent information without using valuable time asking questions

Documentation Forms

Enables Provider to document all pertinent information and fulfill Quality Measure
The aim of the Preventive Services Improvement Project (PreSIP) was to determine:

- If Bright Futures could be implemented in a busy practice setting and
- Evaluate if practices could implement office systems-based changes in care processes to meet birth to age 3 health supervision recommendations

Hypothesis: Practices will perform each service at least 85% of the time during 9- and 24-month preventive services visits as a result of PreSIP participation
21 practices participated in a modified Breakthrough Series collaborative from January to November 2011.

Changes tested to improve health supervision care processes in 3 areas:

- New Screening Recommendations
- Additional Health Supervision Care
- Office-Based Changes

Patient chart review conducted to track changes in performance of implementing Bright Futures in practice.

Office systems also examined.

Chart review requirements:
- 20 charts at baseline (9 & 24 month visit)
- 10 charts each month for action period (9 & 24 month visit).
Preventive Services Components

- Elicit & Address Parental Concerns
- Age Appropriate Medical Risk Assessment/Screening
- Weight For Length or BMI
- Developmental Screening/Follow-up (9 & 24 M)
- Autism Specific Screening/Follow-up (24 M)
- Addressing 3 *Bright Futures* Priorities in AG
- Evaluation Of Parental Strengths
- Oral Health Risk Assessment
- Maternal Depression Screening
Measures (9 and 24 month visits)

Office-Based Systems Components

- Utilize a preventive services prompting system
- Utilize a recall/reminder system (to address immunizations and well child visits)
- Utilize a system to track referrals (paper-based or electronic)
- Utilize a system to identify children with special health care needs
- Link families to appropriate community resources
- Utilize a strength-based approach and shared decision-making strategy
## Practice-Level System Changes from Baseline to Completion

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Baseline</th>
<th>Completion</th>
<th>P value ( P &lt; .05 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prompt preventive services</td>
<td>11/21</td>
<td>16/21</td>
<td>0.096</td>
</tr>
<tr>
<td>Accessible community resources</td>
<td>9/21</td>
<td>16/21</td>
<td>0.02*</td>
</tr>
<tr>
<td>Person responsible for updating resources</td>
<td>8/21</td>
<td>14/21</td>
<td>0.01*</td>
</tr>
<tr>
<td>Track referrals</td>
<td>14/21</td>
<td>17/21</td>
<td>0.08</td>
</tr>
<tr>
<td>Contact families behind on preventive services</td>
<td>7/21</td>
<td>16/21</td>
<td>0.004*</td>
</tr>
<tr>
<td>Learns from family feedback</td>
<td>15/21</td>
<td>18/21</td>
<td>0.24</td>
</tr>
<tr>
<td>Uses motivational interviewing or shared decision-making</td>
<td>14/21</td>
<td>18/21</td>
<td>0.21</td>
</tr>
<tr>
<td>Identify children with special health care needs</td>
<td>9/21</td>
<td>15/21</td>
<td>0.03*</td>
</tr>
</tbody>
</table>
Conclusions

Findings suggest that Bright Futures can be implemented in diverse clinical settings.

- All Bright Futures measures showed statistically significant improvement between baseline and follow-up
  - Four measures were over 90%
  - Assessment of parental strengths saw greatest increase

- On average, practices implemented
  - 6/7 preventive care measures at the 9-month visit
  - 7/8 preventive care measures at the 2-year visit

- For the 9-month visit, slight increase in time spent between baseline and follow-up
Quality Improvement Roadmap

- Develop SMART Aim & Measure
  - Observe & document current process & collect baseline data
  - Identify Key Drivers
  - Identify & quantify process failures
  - Identify possible interventions / testable ideas
  - Design & execute PDSA cycles
- Make decisions based on learning
  - More PDSA cycles & scale-up
  - Implement successful interventions
  - Develop & execute a sustainability plan
  - Plan for spread as appropriate
Aim Statements

- Answer the question:
  - What are you trying to accomplish?
- Include the measure which answers the question:
  - How will you know a change is an improvement?
“SMART” Aim

- **S** – Specific (clearly stated)
- **M** – Measurable (measurable numeric goals)
- **A** – Actionable (within the control/influence of your team)
- **R** – Relevant (aligned with the organization’s priorities)
- **T** – Time bound (specific time frame)
By April 2016, XYZ Pediatrics will increase the percentage of 9 month ASQ screenings done during well child visits in the practice from 17% to 50%.
A Key Driver Diagram:

- Organizes the “theory of improvement” for a specific project.

- Connects the aim/ outcome, key drivers, and interventions (change concepts) to create a “Learning Structure”.

- Helps to focus the selection of changes to test by identifying the key drivers.

- Serves as a communication tool to present your work.
SMART AIM

Aim

By April 2016, XYZ Pediatrics will increase the percentage of 9 month ASQ screenings done during WCC in the practice from 17% to 50%

Key Drivers

Interventions
Key Drivers - Critical Issues

- Ideal = evidence or data based

- Level of abstraction
  - High enough level to allow creativity in generating ideas for interventions
  - Low enough to provide concrete guidance for testing

- Key drivers are the WHAT, interventions are the HOW.

- Important to revisit as you understand the project more

- By convention they should be stated in the affirmative.
**Aim**

By April 2016, XYZ Pediatrics will increase the percentage of 9 month ASQ screenings done during WCC in the practice from 17% to 50%

**Key Drivers**

- Knowing a 9 month old is coming in for a well visit
- Time for parents to fill out the screen
- Time for scoring and interpretation
Validating your key drivers

- Evidence
- Data
- Observation of the process
- Interviews
- Discussion with your team who are directly involved with the process
Identify possible interventions/testable ideas

- Use your key driver & brainstorm possible ideas to test with your team.

- Check to be sure the ideas to test relate to one or more of your key drivers.
Using a Key Driver Diagram

**Aim**

By April 2016, XYZ Pediatrics will increase the percentage of 9 month ASQ screenings done during WCC in the practice from 17% to 50%

**Key Drivers**

- Knowing a 9 month old is coming in for a well visit
- Time for parents to fill out the screen
- Time for scoring and interpretation

**Interventions**

- Identifying 9 month olds coming in for WCC in a pre-session “Huddle”
- Give 9 month ASQ to all 9 month olds when they check in at front desk
Quality Improvement Roadmap

1. Develop SMART Aim & Measure
2. Observe & document current process & collect baseline data
3. Identify Key Drivers
4. Identify & quantify process failures
5. Identify possible interventions/testable ideas
6. Design & execute PDSA cycles
7. Make decisions based on learning
8. More PDSA cycles & scale-up
9. Implement successful interventions
10. Develop & execute a sustainability plan
11. Plan for spread as appropriate
Improvement Ideas
Tools and Partnerships
Screening and Smart Sets
* Housing problems (overcrowding, roaches, rodents, utilities, mold, lead)?
  - Yes
  - No

* Threatened with eviction or losing your home?
  - Yes
  - No

* Do you feel that you and/or your children are unsafe in your relationships?
  - Yes
  - No

Are you having any trouble with insurance coverage?
  - Yes
  - No

Since your last appointment, have you had trouble paying for medications or have you chosen not to fill a medication due to cost?
  - Yes
  - No

Do you ever have any trouble getting to doctor’s appointments, pharmacy, or other medical needs?
  - Yes
  - No

* Would you like to speak with a social worker or legal advocate in the clinic?
  - Yes
  - No
Well Child c. 2 months-11 months

DIAGNOSIS

- General
  - Well child check [Z00.120] [edit]
- Behavior and Development
- Dermatology
- Gastrointestinal
- Infectious Disease

IMMUNIZATIONS

- Hepatitis B--birth, 1-2 months, 6 months (3rd must but 6 months or older)
  - 10 mcg, Intramuscular, ONCE
- Rotavirus (Rotarix)-- 2 months, 4 months (min age 6 weeks; max 1st dose <15 weeks; max final dose 8 months)
  - 1 mL, Oral, ONCE
- DTaP Infanrix -- (min 6 months after 3rd dose)
  - 0.5 mL, Intramuscular, ONCE
- PentaLP (DTaP-HIB-IPV)-2, 4, 6 months (minimum age 6 weeks)
  - 0.5 mL, Intramuscular, ONCE
- Pediarix (DTaP-IPV-Hepatitis B)-- 2, 4, 6 months (minimum age 6 weeks)
  - 0.5 mL, Intramuscular, ONCE
- PCV-13 (Pneumococcal Panel)-- 2, 4, 6 months (minimum age 6 weeks)
  - 0.5 mL, Intramuscular, ONCE
- Influenza vaccine 0.25 (Give after 6 months of age; additional dose in 4 weeks if first vaccine)
  - 0.25 mL, Intramuscular, ONCE
DFCP Community Program Directory

This Community Program Directory represents an ongoing commitment by DCF to increase access to resources that are designed to strengthen families and prevent child abuse or neglect. The services identified in this Directory are funded by DCF’s Family and Community Partnerships, a grant-making and best practices team committed to strengthening New Jersey’s families.

This Directory will be continuously updated online as additional resources for families become available.

Download the statewide FCP Community Provider Directory
FCP Directorio de Programas de la Comunidad

Click on the links below for individual county directories.

Atlantic
Bergen
Burlington
Camden
Cape May
Cumberland
Essex
Gloucester
Hudson
Hunterdon
Mercer
Middlesex
Monmouth
Morris
Ocean
Passaic
Salem
Somerset
Sussex
Union
Warren
Early Childhood Services

Home Visitation Programs

FCP oversees the implementation of an array of evidence-based home visiting services to provide early support to families with infants and young children across the state. Eligibility criteria for HV services vary by model, but typically programs begin working with families during pregnancy and continue until the child is age two or three.

Home visitors provide pregnant women and new parents with health information, parenting education, and linkages to other resources that support child and family well-being. The directory provides information on all DCF-funded HV models that include:

- Healthy Families (HF-TIP) – pregnancy/birth to age three
- Nurse-Family Partnership (NFP) – first-time pregnancy to age two
- Parents As Teachers (PAT) – pregnancy/infancy to preschool
- Home Instruction for Parents of Preschool Youngsters (HIPPY) – age three to five

In addition, we have included federally funded Early Head Start programs that provide home-based services.
Strengthening Families: A Protective Factors Framework

Strengthening Families is an evidence-based approach that provides training and guidance to child care providers, who in turn engage and support parents/families of infants and young children who are enrolled in the child-care/family-child care setting.

The Child Care Resource Referral agencies (CCR&R) in each county are the trainers who work with the child-care/family-child care providers to incorporate the five Protective Factors and seven program strategies in the program's daily activities. The child-care providers learn new approaches on how to partner with parents and families in protecting, educating and caring for young children while promoting their social and emotional development.

For more information on Strengthening Families in your county, contact the Strengthening Families trainer(s) under the Early Childhood Services section in the directory.