Choosing The Bright Futures Guidelines: Lessons from Leaders and Early Adopters

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The Bright Futures Guidelines for the Health Supervision of Infants, Children and Adolescents, third Edition\(^1\) was developed under a cooperative agreement between the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services and the American Academy of Pediatrics (AAP). More than 50 experts and more than 1,000 reviewers — pediatricians and family physicians, nurse practitioners, mental health colleagues, pediatric dentists, nutritionists, and families — worked collaboratively to ensure completeness and accuracy. When published in 2008, it became the uniform guideline for the health supervision care for U.S. youth.

Prior to the publication of Bright Futures, multiple guidelines competed for practitioners’ attention, often with contradicting suggestions. Older guidelines often cataloged what might be done, rather than direct what could be done. In the third edition, the Bright Futures experts committed to craft 32 health supervision visits, from the prenatal visit to age 21, which were appropriate to current practice, relevant to children and families, and efficient, community-based and culturally competent. When used with the Bright Futures Toolkit, the guidelines allowed for a Bright Futures health supervision visit to achieve excellent care in an 18-minute provider encounter. Changes in practice were anticipated, not to just add new services or to respond to new evidence or expert opinion, but also to attain new efficiencies.

First, two voices of experience. Dr. Lopreiato tells how through his career his practice has evolved into a Bright Futures practice, even as Bright Futures itself has been evolving. Dr. Bedingfield reflects on his suburban pediatric primary care practice of more than 26 years and the impact of Drs. T. Berry Brazelton, Barry Zuckerman, Steven Parker, and Morris Green and their contributions to how he practices. In a side comment, Dr. Bedingfield also astutely describes what makes pediatrics different from other types of medical practice.

“Well-child Care: a Senior Pediatrician’s Perspective” by Joseph O. Lopreiato, MD, MPH, FAAP, Naval Medical Center, San Diego, California

There is no doubt in my mind, as I reflect on my own health maintenance visit skills, that they have changed considerably over the years. Early on, I was consumed with checking all the developmental and anticipatory guidance boxes on the various well-child and adolescent forms, barely looking up to engage the patient in any meaningful conversation. I spent perhaps 10 minutes on the history-gathering portion, dutifully following the predesigned script on the form or recalling from memory what questions I would ask. The cursory, “How are things going?” introductory statement was a rote opening line to which the parent’s responses barely registered in my mind. I would spend 10 to 15 minutes on a detailed physical exam, always fearing that missed abdominal tumor or leukocoria case that we heard so much about as housestaff at grand rounds or from cases admitted to the ward. Over time, this type of health maintenance visit became more of a chore than a clinical examination, and I came to regret this part of general pediatrics.

Over time and with some wisdom from my mentors, I came to realize a whole new purpose of this visit — the parent agenda. Instead of dutifully re-
What Sets Apart Pediatrics From the Rest of Medicine?

by Francis C. Rash, MD, FAAP, Naval Medical Center, San Diego

What are the attributes of pediatricians that set them apart from other practitioners? How is being a graybeard pediatrician different from being a young turk?

The answer to the first question, I think, is that we’re very much more a cognitive specialty than any other, not that other specialties don’t use brainpower, too. But in pediatrics, we’re far less likely to be procedurally-oriented like surgical specialties. We’re also less likely to reach for the prescription pad for many of our diagnoses, preferring instead education, observation, anticipatory guidance, and behavior management for many of the conditions we treat. We do a lot of talking.

Once a Marine Corps Major, then a brand-new father, asked me for specific examples of what qualities make pediatricians different from other doctors. This question came as a follow-up to a long post-natal visit with him and his wife, discussing the problems we were having with their newly-born preemie son. He thought it was unusual for a physician to sit so long with family members, making sure that all their questions were answered and that they understood everything. He also noted that his question also came in the context of his Marine Corps training, or in his words, “In, out, boom, done.” But in this case he was asking me to be a bit more analytical.

I told him that three attributes set pediatricians apart:

1. We listen. I explained that other doctors listen, too, but that for us in pediatrics, listening is the life-blood of our cognitive approach.

2. We talk to the patient and parents, not down to them. I explained that other doctors listen, too, but part of our job, perhaps the largest part, is making sure that parents understand the diagnosis and the treatment plan. As I said, we do a lot of talking, as well as clarifying, expanding, and selling the product, in this case the diagnostic and therapeutic plan.

3. We care, not meaning to imply that other specialties don’t care, but rather that we project that caring better than others (in my opinion, anyway).

The pay-off in being a greybeard is that clinical experience leads to confidence in communication, allowing us to get information across to parents in a meaningful and especially in an understandable way. When I was much younger, the focus during an encounter was on the process itself, the driving need to cover every aspect of History of Present Illness, Review of Systems, and Personal Family and Social History, making certain that every box in that mental checklist was checked. Likewise for the Physical Examination, I would have the mental checklist, all the boxes requiring check marks. Synthesis would follow, leading to a diagnostic and therapeutic plan, but overlooking all the nuances of communication and missing completely the rhythm, cadence, and inflection of speech and body language.

Now, at a relatively advanced age, my focus is on the dialogue, the interchange, and the unspoken. Now I have no difficulty hearing the troubled inflection in speech. I see the distressed posture. I note the facial expressions and other body language. I hear all the words, just like when I was younger, but I get more information from them. One recent example comes to mind, the toddler son of a surgeon who had just returned from Iraq. The purported reason for the visit was his slightly late 2-year-old well-child visit. I went through the process, discussing the normal exam with mom and reviewing appropriate anticipatory guidance issues. Since I “see” more now than when I was younger, I sensed there was more to the encounter than advertised. I asked mom how things were going at home, and she said fine — well, not fine. Her husband seemed distant with both her and his son, and I asked, “That’s really why you’re here, isn’t it?” It was, so we spent a bit more time going over that issue.

One other good thing about being a greybeard is that many of the on-board staff who now direct divisions and departments and directorates are folks who rotated through pediatrics during their training years, and I know most of them at a personal, sometimes paternal level. I made a call to the surgeon and asked if he could spare a few minutes. In his office, after the initial social exchange, I asked him how he was doing. Fine, he said. I asked, “You still think about it, don’t you?” He didn’t hesitate, nor did he ask me what I was talking about. He simply said, “Yes. All the time.” After an additional 15 minutes or so, it was clear to me that he had at least a mild form of post-traumatic stress disorder (PTSD). He knew it, too, but was reluctant to seek help. I said, “You’re an idiot.” He said he already knew that.

The upshot of my going to him was his promising to seek input from mental health services, which he did. Now under treatment, he’s much better. Years ago, I would have not have seen this problem at all, missing all those unspoken cues during that well-child exam. Years ago, I wouldn’t have had the credibility that allowed me to make a cold call on another professional that way. Those are both benefits of time and experience. I wish I’d had these skills 25 or 30 years ago.

We’re a cognitive specialty: we listen, we talk to patients and not down to them, and we care, and with age and experience, we see things differently and more clearly. And there is one more benefit of age: enjoyment in the true affection we feel for the kids. At the commissary recently, I saw one of my patients, now 5 years old, with the residual problems we see in some of our former preemies, including spastic diplegia. His gait is stiff-legged, making it almost comical when he tries to run. He doesn’t care. When he saw me, he began running toward me, an indication that he wanted to play the game that we play in the clinic when he comes in for visits. He will run toward me and I toward him, and just before we meet, I do a little hop. He does likewise, jumping into my arms. That’s what we did at the commissary that day, with him squealing happily. Years ago, I would not have been able to comfortably do that in such a public setting, much less honestly share in his elation and joy. But that day I felt both of those things myself and didn’t care what anyone else thought.

The vagaries of age bring their own sets of problems, but there is definitely an upside to getting old.
cording all the items on my pre-printed form, I would find more enjoyment in listening to the parents’ concerns, even if not on the form, than to any items on my agenda. Suddenly, the well-child visit became a conversation between parent or patient and me, and not so much a task to accomplish. Naturally, I did not cover all the items on my form, but I realized that most of what I was supposed to cover did not incur patient harm if I did not do it all. Issues such as parental stress, sleep concerns, family finances, reading to children, and deployment of family members (in military families) became the topics that parents wanted to talk about when I asked them. These were the issues they wanted help with, issues I would have missed if I’d stuck to my form. In time, I became a better listener and less of a director, a better solver of problems and less of a taskmaster with lists of anticipatory guidance items to rattle off. My favorite opening lines became: “Before we begin — what are your concerns today?” and “What type of personality does your child have?” These and other open-ended questions were never on any forms — they just seemed a natural way to get a conversation started.

My physical exam switched to a more focused exam based on parental concerns or abnormal screening — the growth chart became a powerful tool in looking for occult medical concerns, as did simple developmental questions. Sure, I would still listen to the heart and feel the abdomen — areas where parents could not examine, but by and large I missed very little by listening to parents’ concerns and asking a few simple questions. The exam would take only 5 to 8 minutes to complete. The remainder of the time was problem-solving with the parent about their concerns and any red flags I had detected in my conversations.

To make sure I had addressed all concerns, I began concluding most visits with a simple statement: “Do you have any other questions?” To probe for understanding when a problem had to be solved, I would say: “When you go home tonight and explain to someone else what the doctor said, what will you say?” This became a powerful check on my communication skills and whether or not the parent was engaged.

All in all, the health maintenance exam has become less a task and more of an exchange of concerns, a thoroughly enjoyable experience for me. Although the concerns may vary little from new parents or young teens, the chance to listen to patients explain their concerns and to problem-solve where needed is what motivates me in this area of pediatric practice.

“Bright Futures, Indeed” by Bruce Bedingfield, DO, FAAP, FACOP, Hoffman Estates, Illinois
I was asked to write my thoughts on using Bright Futures in the private pediatric office, writing from the perspective of a clinician in the later stages of practice. (Ouch! How did that happen so fast?) I am, indeed, a pediatrician and have practiced in the northwest suburbs of Chicago for 26 years. My original solo practice has grown to include four pediatricians and two nurse practitioners. Throughout my career, I have faced the challenge of trying to balance high-quality well-child care with competing demands for punctuality, productivity, and a calm, unhurried demeanor.

I was honored to serve on the most recent Bright Futures Users Panel. I was asked to serve, I believe, upon the recommendation of Tom Tonniges when he was director of Community Pediatrics at the AAP. He and I had entered into a discussion at a pediatric conference on the challenges of performing high-quality well-child care. We discussed my thoughts on trying to incorporate the best aspects of T. Berry Brazelton’s Touchpoints,2 Zuckerman and Parker’s Healthy Steps,3 and Morris Green’s Bright Futures.4,5 I can’t say we came up with anything brilliant, but I soon found myself on that Bright Futures panel.

To be honest, I was not a huge fan of the first two editions of Bright Futures. I would sometimes deride it all as “health maintenance by committee.” Eventually, I had to admit to my fellow panel members, “At least now I’m part of the committee.” In my mind, the very first Bright Futures was not the 1994 edition nor, of course, was it any of the subsequent versions. I remember first reading Morris Green’s marvelous article in the November 1986 Pediatrics in Review, “Behavioral and Developmental Components of Child Health Promotion: How Can They Be Accomplished?”6 That article came at an ideal time for me. Five years into practice, I was well aware of the limitations of my well-child visits and was looking for better ways to do them. When the article was published, it opened my mind to a wonderfully “holistic” approach to incorporating development, behavior, and parent education into the standard pediatric healthcare approach, the kind of practice that Green would later describe in Bright Futures.

That article had a profound impact on my own practice, and I believe it impacted the evolution of pediatric healthcare itself. It suggested that the pediatric office become a “parent and child resource center.” It taught us all how to ask “facilitative,” open-ended questions. It suggested that we include developmental assessment, promotion of positive parent-child interactions, observation of

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behavior and interaction of parents and child, and it emphasized the importance of parent education and support. It encouraged the pediatrician’s role as the “child’s health mentor,” and concluded that, “pediatric health supervision is in the service of healthy children and happy families.” It was interesting for me, then, to watch that article eventually evolve into Bright Futures.

It’s one thing for a pediatrician, anxious to enhance his well-child care, to adopt ideas from a nine-page journal article. What are we to do, however, with a 500+ page Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents, third edition, knowing that additional books and the Bright Futures Toolkit will be forthcoming? The challenge is even greater now that a recent study showed only 40.7% of children receive indicated preventative care.8

Perhaps the best way for us to think of Bright Futures is as the current “state-of-the-art” for pediatric well-child care. That is especially true in that Bright Futures, third edition, takes the place not just of previous editions, but also of the AAP Guidelines of Health Supervision,9 and the AMA’s Guidelines for Adolescent Preventable Services.10 I personally find it helpful to realize that Bright Futures, third edition, is not so much “health maintenance by committee” as it is the refinement of Dr. Green’s original concept, based on two decades of experience and input from innumerable pediatric health providers. It is quite evident that Bright Futures itself is an answer, if not the answer to the question incorporated into the title of Dr. Green’s 1986 article.

That really is the gist of what we’re trying to do with our pediatric health maintenance — answer that question: how can it all be done, done well, and done efficiently? It was the question I sought to answer in a recent commentary, “Pediatric Health Maintenance in the 21st Century: a View from the Trenches.”11 It’s a challenge that pediatricians, pediatric nurse practitioners, and family physicians face just about every day.

Actually, there are some resources available to us. There is a very useful book written for physicians and other health-providers-in-training — Pediatrics in Practice: a Health Promotion Curriculum for Child Health Professionals, edited by Henry H. Bernstein.12 This is a book that specifically promotes the Bright Futures concept. Although it is written for a generation of health professionals trained after the development of Bright Futures, it contains lessons and strategies from which we can all benefit.

I also recommend that any pediatrician or other health professional interested in performing high quality well-child care become familiar with both Touchpoints and Healthy Steps. Although they are pediatric care programs that focus on the 0 to 3 age groups, they each offer an invaluable perspective on children’s healthcare. The highly-motivated pediatric professional will also want to read Encounters with Children by Dixon and Stein.13 This is a wonderful resource with special emphasis on the development of mental and behavioral aspects of pediatric health maintenance.

It is the Bright Futures, third edition, that now offers the most complete outline for pediatric health maintenance, representing both the AAP and AMA’s protocols. This new version, in my mind, offers three very special new benefits. First, it emphasizes five top priorities for each healthcare visit. If we pay attention to nothing else in Bright Futures, we’re wise to heed what the “Expert Panels” deemed those top priorities.

Secondly, this new version places special emphasis on mental health and healthy weight. Both, of course, have always been important to children’s health, but they seem to have taken on increased importance in the 21st century.

Finally, with our current battle cry for evidence-based medicine, this newest Bright Futures has an extensive section on “Rationale and Evidence.” Even there is the disclaimer, “It probably would be more accurate to describe this edition of Guidelines as evidence informed rather than fully evidence driven,” admitting that there is often little if any good published data on the effectiveness of the well-care that we give. This is hardly new, as Dr. Green’s 1986 article stated, “Lacking scientific proof of the effectiveness of much that is done in health promotion, present practice must depend upon the best of cumulative experience and expert judgment while eschewing unrealistic expectations.” I have a personal theory that evidence-based medicine is a left-brain activity, while much of what we do in well-child care is right-brain. That doesn’t mean that evidence is not important, however. The Bright Futures chapter on “Rationale and Evi-
dence” invites both challenges and opportunities for future clinical research.

For wherever we are in our practice — early, late, or in-between, we want our well-child care to be as accurate and effective as possible. That is why we’re all wise to study and at least selectively adopt Bright Futures. There is the all-too-familiar adage, “You can’t teach an old dog new tricks.” But we’re clinicians, not canines; we’re scientists. I much prefer a quote from the late columnist and philosopher, Sydney J. Harris, who wrote, “The race indeed is not to the swift, nor battle to the strong, but triumph comes to those who every day and every year, get better at what they do.”14 That, after all, is the purpose of continuing medical education — to become a better physician today than we were yesterday. In that spirit, we can strive to perform our well-child care measurably better this year than we did last, and as we do, both we and our patients can look forward to “bright futures,” indeed.

EXPERIENCE

Experience may bring wisdom and often wise guidance. The practices of Dr. Lopreiato and Dr. Bedingfield developed to embrace many of the components of the Bright Futures approach. What exactly is this concept of primary care for children and adolescents embodied in the Bright Futures Guidelines? How can it be defined for practitioners who may wish to assess or adopt the Bright Futures Guidelines?

When work on Bright Futures, third edition, began, the Bright Futures Project Advisory Committee convened by the AAP sought to define what was meant by Bright Futures, what are guidelines, and what may constitute a “Bright Futures practice.” Their definition is found in the introduction to the third edition:

Bright Futures is a set of principles, strategies, and tools that are theory-based, evidence-driven, and systems-oriented, that can be used to improve the health and well-being of all children through culturally appropriate interventions

that address the current and emerging health promotion needs at the family, policy, community, and health systems levels.

We have invited our other contributors to help us parse this definition.

“Bright Futures is a Set of Principles…”

by Ann E. Burke, MD

Dayton Children’s Hospital, Wright State University, Dayton, Ohio

As a pediatric generalist practitioner and program director for the past 13 years, I have come to know and love the Bright Futures Guidelines. I remember reading the initial guidelines as a second-year pediatric resident and having a distinctly affirming feeling of how glad I was to have chosen pediatrics as a vocation. Bright Futures is not only a guide for the well-baby visits regarding the exam and screening, but a comprehensive guidebook to help families and their children navigate the real world; to make life less scary and more loving; to empower families to deal with and enjoy the unfolding of their children’s lives and potentials.

Bright Futures made wonderful sense when I first “discovered” it. The coolest part, though, is that it makes even more sense 13 years later and daily fills my clinical practice with a great sense of helpfulness and satisfaction.

When practicing Bright Futures, I often ponder the philosophy of it and the power its mission, core values, and vision hold. These reflective moments tend to occur when finishing a well-child appointment, but may occur any time in my busy day.

I have come to think about, over the years, the role of Bright Futures and my small part in the health of children in the form of a myth from the Buddhist tradition. It is, perhaps, a nearly perfect analogy to why the Bright Futures philosophy is of utmost importance for us all, makes such good sense and is truly cogent. The parable describes an enormous net suspended above the palace of Indra, the Buddhist god who symbolizes the natural forces that protect and nurture life. The magnificent idea is that in this net there are brilliant gems attached to each of the millions of overlapping knots in the net. Each gem reflects the image of all the other gems in the net, which sparkles brilliantly in the totality of all of the jewels. This is a beautiful metaphor for the interdependence of all people.

How are we helping parents and their children and adolescents to shine and reflect well upon each other, the larger world, and us all? It may be a meaningful discussion with a family about sleep issues; the questioning of a mom about her adjustment to the new baby that subsequently brings tears and then feelings of reassurance; the talkative sixth-grade boy who plays basketball and wonders how tall he will grow. All of these and hundreds of other examples played out daily in pediatric offices everywhere which, little by little, add to the strength and brilliance of the “net.” The premise that “All our nation’s children deserve the attention, the encouragement, and the intervention of health professionals from many disciplines to ensure that they develop the healthy bodies, minds, emotions, and attitudes to prepare them to be competent and contributing adults” is so pertinent and powerful that I am not sure how to practice and enjoy pediatrics without this guiding principle. This philosophy celebrates the concept of Indra’s Net.

Moving onto a less philosophical and more practical application of Bright Futures, I step into my role as educator of future pediatricians. The clear, organized way that Bright Futures is set up allows residents to arrange their well-baby visits in a meaningful manner. Not only do they become competent vessels of health supervision by recognizing
which screening tests to obtain at specific visits, they also learn important aspects of social, developmental, and parental trigger questions to inquire about. The third edition “themes” are well-presented topics that are pertinent to our institution’s community medicine rotation and the ambulatory clinic experiences. For example, “Promoting Oral Health,” “Promoting Healthy Weight,” and “Promoting Mental Health” are all rich discussions that residents can utilize. Trainees can obtain in-depth authoritative information on a myriad of topics in Bright Futures. Additionally, the six “core concepts” that are integrated throughout the Bright Futures’ Health Supervision Guidance align very nicely with the Accreditation Council for Graduate Medical Education’s (ACGME) and American Board of Pediatrics’ six “core competencies.” Bright Futures is a practical way to teach health supervision while getting at the deeper, richer layer of how to talk with and problem-solve for families.

Bright Futures adds significantly to my life as a pediatrician. Sounds sort of corny, I know, but it’s true. I love going to my clinic. The feeling of helping others become more healthy, safe, and valued people is wonderful. Bright Futures provided the tools to teach me how to do this effectively and comprehensively as a resident, and continues to grow with me as a practitioner and residency director to meet my needs. May the many gems continue to shine and amaze us all!

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**Strategies**

by Rick Goldstein, MD, FAAP

Boston Medical Center, Boston University, Boston, Massachusetts

I finished residency in 1992 and currently divide my time between a primary care group practice and duties as an associate program director for a pediatric residency. At the beginning of each day, and I suspect this is true for most all of us, I look over my schedule of patients.

The ritual of scanning those lists started out of nervousness. When I started out in practice, I was less focused on the individuals on the schedule, although from the beginning there were problems. My worry was that I wouldn’t know enough, that I would somehow leave out something really important during an appointment, or that I would not carry myself as the thorough, interested, whole-child pediatrician I wanted to be. I needed to prepare myself.

I still have the crib sheets I scribbled and hid beneath a blotter on my desk. They are mostly notes about child development and its surveillance, and age-appropriate anticipatory guidance. There are also a few notes on screening and vaccination. To put them together, the first place I looked was Ambulatory Pediatrics III by Green and Haggerty. It helped me prioritize the use of my time and modeled the thoughtful, knowledgeable voice that I was interested in developing. I augmented that with equal measures of Bright Futures and the Bright Futures Guidelines for Health Supervision, third edition, which I turned to for their exhaustive nature.

I worked hard to incorporate these sources into my own internal checklists and patient interview “scripts.” I gained fluency with the nuts and bolts of each kind of visit. I worked very hard at developing my own practice with a perspective and voice that melded my training, personality, knowledge, and professional standards, and managed to translate all of this information into something unmistakably my own. It is the core of my practice and, I think, my reputation.

Years have gone by. My practice is full and well-regarded. In my practice, I’ve caught some things and, thankfully, missed many fewer. I have come to appreciate what it means to have patients who come back for follow-up or who will call when things are not progressing as I had thought they might. I have had a chance to see what families need over time. I am raising two children of my own. Through all this I have learned to approach my visits differently.

Now when I look over my schedules, I see families with different styles of interaction and sets of needs. In contrast to when I was starting out, I have come to see that the power of our practice in primary care pediatrics does not simply lie in all the information we cram into our heads. It lies in our relationships. Those relationships change when we get to the point that a visit is not a matter of our checklists, but rather the patient and family’s agenda. One thing I often feel I need to challenge residents about is whose show the visit actually is. It’s crucial to know your stuff but even more crucial not to get too distracted by it. Good doctors know the true value of the relationship comes when we are successful in meeting our patients on their terms and responding meaningfully to their needs and their agenda.

Jazz musicians speak of woodshedding, where a musician works long hours alone, learning the fundamentals, taking apart the music, and understanding the foundations of their musicianship. They know that once they achieve a certain command of their instrument and the internal workings of the music, their performance can move beyond the static...
nuts and bolts of notes on a page. Their music can become something more synthetic and wonderful, responsive to the crowd and the other band members and whatever happens to be in the air. I didn’t work at it alone, but going to Bright Futures in preparation for my visits was my woodshedding. That effort was an essential foundation and an important tool. Now, when I make the music that is successfully caring for my patients, my experience allows me to move beyond the form of the Bright Futures recommendations and respond to the lives I feel so fortunate to care for.

“… and Tools that are Theory-based, Evidence-driven, …”
by Timothy R. Shope, MD MPH, FAAP Naval Medical Center, Portsmouth, Virginia

In my early career, the focus was on competency and process: make sure I don’t forget anything, make sure I say everything I am supposed to say and do everything I am supposed to do, and hopefully look good in the process. The “checklist” of things to do at well-child visits was overwhelming: historical risk factors; dietary, developmental, TB, lead, anemia, and violence screening; anticipatory guidance; and lists of needed immunizations. The checklist was daunting, but without it I knew I had no chance of remembering everything. To do everything on the list was the goal; I knew it was out there, but could never really reach it. Looking back, well-child visits were mechanical, with primarily one-way communication, and not very enjoyable compared with later in my career.

In my first practice after residency, I discovered for the first time that there were different well-child checklists out there. The one in my new practice was different from the one I learned in residency. I was too naïve to question the validity of the questions and where they came from because I was still focused on process and competency. After a year, this checklist became rote memory. For many years, I celebrated the fact that I no longer had to focus on looking like I knew what I was doing. In addition, I realized that with multiple visits with the same child and family there was some overlap of concepts. The visits became more tailored and there was more two-way communication. Relationships were built over time and this was the most rewarding time for well-child care for me because it was still fresh.

Mid-career, more than 5 years after residency, I began to wonder about how I was doing in well-child care. I became aware of all of the important issues that needed to be touched on or screened for in well-child visits. The lists were actually increasing exponentially. I became aware of Bright Futures and was initially discouraged at the gap between what was on the lists and what could be accomplished in the brief visit. I became more critical in examining what was effective, for whom, in what setting, and where these recommendations came from. I wanted to do the most I could for the most people, avoid morbidity in the highest proportion of children, and do the right thing for my patients. I realized that despite being able to gracefully flow through a visit, enjoy myself, and make the patient and families happy, I was not sure how effective I was.

After 15 years post-residency, I have now seen at least five different types of “well-child visit forms.” I have seen the demand for “productivity” increase so that all of the pressures I was already feeling are exacerbated by a shorter visit. Finally, I will admit, doing 10 to 15 well-child visits a day can become monotonous and unfulfilling. I am convinced that there must be a different way.

First, we must have evidence-based and realistic expectations for what can be accomplished at well-child visits. Second, we must develop more efficient screening tools with the best evidence for detecting areas that need focus. One example of this is the Ages and Stages Questionnaire (ASQ)\(^\text{17}\) for developmental screening. The parent completes the ASQ prior to the visit. If all aspects are normal, time is saved by not having to ask rote developmental questions. This time can be used to focus on other concerns of the parent. Tools like this can be developed for risk-factor screening for tuberculosis, lead, nutritional deficiency, injury prevention, etc. Perhaps these could be completed online ahead of the visit. Deficiencies could be identified and focused on. Handouts could be tailored to the interest and needs of the patient. (Editor’s note: Many of these components on Dr. Shope’s wish list are included in the upcoming Bright Futures Toolkit.)

The visit would be more meaningful and effective, and there would be time for meaningful conversation, creativity, and interaction.

In summary, I am convinced of the following regarding well-child visits:

1. Checklists are necessary.
2. We cannot possibly do all the things people say we need to do in the current paradigm.
3. It is not enjoyable for some (like me) to do the same thing every day with no room for creativity and meaningful interaction, yet a constant pressure for time.
4. Checklist recommendations need to be evidence-based or there must be transparency regarding the rationale of these recommendations.
5. Screening is important, and there are glimpses of a better way of doing things by using electronic medical record technology.

I know Bright Futures has taken all of these considerations in their newest design and I look forward to implementation.

“… and Systems-oriented …”
by Christine Johnson, MD, FAAP Naval Medical Center, San Diego, California

I am a general pediatrician with a strong interest in academic medicine as well as environmental health. I have
been in practice since graduating from residency training in 1997. I graduated from medical school on a Health Professions scholarship through the United States Air Force, and therefore completed my residency training at the Wright Patterson Air Force and Wright State School of Medicine Pediatric Residency Program. I then had the opportunity to serve as a general pediatrician overseas at a small air base just north of Tokyo, Japan, for 2 years. After that assignment I served as general pediatrician at McGuire Air Base in New Jersey before taking a teaching assignment at the military’s medical school, the Uniformed Services University of the Health Sciences, in Bethesda, Maryland. I am now the Pediatric Residency Program Director at Naval Medical Center San Diego, California.

In each of the above assignments a large part of my daily routine entailed routine well-child care. Initially, shortly after residency training, my approach to well-child care was more of a check-list approach. I quickly learned a great deal from my patients, and integrated my knowledge to care of other children. As I became more comfortable with my clinical judgment, knowledge, and skills, my approach to well-child care became more relaxed and conversational, yet systematic. It is now my passion to teach the joys of preventive health maintenance visits to students and residents in training.

My focus at well-child visits is, first and foremost, any parental concerns. As I assess the parent’s level of knowledge and understanding of their child’s development, I then gear my discussion and anticipatory guidance specifically to that parent–child dyad. I keep a scaffolding of systems in my mind, and as I finish with my easy conversation of questions and answers, I go through this scaffolding ensuring that I have addressed all important systems.

In all well-child encounters, in addition to parental concerns, I like to address any previous medical issues or concerns, nutrition and elimination, physical activity, sleep patterns, growth and developmental milestones, immunizations, and any physical exam findings whether incidental or of clinical significance. At particular visits I will also accomplish any recommended screening questionnaires such as post-partum depression screening, lead risk questionnaires, and family history risk (ie, childhood diseases, genetic risks, coronary risk factors).

The new American Academy of Pediatrics Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, third edition, is an exciting new rubric or framework for well-child care. With focused goals for each well-child encounter, as well as an evidence-based and scientific or expert opinion focus for specific topics, I believe these new guidelines can be incorporated easily into practice. Through its systematic approach to well-child care, Bright Futures may indeed make teaching preventive health maintenance visits a more manageable prospect. It has been my experience that for new medical students, residents, or other learners, well-child care is often viewed as being very “cookbook” or “checkbox.” The Bright Futures approach will hopefully change this perception with more of an emphasis on collaboration with patients and families to address specific areas of concerns that are developmentally and age-appropriate and relevant.

My contribution is not exciting (no lifesaving CPR or messy trauma surgery for me), yet my contribution is significant. I prevent fear, and I do this well.

I look forward to incorporating the new Bright Futures Guidelines into my already systematic personal practice of well-child care, and using this approach in teaching future students and residents the “art” as well as the science of preventive health maintenance visits.

“… Improving the Health and Well-being of All Children through Culturally Appropriate Interventions at the … family …” by Frances E. Biagioli, MD Oregon Health and Science University, Portland, Oregon

I reflect on my past decade of medical practice and search for where I have truly made a difference. My contribution is not exciting (no lifesaving CPR or messy trauma surgery for me), yet my contribution is significant. I prevent fear, and I do this well.

The father comes in concerned about the heart murmur he was told their baby had at birth. I explain in simple language what might cause a benign murmur. I do an examination, reassure, and make a plan to follow the heart murmur and what to do if it does not resolve. The fear lifts from his face.
A mother has multiple sclerosis and mentions at a well-visit that her daughter complained of dizziness 2 weeks ago; the mom worries she has given MS to her child. The history is consistent with dehydration; the complete neurologic examination is normal. Although I explain the normal exam and my thought process, the mother smiles with relief.

A teenager is in tears at her well-visit because her period is late; she is sexually active. After the pregnancy test proves negative, I explain what might cause a late period. We prevent her future monthly fear of her period not coming; we discuss abstinence and birth control options.

As a parent, I fear a lot: that my child will become gravely ill, that they will get into serious accidents, or they will make poor choices and become involved in drugs. The best way to keep the bad outcome from happening is to equip the family with the resources to maximize the child’s potential and health. Fear comes from the unknown. Prevention of fear is what a comprehensive well-visit can accomplish: making the unknown more familiar and understandable. Explaining normal body functions, discussing normal exam findings, talking about what to expect, asking about development, and reassuring about the normal progress a child has made are all ways the clinician can help prevent fear and promote understanding. These discussions will not quell all fears but will prepare patients and parents to live with a level of uncertainty.

“The best way to keep the bad outcome from happening is to equip the family with the resources to maximize the child’s potential and health.”

by Nathaniel S. Beers, MD, MPA, FAAP
George Washington University, Washington, D.C.

There are multiple challenges in providing primary care for children in a large, inner-city academic practice. As the Medical Director of the Children’s Health Center at Children’s National Medical Center (CNMC), I have had to manage the issues of trainees, pediatricians with limited clinical time, and high no-show rates to name a few. Beyond these administrative challenges, we struggle with how to address the social risk factors many of our patients face on a daily basis, such as poverty, hunger, homelessness, and violence. At times, it can feel like the challenges are too numerous to overcome. A critical part of successfully practicing in these circumstances is the provision of culturally-sensitive care while also trying to address the needs of the family and the child.

At CNMC, we are fortunate to have established strong partnerships to address the needs of the whole patient. We have social workers in our clinics to assist in managing the complex social needs of the patients. We have undergraduate students as part of Project Health to help our patients connect to the wide array of social services that are in the community to help them. We have lawyers as part of the Health Access Project collaboration with the Children’s Law Center, to assure our patients receive adequate legal representation in housing, education, and eligibility issues.

These support services certainly help in addressing the needs of our patients, but do not obviate the need to actually provide high-quality comprehensive culturally-competent pediatric care. To this end, we have worked to facilitate training for faculty in how to provide culturally-competent care with partnerships with the Zero to Three organization to train faculty and residents. Although patients may seem to have immense lists of stressors and risk factors in their lives, we have had to learn not to be paternalistic in how we provide anticipatory guidance and recognize the patients’ priorities. To do this we must be facile with recommended anticipatory guidance on a multitude of topics, such as many of those listed in Bright Futures, and prepared to allow the parents to express their own concerns.

In the District of Columbia, we also have been able to leverage a court decree against Medicaid to improve the documentation of well-child care for children enrolled in Medicaid. In 2002, the DC Chapter of the AAP and pediatricians at Children’s National Medical Center stood up and said there must be a better way. The court was willing to allow the pediatricians in DC to determine how to improve the capacity of the District to capture the needed well-child metrics in a way that would not encumber providers’ ability to provide high-quality care.

The pediatricians formed a work group that looked at multiple well-child encounter forms to develop standardized medical record forms (SMRFs) to be used by pediatric providers. The team used the Bright Futures, second edition, text revision, encounter forms as one of the models from which to draw. Beyond just meeting the requirements for DC Medicaid, the pediatricians felt it was important to provide guidance to pediatricians and family practitioners (including trainees) on how to ensure they were meeting the requirements but also push providers into providing high-quality comprehensive care. To this end, the SMRFs include the recommended anticipatory guidance from Bright Futures as well as specific items that are critical to patients in DC.

The next phase was convincing practices that the SMRFs were worth implementing and would help them provide excellent primary pediatric care and not increase their workload. To accomplish this goal, the providers worked with...
funding from the Vermont Child Health Improvement Plan and the Commonwealth Fund to form the DC Partnership to Improve Children’s Healthcare Quality (DC PICHQ). The DC PICHQ was able to work with Medicaid and the Medicaid Managed Care Organizations to develop a pay-for-performance system that encouraged participation. Five years later, more than 90% of the Medicaid enrollees are receiving care in participating practices that are using the SMRFs and learning how to improve the quality of care they are providing to their patients.

Now we can focus on improving the quality of care in DC. The presence of the substantial amounts of data from the SMRFs entering a registry have allowed the DC PICHQ to secure funding to tackle quality-improvement strategies to increase the use of standardized developmental screening and to implement the National Initiative for Children’s Healthcare Quality Obesity Recommendations. The DC PICHQ is in the process of reviewing the new Bright Futures, third edition, standards to determine what changes should be made to SMRF to be better positioned to continue improving the quality of care for children in DC. This will include figuring out how to translate the SMRF into electronic medical records as the practices in DC start to develop them. This will also include figuring out how to incorporate the required screenings and the recommended anticipatory guidance in a way that continues to encourage comprehensive care. The soon-to-be-released Bright Futures Toolkit will assist in our upgrading work.

A BRIGHT FUTURE

When we asked early adopters and leaders in pediatrics to write essays describing their health supervision practices, we knew these authors could bring alive the newest definition of Bright Futures. The hope was to pique interest in how readers could implement Bright Futures Guidelines in actual practice — providing individual care, operating practice in real-life settings, and becoming engaged within their communities to support and deliver the highest quality of care to infants, children, and adolescents. No author is held up as an exemplar of perfect practice; instead we wish to share our journeys of challenging ourselves, our practices, and our systems to improve. Our common goal remains to provide the highest quality health supervision for our children in the context of their families and communities. We hope the authors’ experiences resonate with your own, and that all are challenged to consider improvements to their approach to health supervision visits at the individual, practice, and community levels.

REFERENCES


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