Rethinking Well Child Care Visits: Strategies to change content and format

Martin T. Stein, MD
University of California San Diego
Rady Children’s Hospital San Diego

Disclosure

- Neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services related to the content of this CME activity.
- My content will not include discussion/reference of any commercial products or services.
- I do not intend to discuss an unapproved/investigative use of commercial products/devices.

Rethinking Well Child Care

- Historical legacy and current practices
- Why change now?
- Qualitative research to define current practices and promote change
- Innovations and the future

AAP: guidelines for WCC visits

- 1967: “Periodicity Table” for WCC
- Expert opinion and observed practices
- Visits timed to immunizations
- Revised guidelines 2 to 3 times each decade
- Topics for discussion increased 4-fold

AAP: Standards of Child Health Care: Council on Pediatric Practice (1967)

Rethinking WCC: a history

- Pediatrics: a limited specialty prior to 1900
- George Armstrong: London clinic for the poor children; pioneered preventive pediatrics
- Progressive Era: concern for child welfare
- New York City “health stations” (wt and ht)
  Abraham Jacobi, Job Smith, L. Emmett Holt
- 1933: AAP founded on public health notion of prevention (malnutrition) and health maintenance…the origin of well child care

Current Content of WCC Visits

“growth and development”

- Growth
- Nutrition
- Safety/injury prevention
- Immunizations
- Developmental
- Behavior
- Family and social relationships
- Learning
Current WCC References for Pediatricians

- Bright Futures: *Futures Guidelines for Health Supervision of Infants, Children, & Adolescents* (2002)

Clinical Methods: WCC Visits

- Clinical interview
- Screening questionnaires
- Physical examination
- Developmental/Behavioral observations
- Laboratory procedures
- Anticipatory guidance

International Trends in WCC

- US: only country where board certified pediatricians deliver WCC
- Australia, UK, Sweden: nurses w/ PH training; home visits
- Netherlands: WCC MD’s (no internship or residency; 3-wk training in WCC)
- Group Well Child Care: Japan and Denmark

Kuo. A: Rethinking Well-Child Care in the United States: An International Comparison

Reason for Visit to Pediatrician

- Preventive Visit: 37%
- Sick Visit: 32%
- Follow-up Visit: 15%
- Psychosocial Problem: 6%
- Other: 8%

Average Length of Preventive Care
Total Time in Office (Minutes)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Waiting Time (Min.)</th>
<th>Contact Time (Min.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2 yr</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>3-5 yr</td>
<td>35</td>
<td>15</td>
</tr>
<tr>
<td>6-11 yr</td>
<td>30</td>
<td>20</td>
</tr>
<tr>
<td>12-17 yr</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>18+ yr</td>
<td>20</td>
<td>30</td>
</tr>
</tbody>
</table>

Pediatricians Always Counseling
for Children 2-5 Years

- Firearm Safety: 15%
- Tobacco Use: 34%
- Physical Activity: 41%
- Car Seat: 48%
- Healthy Weight: 49%
- Diet & Nutrition: 71%

Parent Health Asked About by Child’s Health Care Providers

- Domestic Violence: 8.5%
- Depression: 50%
- Alcohol or Drug Use: 70%
- Social Support: 58%

Parents Want More Information On:

- How to Help Learn: 51%
- How to Discipline: 42%
- Toilet Training: 41%
- Sleep Patterns: 30%
- Crying—What to Do: 23%

Bethell et al. Commonwealth Fund, Sept. 2002
Ericson et al. Pediatrics 2001

Child Health Care Utilization

Medical Expenditure Panel Study 2000

- Total Visits
- Recommended Well Visits
- Well Visits

Ages of Children (Yrs)

Continuity of Care

- Primary care: first contact, integration of services, continuity, family focus
- Therapeutic alliance: a trusting relationship developed over time
  Green, M. Guidelines to Health Supervision Visits III. AAP:3-9, 2002

Continuity of Care

- Improved parent satisfaction
  Pediatrics, 109: 2002
- Reduced emergency room utilization
- Contemporary trend: Only 46% of parents report that their child saw the same pediatric clinician for well child visits up to 3 years of age (NSECH)

Limited Evidence-base: the Challenge

- Promoting optimal nutrition after infancy: prevention of obesity and eating disorders
- Safety: bicycle safety (helmets), guns in homes, preventing burns and motor vehicle injuries
- Substance abuse: education/prevention
- Early recognition of school-related problems: ADHD, learning disabilities, social relationships
- Early detection and diagnosis of behavioral conditions: Autistic Spectrum Disorder, ODD, Anxiety, Depression, PTSD
Young Children at Risk

• Severe disabilities 2-4%
• Special health care needs 10-14%
• Behavioral, mental health, learning problems 30-40%
• “Good enough” (low risk) 60-70%

Innovations in WCC in Promotion of Development/Behavior

• Systematic screening: standardized tests
• Theme for each visit
• Risk categories
• Co-locating
• Healthy Steps model
• Family drawings
• Attention to parent’s mental health
• Group discussions
• Group WCC
• Reach Out and Read
• Limit PE’s to increase time for dev-behavior screening/counseling
• Computers/DVDs
• Links w/ community

Innovations in WCC Developmental-Behavioral Pediatrics

• SYSTEMATIC STANDARDIZED SCREENING
• DEVELOPMENTALLY FOCUSED WCC
• GROUP WELL CHILD CARE
• REACH OUT and READ
• FAMILY DRAWINGS
Pediatricians Reporting Screening Young Children for Developmental Problems

- Any Screening: 85%
- Always Only Clinical Assessment: 71%
- Sometimes Only Clinical Assessment: 15%
- Standardized Instrument: 23%

AAP Periodic Survey #52, 2000

AAP: Recent Policy for Developmental Surveillance and Screening (0-3 years)

- Developmental Surveillance: all well child preventive visits
- Developmental screening: standardized developmental screening test at: 9, 18 and 30 month WCC visits


Developmental Screening
Motor, Language and Personal-social skills

*Arnold Gesell: neuro-maturational model*

- **Denver II**
  - 0-6 yr
  - 20 min.
- **Ages and Stages**
  - 0-5 yr
  - 7 min.
- **PEDS**
  - Parents’ Evaluation of Developmental Status
  - 0-8 yr
  - 2-3 min.

PEDS
Parents’ Evaluation of Developmental Status

- Organized method to focus on parent’s agenda for developmental assessment
- Language used to ask questions is critical “CONCERNS”
- “List any concerns about your child’s learning, development and behavior.”
- Sensitivity/Specificity: 70-80%


**Do you have any concerns** about how your child

- talks and makes speech sounds?
- understands what you say?
- uses his or her hands and fingers to do things?
- uses his or her arms and legs?
- behaves?
- gets along with others?
- is learning to do things for himself/herself?
- is learning preschool or school skills?

**Please list any other concerns**
Behavioral Screening

- Pediatric Symptom Checklist (4-16 yr)
  * J Pediatr 112:201, 1988
  * http://psc.partners.org/

- Family Psychosocial Screening
  * http://www.pedstest.com/links/resources.html

- M-CHAT (18-24 mo. screen for autism)
  * J of Autism and Develop Disorders. 31: 131-144 (2001)

Developmentally Focused Well Child Care Visits

- Major developmental theme for each visit
- Parents’ agenda
- Relate counseling to developmental observations
- Communicating with children and parents
- Spectrum of normal development


Developmentally Focused Well Child Care Visit: Newborn

“Innate readiness for interaction with the environment”
- Neonatal vision and hearing
- State variations
- Intersensory coordination
- Primitive reflexes
- Motor behaviors


Developmentally Focused Well Child Care visit: 18-months

“Asserting oneself—a push-pull process”
- Autonomy vs. dependence/attachment
- Self-determination
- Predictable regression
- Discipline
- Transition object
- Behavior Modification


Group Well Child Care

First published description in a pediatric practice

- Improved attendance at WCC, less calls between visits, more time for personal issues, more open-ended questions

- More WCC topics discussed (safety, nutrition, behav/develop, sleep, parenting)

- Pre and post tests similar on maternal knowledge, providing social support, and decreasing maternal depressive symptoms

- High-risk families: child develop status, mat-child interactions, home environment, provider time—no differences. Lower show rate in group WCC. Similar measures of parental competence, social isolation, social support and reports to CPS


Reach Out and Read

- Significant association between early reading aloud and later academic outcomes
- Developmentally appropriate book at all WCC visits (6 months to 5 years)
- Demonstrate reading to child during visit

**Reach Out and Read**  
*(controlled trials)*
- Increased reading aloud at home
- Increase in expressive and receptive language at 2 years
- Reading aloud as a favorite parenting activity
- Reading aloud at bedtime
- Reading aloud >3 days/week
- Ownership of >10 picture books


**Kinetic Family Drawing**

“Draw a picture of everyone in your family---all doing something”


**Focus Groups: Core Questions**
- Have you ever considered change in the format and/or content of WCC? What changes? What was your motivation for change?
- What is the most effective component of WCC visits?
- If your practice was redesigned to emphasize child development and family adaptations, what are the themes you would routinely focus on? At what particular ages?
- Assume you could design the ideal primary care pediatrics practice…….
Themes from Focus Groups with Pediatricians

- Therapeutic alliance ("trust")
- Major focus on parents’ concerns
- Use of screening tests wisely; not a substitute for clinical interview
- Evidence-based when applicable
- Beyond children: family pediatrics
- Innovations in practice of well child care

Innovations in WCC in Promotion of Development/Behavior

- Systematic screening: standardized tests
- Theme for each visit
- Risk categories
- Co-locating
- Healthy Steps model
- Family drawings
- Attention to parent’s mental health
- Group discussions
- Group WCC
- Reach Out and Read
- Limit PE’s to increase time for dev-behavior screening/counseling
- Computers/DVDs
- Links w/ community

Evidence-Based Medicine and Real World Pediatric Practice

- Strength: diagnostic and therapeutic decisions
- Limitation: core principles of practice that promote physical health, psychological and social development:
  - Therapeutic Alliance
  - Trust
  - Doctor-patient relationship
  - Communication skill
  - “You’re doing a great job as a parent….what a terrific kid!”

Evidence-Based Medicine and Real World Pediatric Practice

- Strength: diagnostic and therapeutic decisions
- Limitation: core principles of practice that promote physical health, psychological and social development:
  - Therapeutic Alliance
  - Trust
  - Doctor-patient relationship
  - Communication skill
  - “You’re doing a great job as a parent….what a terrific kid!”

Statistics are key actors to social change, for only when it is possible to measure a problem is it possible to arouse the interest in solving it.”
John Kenneth Galbraith

“The translation of (advances in medicine) to patient care rests on the psychosocial competence of clinicians. Technology isn’t worth a damn unless doctor and patient become informed allies. Time with the patient will remain the currency of medical care.”
Leon Eisenberg, M.D.

There is always one moment in childhood when the door opens and lets the future in

Graham Greene (1940)  
The Power and the Glory