History of Bright Futures

Judith S. Palfrey, MD, FAAP
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CME EDUCATIONAL OBJECTIVES

1. Review the history of anticipatory guidance and preventive care for children in the United States as the foundation for the development of the Bright Futures Guidelines.

2. Discuss the work of the four working groups commissioned to study the health promotion potential for the original age based groupings used in the Bright Futures program.

3. Determine the major components of the Bright Futures Charter and how they relate to the latest edition of the Bright Futures Guidelines for care delivery.

ABOUT THE AUTHOR

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Dr. Palfrey has disclosed the following relevant financial relationships: Merck Manual: Pediatric Editor.

PARTICIPANT ATTESTATION

___ I certify that I have read the article(s) on which this activity is based, and claim credit commensurate with the extent of my participation.

INSTRUCTIONS

1. Review the stated learning objectives of the CME articles and determine if these objectives match your individual learning needs.

2. Read the articles carefully. Do not neglect the tables and other illustrative materials, as they have been selected to enhance your knowledge and understanding.

3. The following quiz questions have been designed to provide a useful link between the CME articles in the issue and your everyday practice. Read each question, choose the correct answer, and record your answer on the CME REGISTRATION FORM at the end of the quiz. Retain a copy of your answers so that they can be compared with the correct answers should you choose to request them.

4. Type your full name and address and your date of birth in the space provided on the CME REGISTRATION FORM.

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Practically on the evolving needs of the family.

The development of the Bright Futures Guidelines has been nearly two decades in the making, with efforts focused on optimizing health maintenance while acknowledging the ever changing developmental needs of children. Recognizing the need for stronger evidence behind some of the proposed guidelines, the authors have appropriately dubbed many as evidence-informed. Indeed, the latest edition of the Bright Futures Guidelines is specifically geared toward successful deployment in the busy primary care office, with emphasis placed less on disease detection and more appropriately on the evolving needs of the family.

This issue of Pediatric Annals provides several excellent reviews that will allow the participant to better understand the most recent guidelines for health supervision and prevention, and more importantly, successfully integrate the guidelines into their daily care of children.

TABLE OF CONTENTS

135 History of Bright Futures
   Judith S. Palfrey, MD, FAAP

143 Well Child Care: Looking Back, Looking Forward
   Lynn M. Olson, PhD; J. Lane Tanner, MD, FAAP; Martin T. Stein, MD, FAAP; and Linda Radecki, MS

152 Bright Futures: The Screening Table Recommendations
   Paula M. Duncan, MD; Elizabeth D. Duncan, BA; Jack Swanson, MD

159 Practice Improvement: Child Healthcare Quality and Bright Futures
   Judith S. Shaw, EdD, MPH, RN

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History of Bright Futures

Judith S. Palfrey, MD, FAAP

The publication of the third edition of the Bright Futures Guidelines for the Health Supervision of Infants, Children, and Adolescents, opens a new chapter in the story of child health in the United States. To understand the relevance of the Bright Futures initiative, it is well to put the work into a historical context.

Bright Futures grows out of a long tradition in pediatrics and public health...

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of supporting the healthy growth and normal development of children. Early pediatric providers like Abraham Jacobi and Job Lewis Smith created milk stations and child health dispensaries to meet the basic health and nutritional needs of infants and young children. Jacobi wrote pamphlets for mothers about hygiene and breastfeeding. He was eager to encourage healthy child-rearing practices. The pamphlets signaled a day when doctors began to elevate well child care to a topic worthy of scientific consideration. Unfortunately, the pamphlets also signaled a level of professional distrust of what were considered to be unfounded old wives’ tales and suspect child-rearing practices.

In the 1920s and 1930s, the newly established Children’s Bureau developed the book *Infant Care* to distribute widely to young families. In 1934, the *New York Times* reported that *Infant Care* had sold more than 8 million copies. Families wanted comprehensive information on the health and development of their babies and looked to the Children’s Bureau as an authoritative source for such guidance.

As the American Academy of Pediatrics (AAP) formed, the organization began to consider its role in defining the content of well child care. Throughout the course of the 20th century, well child care gained more and more content. Although initially doctors had little more to give parents than expert advice derived from clinical experience, as scientific developments unfolded, there was much to offer, including sound nutritional support, vitamins, and immunizations. As the century progressed, the tools of epidemiology and risk assessment provided clearer delineation of what diseases children were susceptible to under what circumstances. Pediatricians began to incorporate screening for anemia, lead toxicity, and tuberculosis into their well child care. In the 1970s and 1980s, the AAP became active in setting Guidelines for Health Supervision and creating a standard schedule for well child visits. These guidelines ultimately were tabulated as the “Periodicity Schedule for Pediatric Care.”

In the early 1990s, the leadership of the Bureau of Maternal and Child Health and Medicaid were impressed that health supervision was a powerful mechanism but were concerned that not all aspects of health supervision were being used to their full potential. The Medicaid Administration was concerned that traditionally underserved children were not benefiting sufficiently from health supervision activities. The 1980s had been a particularly challenging period for families with increases in single parenthood, drug use (especially crack/cocaine), domestic and community violence, homelessness, and the emergence of HIV/AIDS. There was a sense of urgency to find ways to mitigate the effects of these factors on young families and children.

The Bureau of Maternal and Child Health was charged with implementing the Healthy People 2000 public health interventions, and Medicaid was responsible for Early Periodic Screening Diagnosis and Treatment. Together, they decided to fund a large-scale review of child health supervision activities with the notion that 1) there were many new interventions and tools available to child health professionals that were not being used to their maximum potential; 2) that there was a much larger role that families and communities could play in assuring the health of children; and 3) that there should be an examination of whether health could not only be maintained, but actually “promoted.” Finally, the Medicaid leadership wanted to find ways to optimize the delivery of health supervision to the children for whom they had responsibility. Dr. Morris Green was called upon to lead the effort because of his longstanding interest in health supervision and his experience in leading the AAP’s effort in Health Supervision. The initial project was housed at the National Center for Education in Maternal and Child Health at Georgetown University.

**LAYING THE BRIGHT FUTURES FOUNDATION**

The Bureau of Maternal and Child Health and Medicaid Administration established an overall advisory board for the Bright Futures project including leaders from national professional, community, and parent organizations. They commissioned four working groups to study the health promotion potential for four age-based groups: infants, young
children, school-aged children, and adolescents. The decision to create age-based groups signaled an initial principle that has carried through all of the Bright Futures activities to date. Bright Futures is based on a developmental orientation that recognizes the ever-changing nature of children’s needs, strengths, weaknesses, relationships, and experiences as they grow, learn, and develop. The panels included physicians, dentists, nurses, educators, and public health professionals. This multidisciplinary approach was a new venture in creating standards for healthcare practice.

Infancy Panel

The Infancy Panel, chaired by Dr. Barry Zuckerman, took into consideration the extensive work that was emerging on family formation and attachment by child development experts around the world. They incorporated the lessons from Healthy Steps and Touchpoints into their recommendations. They emphasized the importance of a prenatal encounter as part of the Bright Futures process to highlight the importance of preventive interventions in pregnancy and the salience of a therapeutic alliance between family and child health professional. They also recognized the critical nature of communication from the nursery to the initial primary care visit. The Bright Futures work took place in the middle of the HIV epidemic. The critical nature of the obstetric-pediatric connection was underscored by the fact that information about HIV infection, hepatitis B status, and drug and alcohol exposure were so important to the newborn’s health and safety.

The Infancy Panel underscored the importance of immunizations. The early 1990s was an extremely productive time in vaccine development. Infectious disease experts and vaccine producers were engaged in research and development on a number of new and/or improved vaccines targeted at diseases such as Haemophilus influenza infection, pertussis, pneumococcal infection, rotavirus, and RSV.

One of the major topics that the Infancy Panel addressed was nutrition, with a heavy emphasis on breastfeeding and a delay of introducing formula and solids. Contemporary epidemiologic data pointed to a very low rate of breastfeeding initiation and an even poorer maintenance of breastfeeding beyond 3 months. The panel recognized that many families had to rely on daycare, and so it advanced suggestions for ways to incorporate multiple caregivers into the nurturing and the nutrition provision for young infants.

The Infancy Panel was acutely aware of the epidemiologic data that were pointing to sudden infant death syndrome (SIDS) as the single largest identified cause of post-neonatal infant mortality. New evidence-based research offered hope that a campaign of putting infants “back to sleep” held great promise for prevention. The Infancy Panel incorporated strong injury prevention strategies, setting a tone for all the panels in making injury prevention a high priority for Bright Futures. The panel recognized that health maintenance visits would be increasingly effective if they provided specific harm reduction strategies and equipment such as smoke detectors, electrical wall socket covers, door latches, etc. The panel emphasized that these injury prevention interventions would be as effective and important to the health supervision effort as immunizations and antibiotics.

The developmental orientation of Bright Futures played out in the Infancy Panel in the recommendation for developmental monitoring. The purpose was to review milestones and behavior and to check for signs of maternal depression and/or interactional difficulties such as poor attachment. Building on T. Berry Brazelton’s work on anticipatory guidance, the Infancy Panel suggested specific topics for discussion at each well child visit that would prepare the family for the next developmental stage so that the parents could support and fully enjoy their child’s emerging capabilities.

Preschool Panel

The Preschool Panel, chaired by Dr. George Stern, continued the emphasis on injury prevention because of the high rate of injuries among young toddlers during their daredevil period of unfettered exploration. The panel benefitted greatly from the dental and nutritional expertise among its members. They pointed to the value of dental screening and the
The work of the four panels was reviewed extensively by more than 1,000 people ...

reduction of high-sugar content foods. Focus on these areas made it clear that Bright Futures was not just about what happened in the child health office; it was as much about healthy choices at home and the establishment of life-long healthy behaviors.

**Middle Childhood Panel**

Chaired by Judith Palfrey, the Middle Childhood Panel had several goals: 1) to define the active functions and changes in the middle childhood period; 2) to raise professional and public awareness that the behaviors set down in this period form the foundation for teen and young adult years; 3) to respond to the secular trends of increased exposure of children in the middle childhood period to TV, movies, and other external forces that relate to health risks, including obesity, violence, and early initiation of sexual behaviors.

The Middle Childhood Panel concentrated its efforts on ways to promote healthy lifestyles. Using a developmental framework, the panel considered that the biggest changes in the middle childhood period related to the emerging autonomy of the children, the development of their awareness of their bodies, and their responsibility for their actions and choices. The panel worked to create opportunities within the healthcare visits for conversations among the healthcare provider, the parent and child about health topics such as street crossing, bicycle riding (with helmet use), seat belt use, TV watching, bullying, peer interactions, nutrition, and dental health.

The Middle Childhood Panel considered school functioning as a major component of healthy development. The panel recommended programs such as Reach Out and Read. The panel also made specific suggestions about limitation of TV watching and provided guidance around homework time.

**Adolescent Panel**

Chaired by Elizabeth McAnarney, the Adolescent Panel took advantage of the work that had been done by the American Medical Association’s (AMA) work group on Guidelines for Adolescent Preventive Services (GAPS). The Adolescent Panel framed their work in health promotion with the recognition that adolescents themselves needed to be fully invested in the process. They also worked to include parents as supporters of their children’s growth.

In addition to the areas included in the other panels, the Adolescent Panel addressed issues of relevance to teenagers including STI and HIV prevention, sexuality/abstinence, drug and alcohol, violence, productive life choices, and mental health.

With the benefit of the GAPS experience, the Adolescent Panel based as many recommendations as possible on evidence-based practices in the fields of adolescent and young adult medicine and in conformance with the U.S. Preventive Medicine Task Force recommendations.

The work of the four panels was reviewed extensively by more than 1,000 people from pediatrics, adult and family medicine/abhstinence, drug and alcohol, violence, productive life choices, and mental health.
Family Voices

This latest edition of Bright Futures embodies the evolution of the partnership between families and primary care providers; the influence of families is apparent throughout. The 3rd edition reflects the expertise and unique viewpoint that families bring as team members with primary care providers on behalf of our children. Key milestones in this evolution over the past 14 years include the following:

1993: The Maternal and Child Health Bureau (MCHB) brings the idea of Bright Futures to family leaders who have children with special healthcare needs. Families ask to be included in the development of the guidelines. One parent is added to the Bright Futures Board of Directors.

1994: By the second edition, the national organization, Family Voices, makes it easier to identify family leaders who can comment on Bright Futures content.

1995: MCHB requests that Family Voices add Bright Futures activities to one of its projects.

1995-2004: Family Voices develops Bright Futures Family Pocket Guides, fact sheets, and newsletters for families that correspond with materials for professionals. Families also review and comment on Bright Futures materials for professionals.

2003: Family Voices receives funding from the Centers for Disease Control and Prevention (CDC) for a research project testing family interventions that use Bright Futures’ concepts.

2005-2007: Family leaders are included from the beginning in the development of the 3rd edition of Bright Futures Guidelines, serving on the Bright Futures Steering Committee, the Children and Youth with Special Health Care Needs (CYSHCN) Committee and the Toolkit Committee. Each expert panel includes a family leader, one serving as co-chair. Many families and youth contribute to drafts and key guidance about families and family-centered care.

2007: When the new Bright Futures Guidelines are published, the family viewpoint on care for CYSHCN is infused throughout.

Health and Wellness: Families are ready, and Bright Futures is integral to the work of Family Voices.

For the family perspective on well child care for children and youth with special healthcare needs and the evolution of families as partners with health providers, see the April 2008 issue of Pediatric Annals and the article, “Families on the Team: Opportunities to Improve the Health of All Our Children.”

For more information on Family Voices and Bright Futures resources for families, visit www.familyvoices.org.

SIDEBAR 2.

Family Voices

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BUILDING BRIGHT FUTURES

With the publication of the first edition of Bright Futures, the project moved into a phase of early implementation. To take the theoretical constructs of the Guidelines Book into real-world practice, the MCH Bureau established the Building Bright Futures team, housed at the National Center for Education in Maternal and Child Health at Georgetown University and chaired by Judith Palfrey from Harvard University. Betsy Anderson of Family Voices and Patricia Smith of the National Parent Network for Children with Special Health Care Needs (CYSHCN) added the crucial participation of families to the process. The Building Bright Futures team set out to create practical tools and processes that could be piloted and field tested and then put into wide-spread practice.

Several groups were commissioned to write a series of Bright Futures in Practice monographs, which included Bright Futures in Practice: Oral Health; Bright Futures in Practice: Nutrition; Bright Futures in Practice: Physical Activity; Bright Futures in Practice: Mental Health; and The Bright Futures for Family Pocket Guide. In addition, the Building Bright Futures team produced a pocket guide for practitioners, which outlined specific questions and activities in a readily available format. The staff also produced Encounter Forms for providers and parents tied into Bright Futures that could be tailored to individual practices for monitoring child health promotion activities as well as for billing for those interventions.

medicine, public health, nursing, nutrition, dentistry, community-based organizations and parent groups. Whenever possible, the recommendations were made to conform to the current recommendations of the child health professional organizations.

Dr. Morris Green believed that the work of the Bright Futures panels needed to be grounded in the context of a “Bright Futures Charter.” Even the acknowledgment that such guidelines needed to be “multidisciplinary” was not enough. If children were to have healthy lives and bright futures, all those who cared about children must have a vision of what that bright future would look like. As the panels met and worked together, it became increasingly evident that a charter could make the explicit statement that children’s growth, health and development depended on far more than the interventions that could be provided in health care settings as outlined in a set of guidelines. Moreover, such a charter would establish a way to know when we had arrived. Julius Richmond, the author of Healthy People, said, “You cannot get somewhere if you do not know where you are going.” To provide a framework for health supervision, the Bright Futures team wrote the Bright Futures Charter (see Sidebar 1, page 138). The charter is a call to action that makes clear that the health and well being of children is the responsibility of children and families, community agencies, health professionals, local and state governments, the business sector... everybody. It is comprehensive and visionary, but also practical and ultimately attainable.
The Maternal and Child Health Bureau also supported the development of curricular materials for pediatric training, which included case-based teaching materials, instructional modules, and Web-based materials including a video that introduced six Bright Futures core principles.

During the Building Bright Futures phase, a number of states incorporated Bright Futures principles into their public health campaigns (most notably Virginia, Georgia, Washington, South Carolina, Maine, and Louisiana), and began to collaborate with physicians, nurses, daycare providers, community-based organizations, schools, parent groups, and others to meet the goals of Bright Futures.

As more materials and tools became available and as experience with Bright Futures accrued, the staff of Building Bright Futures participated nationally in many multidisciplinary forums to begin to disseminate the idea of Bright Futures and to alert professionals, community groups, and parents about both the philosophical and the practical aspects.

The Building Bright Futures team emphasized three core ideas.

Prevention Works
Bright Futures incorporates the most up-to-date methods for disease prevention. Many highly effective tools exist to keep children healthy and productive, but there is unequal access to these tools by children of different socioeconomic, racial, and cultural groups. The causes of health disparities such as prematurity, obesity, mental health concerns, injuries, and violence lie in unequal access to effective preventive health strategies.

Families Matter
A key component of the Bright Futures methodology is the partnership of families and professionals to implement health promotion for children. In stark contrast to Abraham Jacobi’s admonition to families that they should shun the advice of other parents and listen only to the pronouncements of doctors, Bright Futures depends on trust and mutual respect between families and professionals. Throughout the Bright Futures process, the voice of parents has been actively incorporated into all of the documents, tools, and processes (see Sidebar 2, page 139).

Health Promotion is Everybody’s Business
As the Bright Futures’ Charter affirms, children’s health and development is supported and promoted by healthy communities and families. The wider society does determine many of the environmental conditions that affect the lives of children and families.

If fruits and vegetables are more expensive and less accessible than fatty foods, a family may have no choice but to provide poor nutrition to their children. If schools opt to finance their sports teams with money from soda machines, children will naturally assume that there is nothing wrong with spending their lunch money on the school-sponsored sugar-sweetened drinks. If children see that violent behavior and sexual promiscuity are rewarded on television, they may have trouble understanding why they should not bully or “hook up” with multiple partners. What is harming children and young people in America in the 2000s is not just viruses and bacteria. The “millennial morbidity” requires new approaches that must involve the business community in seeing the role they play and in enlisting their help to solve the problems. The Building Bright Futures process benefited greatly from the public-private partnership of the Maternal and Child Health Bureau with the Pfizer Corporation as well as productive relationships with health insurers through the National Institute for Health Care Management. Many other businesses are working on creative solutions. Bright Futures calls on everyone to play a part.

In 2000, several factors led to the need for revision of the Bright Futures text. The CDC was releasing new standards for height and weight and was calling on all child and adolescent providers to adopt BMI as a measure of nutritional status. Nationwide, there was increasing recognition of an emerging epidemic in childhood obesity. The licensing of new vaccines called for the revision of the immunization schedule. The Bright Futures team carried out a
modest revision of the central document in response.

**BRIGHT FUTURES, THIRD EDITION**

In 2002, the Maternal and Child Health Bureau felt that strong partnerships had been established among parents, community groups, public health departments, and the practicing child health providers and that Bright Futures was ready for wide dissemination. To reflect the partnerships among parents, community groups and parents, the current phase of Bright Futures has included an extensive revision of the Bright Futures Guidelines. In addition, the AAP, the Georgetown Center on Bright Futures, the Maternal and Child Health Bureau, state-level public health groups, community-based organizations, insurers, and parent groups have been working hard to create policy-level change that will sustain the Bright Futures effort.

Historically, the publication of Bright Futures, third edition, is an important moment because it documents the bringing together of the practicing community, the public health community, parents, community-based organizations, and insurers in an alignment that the United States has rarely witnessed in child health. It has required hard work and substantial compromise to accomplish this but offers to move child health policy forward in significant ways that are becoming apparent throughout the country. Bright Futures now serves as to integrate the initiatives of the Maternal and Child Health Bureau (such as Healthy People 2010), the Early Periodic Screening Diagnosis and Testing (EPSDT) mandates under Medicaid, the Health Supervision Guidelines and Medical Home Initiative of the AAP, and the GAPs program of the AMA. Prior to the launch of Bright Futures, each of these groups moved along separate but parallel paths on similar programs to ensure the dissemination of disease prevention and health promotion strategies. The Maternal and Child Health Bureau’s approach was largely population based and multidisciplinary. The AAP and AMA’s approaches were clinically based and relied on a well-organized practice structure with individual encounters for individual children and adolescents. Medicaid was predominantly concerned that poor children benefited as much from health monitoring as other children. Recognizing the significant role that poverty plays in determining poor health outcomes, the Medicaid administration was most interested in seeing how the EPSDT program could be improved and brought up to date, particularly in the area of development and behavior. Bright Futures brought all these streams together into one major policy effort.

At the time of this publication, the benefit of this integrative approach is already apparent. Parents and consumer groups in several states have initiated lawsuits and legislation demanding that child health providers incorporate health supervision activities into their practices and that they be paid for that work such as the requirement for developmental screening in Rosie D in Massachusetts, the “Mother’s Law” mandating screening for maternal depression in New Jersey, and the Health Check program of overall screening in the District of Columbia. Insurance monitoring systems are including more and more aspects of well child and adolescent care as critical measures for payment.

The vision of an integrated program through the Bright Futures mechanism was bold and comprehensive. Some felt it was too ambitious and could not be done. Critics of Bright Futures have argued that the goals are overly ambitious and that a more scholarly approach is required to document the effectiveness of the recommendations. Bright Futures, third edition, addresses many of these concerns with a lively research agenda. Moreover, there are now questions in many of the national child health surveys to the extent to which the components of Bright Futures guidelines such as anticipatory guidance and developmental screening are being incorporated into practice. The years to come will tell whether the Bright Futures was too bold and too comprehensive or whether children’s health and development benefited from an all out-effort to afford a bright future to every infant, child, and adolescent.

**REFERENCES**


