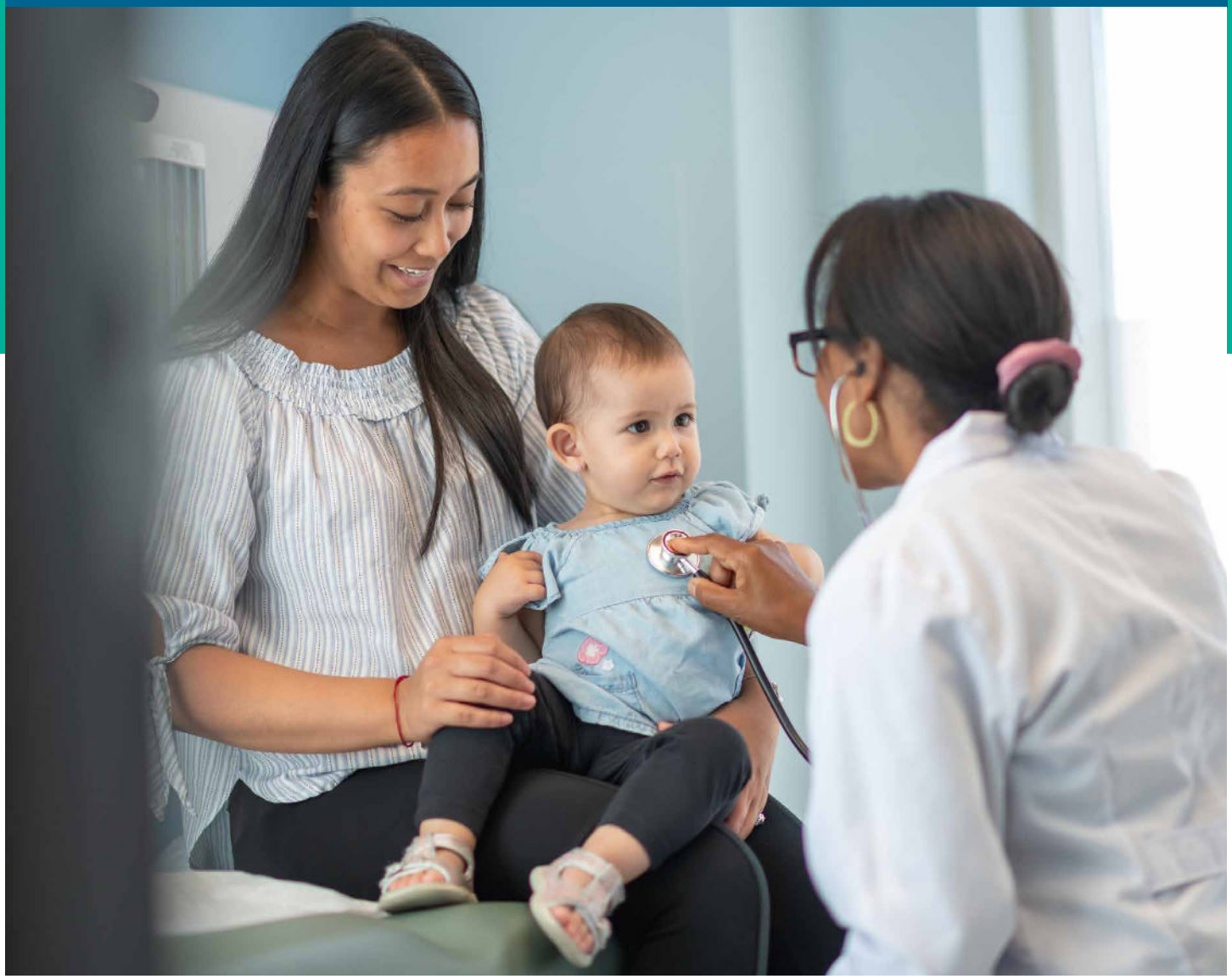
Center *for the* Study *of* Social Policy
Ideas into Action

PEDIATRICS Supporting PARENTS

OCTOBER 2019

Fostering Social and Emotional Health through Pediatric Primary Care: Common Threads to Transform Everyday Practice and Systems

Prepared by the Center for the Study of Social Policy



About CSSP

The Center for the Study of Social Policy works to achieve a racially, economically, and socially just society in which all children and families thrive. We do this by advocating with and for children, youth, and families marginalized by public policies and institutional practices. For more information, visit http://www.CSSP.org.

Acknowledgments

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Introduction

Research has shown that children's social and emotional development (SED)[i,1] is vital for school readiness and is a key building block for cognitive development and learning at very young ages.[2] In navigating the joys, uncertainties, and challenges of raising a child, parents are often supported and guided by the love and wisdom of family, friends and trusted professionals. Making sure their children are healthy is a priority for families, with over 90 percent of all young children receiving at least one well-child visit in 2017.[3] Pediatric well-child visits present a unique opportunity for supporting parents in nurturing their children's social and emotional development and relational health.[ii] They are frequent in infancy and early childhood, and they provide the setting for parents and pediatric health professionals to establish long-term partnerships to help children thrive.

In 2017, several leading national foundations joined together to capitalize on this opportunity and launched Pediatrics Supporting Parents (PSP), an initiative to support partnerships between pediatric primary care providers[iii] and parents to protect and promote the social and emotional development of young children.[iv] The initiative is informed, in part, by earlier work reported on in 2016 by The National Institute for Children's Health Quality (NICHQ), Ariadne Labs, and the Einhorn Family Charitable Trust (EFCT) in *Promoting Young Children's (ages 0-3) Socioemotional Development in Primary Care.*[4] That work sought to identify "optimal, scalable approaches for promoting healthy socioemotional development and improving the caregiver-child bond via well-child care."[5] It produced a high-level picture of eleven design elements for pediatric well-child visits to achieve these improvements and recommended several next steps for taking this early learning further, including a deeper examination of the elements and associated implementation strategies.

The foundation consortium acted on these suggested steps by engaging the Center for the Study of Social Policy (CSSP) to take a deeper look at what is currently being done and what may be possible in the pediatric well-child visit (ages 0 – 3) and the pediatric primary care setting to promote positive outcomes around social and emotional development, the parent-child relationship, and parents' mental health as it is a critical mediator of the parent-child relationship. In the rest of this report, these outcomes are referred to collectively as "social and emotional development." This report describes the findings from CSSP's qualitative program analysis on the common practices used by innovative primary care sites

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[i] Social and emotional development refers to the *developing capacity of the child from birth through 5 years of age to form close and secure adult and peer relationships; experience, regulate, and express emotions in socially and culturally appropriate ways; and explore the environment and learn—all in the context of family, community, and culture.*

[ii] The definition of relational health is currently evolving. In this paper it is defined as *the capacity for and ongoing engagement in growth-fostering, empathetic and empowering interpersonal interactions. Positive, nurturing, and stimulating early relationships build the foundations for a lifetime of relational health, along with its associated impacts on physical health, well-being, and resilience.*

[iii] Throughout this report, we refer to pediatric primary care providers primarily as "providers," which includes anyone who provides primary medical care for children, such as pediatricians, family physicians, physician assistants, and nurse practitioners.

[iv] *Pediatrics Supporting Parents (PSP)* is a national initiative conceived and sponsored by six early childhood funders: Einhorn Family Charitable Trust; J.B. and M.K. Pritzker Family Foundation; The David and Lucile Packard Foundation; W.K. Kellogg Foundation; Overdeck Family Foundation; and an anonymous individual contributor.

implementing a variety of evidence-supported programs. In a related effort, CSSP and Manatt Health are studying and demonstrating how Medicaid can help finance effective strategies to foster the social and emotional development of young children, making it more likely that such strategies become routine, expected, and valued components of pediatric primary care. Initial results from that work appears in *Fostering Social and Emotional Health through Pediatric Primary Care: A Blueprint for Leveraging Medicaid and CHIP to Finance Change*.

In the remainder of this introduction, we provide background on the context in which the program analysis was conducted, and the methodology employed. We conclude with an outline of subsequent chapters that describe our findings, reflections, and recommendations.

Program Analysis Context

Growing research about child development, current trends in demographics and health care transformation, and the role of pediatric primary care as a universal access point for families all set the stage for exploring how well-child visits are currently a platform for and could be further enhanced to promote healthy social and emotional development. These influences are summarized below.

Healthy social and emotional development in early childhood requires support for multigenerational and collective action.

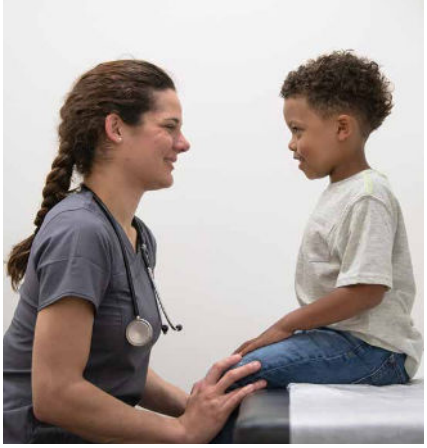
Research has demonstrated the importance of nurturing children's social and emotional development. Over the past few decades, a growing focus on children's early social and emotional development has risen alongside an increased understanding of early brain science and social determinants of health (SDOH). Studies on early brain science have underscored that early experiences, especially those in the first three years of life when babies' brains are developing at incredible rates,[6] have lifelong effects on health,[7] education, social and emotional well-being, future relationships, personal behavior, earning potential, and more.[8,9]

Moreover, these early experiences are greatly influenced by both relational and environmental factors. In terms of relational factors, research has underscored that a healthy parent-child[v] relationship[vi,10] is a primary driver of healthy social and emotional development,[11] as are the contributions of other caregivers, such as grandparents and other extended family members and non-family members (e.g. child care providers) who are caring support to children. Parents are more likely to engage in activities that promote healthy development when they themselves are healthy, socially-supported, and more resilient in the face of stress. Given how the physical and emotional health of both the child and the parent are intimately connected, the promotion of the social and emotional well-being of young children requires an inclusive, multigenerational approach that is attentive to parental and family well-being.[12,13] With respect to environmental factors, research on social determinants of health[14] shows that the economic and social conditions of where families live, work, and play can affect the physical and mental health of children and parents, and the quality of their lives in their communities. In sum, the enduring outcomes of children are affected by the support families receive, the opportunities they have, the

[v] Throughout this report we use the term "parent" to refer to the significant caregivers in a child's family. These individuals provide unconditional love to the child.

[vi] Throughout this report, we use "parent-child relationship" to refer to "A selective, meaningful, and significant psychological relationship between parent and child that develops through mutual interactions and persists over time."

programs in which they are involved, and the policies enacted to help—or hinder—them in the work of raising their children.



Pediatrics is transforming to support the changing needs of children and families.

Pediatric primary care providers are witnessing first hand changing national demographics and family economic conditions. They are seeing increased diversity,[15] including more children of immigrants.[16] Forty-four percent of all young children under three years are part of families with low income. Children of color experience higher rates of poverty and related adversities as their families are challenged by the stressors of inadequate, unaffordable housing; food insecurity; and meeting their other basic needs.[17] These experiences are linked to disparities in health outcomes, including social and emotional health.[18,19,20]

Increased awareness and knowledge of the life circumstances and experiences of young children such as trauma, SDOH, and adverse childhood experiences (ACEs),[21] early relational health, and social and emotional development, has driven individual practice and field-wide efforts to address these issues. Pediatric primary care has been transforming to create a system that can adequately support the changing pediatric population and the intersections of a child's physical health, mental health, and social needs. There is widespread recognition of the importance of supporting families by addressing SDOH, as found in documents such as the American Academy of Pediatrics' (AAP) recent 4th Edition of *Bright Futures™,* a comprehensive guideline for well-child visit schedules, anticipatory guidance, screening, and assessments.[22] In addition, child health care over the last 75 years has shifted from a major focus on acute infectious diseases to a greater focus on other, often chronic health conditions such as asthma, mental illness, obesity, and neurodevelopmental disorders that reflect social circumstances and which require a different approach to delivering care. In 2002, in order to address the greater needs of children with chronic conditions, the American Academy of Pediatrics created an operational definition of the medical home as "medical care of infants, children, and adolescents that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."[23] Simultaneously, the AAP has called for providers to promote and monitor social and emotional development.[24] Evidence-based interventions and family supports with a multigenerational framework are increasingly being adopted by child health care professionals, building on the existing strengths of primary care, recognizing systemic challenges, and more effectively supporting families.[25]

Program Analysis Methodology

Against the backdrop of growing knowledge and trends in pediatric primary care, a number of programs intended to support parents as they foster social and emotional development of their young children have been designed for use in pediatric primary care (and related) settings.[26] These programs either have existing evidence or are building evidence of effectiveness. CSSP's analysis offered an opportunity to identify similarities among programs ("common practices") that might be of value in pediatric primary care settings that do not adopt a particular, branded program. The goal of the program analysis was not to choose one or more programs as "the best program," but rather to understand what

program characteristics work well to promote the social and emotional development of young children in pediatric primary care. This analysis also provided the opportunity to intentionally consider health equity by learning how sites engage and partner with families, embrace parent voice, honor culture, address implicit bias, attend to power differentials in interactions, and develop community partnerships to address SDOH.

We identified and vetted nearly 70 programs that have established evidence of effectiveness or are building evidence of supporting social and emotional development and/or the parent-child relationship. These were winnowed to 13 using criteria such as population served, evidence of outcomes, and the fit with well-child visit parameters. We completed the site selection process after talking to program developers about implementation. A full description of the process to identify programs and select sites can be found in Pediatric Supporting Parents Program Analysis Program and Site Selection Process and Results.[27] Ultimately, we conducted 12 site visits to the implementation sites of 10 programs, with two programs being visited in two different implementation sites. (See **Table 1** for programs and locations.) The implementation sites were diverse in geographic location, populations served, reach, and type of care delivery setting. Visiting implementation sites provided the opportunity to learn not only about program-specific well-child visit practices but also about other site-specific and unique activities and community connections to support the social and emotional development of young children.

Site visits were conducted by a diverse team. Every team had a family leader, recruited and supported by Family Voices; a consulting pediatrician with both clinical and national policy experience; and two researchers from the Center for the Study of Social Policy. During the visits, information was compiled from multiple observations and informants with differing experiences and perspectives. The team members' diversity in perspectives and experiences allowed for rich discussions among team members about what they were observing and learning from each visit. In addition, CSSP partnered with Family Voices to recruit, mentor, and facilitate a Brain Trust of five family leaders who helped develop the site visit interview protocols and review and assist with the analysis of the site visit findings and the common practices that emerged. The five family leaders were representative of the racial, ethnic, language, gender, and geographic diversity of the programs we observed.

Finally, after the site visits were completed, we convened a national meeting of family leaders, physicians, program developers, and site implementation representatives. The meeting helped to validate the program analysis findings and suggest recommendations that would eliminate barriers and accelerate the spread and adoption of the practices identified. For more information about the program analysis methodology, see **Appendix A**.

Program Analysis Limitations

This analysis has several features that contribute to the strength and validity of the findings, but it is also important to acknowledge that the depth of analysis is affected by some limitations. One limitation is in site selection. As noted, site selection was dependent on identifying programs. Programs were selected based on the quality of documented existing or emerging evidence. However, many of these programs were not created with the explicit goal of impacting social and emotional development and parent-child relationships. Further, other effective programs, no doubt, did not come to our attention because the necessary research does not exist. We attempted to overcome this limitation by casting a broad search for programs and innovative pediatric practices that may be building evidence. Another

limitation is the number of site visits we were able to complete. Scheduling visits to a total of 15 implementation sites, as originally planned, was dependent on site availability and schedules; program implementation issues kept us from conducting three planned site visits. We did, however, engage in several conversations with two of the programs we were not able to visit while leadership turnover at the third site limited our data gathering interviews to the developer and researchers of the program. Finally, there were challenges to conducting interviews of participating family members or observing caregivers and children in well-child exams. Such observations were not feasible at all sites, but we were able to interview caregivers and observe several well-child visits at nearly every site.

Report Organization

This report shares the key findings from the Pediatrics Supporting Parents program analysis, synthesizing and summarizing what we learned through research, conversations, site visits, and a national PSP Convening. It is organized as follows:

- Chapter II describes the findings from the implementation site visits of common practices to support families as they foster the social and emotional development of their children.
- Chapter III describes the implications for scaling the common practices.
- Chapter IV concludes with recommendations for action.

TABLE 1

Programs Included in Program Analysis

Programs and Sites Visited	
CenteringParenting® Philadelphia, Pennsylvania	**Promoting First Relationships® in Pediatric Primary Care (PFR-PPC)** Seattle, Washington
Developmental Understanding and Legal Collaboration for Everyone (DULCE) Long Beach, California	**Quality through Technology and Innovation in Pediatrics (QTIP)** 3 locations, South Carolina
Family Connects Durham, North Carolina	**Reach Out and Read™ (ROR™)** Tacoma, Washington
HealthySteps Show Low, Arizona | Bronx/NYC, New York	**TMW Well-Baby** Chicago, Illinois
Massachusetts Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) Worcester, Massachusetts	**Video Interaction Project (VIP)** Brooklyn/NYC, New York

Programs Interviewed But Not Visited		
Empowering Mothers Oakland, California	**The Incredible Years®** Kansas City, Missouri	**Mental health Outreach for MotherS (MOMS) Partnership®** Washington, DC | New Haven, Connecticut

Common Practices

As we visited implementation sites and talked with program developers, we looked and listened for the common practices that sites use to promote the social and emotional development of young children and the parent-child relationship. We tried to understand not only the family experience but also the policies, resources, and infrastructure that supported successful implementation. As previously noted, we were looking for how implementation sites executed the strategies described in the research and other literature about their program and how they might be adapting and enhancing these strategies. In partnership with a consulting group of pediatricians, an advisory committee of family leaders, and NICHQ, we identified **14 common practices,** each observed across several or all of the sites we visited. The common practices are described in this section with call-outs boxes that offer examples from the programs visited. They represent three categories of actions pediatric primary care providers can take: **1. nurture parents' competence and confidence; 2. connect families to additional supports to promote healthy social and emotional development and address stressors;** and **3. develop the care team and clinic infrastructure. Figure 1** depicts the practices in the action categories and the centrality of relationships that runs throughout the actions.

"The site visits gave us the ability to see and learn what's possible in pediatric primary care. These are parents who are doing amazing things, and [care teams] that are working well despite the systems working against them."

— Pediatrician Panel, PSP Convening

The Centrality of Relationships

No single practice is sufficient to achieve the outcomes under study, and often several practices were observed in a site visit, as sites implemented the programs among other services and supports for families. The strategies used to implement the practices varied among sites, reflecting their unique context and strengths. However, we observed a common thread that ran through the practices: **strong, strengths-based, trusting, and humble relationships among and between parents, the care team, and the community are essential for promoting the social and emotional development of young children.** We observed an intentional focus on developing and nurturing relationships throughout the program delivery and practices, reflected in interactions with families, the collaboration among the care team, and the building of community partnerships.

"A physician doesn't necessarily need to 'look' like you (a parent) in order to build a connection and relationship. But they do need to see you as a person, recognize your culture, understand your unique struggles, and find somewhere you can relate to each other on a personal level as parents and people.... Providers need to address their own biases to bridge gaps and build relationships."

— Family Leader Panel, PSP Convening

Between parents and the care teams, relationships exhibited a level of trust that went beyond confidence in the provider's medical advice. Parents comfortably shared their cultural beliefs and customs that shape their parenting

and more openly revealed the familial, social, and environmental challenges they are facing. They were also open to trying new ideas with their children, being connected to services, and creating an ongoing relationship with the care team. The humility and respect shown by the care team to family members allowed them to build bridges across social and cultural differences. Some sites visited also worked to develop care teams that mirrored the population of the community, recognizing that relationships are also built on cultural similarities and shared experiences between families and care team members. These similarities facilitated stronger connections between pediatric clinics and the families they served.

FIGURE 1

Common Practices

Nurture parents' competence and confidence

- Use strengths-based observations and positive, affirming feedback
- Model activities and use strengths-based observations
- Provide enhanced and tailored anticipatory guidance materials
- Partner with parents to co-create goals
- Create opportunities for families to connect with other families
- Integrate strategies to support the parents' well-being and mental health

Connect families to supports to promote SED and address stressors

- Standardize workflow to provide developmental, behavioral, and SDOH screenings, health promotion, support, and resources
- Cultivate community partnerships through clear processes and protocols
- Outreach to parents during pregnancy

Develop the care team and clinic infrastructure and culture

- Integrate new roles into the care team
- Foster care team communication and collaboration
- Provide ongoing learning and development opportunities
- Support care team well-being to prevent burnout/stress/fatigue and retention issues
- Create environments and structures that promote respectful relationships and positive patient experiences

Strong, strengths-based, trusting, and humble relationships among and between parents, the care team, and the community are essential

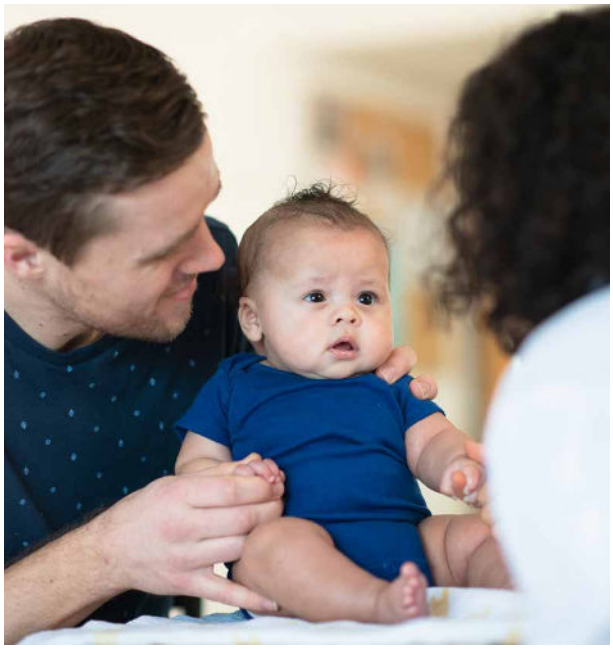
Site informants often described that trust, collaboration, and shared decision-making among the team were part of the site "culture," supported by routines for communication and shared learning and a flattened hierarchy. Staff described being valued, heard, and encouraged to share their concerns or ideas related to patient care. We observed, and families told us about, the empathy and collaboration of all staff from the front desk staff to nurses to clinicians. Despite the constraints virtually all pediatric primary care settings face and will be described later in this report, the sites visited were successfully creating well-functioning teams.

Nurture parents' competence and confidence

The common practices that **nurture parents' competence and confidence** involve direct, interpersonal, and culturally responsive interactions with families around their children's social and emotional development.

Strengths-based observations and positive affirming feedback guide well-child visits and interactions with families.

Intentionally observing the interactions between parents and children allows providers to be more present in the visit and better able to reinforce healthy behaviors and strengthen parents' confidence. Using positive and affirming feedback while observing parent-child interactions and relational health, providers can note, support and encourage the shared positive affect and back-and-forth (sometimes called "serve and return") interactions that promote healthy development. According to care teams, this approach encourages parents to continue doing these positive actions and do them more often while also developing their own reflective capacity. The approach helps them feel better about themselves and more confident as parents, coming to visits with information to share about their child's development, asking more questions, and having an increased readiness to advocate for their children. While this high-impact strategy is seemingly simple, clinicians we spoke with shared that it requires a significant shift in mindset from how they were trained. It requires initial training as well as ongoing team support to maintain this mindset and develop skills over time.



These observations and positive feedback activities could be done in many settings, at different points in the visit, and by all members of the care team. They can be done:

- **Within casual parent-child interactions in the well-child visit or more stressful moments, such as vaccinations.**
- **While taking the family's history by asking open-ended questions that elucidate values or visions for the future such as "what is your favorite thing about your child or being a parent?" or "what are your hopes and dreams for what your child is like as a young adult?"**
- **While parents and children are reading a book or playing with a toy together.**
- **While providing lactation support for mothers, a particularly vulnerable time for families, to support the mother's efforts as well as reinforce the support she is receiving from her partner.**
- **When both parents are present to promote a discussion of how they are working together.**
- **At a video-based session, where interactions between the parent and child playing or reading are recorded and then more formally reviewed and reflected upon between a provider, or extended care team member, and the parent.**

Sites were intentional in honoring the culture of families and engaging fathers in these strengths-based interactions. In Show Low, Arizona, HealthySteps Specialists ask families, "What have people told you to do/not do with your baby?" This opens up a conversation where they can learn about cultural and familial parenting practices, reinforce strengths, and encourage parents to follow their intuition (for example, "you can't spoil a baby").

Using strengths-based observations and positive, affirming feedback

Promoting First Relationships® in Pediatric Primary Care (PFR-PPC)

Promoting First Relationships® in Pediatric Primary Care is a framework for providing strengths-based, relational care in well-visits. The steps build on one another and encourage the provider and parent to reflect and join with each other and the child. The PFR-PPC Consultation Strategies are:

1. **Joining** with the parents and child by considering their experiences, needs, and feelings
2. Doing **reflective observations** of parent-child interactions
3. Providing **verbal feedback** to the parents that is always positive, and sometimes instructive
4. **Supporting parents' reflective capacity** about their feelings and their child's feelings by asking reflective questions and making comments
5. **Sharing information on social and emotional development** through conversation and with the PFR-PPC developed handouts

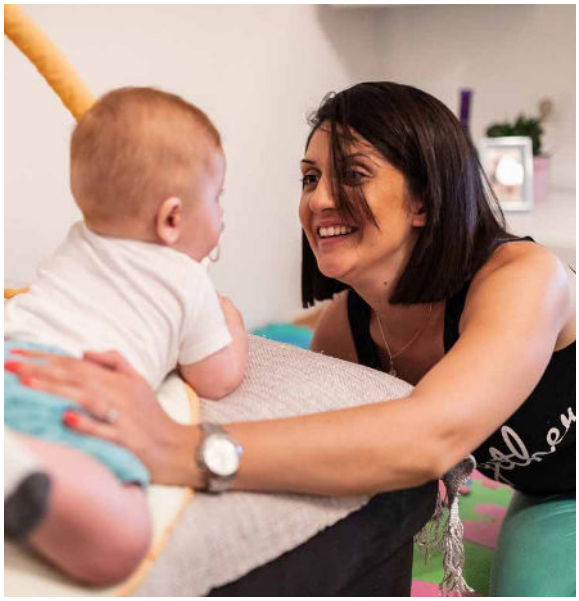
We visited three clinical settings that used the PFR-PPC framework.

- At Allegro Pediatrics, a mother we interviewed has multiple children who receive care from a pediatrician implementing PFR-PPC in well-child visits. She deeply appreciated her pediatrician, describing that the PFR-PPC strategies modeled and provided in the visits supported her son's social and emotional development and their relationship. She said, "My doctor has helped me to co-regulate my son's emotions, connect with him, and redirect his emotions. This has led to good communication between us, and openness with feelings vs. him shutting me out and being angry."
- At the Harborview Medical Center, many staff who work with young children and families are trained in PFR-PPC to provide care with the same strengths-based messaging. Staff we talked with included providers, family resource coordinators, and a social worker, who all appreciated that the PFR-PPC framework brought joy, positivity, and connectedness into their visits with families.
- The Seattle Children's Hospital embeds PFR-PPC in its residency program. Training builds residents' capacity to observe, reflect, and empower their patients. The training can be reinforced over time if their clinical instructors support the residents as they practice the PFR-PPC approach.

PFR-PPC provides training and materials in this framework for providers and staff who work with parents and children.

In addition, they intentionally engage fathers during the well-child visit by asking them to complete screens, directing questions to them, and engaging them in supporting the mother in breastfeeding.

The pediatric provider, or another care team member, models activities that promote social and emotional development and the parent-child relationship and uses strengths-based observations with reading, play, and interactions with children.



During our visits with several sites, we witnessed the pediatric provider, or another care team member, model activities and interactions with children and parents. Modeling benefits families by demonstrating how parents' simple actions, such as talking, reading, playing, and singing, build a positive relationship with their child through serve and return interactions and encourages parental engagement in reading and play. Reading aloud and playing together have been documented to be beneficial for social and emotional development in part through the enhancement of the parent-child relationship.[28] The care team often uses props to model the interactions, such as developmentally appropriate books and toys that support the child's learning and development of their executive functioning skills. During the visit, parents also have an opportunity to practice the interactions and skills, receive encouragement, and make plans to integrate into daily routines at home. Furthermore, these parent-child interactions during visits serve as a springboard for the **strengths-based observations and positive feedback** discussed in the previous common practice. Modeling and making strengths-based observations allow the pediatrician to do developmental surveillance and teach families about developmental milestones while observing the child playing and interacting with their parents.

Modeling activities and using strengths-based observations

Reach Out and Read™ (ROR™)

The **Reach Out and Read™ Program** promotes early literacy and a strong parent-child relationship. During well-child visits, providers model reading, talking, and playing with a child using a new, developmentally- and culturally-appropriate book. They observe the child and comment on the developmental significance of their responses. Parents can also read to and with the child while the provider makes strengths-based observations of their interactions. The provider gives them the book, sharing ways that the parent can continue reading and engaging with their child at home.

A pediatrician at Pediatrics Northwest in Tacoma, WA modeled reading and play to promote social and emotional development of a 2 year-old. She read a children's picture book about a character experiencing a range of positive and negative emotions. The story introduced a discussion with the child's mother and grandmother about the importance of naming and talking about emotions with young children, especially at their developmental stage, when they are experiencing big emotions that they cannot identify. The grandmother noted, "With books you can teach me how to teach my child." She shared that the pediatrician's approach gave her insight on how her granddaughter was developing mentally and how she could encourage her, help teach words, and build her granddaughter's knowledge. At the end of the visit, the pediatrician also provided a **Promoting First Relationships® in Pediatric Primary Care handout** that complemented the book and the discussions of social and emotional development, providing tips about connecting with children in difficult emotional moments.

Video Interaction Project (VIP)

In the **Video Interaction Project (VIP),** families have the opportunity to meet with a bachelor's degree level parent coach for 25-30 minute sessions that take place before or after every pediatric well-child visit from birth to five years old. During each session, the coach helps parents to reflect on their observations of their interactions with their child in their homes, provides developmental education, gives a developmentally appropriate learning material (toy and/or book), and helps parents to set their own goals for interacting with their child. The coach takes a video of the parent and child playing for 3-5 minutes (any caregivers and siblings can also participate), and then reviews the video with the parent *in real time,* pointing out and reinforcing strengths in their interactions, supporting the parent-child relationship and sharing skills to support parents taking an active role in their child's development. Parents take the video home, and are encouraged to watch it with other family members. Mothers in VIP at NYC Health+Hospitals / Woodhull in Brooklyn, NY, appreciated the positive, instructive feedback given during VIP sessions. One mother expressed that the reinforcement in her parenting was encouraging and expanded her understanding of how to raise her child. Another appreciated that the coaches made connections to the baby's current and future developmental stages. The staff felt that the parents had "gained so much confidence" over the course of several visits and were better able to advocate for themselves and their children. For example, parents would come to the well-child visits more prepared to explain their needs, and strengths to their provider.

Newborn Behavioral Observations (NBO™)

We observed some sites using the **Newborn Behavioral Observation (NBO™)** with families to strengthen the early parent-child relationship while the family is still in the hospital or during well-child visits in the first and second months. NBO provides an opportunity for parents and a provider/care team member to co-observe newborn babies' early behavioral signals about their moment to moment needs, as well as their responses to parents' faces, voices, and efforts to soothe and connect. Through modeling by the provider and strengths-based observations of the parent-infant interactions, the NBO nurtures early attachment, revealing to parents their newborn's cues and the unique individual strengths and temperament their babies express, as well as their own resources to become the confident parents they want to be.

Anticipatory guidance materials are enhanced and tailored to support parents' knowledge about social and emotional development, the parent-child relationship, and the parent's mental health.

During the site visits, we observed providers and other care team members use anticipatory guidance materials that offer in-depth information about social and emotional development, the parent-child relationship, and the parents' well-being. Materials and guidance are tailored and timed to the specific well-child visit to ensure that families are ready for new milestones and are supported around upcoming challenges that may be stressful (for example, increased crying or going back to work). In addition, the materials were designed so parents can "see" parenting strategies through video, stories, or images.

Examples of enhanced anticipatory guidance materials include:

- **Handouts that are accessible to families of different racial, ethnic, and cultural backgrounds, such as materials available in the primary languages of the patient population, written at basic literacy levels, and having pictures of families of different races and cultures. Accessible handouts may also have drawings and graphics that depict the parent/child behaviors and the suggested responses, so that parents can easily "see" and understand the lesson, even if the handout isn't in their language.**
- **Interactive worksheets that include tips for parenting and play, developmental milestones, and sections that the parent can fill out with the support of a provider/ care team member. For example, The Video Interaction Project provides a "VIP Guide" worksheet corresponding to the age and/or visit that includes developmentally relevant information and tips for playing. The coach also works with parents to fill out sections about the parent's observations, favorite moments together, and plans for playing with their child.**
- **Developmentally, linguistically, and culturally appropriate books and toys that support the child's learning. Books can promote cultural understanding by exposing children to diverse races and cultures as well providing representation of their own race and culture. The toys and books can also expose children to and model social and emotional skills that they are learning and practicing. In addition, parents and children can witness different parenting practices and familial experiences.**
- **Use video modules to engage families as they wait for the visit or between visits (i.e. apps), displaying parent-child interactions practically demonstrated in realistic scenarios by parents that look like them.**

Modeling *with* Tailored and Enhanced Materials

TMW Well-Baby
The TMW Well-Baby Intervention uses downtime as the parent waits for the provider in the exam room to show parents video modules at each well-child visit from birth to 6 months old. The content from the videos is designed to be reinforced by the provider in the visit. With the goal of centering parents as their child's most influential teacher and promoting responsive parenting and parent-child attachment, the videos stress the importance of parent-child talk, interactions, and relationships, while reinforcing and scaffolding lessons on brain development. The videos depict parent-child interactions and use strengths-based, non-judgmental, and non-stigmatizing messaging. The developers noted that it was important that parents could "see" themselves and relate to the parents in the videos, as they showcased many demographics of families. The TMW Center engaged families and the community in the development of the program. The videos and program materials were vetted by parents, and community input contributed to a culturally adapted Spanish-language version of the video series.

The provider and/or another care team member partners with parents to co-create goals and reflect on them in subsequent visits.

Goal-setting is intended to increase parents' self-efficacy by giving them an opportunity to reflect and visualize their life, needs, hopes, and future. It is especially powerful when parents set reasonable goals and create an action plan, considering concrete steps, needs, and even challenges to achieving them. Furthermore, goals can be multifaceted. They can include family and parenting goals, such as reading and playing with their children, keeping them safe, and building relationships. Goals can also be personal, social, educational, or career-oriented for the parent. Goals may also be related to connecting to services and referrals for the needs that are most important to the family to address. Some programs and implementation sites created simple worksheets to use with parents to prioritize their goals and make concrete plans of action that can be taken home as a support to the parent and included in the family's medical record. Goal setting can be most effective when the provider and/or care team member follows up and reflects on the parents' progress with the goals in following (or between) visits. For example, the Massachusetts Project LAUNCH team in Worcester, Massachusetts, asks parents to create a plan with three concrete goals. This plan is created in one of the first meetings with a new family and is revisited by providers or the care team throughout their sessions together.

> "A partnership starts with the parent knowing their input matters, and that they are the best advocate for their children."
>
> **— Family Brain Trust Member**

Opportunities are created for families to connect with other families.

Several of the sites convene group activities for parents as part of the program model they are implementing or as an additional component created to meet family needs and fill a community gap. Still others refer families to community group activities, which is a key strategy described in the subsequent action category. Parents appreciate the opportunity to socialize and connect with other families while building their parenting confidence and supporting their own well-being. Involvement in group activities can address social isolation, particularly with families who do not have a strong support network in their personal lives. Groups can also be powerful for connecting families of similar ethnic, cultural, and/or linguistic backgrounds. According to family leaders involved in the PSP project, group activities are great at connecting parents of foster children or children with special health care needs as they appreciate learning from other families' experiences navigating systems and services. If group activities were conducted by clinical staff, they also helped build relationships with staff and increased openness to referrals. Some sites hosted playgroups or classes open to all parents in the clinic with children 0-3, while others conducted group well-child visits. For example, DULCE at the Children's Clinic in Long Beach, CA, facilitates a weekly infant massage group that one mother said "Gave [her] hope [and] it got [her] out of the house to do an activity with [her] two children." Two sites used group well-child visits with groups of six to eight families to transform how families experience care. During extended sessions, families build deep social connections with one another and the care team. They learn from one another about child development, parenting, and self- care.

Creating opportunities for families to connect with other families

CenteringParenting®

CenteringParenting® is a two generation intervention that supports healthy parent-child interactions and early learning within the framework of group well-child visits. CenteringParenting® brings 6-8 parents, caregivers, and their same-age children together with their health care team for 1.5 - 2 hour well-child visits following the American Academy of Pediatrics (AAP) Bright Futures™ Periodicity Schedule for nine well-child visits over the first two years. Participants are actively engaged in their child's assessment at every visit: tracking their growth, development, immunizations, and oral health. This active participation makes them more aware of the results and what these health indicators and milestones mean to their child's health, growth, and development. The longer group visit format allows the health care team to better observe parent-child interactions, model behaviors and developmentally appropriate activities, and to explore the topics that matter most to parents. When planning each session, the group facilitators are encouraged to include an activity, materials, or facilitated discussion that highlights healthy parent-child interactions at that developmental stage and to read books aloud at every visit. There are opportunities to introduce community resources and other interventions, such as Reach Out & Read™. Centering is the billable primary care visit, not an additional program or class, and can be a cost-neutral, scalable intervention.

With the group well-child visit format of CenteringParenting®, families spend a significant amount of time with providers, care team staff, and other families, building strong, trusting relationships with one another over time. The group environment is safe and inclusive; members are encouraged to share from their own experiences, cultural beliefs, and values. In a group well-child visit we observed at Einstein Medical Center in Philadelphia, Pennsylvania, the families had multiple opportunities to connect with everyone in the room. The visit started casually, with the families playing with their children while each family was individually pulled aside by the provider for health assessments and vaccinations. The informal playtime allowed families to connect, share stories, and get advice from each other and the care team staff. During the more formal educational portion, the care team posed open questions and facilitated the discussion, empowering the families to guide the conversations and breaking down the "hierarchy" between families, care team members, and providers. During the discussion, families were comfortable disclosing their challenges and needs with each other. Not only do such disclosures allow for more targeted guidance and linkages to necessary health or social referrals, but they also allow families and the care team to support and comfort each other. During the observed visit, the deep personal connections were evident. For some of the families, the social capital and friendships extend past the doctors' office, as some have attended each other's birthday parties, and go on playdates to the park.

Empowering Mothers

The Empowering Mothers group well-child visits in Oakland, California, is a local program created to support the Asian-American immigrant and refugee community served by a Federally Qualified Health Center, which is a population that is more linguistically and socially isolated. The curriculum, based on the Bright Futures guidelines and the Family Nurturing Program, has been translated into multiple Asian languages, such as Chinese, Vietnamese, Mongolian, and Burmese. The groups are culturally responsive and encourage participants to share and connect with their racial, ethnic, and cultural backgrounds. For example, participants often reflect on their experiences of parenting in their home countries and in the US, highlighting what has been challenging for them in that context. Additionally, health navigators that are culturally and linguistically concordant create a bridge between the families and staff and help families navigate the health system. The Empowering Mothers group well-child visits allowed mothers to create meaningful friendships with each other and find trust in the health system, which is especially impactful for those who are socially isolated and have recently been separated from extended family.

Strategies to support the parents' well-being and mental health are intentionally integrated throughout the well-visit in service of promoting the parent-child relationship and child's social and emotional development.

Parental well-being and stress are important factors affecting the parent-child relationship and child's social and emotional development. Many sites integrate an intentional focus on promoting the parents' well-being, seeing it as an important part of nurturing parents' competence and confidence. This often involves connecting families to community supports, which is a key strategy described in a subsequent action category.

Parental well-being is acknowledged and addressed in several ways:

- **Incorporating questions about parents' well-being and the supportive relationships within their family and social network when taking down their history.**
- **Observing and recognizing the parents' well-being as a strength.**
- **Including information about self-care in anticipatory guidance and including parents' personal goals for their well-being in goal-setting activities.**
- **Providing universal promotion, screening, and linkage for maternal depression and intimate partner violence.**
- **Offering mental health services in the clinic for the parent-child dyad to provide for parents with acute mental health needs.**
- **Connecting families to a group well-visit. With the additional time that the visit affords, providers and other care team members can focus on parental well-being in individual assessments and group discussions. At CenteringParenting® visits, providers are able to assess and discuss stress and depression with families individually. Well-being and self-care are also topics for group discussion at each session. CenteringParenting® care teams may also integrate a social worker. If families express specific needs or issues, the social worker can pull them aside in the visit, bring them to their office, or do warm handoffs with other providers (such as a domestic violence advocate).**
- **Connecting families to community resources and supports, such as parenting support and education groups, which are specifically focused on parental mental health.**

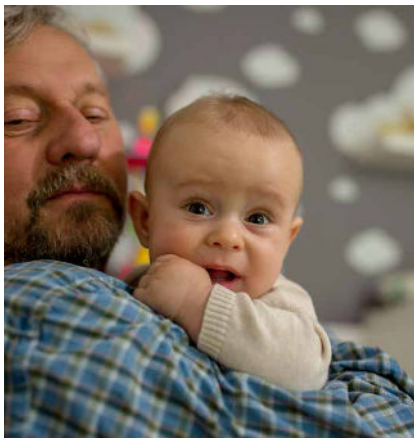
Supporting the parents' wellbeing and mental health

Mental health Outreach for MotherS (MOMS) Partnership®
The MOMS stress management courses are co-facilitated by a licensed mental health clinician and community mental health ambassador (CMHA). The courses use cognitive behavioral therapy to help mothers identify stress, anxiety, and depression, and how these factors affect different aspects of their relationships with their children and in their community and employment. The MOMS stress management course builds skills that help mothers recognize feelings, redirect unhelpful thoughts, elevate mood, and practice self-care and mindfulness. Participants can also easily be connected to other services or material needs (such as diapers). The DC MOMS model, which is being initiated through the office that administers the federal Temporary Assistance for Needy Families (TANF) program, has a resource guide for mothers who need additional support and partnerships with other government agencies and services to which they can easily refer. A study of the original New Haven model showed that 76 percent of mothers experienced a decrease in depressive symptoms and that there was over a 78 percent retention rate in the program.[29] MOMS is also being replicated in the State of Vermont, New York City, and the Commonwealth of Kentucky.

Connect families to supports to promote healthy social and emotional development and address stressors

Implementation sites recognize the importance of using established screening tools to assess child and family needs and of connecting families to supports in the community that may be able to meet those needs. As a result, families are linked to resources that are designed to directly support the child's social and emotional development, such as Early Intervention, play groups, parent support groups, and library story times. Often, clinics must also refer to resources that address key family stressors that affect the parent-child relationship and the child's social and emotional development. These stressors fall into two basic categories: (1) personal and interpersonal challenges (e.g. depression or other mental health issues, intimate partner violence, and substance abuse challenges), and (2) struggles meeting basic needs that require concrete supports such as food and housing assistance.

A standardized workflow is created to provide developmental, behavioral, and SDOH screenings, health promotion, support, and resources.



All sites implement a standardized workflow to ensure that universal screenings are consistently completed, families are provided education on developmental milestones, and families are connected to any needed supports and resources. While all sites visited provide screenings universally to parents, the types of screenings vary by site. In addition to the general developmental and autism-specific screens recommended by the AAP,[30] many sites added screenings for social and emotional development, specifically, and assessments of parental needs which included screens for intimate partner violence, parental depression, and concrete supports related to the SDOH.

We observed different methods for standardizing workflow for screenings, including the following:

- **Assigning screens to specific well-child visits based on the child's age and using both visual and electronic medical record reminders to prompt staff to provide the correct screens to families.**
- **Designating roles among the care team for every step of the screening process—implementing the screening, interpreting the results, communicating with the clinician, discussing with the family, coordinating referral and linkage, and following up with families.**
- **Reducing stigma by (1) providing a set of "universal resources" and information about social and emotional development (such as free resources at Birth to 5 Watch Me Thrive); parent mental health (such as maternal depression); and concrete supports (such as food pantries and job training); and (2) encouraging all parents to take part in opportunities for social support such as playgroups, library story times, and parent groups.**

Standardizing workflow to provide developmental, behavioral, and SDOH screenings, health promotion, support, and resources.

Quality through Technology and Innovation in Pediatrics (QTIP)

QTIP is a quality improvement collaborative led by the South Carolina Department of Health and Human Services (DHHS) that works to improve health care for children. The collaborative began with funding through the CHIPRA Quality Demonstration Grants in 2010 and much of the infrastructure has been sustained when the grant ended in 2015. QTIP brings over 30 pediatric clinics (who serve over 32 percent of the children receiving Medicaid) together to collaborate on quality improvement projects that promote the physical and social and emotional health of children across South Carolina. A partnership with the South Carolina Chapter of the American Academy of Pediatrics (SC AAP) has been critical to QTIP's success, allowing for a strong relationship between the state agency and pediatric providers.

QTIP pediatric clinics participate in two learning sessions and site visits per year, collect and submit monthly data, and access technical assistance from the QTIP staff who provide quality improvement and behavioral health integration coaching, curate resources, and rapidly connect them to their peers who may have best practices to share. The collaborative has successfully increased developmental screening by 362 percent since 2011 and emotional/behavioral screening by 374 percent since 2015 statewide. At the beginning of QTIP in 2011, 17 percent of QTIP clinics (three of 18) screened for maternal depression. With focused attention through the collaborative, this number grew. In 2017, 78 percent (14 of 18) and at the end of 2018, 85 percent of QTIP clinics (22 of 26) were screening for maternal depression and 69 percent (18 of 26 reporting) are screening for SDOH.

Valuable learnings from the experiences of testing and implementing changes in diverse settings in the collaborative inform policy at the state level. These include making changes to rates, opening billing codes, and increasing access to needed materials, services, and infrastructure. Once ideas and learning are proven, QTIP and the South Carolina AAP chapter disseminates best practices, thereby accelerating their adoption across the state. Providers interviewed through the site visits and at a QTIP learning session identified that the connections to both policy and peers across the state are incredibly valuable to their work. One provider noted that it helps "prevent [their] burning out" by being part of a statewide effort, accessing support and resources, and seeing the changes they are implementing make an impact at their own clinics and across South Carolina.

We visited three pediatric practices in QTIP who were using different strategies to implement screenings based on their resources and community:

- AnMed Health Children's Health Center in Anderson, South Carolina, did not have the resources to hire additional social workers or community health workers. Instead, a nurse "specializes" in connecting families to resources, as a result of needs identified in SDOH screens. Passionate about this issue, she maintains a resource list and relationships with community partners, tracks follow-up, and ensures families are linked to the resources.
- Carolina Pediatrics in Columbia, South Carolina, a private clinic, has found that the screenings open up new conversations that can be challenging to address within the time constraints of a well-child visit. To manage this, the clinic has each pediatrician work with a consistent nurse who can support referrals and schedules a follow-up appointment, that same day or within a week, to address the specific concerns with the family.
- The care team at Center of Pediatric Medicine in Greenville, South Carolina, includes social workers and case managers who can work closely with families to connect them to resources. To reduce burdens for families, they have co-located resources at their clinic such as an office for the federal Women, Infants, and Children program; Medicaid; PASOs Hispanic community health workers; and child psychiatrists; they also serve as a site for fresh food box ordering and pickup.

In addition, all three care settings provide universal resources in order to ensure all families are aware of the resources in the community and decrease stigma by encouraging families to share them with family and friends who may need them even if they themselves do not.

Community partnerships are cultivated through clear processes and protocols.

A common barrier to screening is a concern for not having a solution or resource that meets a given family's needs. Therefore, a key step to implementing such screening is developing robust community partnerships to have access to an array of quality, culturally effective/appropriate community referrals that can best support families' mental and physical health and concrete needs. Building relationships with community partners can help facilitate "warm hand-offs" between the parent, provider, and the resource and create feedback loops about referrals that ensure connections are made and needs are met. Some communities have existing centralized systems for community resources that include information, linkage, and referral, while others do not. The implementation sites visited were often part of developing or maintaining these systems in order to better serve families in their communities. They often were intentional about making sure that partnerships with community-based organizations and referral partners are representative of the diversity and needs of the patient population.

Some observed processes for developing community partnerships are outlined below:

- **Conducting "community visits," where clinic team members meet with local community organizations to build a relationship, learn about the resources and how to make appropriate referrals, and set up feedback loops about the referrals. Often, follow-up meetings and communication occur as the partnership develops. In South Carolina, QTIP staff coordinate and facilitate visits between multiple clinics and community partners when a shared need and gap is observed across the clinics.**

- **Joining local community meetings that occur monthly and quarterly allow for regular updates about available resources in the community, identification of gaps, and stronger referral pathways.**

- **Connecting with centralized resource and referral agencies in the community, such as Help Me Grow, provide a central access point to child development services and supports for families and professionals.**

- **Connecting with federally-funded, family-run state Family to Family Health Information Centers, Family Voices Affiliate Organizations or other family-led organizations help parents learn about state-specific services and supports, navigate systems of care, and connect with other families who share a similar life experiences. Family-led organizations often also provide mentoring, skill building, and leadership development that can help families be more effective advocates not only for their own children, but also for all children and families. Family Connections, the Family to Family Health Information Center in South Carolina, is an important resource for families, providing them with a range of supports including mentoring, advocacy, training, and specific outreach to Latinx families.**

- **Recommending a potential connection that may not have occurred to the clinic or been a priority. For example, Reach Out and Read™ clinics are encouraged to connect and collaborate with their local public libraries to create literacy-rich waiting rooms.**

- **Maintaining community partnerships; often clinics designate a point person to update referral lists and ensure effective communications for how referrals and services can be improved.**

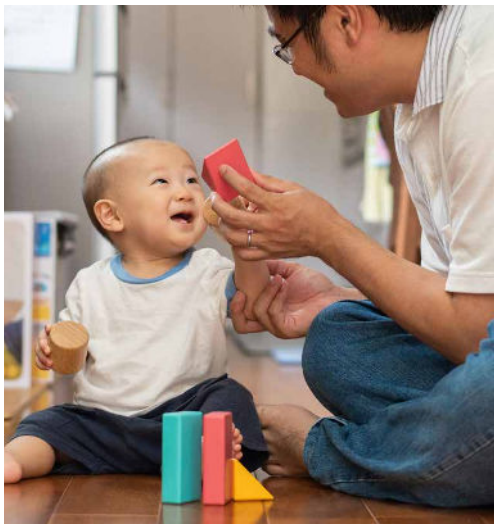
Cultivating community partnerships through clear processes and protocols

Family Connects

Family Connects in Durham, North Carolina, is a universal newborn nurse home visiting program with intentional, strong connections to pediatric primary care medical homes and community resources. During the home visit that occurs approximately three weeks after the baby's birth, the nurse home visitor conducts assessments and connects families to needed supports and services in the community. The program has a communication protocol to share information between Family Connects and the pediatric primary care team so that the home visit and community connections become an extension of the well-child care.

Family Connects has a dedicated staff member—a Community Alignment Specialist—who leads implementation of a robust community engagement and alignment model. To facilitate referrals to community providers, Family Connects creates or links into existing "agency finder" tools, generating a comprehensive list of referral sources in the community that then is used to find the "best match" for both the family and the agency. The Community Alignment Specialist consistently engages with the community agencies, by attending community collaboratives and by leading a community advisory board composed of a representative sample of the types of agencies in the community. The community advisory board disseminates information about issues in the community, problem solves, and creates feedback loops about what they offer and what can be improved. "Alignment" occurs when the specialist uses the data Family Connects collects about family needs, satisfaction with services, and barriers to connecting with referrals to spur providers to improve delivery, fill gaps, and remove barriers at the community level.

Outreach is made to parents during pregnancy to build relationships with the family, identify concrete support needs, and connect to resources.



Connecting with parents during pregnancy can help build early, trusting relationships with families and ease the transition from pregnancy to parenting. For decades, pediatric primary care providers have been able to meet with expecting parents selecting a primary care provider for their baby. In addition, this prenatal appointment can be used to build a relationship with the family, offer anticipatory guidance, and connect them with services and supports they can benefit from immediately and before the child is born. This visit is recommended by the American Academy of Pediatrics and is part of the periodicity schedule. However, a recent study found that, overall, only 38 percent of families attend the visit and less than five percent of families from low-income, urban communities attend the prenatal visits.[31] Some sites were experimenting by building relationships with maternal health providers to meet families at their prenatal appointments or by partnering with CenteringPregnancy® groups to join and participate in the group visits in the later months of the pregnancy. Although this practice was less frequently observed across the visits, the Family Leaders participating in the PSP Brain Trust prioritized this practice as one that they would find very valuable to themselves as parents.

Examples of Existing and Emerging Community Resources for Building Connections

CSSP's scan of national programs revealed a variety of community-based parenting groups that can have strong benefits for families. Of the 68 programs reviewed, 17 were group-based parenting curricula. Such parenting programs may exist in many communities, and while they are not in the pediatric setting itself, clinics can work to connect and make families aware of these groups. In addition, many programs are tailored or can be adapted to meet the specific needs of cultural groups, expecting parents, young parents, mothers, and fathers. These groups can provide deeper and more targeted focus on different subjects, such as parenting or stress management. Among the programs CSSP was not able to visit, we engaged in several conversations with community-based group programs that have strong evidence of effectiveness, one being The Incredible Years®.

The Incredible Years® (IY) offers a set of three interlocking developmentally based curricula and training for group-based community programs for families, children, day care providers (ages 1-3 years), and preschool and primary school teachers (ages 3-8 years) that are widely offered across the country. There are also home coaching and individually tailored versions of all the IY parent programs (birth to 12 years) which can be offered to parents who are child welfare referred and need a parent program quickly or parents who can't attend the existing parent group being offered due to schedule or distance of travel. Often parents who start these individually based IY programs (in home or clinic) are then encouraged to join a parent group to build their support system.

The series of programs are designed to promote the social and emotional development, school readiness, and academic competence of children, and to reduce behavioral and emotional issues. Many of the programs have a large body of evidence of outcome effectiveness, including not only child behavior improvements but also more supportive, positive, and responsive parenting and child care interactions, reduced harsh and critical discipline, increases in parenting or teaching competence and social support, and reductions in parent or day care provider or teacher stress. The Incredible Years® has two specific parent curricula for babies and toddlers that emphasizes building parents' bonds with children through child-directed play, social, emotional, persistence and language coaching as well as proactive discipline. While the baby program has been adapted for use in an individual well-baby visit setting, the developer believed the group dynamics and support are a key component in the success of the program. For higher-risk families, the individual or home-based coaching IY model has been added as a supplement to the group approach.

Develop the care team and clinic infrastructure and culture

The common practices related to **developing the care team and clinic infrastructure and culture** create a backbone that make it possible to implement innovative programs and practices, and to facilitate trustful team environments. While the sites visited all face constraints and challenges, care teams are working together to support families in hectic primary care settings where time and resources are limited. Many had succeeded in creating both well-functioning teams and a warm and welcoming environment for families. Trust and support among care team members and between the care team and families is essential to effective communication and care. In a trusting environment, there is empathy and generosity, allowing information to be conveyed in such a way that it can be heard and effectively acted upon by the recipient—whether they be a parent, nurse, medical assistant, physician, or some other care team member. It is what is often referred to as "a parallel process" or "the golden rule": families will likely experience what the care team experiences. Trust among team members is especially important when supporting families with complex developmental needs and barriers to concrete supports such as food, employment, housing, and transportation.

New roles are integrated into the care team to promote the parent-child relationship, connect families to resources, and support parents' well-being.

Many sites visited are integrating new roles into their care teams, either through hiring new staff or by integrating culturally effective and diverse community partners. These roles bring new expertise and perspectives to the team, allowing for greater ability to partner with families to support their child's social and emotional development and address family stressors. Qualifications of staff filling new roles can include a variety of personal and professional backgrounds and experiences, from non-specialist college graduates, to licensed psychologists, to families and parents from the community.

Sites visited integrated new roles into the care team in several ways:

- **Including a family specialist trained in child development and relational practice. These specialists help administer critical child development and SDOH screenings and assessments and offer needed supports, services, and referrals to families. Often, they can assist families navigating resources and systems, following up on connections made, and empowering families to navigate systems on their own.**
- **Including a Family Partner role. Family Partners reflect the cultural, ethnic, and racial identities of the patient population. These professionals use a unique combination of personal experience and family support skills to relate to families with purpose and intent, building relationships to understand individual needs, amplify family voice and choice, empower parents, and customize connection to supports. The role enhances contact between the family and the primary care setting.**
- **Co-locating social workers and behavioral health specialists that offer mental health consultation about families to the team in addition to providing direct services to families.**
- **Integrating community partners who bring diverse knowledge of community resources or have expertise not typically found in health care, such as legal partners.**

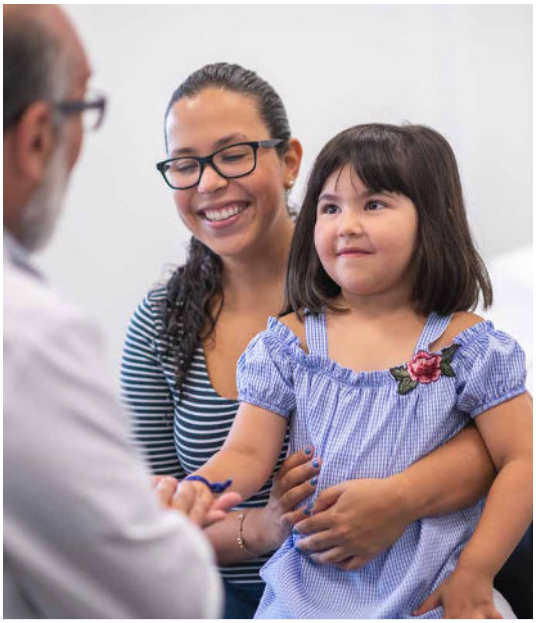
Integrating new roles into the care team

HealthySteps, a program of ZERO TO THREE (HS)
HealthySteps (HS) is an evidence-based, affordable, population health model that reaches families most in need of services. The HealthySteps Specialist, a child development expert, joins the pediatric primary care team to integrate universal screenings, teach parents about their child's developmental and behavioral needs, refer and connect families to needed resources, and provide intensive services, if needed. The national model is composed of three tiers of service that allow practices to stratify services by risk. The first tier, "universal services," are provided to all families with children ages birth to three in the practice and include child development, social and emotional, and behavioral screenings, screening for family needs and maternal depression, and a child development support line; the second tier, "short-term supports," adds child developmental and behavioral consults with the HS Specialist, care coordination and systems navigation, positive parenting guidance and information, and early learning resources; and the third tier, "comprehensive services," adds ongoing, preventive team-based well-child visits, in which the HS Specialist partners with the provider to deliver enhanced well-child visits. We visited two HealthySteps sites that offered services designed to address the unique needs of their communities.

- The HealthySteps sites at Montefiore in the Bronx, New York, can support families with a range of needs. Montefiore's HealthySteps program provides services to families aged birth to five years, and is staffed by clinical psychologists (or licensed clinical social workers) with specialized training in dyadic trauma-informed interventions. In addition to implementing the national HealthySteps model, Montefiore's HealthySteps Specialists offer long-term mental health treatment for parents (at some sites), as needed. Montefiore's HealthySteps Specialists also provide training to pediatric medical providers, pediatric residents, and medical students enrolled in Albert Einstein College of Medicine.
- In Show Low, a rural mountain town in Arizona, the HealthySteps Specialists provide Tier 3 team-based well-child visits to nearly the full population of children in the Summit Health Care system. The HealthySteps program also provides additional services to families in the Show Low community. For example, they also offer lactation support, Thera-Play, and a community playgroup. They have also helped to recruit, train, and/or house pediatric therapists, a neuropsychologist, a speech language therapist, and other resource professionals.

Massachusetts Project LAUNCH
Massachusetts Project LAUNCH integrates early childhood mental health promotion and prevention services within pediatric primary care settings. The model includes an "early childhood mental health team" of a family partner and mental health clinician who meet with families with children 0-8 years old to engage and assess social-emotional wellness and provide family-centered brief treatment, parent support, and facilitated referrals to ongoing services and resources. The family partner role is an important aspect of the program, as their personal background and experiences as a parent enrich the relationship between the family and primary care. At the Family Health Center of Worcester, the family partner uses her personal experiences of navigating systems such as education, behavioral and medical health, and housing to provide authentic support to other families navigating systems. She always tries to make personal connections with families and let them know they are not the only ones who have these experiences, and there are many resources in the community that can help. The staff expressed that the different perspectives, expertise, and experiences of the mental health clinician and the family partner are equally important as a team in providing care to the families, and a key feature of the model is supporting this non-hierarchical relationship between the family partner, the clinician, the medical staff, and the family.

Structures are created to enhance care team communication and collaboration.



Sites described the critical importance of a care team that has a high level of trust and can effectively collaborate to support families, especially those with complex needs. This trust is developed over the course of working together and supported by structures and processes that facilitate communication, problem-solving, hand-offs, and follow up. It is critical that these processes be consistent parts of the routine and improve over time to ensure effective communication and that quality care is being delivered.

Processes that were observed or described included:

- **Regular care team meetings such as daily huddles or weekly multidisciplinary case reviews. Case reviews enable collective problem-solving by reviewing family and child health, developmental and basic needs, and how best to connect families to needed services and supports. Case reviews can include nurses, community resource specialists, social workers, child development specialists, legal partners, behavioral health specialists, etc. They can also allow care teams to identify patterns, trends, and resource gaps that can inform practice improvements and community partnerships or advocate for action at a system or policy level. In Family Connects, case reviews with home visitors, including lactation consultants, and the Community Alignment Specialist allow home visitors to share challenges families are facing and get advice for care plans and potential community resources.**
- **Using Electronic Health Records or other technology platforms to record positive screens and/or notes about a family that the provider or another care team member can access easily.**
- **Designating roles within the visit for care team members and creating workflow routines for communication before, during, and after the visit. In models where a family partner or specialist may meet with the family in advance, the provider, nurse practitioner, and the family partner often had a transition routine where the family partner described what had been discussed prior to the provider coming into the room and prompted the family to share some of their priorities for the visit.**
- **Minimizing workflow disruption when implementing new practice changes. For example, staff mentioned that the TMW Well-Baby Intervention "did not interfere with" normal well-visit workflow, as the Medical Assistant was able to quickly set up the TMW videos to be viewed before the provider arrived.**

Integrating New Roles *and* Using Weekly Case Reviews to Ensure Family-Centered Collaboration

Developmental Understanding and Legal Collaboration for Everyone (DULCE)
Starting with a baby's first routine health care visit, DULCE[vii] **integrates new roles to create an interdisciplinary care team** that supports infant development through the Touchpoints® approach and screens families for eight SDOH (food insecurity, financial/employment, housing instability, housing conditions, utilities, parenting supports, maternal depression and intimate partner violence). This interdisciplinary team—which includes a Family Specialist, pediatric provider, mental health specialist, legal partner and early childhood system representative—conducts a weekly case review that provides structured time to engage multiple professional perspectives in discussing family strengths and jointly problem-solving to address families' needs holistically. DULCE's integrated, data-driven approach positions teams to address system- and policy-level barriers when they arise, such as improvements in newborn Medicaid enrollment and piloting innovative transportation services.

At the Children's Clinic in Long Beach, California, the Medical Legal Partner reported that participating in case reviews allowed her to identify legal needs for families much earlier and more frequently. By supporting the Family Specialist in providing clear information and advocacy to families, needs are addressed before becoming more complex, legal issues. When direct legal services are needed, the Family Specialist can make a referral with a warm handoff for legal representation.

Care teams and staff are engaged in ongoing learning and development.

The implementation sites stressed the importance of training medical providers, clinical staff, and office staff to strengthen their knowledge and skills for effectively working with families. While initial training provides a foundation in these areas, sites provided ongoing learning opportunities and supports that helped the care team integrate the new knowledge and approaches into their daily work. For example, reflective supervision was identified as a way to support care team staff to reflect on experiences with families, understand their feelings, and make plans for next steps.

Topics of training and ongoing learning opportunities for staff and medical providers in clinics visited included:

- **Strengths-based relational approaches such as Brazelton Touchpoints®, Promoting First Relationships® in Pediatric Primary Care, or Strengthening Families Protective Factors.**
- **Adverse Childhood Experiences (ACEs) and trauma-informed care.**
- **Social determinants of health (SDOH).**
- **Cultural humility and implicit bias.**
- **Early childhood mental health and early brain development.**

[vii] DULCE is an approach being further developed by CSSP and partner jurisdictions with support from The JPB Foundation, as part of the foundation's overall interest in developing community responses to early life stress in young children and their families. We felt that the level of evidence for DULCE, derived initially from a federally-funded randomized control trial conducted at Boston Medical Center and now the subject of an evaluation by Chapin Hall, as well as the potential lessons from its innovations, warranted inclusion in this study. We want to bring awareness to CSSP's connections to DULCE.

Care team well-being is supported to prevent burnout/stress/fatigue and retention issues.

During the visits, providers and clinical staff described that some programs and practices, notably those that helped build relationships with families, had the secondary effect of helping them feel and do better in their role. They felt more connected to their work and experienced joy in practice. Intentional structures of support can also strengthen staff satisfaction, motivation, and experiences, contributing to higher retention rates.

Structures shared from site visits and the national meeting of partners include:

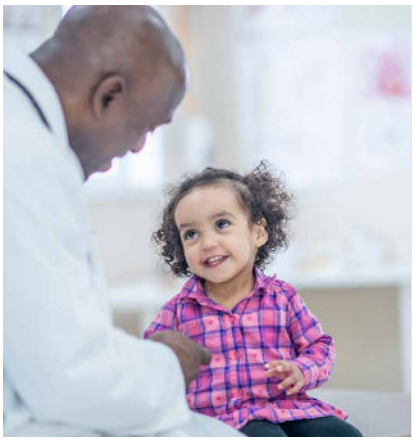
- **Reflective supervision (individually, peer-to-peer or in group).**
- **Regular check-ins to address stress.**
- **"Stay" interviews or "leadership rounding" where staff are regularly asked to share what they enjoy about their work and their frustrations/challenges so that actions can be taken to address issues.**

Environments and structures are used to promote relationships and patient experiences.

The family's general experience with the clinic—how they access appointments, receive information, or feel welcomed—can either promote or be a barrier to a trusting relationship between the care team and the family. We observed sites intentionally designing the structures and environments of their clinics to promote long-term, trusting relationships between parents and the care team, such as:

- **Patients receive continuity of care from a consistent care team.**
- **Processes are in place to ensure on time well-child visits, because in addition to affecting quality metrics and revenue, every missed appointment is a missed opportunity to build a relationship. Timely care communicates respect to families, especially those that travel distances for care and whose employment may be jeopardized by absences.**
- **Creating a welcoming and stimulating environment in the waiting room and clinic for families such as having children's books in multiple languages and reflecting diverse cultures and races; educational posters with community resources; toys and playroom specifically for young children; toys and books in the well-child visit room; and informational handouts.**
- **Expanding telehealth options or virtual check-ins to follow-up with families in between visits or as an option for families with transportation difficulties.**

Implications for going to scale



The described common practices make it evident that enhancing pediatric primary care to better support the social and emotional development of young children is possible. Unfortunately, their reach is still limited as not all families who could benefit have access to pediatric primary care settings that employ these practices. Program developers, staff at the pediatric primary care settings visited, family leaders and the consulting pediatricians on our study team all acknowledged that taking these practices to scale[viii,32] is challenging. This was true for programs that were currently operating in only one or two places as well as those that have been disseminated widely or were in the process of being implemented in multiple sites.

There are two barriers that are likely holding back or limiting large-scale adoption of the identified common practices among pediatric primary care teams nationwide. First, there are **systemic issues** that influence medical practice universally. Second, even if the systemic issues are addressed, thus creating a more conducive environment for change, insufficient attention to factors that are critical to the **readiness and capacity** of pediatric primary care teams and communities may still limit the widespread adoption and installation of the identified practices.

SYSTEM CONSTRAINTS

Time and money (financing systems).

Fundamentally, attending to social and emotional development of young children requires time, both to integrate the common practices described and to foster trusting relationships within care teams and between families and providers. However, care teams frequently face pressure to keep well-child visits short - typically 15-20 minutes. How primary care clinics are reimbursed can also constrain (1) who can provide which services, (2) what they can do, and (3) what they can offer to families outside of the well-child visit. Financing is needed for additional staff to join the care team and work effectively together, staff training and development, materials such as books and toys, coordination of community partnerships, and space to name just a few important aspects of supporting the identified practices. Implementation sites we visited blended multiple funding streams, such as insurance, state and federal grants, and private philanthropy to support their enhanced services to promote social and emotional development.

Data for learning and improvement.

The 2016 report from NICHQ, Ariadne Labs, and EFTC noted "there is an evident need to address the scarcity of existing validated measurement tools and relatively low instances of interventions measuring this critical bond in a standardized way within the context of the pediatric setting."[33] Despite on-going work to develop appropriate measures and measurement tools, this finding is still relevant. There are no routinely collected, universally agreed upon measures in pediatric primary care to help us understand and quantify the benefits or provision of services and interventions to promote social and emotional development and the parent-child relationship during the first few years of life. We observed sites collecting data pertinent to the desired outcome of social and emotional development

[v] We are using the World Health Organization's definition of scale as "deliberate efforts to increase the impact of successfully tested health interventions so as to benefit more people and to foster policy and program development on a lasting basis."

for research studies. However, such data collection may not be feasible in a busy pediatric clinic once the research component concludes. Other implementation sites collected data to satisfy fidelity requirements for national programs or conditions of funders. However, there was limited use of these measures to routinely inform population health management and quality improvement.

Physician training.

An emergent theme was physicians feeling that their education and training did not prepare them to use the strengths-based, relational practices that we observed in many of the visits; nor did it give them guidance on how to explore and address needs around concrete supports and parental mental health. For some, it may come naturally. For others, it takes practice and coaching to get comfortable, and to establish a supportive relationship with parents that builds on, but is not limited to, the doctor's medical expertise.

PEDIATRIC TEAM READINESS FACTORS: PREPARATION AND CAPACITY

Care team development and support.

Many pediatric primary care settings may need encouragement and support to create hospitable and enabling organizational capacity and environments that will increase the likelihood that the implementation of the described common practices will be successful. For example, our consulting pediatricians noted that implementing team "huddles" without the necessary work to build trust and inclusion among the staff may check a figurative box, but could result in an environment that is less able to effectively serve families. As we learned, many sites visited had mechanisms to build a culture of trust and shared decision-making with both clinical and administrative champions. Many had care teams composed of various staff and/or community partners with diverse perspectives and expertise that together supported the child and family. Creating a hospitable culture and a care team with greater diversity requires intentional actions. To fill care team positions, sites emphasized the need to find people with interpersonal relational skills (warmth, empathy, and humility, to name a few) and the capacity to learn the technical skills required of the role they were fulfilling. They also prioritized staff that reflect the language and culture of the patient population, allowing care to be provided in the preferred language of the family and increasing capacity to honor culturally specific parenting practices. These important attributes potentially require special recruitment and training. Installing communication and collaboration routines also requires time, thoughtful planning, and champions.

Training and technical assistance capacity.

Introducing and implementing new practices into the pediatric primary care setting requires training and technical assistance to ensure high quality implementation and outcomes. This support is not readily available to many pediatric clinics. Most care team members at the sites visited received foundational training for program delivery and provided ongoing training to staff in social and emotional development, relational health, trauma-informed care, SDOH, cultural humility, and implicit bias. They also received technical assistance to support implementation and improvement such as integrating new team members, developing workflows, and facilitating case review meetings. Currently, this training and technical assistance is dependent on the capacity of specific national programs and there is little guidance for how to align and coordinate multiple programs that exist within a clinic or community, as we often observed. In addition, there are limited, structured opportunities for clinics to learn from others' lessons learned or successes in a network.

Family partnership in systems change.
Family engagement is important to scaling quality. Parents can provide critical insights into the challenges they face, how problems are exacerbated or addressed by surrounding systems, and their priorities in the design and implementation of services and policies. They also can hold sites accountable for the quality of services and the achievement of family-centered outcomes. We did not see ongoing and robust engagement of families in the implementation and quality improvement at the sites we visited, but we believe this is a need. The lack of capacity to meaningfully engage families could hinder the effectiveness of adoption of the common practices in diverse settings.

Community engagement.
Many care teams understand the challenges families are facing but may hesitate to screen and assess for needs because they do not have a meaningful way to respond in the context of clinical practice. Most families can benefit from access to a range of community resources; however, pediatric primary care settings are limited in their ability to cultivate the many community partnerships they need to ensure they are able to refer and link families to appropriate resources and supports. In addition, there may be gaps in availability of certain resources, resources specific to the unique needs of early childhood, concerns about fit for diverse families and the quality of services, and barriers to accessing them in the community. Pediatric primary care providers need to be effectively linked with broader community efforts to support the social and emotional development of young children.

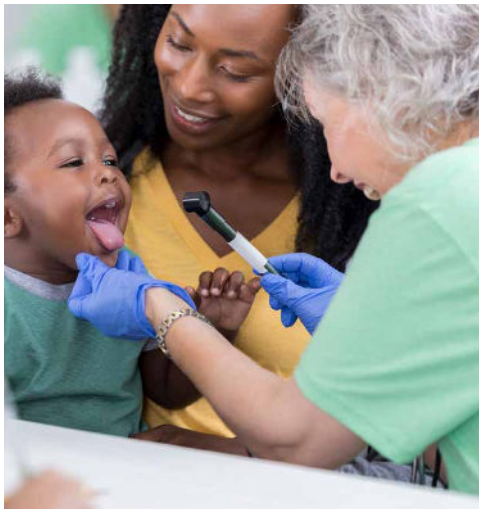
Recommendations

Philanthropic leaders, policymakers, health care payers, pediatric and public health leaders, other child and family-centered providers, researchers, and family-led organizations all have important roles to play as catalysts of reform and capacity builders. The recommendations for their actions offered here build on the steps suggested in the 2016 report by NICHQ, Ariadne Labs, and EFCT, but they are necessarily broad as the scope of the program analysis did not allow for in-depth study of any one of the barriers that would have yielded more specific steps. Nevertheless, we recommend a focus on three areas: **(1) building national leadership for systems change, (2) identification and elimination of specific systemic barriers, and (3) supporting pediatric primary care team and community readiness.** While activities in each of these areas can be initiated immediately, all will require sustained attention over a period of many years. Ultimately, stakeholders should work in concert to advance enhanced pediatric primary care that supports parents to promote the social and emotional development of young children.

1. NATIONAL LEADERSHIP FOR SYSTEMS CHANGE

Although the analysis identified numerous examples of primary care settings supporting parents to nurture their children's social and emotional development, there is not yet a national movement to build the expectation and accompanying financing and infrastructure

to make the practices universal. National leadership is needed to create demand for system transformation, rooted in the belief that universal attention to the parent-child relationship and social and emotional development in pediatrics is achievable and will be good for children, good for families, good for pediatric providers, and good for society. Expanding and institutionalizing these practices involves many stakeholders, but would be particularly powerful if led by two groups of people: pediatric providers and other health professionals who believe that this work is essential and leaders from family-led organizations that represent families and advocate for system responsiveness to family needs.



Supporting leadership in this effort is not a one-time activity. Once launched, it needs to be sustained until results are institutionalized:

Convene and support the development of a diverse set of leaders.
Convening goals include building (1) leadership from among health professionals and organizations, medical schools and residency programs, parents, representatives from other early childhood systems, and policy and law makers; and (2) cross-cutting advocacy, policy development, and communications agendas to accelerate the changes in financing mechanisms, traditional pediatric primary care infrastructure, and community-based systems that are needed to support widespread adoption of practices to promote social and emotional development and the parent-child relationship. Nationally, networks of pediatric leaders could take on an important role in influencing norms of pediatric practice and building enthusiasm and support among their peers. Success of this effort could be measured by the increased attention the issue receives from relevant organizations and policymakers and their related actions; establishment of virtual networks to support collaboration; private funding support through health care affinity organizations; regularly funded in-person conferences or professional journal issues devoted to the significance of social and emotional development and strategies for supporting families; and changes in financing systems and infrastructure.

Make racial equity explicit.
Promoting social and emotional development in pediatric settings is good for all children, regardless of race, gender, ethnicity, or income. It is also an important strategy for reducing disparities in school readiness that exist along racial and socioeconomic characteristics. An explicit connection to racial equity could be demonstrated in several ways. While creating the conditions for all pediatric primary care settings to adopt and adapt the practices identified in this analysis, targeted engagement and support may be given to building capacities of providers serving families in communities experiencing racial and systemic disadvantages, including diversifying the clinical workforce, ensuring language accessibility, and continuous learning in implicit bias and cultural humility. Second, implementation should be accompanied by the capacity to collect, track, analyze, report, and use for improvement outcome data by race/ethnicity. Third, practice change is complemented by advocacy for policies to address the social determinants of health that greatly impact the social and emotional development of young children and disproportionately impact families of color and those with limited incomes.

2. ADDRESSING SYSTEMIC BARRIERS

As previously described, the program analysis revealed three systemic barriers to widespread adoption of the common practices: (1) time and financing constraints, (2) lack of useful data, and (3) gaps in physician training. In general, none of these are new issues for health care as they are the focus of discussion and study by policy makers and the health care profession. Building national leadership as described above can bring greater attention to these issues as they are connected to strengthening the social and emotional development of children. The specific steps offered below will require further refinement by the experts in the field but we believe they are priorities for immediate attention.

Create reliable and sustainable financial support.

Policymakers, supported by both publicly and privately funded research and analysis, should examine health care financing mechanisms to identify what is being done currently or could be done to encourage innovation in health care delivery and ultimately to ensure sustainable financial supports. An example of such analysis is in *Fostering Social and Emotional Health through Pediatric Primary Care: A Blueprint for Leveraging Medicaid and CHIP program to Finance Change* by the Center for the Study of Social Policy and Manatt Health. This new resource is a practical guide for states that identifies strategies to promote social and emotional development as a key component of financing mechanisms for pediatric primary care. The Blueprint was developed based on a thorough review of federal statutes and regulations, Medicaid State Plans and policy documents, managed care contract language, and other resources; and it presents specific tools for implementation. A brief summary of the strategies is provided in the sidebar. With Medicaid and CHIP covering 50% of young children, an immediate next step that state policymakers can take is to capitalize on the opportunities identified in the Blueprint over the next two years while exploring similar and unique strategies with private insurance payers. Finally,

Medicaid and CHIP provide states with opportunities to emphasize benefits and payment strategies that support children's social and emotional development. States can:

- **Cover and support a full range of screening, assessment, and treatment services for children and their parents.**
- Incorporate a focus on social and emotional development into their **statewide quality strategy. This option should be leveraged** to spur changes in pediatric practice by establishing performance and outcome indicators and providing fiscal incentives for improvement.
- Offer financial incentives to health plans and providers to focus on children's social and emotional development, including through enhanced reimbursement for high-performing pediatric medical homes. Therefore, states have the option to **establish payment models that support and incentivize a focus** on the social and emotional development of children.
- **Support the use of team-based care** to make it more feasible for pediatric practices to provide more comprehensive care, connecting families to public benefits and community resources, supporting the parent-child relationship, and promoting social and emotional development. **Medicaid reimbursement for preventative services can be used** to finance expanded care teams including community health workers. **States can also use Medicaid administrative funds** to cover training on relevant topics, such as trauma-informed care, as they relate to the delivery of services.
- The **Children's Health Insurance Program (CHIP),** Medicaid's companion program, also provides some flexibility for financing interventions aimed at supporting children's social and emotional development. **State policymakers can leverage a CHIP Health Services Initiative** which is an activity designed to improve the health of children from families with low-incomes and can cover the costs of direct services or to support public health priorities, such as the operation of poison control centers or intensive lead screening promotion and lead abatement.

where current and existing opportunities in the financing systems are insufficient to achieve adoption of the practices and outcomes at scale, private and public funders and policymakers can partner to support innovative pilots with an eye towards long-term spread. Proposals should also be developed and pursued for federal policy and financing changes that can accelerate and sustain this work across the nation.

Generate data for learning, improvement, and case-making. Policymakers and all insurers should be committed to making sure the public gets the most effective health care and wellness guidance. But knowledge about "what works" to support parents' abilities to foster their children's social and emotional development will remain limited until there are collective efforts to engage in the development and/or universal agreement of a limited set of performance and outcome measures and measurement tools that make sense in the context of how busy pediatric primary care settings currently work. This means that data can be collected without undue burden (of time and cost) to families and staff, meaningfully inform clinical care, create a basis for population health management and quality improvement efforts, and be used to make a persuasive evidence-based case for the value of increased attention to social and emotional development and the parent-child relationship.

One opportunity for advancing this work is state reporting on the Child Core Set measures, developed by the Centers for Medicare & Medicaid Services (CMS).[34] This is a set of children's health care quality measures for voluntary use by Medicaid and CHIP programs and as of 2024, states will be mandated to report on all of the measures. It includes a range of children's health care quality measures encompassing both physical and mental health. According to the authors of the Medicaid Blueprint:

> *"States and other stakeholders could encourage the federal government to incorporate specific measures related to social and emotional development into future versions of the Child Core Set. However, states do not need to wait for the federal government to act. They could develop their own measures that help assess progress on improving social and emotional development. For example, measures related to family experiences and changes in parenting behaviors and social circumstances as a consequence of health care received could be tracked."*[35]

This task can build on measure development work that is currently being invested in by both private and public funders. Additional investments are needed to accelerate development and adoption of the measures by, for example, creating structures to rapidly share current learning among those working on measures development, testing feasibility of data collection in busy pediatric primary care settings, and engaging family-led organizations and professional groups to advocate for quality measurement at scale.

Enhance medical education.

Considerations should include curriculum changes and enhanced opportunities to develop and practice skills in all educational settings for health care professionals: classroom, clinical practicums, internship, and residency. Some programs studied, like Promoting First Relationships® in Pediatric Primary Care, Reach Out and Read™, and Touchpoints®, offer curriculum components that could be transferred into on-going education and medical practice. The training and coaching need not be limited to clinical outpatient practices, but could be expected and coached in all care settings, including in-patient settings. Strength-based observation about the parent-child relationship is important, regardless of the circumstances that bring the family to the attention of a medical provider. In addition, incorporating the principles of strengths-based, relational, and team-based approaches throughout medical education would increases the likelihood of transformation in patient care. This work should be embedded in the planning efforts of groups with influence on medical education and training for pediatric primary care providers, including the American Council of Graduate Medical Education (ACGME), the Association of Pediatric Program Directors, the American Academy of Pediatrics (AAP), the American Board of Pediatrics (ABP), the National Association of Pediatric Nurse Practitioners (NAPNAP), the American Academy of Family Physicians (AAFP), and other professional bodies responsible for accreditation and certification. This planning should begin immediately in order to make a difference for the next generation of families and pediatric primary care providers.

3. ACCELERATING PEDIATRIC TEAM READINESS

Creating greater awareness and advocacy for system and financing reform to support evidence-informed practices will clear the path for more pediatric primary care providers to adopt practices to better support parents and the social and emotional development of their children. However, providers need to be positioned and ready. Thus, policymakers, medical educators, health professionals, and insurance payers can take the following steps, designed to create readiness simultaneous to system transformation.

Support care team preparation and expansion.

Care teams should be prepared to effectively engage in continuous learning about early relational health, trauma-informed care, SDOH, cultural humility, and implicit bias. Support and preparation also includes creating the conditions for effective team communication and collaboration with and for families, such as having routine team meetings to reflect on practice challenges and communicate about family needs. Expanding care teams can effectively distribute the multiple tasks pediatric primary care is being asked to perform: screenings for various needs (developmental, behavioral, basic needs, maternal depression, etc.); linkages to a larger, community-based system of care; and parent support with "just in time guidance and help," etc.

Depending on the community context of the pediatric primary care setting and the needs of families served, the expanded care team may include roles for: (1) parents who have experience navigating services and systems; (2) community health workers specializing in early relational health; (3) mental health specialists; (4) community resource navigators; and (5) legal partners. Medicaid can be used to support expanded care teams. States can take advantage of Medicaid reimbursement for preventive services to finance teams, including community health workers.[36] States that have Medicaid managed care plans can require the plans to "contract with pediatric providers that deploy a team-based approach."[37] Family-led organizations can build awareness among parents about the benefits of these

new roles and care teams to social and emotional development, helping them to make informed choices about where to receive health care. Finally, stakeholders can join together to create comprehensive guidance and metrics that define team-based care in service of social and emotional health for the pediatric medical home.

Support training and technical assistance capacity.

Possible solutions to meeting implementation technical assistance requirements are described below:

- **Establish a network of regional technical assistance/training centers** with a sustainable funding source and institutional home to help pediatric primary care settings identify the changes they want to make to promote social and emotional development and early relational health, and then implement those changes successfully. This would enable the setting and the families they serve to determine what best fits their circumstances, promote effective implementation, and facilitate coordination among existing programs and resources. In addition to practice-specific technical assistance, the centers could include linkage to a range of expertise and tools to support the needed infrastructure, policies, and partnerships. A rich foundation of knowledge and experience exists among the developers and implementers of evidence-based pediatric primary care programs. We also observed an appetite and early action among the programs to share learning, collaborate in local communities, and explore how the "pieces fit together." The center should intentionally build upon that experience and facilitate collaboration and innovation. Such a center would support joint problem-solving and share information and lessons from others tackling similar or related issues in expanding this work.

- **Support networks of pediatric primary care settings to promote joint learning.** Policymakers, state and local organizations (such as state chapters of the AAP), and funders can promote and support networks of pediatric practices working to improve social and emotional development. This can be accomplished by building on the existing strengths found in the networks of national programs (i.e. Reach Out and Read™ affiliates that have trained over 30,000 providers) and established quality improvement networks in states (i.e. QTIP in South Carolina) and, where necessary, form new networks among pediatric primary care settings at the local and state levels. Such networks can accelerate the adoption of effective changes such as how to integrate video feedback to promote early relational health in the well-child visit, implement a case review, solve a medical records problem, or develop strong working relationships with home visiting programs, food banks, and other service providers. As demonstrated by the QTIP collaborative, barriers to effective implementation can be identified across settings and addressed through policy and systems change that is truly informed by practice. States can capitalize on the opportunities presented by Medicaid and CHIP to reward high performance with incentives through managed care contracts or use administrative funds from these funding streams to improve "the delivery of program services by conducting training and practice support for providers. Medicaid administrative funds

can be used, for example, to support pediatric providers in establishing or strengthening a high-performing pediatric medical home and on training related to evidence-based strategies and interventions to improve the social and emotional health of children."[38]

Invest in and incentivize partnerships with family-led organizations in systems change.

Family-led organizations such as Family to Family Health Information Centers (F2Fs) exist in every state, five territories, and three Tribal Nations. They are ready partners that can be enlisted to support family engagement at all levels. The family leaders who run these centers are expert at informing and supporting families to partner with their providers in decisionmaking. They can gather feedback from diverse families in their networks and recruit, support, and mentor families participating in policy and program planning efforts. Rather than inviting individual parents to participate on advisory boards or conducting point-in-time focus groups, partnerships with family-led organizations allow for robust, continuous, and consistent parent voice in the planning, implementation, and ongoing improvement of both clinic and system transformation initiatives. A deeper level of parent engagement and leadership requires both capacity building of health clinics, systems, and policy makers to welcome, integrate, and effectively share decisionmaking with families and making an adequate investment of resources to compensate families for their time and provide them with the mentorship and support to be effective leaders and advocates.

Support emerging community systems designed to promote children's social and emotional development and respond to family needs.

The 2016 NICHQ, Ariadne Lab, EFCT report acknowledged that the best opportunities to address social and emotional development spans multiple settings and that those settings "might be leveraged through collaboration with primary care settings."[39] To this end, rather than each clinic developing partnerships and curating resources to meet the needs of the families they serve, there is a need to expand and strengthen the infrastructure and capacity of local early childhood systems-building efforts. Integrating pediatrics into the local system would create greater access for families to needed supports and services. Sharing of data across pediatrics and early childhood systems[vi] would also allow systems leaders to address gaps in the availability and accessibility of resources, identify trends to inform policy and system change, and improve quality. There are efforts underway to support early childhood community system development (The National Collaborative for Infants and Toddlers, CSSP's Early Childhood Learning and Innovation Network of Communities [EC-LINC], Help Me Grow, and the Early Childhood Comprehensive Systems [ECCS] Collaborative, among others) that could be ready platforms for testing and implementing effective integration of pediatrics into the early childhood system to promote the parent-child relationship and social and emotional development of young children.

Final Reflections

We deliberately chose diverse programs and settings for inclusion in the program analysis. This diversity made the learning richer and the identification of common themes and practices well supported, with multiple examples from large urban and rural clinics to small private suburban pediatric partnerships. All of the implementation site personnel proudly shared their work and their experiences about how they were making real contribution to the well-being of their patients. Our interviews and conversations produced rich learning, and our site visit teams—including parents and pediatricians—were consistently impressed by the work underway.

A common sentiment across all implementation sites was that: "our program is just one piece of the puzzle." None of the program developers and implementers thought that their program was the only approach or strategy for promoting healthy social and emotional development, because by itself, it would not meet all of a family's needs. Rather, they see their programs as fitting into a system that holistically supports families and strengthens relationships. When combined and coordinated with complementary strategies in early childhood education and family support, the programs and strategies have the potential to achieve greater, sustained outcomes for families.

Appendix A: Program Analysis Methodology

This appendix includes (1) the outcome definitions used for the program analysis, (2) an overview of the foundational work behind the research questions, (3) the research questions, and (4) the phases of the analysis from site selection to final synthesis of findings.

The Outcomes of Interest

The program analysis was specifically looking for practices that could be implemented in pediatric primary care settings during well-child visits that would help improve (1) the social and emotional development of children, (2) parent-child relationship, and (3) parents' mental health. For purposes of this analysis, these outcomes were defined as follows:

Social and Emotional Development (SED). *The ability for children to experience, manage and express the full range of positive and negative emotions as well as read the emotions of others; develop close, satisfying, trusting and sustained relationships with other children and adults; and actively explore their environment and learn.*[40,41,42,43] *Importantly, we simultaneously note that a child's capacity for healthy social and emotional development exists in the context of family, community and culture.*[44]

Parent-Child Relationship. *A selective, meaningful, and significant psychological relationship between parent and child that develops through mutual interactions and persists over time.*

Parents' Mental Health: *A parent's state of well-being which allows them to live productively, create and maintain strong relationships, cope with day-to-day stress of life, and adapt to changing circumstances.*

Foundational Research for the Program Analysis

In 2016, NICHQ and Ariadne Labs completed an environmental scan[45] identifying 35 programs that have been shown to be effective in promoting early childhood social and emotional development through rigorous evaluations. Examples of the programs listed include CenteringParenting, Parent-Child Interactive Therapy, and HealthySteps. They are programs that have implementation manuals and required training to help providers adhere to the program elements. It produced a high-level picture of eleven design elements for pediatric well-child visits to achieve these improvements. Subsequently, these 11 elements were consolidated and pared to the four that became the focus of the *Pediatrics Supporting Parents* initiative. These four are as follows:

1. **Assessment.** *The bond between caregiver and child and parental family stressors are assessed through formal screening tools, interactions, and observations.*
2. **Modeling.** *All members of the caregiving team model behaviors that promote socioemotional development.*
3. **Education.** *Provide families with information about socioemotional development and age-appropriate expectations.*
4. **Connection.** *Assess and refer to tailored, concrete resources that families can access during and between visits and help families navigate systems.*

Following the recommendation of the 2016 report to conduct a deeper examination of these elements and associated implementation strategies, these four elements became the focal point for the program analysis. An investigation of the evidence-informed programs was aimed at understanding how these elements are implemented.

Analysis Questions

The program analysis was intended to answer the following research questions:

1. What are effective well-child visit practices for advancing social and emotional development, child-parent bond, and parent mental health? And why are they effective?
2. What can we learn about what has not been effective?
3. How do community conditions and population differences among those served by well-child visits affect implementation strategies? What adaptations are necessary?
4. What promising well-child visit strategies will be most scalable across primary care settings serving low income families and communities of color?
5. What are lessons from exemplar programs on what it takes to scale promising strategies?

Phase I: Site Selection

We completed a literature review and compiled a comprehensive list of potential programs from a variety of sources starting with the 2016 report. We augmented the list with programs drawn from a review of evidence-based registries, suggestions from the PSP Steering Committee, interviews with key experts in the field and a national call for nominations of programs that are in the process of building their evidence and have yet to be listed in any public compendium.

In collaboration with NICHQ and the PSP Steering Committee, we drafted a set of selection criteria to apply in ultimately arriving at list of programs to study further. In applying these criteria, we arrived at 13 programs to investigate further. A detailed description of the selection criteria and entire process is available here: https://cssp.org/resource/pediatrics-supporting-parents-program-analysis-program-and-site-selection-process-and-results/

Phase II: Pre-Visit Preparation

Simultaneous activities during this phase included **telephone interviews** to prepare for the site visit and to gather more in-depth information about the program implementation at the selected sites. It also included development of **on-site data collection protocols.**

The **site-visit scheduling and preparation interviews** gathered and provided information about community and patient characteristics, clinic/office setting and typical well-child visit expectations, staffing patterns and capacities, data capacities, and procedure manuals and fidelity checklists sites may employ. We also explored the degree to which they engage parents and community as partners in service delivery and support for families, and practice governance. Depending on what we learned, we asked to interview members of parent and/or community advisory boards or other arrangements. Finally, these conversations established the scope and requirements of the interviews and observations we would be

able to make on site. For example, we discussed the degree to which observations of specific patient and care team interactions would be allowed and what confidentiality procedures would need to be in place.

Each site visit was unique but the agendas generally included the following activities:

- Interviews with key staff such as national developers, local implementers and clinical staff;
- Interviews or focus groups family members who were receiving or had received services;
- A tour of the practice/ facility; and
- Observations of the program/ intervention in action.

The **data collection protocols** were designed to help the study team learn not only about the strategies themselves and how to implement them effectively, but also about the broader conditions that enable such strategies to be effective (e.g., site leadership, staff skills and knowledge, investment in the necessary infrastructure, community characteristics and resources, community engagement, local/state policy, etc.). The consulting group of pediatricians and Family Voices Program Analysis Advisory group, also known as "The Brain Trust," reviewed all protocol drafts and discussed suggested changes with us. Their comments, questions, and suggestions were used to refine the protocols before the site visits.

Phase III: On-site data collection

On-site data collection was conducted by 4-person teams. The teams were culturally diverse and brought a range of experience and knowledge. Every team had a family leader, who was recruited through Family Voices and often from the area of the implementation site. Each team also included a consulting pediatrician with both clinical and national policy experience and two researchers from the Center for the Study of Social Policy. These different perspectives enriched both the on-site interviews and subsequent analysis of what we heard and learned. After each site visit, the teams debriefed to identify themes and follow-up questions. Site team members also debriefed the visit with the Family Voices Brain Trust to help pull out themes and additional questions raised by what we were learning.

Most site visits were completed in one day. Data collection at each pediatric primary care setting included:

- Observing the pediatric primary care setting environment, care team interactions, and when permitted by parents, well-child exams;
- Interviewing care team members and support personnel (for example, data analysts);
- Interviewing parents; and
- Collecting written materials, including reports, manuals, forms, brochures, etc.

The diversity of programs and locations made each site visit unique. The interview protocol, however, asked similar questions in all settings, aimed at getting a sense of the

pediatric primary care setting and the motivation for implementing the program the team was there to learn about. Topics in some or all of the interviews, depending on the role of the informant, included:

- Results achieved and program adaptations made during implementation;
- Strategies employed to assess child and parent needs, model behaviors for enhancing SED, provide anticipatory guidance and education to support SED, and connect families to community resources;
- Parent/caregiver engagement activities;
- The roles, responsibilities, preparation, and support of care team members;
- Data used for measuring child and family progress and continuous quality improvement;
- Community engagement/collaboration;
- Implementation funding; and
- Implementation and spread challenges.

Phase IV: Analysis/Research Synthesis

Synthesizing the multiple sources of information, which included observations, interviews, and program documentation, we identified the common practices described in this report. As a means of validating the findings, we convened a national meeting that brought together family leaders, physicians, program designers and developers, and site implementation representatives. Participants were asked to comment on and amend the findings we presented. There was universal support for the practices we identified as well as agreement on the challenges of taking any program or practice to scale. Participants also provided guidance about the recommendations that we should advance.

Program Analysis Strengths and Limitations

This analysis has several features that contribute to the validity of the findings. It is also important to acknowledge that the depth of analysis we were able to complete may be affected by some limitations. First, by using a multi-program, multi-site approach, rather than focusing on a single program in multiple sites, this analysis includes a range of approaches in diverse geographies. Second, the analysis included multiple sources of information and perspectives collected from documentation and first-person interviews. The site visit teams included diverse perspectives and experiences that allowed for rich discussions among team members about what they were observing and learning from each visit. After the initial analysis, the findings were vetted with key informants from each site at a national meeting, and the consensus supported the analysis. However, in selecting the programs that would lead to implementations sites, the evidence review was based on the quality of existing evidence or on program efforts to build evidence. Many of these evidence-based programs were not created with the goal of impacting SED and parent-child relationships. Further, there may be other effective programs that did not come to our attention because the necessary research does not exist. We attempted to overcome this limitation by casting a broad search for programs and innovative pediatric practices, who may be building evidence. Scheduling visits to a total of 15 implementation sites as originally planned, was dependent on site availability and scheduling, and program implementation issues kept us from conducting

three planned site visits. We did, however, engage in several conversations with two of the programs we were not able to visit, while leadership turnover at the third site limited our data gathering interviews to the developer and researchers of the program. We also learned that implementation sites did not necessarily have strong data capacities and were not generating information about the specific achievement of the three focus outcomes. Therefore, we were able to gather very little information confirming the effectiveness of program implementation outside of a research setting. Finally, we anticipated challenges to conducting interviews of participant family members, or observing caregivers, and children in well-child exams. While we were not able to make such observations at all sites, we were able to interview caregivers and observe several well-child visits at nearly every site.

Appendix B: Complete Acknowledgments

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CSSP thanks and acknowledges the contributing authors who provided their individual and professional expertise to the development and content of this report, as well as to all aspects of the project. We consulted regularly with The Family Voices Brain Trust and five nationally respected pediatricians, who provided their unique perspectives as parents and pediatricians and guided development of the site visit protocol and participated in site visits. These individuals, along with our close partners at Family Voices, CSSP, and the National Institute for Children's Health Quality (NICHQ), gave initial input on the content of the report and were instrumental in reviewing and editing drafts.

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