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Helping Leaders Advance Child Health Care Transformation

EXEMPLARY AND EVIDENCED-BASED HEALTHY PARENTING IN PRIMARY CARE PROGRAMS, PRACTICES, AND SYSTEMS CHANGE INITIATIVES

Descriptions and Summary from the NASEM Healthy Parenting in Primary Care Scoping Review

July, 2024

Through its initial scoping review, the National Academies of Science, Engineering, and Medicine (NASEM) Healthy Parenting in Primary Care Work Group identified over sixty different programs and practices operating within primary care with a significant research and evidence base for strengthening parenting in primary care that advances healthy child development, as well as a number of system transformation efforts within pediatric systems. The results from this scoping review are described in section two of its report, *The State of Healthy Parenting in Primary Care Interventions to Advance Child Equity* (Damian et.al. forthcoming 2024).

The identified programs and practices covered a wide range of populations, specific objectives, and foci within the primary practice and varied in their degrees of evidence of their efficacy and their ability for successful replication and adaptation within other practices or for other populations. For some, the evidence largely was at a case study level; for others there was extensive research that included experience in replication and diffusion. This represents an initial scoping review and does not include all the emerging practices and experiences in the field. A more extensive scoping review and/or a meta-analysis with research criteria for inclusion would both broaden and deepen understanding of the field of knowledge and the size of expected program impact and even begin to identify programs and strategies with the most potential for strengthening parenting and impacting healthy development at a population level. The system transformation efforts often also had a research component providing very impressive findings of impact (generally of a pre-post nature or in comparison with other pediatric systems), showing the potential for even greater impacts when program and practice changes were combined.

While none may represent a total transformation of pediatric practice to strengthen parenting, the number and breadth and depth of identified programs, practices, and system transformation initiatives showed the potential of primary child health care to truly strengthen parenting and improve healthy child development. It also showed that there are many different components of primary child health where actions can be taken.

The appendix first provides brief summaries of each identified program or practice and systems change initiative. Some are focused upon a very specific aspect of primary child health care, while others involve primary care practice in multiple ways. The appendix then provides a grouping of them in terms of where they seem to best fit within the different components and groupings within those components.

Many of the descriptions are drawn from an excellent review of exemplary practices specific to addressing issues of relational health and descriptions of representative interventions and programs (Li, J., & Ramirez, T. (2023). Early Relational Health: A Review of Research, Principles, and Perspectives. The Burke Foundation. Retrieved at: https://www.gse.harvard.edu/sites/default/files/2023-09/ERH-Report_final.pdf)

BRIEF DESCRIPTIONS OF PROGRAMS AND PRACTICES AND SELECT SYSTEMS CHANGE INITIATIVES

Programs and Practices

Abriendo Puertas. The Abriendo Puertas/Opening Doors program is the nation's first evidence-based, comprehensive training program developed by and for Latino parents with children ages 0-5. It aims to improve the outcomes of the nation's Latino children by building the capacity and confidence of parents to be effective first teachers and advocates for their children. The program focuses on enhancing parenting practices, knowledge of early childhood development, and leadership and advocacy skills to improve the well-being and development of children, ensuring they have a strong foundation for academic success. For more details, visit the official website.

Adverse Childhood Experiences (ACE) Screening. Screening for Adverse Childhood Experiences (ACEs) is a new approach used in pediatric primary care to identify children who have been exposed to potentially traumatic events and to mitigate the long-term effects of such experiences on healthy child development. Different screening tools, including PEARLS, have been used, although they often have not been adapted to a pediatric setting, as the ACEs measures generally accrue through childhood and, particular for young children, may be on the horizon. Some tools are being developed to measure the risk for ACEs occurring, based upon the safety, stress, stability, and nurturing of the home environment. California now provides specific Medicaid coverage for ACEs screening for children.

African American Infant and Maternal Mortality (AAIMM) Doula Initiative This AAIMM Initiative addresses the disproportionately high rates of Black/African American infant and maternal mortality. It aims to increase awareness of the value of doula support in positive birth outcomes for Black individuals and their babies, connect pregnant Black individuals with birth doula services, and ensure Black doulas

have access to workforce development opportunities and are paid a living wage. For more information, visit https://www.blackinfantsandfamilies.org

ABCD Program. The Assuring Better Child Health and Development (ABCD) program was a multi-site initiative supported by the Commonwealth Fund designed to integrate developmental screening and referral into pediatric primary care settings. Its goal is to ensure early identification of developmental delays in children from birth through age three, facilitating timely intervention and support. By promoting universal developmental screening in primary care practices, ABCD seeks to improve long-term outcomes for children by addressing developmental issues as early as possible. This program supports the implementation of standardized screening tools and the development of efficient referral and follow-up systems for children who need further evaluation or services.

Attachment and Biobehavioral Catch-up (ABC). ABC is a strengths-based program of 10 weekly, one-hour home visits focused on enhancing parental sensitivity. The active ingredient for parent behavior change is "in the moment" commentary, which highlights moments that parents are engaging in behaviors known to enhance child attachment and regulation during the session. The first intervention component helps caregivers reinterpret children's behavioral signals so they can provide nurturance even when it is not elicited. The second intervention component helps caregivers provide a responsive, predictable, warm environment that enhances young children's behavioral and regulatory capabilities. The third intervention component helps caregivers decrease behaviors that could be overwhelming or frightening to a young child. For more information, visit https://www.abcintervention.org.

Brazelton Touchpoints. The Brazelton Touchpoints Approach is an evidence-based professional development program rooted in the understanding that children's developmental spurts (Touchpoints) can disrupt the family system, presenting both challenges and opportunities for growth. It emphasizes the importance of building positive relationships between families, young children, professionals, and communities, aiming to engage families effectively during critical periods of child and family development. Through Touchpoints, professionals and parents can work together to anticipate and navigate these developmental milestones, supporting the child's healthy growth and family resilience. For further information, explore Brazelton Touchpoints and Central Michigan University's overview.

Centering Parenting. Designed as a continuation of Centering Pregnancy, and also functioning as a standalone care delivery option, Centering Parenting is a dyadic model of group care during a child's first two years of life. During nine sessions within 6-7 months, a clinician provides pediatric group care with individual well-baby health assessments, immunizations, and screenings. A clinical provider and co-facilitator guide group discussions on such topics as safe sleep, nutrition, and early language. Caregivers engage in their infants' care and discuss questions and health or safety concerns in a supportive peer-learning community. For more information, visit https://centeringhealthcare.org

Centering Pregnancy. This 10-session model of group prenatal care assists women and support partners throughout their pregnancies. Each session brings 8–10 women due at the same time together with clinicians for 90–120 minutes, giving pregnant mothers more time with their healthcare providers and peers. Providers lead activities and facilitate discussion on such topics as relationships, breastfeeding, and depression to build community and support better health. Moms engage in their care by taking

their own weight and blood pressure and recording their own health data and having private time with their provider for belly check. For more information, visit https://centeringhealthcare.org.

Child First. Child First is an intensive, two-generation intervention aimed at very young children and their families who are experiencing high levels of stress due to factors such as violence, neglect, mental illness, or substance abuse. It operates on a national scale, providing mental-health, home-visiting services to build strong, nurturing, and responsive relationships between parents and children. This approach is designed to shield children's developing brains from the harmful effects of trauma and stress, promoting healthy development focused on learning rather than survival. For more details, visit Child First.

Circle of Security Parenting (COS-P) COS-P is an attachment-based parent education program to improve caregiver-child relationships and enhance secure attachment. Trained facilitators use stock video clips of caregiver-child interactions, then pause at designated moments to add information, ask reflection or discussion questions, and engage participants in exercises. The program aims to help caregivers: (1) understand their child's emotional world by learning to read emotional needs, (2) support their child's ability to successfully manage emotions, (3) enhance the development of their child's self-esteem, and (4) honor their own innate wisdom and desire for their child to be secure. For more information, visit https://www.circleofsecurityinternational.com

Collaborative Problem-Solving Approach. The Collaborative Problem-Solving Approach (CPS) is an evidence-based method designed to aid children with behavioral challenges. Developed at Massachusetts General Hospital, this approach is centered around the belief that children do well if they can, focusing on the idea that challenging behavior stems not from a lack of will but from a lack of crucial skills such as problem-solving, flexibility, and frustration tolerance. CPS works by identifying the specific skills a child needs to develop and partnering with them to build these skills, thereby finding lasting solutions to problems that are agreeable to everyone involved. It has been proven to reduce challenging behaviors, decrease stress among teachers and parents, and improve parent-child interactions as well as children's executive functioning skills. This approach not only teaches kids the skills they lack but also fosters stronger relationships between children and the adults in their lives, making it a compassionate and effective strategy for managing challenging behaviors. For further exploration of the CPS approach, visit Think:Kids .

ECHO training. Project ECHO (Extension for Community Healthcare Outcomes), a product of Arizona Statue University's College of Health Solutions, fosters continuous learning through virtual meetings of interdisciplinary specialist teams and health care professionals. Through case-based learning, health care professionals gain the expertise to manage complex patient cases locally, ensuring patients receive high-quality care close to home. Specialists stationed at a central "hub" collaborate with primary care providers, and through case-based learning help them develop essential skills for delivering specialized care services. The driving force behind Project ECHO is the movement to democratize medical knowledge and amplify local capacity to address the needs of the most vulnerable patients by equipping communities with the right knowledge, at the right place, at the right time. ECHO has been used in pediatric practice settings to respond to both medically complex children and children with social and relational health complexities. Mississippi Thrive! Employed the ECHO training as a core part of its primary child health transformation initiative. For information on ECHO, see: https://chs.asu.edu/project-echo. For information on Mississippi Thrive, see: https://mississippithrive.com/.

Family Check-Up (FCU) FCU is a brief, strengths-based program tailored to families' individual needs. It consists of a 3-session sequence grounded in motivational interviewing that includes: (1) an initial interview that involves rapport building and motivational interviewing to explore parental strengths and challenges related to parenting and the family context; (2) a family assessment that includes parent and child questionnaires, a teacher questionnaire for children in school, and a videotaped observation of family interactions; and (3) tailored feedback that involves reviewing assessment results and discussing follow-up service options for the family. Caregivers and providers decide together which follow-up services can help the families reach their goals, which may involve engaging with a structured 12-module curriculum addressing the caregiving environment (e.g., positive behavior support, limit setting and monitoring, and relationship quality). For more information, visit https://fcu.uoregon.edu

Family Connects. This evidence-based model supports whole-person, integrated health for all families of newborns at a moment of life-changing transition. Newborns' primary caregivers, including foster, adoptive, and bereaved parents, are offered a Family Connects visit shortly after the baby's birth. Often, this invitation is extended in the hospital, but families of newborns learn of the program via other channels, including pediatricians, OB-GYNs, and community agencies. Family Connects nurses visit the homes of the newborns in their communities, providing health checks for both the infant and the birth mother. The nurse documents the visit — including physical assessments and community referrals — and relays the appropriate information to the family's healthcare providers. In some cases, the nurse recommends longer-term programs, such as Healthy Families America and Early Head Start. For more information, visit https://familyconnects.org/

Family Foundations. Family Foundations is a program designed for expectant parents and focuses on enhancing coparenting, parenting, and child self-regulation. This evidence-based series of classes, offered both before and after the birth of a child, aims to support couples by addressing individual parent adjustment (including stress, depression, anxiety), fostering coparenting cooperation and support, and promoting early parenting sensitivity. Research shows that participation in Family Foundations leads to significant improvements in all these areas, contributing to a higher sense of parental competence, reduced parenting stress, and more positive parent-child interactions. The program has been linked to lower levels of anxiety and depressive symptoms among mothers, enhanced coparenting relationships, and reduced negative parenting behaviors, including harshness and physical punishment. Children of parents who participated exhibited better emotional adjustment and fewer behavioral problems. For more detailed insights and findings on the impact of Family Foundations, visit CEBC detailed program overview and Penn State's research on the program's resilience.

Family Nurture Intervention (FNI). FNI helps mothers and their preterm infants reestablish emotional connection and autonomic co-regulation if they have been interrupted. During FNI, a trained Nurture Specialist works with the family to help facilitate emotional connection. Each facilitated session is a calming session, with mother and baby being together physically and emotionally until both are calm. With practice, calming-cycle interactions take less time for mother and infant to lower stress levels and calm each other. For more information, visit https://nurturescienceprogram.org

Family Spirit Program. The Family Spirit Program is a culturally tailored home visiting intervention aimed at supporting caregivers from pregnancy through early childhood. Developed with Indigenous communities, it's delivered by Native American paraprofessionals to promote children's development across various domains. The program includes a core curriculum of 63 lessons and has shown significant

outcomes in improving parenting knowledge and skills. For more details, you can visit the program's page on the Johns Hopkins Center for Indigenous Health website.

Filming Interactions to Nurture Development (FIND). This 10-week video coaching intervention begins with videotaping caregivers and their children interacting in everyday activities. Coaches then use clips of adult-child interactions to highlight and reinforce serve-and-return interactions in a practical, strengths-based way. Within the context of FIND, five specific elements of serve-and-return are emphasized, with one element introduced in each coaching session. The elements are: (1) Sharing the Child's Focus, (2) Supporting and Encouraging, (3) Naming, (4), Back and Forth Interaction, and (5) Endings and Beginnings. For more information, visit https://www.thefindprogram.org

Health Leads. Health Leads focuses on addressing the social determinants of health within pediatric and primary care practices. Founded in the mid-1990s,, the program recognizes that health outcomes are significantly influenced by non-medical factors such as access to nutritious food, stable housing, and reliable transportation. By integrating social care into the healthcare system, Health Leads aims to ensure that all patients have access to the basic resources necessary for good health. Health Leads operates by placing trained volunteers, often college students, in clinical settings where they work directly with patients and families. These advocates assist in identifying social and environmental needs that may affect a patient's health, such as food insecurity, inadequate housing, or lack of employment and connect patients with local resources and support services to address these needs. A key element of Health Leads is its collaborative approach, involving healthcare providers, patients, community organizations, and a network of social services. Health Leads continues to operate in various healthcare settings across the United States, evolving its model to meet the changing needs of communities.

Group Well-Child Visits. Group well-child visits have been employed effectively to enable children not only to receive regular medical examinations from a pediatrician, but also to interact with other parents and receive additional information and guidance around parenting and supporting healthy and age-appropriate child development. They sometimes also have been developed as DIGMA's (drop-in group medical appointments). Group well-child visits can employ more team-based and interaction than is available in traditional well-child visits, and make it more possible to respond to the full range of anticipatory guidance recommended in Bright Futures. For an overview, see: https://publications.aap.org/pediatrics/article-abstract/141/1_MeetingAbstract/41/1681/Redesigning-Primary-Care-Well-Child-Visits-A-Group?redirectedFrom=fulltext

Healthy Families America (HFA). Healthy Families America is a leading evidence-based home visiting program designed to support and strengthen families during pregnancy and the early years of a child's life. Aimed at improving healthy child development, HFA focuses on building positive parent-child relationships, enhancing child health and development, and promoting positive parenting practices. The program is particularly targeted at families considered at-risk due to socioeconomic challenges, health disparities, or other stressors that may impede a child's development. HFA can be utilized in pediatric primary care as a referral resource for families who can benefit from additional support. Pediatricians and healthcare providers play a crucial role in identifying families who might be at risk and connecting them with HFA services. Sponsored by Prevent Child Abuse America (PCA America) since its inception in the early 1990s, PCA America provides the framework, standards, and support for local agencies to deliver the program effectively, ensuring fidelity to the model that research has shown to be effective in improving child and family outcomes.

Healthy Steps. A team-based pediatric primary care model, Healthy Steps promotes the health, well-being, and school readiness of babies and toddlers, with an emphasis on families living in low-income communities. It integrates a child development expert, the Healthy Steps Specialist, into the pediatric primary care team to support young children's social-emotional, cognitive, and behavioral development, all via a two-generation lens. The Healthy Steps Specialist also supports caregivers by addressing parental depression, social determinants of health, and adapting to life with a baby or toddler. All children ages birth to three and their families receive a set of screenings and needed follow up. Follow-up can be short term for mild concerns or include co-managed well-child visits alongside the primary care provider for more intensive support. For more information, visit https://www.healthysteps.org

Help Me Grow (HMG). Help Me Grow is an innovative program designed to enhance early childhood development through the integration of community resources and pediatric primary care. Established to identify children at risk for developmental and behavioral problems, HMG facilitates early detection and intervention, generally through telephone care coordination. The program emphasizes the importance of universal developmental surveillance, screening, and timely referrals to developmental and behavioral services for families in need. In pediatric primary care settings, HMG is utilized to streamline the process of connecting children and their families with essential services. By working closely with healthcare providers, HMG enables the early identification of developmental concerns during routine health checks. This proactive approach ensures that interventions are provided as early as possible, which is critical for the child's developmental trajectory.

Integrated Care for Kids (InCK) Initiative. The Integrated Care for Kids (InCK) Initiative is a multi-state innovation demonstration program supported by the Center for Medicare and Medicaid Innovation (CMMI) designed to improve child health and well-being through integrated pediatric care models. It targets children at risk of poor health outcomes by coordinating healthcare, behavioral health, and social services. This holistic approach aims to streamline access to necessary services, thus addressing health disparities and improving overall health and developmental outcomes for children. For more details, please refer to official resources or healthcare providers involved in the InCK Initiative.

Incredible Years Parent Training Program. The Incredible Years is a group-based behavioral training approach to improve parenting skills of caregivers of children with, or at risk of developing, conduct problems. Trained facilitators use video case analysis and role play to prompt discussion, problem-solving, and idea sharing on such subjects as setting limits, handling misbehavior, play skills, and praise and rewards. The parenting programs are grouped according to age: babies (up to 12 months), toddlers (1–3 years), preschoolers (3–6 years), and school age (6–12 years). For more information, visit https://www.incredibleyears.com

Infant/Early Childhood Mental Health Consultation (IECMHC) program. IECMHC is a preventive intervention aimed at enhancing the social-emotional development of children from birth through age six. IECMHC works by offering direct support to pediatricians, early childhood educators, and other caregivers, enabling them to better understand and meet the mental health needs of infants and young children. This includes training on recognizing early signs of emotional distress, implementing developmentally appropriate practices, and fostering nurturing environments that support optimal mental health and development. Operational since the early 2000s, the IECMHC program has grown significantly, reflecting an increasing recognition of the importance of mental health in the early years. Through its focus on early intervention and prevention, the program aims to mitigate the impact of

stress and trauma on young children, thereby supporting their emotional and psychological development and preparing them for a healthier future.

The Infant Health and Development Program. The Infant Health and Development Program (IHDP) was a comprehensive intervention aimed at improving outcomes for premature and low birthweight infants. Sponsored by the Robert Wood Johnson Foundation, it operated from 1985 to 1988. The program combined home visits, parent group meetings, and pediatric care to support children's development and health up to age 3. Its goal was to enhance cognitive, behavioral, and health outcomes, showing significant benefits in early childhood development for participants.

Infant-Parent Psychotherapy (IPP). Infant-Parent Psychotherapy is an evidence-based treatment aimed at strengthening the parent-child relationship. It focuses on creating a positive bond between parents and young children, targeting ages 0-3, to lay the foundation for a strong, ongoing relationship. IPP has shown that a secure infant-parent attachment leads to numerous positive outcomes for the child, including improved problem-solving abilities, better peer relationships, higher self-esteem, and increased empathy. It is particularly beneficial for parents dealing with issues like postpartum depression, anxiety, and trauma, as well as children facing behavioral, sleep, and regulation difficulties due to life changes. For more information, you can visit Manhattan Psychology Group.

Medical-Legal Partnership (MLP) program. The MLP program integrates legal services into pediatric primary care to address and mitigate the non-medical determinants of health affecting child development. Recognizing that legal and social issues often underpin health disparities, MLPs provide families with direct access to legal professionals within the healthcare setting. These professionals are equipped to handle issues such as inadequate housing, food insecurity, education barriers, and insurance disputes, which can significantly impact a child's health and development. The MLP model has been operational since the early 1990s, with the first program established at Boston Medical Center. Since then, it has expanded nationwide, with hundreds of partnerships formed across the United States. This growth reflects the recognition of the critical role that legal and social services play in supporting pediatric health and ensuring a holistic approach to child development.

Minding the Baby. The "Minding the Baby" (MTB) program, developed by Yale University, is a preventive and interdisciplinary home visiting intervention aimed at first-time young families. It focuses on promoting positive health, mental health, life course, and attachment outcomes through an intensive, reflective parenting approach. The program emphasizes the importance of building strong, nurturing relationships between parents and infants to support families and mitigate the effects of chronic stress. For more information, visit the Yale School of Medicine's page on Minding the Baby.

Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Interventions. NAS Interventions address the opioid epidemic by supporting enhanced care and treatment for mothers and infants affected by opioid use. NAS initiatives develop or enhance programs for opioid-exposed infants at risk of developing NAS and pregnant and postpartum women with opioid use disorder through a dyadic care model, providing rooming-in care for the mother and infant for the duration of the infant's inpatient stay. Many initiatives also offer integrated pre- and postnatal supports, including coordinated access to behavioral health care, medication-assisted treatment, education and support for breastfeeding, and early intervention programming for full family care both in the hospital and in the community after discharge. For more information, visit https://mass.gov/HPC

Mount Sinai Parenting Center. The Parenting Center supports parent-child relationships and early child development within everyday healthcare interactions. It trains staff to use everyday healthcare interactions and physical spaces to deliver information about early child development. Projects at the Parenting Center include: (1) Keystones of Development, an online curriculum that demonstrates how providers can promote brain development and help strengthen parent-child relationships within routine well-child visits; (2) Sparks Parent Video Series, a free video curriculum for parents that blends social-emotional-cognitive development with medical, safety, sleep and nutrition topics, and promotes parenting behaviors that research has proven to help child health outcomes; and (3) Caring For Your Newborn, a 35-minute newborn education and discharge class that addresses routine infant care, common parent questions, and ways to promote brain development and parent-child connection. For more information, visit https://www.parenting.mountsinai.org

Newborn Individualized Developmental Care and Assessment Program. The Newborn Individualized Developmental Care and Assessment Program (NIDCAP) is an innovative approach in neonatal care focusing on adapting the caregiving environment to meet the developmental needs of each newborn, especially premature and medically fragile infants. It emphasizes observation of the baby's cues to tailor interventions that support development, promote parent-infant bonding, and reduce stress. NIDCAP Federation International sponsors the program, which has been operational since the 1980s. This program has shown to improve long-term developmental outcomes, enhance family satisfaction, and potentially reduce hospital stay lengths. For more detailed information, visiting the official NIDCAP website is recommended.

Nurse-Family Partnership (NFP) In NFP, specially-educated nurses regularly visit young, first-time moms-to-be, starting early in the pregnancy and continuing through the child's second birthday. Expectant moms receive the care and support they need for a healthy pregnancy from a nurse who becomes a trusted resource they can rely on for advice on safely caring for their child and taking steps to provide a stable, secure future. Through the partnership, the nurse provides new moms with the confidence and the tools to support a healthy start for their babies and to envision a life of stability and opportunities for success for mom and child. For more information, visit https://www.nursefamilypartnership.org

Parent-Child Interaction Therapy (PCIT). Parent-Child Interaction Therapy is a dyadic behavioral intervention for children (ages 2-7) and their parents or caregivers designed to enhance parent-child relationships and alter interaction patterns. Developed in the 1970s, it integrates aspects of play therapy and behavioral therapy. The program focuses on two primary components: Child-Directed Interaction (CDI) and Parent-Directed Interaction (PDI). In the CDI phase, parents are coached to adopt an approach of play that is child-led, aiming to foster positive interactions and strengthen the parent-child bond. Techniques such as praise, reflection, imitation, and enthusiasm are emphasized, while avoiding criticism, questions, and commands. The PDI phase teaches parents specific techniques to manage challenging behaviors effectively, establishing clear expectations and consistent consequences. Sessions are typically conducted weekly, with therapists observing interactions through a one-way mirror and providing real-time feedback to parents via an earpiece. PCIT is now implemented in pediatric practices and mental health settings globally, adapted to meet diverse cultural contexts and family structures.

Parents as Teachers (PAT) PAT supports families by matching parents and caregivers with trained professionals who make regular personal home visits during a child's earliest years — from prenatal

through kindergarten. This partnership supports early detection of developmental delays and health issues and helps parents understand their role in encouraging their child's development. PAT develops curricula that support a parent's role in promoting school readiness and healthy development, embracing learning experiences that are relevant and customized for the individual needs of each family and child. For more information, visit https://parentsasteachers.org

PEARLS. The Pediatric ACES and Life-Events Screener (PEARLS) is a seventeen-item screening tool that starts with the ACEs questions but extends to other social determinants of health. The PEARLS tool was developed as part of the BARC Pediatric ACEs Screening and Resilience, a partnership between the Center for Youth Wellness, UCSF Benioff Children's Oakland, and the Adversity Bio- Core (ABC) Bank at the UCSF School of Medicine and Pharmacy. It has been used extensively in California. Adverse Children Experiences have been shown in adults to be associated with many adverse health outcomes, but generally accrue over childhood so young children, in particular, generally have fewer ACEs and screening just for ACEs only identifies a portion of those who are at-risk for adversity and related trauma and stress. The screening tool is available at: https://www.acesaware.org/wp-content/uploads/2019/12/PEARLS-Tool-Child-Parent-Caregiver-Report-De-Identified-English.pdf

Pediatric Community Health Workers. Employing Community Health Workers (CHWs) in primary child health care has been shown to improve both parental nurturing and child health and development by serving as vital links between healthcare systems and communities and offering education, support, and navigation services that are culturally and linguistically tailored to children and families receiving primary pediatric care. They can play a crucial role in promoting vaccinations, nutritional practices, and preventive care, thus reducing hospitalizations and emergency room visits. Examples of practices utilizing CHWs extensively include home visiting programs for newborns, asthma management education, obesity prevention initiatives, and family strengthening and support in poor and underserved communities, demonstrating improved outcomes in child health across various settings. They come by many names, including family navigators, accompagneurs, health coaches, and relational care coordinators. Doulas are recognized as CHWs who provide perinatal services to support pregnancy and the first year of life.

Play and Learning Strategies (PALS). The Play and Learning Strategies (PALS) program is a comprehensive, evidence-based intervention designed to strengthen the parent-child relationship and enhance child development through play and learning activities. PALS focuses on improving children's social, emotional, and cognitive skills by teaching parents how to effectively engage with their children in a supportive and developmentally appropriate manner. Implemented in pediatric primary care settings, PALS is integrated into the routine care provided to young children, making it accessible to families who may not otherwise have access to such resources. Pediatricians and healthcare providers are trained to deliver the program, offering guidance and tools to parents during regular check-ups. Operational since the early 2000s, PALS has undergone numerous evaluations demonstrating its effectiveness in improving parent-child interactions and child outcomes.

PlayReadVIP, formerly the **Video Interaction Project (VIP)** This evidence-based parenting program uses videotaping and developmentally-appropriate toys, books, and resources to help parents use pretend play, shared reading, and daily routines as opportunities to strengthen early development and literacy for their children. VIP sessions take place in pediatric clinics on days of routine well-child visits. At each session, families meet individually with an interventionist for approximately 25 minutes. VIP helps build

parenting skills and self-efficacy in low-income families by using and building on the Reach Out and Read model using pediatric primary care as a platform for reaching high-risk families. VIP 0–3 is designed for parents of infants and toddlers and can be complemented by an additional component for families with children aged three to five. For more information, visit https://www.videointeractionproject.org

Power of Two. Power of Two helps families heal from the root causes of trauma, helps children thrive, and strengthens community cohesion. The program promotes healthy early childhood development for infants living in poverty and experiencing other ongoing, serious stressors. It implements Attachment and Biobehavioral Catch-Up (ABC), a home visiting program of targeted parent coaching sessions. In addition, Power of Two provides families with comprehensive referrals to resources offered by trusted partners in the community. Program graduates also can take part in community building and advocacy initiatives. For more information, visit https://powerof2.nyc/

Prescription for Play. Prescription for Play emphasizes play's critical role in early childhood development, particularly in the first two years of life. Pediatricians are encouraged to promote play at every well-child visit, offering strategies for incorporating play into daily interactions. This approach supports physical, social-emotional, language, literacy, and cognitive development through various play activities tailored to different developmental stages, from infants to preschoolers. The American Academy of Pediatrics highlights that simple and inexpensive items can enhance children's play, underscoring play's accessibility and importance for child well-being. For more insights, visit the American Academy of Pediatrics' page on the Power of Play in Early Childhood.

Pri-Care. The Pri-Care program is designed to integrate primary care with specialized pediatric services. It emphasizes continuity, comprehensive care, and close coordination between primary care providers and pediatric specialists. Essential features of the Pri-Care program include a patient-centered model that focuses on preventive care, early detection of health issues, and management of chronic conditions. It employs a multidisciplinary team approach, where pediatricians, family physicians, nurse practitioners, and pediatric specialists collaborate to provide tailored care plans for each child. Currently, the Pri-Care program operates across various healthcare settings, including hospitals, community clinics, and private practices. It leverages technology, such as electronic health records and telehealth platforms, to facilitate communication among care providers and to provide accessible, high-quality care to children and their families.

Project DULCE (Developmental Understanding and Legal Collaboration for Everyone). DULCE is known for its innovative approach that combines legal, health, and community resources to support families with infants in pediatric care settings. It emphasizes the importance of early child development and addresses social determinants of health, aiming to ensure that every family has access to the support and resources they need for their children to thrive. It focuses upon the first six months of life and incorporates a developmental specialist with the pediatrician in the well-child visit.

Project LAUNCH. Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) is a federal initiative designed to foster the wellness of young children from birth to 8 years by addressing the physical, emotional, social, and behavioral aspect of their development. The program aims to improve the systems that serve young children using evidence-based strategies, thereby preventing or minimizing the impact of mental, emotional, and behavioral disorders. It integrates health, behavioral health, early education, and family support services to ensure a comprehensive, holistic approach to

supporting child well-being and development. For detailed information, please refer to the official Project LAUNCH website or contact your local health department.

Promoting First Relationships. (PFR) PFR trains providers to implement a 10-week strengths-based home visiting program based on infant mental health principles and attachment theory. Designed for caregivers and children aged 0–3 in the welfare system (e.g., during or after foster care placement), PFR videotapes caregiver-child interactions, then engages parents in conversations to build confidence and support caregivers to read nonverbal cues, comfort children when distressed, and understand social and emotional needs. For more information, visit https://pfrprogram.org

Reach Out and Read (ROR) ROR is a pediatric early literacy program that partners with pediatricians to prescribe books and encourage families to read together. It seeks to maximize the impact of primary pediatric care on positive early development by supporting daily, language-rich interactions with caregivers. Program components include education and guidance about reading aloud as part of routine preventive care, picture book gifts at check-ups between 6 months and 6 years of age, and volunteers in waiting rooms to read to children and model effective strategies. For more information, visit https://reachoutandread.org

SafeCare. The SafeCare program is a structured, evidence-based intervention designed to improve the health and safety of children and reduce the risk of neglect and abuse among families with children aged 0 to 5 years. It connects with pediatric primary care by providing parents with the skills and knowledge necessary to care for their children's health, safety, and developmental needs, complementing the preventive and health promotion efforts of pediatric primary care providers. Key features of the SafeCare program include home visits by trained professionals who deliver modules on health care, home safety, and parent-child interactions. These modules are tailored to meet the specific needs of each family, focusing on practical skills such as recognizing symptoms of common childhood illnesses, performing basic first aid, ensuring a safe home environment, and enhancing positive parent-child interactions. Originating in the early 2000s, SafeCare was developed by researchers and clinicians aiming to address gaps in services for at-risk families. It is based on principles of behavioral health and seeks to empower parents with the tools they need to provide safe and nurturing environments for their children.

Safe Environment for Every Kid (SEEK). The Safe Environment for Every Kids is a screening tool for use in pediatric practice to support practices in responding to social determinants of health that jeopardize healthy child development. SEEK is generally recognized for its focus on preventing abuse, neglect, and maltreatment of children by integrating child maltreatment prevention into primary care. It aims to create a safe environment for every kid by addressing underlying risk factors like parental depression, substance abuse, and stress, promoting the health, development, and well-being of children.

Simple Interactions. (SI) SI is a practice-based, strengths-focused, and community-driven approach to support practitioners who serve children, youth, and families. Using the Simple Interactions Tool, practitioners can identify, describe, and reflect back to caregivers and families moments that embody one or more underlying dynamics of a developmental interaction: connection, reciprocity, inclusion, and opportunity to grow. To develop the training, the SI team uses video to capture authentic and unscripted interactions between adults and children in everyday settings. The tool can be used with or without videos. For more information, visit https://www.simpleinteractions.org

Small Moments … Big Impact. Small Moments … Big Impact includes a number of short videos on select topics related to parenting that can be chosen for viewing in the well-child visit by the child health practitioner to foster more meaningful interactions with parents around their roles in nurturing healthy development. The videos also can be accessed online by parents on line. By showing parents presenting and in active roles, the videos affirm the positive role parents play in their child's health. See: https://smallmomentsbigimpact.com/

SMART Beginnings Starting shortly after birth, SMART Beginnings is a universal primary prevention strategy that promotes school readiness in low-income families by targeting positive parenting practices in pediatric primary care settings (e.g., pediatric clinics) during well-child visits through the Video Interaction Project (VIP). VIP involves recording and discussing play and interactions between the caregiver and child, the parent receiving a toy or book, and shared completion of a pamphlet with additional suggestions. For more information, visit https://steinhardt.nyu.edu/ihdsc/projects/smart

Strengthening Families Program. (SFP) SFP is a drug-prevention family skills-training program for high- and average-risk families. Sessions cover such topics as appropriate developmental expectations, positive family communication, and consistent and effective discipline. SFP includes time for caregivers and children to interact in family sessions to practice skills including positive interactions and communication. For more information, visit https://strengtheningfamiliesprogram.org

Strengthening Families Protective Factors Framework. The Strengthening Families Framework is a research-informed approach to increase family strengths, enhance child development, and reduce likelihood of child abuse and neglect. It is based on engaging families, programs, and communities in building five key Protective Factors: (1) parental resilience, (2) social connections, (3) knowledge of parenting and child development, (4) concrete support in times of need, and 5) social and emotional competence of children. Strengthening Families is implemented through small but significant changes in daily practice, supported by shifts at the program level that allow workers to make those changes. A number of tools are available to support those shifts in practice. For more information, visit www.strengtheningfamilies.net or https://cssp.org

Survey for the Well-being of Young Children (SWYC). Developed by Tufts University, the Survey of Well-being of Young Children (SWYC)™ is an open-source, comprehensive screening instrument for children under 5 years of age. The SWYC was written to be simple to answer, short, and easy to read. The entire instrument is drawn from validated screening questions and covers different topics. It requires 15 minutes or less to complete and is straightforward to score and interpret. The Family Checklist is one of the screening topics and addresses social determinants of health. Source: https://www.tuftsmedicine.org/medical-professionals-trainees/academic-departments/department-pediatrics/survey-well-being-young-children

Thirty Million Words (TMS). The Thirty Million Words initiative is a program designed to harness the power of parent-child communication to foster early brain development and improve lifelong learning outcomes for children. Rooted in research that shows a significant gap—in the order of thirty million words—between children from language-rich and language-poor environments by age three, TMW aims to bridge this gap through education and empowerment of parents and caregivers. The connection with

pediatric primary care is pivotal; TMW integrates into routine pediatric visits, utilizing these touchpoints as opportunities to educate parents about the importance of early language exposure. Pediatric healthcare providers are trained to deliver key TMW messages, emphasizing the three T's: Tune In, Talk More, and Take Turns. Originating from academic research in early childhood development and linguistics, TMW was officially launched in the early 2010s. Currently, TMW operates through various channels, including direct partnerships with healthcare providers, community-based workshops, and digital platforms offering resources and support to families. It has expanded its reach beyond the initial pilot sites to national and international communities.

Triple P Positive Parenting Program. The Triple P Positive Parenting Program is a multifaceted system designed to provide parents with the skills and strategies they need to manage their children's behavior in a positive and constructive manner. It aims to reduce stress in parenting and improve the emotional and behavioral outcomes of children. The program offers various levels of intervention, from broad informational seminars to intensive one-on-one sessions, making it adaptable to the diverse needs of families. In pediatric care, Triple P is used to support parents, improve parent-child relationships, and contribute to better child health and well-being outcomes.

Video Feedback Intervention to Promote Positive Parenting-Sensitive Discipline (VIPP-SD) VIPP-SD is a home visiting model that involves making video recordings of diverse parent-child interactions in everyday play situations and discussing them. The caregiver and certified intervener work together on increasing caregivers' (1) knowledge of child development, (2) skill in observing and responding to their children's signals, (3) capacity to empathize with their children, and (4) use of appropriate discipline strategies. VIPP-SD has been adapted for specific populations, including families with infants (VIPP), families with children who have autism (VIPP-AUTI), children in foster care (VIPP-FC), and second-generation Turkish families (VIPP-TM). For more information, visit https://www.universiteitleiden.nl/en/vipp

Vroom Vroom is an online platform that shares early brain development tips, strategies, and knowledge with caregivers and communities. The tips bring attention to brain-building opportunities to promote language development, executive function skills, and serve-and-return interactions between children and the adults during such everyday moments as mealtime, bath time, and trips to the grocery store. For more information, visit https://www.vroom.org.

WE CARE. We Care at Boston Medical Center is a fairly simple intervention that integrates social determinants screening with a resource and referral to appropriate services and additional staff support to follow-through and with the family in accessing what they want and need. It stresses developing strong clinician buy-in, being flexible in implementation, securing and listening to family feedback, and continually learning in going forward. For more information: https://www.bmc.org/pediatrics-primary-care/we-care/we-care-model

Well Visit Planner (WVP) and Cycle of Engagement (CoE). The Well Visit Planner and Cycle of Engagement Program, designed by the Child and Adolescent Health Measurement Initiative (CAHMI), is aimed at optimizing pediatric care experiences and outcomes. This tool enables parents to customize well-child visits based on their child's specific health needs and developmental stages, ensuring a more

focused and effective visit. By facilitating pre-visit planning and post-visit follow-ups, it enhances communication between caregivers and healthcare providers, promoting proactive and preventive pediatric care. This program has been part of a broader effort to improve child health services by engaging families more deeply in the care process. For more information, you can visit the CAHMI website.

Systems Change Initiatives

Bayview Child Health Center-Center for Youth Wellness is an FQHC in San Francisco with an integrated pediatric care model to recognize the impact of Adverse Childhood Experiences (ACEs) on health and seeks to treat toxic stress in children. The Center for Youth Wellness provides research, training, and advocacy support. The Bayview Child Health Center emphasizes a comprehensive medical home which provides services to treat children, adolescents and their caregivers. This involves routine screening for all patients, paired with a multidisciplinary, trauma-informed approach to address identified concerns. Care coordinators are embedded in the pediatric clinic and offer education to children and their caregivers about the impact of ACEs and toxic stress on health. They can provide brief interventions, information and referral resources, and coordinate care among internal and external providers for families. The Center for Youth Wellness helped to develop and uses the PEARLS screening tool, which has been selected as one of three approved for use in California Medi-Cal.

Boston Medical Center for the Urban Child's Pediatric Practice of the Future was launched in 2016 to revolutionize care for pediatric patients and their families, building on its ongoing work as the largest safety net health center in New England. BMC Pediatrics is home to widely disseminated care innovations, including: Reach Out and Read, Medical-Legal Partnership, Project DULCE, We Care, and Health Leads. The Center for the Urban Child and Healthy Family and Pediatrics Primary Care are leading efforts to build the "Pediatric Practice of the Future" through fundamental systems change—creating and scaling novel health delivery approaches, and working with families, interdisciplinary colleagues, communities and other family-serving sectors. One of the core tenets of the Center's work is the belief that redesign of health care will only be successful if families co-create solutions, and the Center is using a Human Centered Design process to deeply understand what Boston Medical Center pediatric families expect and hope for from their health care.

Children's Hospital at Montefiore (CHAM) is located in the Bronx in New York City, serving a large population of children of color, many of whom live in adverse conditions. Montefiore Medical Center is the university hospital and academic medical center for the Albert Einstein College of Medicine. CHAM is the hub of Montefiore's Child Health Network. In addition to primary care, this network offers a range of specialized programs to help the most vulnerable children, including: innovative service delivery approaches for children with developmental disabilities, lead poisoning prevention and treatment, HIV related care, and a child protection center. To promote optimal young child development, CHAM/Montefiore has employed Healthy Steps and Medical-Legal Partnerships as part of its responses. The work has served as a model for New York State efforts to expand Healthy Steps and initiate a First 1000 Days in Medicaid Initiative.

Children's Clinic, "Serving Children & Their Families" (TCC) was founded in 1939 in the greater Long Beach Community in California to provide health care for all children. TCC serves as the anchor organization for the Moving Health Care Upstream team in Long Beach to provide innovative, integrated, quality care that contributes to a healthy community. TCC offers an advanced medical home that goes well beyond medical care and responds to legal concerns and social risks, as well as partnering with children and their families. The clinic uses a multi-disciplinary team approach including physicians, nurse practitioners, mental health professionals, Medical-Legal Partnership, care coordinators, and health educators. Services also include health coverage eligibility screening and enrollment, interpretation and translation, and referrals. TCC recently implemented the Everychild Bright Beginnings Initiative to screen pregnant women and parents of young children for protective and risk factors and to provide interventions and referrals for those most at risk.

Cincinnati Children's Hospital Medical Center (CCHMC) has become a recognized national leader in children's health quality and innovation. Community-based primary care transformation efforts are underway. Select CCHMC pediatric primary care clinics were part of a project delivering a bundle of preventive services for infants and toddlers (including screening for lead, developmental concerns, maternal depression, and food insecurity), which increased the proportion of visits including preventive services from 58% to 92%. An effort using care coordination significantly improved the prompt delivery of newborn visits. CCHMC is the home for Every Child Succeeds home visiting, which creates opportunities to link primary care and home visiting. As an example of how individual clinics respond to their communities, the Hopple Street Health Center in the CCHMC network includes use of integrated behavioral health, Healthy Steps, Medical-Legal Partnership, a food pantry, social determinants of health screening, and other approaches to identify and address social risks among the children and families served.

Health Share of Oregon is a nonprofit joining four competing health plans, three county-run mental health agencies, and several provider organizations in the greater Portland area. Oregon Medicaid requires any participating health plan or provider to be in a regional coordinated care organization (CCO), and Health Share is one of 16 COOs. Health Share leaders increased investment in young children based upon data showing that for more than half of Health Share adult members with complex and costly health conditions, negative social determinants and adverse experiences had accumulated from childhood to become a cascade of risk multipliers. The "Ready + Resilient" plan strategies for assuring a strong start for children include: improving the quality and quantity of screening of women and children in health care and community settings; building and enhancing clinical and community interventions and referral systems; and improving systems of care for populations with complex social or medial needs. Health Share's goal is that children are ready for kindergarten, and families are connected to the health and social resources they need to thrive.

Healthy Development Services (HDS) operates from the Rady Children Hospital-San Diego with funding from First 5 San Diego. HDS was created to address service gaps for young children with mild to moderate developmental and behavioral concerns not severe enough to qualify them for Part C Early Intervention Services. It operates through a partnership between First 5 San Diego,

AAP-CA3 Chapter, and local service providers, creating a countywide system with coordinated services. HDS reaches a number of pediatric health care settings and other community sites across San Diego County to provide developmental screening and follow up, through parent coaching, care coordination, and direct intervention and treatment services for more than 25,000 children annually. HDS works with a wide range of community providers and organizations to ensure parents and other caregivers have the help and support to address developmental and behavior child health concerns.

With federal funding from Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), the **MA Partnership for Early Childhood Mental Health Integration** designed and tested a model (known as MYCHILD) to address early childhood mental health needs at 7 Boston sites. Staff provide consultation and support within the primary care setting related to early childhood mental health, as well as conduct mental health consultation in early care and education settings. Full integration into pediatric primary care settings and deployment of a unique Family Partner-Clinician team – an early childhood trained, master's level mental health clinician and a trained "family partner" with lived experience – were key features of the model. Families were linked to teams via a warm hand-off by a pediatrician, based on screening or clinical judgment. Activities included family case management and suppor family, provider and community consultation and education about early childhood mental health; and short- and medium-term family-centered, dyadic care for children in need of intervention.

Maricopa Integrated Health System (MIHS) is the only public, non-profit teaching hospital and health care system in Arizona, with a140-year history of providing health care in Maricopa County (including Phoenix). The safety-net health system name recently changed to **Valleywise Health**, with a vision to be nationally recognized for transforming care to improve community health. This health system operates a care coordination/medical home model which uses trained care coordinators to provide services to children birth through age 5 and their families, employing evidence-based clinical guidelines and measuring progress on improving outcomes for children with developmental delays and asthma and on promoting healthy nutrition and weight. Key to operations is a warm handoff from the practitioner to the care coordinator and an individualized care plan developed for all families. With support from Arizona's First Things First early childhood initiative, the health system has created five Family Learning Centers as places that support families in providing safe, stable, and nurturing home environments, integrated with Valleywise Health.

Nemours Children's Health System. Nemours is a nonprofit children's health organization, delivering family-centered care to 250,000 children annually in hospitals and clinics in Delaware, New Jersey, Pennsylvania, and Florida. In the Delaware Valley, Nemours employs more than 100 pediatricians who are primary care providers. In 2004, the Nemours Health and Prevention Services initiative was created to focus on innovation to promote optimal child health and well-being. They also received a grant from the Center for Medicare and Medicaid Innovation (CMMI) Health Care Innovation Awards to target asthma prevention. Recently, Nemours has designed a multi-pronged transformation, with efforts to negotiate outcome-based contracts with payers, including assessments of social determinants of health, expanded prevention efforts, and work to transform the way the state pays for children's care under Medicaid. Nemours believes its

willingness to invest in prevention efforts, shift to value-based reimbursement, and work with the state to take on risk will yield better care for patients.

Odessa Brown Children's Clinic (OBCC) at Seattle Children's Hospital is dedicated to promoting quality pediatric care, family advocacy, health collaboration, mentoring, and education in a culturally relevant context. From its beginning in 1970, OBCC has grown at two sites with a care team includes 5 pediatricians, 5 nurse practitioners, and other nurses, social workers, mental health professionals, dentists, nutritionists, and community program staff. OBCC augmented services for young children to include: Promoting First Relationships (PFR) for children from birth to age 3 and their parents, and Parent-Child Interactive Therapy (PCIT) for children age 3–7 and their caregivers. The clinic also has a strong program for serving children and families with sickle cell disease and works in partnership with the Washington Medical-Legal Partnership (MLP).

Primary Health Care (PHC) is a federally qualified center with six primary care sites in Des Moines, Ames, and Marshalltown, Iowa. More than half of young child patients are covered under Medicaid, with another large share immigrants or refugees without health coverage. PHC uses a team approach that enables primary care practitioners to call in either a family support worker or a behavioral health specialist at the time of the office visit to respond to social and mental health concerns. Family support workers play vital care coordination roles in linking families to culturally and linguistically responsive community resources. Referrals include formal connections with Iowa Legal Aid for medical-legal assistance and with Iowa First Five (a state program modeled after Help Me Grow) for connections to developmental services. PHC makes use of its location in underserved neighborhoods to be a locus not only for providing medical care but also for connecting isolated families with culturally and linguistically responsive support.

The **Rhode Island Patient-Centered Medical Homes for Kids (PCMH-Kids**) is a multi-practice, multi-payer initiative through which practices share a common contract with all payers. Since 2015, the PCMH-Kids Initiative has involved a total of 20 pediatric practices. The patient population represents more than half of Rhode Island children and nearly all of the state's children covered by Medicaid. Funding from the Centers for Medicare and Medicaid Services has helped to support practice transformations. The screening framework identifies and responds to children: 1) who have high utilization (e.g., ER visits or hospitalizations for behavioral health), 2) have poorly controlled or complex conditions (e.g., asthma, ADHD, or other behavior diagnoses), or 3) are at-risk based on social, family or environmental factors (e.g., homelessness, gaps in care, high lead levels/exposure). Responses have included: increased developmental screening, integrated behavioral health, and shifts in the approach to care coordination. This project advanced care coordination through a multidisciplinary team, including parent consultants and social workers who offer care coordination that can address social determinants which significantly affect a child's health.

Together Grow Strong in Sunset Park, Brooklyn, is an initiative aimed to transform child primary health care through a holistic, community-centered approach and through integrating medical, educational, and social services to create a supportive environment that nurtures the physical, mental, and emotional health of young patients. At its core, Together Grow Strong offers accessible, high-quality medical services emphasizing preventive care, early diagnosis, and the management of chronic conditions through regular check-ups, vaccinations, and screenings. The program employs a team of

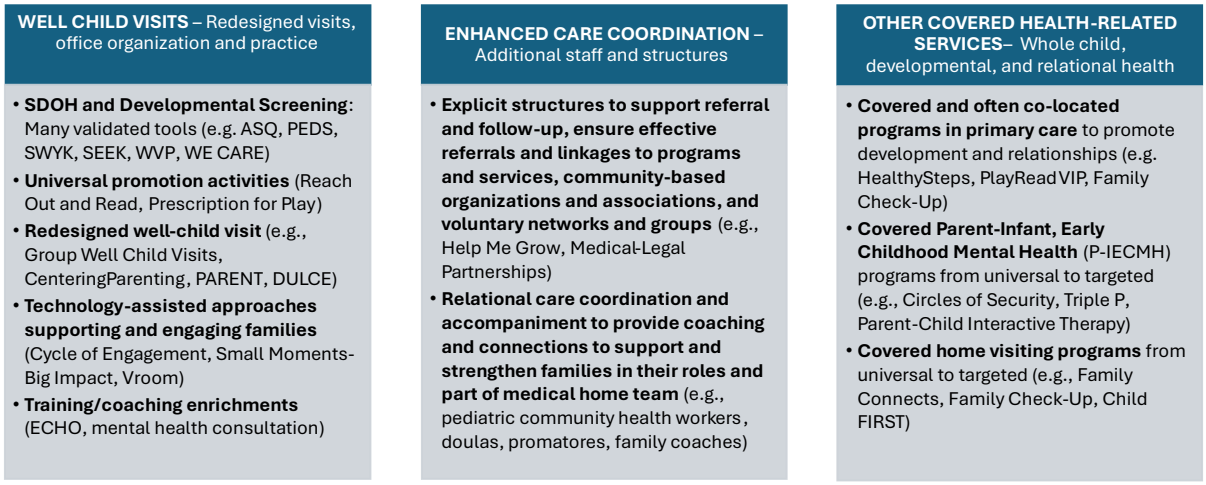
dedicated pediatricians, nurses, and health educators who work closely with families to ensure that children receive continuous, personalized care. Beyond medical services, Together Grow Strong places a strong emphasis on health education and community engagement. The program offers workshops and resources on nutrition, exercise, mental health, and other critical aspects of healthy living. A further key component of the program is its commitment to addressing social determinants of health. Together Grow Strong collaborates with local organizations to provide comprehensive support services. This includes access to affordable housing, educational resources, and family counseling. See: https://med.nyu.edu/departments-institutes/population-health/divisions-sections-centers/health-behavior/together-growing-strong

GROUPINGS OF PROGRAMS BY CORE COMPONENTS

The Integrated Care for Kids InCK Marks Initiative funded by the Robert Wood Johnson Foundation has described child health care transformation as moving from primary child health care in current practice to a new standard of care with much greater value in promoting healthy child development. That new standard recognizes the major role that the safety, stability, and nurturing in the home environment plays in children's healthy development and the importance of primary care promoting healthy parenting. The 2018 framework for a "high performing medical home" includes restructuring the well-child visits themselves, incorporating enhanced care coordination, and providing additional primary health care services, many of which focus upon strengthening parenting to advance healthy child development. While this research and conceptualization on child health transformation overall involves more than advancing healthy parenting, that represents a very core element of that transformation and what child medical homes must do to achieve optimal child health and development.

The grouping of these research-based programs under these three components of high performing medical home shows that different programs and practices can be further distinguished within the categories.

Evidenced-Based Programs and Practices Grouped by Child Health Transformation Elements



NOTE: *Many more evidence-based models and programs exist that can contribute to and are consistent with health care transformation for young children– this slide shows only some examples.*

Regarding well-child visits themselves, some of the research-based programs and practices focus upon screening and surveillance to identify (and then respond) to parenting-related factors that contribute to child health. Some relate to the content of the well-child visit itself, particularly around parenting roles. Some effectively restructure the visit as a group visit or with additional personnel involved. Some involve training tools and supports so the practice and primary practitioner are more attuned to and able to respond to support effective parenting. Some use technology for additional add-ons that then more continuously provide parents with information about their child's development.

Regarding care coordination, some involve much more explicit and directed referral to community services that incorporate follow-up and additional help, where needed, in securing them. Others build a relationship with the child and family and serve that care coordination linkage but also accompany families and help ensure that family voices are heard both within the practice and in the community.

Regarding additional covered services, some involve additional office-based or referred dyadic or group services around effective parenting (which may respond to different issues parents and their children face). Some are home visiting programs, which themselves vary in their intensity and population of parents served. All have, at least in some systems, received funding (including under Medicaid) as a health-related services covered under primary care.

While some programs can fit into more than one grouping or element, the chart shows that there are multiple programs and practices on which to draw within each of the components and groupings to advance healthy parenting in primary care. Of course, combining them together may prove that the "whole is more than the sum of its parts," but even adopting changes in one component can produce impacts and is likely to encourage actions in other components.