



## **TRANSFORMING YOUNG CHILD PRIMARY HEALTH CARE PRACTICE: BUILDING UPON EVIDENCE AND INNOVATION**

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Child health is a state of physical, mental, intellectual, social and emotional well-being and not merely the absence of disease or infirmity. Healthy children live in families, environments, and communities that provide them with the opportunity to reach their fullest developmental potential.

– World Health Organization

Health equity is achieving the highest level of health for all people. Health equity entails focused societal efforts to address avoidable inequalities by equalizing the conditions

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<sup>1</sup> Members of or staff to the Kitchen Cabinet of the Collaborative Innovation Network (CoIN) on Health Equity and Young Children. The Learning Collaborative on Health Equity and Young Children supports this CoIN and is a partnership between the Child and Family Policy Center and the BUILD Initiative, whose goal is to be a point of connection for state and community early childhood leaders and health practitioners and champions to learn from one another, in order to further both the policy and practice of health equity for young children.

for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices.

– Healthy People 2020

[A]ny effective integrator will strengthen primary care for the population. To accomplish this, physicians might not be the sole, or even the principal, provider. [The] expanded role includes ...coordinating care; and providing innovative access to services through...connection to community resources, and new means of communication among individuals, families, and the primary care team.

- Berwick, The Triple Aim: Care, Health and Cost

## INTRODUCTION

Pediatrics has long recognized the need to provide patient-centered care. For young children, that means family-centered care. The concept of a medical home began in pediatrics and continues to be advanced – with particular attention to children with special health care needs. Now, a new vision for primary child health care practice is emerging that focuses upon improving child health trajectories by responding to social, as well as bio-medical determinants of health. This vision holds potential to transform primary child health practice to move beyond treating illness and chronic physical health conditions to improving child health trajectories across physical, social, cognitive, and emotional dimensions of health. It is based upon a large body of science on the critical importance of the first years of life and the role that social, as well as bio-medical, determinants play in impacting children’s healthy growth. It further is key, over the long-term, to achieve the health system’s triple aim of improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

Most important, this vision holds promise to contributing to larger societal goals of improving children’s overall development, reducing social and economic as well as health disparities, ensuring equitable opportunities, and truly equipping the next generation to compete and lead in a world economy.

Currently, this new vision of primary child health care practice largely is reflected in an array of innovative, research-based programs established by pediatric practitioner champions. These programs have extended their responses to young children in vulnerable and stressed households and neighborhoods in ways that strengthen the safety, stability, and nurturing in the home environment – with impressive outcomes that include both improved family functioning and improved child (and often adult) social, emotional, cognitive, and physical health outcomes. While these programs have somewhat different emphases and ways of working within different practice settings, they share much in common, enough to be considered as representing a new approach, vision, and field of primary pediatric practice. They are building a research base as evidenced-based programs that impact healthy child development through strengthening families and the safety, stability, and nurturing in the child’s home environment.

## WHAT EXEMPLARY PROGRAMS AND PRACTICES HAVE ACHIEVED

The first **Medical-Legal Partnership (MLP)** program was established in 1993 at Boston City Hospital (now Boston Medical Center), the largest safety net hospital in New England. Its success in responding to patient, family and community health-harming social and legal needs has led to substantial adaptation and expansion, with a National Center for Medical-Legal Partnerships established in 2006 to support this work. MLPs now are present in 292 health care institutions in 36 states. MLPs first were initiated in pediatrics, but now exist in a range of primary care and other medical settings. MLPs embed legal professionals into the health care team to identify and respond to the social and legal issues that jeopardize patient and family health and stability and contribute to stress. MLP legal staff is available to address such issues as evictions and utility shutoffs, difficulties securing SSI and other benefits, legal issues affecting employment, and other justice issues that jeopardize health. In partnership with health care providers, MLP legal staff provide individual advocacy for patients and families as well as engage with the larger community to resolve systemic issues and support policy changes aimed at improving community health. The MLP approach also includes training and support for health professionals to help them identify and address the social determinants of health, with the goal of creating an environment for robust inter-professional collaboration to achieve the best outcomes for patients. In its more than twenty years' experience, MLP has demonstrated its effectiveness in stabilizing families of young children so they can provide a nurturing home, removing environmental risks from the home itself, and supporting young children's engagement in evidence-based programs to improve their health and development.

**Healthy Steps for Young Children (Healthy Steps)** originated in 1996, with partnerships formed with 24 pediatric and family practice sites across the country in 1997. The goal of Healthy Steps was to design and test a new approach to primary care for young children that would focus upon supporting parents in nurturing their child's development. Healthy Steps specialists who were nurses, nurse practitioners, child development specialists, and social workers, were integrated into the primary practice to respond to the family's needs for information and support about their child's healthy development. The 2003 national evaluation of more than 4,500 children served by 15 of the original Healthy Steps sites showed impressive gains in improving family participation in well-child visits, in securing child immunizations, in increasing positive mother-child activities, increasing the sensitivity of parents to their children's cues for attention, and in reducing the use of harsh disciplinary practices – all related to the safety, stability, and nurturing in the home environment recognized as foundational to healthy child development. Through a national resource center, Healthy Steps continues to be replicated and adapted and further evaluated for its impacts. One recent research article on a Healthy Steps site, Montefiore in New York City, showed very positive impacts by age five not only on parent-child interactions and child social, emotional, and cognitive development, but on body weight and reduction in obesity (bmi>.95).”

The pilot **Help Me Grow (HMG)** program began in Connecticut in 1997, with a National Center established in 2010 that now serves and supports 25 affiliate states replicating the HMG system model. HMG serves all young children (birth to eight) and their families through early identification and response to children at risk of developmental or behavioral concerns. The HMG model includes four components: (1) child health provider outreach and support to conduct developmental screenings and make referrals to HMG; (2) a central utility and access point (call center) providing telephone care coordination to ensure successful linkage to information and community services; (3) community outreach to serve as a conduit between local programs, the call center, and practitioners and to facilitate networking activities, operating as a community utility in this respect; and (4) data collection

that tracks progress and provides for continuous improvement in responding to children and families and tracks progress toward reaching goals. HMG has demonstrated greater effectiveness in family engagement with resources in their community, both specific to their children's developmental concerns and to their overall family well-being; strengthening of protective factors known to impact child optimal development; and some overall reduction in the use of higher cost medical services through earlier and more community-based responses to child and family concerns.

**Project DULCE (Developmental Understanding and Legal Collaborations for Everyone)** supports families for the first six months following the birth of a new infant. Based at the infant's primary care medical home, a DULCE family specialist joins the healthcare team and provides additional support on healthy child development and parenting support by helping parents connect to both formal and informal community resources. The DULCE intervention incorporates a protective factors approach and draws on and incorporates components of the Medical-Legal Partnership model to ensure that families have access to the resources they need. Initially established as a research program at Boston Medical Center, Project DULCE improved parental knowledge of child development, better met family needs for concrete services, and successfully engaged and produced substantial gains in parental resiliency for families determined to be at-risk. The Center for the Study of Social Policy (CSSP) and city and county partners are testing the adoption and adaptation of DULCE in five localities within seven clinical settings across the US, including in three California counties (Alameda, Los Angeles and Orange Counties); Palm Beach County, FL, and Lamoille Valley, VT.

**Child First** is a two-generation, home-based, psychotherapeutic intervention that works with very vulnerable young children, prenatal through age 5 years, and their families, most of whom have experienced significant trauma and adversity (including poverty, domestic violence, maternal depression, substance abuse, and homelessness). The goal is to decrease serious mental health concerns in child and parent, child developmental and learning problems, and abuse and neglect. Child First began in Bridgeport, Connecticut in 2001. Teams of mental health clinicians and care coordinators provide home visits that respond holistically to the family, including psychotherapy to foster a responsive, nurturing caregiver-child relationship to heal the effects of trauma and adversity, connection to comprehensive services and supports, and scaffolding of executive functioning skills. Child First has shown strong research results. A randomized clinical trial found statistically significant improvement in young child mental health, language development, and maternal mental health; reduced involvement in child protective services; and connection to comprehensive community services and supports. Evaluation through six years of replication has continued to show these strong outcomes. Child First is one of the HRSA designated, national, evidence-based Maternal, Infant, and Early Childhood Home Visiting (MIECHV) models. Child First has established a National Program Office to support replication through state affiliates that include a clinical director as well as home visiting teams.

**Safe Environment for Every Kid (SEEK)** model was developed through the University of Maryland School of Medicine to help promote children's health, development and safety and to prevent child abuse and neglect. This is done by enhancing pediatric primary care by identifying and helping address prevalent psychosocial problems such as parental depression. SEEK includes training of health practitioners, routine screening of families during children's checkups, collaboration with a social worker or behavioral health professional, parent handouts and follow-up. Two large randomized, controlled studies - one in an urban clinic serving a very low-income population and one in suburban private practices serving a middle-income population - had very promising findings. The first showed substantial reductions in reported child abuse and neglect; the second showed significantly less use of harsh disciplinary practices

and psychological abuse. In both, SEEK practitioners had greater comfort, perceived competence and improved behavior regarding their roles, and this was sustained for up to 36 months. An economic analysis of the cost of SEEK compared with medical costs associated with child abuse revealed substantial cost savings. Much work has been done to help interested clinicians implement SEEK, such as the online SEEK training videos.

**First 5 San Diego's Healthy Development Services (HDS)** operates through a number of pediatric health care settings and community sites in San Diego County to provide developmental check-ups for children birth-to-five and to follow up, where concerns are identified, through parent coaching, classes, workshops, and therapy. HDS further 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. HDS has shown individualized gains, after even brief interventions, in either behavioral or development areas of concern for most of the children served. Qualitative findings have shown an increase in parent-child interactions among participants in the program. Moreover, HDS has shown impact in improving the communication and collaboration between practitioners and parents and with community providers. In 2015, HDS received the prestigious designation as a Bright Idea from the Government Innovators Network, a program of the John F. Kennedy School of Government at Harvard University

The SAMHSA-funded **MA Partnership for Early Childhood Mental Health Integration** designed and tested a model to address early childhood mental health needs at 7 Boston sites: 5 CHCs, 1 hospital clinic and Boston's Health Care for the Homeless program. Full integration into pediatric primary care settings and deployment of a unique two-person 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. Teams were linked to families via a warm hand-off by a pediatrician, based on screening or clinical judgment. Team activities included family case management and support, family, provider and community consultation and education around early childhood mental health needs, and short- and medium-term family-centered, dyadic care for children in need of intervention. Outcomes included reduced maternal stress and depression, improved child social and emotional health and improved provider satisfaction with the process of care. The model is now being replicated in three additional MA cities; an online toolkit offers guidance to other sites interested in replication.

**Cincinnati Children's Hospital Medical Center (Cincinnati Children's)**, a recognized national leader in children's health, established the Health Network by Cincinnati Children's (HNCC). HNCC is a Pediatric Population Health partnership with Medicaid managed care, negotiating a variable capitation on the population of children in the eight counties in southwestern Ohio. Cincinnati Children's Hospital, in turn, takes risk for inpatient services for these children. HNCC supports children's healthy development, investing in early primary care responses to impact young children's healthy trajectories that can produce lifelong gains in well-being. HNCC supports accountable care through its role in providing practitioner early identification and response to the developmental, social, safety, and economic needs of young children and their families and follow-up responses that draw upon social service providers and other community resources. HNCC has shown pronounced impacts upon both the continuity of care for and the developmental trajectories of children in the child welfare and foster care systems. Its approach has been successful in reducing the overall costs for children who have been high-end users of emergency services and reinvesting savings in more preventive and developmental services.

## HOW THESE PROGRAMS AND PRACTICES REPRESENT A FIELD WITH NEW ELEMENTS OF PRACTICE

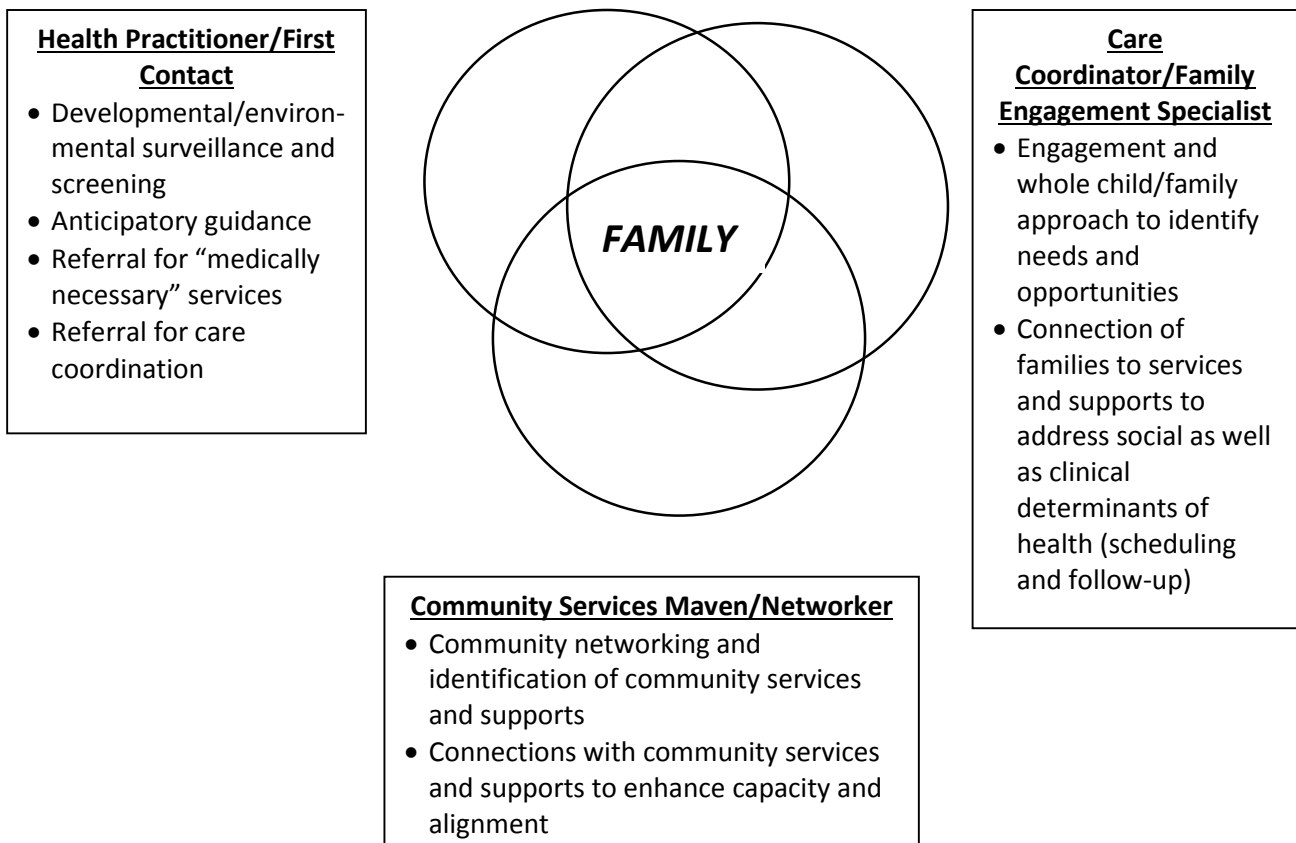
Taken together, these programs and practices offer strong evidence of the ability to make significant contributions to young children’s healthy development through responding to social as well as bio-medical determinates of health. While not silver bullets that eliminate physical, social, educational, and other health disparities, they contribute to that end. Specifically these programs show that when children are very young, the health practitioner and health system can play a significant role as a point of first contact for families who need support in addressing social and environmental factors.

While they differ in terms of the child populations they serve and some of their particular emphases in providing services, these exemplary programs share important characteristics related to their functional components, their underlying approaches and attributes.

In terms of their functional components, each:

- Supports pediatric practitioners and their offices to use their engagement with the family (often as the first contact with any professional system) to identify issues that extend beyond the physical well-being of the child to the social and environmental factors that affect healthy child development (e.g. maternal depression, food insecurities).
- Supports a warm and effective “handoff” from the practitioner to a care coordinator or other family engagement specialist (financed for this purpose) for more extended connection with the family to identify concerns, strengths, and needs, and to securing (from referral to scheduling and follow-up) resources and supports that meet needs and build family strengths and resiliency.
- Identifies and networks with other resources in the community so the care coordinator/family engagement specialist can make effective referrals and those community resources are responsive to the families being referred.

These functional components are shown in the diagram below:



In terms of their underlying approaches and attributes, each:

- Uses a team approach that values the expertise of the care coordinator/family engagement specialist.
- Commits to strengthening families that builds family resiliency as well as providing specific services.
- Is rigorous in its recruitment, selection, training, supervision, and team-building approach, with an underlying emphasis on maintaining a strength-based approach to working with families.

In addition to ensuring that such pediatric transformations include the three components and their functions, the fidelity of replication is based upon incorporation of the underlying approaches and attributes. These are essential to establishing authentic relationships with families and to producing organic and individualized actions with (not simply to or for) families that produce success.

These programs also enhance their impacts when they are able to refer families to make use of other evidence-based programs as Triple P-Positive Parenting, Incredible Years, the Infant Health and Development Program, Circle of Security Parenting, Reach Out and Read, Nurse-Family Partnerships (and other home visiting programs), the Video Interaction Project, the We Care Project, and Abriendo Puertas (and other forms of community health workers). Some of these programs also incorporate many of the elements contained in the exemplary programs described earlier and all share some of the same fundamental approach. In addition, some can be funded as medically necessary services under the EPSDT provisions of Medicaid (although this usually requires state interpretation and definition to do so).

While none of the exemplary programs has all the answers on how to best respond to all the diverse types of families with young children, they represent a significant advancement on current routine young-child primary pediatric practice. Collectively, they represent an emerging field of exemplary practice (as Nurse Family Partnerships, Child First, Healthy Families, and Parents as First Teachers represent a field of exemplary home visiting practice) that requires further diffusion and adoption. Ultimately, they can help set the standard for practice for young-child primary practice and be fully integrated into financing, monitoring, and accountability systems that provide health services to young children.

#### WHAT NEEDS TO HAPPEN TO BUILD THIS VISION AND FIELD

Realizing this vision for primary child health practice and building this field from the current array of exemplary programs into a standard of practice requires three levels of activity. While conceptually these might be sequenced, there is interplay across them, each involving somewhat different champions and leaders, and there are opportunities to advance activities in each area. These include:

1. Expanding the evidence base on effective practice and its application to different practice settings, family populations and situations, and presenting concerns and issues.
2. Expanding the adoption and diffusion in the field to create a larger and more “critical mass” of such practice.
3. Developing financing and accountability structures, particularly within Medicaid and health reform’s emphasis upon meeting the triple aim, that support and sustain such practice.

On the first, the Learning Collaborative on Health Equity and Young Children, through its Collaborative Innovation Network (CoIN), has convened many of the practitioner champions of different evidence-based programs to expand the knowledge base and further develop the field. This includes exploring the strengths and limitations of existing programs – and how they can collectively contribute to one another in their own growth and development. For example, MLPs have expertise on responding to legal issues and the need for hard services; Healthy Steps has expertise on promoting child development activities in the home across cognitive, social, and emotional areas; HMG has expertise in early identification of young children with developmental concerns and responding holistically to them; Child First has expertise on working successfully with very vulnerable families with complex needs. Different programs have developed different screening and assessment tools both for identifying children and families who can benefit from services and supports beyond medical needs – with different strengths and abilities to assess need. While the exemplary programs have been successful at recruiting and supporting staff with the passion and skills for engaging families and empowering them, this is still more of an “art” than a “craft” or a “science.” Yet, fidelity in selecting the right staff and supporting them to achieve their goals is at the heart of successful replication and must be part of implementation efforts. Further, particularly when dealing with different cultures and languages, it is important to ensure that strategies and approaches are culturally and linguistically responsive and reciprocal – which in most programs has not been subject to explicit analysis and practice design. The knowledge base of the field continues to be built through the actions and experiences of those on-the-ground in neighborhoods and communities, and this requires active support, shared learning, and dissemination to continue to improve results (with increased attention to issues of race, language, culture, and developing inclusive responses that counter the impacts of discrimination).

Importantly, in addition to this work and related to the second point, CoIN participants also identified the need for activities that support additional early adopters as an initial diffusion strategy to go to scale. Because of their promise, these exemplary programs have been recruited to support others in the field, and many have developed their own replication and adaptation strategies. Foundations have supported some expansion of individual programs and a few states have developed demonstration programs or other financing efforts. Building this field will require enlisting additional champions and early adopters, and establishing a critical mass of exemplary practices within and across states that can help model and guide further diffusion and movement into mainstream practice. Both foundations and the federal government (particularly through the Center for Medicare and Medicaid Innovation) can play important roles in fostering further innovation and diffusion.

On the third point, for this to become a true practice transformation rather than a promising set of individual efforts that benefit children, there needs to be support of practice standards, financing, accountability, and administration that supports the broader child health practitioner role. The next edition of *Bright Futures*, already recognized in federal legislation as a standard of primary pediatric practice, will promote an increased role for primary child health practice in identifying and responding to social determinants of health as well as child-specific health needs. Some of the emerging work on developing pediatric accountable care organizations is recognizing the need to incorporate within Accountable Care Organization (ACO) contracts more specific requirements for value-based care that involve additional investments in health prevention and promotion. This is especially crucial in the early years of child development, where gains in terms of overall health care costs (and other costs and benefits) will likely be reflected over decades and not within a contractual cycle. Even as the field is



developing and gaining new insights on how best to impact child health trajectories, financing and regulatory systems, particularly within Medicaid, need to be structured to support such activities.

## CONCLUSION

There is a growing awareness that to improve child health and health equity – the primary child health pediatric needs to support and strengthen families, particularly through connection to other social and community resources. There is a growing array of exemplary and research-based programs and practices – sharing common components and approaches – that are showing the way to doing so.

We do not need to start from scratch in this work, as demonstrated by the exemplary programs described above. However, moving these exemplary programs into routine practice will require cross-sector action and collaboration involving the health care and early childhood fields, lawmakers and child advocates, philanthropic organizations, policymakers, health care financing and administration agencies, and the general public. As the appendix below highlights, forces are aligning on the critical importance of making such primary child health transformation.

\* The Kitchen Cabinet members serve to guide and support the work of the CoIN in furthering innovation, diffusion, and policy reforms and investment in the use of the primary child health care practice to address the social and environmental factors in a family's life that affect the healthy development of their child.

## **Appendix: Transforming Primary Child Health Practice and Policy: Excerpts from Recent Documents and Recommendations in the Field**

In addition to the work of the Learning Collaborative on Health Equity and Young Children to support innovation, diffusion, and policy reforms and investments to transform primary young child health practice, there have been other important calls for such action. Many of these stem from the new focus on meeting the “triple aim” in health care of improved quality, improved population health, and reduced per capita health costs. While much of the work under the Triple Aim has focused upon high cost adult and chronic care populations, the seminal document on the triple aim (#1) actually places a strong emphasis upon expanding the role of primary and preventive care. Both the American Academy of Pediatrics (#2) and the American Enterprise Institute and Brookings Institute (#3) have promoted this expanded primary pediatric role in responding to poverty and other social determinants of health. The National Institute for Child Health Quality, Ariadne Labs, and the Einhorn Foundation (#4) have similarly recommended expanding the role of child health practitioners, and the United Hospital Fund (#5) has articulated a series of specific practice and policy actions to further such work. While its major focus has been on community-based responses and services to address the dangers of toxic stress, the Center on the Developing Child (#6) also has recommended continued work to expand the primary child health practitioner’s role in the birth to three years.

Under the guidance of its Kitchen Cabinet, the Collaborative Innovation Network (CoIN) of the Learning Collaborative on Health Equity and Young Children is working to further innovation, diffusion, and policy reforms and investments in precisely this area – consistent with the recommendations made in these documents.

### **1. Berwick, D, Nolan, T, & Whittington, J (2008). *The Triple Aim: Care, Health and Cost. Health Affairs.***

Improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. ...

Preconditions for this include the enrollment of an identified population, a commitment to universality for its members, and the existence of an organization (an “integrator”) that accepts responsibility for all three aims for that population. The integrator’s role includes at least five components: partnership with individuals and families, redesign of primary care, population health management, financial management, and macro system integration. ...

The components of the Triple Aim are not independent of each other. Changes pursuing any one goal can affect the other two, sometimes negatively and sometimes positively. ... The situation is made more complex by time delays among the effects of changes. Good preventive care may take years to yield returns in cost or population health. ... Pursuit of the Triple Aim is an exercise in balance. ...

[A]ny effective integrator will strengthen primary care for the population. To accomplish this, physicians might not be the sole, or even the principal, provider. [The] expanded role includes establishing long-term relations between patients and their primary care team; developing shared plans of care; coordinating care; and providing innovative access to services through improved scheduling, connection

to community resources, and new means of communication among individuals, families, and the primary care team.

**2. American Academy of Pediatrics Council on Community Pediatrics (March 2016). Policy Statement: Poverty and Child Health in the United States.**

Children who experience poverty, particularly during early life or for an extended period, are at risk of a host of adverse health and developmental outcomes through their life. Child poverty influences genomic function and brain development by exposure to toxic stress. Children living in poverty are at increased risk of difficulties with self-regulation and executive function, such as inattention, impulsivity, defiance, and poor peer relationships. Poverty can make parenting difficult. ...

Although every family wants to provide the best resources and care to their children, economic barriers can stand in the way. An enhanced medical home providing integrated care for families in poverty is informed by the understanding that emotional care of the family ... is within the scope of practice for community pediatricians and that the effects of toxic stress on children can be ameliorated by supportive, secure relational health during early childhood.

**3. American Enterprise Institute and Brookings Institution Working Group on Poverty and Opportunity (December 2015). *Opportunity, Responsibility, and Security: A Consensus Plan for Reducing Poverty and Restoring the American Dream.***

Chronic stress can cause substantial changes in children's brains. ... Low stress, high predictability, and strong, stable relationships with caring adults all help children become measurably better at self-regulating, delaying gratification, and controlling their impulses. ... If we want adult citizens who can exercise responsibility, we should do as much as we can to improve the security of childhood, especially among the poor. ...

The government isn't an effective parent, and it shouldn't dictate to parents how to raise a child. But government can play a positive role by providing guidance, almost always through a third party receiving government funding, on the practices and skills that fit best with the high aspirations parents hold for their children. ...

First, the nation should use its universally available network of pediatric primary and preventive care practices to mount evidence-based parenting and early child development interventions. Thanks in large part to expansions of federal and state health insurance coverage of children, nearly all infants and toddlers have access to basic health care and are now taken to a schedule of 10–12 well-baby visits over the first three years of life. Consequently, pediatricians and other health service professionals have developed low-cost, evidence-based approaches to supplement pediatric visits with parent-child interventions that can promote early cognitive-language and social-emotional development.

**4. Einhorn Family Charitable Trust, Ariadne Labs, and National Institute for Child Health Quality (2016). Promoting Young Children's (0-3) Socioemotional Development in Primary Care. Author. P. 4-5.**

Substantial literature highlights the importance of fostering socioemotional development in young children and the opportunity to do so within the context of pediatric well-visit care. Individuals' development in early childhood has critical implications on later physical, social, emotional, and economic outcomes. A healthy caregiver-child bond is critical for healthy socioemotional development; the child feels safe and securely attached and receives consistent and reliable responses from the primary adult caregiver. Indeed, the quality of infants' early relationships and interactions shape the architecture of the brain and affect long term sensory, language, and cognitive development.

Pediatric primary care is a nearly-universal, de-stigmatized point of connection for families with young children, even in high-risk populations. For example, 88 percent of children on Medicaid receive pediatric well-care in the first six months of life. These visits also serve as a source of trusted advice for families, especially when a longitudinal relationship can be established. Healthcare providers are in a unique position to address the intersection of physical and socioemotional health and development. Unfortunately, relatively few socioemotional interventions take place in primary care settings, and socioemotional screening within primary care for infants and toddlers is not universal.

At the expert meeting, a broad range of experts (including those with lived experience, such as parents, grandparents, and caregivers) identified 11 specific design elements for the pediatric well-child visits that incorporate the above principles. Six main design elements (#1-6) are relevant to the well-child visit itself. Five others (#7-11) relate to, but extend beyond, the clinical well-child visit.

1. Use well visits to assess bond between caregiver and child.
2. Model behaviors that promote socioemotional development during well visits.
3. Educate families about socioemotional development and age-appropriate expectations during visit.
4. Modify visit structure and timing to allow for meaningful interactions.
5. Provide access to extended care team members (i.e., in addition to the physician) during and between visits to continue family support and identify families requiring extra resources; build team unity so all care team members feel they are part of team (including parent supports and community supports).
6. Improve the quality of interaction between care team and caregivers.
7. Create an office culture that promotes openness and nurturing and fosters the bond between care team and caregiver, as well as caregiver and child.
8. Use the waiting room to foster and model pro-social interactions.
9. Provide all families with resources to promote socioemotional development and age-appropriate expectations between visits.
10. Connect families to tailored resources they can access during and between visits. Tier resources based on level of need. Use extended care team to help families navigate systems.
11. Use time between visits to strengthen bond between care team and caregivers.

The environmental scan and survey of existing interventions highlighted two key challenges to overcome on the path toward the vision of success. There is an overall lack of standardized measurement of the caregiver-child bond, which may be a reflection of the few existing standardized tools that measure it. In addition, there are barriers to scaling, including financing, training, buy-in, and the pediatric visit structure.

**5. Brundage, S (2016). *Seizing the Moment: Strengthening Children’s Primary Care in New York*. United Hospital Fund (<https://www.uhnyc.org/assets/1448>)**

Below we lay out four steps that can help New York seize its present opportunity for an organized approach to strengthening pediatric primary care. The first step—developing a much-needed framework—is intended for those on the operational side: providers, researchers, and others working in pediatric medicine. The second, third, and fourth steps are directed toward policymakers. Here, a critical dimension will be engaging New York’s major health care reform initiatives that are underway, particularly Medicaid’s transition to value-based payment and the State’s effort to define and make financially sustainable “Advanced Primary Care.”

*1. Defining an early childhood development framework for pediatric primary care.* Most fundamentally, a framework is needed to identify the essential functions and parameters of a pediatric practice that encourages healthy early childhood development using the latest available science and techniques—and to promulgate an agreed-upon set of outcomes and associated measures for identifying interventions’ success. Such a framework, if broadly accepted, could begin to create consensus on what a comprehensive approach to promoting early childhood development in New York could look like. It would:

- (1) Describe the basic elements and parameters of a pediatric-based early childhood development approach;
- (2) Define the population of children that would receive those services and how they would be identified by pediatric practices; and
- (3) Identify some of the measures that could be used to assess, particularly by payers, how the practice is doing in implementing the framework.

Developing a framework would also require the participation of private foundations, government, and payers to give the collaborative structure, provide supplemental resources to practices such as planning grants or salary support, and ensure that the lessons emerging from the group are documented and shared broadly. Follow-on work would also include:

- (1) Defining the characteristics of practices that are able to adopt the framework approach in their practice;
- (2) Identifying methods for helping practices incorporate the model into their practice;
- (3) Identifying the short- and long-term costs associated with implementing the model in practices of different size and organization, and how those costs would best be paid for; and
- (4) Tracking the short- and long-term outcomes associated with the model.

*2. Determining how new value-based payment efforts can support effective early childhood development interventions in pediatric practices.* Under its Delivery System Reform Incentive Program waiver, New York’s Medicaid program envisions transitioning 80 to 90 percent of all Medicaid managed care payments to a value-based payment system by 2020. Given this increased focus, it is critical that consensus is developed around the articulation of the “value” sought from pediatric primary care settings, so that efforts to promote early childhood development can comfortably fit within Medicaid’s accepted value-based payment approaches.

*3. Specifying the measures and outcomes public and private payers will accept for monitoring investments in early childhood development services.* It is important to understand which outcomes pediatric providers and payers will be willing to use and the timeframe in which those outcomes could be measured.

4. *Identifying and resolving barriers that prevent pediatricians from using evidence-based approaches to promote healthy development.* In giving pediatric providers greater latitude in responding to the needs of children and their families, key issues still need to be resolved, including how to pay for two-generational approaches, how to improve pediatric capacity to do that work, and how to engage other critical care providers, such as obstetricians, who can influence health outcomes for both child and parent.

**6. Center on the Developing Child at Harvard University (2016). *From Best Practices to Breakthrough Impacts: A Science-Based Approach to Building a More Promising Future for Young Children and Families.* <http://www.developingchild.harvard.edu>**

Neuroscience is producing extensive evidence suggesting that the later we wait to support families with children who are at greatest risk, the more difficult (and likely more costly) it will be to achieve positive outcomes, particularly for those who experience the biological disruptions of toxic stress during the earliest years. More specifically, at a time when the discourse around early childhood investments is dominated by debates over preschool for 4-year-olds, the biological sciences cry out for attending to a missing niche in the field—new strategies in the prenatal-to-three period for families facing adversity. ...

Although recent expansions in health insurance coverage in the United States have improved access to needed medical services, persistent racial, ethnic, and socioeconomic disparities in low birth weight, infant mortality rates, and many chronic diseases remain a serious challenge. ... In 2012, the American Academy of Pediatrics (AAP) acknowledged the limits of clinical practice alone in a technical report on toxic stress and a policy statement on the role of the pediatrician, which included the following call to action: “Because the early roots or distal precipitants of problems in both learning and health typically lie beyond the walls of the medical office or hospital setting, the boundaries of pediatric concern must move beyond the acute medical care of children and expand into the larger ecology of the community, state, and society.... there is a compelling need for bold, new thinking to translate advances in developmental science into more effective interventions.”

Many thought leaders in the early childhood arena point to primary health care as the most appropriate point of entry for a universally available, prevention-oriented system for promoting the development of young children and providing trusted information and support for their parents. That said, even the core objective of achieving full compliance on the basic AAP schedule for immunizations and well-child visits continues to be an elusive goal for many children. With appropriate training and incentives, however, a skilled and motivated team based in a “medical home” could play a more effective, coordinating role in dealing with the more complex challenges of developmental surveillance, early detection of concerns, and prompt referral to community-based services—a role that is not currently fulfilled successfully by most primary care settings.

The range of current performance in these domains is broad. At one end of the spectrum, fewer than half of the pediatric practices in the United States include regular, standardized, developmental screening as a consistent part of routine primary care in the first 36 months after birth. At the other end, a growing number are incorporating a variety of developmentally oriented services that: (1) promote early reading and distribute books during office visits (e.g., Reach Out and Read); (2) facilitate early detection and connections to community-based services for developmental concerns (e.g., Help Me Grow); (3) use videotape coaching to promote positive parent-child interactions (e.g., Video Interaction

Project); (4) provide guidance on managing behavior problems in young children (e.g., Triple P Positive Parenting Program); and (5) offer a range of integrated behavioral health services within the primary care setting (e.g., Healthy Steps). The reported benefits of these programs include high levels of parent satisfaction, increased participation in well-child visits, modest changes in parenting behaviors, and variable effects on child outcomes. The inconsistent nature and magnitude of the child impacts, however, underscore the need for new strategies in the health care setting to fully address the diversity of challenges facing families with young children.