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

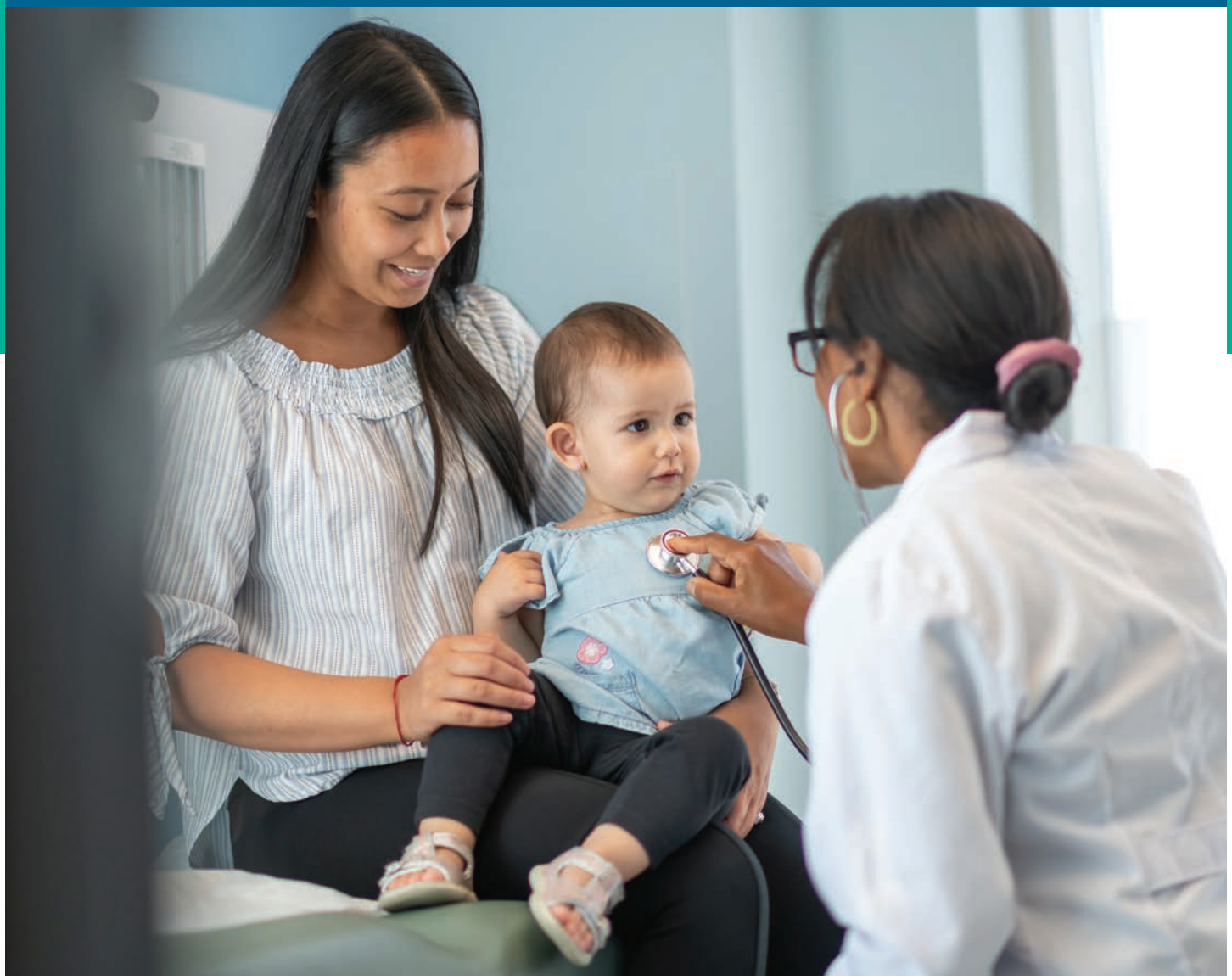
PEDIATRICS *Supporting* PARENTS

OCTOBER 2019

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

EXECUTIVE SUMMARY

Prepared by the Center for the Study of Social Policy



About CSSP

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

Acknowledgments

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Introduction

Research has shown that children's social and emotional development (SED)[i,1] is vital for school readiness and is a key building block for cognitive development and learning at very young ages.[2] Pediatric well-child visits present unique opportunities for supporting parents in nurturing their children's social and emotional development and relational health.[ii] They are frequent in infancy and early childhood, and they provide the setting for parents and pediatric health professionals to establish long-term partnerships to help children thrive. In 2017, several leading national foundations joined together to capitalize on this opportunity and launched Pediatrics Supporting Parents (PSP), an initiative to support partnerships between pediatric primary care providers[iii] and parents to promote the social and emotional development of young children.[iv] The initiative focuses on nurturing the parent-child relationship and recognizes that the parents' mental health is a critical mediator. PSP is informed, in part, by earlier work reported on in 2016 by The National Institute for Children's Health Quality (NICHQ), Ariadne Labs, and the Einhorn Family Charitable Trust (EFCT) in *Promoting Young Children's (ages 0-3) Socioemotional Development in Primary Care.*[3] That work sought to identify "optimal, scalable approaches for promoting healthy socioemotional development and improving the caregiver-child bond via well-child care."[4] It produced a high-level picture of 11 design elements for pediatric well-child visits to achieve these improvements and recommended several next steps for taking this early learning further, including a deeper examination of the elements and associated implementation strategies.

The foundation consortium acted on these suggested steps by engaging the Center for the Study of Social Policy (CSSP) to take a deeper look at what is currently being done and what may be possible in the pediatric well-child visit (ages 0 – 3) and the pediatric primary care setting to promote the desired outcomes. This report shares the learning from that program analysis. In a related effort, CSSP and Manatt Health are studying and demonstrating how Medicaid can help finance effective strategies to foster the social and emotional development of young children, making it more likely that such strategies become routine, expected, and valued components of pediatric primary care. Initial results from that work appears in *Fostering Social and Emotional Health through Pediatric Primary Care: A Blueprint for Leveraging Medicaid and CHIP to Finance Change.*

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

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

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

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

Against the backdrop of growing knowledge and trends in pediatric primary care, a number of programs that support parents to foster the social and emotional development of their young children have been designed for use in pediatric primary care (and related) settings.[5] These programs have research evidence or are building their evidence of effectiveness. This study was conceived to identify and learn about what might be common practices across programs as a means to obtain a full picture of how pediatric primary care can best support all children and families and achieve key outcomes in their social and emotional development. It also provided the opportunity to examine questions related to equity by learning how sites engage and partner with families, embrace parent voice, honor culture, address implicit bias, attend to power differentials in interactions, and develop community partnerships to address the social determinants of health (SDOH).

The program analysis was designed to collect information from multiple programs and implementation sites, augmented with a review of appropriate literature. After identifying and vetting nearly 70 programs against a set of criteria, we selected 13 programs[6] for further investigation. **Table 1** lists the programs included in the study and associated implementation sites visited. The site visits were conducted by study teams that included a family leader (recruited and supported by Family Voices); a consulting pediatrician with both clinical and national policy experience; and two researchers from the Center for the Study of Social Policy (CSSP). During the visits, the study teams conducted interviews with site leadership and care team members and made observations of practice environments and process. When permitted, efforts were made to interview family members and observe well-child visits. The full report has a description of the study methodology.

TABLE 1

Programs Included in Program Analysis

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

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

Common Practices

As we visited implementation sites and talked with program developers, we looked and listened for the common practices that sites use to promote the social and emotional development of young children and the parent-child relationship. We tried to understand not only the family's experience, but also the policies, resources, and infrastructure that supported successful implementation.

In partnership with a consulting group of pediatricians, an advisory committee of family leaders supported by Family Voices, and NICHQ, we identified **14 common practices,** each observed across several or all of the sites we visited. We learned that no single practice is sufficient and often several practices were observed in a site visit, as sites implemented the programs as well as other services and supports for families at their clinics. The strategies used to implement the practices varied from site to site, reflecting the unique context and strengths of each site. However, we observed a common thread that ran through the practices: **strong, strengths-based, trusting, and humble relationships among and between parents, the care team, and the community are essential for promoting the social and emotional development of young children.** There was an intentional focus on developing and nurturing relationships throughout the implementation of the practices, reflected in interactions with families, the collaboration among the care team, and the building of community partnerships.

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

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

With this common thread in mind, we determined that the 14 common practices could be organized into three overarching actions:

Nurture parents' competence and confidence through direct, interpersonal, and culturally responsive interactions with families around their children's social and emotional development.

Connect families to additional supports to promote healthy social and emotional development and address stressors. These stressors fall into two basic categories: (1) personal and interpersonal challenges (e.g. depression or other mental health issues, intimate partner violence, and substance abuse challenges), and (2) struggles meeting basic needs that require concrete supports such as food and housing assistance.

Develop the care team and clinic infrastructure and culture by creating a backbone that makes it possible to implement innovative programs and practices and to facilitate trustful team environments.

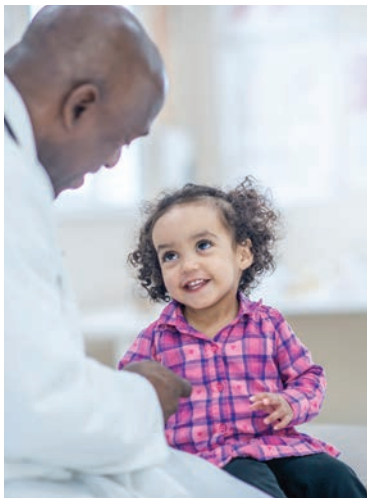
Figure 1 depicts the practices in the overarching actions and the centrality of relationships appearing throughout practices and across actions.

FIGURE 1

Common Practices

The full *Fostering Social and Emotional Health through Pediatric Primary Care: Common Threads to Transform Practice and Systems* report provides detailed descriptions of the 14 Common Practices and describes specific examples of how they are being implemented by the exemplary programs and pediatric settings we visited. We highlight stories from the staff and families we interviewed and the observations we made during our site visits around the country. The report can serve as an initial guide for practical implementation of the common practices and/or as an introduction to each of the pediatric programs.

Implications for going to scale



The common practices described more fully in the report make it evident that enhancing pediatric primary care to better support the social and emotional development of young children is possible. Unfortunately, their reach is still limited as not all families who could benefit have access to pediatric primary care settings that employ these practices. Program developers, staff at the pediatric primary care settings visited, family leaders, and the consulting pediatricians on our study team all acknowledged that taking these practices to scale[v,7] is challenging. This was true for programs that were currently operating in only one or two places as well as those that have been disseminated widely or were in the process of being implemented in multiple sites.

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

SYSTEM CONSTRAINTS

Time and money (financing systems).

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

Data for learning and improvement.

The 2016 report from NICHQ, Ariadne Labs, and EFTC noted "there is an evident need to address the scarcity of existing validated measurement tools and relatively low instances of interventions measuring this critical bond in a standardized way within the context of the pediatric setting."[8] Despite ongoing work to develop appropriate measures and measurement tools, this finding is still relevant. There are no routinely collected, universally agreed upon measures in pediatric primary care to help us understand and quantify the benefits or provision of services and interventions to promote social and emotional development and the parent-child relationship during the first few years of life. We observed sites collecting data pertinent

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

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

Physician training.

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

PEDIATRIC TEAM READINESS FACTORS: PREPARATION AND CAPACITY

Care team development and support.

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

Training and technical assistance capacity.

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

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

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

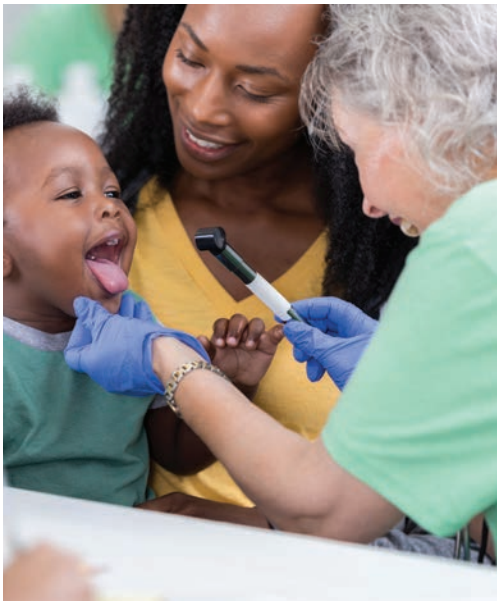
Recommendations

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

1. NATIONAL LEADERSHIP FOR SYSTEMS CHANGE

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

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



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

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

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

2. ADDRESSING SYSTEMIC BARRIERS

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

Create reliable and sustainable financial support.

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

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

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

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

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

One opportunity for advancing this work is state reporting on the Child Core Set measures, developed by the Centers for Medicare & Medicaid Services (CMS).[9] This is a set of children's health care quality measures for voluntary use by Medicaid and CHIP programs and as of 2024, states will be mandated to report on all of the measures. It includes a range of children's health care quality measures encompassing both physical and mental health. According to the authors of the Medicaid Blueprint:

> *"States and other stakeholders could encourage the federal government to incorporate specific measures related to social and emotional development into future versions of the Child Core Set. However, states do not need to wait for the federal government to act. They could develop their own measures that help assess progress on improving social and emotional development. For example, measures related to family experiences and changes in parenting behaviors and social circumstances as a consequence of health care received could be tracked."*[10]

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

Enhance medical education.

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

3. ACCELERATING PEDIATRIC TEAM READINESS

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

Support care team preparation and expansion.

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

Depending on the community context of the pediatric primary care setting and the needs of families served, the expanded care team may include roles for: (1) parents who have experience navigating services and systems; (2) community health workers specializing in early relational health; (3) mental health specialists; (4) community resource navigators; and (5) legal partners. Medicaid can be used to support expanded care teams. States can take advantage of Medicaid reimbursement for preventive services to finance teams, including community health workers.[11] States that have Medicaid managed care plans can require the plans to "contract with pediatric providers that deploy a team-based approach."[12] Family-led organizations can build awareness among parents about the benefits of these new

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

Support training and technical assistance capacity.

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

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

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

can be used, for example, to support pediatric providers in establishing or strengthening a high-performing pediatric medical home and on training related to evidence-based strategies and interventions to improve the social and emotional health of children."[13]

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

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

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

The 2016 NICHQ, Ariadne Lab, EFCT report acknowledged that the best opportunities to address social and emotional development spans multiple settings and that those settings "might be leveraged through collaboration with primary care settings."[14] To this end, rather than each clinic developing partnerships and curating resources to meet the needs of the families they serve, there is a need to expand and strengthen the infrastructure and capacity of local early childhood systems-building efforts. Integrating pediatrics into the local system would create greater access for families to needed supports and services. Sharing of data across pediatrics and early childhood systems[vi] would also allow systems leaders to address gaps in the availability and accessibility of resources, identify trends to inform policy and system change, and improve quality. There are efforts underway to support early childhood community system development (The National Collaborative for Infants and Toddlers, CSSP's Early Childhood Learning and Innovation Network of Communities [EC-LINC], Help Me Grow, and the Early Childhood Comprehensive Systems [ECCS] Collaborative, among others) that could be ready platforms for testing and implementing effective integration of pediatrics into the early childhood system to promote the parent-child relationship and social and emotional development of young children.

Final Reflections

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

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

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