



# Accelerating Child Health Care Transformation: Key Opportunities for Improving Pediatric Care

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## ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit [www.chcs.org](http://www.chcs.org).

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## Introduction

Children and families require a child health care system that serves their unique needs and supports opportunities for life-long health and well-being.<sup>1</sup> The current system, however, fails too many children, especially Black, Indigenous, Latino, and other children of color.<sup>2</sup> The impact of racism on children’s health ranges from ever-widening racial disparities in the infant mortality rate to prolonged exposure to stress hormones that predisposes children and adolescents to chronic disease.<sup>3, 4, 5</sup> Inadequate and ineffective engagement between patients, families, and their care teams as well as insufficient attention paid to the health-related social needs of families are also ubiquitous, negatively impacting child and family well-being.

A cadre of child health care leaders have invested considerable energy in identifying opportunities to transform child health care from the traditional child-focused model of well and sick visits into a more upstream, preventive, holistic delivery system model that treats all patients with dignity and respect.<sup>6</sup> This re-envisioned model: (1) is consistently anti-racist; (2) seeks to share power between children, families, and health care professionals; and (3) takes a strengths-based approach to addressing health-related social needs.

Across the child health care field, providers and health care focused organizations have made significant progress in identifying critical opportunities for transforming child health care, including: broad adoption of patient-centered medical homes; efforts to promote screening and referral for social needs; pediatric clinical quality improvement efforts; and national activities to support guidelines and standards of practice, such as those in Bright Futures.<sup>7,8,9,10</sup> Additionally, many state Medicaid agencies have adopted financing policies to help cover specific programs and practices that improve maternal and child well-being, including maternal depression screening in well-child visits, early childhood mental health, and home visiting.<sup>11,12</sup>

Over the last decade, many pediatric health care models have incorporated one or more of the strategies or programs identified above (see [Appendix](#)). This initial diffusion into the field suggests the ability to retain effectiveness as strategies to improve child health services start scaling and spreading. There is, however, still a crucial need to identify,

### ABOUT THIS REPORT

This report provides practical recommendations for providers, payers, and policymakers to consider in adopting approaches to transform child health care delivery. The report is a product of the [Accelerating Child Health Transformation](#) (AHT) initiative, led by the Center for Health Care Strategies and made possible by the Robert Wood Johnson Foundation. AHT is convening a learning community of health care providers and family representatives — with input from health system leaders, payers, and policymakers — to identify, test, and disseminate a comprehensive and adaptable set of blueprints that can support an effective, anti-racist, family-focused, wellness-enhancing, and sustaining transformation of child health care services that can lead to improved child and family well-being as well as racial equity.

test, and disseminate strategies that foster the holistic well-being of children and their families and that yield an anti-racist health care system to serve children and their families equitably.<sup>13</sup>

This report, developed by the Center for Health Care Strategies (CHCS) with support from the Robert Wood Johnson Foundation, distills insights from interviews with more than 40 child health care leaders across the country, along with a literature review, to identify opportunities to improve child health care services — beyond improvements in medical care — and explore barriers to widespread implementation.

Through these conversations and subsequent research, CHCS identified **three key strategies that are integral to child health care transformation**. These strategies create the underpinnings for improving children’s health care beyond medical care, centering child and family well-being, and incorporating an upstream approach to prevention. Recognizing that the concept of child health care transformation will evolve over time, transformation as proposed in this paper calls for:



**1. Adopting anti-racist practices and policies to advance health equity.**

It is critical to intentionally acknowledge and work to eliminate racism in provider and family interactions with the health care system. All who work within the child health care delivery system should put race equity at the forefront by being explicitly anti-racist. These efforts help undo harmful biases and dismantle racist structures that are built into everyday life.



**2. Co-creating equitable partnerships with patients, families, and providers.**

Equitable partnerships with patients, families, and providers as engaged members of the care team can rebalance existing power dynamics. Providers can partner with children and their families to better support them and give them freedom to define their priorities. Recognizing that families are the experts on themselves, a transformed child health care system would ensure that each child and their family receive high-quality care.



**3. Identifying family strengths and addressing health-related social needs to promote resilience.**

There is a need for greater collaboration with families to identify their unique strengths while simultaneously working to address health-related social needs. This requires moving beyond a traditional health care approach, which is often problem-oriented, to a broader reaching approach that uplifts strengths and values physical, social, emotional, and cognitive well-being.

Despite a growing desire to transform child health care, many pediatric practices struggle to implement improvements in care due to restrictions in time, funding, and capacity, as well as barriers within health systems that inadvertently prevent the scale and spread of these efforts. Providers and payers also lack opportunities to share ideas and test innovative approaches. In addition, through conversations with stakeholders in the field, CHCS identified measurement and financing barriers impeding practice site transformation. In response, this report offers **two primary levers to support, scale, accelerate, and sustain child health care transformation efforts.**<sup>14</sup>

- **Accountability metrics** that are patient-centered, focus on the specific developmental needs of children, and gauge progress in addressing racial and ethnic health disparities can better support child and family well-being. New metrics, which reflect the multidimensional nature of health, are needed at several levels, including the practitioner, community, and policy levels, to assess child well-being, track performance, incentivize practice change, and increase accountability in pediatric settings.
- **Financing structures** that encourage investment in healthy child development and upstream prevention and provide flexibility for providers to best meet these goals. A shift toward financing models reflecting value and quality of care will support efforts on the clinical, community, and policy levels to advance anti-racist practices, co-create meaningful strengths-based partnerships with patients and families, and address health-related social needs.

Pediatric health care providers and their multidisciplinary teams are uniquely poised to affect life-long health and well-being by intervening to prevent development delays; reduce the risk of chronic disease, trauma, and mental health difficulties; and address health-related social needs. If pediatric health care were consistently anti-racist, strengths-based, and delivered in partnership with families and communities, more children would have access to the relationships, resources, and care they need to thrive.

### Using a Dignity Framework<sup>15</sup>

A dignity framework, foundational to antiracist practice, centers dignity in all work to advance equity. Dignity is achieved through individual, interpersonal, institutional, organizational, and societal experiences. Dignity is not only based on how an individual values themselves, but how society and community values the individual. Co-design, a participatory approach to develop innovations cooperatively with community members, can honor the dignity of all patients and expand caregiver, youth, and community leadership at every stage of the process — from visioning and planning, to decision making and implementation. Engagement processes that uphold dignity lay the foundation for enduring partnerships and collective actions that support wellness and child health transformation.



# Key Strategies for Child Health Care Transformation

The following section describes the three key strategies for improving child health care and provides practical recommendations for providers, payers, and policymakers to consider adopting these approaches.

## STRATEGY 1. Adopt Anti-Racist Practices and Policies to Advance Health Equity



Leaders in the child health care field have acknowledged racism as a driver of health inequities.<sup>16</sup> Racism is experienced in the health care system by patients, caregivers, and providers alike and is reinforced by policies, practices, and interpersonal relationships. The legacy of racism in medicine includes systematic segregation, differential medical treatment based on race and ethnicity, failure to recognize the impact of racism on child and family health and long-term outcomes, and limited resources allocated to people and communities of color.<sup>17</sup> Historically, Black Americans, Native Americans, and other people of color have also experienced intentional harms by the medical system, ranging from the Tuskegee Project to study untreated syphilis, coercive and compulsory sterilizations, and the study of Henrietta Lacks' cells without consent to deprived access to medical care for infectious diseases, such as smallpox and cholera.<sup>18,19</sup>

Racism and racial health disparities persist in medicine today. Children of color, particularly Black children, are far likelier to experience poor health outcomes due to systematic and structural racism.<sup>22</sup> Infants born to Black women are twice as likely to die compared to those born to white women.<sup>23</sup> Black, Alaska Native, and Native American women are up to three times more likely to die in pregnancy-related deaths than white women.<sup>24</sup> Centuries of historical trauma related to colonization and forced assimilation into white-dominant culture and the current underfunding of health services for Native Americans have resulted in poor physical health and compromised emotional well-being.<sup>25</sup> Most recently, systemic racism has been underscored by the disproportionate rate of COVID-19 infections and deaths among Black, Indigenous, and Latino individuals.<sup>26</sup>

**ANTI-RACISM** “is the active process of identifying and challenging racism by changing systems, organizational structures, policies and practices, and attitudes to redistribute power in an equitable manner.”<sup>20</sup>

**HEALTH EQUITY** “means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”<sup>21</sup>

At an individual level, even when low or moderate levels of bias against people of color are found among health care professionals, treatment decisions, treatment adherence, and health outcomes are negatively impacted.<sup>27</sup> For example, in studies of pain management related to pediatric appendicitis, researchers found that providers were less likely to provide pain medication to Black children than white children.<sup>28</sup> A recent study illustrated the benefits of providers mirroring patient populations — mortality is cut in half when Black newborns are cared for by providers of the same race.<sup>29</sup> However, only five percent of U.S. physicians identify as Black or African American, while 13 percent of the U.S. population identifies as Black or African American.<sup>30, 31</sup>

**The Medicaid program can help reduce significant health**

**disparities for children of color.** Currently, nearly six in 10 Black, Latino, and Native American/Native Alaskan children rely on Medicaid for health care coverage.<sup>32</sup> Since Medicaid covers a large proportion of children of color, policymakers at the state and federal levels can help maximize Medicaid opportunities to increase health equity and accelerate child health care transformation.



With 35 million children on Medicaid and nearly 10 million on the Children’s Health Insurance Program (CHIP) in FY2019, even small changes to these publicly funded health coverage programs can have large impacts on access to health care services and children’s health outcomes.<sup>33</sup> Medicaid, CHIP, and Medicaid managed care plans can explicitly view success through an anti-racism and health equity lens, which have the potential to make measurable improvements in health disparities for children.<sup>34</sup>

Building trust between patients and families of color and medical teams is linked to better health outcomes.<sup>35</sup> For some families, particularly Latino families that have newly immigrated to the United States and are undocumented, a visit with a pediatric medical team can incite fear of being separated from their family or deported.<sup>36,37</sup> Black families often experience similar fears when engaging with medical providers as they have historically been, and continue to be, disproportionately represented in the child welfare system and health practitioners are mandatory child abuse reporters.<sup>38</sup> Studies show that medical professionals’ racial biases directly impact rates of reporting suspected maltreatment to child protective services among children of color (even when controlling for income).<sup>39,40</sup> To support trusting relationships, providers can look at their practice policies, but also examine their own mistrust of patients and families of color and actively work against their biases.

Providers can work to ensure an inclusive and supportive practice culture that honors racial and cultural identity, treats all patients with dignity, and fosters racial



socialization, which all support optimal child development. Racial socialization, wherein families of color teach their children about the meaning of race and culture, can serve as a protective factor against negative health outcomes associated with racism in infants, children, and their parents. Pediatric providers can help instill a sense of race-related pride in patients and families of color by encouraging them to connect with supportive community groups and by partnering with initiatives such as Reach Out and Read,<sup>41</sup> which actively seeks to provide pediatric practices with diverse and inclusive books with lead characters of color, LGBTQ identities, or characters with disabilities.

Health care providers and institutions, including pediatric practices, have a responsibility to not only acknowledge historical and current racism in medicine, but to work to dismantle racism in health care through explicit anti-racist efforts, such as establishing anti-racist policies and practices that can disrupt systemic racism and promote equity among all groups with intersecting, marginalized identities related to race, gender, ability, class, and religion.<sup>42,43</sup> Child health care providers have an opportunity to hold their organization and staff accountable to anti-racist practices and can also play an important role in combatting racism within their own communities at a structural and institutional level.<sup>44,45</sup> Some pediatric practices across the country are already working to identify and implement anti-racist practice changes through some of the strategies described below, which can help to redress health inequities.<sup>46</sup>

## EXAMPLES OF PRACTICE CHANGES

### Adopting Anti-Racist Practices to Promote Health Equity

Below are practical strategies for adopting anti-racist practices to promote health equity in the pediatric practice setting:



#### During health care provider visits:

- ✓ **Promote an environment of mutual trust and respect, rooted in dignity**, to validate feelings that families of color express about their health care treatment, ensure that interventions are responsive to families' unique needs, and consider beliefs and cultural backgrounds in the planning and delivery of care.<sup>47</sup>
- ✓ **Ensure inclusive and supportive environments to build trusting relationships** through continuity of care by the same provider and partnership-building communication styles.<sup>48</sup>
- ✓ **Use strengths-based approaches** by encouraging caregivers of color to learn more about racial socialization, for example, and how that can serve as a protective factor against negative health outcomes associated with racism in infants, children, and their parents.
- ✓ **Ensure accessibility and inclusion while reducing barriers resulting from racism, intolerance for non-English speakers, ableism, and other biases** by ensuring appropriate interpreters and multi-lingual documents are available for individuals who are not fluent in English and tailoring services to a patient's culture and language preferences using tools and trainings, such as the Culturally and Linguistically Appropriate Services developed by the Agency for Healthcare Research and Quality.<sup>49</sup>

#### Outside of health care provider visits:

- ✓ **Complete organizational race equity assessments** to evaluate current practice culture, internal policies, and capacity for addressing racism using models such as *Race Equity Tools* or *Race Forward*, for example.<sup>50,51</sup>
- ✓ **Encourage cultural humility across the organization** to promote continuous learning, improvement, and commitment to welcoming and inclusive environments.
- ✓ **Provide cultural humility, implicit bias, and race equity trainings**, encouraging trainers with lived experience of racism to share their stories with practice employees, and urging all participants to deepen their understanding of how current systems and organizational practices may contribute to discrimination against marginalized populations in the medical setting. Following formal trainings, encourage regular group reflection across the organization.

- ✓ **Train staff to engage in conversations with families about race and the effects of racism on health**, including experiences of racism in health care, and recognize the strengths that patients and families exhibit in overcoming racial harm.
- ✓ **Create space for staff to discuss the effects of racism on their personal and professional lives and support each other** as they seek to disrupt racist practices within their institutions.
- ✓ **Examine institutional policies and practices to promote organizational accountability to anti-racism and hold practitioners and staff who commit microaggressions or racist acts toward people of color accountable** for their actions by discussing the harmful nature of these acts, enacting disciplinary measures as necessary, and providing trainings, including ones where staff can learn to recognize and interrupt microaggressions and support others who experienced microaggressions.<sup>52</sup>
- ✓ **Develop recruiting strategies** to more closely align the racial and ethnic makeup of providers and organizational leadership with that of the patient population.
- ✓ **Identify and address barriers to equitable pay and promotion** to ensure equitable access to living wages, professional growth, and leadership opportunities.
- ✓ **Value and support staff with diverse life experiences and racial and ethnic backgrounds**, and ensure they feel supported in the practice, including through mentorship and peer-to-peer support.
- ✓ **Join or establish a community collaboration dedicated to anti-racism work**, comprised of interdisciplinary medical professionals, community members, and community organizations, as exhibited by Vital Village Network.<sup>53</sup>

## STRATEGY 2. Co-Create Equitable Partnerships Between Families and Providers



Families, also referred to as caregivers in this report, are a powerful force for supporting child health and life-long well-being. A child’s family and community directly impact their health, particularly through the role they play in providing children with safe, stable, nurturing relationships (SSNRs).<sup>54</sup> Studies show that SSNRs improve a child’s ability to manage their own stress response, which mitigates the risk and effects of toxic stress.<sup>55</sup>

Families should be recognized by the medical team as the *expert* on their family and serve as equal partners. Relying on medical knowledge alone and pulled by the demands of a busy practice schedule, providers can unwittingly fail to recognize and respond to a family’s concerns in the health care context. Valuing a family’s autonomy, expertise about their child, and voice creates an opportunity to gain their confidence and establish a trusted partnership. Children have a better chance of receiving the care they need when their caregivers are confident that they are being heard and feel comfortable asking questions of their child’s health care providers, providing context to inform the care plan, and openly sharing areas of struggle or need.

Family-centered care and family engagement opportunities that promote joint decision-making between the family and health care provider have become widely accepted in the pediatric field, but these approaches are not regularly implemented into clinical practice.<sup>57,58</sup> Family-centered care principles — as developed by Family Voices, Maternal and Child Health Bureau, American Academy of Pediatrics, the Institute for Patient- and Family-Centered Care, and others — include information sharing, respect, partnership and collaboration, negotiation, and care in the context of family and community.<sup>59</sup>

### PATIENT AND FAMILY ENGAGEMENT

involves “direct relationships and partnerships between patients, families, and clinical care team members that are bi-directional, reciprocal, and continuous. Goals, communication, and impacts related to engagement are open, transparent, and clear.”<sup>56</sup>

By meaningfully engaging family members as equal members of the care team, health care practitioners can build on a family’s strengths and hopes for their children to obtain a more holistic picture of a family’s situation and co-create care plans that are more likely to achieve better outcomes. Caregivers, especially those who have children with special health care needs, know how their children’s behaviors, needs, interests, and personalities can impact a care plan. They are in a foundational position to influence and advocate for their child’s optimal development.<sup>60</sup> Beyond their own child’s care, family members who feel empowered, engaged, and respected by their providers are

well-positioned to contribute their experiences to inform policy and practice changes at the organizational or institutional level.

It is important for providers to recognize that caregivers, particularly caregivers of color, often have past experiences with health care systems, which impact how they interact with their child's medical providers and how they see their own needs and the needs of their child. Additionally, there are varying definitions of family based on cultural influences and individual situations. Many health care policies are built on a limited definition of family that can, for example, focus on Eurocentric norms, tax filing status, and dependents in a single household under one roof. There is no one definition for family and some cultures view grandparents, elders, and extended family members as co-caregivers, while other family members take on roles ranging from informal kinship care, to temporary, voluntary, and formal kinship care.<sup>61</sup> Practices can take steps to identify how the family and family members define themselves and enable family engagement accordingly.

Additionally, there is a particular need to affirm father-child interactions and encourage fathers to share observations about their child's development and assume roles early on in the care of the child.<sup>62,63</sup> Research shows that fathers have specific impact on a child's developmental and psychological well-being over time.<sup>64,65,66</sup> Involved fathers can also increase the likelihood of mothers receiving prenatal care in the first trimester, help to identify or mitigate maternal depression, and decrease adolescent risk behaviors, among other benefits.<sup>67</sup>

Providers can also better support children's social-emotional well-being by incorporating a multi-generational approach to care that acknowledges the role of caregiver health as a key factor in the health of the child. Studies reflect a strong correlation between a caregiver's level of stress or mental health status and the economic, social, or cultural issues the family faces.<sup>68</sup> When caregivers are under stress or experiencing depression, they have less energy or time to devote to nurturing and supporting their children. Studies show that among children of mothers being treated for depression, children's psychiatric needs decreased over time as the mother's depression symptoms were treated.<sup>69</sup> These children had fewer psychiatric symptoms, including depression, difficulty concentrating, and disruptive or risky behavior, as well as a lower risk of abuse and neglect. Being sensitive to and responding to multi-generational needs as part of the care plan can contribute to a more positive environment for children.<sup>70</sup>

## EXAMPLES OF PRACTICE CHANGES

### Co-Creating Equitable Partnerships Between Families and Providers

Below are practical strategies for co-creating equitable partnerships between families and providers in the pediatric practice setting:



#### During health care provider visits:

- ✓ **Create a welcoming environment within the office**, beginning at the sign-in process, by encouraging all staff to take time to talk and relate personally to the family.
- ✓ **Foster a collaborative and family-centered environment** that views the family as the expert on their child’s personality, behaviors, needs, and interests. The care team can encourage, support, and partner with the family in decision-making at the level the family chooses regarding the planning and delivery of care for their child.<sup>71,72</sup>
- ✓ **Incorporate screening practices for the whole family as appropriate** during pediatric visits, to include Bright Futures Pediatric Intake Form and the Resilience Questionnaire — which seek to identify family strengths in addition to needs — or other tools that provide screening for social determinants of health.<sup>73</sup> Consider the Well-Visit Planner to engage families prior to well-child visits and support them in asking questions about their child’s development.<sup>74</sup>
- ✓ **Share information that is timely, complete, and unbiased**, using plain language that is free of medical jargon, and in ways that are affirming and useful, to help families effectively engage with provider teams and participate in care and decision-making.<sup>75</sup>
- ✓ **Capture families’ hopes and expectations for their child**, as provided during the visit, in electronic medical records for follow up at subsequent visits.
- ✓ **Provide tailored and timely anticipatory guidance materials** to support caregivers’ knowledge about social and emotional development, important safety topics, the caregiver-child relationship, caregiver mental health and positive coping strategies, and relevant community services.<sup>76</sup>
- ✓ **Build caregivers’ knowledge, confidence, and engagement through strengths-based approaches** and observations while reading, playing, and interacting with the child during visits; model activities that promote social and emotional development; co-create goals that are reflected on at subsequent visits;<sup>77</sup> and provide positive affirmations during interactions with families, including fathers.<sup>78</sup>

### Outside of health care provider visits:

- ✓ **Ensure flexibility in organizational policies, procedures, and provider practices** to support children and families' unique needs, beliefs, and cultural values of each child.<sup>79</sup> This can include increasing hours beyond the traditional weekday 9 am to 5 pm time frame, recognizing that working parents often struggle to balance work and medical visits, particularly for children with special health care needs.<sup>80</sup>
- ✓ **Connect families to community supports**, such as play groups, library time, fatherhood initiatives, and local parks, to foster much-needed support systems. Providers can also connect families to home visiting models most appropriate for them.<sup>81</sup>
- ✓ **Incorporate peer-to-peer models**, such as Parent to Parent, a national network that seeks to empower families of children with special health care needs by pairing an experienced family with a family that has a child who is newly diagnosed to share resources and provide support as they navigate the medical system.<sup>82</sup>
- ✓ **Design family engagement practices alongside family representatives**, for example, through family advisory councils or participation on boards to encourage effective integration of family voices into the clinic setting and solicit family feedback regarding practice culture changes, how patients and families are treated, their connections to community-based resources, and the selection of patient-centered measurement (as discussed [later in the report](#)), among other things.<sup>83</sup>
- ✓ **Solicit feedback from families through accessible avenues**, such as suggestion boxes, town halls, surveys, community nights, and family events.
- ✓ **Encourage families to get involved in influencing broader systems change** through programs like Family Voices, a national organization that supports caregivers of children with special health care needs by empowering them to advocate for better health care services and policies for children and youth with special health care needs.<sup>84,85</sup>

### STRATEGY 3. Identify Family Strengths and Address Health-Related Social Needs to Promote Resilience



The child health field frequently cites the relationship between social determinants of health (SDOH) and health outcomes. Many public health experts have suggested that medical professionals and their teams focus on addressing health-related social needs as well as long-held social, economic, and environmental drivers of health as part of a part of their routine visits.<sup>86,87</sup>

Encouraging a patient or their family to define their own needs alongside the clinical expertise of the pediatric medical team allows a family to inform their care in ways that are equitable and sensitive to concerns about racism and judgement. When families are empowered to define their own priorities, addressing health-related social needs in partnership with the provider can improve the quality of care for children and their families.

In addition to addressing health-related social needs, the pediatric medical visit can serve as an opportunity for children and families to recognize and build on their inherent strengths. Supporting protective factors in children’s lives can increase resiliency and improve health outcomes over the lifespan.<sup>91,92</sup> Resilience is an opportunity to celebrate strengths and joy in the face of adversity. It is, however, exhausting for marginalized groups to be consistently expected to overcome challenges and poor circumstances created by oppressive systems. In promoting resilience, the systems creating the adversity must be held accountable.

Most children will experience some type of stress — often presenting in the form of social risk and need — before age 18. Pediatric medical providers can work with caregivers starting in the earliest years to help build upon a child’s strengths.<sup>93</sup> This can provide lifelong protection that diminishes the physical, emotional, and behavioral health issues that follow prolonged stress or traumatic events.<sup>94</sup> To focus on a strengths-based approach for parents, the Center for the Study of Social Policy developed a framework that showcases everyday actions that caregivers can take to build protective factors and successfully navigate difficult situations.<sup>95</sup> The pediatric medical visit can also serve as

**HEALTH-RELATED SOCIAL NEEDS** “are the social, economic, and environmental drivers of health that have long been overlooked, such as food insecurity, housing instability, and lack of transportation. Health-related social needs (HRSN) are associated with worse health outcomes and are increasingly a focus of interventions within healthcare.” Asking patients and families about HRSN “can reveal key drivers of health inequities and marks a critical first step for targeted referrals for and investments in nonmedical services that can improve health and life expectancy.”<sup>88,89</sup>

**SOCIAL DETERMINANTS OF HEALTH** are the “non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.”<sup>90</sup>



an opportunity to connect families to community resources that provide support in specific areas of need.

Providers can identify resources alongside families based on their unique health-related social needs, such as unemployment, housing instability, or food insecurity. To the extent providers do not take such needs into account, medical interventions are less likely to be effective. As a result of unmet social needs, children, particularly those living below the poverty line, are less likely to have positive health, developmental, and educational outcomes than those whose social needs are consistently met.<sup>96</sup> While medical care itself is important, it contributes only a small share to a person's health, with social determinants of health (SDOH) having a significant impact.<sup>97</sup>

Committing to screen for health-related social needs offers an opportunity for providers to help identify unmet social needs alongside families. In adult care, 27 states require Medicaid managed care organizations (MCO) to screen for social needs, and increasingly embed similar requirements and incentives for provider-level initiatives.<sup>98</sup> In pediatrics, community health centers and children's hospitals have taken some steps to screen for social needs yet relatively few physicians and hospitals broadly screen children and their families for social needs.<sup>99</sup> Broader alignment between payors and states, however, is required to bring this practice to scale throughout pediatric care.<sup>100</sup>

Providers should recognize, however, that screening for social needs carries a risk for some families — particularly for families of color — since perceptions of unmet needs can prompt providers to report families to child protective services, for example. Research shows that health care providers are more likely to evaluate and report children of color for suspected child abuse, which makes some families hesitant to share their unmet needs.<sup>101</sup> In addition, families are too often requested to complete screens or tools that ask them to identify vulnerabilities and unmet needs, but that information is not always followed up with referrals to community resources or public benefits. Screens are the start of a process of engagement and should be used with that in mind. Empathetic engagement, motivational interviewing, and appreciative inquiry (or other techniques involving authentic engagement with the family) are key to using the screen as a basis for discussion and relationship-development.<sup>102, 103, 104</sup> It is also important that providers allow families to refuse screening that they do not feel comfortable completing, in which case a provider can have a conversation with the family about needs instead. Payers can also provide incentives to track screenings administered, referrals made, and meaningful community outreach established to link families with external supports.

### Social Need: Housing

Poor housing quality is associated with worse psychological health in children and a prevalence of elevated blood lead levels.<sup>105</sup> The lack of housing is a social determinant of health that has profound health and long-term impact for children and families. In the latest U.S. Department of Housing and Urban Development annual point in time report for those experiencing homelessness on a single night, nearly 172,000 children with families experienced homelessness.<sup>106</sup> By engaging families in conversation about social needs that is framed by the goals and needs of the patient, pediatricians can help link families to community resources or provide referrals that can best support a child's healthy development.



In addition to screening for unmet needs, some pediatric medical teams screen children for adverse childhood experiences (ACEs). ACEs can have a profound effect on a child's brain development and are associated with a broad range of poor health outcomes in adulthood.<sup>107,108</sup> Emerging science points to the importance of positive childhood experiences, which can alleviate the impacts of ACEs and provide lifelong protection in terms of health and well-being.<sup>109,110</sup> Children can be protected against long-term negative physical and mental health outcomes when a pediatric medical team can identify stress caused by unmet social needs and/or ACEs and provide resources to keep the stress from turning chronic or toxic.<sup>111</sup> Strengthening protective factors in the family and improving safety, stability, and nurturing relationships in the home can buffer against adversity, promote resilience, and support the child's healthy development.<sup>112,113</sup>

## EXAMPLES OF PRACTICE CHANGES

### Identifying Family Strengths and Health-Related Social Needs to Promote Resilience

Below are practical strategies for identifying family strengths and health-related social needs in the pediatric practice setting:



#### During health care provider visits:

- ✓ **Discuss key protective factors with caregivers**, such as caregiver well-being, social connections, knowledge of parenting and development, concrete support in times of need, and social and emotional competence of children, to enhance family resilience and positive child development while also reducing the likelihood of abuse and neglect.<sup>114</sup>
- ✓ **Co-create an eco-map**, a diagram that depicts a family's most important personal and community relationships, to better understand a family's strengths, as well as to help families identify challenges or resource gaps to address.<sup>115</sup>
- ✓ **Establish workflows and responsibilities associated with identifying social needs and connecting to available resources** as part of a team-based approach.
- ✓ **Integrate behavioral health for children and their families wherever possible** or provide community-based behavioral health resources as needed, as seen in Healthy Steps and Networks for Opportunity for Child Wellbeing.<sup>116,117</sup>
- ✓ **Integrate community health workers/promotoras/relational health workers** into the team-based care framework who are trained in child development and/or are parents themselves, as seen in Massachusetts Project Launch and many exemplary practices in the field.<sup>118, 119</sup>
- ✓ **Consider adoption of models, such as DULCE or Medical Legal Partnership**, that provide integrated access to free or low-cost legal services and address SDOH at the individual, community, and policy levels.<sup>120, 121, 122</sup>

#### If implementing social needs screening:

- ✓ **Provide education and guidance for all medical care team members on the importance of screening with dignity**, respecting a family's decision to refuse screening, and understanding the risks associated with screening, particularly for families of color.<sup>123</sup>
- ✓ **Offer screening tools that empower families to identify and prioritize needs**, such as the Well-Visit Planner, the Child and Adolescent Health Measurement Initiative Technical Working Group screening tool, the questions around SDOH in Bright Futures, the PEARLS tool, or the Survey of Well Being for Young Children.<sup>124,125,126,127</sup>

- ✓ **Take a strengths-based approach** when conducting screening for social risk and needs by employing the Strengthening Families framework or other models that focus on the inherent strengths of the child and family.<sup>128</sup>
- ✓ **If screening is implemented, standardize workflows** to ensure health promotion, support, and resources are provided as part of the visit.

#### Outside of health care provider visits:

- ✓ **Engage with community agencies and partners** to ensure that family needs are being addressed, and improve systems and infrastructure designed to help communities and provide centralized supports to providers through shared, community-based resources, such as Help Me Grow.<sup>129,130</sup>
- ✓ **Cultivate community partnerships** to offer an array of high quality, culturally appropriate community referral resources that can best support families' social needs.<sup>131</sup>
- ✓ **Create linkages for families through local resource platforms** that aid in closed referrals to social services, such as Cap4Kids, Aunt Bertha, Now Pow, and many others.<sup>132,133,134</sup>
- ✓ **Develop partnerships with managed care organizations** to support resources and referral pathways for children and families.
- ✓ **Consider advocacy opportunities to advance state policies** that address the holistic needs of children and families.

## Levers to Accelerate Child Health Care Transformation

**W**idespread adoption of the above key strategies within the pediatric practice setting requires new accountability and financing structures to support enhanced approaches to care. For these new care approaches to take root, they need to align with the operating realities of pediatric practice — realities that are currently too often driven by a quality measurement framework and a fee-for-service payment system that too narrowly define what matters for children’s health.

Policymakers and payers have key roles to play in accelerating the pace of pediatric delivery system reforms that advance racial equity, incorporate family voice, and address health-related social needs. Accountability and financial levers have yet to be fully tapped to encourage widespread adoption of these priorities and offer significant promise if employed effectively and at scale. Some examples of accountability and financial levers, as they pertain to the key strategies of child health care transformation outlined in this report, are described below.

### Accountability Levers

In child health care, traditional accountability measures and metrics often focus on ways to manage and improve children’s medical health, including tracking immunization schedules, asthma management, and prescribed medication. To accelerate child health care transformation, new measures are required to assess child and family health more holistically, such as looking at relational health or positive childhood experiences. New metrics are also needed to track changes in measures over time and assess performance of new practice changes or policies, such as looking at how well pediatric practices are engaging with families over time. Measures and metrics are needed at several levels, including the practitioner, community, and policy levels to incentivize practice change and increase accountability in pediatric settings.<sup>135</sup>

Starting at the practitioner level, measures and metrics can be used to identify specific areas of needed improvement in clinical approaches and processes that can lead to improved health outcomes. For example, better screening tools and processes are needed to assess the well-being of children more holistically and regularly.<sup>136</sup> Health is multidimensional — encompassing physical, cognitive, social/relational, emotional, family, and community well-being — and the measures and metrics used to assess health should be as well. Tools should ideally assess the strengths, needs, and risks of children’s caregivers using a strength’s-based approach. To respond to the needs, values, and preferences of patients and caregivers, it is also important to develop person-centered measurements using meaningful feedback from patients and their

families.<sup>137</sup> At the community level, particularly when disaggregated by race and ethnicity, measures and metrics can be used to identify and help address health disparities. At the policy level, they can help focus ongoing delivery system and payment reform efforts toward areas of greatest need and potential impact.

- ✓ **Systematic developmental, quality, and well-being screening measures can benefit children and families.** The AAP promotes measures that are evidence-based or informed, feasible to collect, translatable to improved care, and reflective of the diversity and complexity of pediatric care within an SDOH context.<sup>138</sup> However, even basic developmental screening measures, including the CMS Child Core Set, or the Title V National Performance Measure set, are not systematically used by practices, health plans, or states. The same is true for other types of screening tools, including Ages and Stages, Ages and Stages SE, the Parents Evaluation of Developmental Status, and the Survey of Well-Being of Young Children.<sup>139</sup> Additionally, many current quality and well-being measures do not account for key activities and outcomes that lead to child well-being and that matter most to families. Requirements and incentives can be used to encourage providers and plans to screen patients more regularly and holistically. Researchers find that adding financial incentives for screenings boost screening rates.<sup>140</sup> Particularly for infants and toddlers, screening for developmental milestones related to secure bonding and attachment and early self-regulation and identity are foundational to lifelong healthy trajectories.
- ✓ **Parental engagement can be used to develop better screenings, provide ongoing feedback and accountability, and gather information during their child’s well-visit.** Experts in the field point to a number of best practices to support effective implementation of health-related social needs screenings: (1) families need to be involved in the development of the screening tools; (2) tools must include both risk and protective factors to better evaluate safety, stability, nurturing, and resilience; (3) screenings should follow the families’ lead to empower families to have a say in their children’s care; and (4) staff administering screening tools should be trained in strengths-based approaches to build on existing family strengths.<sup>141</sup> The Child and Adolescent Health Measurement (CAHMI) Initiative developed a Cycle of Engagement process — a set of web-based and parent-focused tools — that engages parents in an ongoing and collaborative approach to create accountability and improve pediatric care.<sup>142</sup> As part of that process, CAHMI also developed the Well-Visit Planner, which collects information and concerns from parents prior to a well-visit so the parents can be informed and active participants during the visit, and it can be better tailored to their needs.<sup>143</sup>

- ✓ **Patient-centered measurement can help inform care delivery and improve health outcomes.** Payers, government authorities, and providers usually decide what measures and metrics are used and how they are collected and tracked. These measurements, however, may not be aligned with the preferences of patients and caregivers. The American Institutes for Research developed principles for making measurements in health care settings more patient centered. They recommend that measurements should be: (1) holistic to take into account patient experiences within and outside the health care system; (2) comprehensible, timely, and transparent so that patients and caregivers easily understand how data are used to inform health care delivery; and (3) patient-driven and co-created to ensure that patients and caregivers have a voice in what is being measured, how performance is assessed, and how data are collected, reported, and used.<sup>144</sup> Including patients and caregivers in measurement decisions can help build trusting relationships with practitioners and provide a more complete picture of the child’s and family’s health and well-being.<sup>145</sup> To serve as accountability levers, metrics can track progress toward effective family engagement and trust-building between caregivers and practitioners, among other indicators.
- ✓ **Accountability metrics can be designed to gauge progress in addressing health disparities and implementing anti-racist policies and practices.** To improve health equity, racial disparities need to be identified and measured. Disaggregating data and metrics by race, ethnicity, and language spoken is an important step to understanding how communities of color are served, treated, and impacted.<sup>146</sup> Collection of race and ethnicity data is central to these efforts, and in communities with specific and predominant racial and ethnic subgroups, the data should be sufficiently disaggregated to assess for disparities among and between these specific communities. For example, a broad category like Asian Americans, Native Hawaiians, and Pacific Islanders does not provide insights into how the more than 50 detailed racial subgroups in that category can differ dramatically across indicators.<sup>147</sup> Similarly, individuals from Middle Eastern or North African descent are usually categorized as white in demographic surveys and thus become invisible to decision-makers, which can leave their critical needs unmet. Identifying and better understanding racial disparities at the practice, community, and state/federal policy levels can help target quality improvement in the care provided. As part of that process, pediatric practices can consider developing and implementing practice culture assessments to measure progress in adopting anti-racist practices (like participation in anti-bias training for staff). Practices can also measure progress made in interviewing, hiring, and retaining a more diverse workforce (at the front staff, provider, and leadership levels) to more

closely reflect the demographics of the populations served and to reduce implicit biases and incidences of interpersonal racism.<sup>148</sup>

- ✓ **Accountability metrics can support value-based payment initiatives at the practice level.** Metrics can be developed to guide performance and incentivize practice transformation. Metrics that relate to practice efforts to support healthy child development, social needs, racial equity, and family strengths and goals can be used in value-based payment initiatives to help incentivize the acceleration of child health care transformation and lead to more rapid improvements in child well-being. Metrics research, development, and testing are important to drive a continuous learning loop that can inform the field over time.<sup>149</sup> While difficult to develop and implement, cross-sector data-sharing systems may be useful to improve the design and evaluation of value-based care models that can effectively impact children’s health. Data definitions, benchmarks, collection methods, and reporting structures need to be better aligned across health, education, child welfare, and social service systems.<sup>150</sup> Short- and mid-term measures that consider the preventive nature of children’s health may be particularly valuable since long-term outcomes for early interventions can take years to measure.<sup>151</sup>

## Financial Levers

Value-based payment (VBP) is one financial lever that can be used to improve pediatric care. With few exceptions, much of the pediatric care in the United States is delivered by providers who are reimbursed through a fee-for-service payment structure. Although primary child health care under Medicaid is increasingly being provided through managed care, the payments for primary care generally remain on a set fee per visit, often with quite low levels of reimbursement. Low payment levels, either within fee-for-service or managed care systems have been problematic for delivering comprehensive care that addresses broad health needs. Shifting to payment models that reflect value and quality of care, as opposed to volume, has significant implications for advancing anti-racist practices, promoting equitable partnerships between patients and families, and addressing health-related social needs.

Whereas VBP models for adult care often focus on cost reductions and shared savings, VBP for pediatric care requires a different focus. As children generally have lower health care costs than adults, a focus solely on short-term cost savings should not be expected and should not be a primary goal of payment reform for children. Instead, alternative payment models for pediatrics should encourage investment in healthy child development and prevention and provide flexibility for providers to best meet these goals. Payment models need to be designed in a way that consider factors that contribute to overall health through prevention and promotion efforts, including



achieving developmental milestones, meeting social needs, enhancing brain development, advancing behavioral health, and impacting broader community conditions. These all have value, as they lay the foundation not only for a healthy childhood but for health and positive life outcomes in adulthood.

There are specific financial models that offer promise for the field, particularly for addressing health-related social needs. For example, enhanced payments may better cover the various community partners and coordination costs needed to address social needs. Similarly, other VBP arrangements that offer predictable, upfront payment not tied to specific payment codes, such as per-member-per-month payments for enhanced, relational care coordination, could provide additional flexibility to support more coordinated care that addresses broader social needs.<sup>152</sup>

✓ **Financial incentives can be used to encourage accountability in advancing anti-racist practices in child health care services.**

For example, practices can explore opportunities to enter VBP arrangements in which practices are rewarded for high performance on race/ethnicity stratified quality measures (e.g., comparable A1c levels across racial and ethnic groups). Policymakers could use financial incentives to encourage MCOs to focus on equity measures and provide guidance on best approaches for meeting equity targets for practices and MCOs. For example, Michigan’s 2021 bonus program rewards providers for improvements in reducing disparities in primary care related measures among Black and Latino patients. Michigan also requires MCOs to partner with primary care providers to deliver interventions that are effective in reducing racial disparities.<sup>153</sup> Policymakers could also implement approaches that incentivize mentoring of new clinicians, maintaining a pipeline of people of color (who are historically underrepresented in medicine), and additional support and training related to anti-racism during residency.

✓ **Payment strategies can promote multigenerational care delivery.**

By focusing on enhanced early interventions, including for those with social stresses and needs — including ACEs — states and MCOs can make a difference in long-term health outcomes over decades. Recent literature has shown the intergenerational effects of maternal depression, homelessness, and ACEs. For example, parents with higher ACE exposure as children are more likely to have children with poorer health outcomes.<sup>154</sup> Pediatric payment models should ideally consider the needs of both the child and their caregivers, thereby supporting the opportunity to impact the health trajectory of both in parallel. States can consider opportunities to expand specific services for both children and families, including expanding the use of dyadic therapy.<sup>155</sup> Pediatric practices can work with MCOs to consider augmented rates or new payment streams to incentivize additional time

with family members, which could include more extensive care coordination for the caregiver or family.<sup>156</sup>

- ✓ **Payment models and funding mechanisms can be used to support practices that address health-related social needs of children and families.** Risk-adjusted payment and enhanced payment rates based on severity of needs is one way that states can support the time it takes providers to address social needs.<sup>157</sup> States can also require MCOs to make community investments and provide incentives for MCOs to address social needs and achieve population health and SDOH-related goals that include children.<sup>158</sup> Payment models can fund providers to screen for health-related social needs and provide flexibility and funding for different levels of staff that can assist in closed loop referrals for patients, which can help providers track the success of connections to local resources.
- ✓ **Statewide cross-sector and collaborative policy efforts focused on child health can address a “wrong pockets” problem, where investment in early interventions by the health care and broad health system result in cost savings to different systems.** Value-based payment systems focused on adult populations are often designed to produce medical savings, or better outcomes at equivalent costs, through alternative responses to patients with presenting health conditions. However, as noted earlier, spending on child health is relatively low, and improving children’s health has impacts that go beyond medical care and costs, to the child’s performance in school, involvement in the community, and preparation for adulthood — with gains to society in improved income, reduced involvement in justice systems, and greater contribution to society down the road. As a result, focusing solely upon medical outcomes and costs leads to underinvestment in children’s health and minimizes the return-on-investment that is possible outside of health care. Children’s health leaders can support longer-term investments by bringing additional cross-sector partners to the table that reap the benefits of investment in children’s health care. Some states have developed formal structures, called “Children’s Cabinets” to better align resources across different sectors that impact children’s health.<sup>159</sup> Other formal examples include the Help Me Grow model, a collective impact model focused on early childhood that relies on cross-sector partnerships at the local, state, and national level to accelerate change.<sup>160</sup> States can play an active role to incentivize comprehensive approaches that address SDOH, including targeted funding streams to advance children’s health or the explicit funding of HUB or bridge organizations that organize multi-system providers and stakeholders.<sup>161</sup>

## Looking Ahead: Care Delivery Transformation

**T**here are many exemplary and dedicated practitioners, payers, and policymakers that offer models for how to transform the child health care system into one that impacts young patients and their families equitably and holistically so all children have the opportunity to thrive (see [Appendix](#)). Based on conversations with leaders in the field, many are grounded in a desire to support the strategies outlined in this report:



1. Adopting anti-racist practices to advance health equity;
2. Co-creating equitable partnerships between families and providers; and
3. Identifying family strengths and addressing health-related social needs to promote resilience.

In taking steps to transform how care is delivered at the practice level — for example, by promoting new metrics that better measure the true health and well-being of children and their families or testing alternative payment mechanisms to support better care for children — providers, health system leaders, payers, and policymakers can collaborate to accelerate the pace of child health care transformation in the U.S. Recognizing that health care represents only one cog in the cross-sector system that contributes to the health and well-being of children and their families, these collective efforts will drive the health care system to improve and support a healthier trajectory over the life course for millions of children across the nation, particularly for those most impacted by racism. By consistently working to dismantle racist policies and practices within health care, this transformation can mitigate the documented effects of racism on health for children and contribute to future generations of healthier adults.<sup>162</sup>

# Appendix

## InCK Marks' Compilation and Crosswalk of Evidence-Based/Promising Programs Involving Primary Child Health Practitioners Serving Young Children (0-3 or Prenatal-3)

This list, based on a literature review, provides examples of recognized, promising, and evidenced-based programs to improve child health services. While the list is not exhaustive, it highlights many programs with evidence that compares favorably with those in the early care and education sectors. Each column represents an environmental scan focused on identifying promising programs in pediatric care. While none of these environmental scans individually provide a comprehensive review, and the compilation of their lists likely does not identify all programs originating in the child health practitioner setting with strong research findings, the substantial overlap of independent reviews points to the emergence of a field of practice with a strong evidence base.

- **Column 1:** [Promoting Young Children's \(0-3\) Socioemotional Development in Primary Care](#), Einhorn Family Charitable Trust, Ariadne Labs, and the National Institute for Child Health Quality (NICHQ)
- **Column 2:** [Fostering Social and Emotional Health through Pediatric Primary Care: Common Threads to Transform Practice and Systems](#), the Center for the Study of Social Policy (CSSP)
- **Column 3:** [Vibrant and Healthy Kids; Strategies for Scaling Tested and Effective Family-Focused Preventive Interventions to Promote Children's Cognitive, Affective, and Behavioral Health; Parenting Matters: Supporting Parents of Children Ages 0-8; Fostering Healthy Mental, Emotional, and Behavioral Development in Children and Youth: A National Agenda; Moving from evidence to implementation of early childhood programs: Proceedings of a workshop—in brief](#), the National Academy of Sciences Engineering and Medicine (NASEM)
- **Column 4:** [Taking Stock of Outcomes and Economic Returns from Early Childhood Programs](#), RAND Corporation
- **Column 5:** [What Is Health Equity? And What Difference Does a Definition Make?](#) the Robert Wood Johnson Foundation (RWJF)
- **Column 6:** [Transforming Young Child Primary Health Care Practice: Building Upon Evidence and Innovation](#), Child and Family Policy Center and Build Initiative's Health Equity and Young Children Collaborative (HE&YC)

PROGRAM OR MODEL	1	2	3	4	5	6
ACE Screening Intervention	✓					
Attachment and Biobehavioral Catch-up (ABC) *			✓			
Brazelton Touchpoints	✓					
Centering Parenting	✓	✓	✓			
Centering Pregnancy			✓	✓		
Chicago Doula Project				✓		
Child First *				✓	✓	✓
Circle of Security Parenting	✓			✓		
Collaborative Problem-Solving Approach	✓					

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PROGRAM OR MODEL	1	2	3	4	5	6
Community Health Workers			✓			
DULCE	✓	✓				✓
Empowering Mothers		✓				
Family Connects *		✓	✓	✓		
Family Foundations	✓		✓	✓		
Family Spirit *				✓	✓	
Filming Interactions (FIND)			✓			
Health Leads			✓			
Healthy Start Plus Family Thriving	✓					
HealthySteps	✓	✓	✓	✓	✓	✓
Help Me Grow			✓			
Incredible Years	✓	✓	✓	✓	✓	
Infant Health and Development Program	✓					
Infant Parent Psychotherapy (IPP)			✓			
Medical Legal Partnerships			✓			✓
Infant/ Early Childhood Mental Health Consultation		✓				
Minding the Baby *	✓			✓		
MOMs		✓	✓	✓		
My Baby and Me			✓			
Newborn Individualized Development Care (NIDCAP)	✓			✓		
Nurse Family Partnership *	✓		✓		✓	
Parent-Child Interaction Therapy (PCIT)			✓		✓	
Parent-Focused Redesign (PARENT)			✓			
Pri-Care					✓	
Project Launch – Massachusetts		✓				
Promoting First Relationships		✓		✓		
Quality Through Technology (QTIP)		✓				
Reach Out and Read	✓	✓	✓	✓	✓	
SEEK (Safe Environment for Every Kid)			✓	✓		✓
Strengthening Families			✓			
Triple P Positive Parenting Program	✓		✓		✓	
Video Interaction Project	✓	✓		✓		
WE CARE			✓			

**Appendix Notes:**

There are many more programs that have a research or evidence base that have or could be used within a pediatric setting than those enumerated in these different reviews, none of which sought to be comprehensive and exhaustive.

Those with asterisks (\*) represent home visiting program models and all five are included in the 19 home visiting programs approved in the federal Home Visiting Evidence of Effectiveness (HomVEE) system as of August 2021.

Project LAUNCH Massachusetts is a particular, well-researched LAUNCH site from a number of Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) Initiatives supported by federal funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) and designed to improve children's healthy development birth to eight. A cross-site, multi-year evaluation is available at:

<https://www.acf.hhs.gov/opre/research/project/cross-site-evaluation-of-project-launch-linking-actions-for-unmet-needs-in>

In addition to specific program models, the InCK Marks report, Young Child Health Transformation: What Practice Tells Us, from which this matrix is taken, also describes a number of systemic efforts that have drawn from these program models (often incorporating features of several) to transform pediatric practice and also have shown evidence of substantial success. Please look to the report for descriptions of over a dozen pediatric sites who are excelling in this realm, but this in no way represents a complete list of such efforts.

The Well-Visit Planner and its Cycle of Engagement, developed by the Child and Adolescent Health Measurement Initiative, represents a screening and engagement model and not a program per se and provides research-based tools and resources which support parents in their own preparation for well-child visits and enable practices to partner with parents in advancing child health across physical/medical, cognitive/developmental, social/relational, and emotional/behavioral development.<sup>163</sup>

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