

Trenna Valado, Jennifer Tracey, Jonathan Goldfinger, and Rahil Briggs

at a given clinic (the intervention group) were compared to families served by clinics that didn't offer HealthySteps (the control group). Researchers consider an RCT to produce stronger evidence than a QE design, since an RCT compares families in the same practice, thus avoiding the potentially confounding effect of differences between practices. But in a QE design, families receiving services were still compared to similar families not receiving those services. RCT and QE designs both contrast favorably with nonexperimental designs that lack a control or comparison group, as this limits researchers' ability to attribute positive results to the intervention being studied. (Nonexperimental research can still yield valuable insights and point to directions for future research, as shown in the discussion of site-level studies below.)

A total of 5,565 children and their parents were enrolled in the national evaluation—2,963 in the intervention group (1,133 in RCT sites, 1,830 in QE sites) and 2,602 in the control group (1,102 in RCT sites, 1,500 in QE sites). All sites followed the same implementation protocols and drew data from the same sources, including:

- newborn HealthySteps enrollment forms
- child medical records
- contact logs
- telephone interviews with mothers or other primary caregivers at three points in time (2–4 months, 30–33 months, and 5–5.5 years), and
- interviews and self-administered questionnaires with practice staff at two points in time (at the start of the

evaluation and 30 months later).

An observation study was also conducted at two of the RCT sites to assess the quality of the home environment, mother-child interactions, and child development among 432 families visited in their homes at 16–18 months and again at 34–37 months. The national evaluation found that HealthySteps had positive impacts on the participating practices, as well as on the children and families served.

Box 2. What Are Adjusted Odds Ratios?

Many results from the national evaluation are presented as adjusted odds ratios (AORs). An odds ratio is a way to measure the association between an intervention and a given outcome. As explained in the final report, “an odds ratio of greater than 1 indicates that subjects in the intervention group were more likely to report a given characteristic than were subjects in the control group; an odds ratio of less than 1 indicates that subjects in the intervention group were less likely to report a given characteristic than were subjects in the control group. An odds ratio of 1 indicates that there was no difference between intervention and control groups.” The larger the odds ratio, the bigger the difference between the groups. For example, an odds ratio of 10 means that, compared to the control group, the intervention group had 10 times the odds that a given outcome would be observed. An adjusted odds ratio accounts for other variables that could influence a given outcome (such as education level or income) and adjusts the odds accordingly.

Practice-Level Results

Physicians in both the RCT and QE sites reported that HealthySteps encouraged a team approach and increased their understanding of families' needs.¹⁵ After 30 months of HealthySteps, clinicians (including pediatricians and clinical specialists other than the HealthySteps specialist) were five times more likely to report being “very satisfied” with their staff's ability to meet the behavioral and

Office is currently customizing this analysis for other HealthySteps sites and state Medicaid agencies.

Synergy with Other Models

Because HealthySteps expands the capacity of pediatric practices by adding a new professional to the care team, HealthySteps sites have consistently noted that the model is an excellent platform for additional innovations. Examples of programs that can be layered onto well-child care include Reach Out and Read (ROR), Video Interaction Project (VIP), Family Information & Navigation Desk (FIND), Health Leads, Safe Environment for Every Kid (SEEK), Kids' Health Insurance by Educating Lots of Parents (Kids' HELP), and Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE). Research has shown that these and similar programs have a range of positive impacts on children and families:

- ROR gives families books in the pediatric office and encourages them to read with their children. ROR has been shown to increase the frequency with which parents read to their children and report reading with their children as a favorite activity.⁴³ It also leads to enhanced language development in preschool children.⁴⁴
- VIP builds on ROR's approach to promoting cognitive, language, and social-emotional development. This program adds a new team member, a child development interventionist, who helps parents identify goals for their child's development. It also provides developmentally appropriate toys and reading materials, and suggests

activities for parents to do with their child at home. The interventionist videotapes parent-child interactions in the office and watches the video with the parents, reinforcing positive parenting and identifying opportunities for improvement. Parents take home a copy of the video to help them carry out the activities and to share as a learning resource for other family members. VIP children are more likely to experience typical cognitive development and less likely to experience developmental delays, and VIP parents experience less parenting stress.⁴⁵

- FIND trains college students, community members, medical residents, care coordinators, and community health workers to screen for social needs in pediatrics and to connect children and families with appropriate community resources. Not only did FIND significantly improve social needs among families screened and connected through a pediatric practice, but an RCT also showed improvements in children's health according to their caregivers.⁴⁶
- Health Leads focuses on helping health care providers tackle unmet social needs—such as food, housing, and employment—that can harm child health and development. Trained student volunteers work with physicians to identify family needs and refer families to the appropriate program. The volunteers then follow up with referred families and give them information on community-based resources. The program has demonstrated success in both

Trenna Valado, Jennifer Tracey, Jonathan Goldfinger, and Rahil Briggs

identifying needs and connecting families to needed supports.⁴⁷

- SEEK focuses on children's exposure to parents' mental and behavioral health problems. The program trains child health care professionals to screen for and address four adverse childhood experiences (ACEs) in parents: depression, stress, substance misuse, and intimate partner violence. SEEK pediatric providers reported feeling more comfortable and competent helping with mental health and social needs.⁴⁸ They also reported fewer referrals to child protective services, fewer documented instances of possible medical neglect, a reduction in delayed immunizations, and fewer severe physical assaults.⁴⁹
- By using trained parent mentors, Kids' HELP produced improvements in child insurance coverage, parent satisfaction with doctors, access to a primary care provider and specialty care, and preventive and dental care needs. It also reduced out-of-pocket costs.⁵⁰
- WE CARE trains pediatric providers to use a 10-item screening tool to assess families' psychosocial needs, and then offers a tailored community resource guide for related referrals. Compared to families who didn't participate in the program, WE CARE families were more likely to access employment, childcare, and fuel assistance, and less likely to remain homeless.⁵¹

Despite these positive results, programs that tackle children's and families' varied needs in a pediatrics setting face two challenges when it comes to financial sustainability. First, health insurers rarely recognize

volunteers, peers, or other "navigators" as professionals whose services should be reimbursed. Second, meeting families' social needs requires a broad array of community organizations and agencies, necessitating costly community engagement and alignment work to develop detailed, accurate resource listings and databases, as well as formal information sharing agreements.

All the enhancements discussed above may be implemented more efficiently through HealthySteps, benefiting from the time and expertise of HealthySteps specialists and from the family-centered culture at HealthySteps sites. Another plus is the fact that HealthySteps specialists' education and licensure are already known to payers, which may increase the chance of reimbursement for additional services in the clinical setting. Several HealthySteps sites have also found that their pediatric practice and/or HealthySteps specialist became a locus for community resource alignment and change, building on relationships developed with community professionals to reduce barriers that prevent families from accessing needed resources.

Beyond the programs mentioned above, other models aim to redesign well-child visits in novel ways. Three examples of this are Parent-Focused Redesign for Encounters, Newborns to Toddlers (PARENT), Project DULCE (Developmental Understanding and Legal Collaboration for Everyone), and group well-child care. PARENT embeds a trained, master's-level parent coach (similar to many HealthySteps specialists) in the primary care team. The coach offers families most of the developmental guidance that usually comes from pediatricians in typical well-child care. This allows doctors to provide more brief, focused interventions for child

and family needs, especially around physical health, growth, and development. PARENT also uses web-based tools to customize the visit, ensure pre-visit screenings, and send text-based health messages to families. In an RCT that enrolled mostly families living on very low incomes, parents who received the program reported more preventive services (such as anticipatory guidance, developmental screening, psychosocial assessment, and opportunities to respond to parents' developmental or behavioral concerns), more family-centered care, and fewer emergency room visits.⁵²

DULCE offers services similar to the core components of HealthySteps—including an integrated family specialist—and adds a medical-legal partnership offering legal services and regular, collaborative, educational meetings of health care and legal professionals to discuss families' cases. Unlike HealthySteps' three years of intervention, DULCE serves families for the first six months of a child's life. An evaluation has shown that outcomes from DULCE include more vaccinations and well-child visits, improved access to concrete resources, and fewer emergency room visits. But the researchers noted that “for many outcomes, the effect size diminished by six months [after the program ended—that is, when the child was 12 months old] to the point that it was not significant.” That drop-off may be related to DULCE's relatively brief intervention time frame.⁵³

Finally, in group well-child care, often referred to as “centering,” families share the well-child visit experience with other families and professionals in a single room—an approach shown to be both feasible and acceptable to parents.⁵⁴ Group well-child care goes a step further than AAP

recommendations to include parents as team members: it uses parents' voices and experiences to support one another. Visits are thus both led by professionals and enhanced by peers; in studies, parents consistently find this approach valuable. However, group well-visits haven't become a norm in pediatrics. One problem is that studies show children in group well-child care may be less likely to receive recommended vaccines, and providers may be less likely to identify unique risks in their home environment.⁵⁵ Parents have also expressed concern about not having enough private time with the provider.⁵⁶ In addition, the sessions are difficult to schedule, given the need to coordinate multiple families and care team members.

The three models described above could benefit from the integration and potential for sustainability offered by HealthySteps. In fact, some HealthySteps sites have already pursued such integration, a process that they should complete while still adhering to HealthySteps' implementation guidelines.

The Future of Relationship-Based Primary Care

Our comparison of enhanced primary care models yields several important lessons. First, by integrating trained team members into pediatric primary care to address child development, parenting, mental health, insurance coverage, and access to health care and social services, practices can consistently transform families' experiences and improve a wide range of child and family outcomes. Second, both parents and providers appreciate and benefit from changes to traditional well-child care, but it's paramount to ensure that innovations don't lead to neglect of other risks and needs (such as child safety and vaccination). Third,

Trenna Valado, Jennifer Tracey, Jonathan Goldfinger, and Rahil Briggs

it appears that innovative interventions in child development, parenting, mental health, and social needs can be more effectively incubated and implemented in pediatrics by adding a dedicated team member, as in HealthySteps, VIP, PARENT, FIND, and Kids' HELP. Without team-based care, it's likely that lack of time and burnout will continue to limit sustainable improvement. A recent article emphasized that burnout "imperils the Triple Aim" of health care ("enhancing patient experience, improving population health, and reducing cost"); it recommended adding another goal for a "Quadruple Aim" that encompasses improvement in the work life of health care providers.⁵⁷ Clearly, we need more research into how team-based care encourages innovation. Such research will be a focus of the HealthySteps National Office work described above, exploring how HealthySteps sites across the network might best deal with breastfeeding, child social-emotional development, childhood obesity, maternal depression, family social needs, and parent-child relationships.

An open-minded, collaborative approach would show funders and payers where synergy truly exists.

One challenge acknowledged by the HealthySteps National Office is that providers, philanthropy, payers, and policymakers may not always recognize the subtle programmatic differences that can alter how much an intervention costs, how many children and families can be reached, which outcomes are plausible and how long they might persist, and the likelihood of

achieving sustainability. We encourage all models and interventions that seek to enhance primary care in early childhood to share what works best, to use the same measurements, and to consider conducting studies that compare models one-on-one and in conjunction—as health care trailblazers have done for treatments that address blood pressure, diabetes, and cancer. Sometimes two models yield better results than one, and sometimes not. Such an open-minded, collaborative approach would show funders and payers where synergy truly exists, and help them make an impact when taking programs to scale.

In this spirit, the HealthySteps National Office has embarked on two place-based partnerships. In Guilford County, NC, the partnership is starting from the model up, piloting the integration of HealthySteps with both the Family Connects model developed at Duke University and the Nurse-Family Partnership model, with support from the Duke Endowment. Family Connects is a universal model that identifies child and family needs in the birth hospital and during later home visits, and then connects families to services. (For more about Family Connects, see the article in this issue by Kenneth A. Dodge and W. Benjamin Goodman.) In Tulsa, OK, the partnership stems from metrics and data, and involves developing integrated care coordination, data systems, and measurement across several models and initiatives. This program is being implemented in partnership with the Birth to Eight Strategy Tulsa of the George Kaiser Family Foundation, which is designed to engage families during pregnancy and follow them through the early years of children's lives. In addition to these two place-based initiatives, the

National Office is exploring opportunities to coordinate HealthySteps with other models, such as VIP and Help Me Grow.

This work raises important questions. Where does one model end and another begin? How do we establish the criteria for adherence to integrated models? Can we still rely on research into each individual model when discussing what integrated models might achieve? And how about the additive effects that could lead to new outcomes not previously shown or assessed? Even with two proven models, administrators can spend months ironing out where services should and shouldn't overlap (for example, which child and family needs benefit from redundancy and which do not) and how to navigate different populations, priorities, measurements, and data systems. Hopefully, the lessons from Guilford, Tulsa, and other communities will help identify ways to do these things quickly and effectively.

Meanwhile, the HealthySteps National Office is confident that momentum is building for relationship-based, team-based primary care to become a norm in the United States. With generous support from Blue Meridian Partners, the National Office at ZERO TO THREE is planning to scale the model over the coming years so that HealthySteps is present in all 50 states and serving one million children per year by 2032.

Two converging trends are creating significant support for system-wide change that will make it possible to scale HealthySteps, and conceivably other forms of enhanced primary care as well. The first is mounting public recognition, based on ever-increasing scientific evidence, that a child's earliest years and relationships strongly affect lifelong wellbeing. Understanding that these

early years and their relationships with their child are critically important, new parents are likely to demand better services to guide them in parenting and to meet their families' needs.⁵⁸

The second trend is the unsustainable rise in health care costs, which is leading public and private payers—including the recent collaboration of massive employers Amazon, JP Morgan Chase and Berkshire Hathaway—to focus on paying for quality preventive care and outcomes rather than paying fees for specific services. Previous value-based purchasing efforts (that is, linking payments to improved clinical outcomes) have focused on adults. But now payers and policymakers are increasingly recognizing that shifting the focus to the early years could generate long-term cost savings and help contain the rise in health care spending—while simultaneously improving long-term health and wellness. Although young children are typically healthy and incur minimal health costs, recent federal efforts in Medicaid and CHIP have shifted to an increased emphasis on pediatric care. The federal government is funding a Medicaid Innovation Accelerator Program to bolster pediatric value-based purchasing efforts for children's preventive oral health services as well as maternal and infant health, including pediatric medical homes and breastfeeding. And in April 2017, the federal Centers for Medicare and Medicaid Services Innovation Center solicited comments on the design of alternative payment models to improve the health of children covered by Medicaid and CHIP.⁵⁹ This is the first effort at the federal level to explore innovative payment approaches in pediatrics, including extending accountable care organizations (a network of clinicians who share financial responsibility to deliver and coordinate care for a given set of individuals, with the goal of improving

Trenna Valado, Jennifer Tracey, Jonathan Goldfinger, and Rahil Briggs

clinical outcomes and reducing associated costs) to pediatric populations. States are also working closely with the federal government on these innovative initiatives, aiming to transform pediatric practice among local providers.

Transforming the Promise

As primary care faces increasingly complex demands, pediatrics must take on the challenges and nuances of team-based care, relationship building, family mental health and social needs, and changes in financing. Still, relationships remain a profound context for learning and positive change, as HealthySteps has proven over the past 20-plus years.

To realize cost savings, all enhanced primary care models would be wise to monitor trends not only in health care financing and the use

of technology to make care more accessible and affordable, but also in developing and integrating innovative models. At the same time, innovation should proceed cautiously and thoughtfully, given that the relationship between staff and patient is at the center of health care. Innovations that both streamline routine activities and foster this growing relationship are the gold standard for future investment.

The birth of a child is an opportunity, and the relationships that support new families offer a critical path for change, with the power to shift generational patterns and improve outcomes for both parents and children. HealthySteps has shown that it can help transform the promise of pediatric care by responding to a wider array of child and family needs that can affect children's health and wellbeing.

Endnotes

1. Laurel K. Leslie et al., "Primary Health Care: Potential Home for Family-Focused Preventive Interventions," *American Journal of Preventive Medicine* 51 (2016): S106–18, <https://doi.org/10.1016/j.amepre.2016.05.014>.
2. Data Resource Center for Adolescent and Child Health, "2016 National Survey of Children's Health," accessed August 11, 2018, <http://www.childhealthdata.org>.
3. National Head Start Association, "National Head Start Fact Sheet: Head Start by the Numbers," accessed August 11, 2018, <https://www.nhsa.org/national-head-start-fact-sheets>.
4. Sheri Madigan et al., "Maternal Adverse Childhood Experience and Infant Health: Biomedical and Psychosocial Risks as Intermediary Mechanisms," *Journal of Pediatrics* 187 (2017): 282–9, <https://doi.org/10.1016/j.jpeds.2017.04.052>.
5. American Academy of Pediatrics, *Addressing Adverse Childhood Experiences and Other Types of Trauma in the Primary Care Setting* (2014), https://www.aap.org/en-us/Documents/ttb_addressing_aces.pdf; Council on Community Pediatrics, "Poverty and Child Health in the United States," *Pediatrics* 137 (2016): e2016033, <https://doi.org/10.1542/peds.2016-0339>.
6. Julie P. Katkin et al., "Guiding Principles for Team-Based Pediatric Care," *Pediatrics* 140 (2017): e20171489, <https://doi.org/10.1542/peds.2017-1489>.
7. Data Resource Center for Adolescent and Child Health, "2016 National Survey."
8. Ibid.; Medical Home Initiatives for Children with Special Needs Project Advisory Committee, "The Medical Home," *Pediatrics* 110 (2002): 184–6, <https://doi.org/10.1542/peds.110.1.184>.
9. Data Resource Center for Adolescent and Child Health, "2016 National Survey."
10. Tumaini R. Coker et al., "Parent-Reported Quality of Preventive Care for Children At-Risk for Developmental Delay," *Academic Pediatrics* 12 (2012): 384–90, <https://doi.org/10.1016/j.acap.2012.05.003>.
11. Vidya Bhushan Gupta et al., "Care Coordination Services in Pediatric Practices," *Pediatrics* 113 (2004): 1517–21.
12. R. Christopher Sheldrick and Ellen C. Perrin, "Evidence-Based Milestones for Surveillance of Cognitive, Language, and Motor Development," *Academic Pediatrics* 13 (2013): 577–86, <https://doi.org/10.1016/j.acap.2013.07.001>.
13. ZERO TO THREE and Bezos Family Foundation, *Tuning In: Parents of Young Children Speak Up about What They Think, Know, and Need* (Washington, DC: ZERO TO THREE, 2016).
14. Bernard Guyer et al., *Healthy Steps: The First Three Years: The Healthy Steps for Young Children Program National Evaluation* (Baltimore: Johns Hopkins Bloomberg School of Public Health, 2003).
15. Ibid.
16. Ibid.; Kathryn Taaffe McLearn et al., "Developmental Services in Primary Care for Low-Income Children: Clinicians' Perceptions of the Healthy Steps for Young Children Program," *Journal of Urban Health* 81 (2004): 206–21, <https://doi.org/10.1093/urban/jth108>.
17. Guyer et al., *Healthy Steps*.
18. Cynthia S. Minkovitz et al., "A Practice-Based Intervention to Enhance Quality of Care in the First 3 Years of Life: The Healthy Steps for Young Children Program," *JAMA* 290 (2003): 3081–91, <https://doi.org/10.1001/jama.290.23.3081>.
19. Cynthia Minkovitz et al., "Early Effects of the Healthy Steps for Young Children Program," *Archives of Pediatrics and Adolescent Medicine* 155 (2001): 470–9, <https://doi.org/10.1001/archpedi.155.4.470>.

Trenna Valado, Jennifer Tracey, Jonathan Goldfinger, and Rahil Briggs

20. Kathryn Taaffe McLearn et al., “Narrowing the Income Gaps in Preventive Care for Young Children: Families in Healthy Steps,” *Journal of Urban Health* 81 (2004): 556–67, <https://doi.org/10.1093/jurban/jth140>.
21. Barry Zuckerman et al. “Healthy Steps: A Case Study of Innovation in Pediatric Practice,” *Pediatrics* 114 (2004): 820–6, <https://doi.org/10.1542/peds.2003-0999-L>.
22. Guyer et al., *Healthy Steps*.
23. Ibid.
24. Margaret O’Brien Caughy et al., “The Effects of the Healthy Steps for Young Children Program: Results from Observations of Parenting and Child Development,” *Early Childhood Research Quarterly* 19 (2004), 611–30, <https://doi.org/10.1016/j.ecresq.2004.10.004>.
25. Ibid.
26. Cynthia S. Minkovitz et al., “Healthy Steps for Young Children: Sustained Results at 5.5 Years,” *Pediatrics* 120 (2007): e658–68, <https://doi.org/10.1542/peds.2006-1205>.
27. Guyer et al., *Healthy Steps*.
28. Ibid.
29. Tess Miller et al., *Healthy Steps: The Affiliate Evaluation Report* (Baltimore, MD: Johns Hopkins Bloomberg School of Public Health, 2003).
30. Eve-Lynn Nelson et al., “Reshaping Health Care Delivery for Adolescent Parents: Healthy Steps and Telemedicine,” *Telemedicine Journal and E-Health* 9 (2003): 387–92; Rebecca R. S. Socolar et al., “Factors that Affect Parental Disciplinary Practices of Children Aged 12 to 19 Months,” *Southern Medical Journal* 98 (2005): 1181–91, <https://doi.org/10.1097/01.smj.0000190177.12387.07>.
31. Colleen E. Huebner et al., “Expanding Developmental and Behavioral Services for Newborns in Primary Care: Program Design, Delivery, and Evaluation Framework,” *American Journal of Preventive Medicine* 26 (2004): 344–55, <https://doi.org/10.1016/j.amepre.2004.01.003>; Brian D. Johnston et al., “Healthy Steps in an Integrated Delivery System: Child and Parent Outcomes at 30 Months,” *Archives of Pediatrics and Adolescent Medicine* 160 (2006), 793–800.
32. Johnston et al., “Healthy Steps.”
33. Miller et al., *Affiliate Evaluation Report*.
34. Melissa Buchholz and Ayelet Talmi, “What We Talked About at the Pediatrician’s Office: Exploring Differences between Healthy Steps and Traditional Pediatric Primary Care Visits,” *Infant Mental Health Journal* 33 (2012): 430–6, <https://doi.org/10.1002/imhj.21319>.
35. Rahil D. Briggs et al., “Social-Emotional Screening for Infants and Toddlers in Primary Care,” *Pediatrics* 129 (2012): e377–84, <https://doi.org/10.1542/peds.2010-2211>.
36. Jane Squires et al., *Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)* (Baltimore, MD: Paul H. Brookes Publishing, 2002).
37. Kathi J. Kemper and K. J. Kelleher, “Family Psychosocial Screening: Instruments and Techniques,” *Ambulatory Child Health* 1 (1996): 325–39; Rahil D. Briggs et al., “Healthy Steps as a Moderator: The Impact of Maternal Trauma on Child Social-Emotional Development,” *Clinical Practice in Pediatric Psychology* 2 (2014): 166–75, <https://doi.org/10.1037/cpp0000060>.
38. Rachel S. Gross et al., “Early Child Social-Emotional Problems and Child Obesity: Exploring the Protective Role of a Primary Care-Based General Parenting Intervention,” *Journal of Developmental and Behavioral Pediatrics* 36 (2015): 594–604.

39. Lance Till et al., *HealthySteps Implementation and Outcome Study Evaluation Report* (Washington, DC: ZERO TO THREE, 2017).
40. Michael C. Barth, *Healthy Steps at 15: The Past and Future of an Innovative Preventive Care Model for Young Children* (New York: The Commonwealth Fund, 2010).
41. Till et al., *Evaluation Report*.
42. Data Resource Center for Adolescent and Child Health, “2016 National Survey.”
43. Natalia Golova et al., “Literacy Promotion for Hispanic Families in a Primary Care Setting: A Randomized, Controlled Trial,” *Pediatrics* 103 (1999): 993–7, <https://doi.org/10.1542/peds.103.5.993>.
44. Alan L. Mendelsohn et al., “The Impact of a Clinic-Based Literacy Intervention on Language Development in Inner-City Preschool Children,” *Pediatrics* 107 (2001): 130–4, <https://doi.org/10.1542/peds.107.1.130>; Iman Sharif et al., “Exposure to Reach Out and Read and Vocabulary Outcomes in Inner City Preschools,” *Journal of the National Medical Association* 94 (2002): 171–7.
45. Alan L. Mendelsohn et al., “Use of Videotaped Interactions during Pediatric Well-Child Care: Impact at 33 Months on Parenting and on Child Development,” *Journal of Developmental & Behavioral Pediatrics* 28 (2007): 206–12, <https://doi.org/10.1097/DBP.0b013e3180324d87>.
46. Laura M. Gottlieb et al., “Effects of Social Needs Screening and In-Person Service Navigation on Child Health: A Randomized Clinical Trial,” *JAMA Pediatrics* 170 (2016): e162521, <https://doi.org/10.1001/jamapediatrics.2016.2521>.
47. Arvin Garg et al., “Addressing Families’ Unmet Social Needs within Pediatric Primary Care: The Health Leads Model,” *Clinical Pediatrics* 51 (2012): 1191–3, <https://doi.org/10.1177/0009922812437930>.
48. Howard Dubowitz et al., “The Safe Environment for Every Kid Model: Impact on Pediatric Primary Care Professionals,” *Pediatrics* 127 (2011): e962–70, <https://doi.org/10.1542/peds.2010-1845>.
49. Howard Dubowitz, “The Safe Environment for Every Kid (SEEK) Model: Helping Promote Children’s Health, Development, and Safety,” *Child Abuse & Neglect* 38 (2014): 1725–33, <https://doi.org/10.1016/j.chiabu.2014.07.011>.
50. Glenn Flores et al., “Parent Mentors and Insuring Uninsured Children: A Randomized Controlled Trial,” *Pediatrics* 137 (2016): e20153519, <https://doi.org/10.1542/peds.2015-3519>.
51. Arvin Garg et al., “Addressing Social Determinants of Health at Well Child Care Visits: A Cluster RCT,” *Pediatrics* 135 (2015): e296–304, <https://doi.org/10.1542/peds.2014-2888>.
52. Tumaini R. Coker et al., “A Parent Coach Model for Well-Child Care among Low-Income Children: A Randomized Controlled Trial,” *Pediatrics* 137 (2016): e20153013, <https://doi.org/10.1542/peds.2015-3013>.
53. Robert Sege et al., “Medical-Legal Strategies to Improve Infant Health Care: A Randomized Trial,” *Pediatrics* 136 (2015): 97–106, <https://doi.org/10.1542/peds.2014-2955>.
54. Cristen Page et al., “WellBabies: Mothers’ Perspectives on an Innovative Model of Group Well-Child Care,” *Family Medicine* 42 (2010): 202–7.
55. James A. Taylor et al., “Health Care Utilization and Health Status in High-Risk Children Randomized to Receive Group or Individual Well Child Care,” *Pediatrics* 100 (1997): e1; James A. Taylor et al., “A Randomized Controlled Trial of Group Versus Individual Well Child Care for High-Risk Children: Maternal-Child Interaction and Developmental Outcomes,” *Pediatrics* 99 (1997): e9.
56. Page et al., “WellBabies.”

Trenna Valado, Jennifer Tracey, Jonathan Goldfinger, and Rahil Briggs

57. Thomas Bodenheimer and Christine Sinsky, “From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider,” *Annals of Family Medicine* 12 (2014): 573–6.
58. ZERO TO THREE and Bezos Family Foundation, *Tuning In*.
59. Centers for Medicare & Medicaid Services, “Pediatric Alternative Payment Model Opportunities: General Information,” accessed August 11, 2018, <https://innovation.cms.gov/initiatives/pediatric-apm>.