NICHQ
National Institute for Children's Health Quality

Pediatrics Supporting Parents

Partnering with parents to promote social and emotional development

Project Charter

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Introduction

Our Vision

The first years of a child's life build the foundation for lifelong health and wellness, educational achievement, and economic security. Yet, data from the Early Childhood Longitudinal Study and the American Community Survey estimate that only 36 percent of kindergartners in the U.S. were considered fully "ready" for school. [1]

The American Academy of Pediatrics outlines five domains of healthy development and school readiness for the child: 1) physical well-being and motor development, 2) social and emotional development (SED), 3) approaches to learning, 4) language development, and 5) general knowledge and cognition.[2] These domains are interconnected but there has traditionally been less focus on social and emotional development despite substantial research highlighting its critical importance.[3]

For children from birth to age 3, well-child visits are a unique opportunity to reach children's parents or primary caregivers and impact their knowledge of beliefs and behaviors which significantly influence the SED of their children. Pediatric well-child visits are a nearly universal experience in which families are available, curious and open to new ideas. The 12 well-child visits from birth to age 3 present an opportunity for conversations and interactions between primary caregivers, children, and primary care providers to set a course for kindergarten readiness.

Our vision is that all children from birth to age 3 receive the supports they need to achieve kindergarten readiness and positive life outcomes. This initiative will identify innovative practices in the pediatric medical home setting that support families' central role in fostering the social and emotional development of their children.

For the purposes of this initiative, we adopt the scope of pediatric preventive care pioneered and developed by the American Academy of Pediatrics as the Pediatric "Medical Home." The "Medical Home" is a concept that has evolved over two decades and embodies the ideals and full scope of care a Primary Pediatric team would deliver to each patient to obtain optimal health: accessible, continuous, comprehensive, family centered, coordinated, compassionate and culturally effective care.[4] The comprehensive and continuous primary care provided by the pediatric or family practice medical home encompasses the discrete well-child visits, continuous patient and family centered partnership, connection to family centered-community based networks, and high-quality transitions as children move along and within systems of care.

Pediatrics Supporting Parents has the ambitious long-term goal of changing the standard of pediatric primary care to foster SED in the same way that it focuses on physical health and cognitive development. The systems change required to shift the standard of care will take decades and require

[1] Pritzker et al., Achieving Kindergarten Readiness for All Our Children: A Funder's Guide to Early Childhood Development from Birth to Five, 2015.
[2] High, Pamela C. "School readiness." Pediatrics 121.4 (2008): e1008-e1015.
[3] Hirai, Ashley H., et al. "Prevalence and Variation of Developmental Screening and Surveillance in Early Childhood." *JAMA pediatrics* (2018)
[4] American Academy of Pediatrics, Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The medical home. Pediatrics.2002; 110 :184– 186.

partnership with stakeholders who have the potential for favorably impacting the SED of children, including professional organizations for providers who care for children and health insurance payers. In the next two years, we will pilot strategies in 10-15 primary care sites to learn what strategies could be implemented in the pediatric medical home setting to improve children's SED, the primary caregiver-child relationship, and ultimately kindergarten readiness. We will better understand how these strategies can be implemented efficiently and effectively for diverse populations and in different settings; what community infrastructure or conditions enable strategies to be most effective; and what it will take to scale each implementation strategy. Recognizing that other initiatives are working towards similar ends, we intend to integrate our learning with other efforts in the field to lay the foundation for broader systems change.

Background

In 2015, the National Institute for Children's Health Quality (NICHQ) worked closely with Ariadne Labs and the Einhorn Family Charitable Trust to define the opportunity to promote healthy SED in the pediatric primary care setting for children ages 0-3. This involved an initial survey of existing programs and interventions and an expert meeting. The expert meeting convened content experts in child health, early childhood development, and families who shared their lived experience. During this two-day meeting, small groups brainstormed approaches to promote SED that could be implemented within pediatric primary care, considering different perspectives of those involved and the potential impact of each approach. The result of this work is the 2016 report, "Promoting Young Children's Socioemotional Development in Primary Care,"[5] that presents an overview of 35 existing programs and interventions and a set of 11 design elements for optimizing SED in pediatric primary care. The design elements are the main drivers of the Pediatrics Supporting Parents initiative. The integration of the design elements into this work can be seen on the driver diagram in Appendix B.

Pediatrics Supporting Parents Initiative

In 2017, the Silicon Valley Community Foundation launched this 3-year initiative supported by five early childhood funders (Einhorn Family Charitable Trust, J.B. and M.K. Pritzker Family Foundation, The David and Lucile Packard Foundation, W.K. Kellogg Foundation, and an anonymous individual contributor). The initiative seeks to learn what strategies can be implemented in the pediatric primary care setting to improve social emotional development of children with a focus on nurturing the primary caregiver-child relationship.

To accomplish this, the Center for the Study of Social Policy (CSSP) is conducting an analysis of leading programs and interventions in and adjacent to the pediatric primary care channel that promote positive outcomes around SED and the primary caregiver-child relationship. During 15 site visits to primary care practices where these leading programs and interventions are occurring, CSSP will learn more about which successful program characteristics may be effectively integrated into the primary care setting. The results of CSSP's program analysis will be tested and refined through a learning community, led by

[5] NICHQ, Promoting Young Children's (Ages 0-3) Socioemotional Development in Primary Care. https://www.nichq.org/resource/promoting-young-childrens-ages-0-3-socioemotional-development-primary-care (2016).

NICHQ with guidance from experts in the field, including CSSP, Family Voices, and a pediatric primary care expert advisory group.

The family and pediatric practices participating in the learning community will test strategies that can be implemented in the pediatric medical home setting that promote the SED of young children and strengthen the primary caregiver-child relationship. The strategies include opportunities along the full continuum of preventive care for every member of the pediatric care team to provide families with anticipatory guidance, link families to early learning resources, and connect families with community-based systems that help them promote their child's SED. The learning community will be organized using the Institute for Healthcare Improvement's Breakthrough Series (BTS) Learning Collaborative model.

While the learning community is underway, the Silicon Valley Community Foundation is also funding CSSP, along with their partners at Manatt Health, to demonstrate how Medicaid can help finance effective strategies to foster SED, making it more likely that such strategies become routine, expected components of pediatric primary care. The results of the different components of this initiative will build confidence in effective and scalable implementation strategies and community characteristics that strengthen families to improve the SED of children and ultimately, make progress towards changing the standard of care.

Our combined work acknowledges that well-child visits offer the opportunity to enhance a family's ability to promote their child's SED and that a child's SED is determined by contexts beyond the pediatric medical home, including their home environment, medical system, community network, access to specialty medical care and early educational opportunities. Keeping the pediatric medical home and the larger community context in mind presents the greatest chance to impact kindergarten readiness.

Learning Community Overview

Learning Community Aim

Between January 2019-April 2020, family and pediatric practices will test and implement tools and changes aimed at supporting families as they support the social and emotional development of their children birth to age 3. Through a collaborative process, we aim to identify the combination of best approaches to be scaled up and spread more broadly.

Expectations for NICHQ and Learning Community Faculty:

Leveraging its background in improvement science, NICHQ will provide oversight and technical assistance to support the family and pediatric practices as they prototype, test and implement changes, collect and analyze data to inform improvement, and report on findings and lessons learned. NICHQ will work with the teams to identify which changes lead to improvement and can be scaled.

Specifically, NICHQ will:

- Assure a process to identify participating family and pediatric practices with a range of diversity in community setting, patient population and performance
- Assure a process to identify teams with the desire and capacity to pilot the Pediatrics Supporting Parents strategies
- Provide the infrastructure to enhance the work of the Pediatrics Supporting Parents teams, including hosting virtual and in-person learning community events and creating an online community (the Collaboratory) for sharing ideas, resources, and reporting data
- Listen and respond to team feedback
- Support alignment of Pediatrics Supporting Parents practice teams' goals through continuous communication
- Set realistic design targets with input from the subject matter experts
- Plan and provide technical assistance to meet communicated needs
- Coach teams on quality improvement and sustainability planning
- Assure the effectiveness of the learning system by expecting full participation by teams and measuring participation in the learning community

Expectations for participating practice teams:

- Connect the goals of the learning community to the strategic initiatives in their practices
- Designate a provider champion for the frontline improvement team
- Convene a frontline improvement team to facilitate the day-to-day activities of the project. Team membership should include a team lead, medical provider champion, data lead, family partner(s), practice manager, clinical support staff, family navigator/care coordinator, and, when possible, an early childhood development specialist. Some team members may be permanent members of the team and others may be ad hoc members. Some team members may take on multiple roles. With the support of the provider champion and practice leadership, this team will:
    - Conduct tests of the recommended changes in alignment with their aims
    - After successful testing and adaption, implement the changes in the practice
    - Actively participate in all learning community collaborative events, including conference calls, WebEx sessions, and in-person meetings to share learnings, results, and questions

- Collect, submit and share data with the learning community. Data will include information on changes being tested and/or implemented
- Provide the resources to support their team, including time to devote to this effort (weekly team meetings, time for testing, huddles, etc.)
- Identify and include family partner(s) as a part of the improvement team.
  - *If your practice would like support in identifying a family partner, we encourage you to connect with your state's Family-to-Family Health (F2F) Information Center. You can find the information for each state's F2F at this website: http://familyvoices.org/affiliates/.*
- Share feedback for improvement to peer teams and communicate areas of need for technical assistance with NICHQ and faculty

Learning Community Guiding Principles

The five guiding principles below provide a foundation for our learning community. To move towards our aim of transforming pediatric care to support families, it is essential that the Pediatrics Supporting Parents teams, NICHQ, faculty and other partners follow these principles:

Patient and Family Centeredness

- An approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, the primary care staff (including non-medical staff), patients and families. It redefines the relationships in health care by placing an emphasis on collaborating with people of all ages, all levels of care and in all health care settings. In patient- and family-centered care, patients and families define their "family" and determine how they will participate in care and decision-making. A key goal is to promote health and well-being of individuals and families and to maintain their control. This perspective is based on the recognition that patients and families are essential allies for quality and safety, not only in direct care situations, but also in quality improvement, safety initiatives, education of health professionals, research, facility design, and policy development. Patient-and family-centered care leads to better health outcomes, improved patient and family experience of care, better clinician and staff satisfaction, and wiser allocation of resources.[6]

Respect for needs of diverse cultures

- Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, religion, sexual orientation, geographic location and socioeconomic status.[7]

Trusting and respectful partnerships with patients and families

- Staff recognize parents and primary caregivers as the expert in their child's care and engage them as partners in setting goals and in the responsibility and plans for meeting those goals. To that end, staff will make well-child visits safe places for families to share their points-of-view, ask questions, participate in decision making and openly express their thoughts and feelings.

Structure for trained and prepared staff

- Staff have the training and supports necessary to be able to confidently and competently provide the right care and supports to the right patient and family at the right time.

Culture of Quality Improvement

- The organization will embrace the following elements, all of which are foundational to transformative change and sustainability:
  - Leadership commitment
  - Quality Improvement infrastructure
  - Employee empowerment
  - Customer focus
  - Teamwork and collaboration
  - Continuous improvement

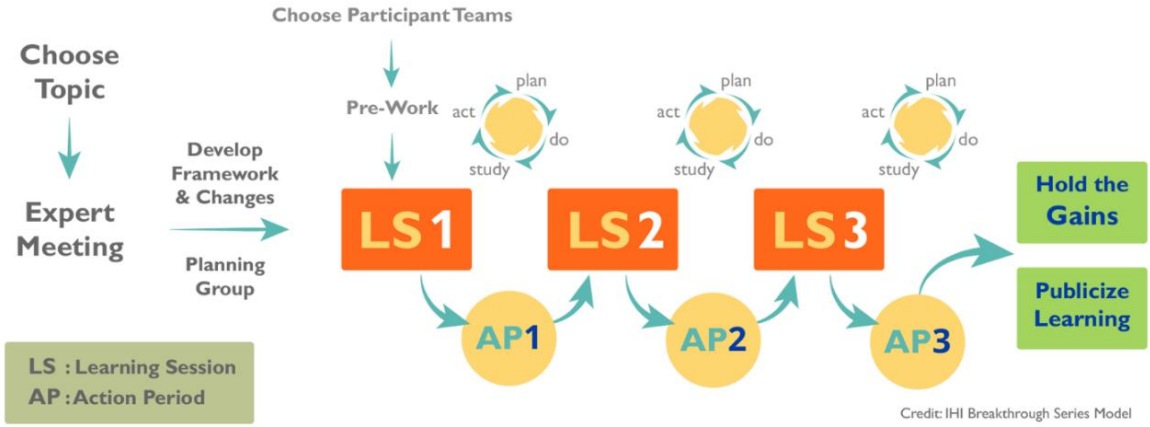
[6] Source: Institute for Patient and Family-Centered Care

[7] Source: National Academy of Medicine's Six Dimensions of Care (formerly Institute of Medicine)

Learning Community Methods

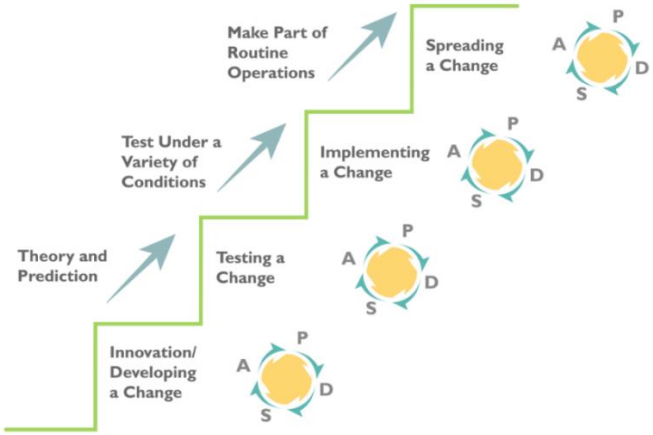
The Breakthrough Series Learning Collaborative Model

NICHQ will use an adaptation of the Institute for Healthcare Improvement's Breakthrough Series (BTS) Collaborative Model to organize the Pediatrics Supporting Parents Learning Community in their efforts to identify, test and spread changes to improve the social and emotional development of children through the well-child visit setting. Based on the Institute for Healthcare's 2003 White Paper on the BTS Model, successful learning collaboratives form to close the gap between sound evidence and practice on topic areas that interested parties want to improve. The below figure provides a visual of the model.



The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)

The BTS Collaborative Model is a method designed to spread existing knowledge to multiple settings to accomplish a common aim. Our "existing knowledge" will be based on learnings from the 2015 expert meeting, the 2016 report, environmental scans, site visits and CSSP program analysis as a surrogate for holding a beginning Expert Meeting. Although we will begin the Pediatrics Supporting Parents Learning Community with some existing knowledge, there will also be an innovation design component to the project, working with participants to discover new ideas and change concepts to advance improved SED of children.



Consistent with the BTS Collaborative Model, we will leverage three key documents to guide the work of the Pediatrics Supporting Parents Learning Community. Those three documents include this project charter, the driver diagram and a companion change package with its accompanying measurement strategy. The driver diagram will represent our design theory and the change package those ideas gathered from the sources mentioned above. The measurement strategy will reflect the design targets and, as with the changes,

we will learn what the best measures are for measuring the improved SED of children as we conduct the learning community.

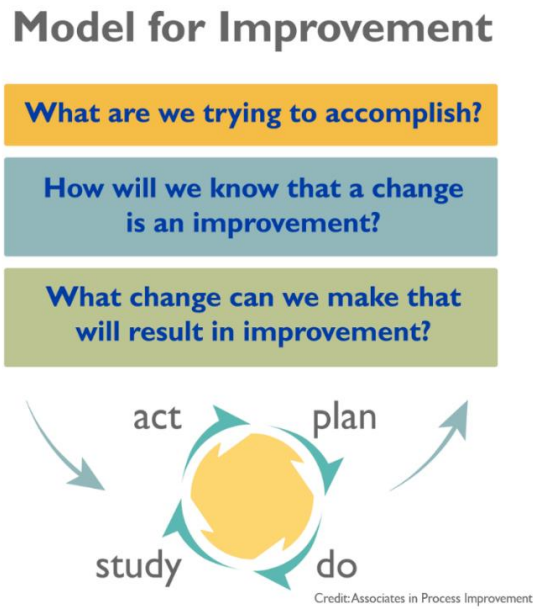
Learning is accelerated as the collaborative teams work together and share their experiences through regular calls and in-person meetings. Teams typically attend three Learning Sessions, during which they learn about relevant topics and discuss the process of making changes to support their work. Action Periods, the time between learning sessions when teams are testing, refining, spreading and adopting changes, are a key component of the BTS. During action periods, improvement teams work together to make major, breakthrough improvements by testing and implementing small tests of change. Teams collect and report monthly data to track improvement and to identify those changes that have resulted in improvement and, thus, are ripe for scale up and spread. Although each team focuses on his/her own community, each remains in continuous contact with other grantees and faculty. Monthly conference calls, regular e-mails, and use of a web-based workspace (the NICHQ Collaboratory) maintain this continuous contact during the Action Period.

A traditional Breakthrough Series ends, per the diagram above, with some way of gathering and publicizing the lessons learned. Our plan is to hold a "Harvest" meeting with the participating teams. A "Harvest" meeting is just that, a time to convene the teams and to gather and document the lessons learned with the purpose of sharing with future change and spread initiatives.

The Model for Improvement is the improvement methodology used during a traditional BTS Collaborative and will be used for this learning community as well.

Quality Improvement: The Model for Improvement

Practices participating in the Pediatrics Supporting Parents Learning Community will learn to apply the Model for Improvement (MFI), a structured approach to systems change that teams use to drive improvement. It stresses a well-focused, time-limited aim; and process and outcomes measures to track improvement and evaluate progress. The MFI, developed by *Associates in Process Improvement*, is a simple yet powerful tool for accelerating improvement. The MFI has been used successfully by hundreds of healthcare organizations to improve many different healthcare processes and outcomes.[8] The model consists of two parts: addressing three fundamental questions and engaging in tests of change.



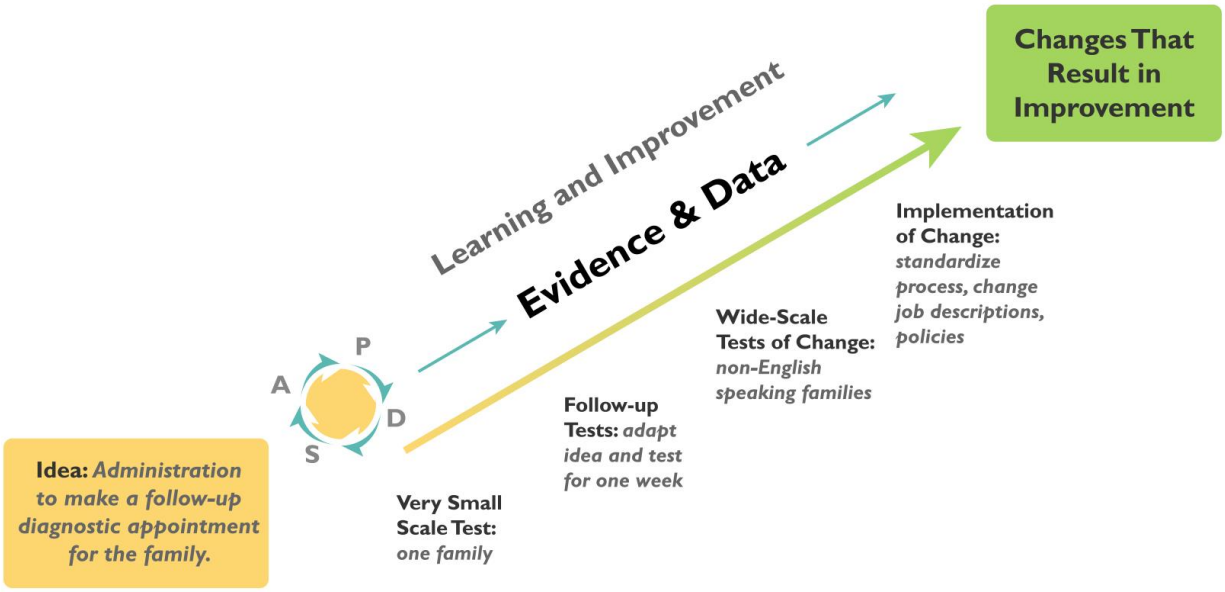
Three Fundamental Questions:

- ***What are we trying to accomplish?*** The improvement team develops a specific, time-limited, and measurable aim statement (**setting aims**).

[8] See the Institute for Healthcare Improvement's website (www.IHI.org) for stories on improved outcomes using the Model for Improvement.

- ***How will we know if a change is an improvement?*** The team identifies process and outcome measures to collect over time to track improvement and evaluate progress (**establishing measures**).
- ***What changes can we make that will result in improvement?*** The team identifies ideas for changes to try out (**selecting changes to test**).

Tests of Change: Plan-Do-Study-Act (PDSA) Cycles: PDSA cycles are used to rapidly test changes in real work settings by planning a change, testing the change, observing the results and acting on what is learned. The PDSA cycle guides the test of a change to determine if the change results in improvement.

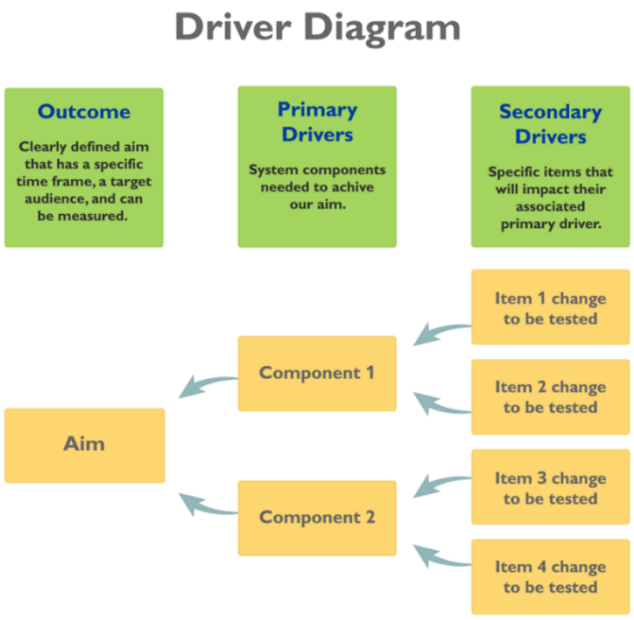


The MFI stresses prediction and measurement as critical features of the PDSA cycle. Teams use PDSA cycles to test changes (initially on a very small scale to minimize risk), quickly identify promising ideas, and build confidence that the changes are leading to improvement. Changes that show promise are expanded for testing on larger and larger scales, until the team can be confident that the change should be adopted widely.

Learning Community Key Documents

Driver Diagram

A driver diagram is a visual display of a team's theory of what "drives" or contributes to the achievement of a project aim. This clear picture of a team's shared view is a useful tool for communicating to a range of stakeholders the exact change ideas a team is testing. A driver diagram shows the relationship between the overall aim of the project, the primary drivers, the secondary drivers, and specific change ideas to test for each secondary driver. Primary drivers or "key drivers" are the most important influencers that contribute directly to achieving the aim; secondary drivers are components of the primary drivers and are influencers or natural subsections of the primary drivers.



The current Pediatrics Supporting Parents driver diagram can be found in **Appendix B**.

Change Package

A change package is an extension of and important companion document to the driver diagram. Key to any learning community, a change package is a list of the essential changes associated with each driver leading to the desired results. A change package does not include every idea. Rather it includes ideas with "a pedigree," including evidence in the literature, information from credible expert opinions and strong empirical evidence. During the Pediatrics Supporting Parents Learning Community, family and pediatric practices will test change ideas leading to a stronger degree of belief of "what works" in the pediatric practice setting. As practices test and learn, we will update the change package with the ideas that lead to the greatest improvement and incorporate those into the plan to scale up and spread.

NICHQ, with support from CSSP, Family Voices, and a physician advisory board, is developing a change package that will be shared with this learning community.

Measurement Strategy

A measurement strategy is a list of the key measures used to track improvement in a learning community. It includes the measures, definitions of each data element and detailed data collection strategies. Measures tell us whether the changes that are being tested are resulting in improvements.

NICHQ, with support from CSSP, Family Voices, and a physician advisory board, is developing a measurement strategy to align with the driver diagram components.

Learning Community Timeline

Overview

Date	Activity
Recruitment	
September 12, 2018	Pediatrics Supporting Parents application and project charter released
September 20, 2018	Application Technical Assistance Call from 3-4 pm ET Join webinar here with the password: **Healthykids123**
October 31, 2018	All practice applications due by 5 pm ET
December 2018	Notifications sent to selected practice teams (anticipated date)
Learning Community Kickoff	
Mid January 2019	Learning Community orientation materials sent to practice teams
Late January 2019	Online Collaboratory Launch
January 24, 2019	Learning Community kickoff webinar from 4-5 pm ET
Early February 2019	Pre-work shared for Learning Session 1 (anticipated date)
Early March 2019	Pre-work due for Learning Session 1 (anticipated date)
Learning Community Collaborative Events (see next page for more details)	
Week of March 18, 2019	Learning Session 1 (in-person)
April - June 2019	Action Period 1
July 2019	Learning Session 2 (virtual)
August - November 2019	Action Period 2
December 2019	Learning Session 3 (virtual)
January - April 2020	Action Period 3
May 2020	Learning Community Harvest meeting (virtual)

Learning Community Activities

Activity	Dates & Times (tentative)	Who?	Total Time Commitment
Agendas for each call will be sent out in advance to help team leads determine which team members should join.			
Kickoff webinar	Thursday, January 24 (4-5 pm ET)	All team members that are available	90 minutes
Action Period Calls	From 4-5 pm ET: April 25, 2019 May 30, 2019 June 27, 2019 August 29, 2019 September 26, 2019 October 31, 2019 November 21, 2019 (third Thursday of the month due to Thanksgiving holiday) January 30, 2020 February 27, 2020 March 26, 2020 April 30, 2020	Always: Team lead, Medical Provider Champion, Data lead Other team members should join as topics relate to their responsibilities	90 minutes each month for the call/prep time
Learning Session 1 (in-person, location TBD)	Two days during the week of March 18, 2019, as well as time to travel to the in-person meeting. Pre-work will be distributed in early February and be due at the beginning of March.	Travel Team: Team lead, Medical Provider Champion, Family Partner(s), Data lead All team members should engage in the pre-work process.	2 days for the meeting, travel time and time to complete pre-work.

Activity	Dates & Times (tentative)	Who?	Total Time Commitment
Agendas for each call will be sent out in advance to help team leads determine which team members should join.			
Learning Session 2 (virtual)	Two half-days during July 2019 for virtual participation	Team lead, Medical Provider Champion, Family Partner, Data lead All other team members are encouraged to attend as available. All team members should engage in the pre-work process.	2 half-days for each meeting and time to complete pre-work.
Learning Session 3 (virtual)	Two half-days during the beginning of December 2019 for virtual participation.	Team lead, Medical Provider Champion, Family Partner, Data lead All other team members are encouraged to attend as available. All team members should engage in the pre-work process.	2 half-days for each meeting and time to complete pre-work.
Harvest (virtual)	Two half-days during the beginning of May 2020 for virtual participation.	Team lead, Medical Provider Champion, Family Partner(s), Data lead All other team members are encouraged to attend as available. All team members should engage in the pre-work process.	2 half-days for each meeting and time to complete pre-work.
Ongoing Activities			
Data submission	Data submission will begin in April 2019.	Data lead, Team lead, Medical Provider Champion	Monthly (estimated: 2 hours per week; dependent on final measurement strategy)
Internal improvement team meetings, and huddles as needed	Practice teams will schedule these meetings. We recommend scheduling your first meeting when the learning community kicks off.	All team members should participate in meetings. We suggest using these meetings to review data, discuss improvement activities, design PDSAs.	Monthly (60-90 minutes)

Appendix

Appendix A. Glossary of Terms

The following definitions were developed to support the work of the Pediatrics Supporting Parents Learning Community.

1. Social and Emotional Development: the ability for children to experience, manage and express the full range of positive and negative emotions as well as read the emotions of others; develop close, satisfying, trusting and sustained relationships with other children and adults; and actively explore their environment and learn.[9,10,11,12] Importantly, we simultaneously note that a child's capacity for healthy social and emotional development exists in the context of family, community and culture.[13]

2. Primary caregiver: defined as the biological parent or an individual who has established a primary caregiver-child relationship.

3. Primary caregiver-child relationship: a selective, meaningful, and significant psychological relationship between a child and their dominant caregiver that develops through mutual interactions and persists over time.

Background: The early childhood literature acknowledges that "bonding" and "attachment" are two different concepts with non-interchangeable terms. More recently, researchers have begun to consider the emotional connection between parent and child as well. **Given that for some children the primary caregiver is not the biological parent, this learning community refers to the 'primary caregiver' and the 'primary caregiver-child relationship' to be inclusive of all family types.** We have drawn from the following definitions to inform the working definition of primary caregiver-child relationship:

- ***Attachment***: a set of infant behaviors, a motivational system, a relationship between mother and infant, a theoretical construct, and a subjective experience for the infant in the form of "working models" (of the caretaker in the infant's mind).[14] It is the learned ability to make psychologically rooted ties between people that gives them significant meaning to each other. Children must learn the skill of making attachments during the first years of their life and do so as a result of mutual interaction with a limited number of primary caretakers.

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[9] NICHQ, Promoting Young Children's (Ages 0-3) Socioemotional Development in Primary Care. https://www.nichq.org/resource/promoting-young-childrens-ages-0-3-socioemotional-development-primary-care (2016).

[10] Kristen E. Darling-Churchill, Laura Lippman Early childhood social and emotional development: Advancing the field of measurement. Journal of Applied Developmental Psychology 45 (2016) 1–7.

[11] National Scientific Council on the Developing Child. Winter, 2004. "Children's Emotional Development Is Built into the Architecture of Their Brains" Working Paper No. 2 (accessed on December 5, 2006)

[12] Cohen, J., and others. 2005. Helping Young Children Succeed: Strategies to Promote Early Childhood Social and Emotional Development. Washington, DC: National Conference of State Legislatures and Zero to Three. (accessed on December 7, 2006).

[13] Yates, T., Ostrosky, M.M., Cheatham, G. A., Fettig, A., Shaffer, L., & Santos, R. M. (2008). Research synthesis on screening and assessing social-emotional competence. Retrieved from Center on the Social Emotional Foundations for Early Learning (http://csefel.vanderbilt.edu/documents/rs_screening_assessment.pdf).

[14] Stern, Daniel (1985). The interpersonal world of the infant. New York: Basic Books.

- ***Bonding***: a significant relationship between people that happens without the knowledge or conscious effort of those involved and not as the result of a learned skill. Bonding implies selective attachment,[15] which persists over time even during a period of no contact with the person with whom bonds exist.[16]
- ***Emotional Connection:*** The degree of emotional connection between parent and child. According to the Nurture Science Program, emotional connection is a reciprocal effort to seek, achieve, and maintain intimacy. Emotionally connected pairs utilize gaze, touch, voice, affect, and timing to achieve closeness, which results in a state of physiological co-regulation. [17] [18]

4. Pediatric medical home: for the purposes of this initiative, we adopt the scope of pediatric preventive care pioneered and developed by the American Academy of Pediatrics as the Pediatric "Medical Home." The "Medical Home" is a concept that has evolved over two decades and embodies the ideals and full scope of care a Primary Pediatric team would deliver to each patient to obtain optimal health: accessible, continuous, comprehensive, family centered, coordinated, compassionate and culturally effective care.[19] The comprehensive and continuous primary care provided by the pediatric or family practice medical home encompasses the discrete well-child visits, continuous patient and family centered partnership, connection to family centered-community based networks, and high-quality transitions as children move along and within systems of care.

5. Pediatric primary care: the American Academy of Pediatrics' Committee on Pediatric workforce defines this term as:
"health supervision and anticipatory guidance; monitoring physical and psychosocial growth and development; age-appropriate screening; diagnosis and treatment of acute and chronic disorders; management of serious and life-threatening illness and, when appropriate, referral of more complex conditions; and provision of first contact care as well as coordinated management of health problems requiring multiple professional services.

Pediatric primary health care for children and adolescents is family centered and incorporates community resources and strengths, needs and risk factors, and sociocultural sensitivities into strategies for care delivery and clinical practice. Pediatric primary health care is best delivered within the context of a "medical home," where comprehensive, continuously accessible and affordable care is available and delivered or supervised by qualified child health specialists."[20]

6. Pediatric primary care setting: defined as any space where pediatric primary care is available to children birth to age 3. This includes family practices, health clinics and other.

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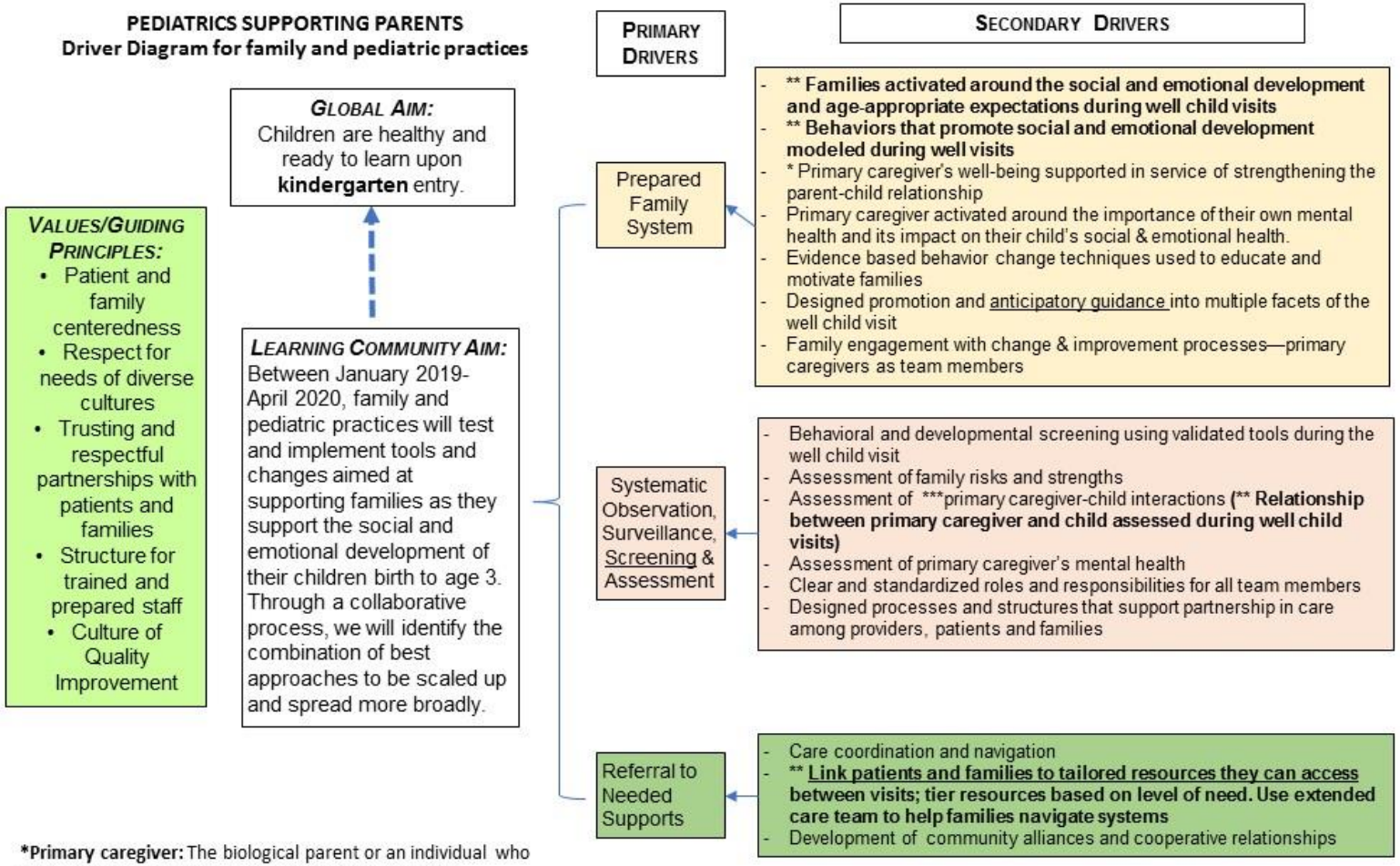
[15] Cohen, L. J. (1974). The working definition of human attachment, Psychological Bulletin 81, 107-217.
[16] Rutter, Michael (1981). Maternal deprivation reassessed (2nd ed.). New York: Penguin.
[17] Welch MG. Calming Cycle Theory: The Role of Visceral/Autonomic Learning in Early Mother and Infant/Child Behavior and Development. Acta Paediatr. 2016 Aug 18
[18] Nurture Science Program, Columbia University Medical Center, Welch Emotional Connection Scale: relational health screening tool for parents and children age 0-5 years.
[19] American Academy of Pediatrics, Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The medical home. Pediatrics.2002; 110 :184– 186.
[20] Committee on Pediatric Workforce. (2011). Reaffirmed policy statement—Pediatric primary health care. *Pediatrics*, *127*(2), 397.

Appendix B. Driver Diagram



***Primary caregiver:** The biological parent or an individual who has established a primary caregiver-child relationship.

**** Design Elements:** Experts identified eleven Design Elements in the 2016 Promoting Young Children's (ages 0-3) Socioemotional Development in Primary Care report; Four of the eleven Design Elements (1,2,3,10), with some minor enhancements, are the focus of this Learning Community.

*****Primary caregiver-child relationship:** A selective, meaningful, and significant psychological relationship between a child and their dominant caregiver that develops through mutual interactions and persists over time.