Early Relational Health

IMPLEMENTATION GUIDE

A practical implementation guide for pediatric primary care and public health professionals

STAR CENTER
Screening Technical Assistance
& Resource Center

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

About the STAR Center

The [Screening Technical Assistance and Resource (STAR) Center](#) through the American Academy of Pediatrics is one piece of the Addressing Social Health and Early Childhood Wellness (ASHEW) initiative which seeks to improve the health, wellness, and development of children through practice and system-based interventions.

Acknowledgements

Introduction

The American Academy of Pediatrics Policy statement, [Preventing Childhood Toxic Stress: Partnering with Family and Communities to Promote Relational Health](), asserts that safe stable nurturing relationships (SSNRs) are biological necessities for all children because they mitigate childhood toxic stress responses and proactively build resilience. Current threats to child wellbeing and long-term health, such as widening economic inequities, deeply embedded structural racism, the separation of immigrant children from their parents, and a socially isolating global pandemic, make the AAP toxic (or is it a relational framework) stress framework as relevant as ever.

While pediatric professionals know relationships are fundamental, the concept of early relational health (ERH) is not as well understood. It describes the positive, nurturing relationships that build and protect the interpersonal connections and emotional security of young children. ERH builds on decades of research showing that the negative impacts of childhood adversity and stress can be buffered by strong foundational relationships and positive childhood experiences.

When supported, valued, and provided the appropriate time and tools, pediatricians and other pediatric healthcare professionals can effectively promote positive relational health. Such efforts should help pediatric healthcare professionals advance healthy child development, strengthen families and their resiliency, and serve as the foundation to community-building and relationships. Pediatricians serve as catalysts for producing greater social development and unity in the communities they serve. Implementing community-level frameworks will require healthy, trusting, and robust partnerships with a wide array of local community partners from multiple sectors (education, social services, and businesses), not only to facilitate family access to the requisite community interventions but also to coordinate effective advocacy campaigns to secure both those interventions and family friendly public policies.

Implementing a public health approach to relational health will require changes at the provider, practice, and community levels, as well as horizontal integration across sectors. Simply put, successfully implementing a public health approach that prevents childhood toxic stress and promotes SSNRs will require pediatricians to put relational health at the center of everything they do. This approach will enhance the current work being done and make practice more meaningful.

The overarching goal of the ERH Guide is to address how pediatricians and pediatric health professionals can promote early relational health. This includes implementing practice and workflow changes and creating an equitable office environment which supports building safe stable nurturing relationships with patients and strong relationships within their communities. By utilizing a public health approach to early relational health approach in their work, pediatricians can improve care of children across the lifespan and refocus on what really matters: healthy, positive child development.

Types of Prevention	Approaches to Relational Health	Examples at the Provider Level	Examples at the Practice Level	Examples at the Community Level
Tertiary	Repair strained or compromised relationships	Build the therapeutic alliance; employ a common-factors approach; explain behavioral responses to stress; endorse referral resources.	Colocate counseling services (warm handoffs); facilitate, track, and follow-up on referrals offered.	Embrace restorative justice and social inclusion (over punitive measures and exclusion).
Secondary	Identify and address potential barriers to SSNRs	Build the therapeutic alliance; surveil for possible barriers to SSNRs; champion screening at practice level; endorse referral resources.	Universal screening for prevalent barriers seen in that practice; facilitate, track, and follow-up on referrals offered.	Identify and address sources of inequality, isolation, and social discord (poverty and racism).
Primary	Promote SSNRs by bulding 2-generational relational skills	Build the therapeutic alliance; promote positive parenting; encourage developmentally appropriate play.	Provide or support positive parenting classes; participate in ROR, VIP, and other programs that support the dyad.	Implement home visiting; support extended family medical care leave.

www.aappublications.org/news at American Academy of Pediatrics

What's Included

The Implementation Guide contains a wealth of materials to define early relational health (ERH), advocacy tools, and resources to build quality community partnerships and creating an equitable office environment. It serves as a guide for pediatricians and public health professionals on how to integrate a public health approach for early relational health across public health sectors. It includes items such as: key background articles, resources, case scenarios, and workflow templates for incorporation of office-based strategies, and trainings.

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STEP ONE:
Organizational Leadership and Office Workflow Changes

IN THIS SECTION:

Obtain leadership support to help practices implement changes.

Leveraging the instrumental work pediatricians are already doing with a lens to address early relational health and promote positive responses to toxic stress requires organizational support, time, and tools to confront the challenge of assessing and addressing families' psychological needs. Ultimately, the ability of pediatricians and other pediatric healthcare professionals to connect with caregivers, promote early relational health and build community supports will benefit and make their work more meaningful.

Pediatric professionals are well positioned to promote safe, stable, nurturing, relationships (SSNRs) by translating advances in developmental science into effective interventions for the home, clinic, and community. To that end, practice leadership buy-in, provider and managerial support and staff development is instrumental to advancing and implementing changes to enhance practice and office workflow to help children build safe, stable nurturing relationships, and protect them from the damaging effects of toxic stress. Leadership support is paramount to the success of this work.

At the outset, it's important to identify a "champion" or clinical leader to work alongside a staff member to lead the implementation of practice improvements, practice changes and communicating new program proposals to senior leadership within the office and clinic environment. The work of primary care is carried out through administrative and clinical workflows, sometimes without the opportunity to reflect on the value of the workflow. Before approaching leadership with a new idea, it is important to demonstrate how this new idea will impact processes, including workflow and other implications for staff.

Review the resources below to explore how to identify organizational structure and members of leadership to support the practice change, identify where in your practice flow you can improve and how to strategically advocate and support staff time to advance implementation within the office setting.

Pediatric Practice: Office Workflow Ideas and Examples

What? Part of providing high quality pediatric care is ensuring a positive experience for patients and families. This is influenced by the ability to access care when needed and an efficient and well-organized visit.

How? The work of primary care is carried out through administrative and clinical workflows. Overall goals should focus on improving the overall satisfaction of providers, staff and patients. Prioritize changes based on staff, provider, and patient feedback information. Understand the community needs—socioeconomic, prior health care availability, customs, and traditions. Quality of care provided, and availability are major determinants in the practice's success.

Who? Obtaining leadership support is paramount to the success of this work. It's important to identify a "champion" or clinical leader to work alongside a staff member to perform the tasks and responsibilities required when implementing practice changes and communicating new program proposals to senior leadership within the office and clinic environment.

How to ensure effective patient workflow:

- Assess how a patient encounter progresses from the patient's point of view.

- Identify the points of care where staff engage with the patient and prep for the visit. The process can then be reviewed as a team (providers, front desk, clinical, and staff) to identify areas that increase delays.

- Patient flow congestion can occur during the check-in process, provider appointment times, interruptions in providers' workflow, documentation practices, cleaning and set up of examination rooms, clinical processes, scheduling, as well as patient checkout.

- In terms of delivery of care, patient scheduling is one of the most crucial operational systems in a practice. For provider, staff and patient satisfaction, it is important to maximize patient appointments and minimize the downtime that happens when patients fail to show up.

Scheduling Methodologies:

- **FIXED:** Appointments are offered every 10, 15, or 20 minutes. When first starting in practice, it would be better to allow more time in developing relationships with patients and families.

- **WAVE:** In this scheduling method, instead of scheduling 4 patients 15 minutes apart, all 4 are set for on-the-hour, and the physician sees each one in sequence of arrival.

- **MODIFIED WAVE**: This method gains the benefits of wave but lessens the disadvantages of long waits for later appointments.

- **OPEN ACCESS**: The goal is to take care of today's work today and minimize future schedules that are already booked.

- **MODIFIED OPEN ACCESS**: This is the style common for small practices especially for those issues parents feel are urgent yet allows the parent to select a preventive care appointment that is convenient for themselves and their child.

Streamline Front Office Tasks

Use MAs and RNs as Flow Managers

Optimize Patient Schedules

Implementation and Change at the Practice Level: "Engaging Leadership to Support Practice Transformation" by Dr. Sara del Campo de Gonzalez, MD, FAAP

What? Organizational levels and members of leadership that need to support the change.

- Identify strategies for determining organizational level and leadership team to approach for support, as well as where in the structure or practice flow the change needs to be made.

- Outline components of a practice change proposal to present to leadership, including steps for preparation of practice environment and comprehensive implementation plan, which includes the vision statement, goals and objectives.

- Outline a plan for keeping leadership updated regarding progress on practice change goals, as well as sustainability needs.

How? Determine where in your practice flow you will propose the practice change should be implemented.

- Which steps in your practice change will require a change in organizational infrastructure or leadership support?

- Identify at which level of organization/infrastructure the change would need to be made?

- Who are the members of leadership to approach for support?

Who? Communicating progress to leadership by adapting the project planning tool/project proposal summary to illustrate goals, progress, as well as to communicate ongoing needs and sustainability goals is imperative to the success of any practice transformation.

Office Templates

- Communicating Progress and Presenting to Leadership Template

- Project Planning Tool Template

- Resource Guide

The Preparation:

- Workflow mapping helps you "see" your processes in a way that helps give you a better idea of the experiences of families, staff, providers, and community practices as they engage with your practice.

- Community Asset Mapping to inform about the strengths and resources of a community.

- Preparation on individual practice environment to implement a practice change proposal.

The Plan:

- The Vision Statement, Goals, Objectives

- Timeline

- Team Leads/Champions

- Assessment and evaluation

- Stakeholder engagement

- Sustainability, Budget

The Ask:

- Highlight the issue.

- High level overview of project planning tool.

- Appeal to priorities of leadership team.

- Propose solution with contributions from Community Asset Map and Workflow Map.

Step Two: Creating an Equitable Office Environment

IN THIS SECTION:

Creating a welcoming environment; improving communication with families and colleagues.

Both the physical environment and the "warmth" of the environment impact how a family feels when interacting with their pediatrician. This includes the practice space as well as the communication style the care team uses and non-verbal cues that are given throughout the visit. A welcoming environment is the responsibility of not just one provider but the entire care team. The clinic integration of co-located services such as behavioral, mental health, case workers and community health workers help address all aspects impacting a families need. For example, when engaging with bilingual families, simply understanding concerns such as those around child's language development and encouraging utilizing all languages to promote cultural sustainability can begin building trust between the provider and parent(s).

Creating an office culture that engages staff around race and ethnic equity can help establish a sense of psychological safety encouraging more individuals to be honest about their experiences. This supports ERH and the ability to improve communication with families and colleagues. Intentional engagement to integrate health equity will build staff comfort not only with each other but communicating with patients. Practice culture that encourages colleagues to have these discussions will promote alignment and shared understanding around the racial and ethnic equity. This shared understanding can lead to changes that positively impact patient care such as the standardization of toolkits utilized, improved care team member integration, screening templates introducing racial equity across age groups, and standardized note taking for providers. For parents to trust, pediatric providers need to listen and understand parental concerns and beliefs before making recommendations. Communication could be further enhanced by cultural humility, implicit bias training, a more diverse health care team (eg, providing families and patients the opportunity to seeing themselves reflected in the sex, ethnicity, and cultural backgrounds of the team members), and access to professional interpreters.

This work cannot be done in silos and ongoing engagement of patients and community organizations is vital. The integration of patient feedback looks like engaging with a family advisor to help providers get another perspective on ways to make the patient experience not only positive but also equitable. Parent/family advocates or advisory boards can work as the linkage for the care team and the patients being seen.

When building a family advisory board, the group makeup and support mechanisms should be part of the discussion. As assets, they can identify changes to make such as improvement or redesign of forms (eg Intake, family communication strategies, transition planning, framing messaging around race and ethnic equity, and well child office environmental assessments. In the absence of this, periodically asking for feedback during an existing or new process is helpful in identifying changes that should be made.

Review the resources below to explore how to identify where changes can be implemented to support an equitable environment.

IMPLEMENTATION TOOLS

Building Equitable Systems: EHR race, ethnicity, and language (REAL) data

What? The collection of REAL data can be helpful in helping to identify inequities in care across patient population but only if accurate data is being examined. Data collection can occur via various platforms or on paper, but it is helpful only if there is a designated role examining and sharing out reports with necessarily staff members.

How? A needs assessment looking at patient population can help bring forth what changes need to be made to improve the patient experience.

Who? For data this is being collected by a care team member, discussions should include what data would be helpful in supporting providers in providing the best care. Particularly looking at the demographic information being collected and if that accurately speaks to and breakdown the patient population. If data is being collected by the larger system that a practice is a part of, one can utilize data that is accessible or pull-out relevant data to the practice to begin building out a better understanding of the patient population.

Examples of changes the examination of REAL data can bring forth:

- Identification of interpreters needed for patient population to support health literacy

- Identification of improvement for screening tools (e.g. Edinburgh postnatal depression scale (EPDS), Survey of well-being of young children (SWYC), Developmental screenings

- Integration of screener into EHR system

Words Matter: How Language Used in Health Care Settings Can Impact the Quality of Pediatric Care

What? This webinar will examine the impacts of conscious and unconscious provider bias, particularly as expressed through written and verbal communication. Speakers explore the power of language in medical settings and its impact on health disparities for historically stigmatized groups and share opportunities to improve trust between patients, families, and care providers.

How? Explore the power of language in medical settings and its impact on health disparities for historically stigmatized groups and share opportunities to improve trust between patients, families, and care providers.
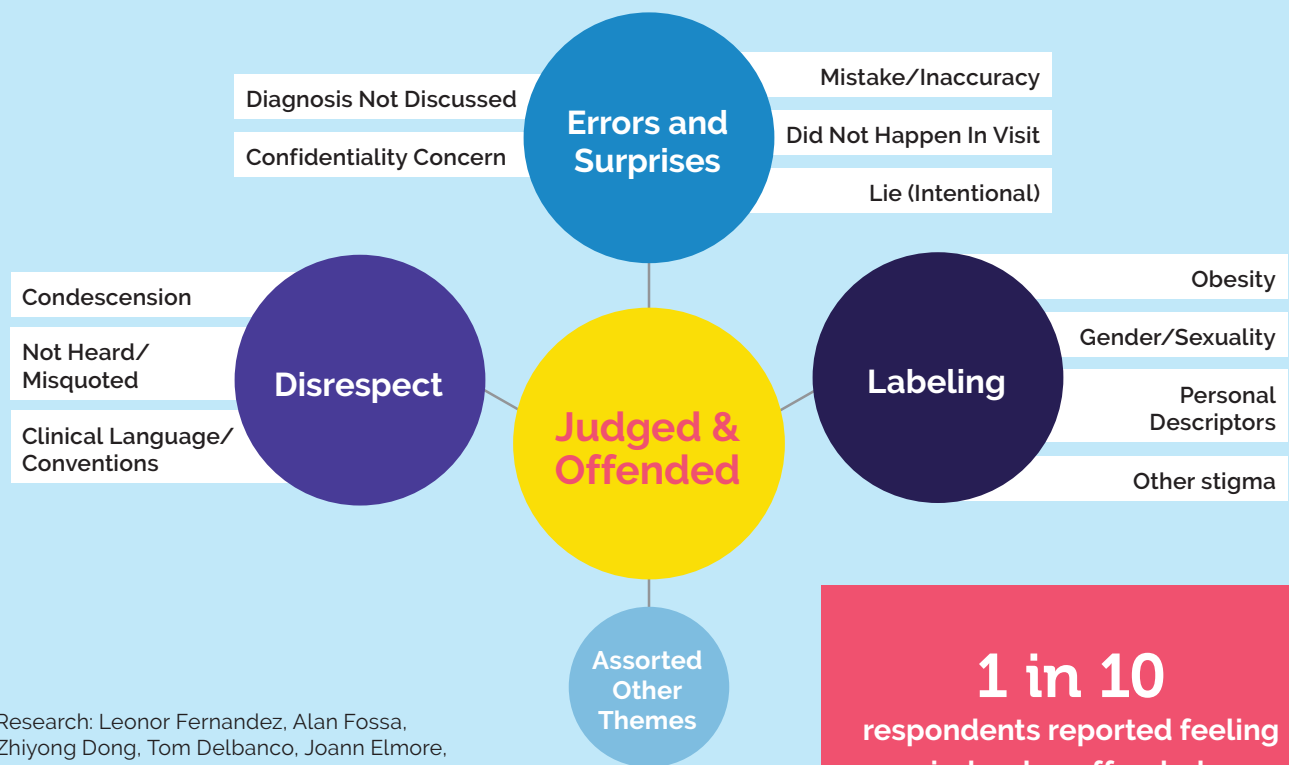
Speakers raise the issue of significant disparities in health care quality experienced by people of color, and discuss the importance of recent research related to language, bias, and empathy in patient care, including:

- The Link Between Stigmatizing Language and Patient Care

- Opportunities to Build Trust Between Patients, Families, and Providers

- Increasing Awareness Among Pediatric Providers

Who? Pediatricians and public health professionals can stay aware of and avoid including language that reflects personal frustration or negative judgments; strive for testimonial justice by being thoughtful, reflective and check assumptions; try to include reasons for nonadherence and think carefully before using quotes.

Words Matter: What Do Patients Find Judgmental or Offensive in Outpatient Notes?

Errors and Surprises
- Diagnosis Not Discussed
- Confidentiality Concern
- Mistake/Inaccuracy
- Did Not Happen In Visit
- Lie (Intentional)

Disrespect
- Condescension
- Not Heard/Misquoted
- Clinical Language/Conventions

Labeling
- Obesity
- Gender/Sexuality
- Personal Descriptors
- Other stigma

Judged & Offended

Assorted Other Themes

1 in 10 respondents reported feeling judged or offended.

Research: Leonor Fernandez, Alan Fossa, Zhiyong Dong, Tom Delbanco, Joann Elmore, Patricia Fitzgerald, Kendall Harcourt, Jocelyn Perez, Jan Walker, and Catherine DesRoches

Step Three: Building Quality Community Partnerships

IN THIS SECTION:

How to assess and build quality community partners.

Pediatricians and public health professionals are well positioned to promote safe stable nurturing relationships (SSNRs) by translating advances in developmental science into effective interventions for the home, clinic, and community. Pediatricians and advocates are expanding their efforts to translate research into communication strategies that convey healthy and positive child development emerges best in the context of nurturing, warm, and responsive early parent/caregiver- child relationships, surrounded by safe communities with strong trust and social connectedness. Building positive early relational health does not just happen in an office visit, and does not just happen in the home, but also happens in the context of a safe and supportive community. By making early relational health a key piece to promote healthy, positive childhood development, pediatricians can further expand and build quality partners to intentionally enhance their level of care.

The American Academy of Pediatrics Council on Community Pediatrics published a policy statement in 2013, in which they addressed the imperative for pediatricians to address the needs of their patients, families and communities across the spectrum, from the individual to the broader community. Community pediatrics is the practice of promoting and integrating the community pediatrics, child advocacy, public health, social determinants of health, positive social, cultural, and environmental influences on children's health as well as addressing potential negative effects that deter optimal child health and development within a community. To do so, pediatricians must successfully merge their traditional clinical skills with public health, population-based approaches to practice, and community advocacy.

Community pediatrics and organization engagement occurs through finding and building relationships to help meet patient's needs. Partnerships that are beneficial in addressing resource referral needs can be food banks, other health systems, childcare needs, early learning hubs, local and regional coalitions, school resources. It is important for providers to expand their network to include community leaders and organizations. Building these relationships help address disparities that exist as barriers to families getting

their needs met. Including this as an integral part of practice, pediatricians and public health professions can gain the following:

- A perspective that expands the pediatrician's focus from one child to the well-being of all children in the community.

- A recognition that family, educational, social, cultural, spiritual, economic, environmental, and political forces affect the health and functioning of children.

- A synthesis of clinical practice and public health principles to promote the health of all children within the context of the family, school, and community

- A commitment to collaborate with community partners to advocate for and provide quality services equitably for all children.

Review the resources below to explore how to identify and build quality community partners.

IMPLEMENTATION TOOLS

AAP Community Health and Advocacy Tools and Training Modules

What? To support and empower pediatricians and public health professionals to effectively address child health needs in their communities through partnerships and advocacy and by equipping them with actionable and effective content and tools.

How? By understanding the benefits of working in partnerships and how to identify other people, organizations, or institutions that are working on similar issues. Working in partnerships helps pediatricians increase the number of people and groups working to improve children's health and well-being and builds strength.

Community partnerships address and consider the environmental and social factors influencing child health, such as:

- Exposure to violence
- Safe places to play
- Poverty
- Child abuse
- Access to healthy foods
- Transportation
- Quality learning environments

Educational Objectives Upon Completion:

- To help pediatricians identify common allies and partners; explore the potential roles pediatricians can play within these partnerships and how partnerships can help them achieve their advocacy goals within a community.

- To increase pediatrician advocacy-related confidence and comfort level in working partnerships.

- To demonstrate that working in partnerships to accomplish an advocacy goal is doable and can fit within the demands of a busy schedule.

Utilizing a Bull's Eye Worksheet

What? A simple bull's eye worksheet can help prioritize who can easily be approached to get involved in community-based projects to advocate on behalf of issues specific to children's health and well-being.

How? Below are three important steps to assist with completing the worksheet and building a coalition of individuals to collaborate with.

- Consider 3-5 individuals and groups with whom you have a direct connection and already know would be supportive of your issue. Write those down in the first ring of the Bull's-eye. These people are your "base." These are the first people to ask to get involved.

- Think of "the next layer out" of individuals and groups – people with whom you have a direct connection, who might be interested in your issue, but are more distant than your base either because their connection is weaker or because the issue is less relevant to them. Write 3-5 groups that fall into this category in the second ring of the Bull's-eye. These people are those you can ask to get involved once you have secured your "base."

- Individuals and groups you would like to see involved, but don't necessarily have a direct connection with. These groups could include unlikely partners. Write these groups in the third and final ring of the Bull's-eye.
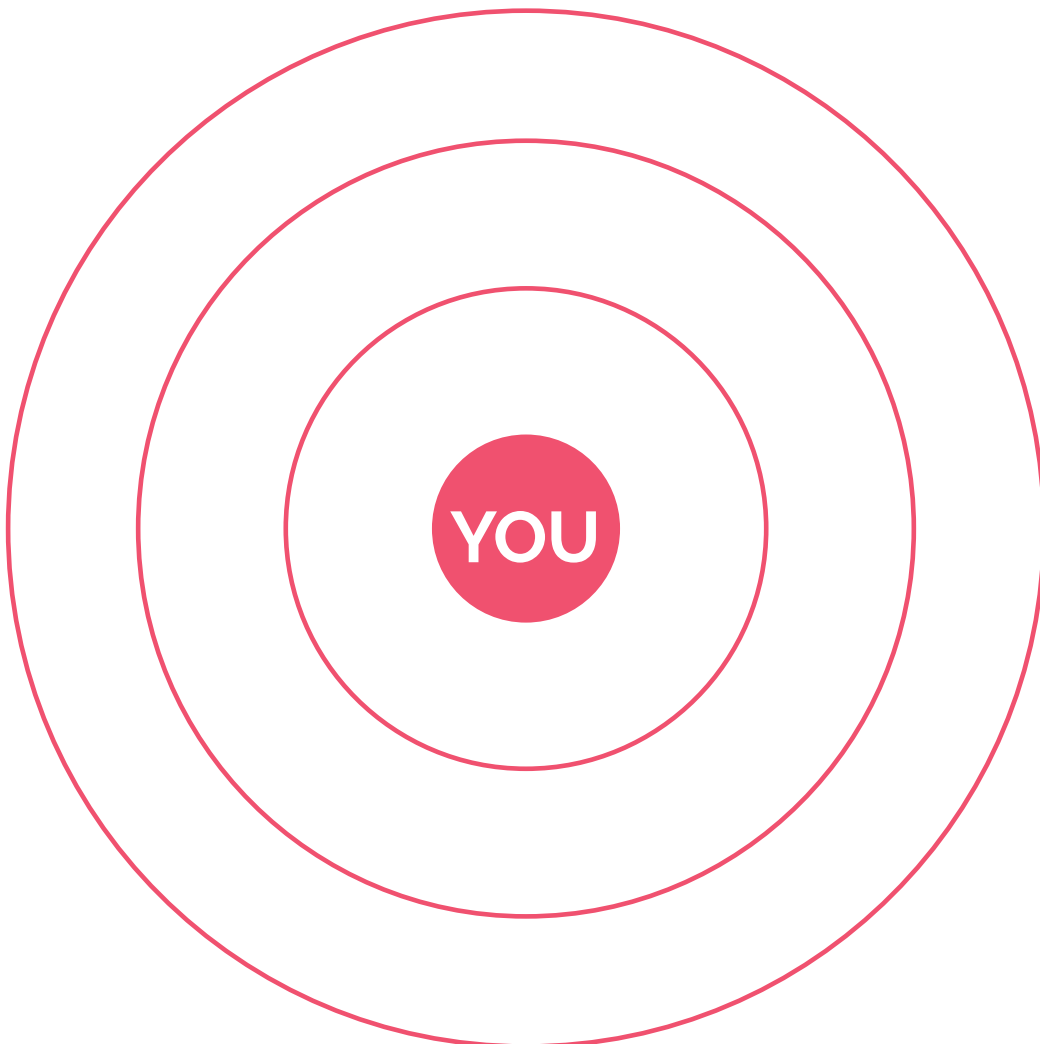
AAP Community Pediatrics Training Initiative

What? Define an issue that you wish to explore, build expertise by thinking through the process, and practice the skills necessary to build collaborative partnerships with a community to advocate for children.

How? By developing a coalition of individuals and groups that can help you plan and implement ideas to achieve the overall goal. When planning and implementing a community-based project, it is very important to work in collaboration with others in the community to accomplish a great deal more.

The Preparation:

- Identify an area of interest related to child health and well-being.

- Locate population-level data and conduct a literature review to develop expertise about a particular advocacy topic.

- Identify key stakeholders and note key shared values and goals regarding a particular issue.

- Define three measurable objectives as they relate to your advocacy topic.

- Develop a plan to impact a community that will ideally lead to a change in your measurable objectives.

- Describe a sample PDSA cycle as it relates to a particular advocacy issue.

- Describe your intended role in advocacy as a part of your professional role as a pediatrician.

Explore Existing Resources:

- What initiatives/projects already exist or have been tried in the past (locally, regionally, and beyond)? It is important to realize that other experts may have already explored the same problem/issue of interest and are already involved in community efforts related to it.

- Consider meeting with your local medical librarian for assistance with identifying the current literature related to your specific advocacy issue (or population) and obtaining the resources that you will need to build your content expertise.

Who? Identify and connect with the individuals and content experts who can aid you in developing and implementing your proposed project. These may include members of local community groups, or even regional or national content experts. When identifying these project "champions" and engaging with them, consider individuals who are passionate about a particular issue or patient population that they care about so deeply.

10 Steps for Building Community Partners and Projects:

1. Identify the problem
2. Define the baseline
3. Learn the literature
4. Explore existing resources
5. Develop your road map
6. Build a coalition
7. Ensure things are done WITH the community, not TO the community
8. Work diligently to accomplish goals and objectives
9. Develop tools for effective evaluation
10. Regularly re-evaluate and reflect on plan and project-related work

Step Four: Training and Education

IN THIS SECTION:

Provide learners with the opportunity to conduct trainings within their own health care organizations or practice networks to assist with integrating and supporting early relational health.

EQUITY CASE SCENARIO 1

Part 1

Paulo is in clinic for his 18th month well visit. His parents Sonya and Carlos requested their bilingual home visitor accompany them to the visit. The couple speak Mixtecos and have U Visas. Sonya G5 P5, tested positive for Covid on admission to the hospital when Paulo was born at 38 weeks gestation weighing 7lb 3 oz. with an Apgar of 8. Sonya and baby were separated after delivery due to an abundance of caution early in the pandemic. Sonya remained asymptomatic after the vaginal birth and Paulo tested negative for covid, both were discharged home after a 1 week stay in the hospital. Sonya and Paulo were referred to a local home visiting program by the promotores who had supported her prenatally. Sonya had breastfed all her children but was discouraged from breastfeeding Paulo. Sonya works during the day as a housekeeper at a local hotel. Carlos is the night janitor at the local Catholic school 3 of the older children attend. They alternate their schedules and can't afford childcare, have very limited English, and no transportation.

Reflections: When reviewing Paulo's previous visits, you make a mental note that the family has not missed any well-child visits, immunizations are up to date, and baby's growth chart is right on track. As the provider you also note that the baby/family is enrolled in a local Healthy Families America home visiting program and receives WIC. Your plan includes complimenting mom and dad on attending all scheduled visits and asking them if other challenges related to social determinants of health have come up since their last visit.

Part 2

Upon entering the room, you observe Paulo sitting in Sonya's lap holding onto the soft blanket he is wrapped in to keep him warm as he is only in a diaper and ready for his exam. The three adults are in conversation, and all are attentive to Paulo. The home visitor introduces herself to you and explains the parents requested her to be there to translate. Sonya is worried that she has harmed Paulo by not having him with her right

after birth and she regrets not breastfeeding him. She feels guilty for not getting the Covid vaccine earlier and fears Paulo will not bond with her as well as the other children did. Paulo begins to wiggle and slides off Sonya's lap and toddles across the room and raises both arms up and smiles as Carlos picks him up. Carlos reaches in his pocket and pulls out a small toy car. Paulo takes the little car and slides off dad's lap down to the floor and begins to make a motor sound as he crawls across the floor pushing the toy car.

Reflections: Paulo's physical exam is normal, the ASQ screen shows Paulo is meeting developmental milestones. You've observed Paulo walking, crawling, and interacting with mom, dad, and the home visitor. Concerns include maternal/paternal depression, social determinants of health, and stressors related to limited English proficiency/language barriers and cultural beliefs, as well as lack of sleep due to work schedules. In conversation mom shares again that she is worried that being separated from Paulo and not breastfeeding his has caused or will cause harm to their relationship. You share your physical exam and developmental screening findings with the parents. As the home visitor translates the parents' response to the good news you've shared about Paulo growing and developing well you see mom and dad smiling. You ask mom and dad if they have other worries to share with you and that you will work with them to help address any concerns they have. You learn from the home visitor that Paulo and the family will be enrolled in program until Paulo turns 3-years old and that that Paulo is on a wait list for a spot at a local Early Head Start program.

Strengths:

Supportive partner, experience parenting, home visitor, social support and strong faith community ties, U Visas, employment, normal delivery, normal Apgar, warm family relationships observed. Home visitor reports baby is still in a rear-facing car seat, parents have received safe sleep education and baby sleeps in a crib, baby gates, cabinet locks, and electric plug covers have been provided, there is a working smoke detector in the home, no firearms in the house, and medications are kept in a lock box.

Challenges/Concerns:

LEP, lack of transportation, lack of childcare, maternal and paternal risk for depression/anxiety, food insecurity, and housing and utility needs. **Immigration status is always an additional stressor, even for this family who were issued U Visas because dad was assaulted and badly injured while walking to his night job. He has recovered over the past year but still receives physical therapy and takes medications for shoulder and back pain.**

Test Questions

1. Prior to the visit, how did you prepare for creating a welcoming office environment for Mixtecos speaking patients?

    a. How to elicit strengths from the responses from the family members and support the care they need.

2. What exercises or community events can you suggest to the mother and baby that will help strengthen their bond?

3. Ask mother where she'd like to see her relationship with the child at this age. How would she like to be supported?

4. Is there enough concern in the mother's behavior to conduct an Edinburgh postnatal depression screen? How do you plan to communicate these concerns to the family in a culturally respectful manner?

5. What community supports programs are you aware of that align with the family's cultural beliefs?

6. What would you have done differently during the well-child visit?

7. Please describe your own reflections throughout the visit.

EQUITY CASE SCENARIO 2

Part 1

Sofia is a term 3-day-old infant born to mom, Rena, and here with dad today for the infant's hospital follow up. Both mom and dad only speak Spanish. Per the hospital discharge summary, Rena had a miscarriage late in her first pregnancy and is G3P3003 and prenatal labs were all unremarkable except history of anemia. The discharge summary says mom had gestational diabetes but mom denies this. Mom had a C-section but Infant and mom went home after 48 hours.

As the provider, you enter the room and notice that dad is watching the baby while sitting in a car seat. Mom is sitting in a chair across the room. As the provider, you introduce yourself and start to ask mom some questions about how the infant is feeding, stooling and voiding. Rena is not sure about how to answer these questions. Rena quickly shares that she is very tired, has a headache and needs some pain medicine. She says it has been hard with having two other children (3 years of age and 9 years of age) to sleep.

Reflections: Mom seems to have a flat affect, looks exhausted and in pain, and not able to listen during the discussion. You are worried about mom's physical and mental health and the impact on the infant and family dynamics. You plan to do an Edinburgh Postnatal Depression Screening.

You decide to ask specific questions about mom's health. Rena shares she is worried as she does not have enough breastmilk and so they are using Enfamil formula. You ask about mom's intake of liquids and she reports she has not drank any water all day. You decide to go get two bottles of water and some Tylenol. You then leave to see another patient and ask the nurse check her blood pressure. When you come back in 10 minutes, you are reassured to see that Rena's BP is 110/70.

Reflections: You decide to ask a few more questions and mom seems to pay attention a little better.

Mom says infant is taking ready to feed Similac formula 40 ml every 1-2 hours. Mom is not sure how to mix the formula from powder and asks for some help. You ask if Sofia is spitting up and mom says just twice but not forceful. You learn that mom is worried because Dad is not finding much construction work and he does not have insurance. Dad also shares that they do not have enough food. Mom has not signed up for WIC yet. Mom reports she does not have a crib and has the baby sleep in a bouncy chair.

Reflections: You are worried about many social determinants of health and plan to do a screening later. You are worried about the several stressors for the family and that could impact the infant's social emotional health. You start to examine the infant and notice that dad is very good at talking, trying to make eye contact with Sofia while undressing her and putting her on the exam table. You praise him for being here at the visit and that there is a need support mom with caring for the child and healing.

Infant on exam is unremarkable and has mild jaundice to mid-chest and has lost 5% from BW. The umbilical cord is still present. The infant also has the name bracelet on her wrist. During your conversation about the infant dad shares that they have no family in the state or country.

Plan: You cut off the wrist bracelet. You bring in an interpreter to help with anticipatory guidance and education for several items. You talk about trying not to overfeed and space out formula feeding and if breastfeed do that first and can promote more milk supply. You review mixing of the formula and also to discuss safe sleep and how to get a crib. The EPDS shows a score of 3 and no suicidal ideation. You screen for social determinants and mom reports they are not able to get utilities when needed and transportation is an issues to get medical care in addition to needs for health insurance for dad and food. You make a referral for care management. You also make a referral for an agency who can provide a crib. Plan is to follow up in 5 days to check weight, jaundice and how mom is feeling and follow up on if can get a crib. Mom agreed to have infant sleep in a laundry basket instead of a bouncy chair for now.

Part 2

Sofia followed up at 8 days of age for a weight check and to see how mom is doing. The infant gained 7 ounces. Mom has enrolled in WIC and is now breastfeeding first and then offering Gerber formula if hungry 2 ounces at a time. Mom is mixing 1 scoop of powder in 2 ounces of water which is correct. Infant is voiding and stooling well. Mom feels like she has much more support. She had a newborn visiting appointment via Facetime the day before. Infant has a normal exam except for an umbilical granuloma which was cauterized.

Concerns:

Attachment to infant and mental health of mother, dad unemployed, family needs food and transportation, unsafe sleep, and non-English speaking

Strengths:

Dad is involved and interacting well with infant and trying to support mom; mom has breastfed before; family has car seat, infant now enrolled in WIC, mom feels supported.

Test Questions

1. Prior to the visit, how did you prepare for creating a welcoming office environment for Spanish speaking only patients?

    a. How to elicit strengths from the responses from the family members and support the care they need.

2. As a provider what interpreter services can contact to prepare for the

3. What is your next plan of action if the screen is positive/if the screen is negative? How would you manage both scenarios and communicate the screen results in a culturally respectful and responsive manner?

4. What community resources can you contact to support the family?

5. What is the developmental milestone marker or outcome the child should be recording at this age? How do you communicate steps to support the family?

6. What would you have done differently during the well-child visit?

7. Please describe your own reflections throughout the visit.

Additional Resources

Organizational Leadership Buy-in

Year	Featured Resource	Format	Description
	[AAP Resource: Electronic Health Information Capacity in Pediatrics (EHICAP) Project: EHICAP EHR Implementation Resource Roll Up](#)	Resource	The Developmental Screener EHR Implementation Resource was created to advance a child health framework in electronic health systems by identifying elements across eight of the most widely used developmental screening instruments for implementation in EHRs. This resource will have broad applicability and be of interest to both the pediatric and public health communities.
2021	[Capturing Social and Behavioral Domains and Measures in EHRs](#)	Literature	Capturing Social and Behavioral Domains and Measures in Electronic Health Records. Standardized use of EHRs that include social and behavioral domains could provide better patient care, improve population health, and enable more informative research.
	[Family-Centered Care Assessment Tool for Providers](#)	Tool	This tool is not designed to provide a score but is meant as an opportunity for reflection and quality improvement activities related to family-centered care within outpatient health care practices. It can also be used by families to assess their own skills and strengths, the care their children and youth receive, and to engage in discussions within health care settings and with policy makers in organizations, health plans and community and state agencies about ways to improve health care services and supports.
2021	[AAP Resource: National Center for Medical Home Implementation: Coordinated Care](#)	AAP Resource	Resources to support care coordination, discover leading concepts, tools and resources to advance your knowledge and understanding of the medical home as it relates to your practice transformation.
	[AAP Resource: Practice Policy Templates](#)	AAP Resource	These policy templates are provided as a reference for practices developing their own materials and may be adapted to local needs. You should consult an attorney who is knowledgeable about the laws of the jurisdiction in which you practice before creating or using any legal documents.

Community Partners

Year	Featured Resource	Format	Description
2013	AAP Clinical Report: Early Intervention, IDEA Part C Services, and the Medical Home: Collaboration for Best Practice and Best Outcomes	AAP Clinical Report	The medical home process and Individuals With Disabilities Education Act Part C policy both support nurturing relationships and family-centered care; both offer clear value in terms of economic and health outcomes.
2014	AAP Policy Statement: Patient- and Family-centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems	AAP Policy Statement	This policy statement stresses the importance of care coordination, with guidance for implementation. Coordination of care across settings permits an integration of services that is centered on the comprehensive needs of the patient and family, leading to decreased health care costs, reduction in fragmented care, and improvement in the patient/family experience of care.
2015	AAP Publication: Road Map to Address the Social Determinants of Health Through Community Collaboration	AAP	A roadmap to help structure primary care approaches to these needs through the development of comprehensive and effective collaborations between the primary care setting and community partners.
2021	AAP Resource: Care Coordination Resources	AAP Webpage	AAP web page that provides links to resources, tools, and templates that promote effective care coordination. These resources are designed to help pediatricians stay current on healthcare trends.
2017	AAP Resource: Referral Directory (Excel)	AAP Resource	Template to facilitate the development of a referral list. Excel collects more details and can be populated and used as a directory.
2017	AAP Resource: Referral Directory (Word)	AAP Resource	Template to facilitate the development of a referral list. The word version is more basic and may be appropriate for practices just starting out.
2021	Addressing Social Needs Through Partnerships	Resources	Policymakers and health care stakeholders have called attention to the inconsistency and initiated new programs to address patients' social needs. This webpage consists of resources on establishing successful referral partnerships.

Equitable Systems

Year	Featured Resource	Format	Description
2019	The Impact of Racism on Child and Adolescent Health	AAP Policy Statement	The objective of this policy statement is to provide an evidence-based document focused on the role of racism in child and adolescent development and health outcomes.
2021	Practicing Socially Responsive Pediatrics: Why Health Equity Begins in Communities Not Clinics	Webinar	Dr. Omolara Thomas Uwemedimo, MD, MPH, provides personal and professional insights into the importance of social responsiveness to advancing health equity for racial/ethnic minority children, children in immigrant families, and low-income families.
2022	AAFP EveryONE Toolkit	Toolkit	This toolkit offers strategies for use in your practice and community to improve your patients' health and help them thrive.
2021	Racial Equity in Action: How to Get Started	Literature	ICMA and the Government Alliance on Race and Equity (GARE) shares the experiences of several city and county managers who are using GARE's framework of normalizing conversations about race, organizing within government and with community partners to achieve racial equity, and operationalizing with new policies, practices, and racial equity action plans.
2022	Health Equity Logic Model	AAP Resource	The National Resource Center for Patient/Family-Centered Medical Home developed a health equity logic model, outlining key activities, stakeholders and anticipated outcomes to support the increase of African American and Black children and youth.
2018	Health Leads Screening Toolkit	Toolkit	The toolkit combines Health Leads' 20+ years of experience implementing social needs programs with well researched, clinically-validated guidelines from sector authorities like the Institute of Medicine, Centers for Medicare and Medicaid Services and the Centers for Disease Control & Prevention.
2022	Anti-Racism Continuum	Resource	Implements structures, policies and practices with inclusive decision making and other forms of power sharing on all levels of the institutions life and work.