Imagine a medical practice that provides comprehensive pediatric care for infants, toddlers, and their families in an integrated, innovative way. One that is multigenerational and considers the history and social determinants of health of the broader family unit, whether parents are having their first child or their fourth. One that appreciates the interplay of nature and nurture. And one that regards the child as a whole person, aiming to address her physical, social, and emotional well-being. That practice currently exists at 102 sites as HealthySteps (HS), a universal program for families being implemented in a growing number of sites across the country. In fact, more than a dozen new sites are launching in 2017. This article offers an overview of HS and its use of a relationship-based and trauma-informed approach to supporting children and families.

**The HS Visit**

Gabrielle, a 20-year-old single mom, attends well-child visits with her son, Luca. While she waits to see Dr. Alastair, she looks forward to talking with Helen, her HS specialist (HSS). She met Helen almost 2 years ago at Luca’s first newborn visit. During those early visits, Helen raised a wide variety of important family needs including asking about protective and risk factors and social determinants of health, screening Gabrielle for depression, and screening Luca for his developmental and social-emotional milestones. These screenings gave Helen opportunities to support Gabrielle in both her parenting and her own mental health. Helen really reached out during and between those early visits to connect with Gabrielle, who had screened positive for postpartum depression. She was also available to answer Gabrielle’s questions about infant sleep, feeding, and how to play with Luca. Now Gabrielle calls her “my personal Google.”

Today Gabrielle is bringing Luca in for his 2-year-old well-child visit. After Helen says hello and checks in to see how Gabrielle and Luca have been doing since their last visit, she gives Gabrielle several developmental screenings to complete on Luca. In addition, Helen checks in with Gabrielle on how she is doing. Helen talks with Gabrielle about how she’s feeling and whether the new apartment she’s recently moved into is a good fit. She also asks how school is going, because Gabrielle had enrolled in evening classes after Helen’s encouragement some months back. Once the screenings are scored, Helen discusses the results with her and suggests that Luca be evaluated by the local early intervention program for a possible

**Abstract**

Pediatric health care practices are ideal settings within which to provide vital screenings, support, and parent education to families of infants and toddlers. HealthySteps (HS) uses an integrated, relationship-based approach to deliver a range of services and supports such as anticipatory guidance, developmental and behavioral screenings, referrals, and care coordination. This article highlights the primary components of HS and the critical benefits from participation that support overall family well-being as well as maternal-child health. These benefits include gains in crucial areas such as higher rates of child development and family social determinants of health screenings and referrals, increased use of positive parenting strategies, and enhanced child safety.
expressive language delay. Gabrielle has a lot of questions, and Helen reassures her that this is the most common form of language delay and she’ll help her through every step of the process. By the time Dr. Alastair joins the visit, Helen has entered the screening results into the electronic medical record and clarified Gabrielle’s questions for Dr. Alastair, allowing the three of them to make the most of the rest of the visit and develop an effective action plan. Helen also took a moment to give the doctor a heads up in the hall on the results of the language screening.

The HS Model

HS is an evidence-based, interdisciplinary pediatric primary care program that maximizes the likelihood that babies and toddlers experience nurturing parenting and healthy development, and that parents have access to the services and resources they need to support themselves and their young children. A child development professional known as an HSS is embedded within the practice as an integral part of the primary care team. The HSS connects with families during well-child visits and is responsible for ensuring that both children and families receive screenings and support, including for developmental milestones, conditions such as autism spectrum disorder, and common and complex issues that parents and caregivers face such as parenting challenges, maternal depression, food and/or housing insecurity, and adverse childhood experiences.

When needed, the HSS refers families to local agencies and programs that can meet their individual needs; referrals may include Early Head Start, early intervention, food banks, Legal Aid, local mental health services, and many others. These connections happen as part of an ongoing and long-term relationship the HSS builds with families over their time in the program. Children are enrolled as early as possible, ideally at their newborn visit and most before their 6-month visit. This early enrollment ensures that the HSS sees a family more often in the early months when the window of opportunity for intervening is strongest. At most sites, families continue until their 3-year-old well-child visit, with some sites extending through the child’s 5th birthday.

The HSS is a key member of the pediatric primary care team and, depending on the site, may co-lead well-child visits or meet separately with families to learn about child and parent strengths, worries, and questions. The HSS is trained to ask open-ended questions, listen attentively, and validate the parents’ experience, while offering reassurance and providing developmental and anticipatory guidance. The HSSs also offer families support between visits through text messaging, a phone line, office visits, home visits, or both; and care coordination tailored to each family’s unique needs and ability to navigate services. All of these services are designed to build parental and caregiver confidence so they feel prepared to respond appropriately to whatever developmental stage or challenge they or their child may face.

HS follows the American Academy of Pediatrics’ Bright Futures guidelines which are among the most respected recommendations for best practices in pediatric primary care, including the most up-to-date information on child development and preventive screenings and services. When combined, these guidelines and HS ensure families with young children have the knowledge and support they need to be successful parents, helping infants and toddlers get the best start in life.

HS visits feel markedly different to families than standard pediatric visits. They immediately recognize the added level of attention and support in early visits and, by design, develop a strong relationship with the entire pediatric practice’s staff over time, including the nurses, medical assistants, front and back office staff, HSSs, and physicians. This is because all staff are trained to create a welcoming, supportive, non-judgmental environment which enhances parent-child and parent-provider relationships to improve healthy child and family outcomes. Parents feel understood and supported, they are encouraged to ask questions, and they are provided with the tools and resources they need for themselves and their children.

This team-based, family-centered approach leads to significantly positive outcomes as established by a 15-site national evaluation that enrolled 5,565 children at birth and followed them for 5.5 years (Minkovitz et al., 2007), as well as by other small studies (Guyer et al., 2003). Here are 10 areas where outcomes are highlighted:

Outcome 1: Better Integration of Behavioral Health Care Into Primary Care

The heart of HS is a unified, team-based approach to well-child visits, as well as the individual relationships the HSS forges and maintains with the families. HSSs come from a wide variety of backgrounds; from social work to nursing to psychology to
The purpose of a typical well-child visit is to ensure that children are growing and developing well and that they are receiving appropriate preventive care and parenting guidance.

early childhood. Their primary role is to engage with families by listening to their concerns, sharing information, and noticing and promoting healthy parent-child interactions in order to foster strong attachment. This approach allows a families’ nonmedical issues and concerns to be addressed on a regular basis—creating a more integrated approach to care. For example, when a family shares they are struggling with their 1-year-old taking the remote control for the TV and pushing all the buttons, the HSS empathizes with the parents’ concern, listens to what they have tried, and then offers anticipatory guidance around development of their “child’s sense of self” that is emerging. This kind of ongoing support assists parents and caregivers in better understanding their child’s behavior and promotes an enhanced “goodness of fit.”

Interdisciplinary primary care is not yet incentivized in health care, where professionals from different disciplines tend to be highly siloed. An integrated approach effectively allows a family to access resources for physical, mental, and social health all in one place and is part of what makes HS so unique.

Outcome 2: Increased Staff and Parent Satisfaction

Imagine our HS mom, Gabrielle, arrives at the well-child visit visibly frazzled and shares with Helen that she has not been sleeping well because Luca’s sleeping patterns have deteriorated. Helen intentionally avoids direct, closed questions and instead acknowledges how incredibly stressful and depleting sleep deprivation can be. This approach is intentional. When she validates the difficulty of Gabrielle’s situation with empathy before rushing to brainstorm solutions, she builds trust and rapport. The 2015 ZERO TO THREE National Parent Survey (ZERO TO THREE, 2016), found that parents tend to be untrusting of expert feedback that is delivered as advice. The HSSs consistently learn from and build on new findings in the field like these to convey parenting information in a way that is warm and respectful.

Both the family and the health care practice benefit from this approach; a randomized, controlled trial on the HS model found that both doctors and patients reported increased satisfaction. In the National Evaluation, physicians reported that HS “facilitated a team approach, increased their understanding of family’s needs, and allowed a greater focus on child development and preventive care” (Guyer et al., 2003, E-3). Clinicians were also 5 times as likely to be very satisfied with their staff’s ability to meet the developmental and behavioral needs of children than when the program began (Guyer et al., 2003).

Parents are viewed as part of the health care team and take an active role in all decision making and care planning. This integrated approach to care could be a factor in HS parents being twice as likely to report that someone at the practice went out of the way for them (Guyer et al., 2003). Parents were more satisfied with care, agreed more that the pediatrician or nurse practitioner provided them with support, and were also more likely to remain with their practice (Minkovitz et al., 2007).

Outcome 3: Improved Adherence to Recommended Schedule of Well-Child Visits and Vaccinations

The purpose of a typical well-child visit is to ensure that children are growing and developing well and that they are receiving appropriate preventive care and parenting guidance, including vaccinations per the schedule recommended by the AAP and Centers for Disease Control and Prevention. Helen may text Gabrielle to remind her of upcoming well-child visits for Luca as one of the ongoing ways to connect her to the practice. She will also answer any questions about the recommended vaccination schedule.

In the National Evaluation, HS children in the research were twice as likely to receive a well-child visit on time (depending on age at visit) and attended a greater number of well-child visits overall (Guyer et al., 2003). With regard to vaccinations, children were more likely to receive vaccinations on time, and to be up-to-date on vaccinations by 2 years old (Guyer et al., 2003).

It was interesting that children did not have more visits overall (likely because of a reduction in visits for urgent concerns).

Outcome 4: Enhanced Child Screenings

The HSS is responsible for ensuring that families participate in a range of surveillance and screenings to track the child’s overall development, including traditional areas such as cognitive, linguistic, and motor skills, and, more recently, recommended areas such as social-emotional and behavioral development. Depending on the site and the tool, screenings may be administered in a variety of ways—via computer at home, pen and paper or tablet computer in the waiting room prior to the visit, or through a discussion with the HSS.

For Gabrielle and Luca, the developmental screening highlighted a possible language delay. After discussing the results with Gabrielle, Helen provided ongoing support over the next 6 weeks as Gabrielle worked to set up a developmental assessment with her local early intervention program.
Results from HS screening help health care providers better understand a child’s overall development and individualize care with information and resources tailored to each child’s unique needs and context. Parents and caregivers are met with non-judgmental support from the HSS and physician, provided with resources and referrals, and offered care coordination to scaffold the entry into other community systems and agencies.

**Outcome 5: Increased Parent/Family Screening and Identification of Risk/Protective Factors and Social Determinants of Health**

All families in an HS practice receive routine monitoring and screening for protective and risk factors and social determinants of health. Through these screenings, the HSS highlights the vital roles of parental health and concrete services to the child’s health and well-being, with a particular focus on the health of the parent-child relationship itself.

The HSS’s relationships with family members are the basis for offering assistance in identifying strengths and areas of challenge and for accessing support or assistance they might need to maximize their family’s or child’s healthy development. HSSs are sensitive to parents’ histories of trauma and other adverse childhood experiences.

“Anything that’s mentionable can be more manageable,” is a phrase coined by Fred Rogers (1995, p. 96) which highlights the importance of an open, supportive, and non-stigmatizing environment. When practices understand how to discuss sensitive issues with families and when they ask questions about difficult topics in a non-shaming manner, families are more likely to respond. In fact, the simple act of asking and answering screening questions is an educational opportunity for parents and one which opens the door to important discussions with providers about “hot button issues” such as guns in the home, intimate partner violence, smoking, food instability, and other challenges that families may perceive to be beyond the scope of the well-child visit. Instead, within HS, parents are encouraged to raise these challenges, questions, and issues.

The National Evaluation demonstrated that mothers enrolled in HS were more likely to discuss their depressive and anxiety symptoms with someone in the practice than were mothers who were not enrolled in HS (Guyer et al., 2003). Because of its emphasis on authentic, trusting relationships and its commitment to screening, HS creates a relationship with patients in which difficult topics can be mentioned and managed.

Substance, tobacco, and alcohol use identification fall under the header of protective/risk factors and social determinants of health, but it also overlaps with child safety and health. If Gabrielle reported tobacco use, for example, Helen could offer information about smoking cessation and the risks of second-hand smoke. Although the National Evaluation did not reveal any significant differences between intervention and control families in the percentage of mothers who smoked before and after pregnancy or in the percentage of mothers who stopped smoking over time (Guyer et al., 2003), a smaller quasi-experimental study found that HS families were more likely to report concern about alcohol or drug use by themselves or by another household member than were comparison non-HS parents (Johnston, Huebner, Anderson, Tyll, & Thompson, 2004).

Does screening matter for children and families? The evidence is strongly positive: The National Evaluation indicated that HS families had higher screening and referral rates and were more likely to receive information about community resources than control families (Guyer et al., 2003). More recent literature suggested that simply screening, referring, and helping families navigate systems for social determinants of health lead to improved child health and family social needs (Gottlieb et al., 2016).

**Outcome 6: Higher Referral Rates**

Depending on their strengths and needs, families enrolled in HS receive timely and individualized referrals (both formal and informal) to community resources. Higher referral rates imply that more families had the opportunity to have their needs appropriately addressed. In fact, the National Evaluation showed that HS children and families were 40% more likely to have one or more non-medical referral, including referrals for behavior, development, speech or language, hearing, maternal depression and mental health, child abuse or neglect, and early intervention (Guyer et al., 2003). By the time children were 30–33 months old, intervention mothers were more than 4 times as likely to receive information about community resources as compared to families at non-HS practices (Guyer et al., 2003).

Careful coordination of care, systems navigation, and connections to community resources are all part of the HS approach. The HSS identifies and develops personal relationships with service providers in the community and also coordinates and
follows up on referrals made with families, increasing the likelihood that families access needed services.

When families encounter challenges, the HSS is there to assist them in understanding and navigating a range of systems. For example, Gabrielle may learn that there is a 6-week wait to receive a language evaluation for Luca through the local early intervention program. Helen could share information about free, local learning programs for young children at the public library and other settings that Gabrielle and Luca could attend to promote his language development in the meantime.

**Outcome 7: Increased Use of Positive Parenting Practices**

Receiving positive parenting information and anticipatory guidance on developmental norms is a vital component for parents in fostering their child’s healthy development. Knowing what to expect developmentally—and being familiar with parenting strategies that support children’s growth and learning at each stage—builds parents’ competence and confidence. This information also helps parents know and understand their children’s needs, preferences, and cues more effectively, strengthening the parent-child relationship.

The National Evaluation showed that HS mothers were more likely than control group mothers “to match their behavior to their child’s developmental level, interests, and capabilities when playing with their toddlers” (Guyer et al., 2003, E-9). Families received more anticipatory guidance that matched their preferences (needs and interests) than families who were in non-HS practices (Minkovitz et al., 2007). Evidence from the National Evaluation showed that HS parents also paid more attention to their children’s behavioral cues (Zuckerman, 2004) and exhibited more developmentally appropriate expectations than non-HS families (Minkovitz et al., 2007). This guidance is critically important because knowing what to expect at each age and stage helps parents respond to their child’s behavior in ways that are supportive and nurturing, rather than harsh and shaming.

For example, consider a common scenario that might occur at a toddler visit: Gabrielle shares that her son’s willfulness is, frankly, driving her crazy and her sister has suggested that Gabrielle spank Luca when he demands a specific cup or pair of pajamas. Helen agrees that the toddler years are tough—as children have strong opinions and very little self-regulation, due to the fact that the part of their brain responsible for this critical skill is still developing. Helen wonders with Gabrielle about a variety of parenting strategies (such as offering age-appropriate choices, consistent limit-setting, or allowing natural consequences). Helen also shares research that shows that spanking children is associated with higher levels of child aggression later in life (Durrant & Ensom, 2012). Gabrielle asks questions and provides feedback on whether these various strategies feel comfortable to her. The two of them come up with a set of “family rules” that are appropriate to Luca’s age and review a range of ways that Gabrielle can respond to toddler defiance. Helen also offers information about a parenting course on limit-setting run by the local school system and reminds Gabrielle to call or text any time a challenge with Luca comes up, even if it’s between visits.

Evaluation data shows that parents enrolled in HS were less likely to rely on harsh punishment (yelling, threatening, slapping their child’s hands, or spanking with their hand) or to use severe physical discipline, defined as slapping their child in the face or spanking their child with an object such as a belt (Zuckerman, 2004). These findings may reflect parents gaining more knowledge about early development and parenting and holding more appropriate expectations of young children’s behavior, through HS’s use of positive parenting guidance and anticipatory information.

**Outcome 8: Increased Support for Early Learning**

The HS site and care team aim to support all parents with concrete learning resources including strategies, activities, tools, or programs specifically designed to help them support their child’s early learning. This support for early learning dovetails nicely with HS’s commitment to screening and invites the inclusion of supplemental evidence-based programs like Reach Out and Read and others. Sites often opt to implement additional interventions and resources (e.g., VROOM) within HS, provided practices continue to fulfill the core requirements of the HS program. See Learn More box for additional information and links about early learning.

At the end of Luca’s visit, Dr. Alastair offers him a few choices of books from the Reach Out and Read program. After Luca makes his selection, the doctor provides some tips on reading aloud to young toddlers and shares information on the importance of reading with children as a strategy to increase their vocabularies—an issue of critical importance for Luca. Helen might follow up by asking Gabrielle if she has any questions and share a few additional tips for engaging active toddlers in book-sharing. She could also offer anticipatory guidance about early literacy and language milestones likely to emerge in the next 6 months. The data show that this emphasis on early learning shapes parents’ routines and practices with their babies. HS mothers in the National Evaluation were more likely to show picture books to their infants every day (Guyer et al., 2003). In turn, HS families were more likely to report 5.5 years later that their children read books at school age (Minkovitz et al., 2007). A strong body of research links early literacy experiences with later literacy achievement once children enter school (Dunst, Simkus, & Hamby, 2012).
Outcome 9: Enhanced Child Safety

Child safety is a top priority. The HSS provides parents with critical information about child and home safety, including up-to-date recommendations on bed-sharing, feeding, car seat usage, household safety precautions, and injury control measures such as proper sleep positioning. This guidance may take the form of discussions, informational resources, or referrals to local agencies (e.g., sources of free car seats or help installing them). Findings from the National Evaluation showed that HS parents were 24% less likely to place newborns on their stomachs to sleep, reducing the risk of sudden infant death syndrome (Guyer et al., 2003). HS children were also 23% less likely to visit the emergency department for injury-related causes in a 1-year period (Guyer et al., 2003). In addition, a quasi-experimental study involving 439 participants in two intervention sites and two comparison sites demonstrated that HS parents were 20% more likely to score a full 5 points on an index of injury control that assigned points for important safety practices: having a functioning smoke detector (1 point); regular and proper car seat use (1 point); not having firearms in the home (2 points); or safe storage of firearms (1 point; Johnston et al., 2006).

During Luca’s visit, Gabrielle mentions to Helen that he is into everything in the house. Helen agrees that this is a common 2-year-old behavior and asks about child-proofing. When Gabrielle discloses that only the stairs are child-proofed—they could not afford child-proofing items for the rest of the home—Helen refers her to a local nonprofit that supplies these items to families on a sliding scale. A few months later, at the family’s home visit, Helen notices that the home is fully toddler-proofed and congratulates Gabrielle on making her home a safe and nurturing space for Luca.

Outcome 10: Strengthened Parent-Child Relationship

HS supports the parent-child relationship on many levels. First, families are integral members of the health care team in HS’s team-based model. Both physicians and HSSs engage families as respected partners in providing care and consult with families to ensure that results and recommendations are understood, “do-able,” and culturally relevant. Joint action planning (i.e., care planning) is a key partnership opportunity to secure good outcomes.

HS’s dyadic approach also provides a support modality that hones in on the parent-child relationship, acknowledging vital attachment patterns and how attachment security (or lack thereof) impacts the ongoing health of babies and toddlers. Noticing possible interruptions in the parent-child relationship early, through careful observation by the HSS or physician, can allow for earlier intervention and increased likelihood of relationship repair.

The evidence bears out HS’s emphasis on parent-child relationships. In the National Evaluation, mothers with children enrolled in HS were 24% more likely to report playing with their infant every day (Guyer et al., 2003), a parenting practice that also predicts language and cognitive development later on (Cates et al., 2012). Home observations at two of the National Evaluation sites indicated that children receiving HS showed greater security of attachment (Caughy, Huang, Miller, & Genevro, 2004). A smaller quasi-experimental study found that when children were 3 months old, enrollment in HS was associated with improved parental knowledge, practice, well-being, and satisfaction (Johnston et al., 2006).

No single professional can treat the whole child and family, including physical, behavioral, social-emotional development, and social determinants of health. However, as a team-based model that partners with professionals across disciplines and families, HS shows great success in understanding and responding to a child’s and family’s strengths and needs, and supporting healthy development at the individual and family system levels.

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