PEDIATRICS Supporting PARENTS

CLINICAL PRACTICE

FAMILY PARTNERSHIP

GOVERNANCE

Early Relational Health in Pediatric Practice:

Insights from Pediatrics Supporting Parents

HOW TO READ THIS SERIES OF THREE WHITE PAPERS

This paper focuses on changes in clinical practice; companion papers examine family partnership and governance.

Each paper can be read on its own with no specific starting point.

These papers are grounded in what the initiative as a whole and the Proof Point Communities experienced, tried, and learned during implementation.

Reflection prompts are included to support discussion, adaptation, and use in other settings.

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Methodology Overview: *This paper focuses on the pediatric care practice as the place where the priorities of Pediatrics Supporting Parents become visible. It describes what Proof Point Communities experienced as they reimagined well-child visit opportunities and workflows: the constraints they encountered, the innovations they tested, and what felt different as a result. Although the work varied across sites, a consistent set of patterns began to emerge. This paper presents a qualitative synthesis grounded in interviews, site experiences, and recurring themes observed across PSP communities.*

Introduction

The pediatric well-child visit is one of the few recurring points of contact that families have with the health care system during the earliest years of a child's life. Throughout the first three years alone, families attend up to 12 well-child visits, creating repeated opportunities to support children's health, well-being, and the relationships and caregiving environments that contribute to their early development.

Pediatrics Supporting Parents (PSP) emerged from a growing recognition, reflected in research from the Center on the Developing Child (2016) and the American Academy of Pediatrics (Garner et al., 2012), that the quality of *early relational health*—the state of the relationships surrounding young children, especially in the earliest years—plays a foundational role in long-term social, emotional, and physical well-being. PSP explored what might become possible if the work already happening in pediatric care, from vaccines and screenings to developmental checks, was approached with early relational health and family partnership in mind.

> **"The goal of Pediatrics Supporting Parents has been to reimagine what's possible in pediatric care—especially in the well-child visit."**
>
> – MARY ANN WOODRUFF, MD, FAAP, PEDIATRICIAN, PIERCE COUNTY PPC

> **"The pediatric channel is a universal access point—a way to meet families where they are."**
>
> – INDIA ALARCON, PSP PROJECT DIRECTOR & FUNDER COLLABORATIVE LIAISON, ALARCON CONSULTING

Through partnership with five competitively selected Proof Point Communities (PPCs), PSP explored how social-emotional development and early relational health could become a consistent part of everyday pediatric practice, with approaches tailored to what each community was learning from its families, systems, and local context. Within these communities, pediatricians, family leaders, administrators, and community organizations worked together to test and refine new ways of delivering care, strengthening relationships during visits and improving connections between families and supports beyond the clinic.

PSP's Journey from Common Practices to Community-Driven Transformation

The first phase of PSP, from 2017 through 2020, identified 14 common practices associated with relationship-centered pediatric care, family partnership, and early relational health. These practices were identified through a systematic analysis conducted by the Center for the Study of Social Policy, which examined more than 70 programs with existing or emerging evidence of effectiveness in supporting parents to foster the social and emotional development of young children (Doyle et al., 2019). The analysis also examined equity directly, with a focus on how pediatric practices engage and partner with families, honor culture, address implicit bias, attend to power differentials in care relationships, and develop community partnerships to address health inequities.

In addition to identifying the 14 common practices that promote social-emotional development and early relational health, PSP also worked to address the systemic barriers that make it difficult to center these priorities in everyday pediatric practice. Barriers include provider reimbursement, limited visit time, documentation burdens, lack of ways to measure progress, and clinician training. In this effort, PSP created resources to enable the conditions for pediatric transformation, including a financing blueprint for Medicaid and the Children's Health Insurance Program (or, CHIP), specific policies and strategies that nine states utilized to leverage public dollars, and a guide to help states leverage opportunities between Title V and Medicaid. (See sidebar.)

This initiative built on existing evidence-based work in pediatric primary care while remaining an intentionally community-driven and model-agnostic program on the premise that meaningful change cannot be fully designed from the outside or applied universally across communities that vary in population, context, and starting points (Doyle et al., 2019).

During the second phase of PSP (2021–2025), selected PPCs that were already engaged in transforming pediatric care alongside families used the 14 common practices as a guiding framework while adapting their approaches to fit local contexts, relationships, and community needs.

- Fostering Social and Emotional Health through Pediatric Primary Care: A Blueprint for Leveraging Medicaid and CHIP to Finance Change
- The Blueprint in Action: Lessons Learned from the Pediatrics Supporting Parents State Medicaid and CHIP Implementation Workgroup
- Guide to Leveraging Opportunities Between Title V and Medicaid for Promoting Social-Emotional Development

PSP's 14 Common Practices

Nurture parents' competence and confidence

- Use strengths-based observations and positive, affirming feedback
- Model activities and use strengths-based observations
- Provide enhanced and tailored anticipatory guidance materials
- Partner with parents to co-create goals
- Create opportunities for families to connect with other families
- Integrate strategies to support the parents' well-being and mental health

Connect families to supports to promote SED and address stressors

- Standardize workflow to provide developmental, behavioral, and SDOH screenings, health promotion, support, and resources
- Cultivate community partnerships through clear processes and protocols
- Outreach to parents during pregnancy

Develop the care team and clinic infrastructure and culture

- Integrate new roles into the care team
- Foster care team communication and collaboration
- Provide ongoing learning and development opportunities
- Support care team well-being to prevent burnout/stress/fatigue and retention issues
- Create environments and structures that promote respectful relationships and positive patient experiences

Strong, strengths-based, trusting, and humble relationships among and between parents, the care team, and the community are essential

Note. SDOH, social determinants of health; SED, social-emotional development.

Authentic partnership with families was central to PSP's approach. PPCs sought to engage families as both recipients of care and as contributors to implementation decisions, training efforts, and communication strategies. This approach highlights the value of incorporating family perspectives and lived experience into efforts to shape and improve pediatric care.

Opportunities to Strengthen the Visit Structure

Clinicians, family leaders, and administrators alike described the well-child visit as both a powerful opportunity and a constrained system. Pediatric primary care offers repeated opportunities to connect with families during the earliest years of a child's life, but those encounters also carry significant clinical, administrative, and operational demands. Providers are expected to address a wide range of priorities during a limited visit window, including the physical exam, screenings, caregiver guidance, developmental surveillance, behavioral health concerns, care coordination, documentation, and preventive medical care. Clinicians noted that this challenge was less about a commitment to relational care and more about a system influenced by time pressures, staffing constraints, reimbursement requirements, and documentation expectations that crowd out deeper conversations and follow-through.

Whether a well-child visit is allotted 12 minutes or 20, there is rarely enough time, and the one-size-fits-all approach is often driven by reimbursement criteria.

> **"An average pediatric visit is maybe 12 minutes, and there are all these things they're supposed to cover, ranging from eating and sleeping to vaccinations, to car seats, to how to keep your children safe."**
>
> – BARBARA IVINS, PHD, CLINICIAN, BAY AREA PPC

Providers also detailed screening and assessment protocols that have expanded over time with the intention of identifying family needs earlier and improving developmental support. However, practitioners often find that the volume of these activities can outpace their ability to respond meaningfully. Referrals lead to waitlists, limited capacity, or no clear next step, and screening can become more about documentation than linkage to actual support.

> **"We do all these things—screener after screener—and we don't always have the space to explain to families what's happening or why."**
>
> – ELLIE ERICKSON, MD, FAAP, IMH-E, PEDIATRICIAN, DURHAM PPC

For families, this gap carries additional weight. Being asked to disclose vulnerable information such as housing instability, financial strain, mental health concerns or other health inequities without knowing who would see that information or what will be done with it can feel less like an offer of help and more like surveillance. Without clear messaging around intentions, sharing can feel risky, particularly for families who have prior reason to distrust institutional systems.

Navigating these social determinants of health and other stressors affects what families are able to prioritize and act on during a visit, even when providers identify concerns.

> **"If a parent is worried about housing, groceries, child care when you're having that conversation about vaccines, like, that's the last thing on their mind."**
>
> – MONICA BELTRAN, MEMBER OF PSP FUNDER COLLABORATIVE, W. K. KELLOGG FOUNDATION

What Was Explored

The PPCs did not begin by asking how to add another intervention or program to the well-child visit. Instead, they questioned assumptions that have long-shaped pediatric care: What is the purpose of the visit? Whose priorities organize the time? What happens when family expertise is treated as essential to care? And how might pediatric care look different if relationships are part of the work? Although PPCs approached these questions from different starting points, there were similar themes. The work has focused on strengthening relationships within the visit, elevating family expertise, and reconsidering how pediatric care can respond to what families are navigating outside the clinic.

REASSESSING VISIT GOALS

Providers have increasingly positioned the well-child visit as a relational opportunity, one that still encompasses the recommended components of a well-child visit but seeks to engage them through stronger listening and greater partnership with families.

> **"PSP changed the way I even started a wellness exam. That I entered, not with my laundry list, but with my wonderings. Tell me what is important to you today and really centering that."**
> – MARY ANN WOODRUFF, MD, FAAP, PEDIATRICIAN, PIERCE COUNTY PPC

This shift often begins with reconsidering how visits start: Who sets the agenda, what concerns are centered first, and how are families invited into the interaction? Several clinicians described moving away from entering the room focused primarily on a checklist and toward a more open, shared approach to the visit.

Medical care and relationship-centered approaches can be integrated in ways that support both children and families. PPCs explored how trust-building, clear communication, and shared observation can strengthen pediatric care and reinforce the importance of attending to both medical and relational aspects of a family's experience.

EMBEDDING FAMILY EXPERTISE

PSP built its approach on the belief that family expertise strengthens both care delivery and implementation efforts. PPCs created opportunities for family leaders to contribute to decisions related to clinical workflows, communication approaches, and training.

These contributions occurred throughout multiple levels of the work—from individual visits to clinic operations. Family perspectives helped PPCs better understand how care processes were experienced and suggested adaptations that reflected community needs.

> **"Parents have answers—but they're not always given the opportunity."**
> – HOPE WILLIAMS-BURT, FAMILY LEADER, BAY AREA PPC

Approaches varied by community, PPCs shared a commitment to engaging family leaders as partners in shaping planning, implementation, and continuous improvement efforts.

EXPANDING CARE USING A TEAM-BASED APPROACH

Practitioners recognized that families arrive at visits carrying stressors and responsibilities that extend beyond what a well-child visit can address. PPCs found that acknowledging and responding to that fuller picture was as important as what happened in the exam room.

> **"If you don't have access to food and housing, then that inevitably impacts how you build relationships with your babies."**
> – MONIQUE HOLGUIN, LCSW, PHD, CLINICIAN, LOS ANGELES PPC

These family pressures are deeply connected to child development, caregiver well-being, and the effectiveness of care. No single provider, working within a constrained visit, can realistically address it all. Integrating mental and behavioral health providers, social workers, and community health workers (CHWs) directly into the pediatric setting can help distribute responsibilities across a team, as is done with models such as HealthySteps. Families gain access to more consistent, coordinated support, and practitioners gain colleagues who can help carry the relational and logistical work that a well-child visit alone was never designed to hold. A single visit or referral may identify families' needs, but a team of support is best positioned to coordinate care effectively.

What Changed in Clinical Practice

Despite variations in approaches to this work, consistent patterns emerged. The shifts that PPCs made have not produced a single model or standardized workflow. Each has adapted on the basis of its own staffing structures, partnerships, resources, and priorities. Throughout this section, PPCs' innovations that can either directly or indirectly affect clinical practice are highlighted. (See Table 1.) The companion paper on family partnership shares additional innovations extending this work beyond the clinic setting.

TABLE 1. PPC Innovations by Subheader

INNOVATION	PPC	WHAT CHANGED IN CLINICAL PRACTICE CATEGORIES					
		Care is more connected and coordinated.	Providers experience the work differently.	Relational care is built into resident training.	Family voice changes decision-making.	The visit feels different.	Communication has changed.
Elevating Parent Perspectives in Early Relational Health Training and Practice	Bay Area			●			
Family-Inspired Clinic Beautification and Learning Through Play	Durham					●	
Parents as Partners: Clinic Policy Collaborative	Durham						●
Parent Education Suite	Durham						●
The Medical-Financial Partnership (MFP)	Los Angeles	●					
The MFP Benefits Explorer Tool	Los Angeles	●					
The MFP Parent Voice Note	Los Angeles				●		
Integration of Maternal Mental Health Services in the Pediatric Medical Home	Onondaga County	●					
Pediatric Residency Advocacy Rotation, featuring Help Me Grow/Early Childhood Alliance	Onondaga County			●			
Embedding Community Health Workers in Pediatric Primary Care	Pierce County	●					
Learning Collaboratives	Pierce County		●				
Reflective Practice with Pediatricians	Pierce County		●				

CARE IS MORE CONNECTED AND COORDINATED

The well-child visit is where provider-family relationships begin, but the work of supporting families extends well beyond it. When care included mental or behavioral health care, families had an easier time accessing the resources they needed, following through with referrals, and staying connected to their care team. The innovations that these PPCs developed expanded the reach of care and improved its continuity between visits and across systems.

In Los Angeles, the Medical-Financial Partnership (MFP) pairs families with embedded social work support that begins during pregnancy or early infancy. Rather than relying solely on referrals, this model focuses on longitudinal follow-through around financial stability, mental health, and early relational health. Within that broader effort, the MFP Benefits Explorer Tool connects families directly to public benefits.

Pierce County's innovation, Embedding Community Health Workers in Pediatric Primary Care, focuses on maintaining trusted relationships with families between visits rather than starting from scratch at each encounter. CHWs help families navigate both clinical and community-based systems, accompanying families through referrals and follow-up processes and reducing some of the friction that often exists between identifying a need and successfully accessing support. Bringing CHWs into pediatric settings requires practices to rethink traditional care team structures and create new workflows, roles, and partnerships that extend past the exam room.

In Onondaga County, the Integration of Maternal Mental Health Services in the Pediatric Medical Home brings mental health support directly into the pediatric setting, so that when a mother screens positive for depression or anxiety, the path to care is clear. The focus is on ensuring timely and easily accessible follow-up, grounded in the understanding that caregiver well-being is closely linked to a child's health and development.

PROVIDERS EXPERIENCED THE WORK DIFFERENTLY

PSP's experience highlighted the realities that many pediatric providers face as they aim to support children and families while managing documentation requirements, productivity expectations, and an expanding scope of responsibilities.

As embedded CHWs, integrated mental health services, and longitudinal family support have taken hold, the positive effects extend to providers as well. PSP found that when families arrived with some of their most pressing needs already addressed, visits felt less rushed and more relational. With a broader care team in place, visits felt less fragmented, with ongoing concerns addressed in a more coordinated way.

Several PPCs created structures that support reflection, collaboration, and relationship-centered practice among providers. In Pierce County, Reflective Practice with Pediatricians includes Lunch-and-Learn sessions, reflective cohorts, and clinicwide wellness efforts designed to build curiosity, self-awareness, and stronger connection with families and colleagues. Learning Collaboratives similarly created opportunities for shared learning and support. Providers described these efforts not as reducing clinical rigor but as improving decision-making, trust, and communication within visits.

> **"If parents feel supported by your institution, then everybody is happier. Your providers feel better about their work . . . you become community."**
>
> – BARBARA IVINS, PHD, CLINICIAN, BAY AREA PPC

INTEGRATING RELATIONAL CARE IN RESIDENT TRAINING

As PPCs expanded their thinking about professional development for providers, their attention turned toward preparing the next generation of clinicians. They focused on embedding relational, family-centered care into training so that residents could enter the field seeing it not as an exception to standard care, but as the standard itself.

In Onondaga County, the Pediatric Residency Advocacy Rotation was designed in partnership with parent leaders and community organizations, and it requires first-year residents to spend time directly with these partners to better understand the referral process, the barriers that families may encounter, and what the system looks like from a family perspective. The rotation is a required part of training, to ensure that all residents have this shared learning experience.

> **"My dream is that the people that we train think this is just the way you do pediatrics. They don't have the historical sense of 'we didn't always do it this way.' They just think 'this is the way it is.'"**
>
> – JENICA O'MALLEY, DO, PEDIATRICIAN, ONONDAGA COUNTY PPC

In the Bay Area, Elevating Parent Perspectives in Early Relational Health Training and Practice brought family leaders into resident training not in an advisory capacity but as the driving force behind what and how residents learn. Family leaders designed curricula, wrote scripts, and filmed training vignettes. The result is an experience informed by the people for whom the residents will ultimately provide care—grounding clinical education in lived experience.

FAMILY VOICE CHANGES DECISION-MAKING

As family partnership became more embedded within implementation, it started to shape how decisions were made within organizations and collaboratives. PPCs created deliberate space for family voice in planning conversations, workgroups, training efforts, and operational redesign, bringing more perspectives into the process. Although this meant that some processes moved more slowly, the result was a more inclusive approach that strengthens the outcomes.

> **"It has completely slowed down our decision-making in the best way, because we come to better decisions we don't have to change later."**
>
> – RACHEL LETTIERI, ADMINISTRATOR, PIERCE COUNTY PPC

Stakeholders viewed listening as an intentional part of organizational design rather than a by-product of good facilitation. Family partnership shaped clinical interactions and the way that institutions considered planning, implementation, communication, and long-term systems change.

In Los Angeles, families partnered with clinicians in co-designing the intake questionnaire and informed the process for its use. The MFP Parent Voice Note was built from the ground up, designed as a conversation where families can share their goals, priorities, strengths, and immediate concerns. The result was their own words incorporated directly into the electronic health record and visible to the entire care team. Providers can walk into the exam room already knowing what matters to that family. Families know that their perspective won't disappear between visits. What makes it most effective is not just what it captures but that parents co-designed it themselves.

> **"[PSP] gave me the confidence to go into the doctor's office and say, 'Hey, we got to talk.'"**
>
> – SEKANI TIMOTHY WAYNE HARRIS, FAMILY LEADER, LOS ANGELES PPC

THE VISITS FELT DIFFERENT

In Durham, family feedback revealed that visits often felt longer, even though appointment lengths remained the same. Providers placed greater emphasis on sitting down, making eye contact, and clearly explaining each step, creating more space to respond to what families brought to the visit while still moving through clinical priorities thoughtfully.

The clinic environment itself can also shape how families experience care before the visit even begins. In Durham, the Family-Inspired Clinic Beautification and Learning Through Play initiative transformed the waiting room with murals, scavenger hunts, and interactive learning activities developed in partnership with the parent advisory team. Through this redesign, the waiting room became an intentional extension of care, a place where play and engagement between caregivers and children helped establish a more relational foundation for the visit that followed.

> **"A year and a half later, we were able to go back to our parents and do the same exact focus group. . . . And the response was, 'our visits are longer' even though they were not. The key is, they *felt* longer."**
>
> – TIFFANY SOLOMON, PROGRAM MANAGER, DURHAM PPC

COMMUNICATION HAS CHANGED

In some PPCs, examining policies and communication practices through a family lens offered new insight into how families experienced them. Family leaders highlighted ways that language, workflows, and institutional communication could sometimes contribute to barriers in accessing care.

Durham's Parents as Partners: Clinic Policy Collaborative worked with clinic staff to improve no-show communication policies and rewrite letters that families perceived as punitive or alienating. In Pierce County, the care team and family leaders reconsidered how missed appointments and follow-up conversations were framed more broadly across the care experience.

Several PPCs invested in language access as a core part of communication equity, providing interpretation services for meetings, producing family-facing materials in multiple languages, and using plain language. In Durham, that commitment extends further, with families serving as active co-designers of solutions, including their work on Thriving Together: A Co-Designed Parent Education Suite.

Together, these changes led to meaningful shifts in how care was experienced and delivered. Overall, PPCs described this less as a set of discrete changes and more as a gradual culture shift, one that moved care toward something more relational, responsive, and grounded in the realities of families.

Conclusion: Reimagining Relational Care

Throughout PSP, these efforts did not converge on a single model of care. Each PPC began from a different starting point and pursued strategies influenced by local needs, relationships, and context. Small shifts in how care was organized meaningfully affected the experiences of families and providers, often in ways that exceeded what any single intervention or innovation could accomplish. Questions of time, trust, and decision-making shaped what was possible, and the work gradually shifted from improving individual visits to reconsidering care delivery more broadly.

This reorientation did not resolve the structural pressures facing pediatric care—time constraints, documentation burdens, reimbursement challenges, and workforce needs. However, it did show that even within these realities, the experience of care could change when relationships, continuity of care, and family expertise are treated as central.

These dimensions are explored in greater depth in the companion papers on family partnership and governance, which examine what meaningful co-design and shared decision-making require in practice and how they expand what is possible in pediatric care. Together, the three papers do not offer a blueprint or universal solution; rather, they suggest that pediatric care can function differently when families are essential partners in its design and delivery.

Considerations for Clinics

Every PPC began somewhere, and the starting point was usually not a major overhaul. More often, it began when someone simply asked a good question or brought a new lens. The following questions are offered as practical entry points for any practice considering how to begin or deepen their integration of early relational health into care, with insights from PPCs on how they approached these questions.

What small shifts in a provider's approach during visits can improve care?

PPCs reconsidered how the pediatric encounter is structured and experienced. Sitting at eye level, creating intentional moments away from documentation, beginning visits with family priorities, carrying parent concerns forward into future visits, and creating more space for conversation have influenced how families and providers experienced their interactions.

What is perceived as "fixed" that might not be?

PPCs found it valuable to revisit practice policies and workflows that have become normalized over time: for example, screening processes, intake forms, no-show communications, waiting room environments, referral procedures, and documentation habits. In several cases, relatively modest adjustments changed how families experienced the clinic before the medical encounter even began.

How can the practice create space for reflection and shared learning?

Supporting provider well-being was another area that PPCs explored. Reflective practice groups, Lunch-and-Learn sessions, and structured opportunities for collaborative discussion gave providers space to process difficult experiences and approach their work with greater curiosity and connection.

Where can continuity of care for families be strengthened?

PPCs found that extended support between appointments and after referrals made a difference for families. Follow-up systems; warm handoffs; and team-based care with embedded social workers, navigators, community health workers, and behavioral health staff helped carry family context forward and maintain connection across the care relationship.

How can more opportunities for family partnership be created?

Beyond surveys and feedback forms, which offer valuable input, partnership deepens when families have space and authority to influence decisions. An initial step toward this goal might be including families on quality improvement or planning committees that are responsible for addressing collected feedback. PSP found that compensation and support meant families were able to more easily participate.

These questions invite a willingness to look at a familiar system from a different perspective and ask what can be achieved within existing constraints and workflows. PSP's work has been iterative, with approaches being tested and refined over time and a goal that is less about finding the right program, protocol, or policy and more about creating the conditions in which families, clinics, and the people they serve can examine and reshape the well-child visit and its context.

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