



Pediatric Bundle Initiative

The Pediatric Bundle Initiative (PBI) is a New York City (NYC) Health Department project that supports pediatric primary care providers in addressing early childhood health and development. The PBI was launched in September 2015 with a roundtable discussion cosponsored by the United Hospital Fund (UHF) and the Department of Health. The goal of the PBI is to transform pediatric primary care through innovations in clinical practice and policy reform.

A cornerstone of the initiative is a set of 14 evidence-based programs and promising practices – the Pediatric Bundle – that improve the health and development of young children from birth to age 5. Providers select the components that best meet their patients' needs and offer them at their clinic. The PBI was developed based on a review of published literature and of program websites and communications with local and national program experts.

Pediatric Bundle Components Include:

- CenteringParenting or well-baby group care
- Circle of Security program
- Co-located services
- Developmental screening
- Fluoride varnish application
- Food insecurity screening
- Health Leads
- HealthySteps
- The Incredible Years
- Maternal depression screening
- Medical-Legal Partnership
- Reach Out and Read
- Triple P – Positive Parenting Program
- Video Interaction Project

These programs and services have been reported to:

- Improve the overall health and well-being of young children, women and their families
- Reduce early behavior problems and improve children’s language, cognitive and self-regulation development
- Increase well-child visit attendance
- Reduce parental stress and increase parents’ self-efficacy and confidence in their parenting decisions
- Identify and address barriers to early development, such as developmental delays, maternal depression and tooth decay
- Identify and address social determinants of health early in life, including housing, food insecurity, insurance coverage and legal issues

Key Initiative Activities

- Assessment of pediatric providers’ knowledge, experience and interest in the Pediatric Bundle components
- Allocation of funding to implement Pediatric Bundle components at NYC Health + Hospitals facilities
- Implementation and evaluation of the Pediatric Bundle with Healthfirst providers and other stakeholders in the Bronx’s Claremont neighborhood
- Identification and tracking of specific outcomes to inform reimbursement and cost savings

The PBI is an effort of the Health Department’s Early Childhood Health and Development Unit in the Division of Family and Child Health, in partnership with:

- The Health Department’s Bureau of Children, Youth and Families
- Healthfirst
- NYC Health + Hospitals

Video Interaction Project (VIP)



Description

The Video Interaction Project (VIP) is a relationship-based intervention that provides families with one-on-one parenting sessions. The sessions are video-recorded and reviewed with an interventionist during routine pediatric visits from birth through age 3. VIP offers developmentally appropriate toys, books and resources for parents to use with their children. These tools help parents use pretend play, shared reading and daily routines to strengthen early development and literacy in their children.¹ Pediatric offices can offer VIP.

Evidence

- Parents can cope better with the stress and challenges of raising their children.²
- VIP enhances parent engagement in reading, play and verbal interactions with their child.³
- Children develop skills necessary for success in school, including reduced behavioral problems.⁴
- VIP enhances socioemotional development and cognitive language outcomes among children from families with low socioeconomic status.⁵
- VIP reduces maternal depressive symptoms.⁶

Implementation

New sites work closely with the VIP Center of Excellence at New York University School of Medicine during a three-year startup period. The center provides critical centralized support, training and oversight to ensure the new site implements VIP with fidelity. Before implementation begins, the site and the VIP Center of Excellence work together to ensure sufficient funding, space and staffing. During the startup period, the center and the site tailor VIP to the site's specific needs and patient population. In addition, the site identifies a VIP facilitator and the Center of Excellence provides the facilitator with formal program training and clinical supervision.

After a three-year startup period, a new site will have the capacity to:

1. Implement the program model consistently and successfully
2. Reach approximately 400 children per year with an average of three sessions per child, for each full-time VIP facilitator
3. Further integrate VIP programs into existing systems and identify long-term funding

Billing and Reimbursement

Reimbursement is not currently offered for this service.

Resources

For information about VIP, visit videointeractionproject.org

For information about implementing VIP (including details on funding, staffing, space or other requirements), please contact:

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1. Video Interaction Project. Retrieved from <http://www.videointeractionproject.org>.
 2. Cates, C.B., Weisleder, A., Dreyer, B.P., Johnson, S.B., Vlahovicova, K., Ledesma, J. and Mendelsohn, A.L. (2016). Leveraging Healthcare to Promote Responsive Parenting: Impacts of the Video Interaction Project on Parenting Stress. *Journal of Child and Family Studies*, 25(3):827-835.
 3. Mendelsohn, A. L., Huberman, H. S., Berkule, S. B., Brockmeyer, C. A., Morrow, L. M., & Dreyer, B. P. (2011). Primary Care Strategies for Promoting Parent-Child Interactions and School Readiness in At-Risk Families: The Bellevue Project for Early Language, Literacy, and Education Success. *Archives of Pediatrics & Adolescent Medicine*, 165(1), 33-41. <http://doi.org/10.1001/archpediatrics.2010.254>.
 4. Mendelsohn, A. L., Dreyer, B. P., Flynn, V., Tomopoulos, S., Rovira, I., Tineo, W., Pebenito, C., Torres, C., Torres, H. and Nixon, A. F. (2005). Use of Videotaped Interactions During Pediatric Well-Child Care to Promote Child Development: A Randomized, Controlled Trial. *Journal of Developmental and Behavioral Pediatrics*, 26(1), 34-41.
 5. Weisleder, A., Cates, C.B., Dreyer, B.P., Johnson, S.B., Huberman, H.S., Seery, A.M., Canfield, C.F., Mendelsohn, A.L. (2016). Promotion of Positive Parenting and Prevention of Socioemotional Disparities. *Pediatrics*, 137(2):1-9. DOI: 10.1542/peds.2015-3239.
 6. Berkule, S. B., Cates, C. B., Dreyer, B. P., Huberman, H. S., Arevalo, J., Burtchen, N., Weisleder, A., Mendelsohn, A. L. (2014). Reducing Maternal Depressive Symptoms through Promotion of Parenting in Pediatric Primary Care. *Clinical Pediatrics*, 53(5), 460-469. <http://doi.org/10.1177/0009922814528033>.

Triple P - Positive Parenting Program



Description

The Triple P Positive Parenting Program follows the behavioral parent training (BPT) model. This approach gives parents the necessary skills to address their children's behavioral issues. The program teaches parents techniques that can enhance their knowledge and confidence, and improve their relationship with their children. Triple P offers various interventions in brief, one-time consultations or more intensive multi-week formats – with single-family or group options. Families can also get help in an online format.

The program has three different curriculum tracks to support parents of children: from birth to age 12; between 12 and 16 years of age; and children with a disability or chronic health condition between the ages of 2 and 12. The Triple P model does not require practitioners to have specific background or educational qualifications. Professionals working with families across many settings and sectors deliver the Triple P program. Pediatric offices or community-based organizations can offer the Triple P program.

Evidence

- Triple P prevents child behavioral problems and child maltreatment.¹
- Triple P reduces problem behavior in children and improves parents' well-being and parenting skills.
- Triple P lowers child abuse rates, foster care placements and hospitalizations from child abuse injuries.²
- In communities where Triple P is widely available, children have fewer behavioral and emotional problems. Parents using Triple P say they are less stressed, less depressed and don't use harsh discipline.³
- Parents of children with autism spectrum disorders using Stepping Stones (a specialized program through Triple P for parents of children with a disability) report being more satisfied as parents. They also report improved behavior from their children and a better relationship with their partner.⁴
- The cost of offering Triple P throughout a community could be saved in a single year if the program reduces child abuse and neglect cases by just 10 percent.⁵

Implementation

Depending on the project scope, we recommend allowing two to six months to prepare for implementation before training practitioners. The training process typically consists of two to five days of initial training, followed by a pre-accreditation workshop four to six weeks later. After this, accreditation takes approximately two weeks (roughly eight weeks post-training). After training, various options support continued model sustainability. We find sites benefit from consultation calls with a trainer in the initial service delivery months. Sites also may benefit from an in-person workshop to further support implementation.

We strongly encourage practitioners to form peer support networks that gather on a regular basis (weekly, bi-weekly or once a month) in small groups (five to eight people). These groups discuss Triple P implementation with families (e.g., case studies), set goals and practice consultations skills. Regular connection in early post-training days is crucial for uptake of Triple P.

Billing and Reimbursement

Triple P services provided to parents of youth with a qualifying diagnosis are routinely billed and reimbursed by eligible behavioral health providers. Interested parties can access a billing crosswalk for the model developed by the Parent Training Institute in San Francisco. Medical providers have also been reimbursed for delivering consultative parenting support using Triple P, often simply by adding extended time to routine well-child visits.

Resources

- Triple P website: triplep.net
- Research repository: pfsc.uq.edu.au/research/evidence/
- Research blog: triplepblog.net/
- Recent program evaluations: digitalmaterials.triplep.net/html/independent-evaluations.html

The following sites may help when adapting Triple P in integrated medical settings:

- Wisconsin Children's Hospital
- Burlington Pediatrics, Alamance County, NC
- Oregon Research Institute

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1. Nowak, C. & Heinrichs, N. A comprehensive meta-analysis of Triple P - Positive Parenting Program using hierarchical linear modeling: Effectiveness and moderating variables. *Clinical Child and Family Psychology Review*. 2008; 11: 114-144.
 2. Prinz RJ, Sanders MR, Shapiro CJ, Whitaker DJ, Lutzker JR. Population-based prevention of child maltreatment: The U.S. Triple P system population trial. *Prevention Science*. 2009; 10(1): 1-12.
 3. Sanders MR, Ralph A, Sofronoff K, Gardiner P, Thompson R, Dwyer S, Bidwell K. Every Family: A population approach to reducing behavioral and emotional problems in children making the transition to school. *Journal of Primary Prevention*. 2008; 29:197-222.
 4. Whittingham K, Sofronoff K, Sheffield J, Sanders MR. Stepping Stones Triple P: An RCT of a parenting program with parents of a child diagnosed with an Autism Spectrum Disorder. *Journal of Abnormal Child Psychology*. 2008; 37(4), 469-480.
 5. Foster EM, Prinz RJ, Sanders MR, Shapiro CJ. The costs of a public health infrastructure for delivering parenting and family support. *Children and Youth Services Review*. 2008; 30: 493-501.

Description

The Incredible Years (IY) training series consists of three comprehensive, multifaceted and developmentally-based curricula for parents, teachers and children. The program promotes social-emotional competence and school-readiness skills. It also prevents and treats aggression and emotional problems in children from birth to age 12. Schools, school districts and related programs (including Head Start, day care and primary grades) may implement the IY curricula as early prevention programs for teachers, parents and children. Additionally, mental health centers may use the child and parent programs as treatment for families with children who are diagnosed with oppositional defiant disorder, conduct disorder or attention deficit hyperactivity disorder. Families with children at risk for aggression, defiance, oppositional and impulsive behaviors may also use the program. Pediatric offices or community-based organizations may offer this service.

Evidence

- Parent programs have increased nurturing parenting and parent involvement in schools, while decreasing harsh discipline and behavior problems.¹
- The classroom social skills and problem-solving curriculum increased children's school readiness (defined as social competence, emotional regulation and parent involvement), increased problem-solving and decreased conduct problems.¹
- IY reduced parental depression and increased parental self-confidence.
- IY increased positive family communication and problem-solving.²
- IY reduced conduct problems in children's interactions with parents and increased children's positive moods and compliance to parental commands.²

Implementation

The organization or school must commit to excellence, evidenced by good administrative support for IY and support for facilitator certification by certified trainers, as well as ongoing technical support and consultant workshops. The programs consist of DVDs, comprehensive facilitator manuals, books, take-home assignments and handouts. We recommend all group participants (parents, teachers and children) have their own individual books and that facilitators have their own manuals. You will need DVD equipment. Each group should have two group leaders. Group leaders complete a certification or accreditation process that involves attendance at a certified training workshop, peer review, video-recorded feedback and consultation.¹

Billing and Reimbursement

Billing and reimbursement varies by state. Some agencies have been reimbursed using group therapy insurance codes.

Resources

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1. The Incredible Years: The Incredible Years Parent, Teacher and Child Programs Fact Sheet. Retrieved from: <http://www.incredibleyears.com/download/administrators/IY-Full-Fact-Sheet-2016.pdf>.
 2. The Incredible Years Program: Evaluation Design and Outcomes. 2013; Retrieved from: <http://www.incredibleyears.com/for-researchers/evaluation/>

Description

Reach Out and Read (ROR) promotes literacy as part of the pediatric primary care visit. The program trains medical providers to provide children with a new, developmentally-appropriate book at each well-child visit from birth through age 5. Trained providers can advise parents on the importance and benefits of reading aloud with their children beginning in infancy. Pediatric offices may offer this service.

Evidence

- Children exposed to ROR had higher receptive language scores (words the child understands) and expressive language scores (words the child says).
- Families participating in ROR read to their children more often (4.3 vs. 3.8 days per week), and their toddlers have higher receptive and expressive vocabulary scores compared to families who did not participate in ROR.¹
- Parents who received books and educational materials were more likely to share books with their children.¹
- English-speaking and non-English-speaking families who participated in ROR increased their weekly bedtime readings.¹

Implementation²

1. Start an online application at myror.org/site_applications/screening/new. After you provide basic contact information, your program site will receive a site ID and password. You will be redirected to myror.org, where you can finish and submit your application.
2. Along with the application you must also submit a letter of support stating your practice's commitment to ongoing funding of the Reach Out and Read program, signed by the departmental head, clinic medical director or executive director.²
3. Applications completed by the third Monday of each month are reviewed by the Reach Out and Read application review committee during that week.
4. Once the medical providers at your practice complete the required online training and staff members have been oriented, your site becomes active and you may begin implementing Reach Out and Read at your practice.

Billing and Reimbursement

There is currently no billing code for this program.

Resources

Reach Out and Read National Center
89 South St., Suite 201
Boston, MA, 02111
617-455-0614
startup@reachoutandread.org

Reach Out and Read of Greater New York
75 Maiden Ln., Suite 1102
New York, NY 10038
646-237-0103
info@reachoutandreadnyc.org

Reach Out and Read Application Process:
To become a Reach Out and Read Program site, visit
reachoutandread.org and search for **start a program**.

Reach Out and Read One-Pager:
reachoutandread.org/FileRepository/One_Pager_English.pdf

Milestones of Early Literacy Development:
reachoutandreadnyc.org/wp-content/uploads/RORmilestones2012_English-1.pdf

Reading Tips:
reachoutandreadnyc.org/ourprogram/resources/

Additional Resources:
reachoutandreadnyc.org/ourprogram/resources/

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1. Reach Out and Read: The Evidence, A proven Early Literacy Intervention. Retrieved from: <http://www.reachoutandread.org/our-impact/reach-out-and-read-the-evidence/>.
 2. Reach Out and Read Application Process: How to Become a Reach Out and Read Program Site. Retrieved from: http://www.reachoutandread.org/FileRepository/How_to_Become_a_Reach_Out_and_Read_Program_Site_for_PDF_on_website_10_12_FINAL.pdf.

Medical-Legal Partnership

Description

The medical-legal partnership (MLP) integrates the expertise of health care, public health and legal professionals and staff to address health-harming civil legal needs for patients, clinics and populations.¹ Pediatric settings may offer this service.

Evidence

- MLPs helped clients address issues such as public benefits, health care coverage and family law issues.²
- A letter from an attorney can often get a response when a doctor's or social worker's letter does not.²
- Legal assistance targeted at improving housing conditions improved the health of asthma patients.²
- MLPs can save patient health care costs and recover cash benefits.²
- MLPs show a positive return on investment, and demonstrate a health-focused program that may be sustained and expanded in underserved communities.³

Implementation

You must have early buy-in and support for your MLP from the front lines and administrations of both the health and legal institutions. Potential partners should understand their roles and responsibilities, such as who can authorize funding and who can help navigate training opportunities from each respective organization. To start a MLP, the partnering organizations should conduct a needs assessment to understand their community's needs, resources and landscape. Additionally, MLPs should fully integrate into the health care system and have secure, private office space. These factors contribute to the MLP's success and sustainability.⁴

Billing and Reimbursement

There is currently no billing code for a medical-legal partnership.

Resources

National Center for Medical-Legal Partnership
Department of Health Policy and Management, Milken Institute School of Public Health
The George Washington University
2175 K St. NW, 513A
Washington, DC 20037
Website: medical-legalpartnership.org/

General inquiries:
Sharena Hagins
Research Associate
shagins@gwu.edu
202-994-4289

Potential local partnerships:
New York Legal Assistance Group – LegalHealth
7 Hanover Square, 18th Floor
New York, NY 10004
212-613-5000
Website: legalhealth.org/
Information for Providers: legalhealth.org/for-providers/

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1. Regenstein M, Teitelbaum J, Sharac J, Phyu E. Medical-Legal Partnership and Health Centers: Addressing Patients' Health-Harming Civil Legal Needs as Part of Primary Care. 2015. Retrieved from: <http://medical-legalpartnership.org/wp-content/uploads/2015/02/Medical-Legal-Partnership-and-Health-Centers.pdf>.
 2. O'Sullivan MM, Brandfield J, Hoskote SS, Segal SN, Chug L, Modrykamien A, Eden E. Environmental Improvements Brought by the Legal Interventions in the Homes of Poorly Controlled Inner-city Adult Asthmatic Patients: A Proof-of-Concept Study. *Journal of Asthma*. 2012; 49(9): 911-917.
 3. Teufel J, Brown S, Thorne W, Goffinet D, Clemons L. Process and Impact Evaluation of a Legal Assistance and Health Care Community Partnership. *Health Promotions Practice*. 2009; 10(3): 378-385. <http://medical-legalpartnership.org/process-impact-evaluation-legal-assistance-health-care-community-partnership/>.
 4. National Center for Medical-Legal Partnership, George Washington University. Medical Legal Partnership Toolkit Phase I: Laying the Groundwork. (2014). Retrieved from: <https://kresge.org/sites/default/files/Uploaded%20Docs/Medical-Legal-Partnership-toolkit-phase-1.pdf>.

Maternal Depression Screening in Pediatric Primary Care Settings

Description

Maternal depression screening identifies mothers who are at risk for maternal depression. The process includes using a screening tool in pediatric primary care settings. A combination of care strategies, including counseling, social support, engagement and referrals, follows the screening. Pediatric offices or community-based organizations can offer this service.

Evidence

- Depression can affect mothers of children of all ages. Maternal depression encompasses perinatal depression – which includes antenatal depression (during pregnancy) and postpartum depression (immediately after delivery or several weeks or months later) – as well as depression experienced by mothers a year or more after giving birth.
- Twelve percent of women screened at a postpartum visit had depression symptoms, according to the New York Medicaid Perinatal Care Study. Additionally, New York City Pregnancy Risk Assessment Monitoring System (NYC PRAMS) data found an 11.1 percent prevalence of postpartum depression symptoms from 2012 to 2013.¹
- Perinatal depression diminishes a child’s cognitive development, as well as their social-emotional, physical and mental health.² It is also associated with poor bonding and attachment, higher rates of child injury and behavioral problems in children.³
- Maternal depression negatively affects a mother’s mental and physical health, heightens the child’s psychiatric illness risk, lowers the child’s development of emotional strength and resilience, and decreases the child’s likelihood of receiving optimal health care.⁴
- Although maternal depression is a serious mental health disorder, it is one of the most treatable mental health conditions. Early detection, referral and treatment of maternal depression can greatly reduce adverse consequences.⁵
- Screening mothers for maternal depression is a best practice for primary care pediatricians and can be integrated into the well-child care schedule.⁶
- Screenings benefit mothers’ well-being and could improve children’s outcomes.⁷

Implementation

The mother’s or infant’s health care provider can provide screening following the baby’s birth. This service can be integrated into the well-child care schedule.⁸

If the mother screens positive for depression, then she must be further evaluated for diagnosis and treatment. Medical practices that do not have the capacity to evaluate and treat mothers who screen positive for depression must have a referral process in place. Providers should closely monitor and evaluate women with current depression or a history of major depression. The current standard of care for pregnant women requires that all pregnant women receive depression screening as part of their routine antenatal and postpartum care.⁴

Billing and Reimbursement

In the pediatric setting, New York State Medicaid reimburses maternal depression screening, using a validated screening tool, up to three times within the first year of the infant's life.

- G8431 (with HD modifier) – Screening for clinical depression is documented as being positive and a follow-up plan is documented.
- G8510 (with HD modifier) – Screening for clinical depression is documented as negative, a follow-up plan is not required.

Resources

Selected Screening Tools⁹

- Beck Depression Inventory Fast Screen (BDI-FS)
- Edinburgh Postnatal Depression Scale (EPDS)
- Patient Health Questionnaire-2 (PHQ-2)
- Patient Health Questionnaire-9 (PHQ-9)

Information and Referral Resources

- New York City Department of Health and Mental Hygiene: Go to nyc.gov/health and search for **postpartum depression**.
- NYC Well: Call 888-NYC-WELL (692-9355) or visit nycwell.cityofnewyork.us.
- New York State Department of Health: Go to health.ny.gov and search for **maternal depression resources**.
- Postpartum Resource Center of New York: Go to postpartumny.org and click on **Get Help – PRCNY Resource Directory**.
- The Motherhood Center of New York: Visit themothhoodcenter.com.
- Postpartum Support International: Visit postpartum.net.

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1. New York City Department of Health and Mental Hygiene, Bureau of Maternal, Infant & Reproductive Health. PRAMS, 2012. Unpublished Raw Data.
 2. New York State Department of Health Office of Quality and Patient Safety, Medicaid Perinatal Care Study, March 2013. Available at: https://www.health.ny.gov/health_care/medicaid/standards/prenatal_care/docs/perinatal_care_study.pdf.
 3. Santoro K, Peabody H. Identifying and Treating Maternal Depression: Strategies and Considerations for Health Plans. National Institute for Health Care Management Foundation. Foundation Issue Brief. 2010. Available at: http://www.nihcm.org/pdf/FINAL_MaternalDepression6-7.pdf.
 4. Beardslee WR, Versage EM, Gladstone TR. Children of Affectively Ill Parents: A Review of the Past 10 Years. *Journal of the American Academy of Child and Adolescent Psychiatry*. 1998; 37:1134-1141.
 5. North Dakota Department of Human Services Medical Service Division: Maternal Depression Screening: Retrieved from: <https://www.nd.gov/dhs/services/medicalserv/medicaid/docs/cpt/maternal-depression-screen-jan2017.pdf>.
 6. Earls MF. Clinical Report—Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice. *Pediatrics*. 2010; 126(5):1032-1039.
 7. Schmidt S, Walker C. Seizing New Policy Opportunities to Help Low Income Mothers with Depression: Current Landscape, Innovations, and Next Steps. CLASP. (2016). Retrieved from: <http://www.clasp.org/resources-and-publications/publication-1/Opportunities-to-Help-Low-Income-Mothers-with-Depression-2.pdf>.
 8. New York State Department of Health: Postpartum Maternal Depression Screening: Updated Billing Guidance. Retrieved from: https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-08.htm#postpartum.
 9. New York State Department of Health: Screening for Maternal Depression. Retrieved from: https://www.health.ny.gov/community/pregnancy/health_care/perinatal/maternal_depression/providers/screening.htm.

Description

HealthySteps is a pediatric primary care program that supports healthy early childhood development and effective parenting. A child and family development professional, known as a HealthySteps specialist, connects with families as part of the primary care team during pediatric well-child visits. The HealthySteps specialist offers screening and support for common and complex parenting challenges, such as feeding, attachment, behavior, sleep, parental depression and adapting to life with a baby or young child. Trained specialists also provide guidance, referrals, care coordination and home visits for families who need them.¹ HealthySteps serves families primarily in the pediatric office but can be extended into the community.

Evidence

- Children were 1.5 to 2.4 times more likely to receive a well-child visit on time.²
- Children were 1.4 to 1.6 times more likely to receive age-appropriate vaccinations on time, and 1.4 times more likely to be up-to-date on vaccinations by age 2.²
- Children were 23 percent less likely to visit the emergency room for injury-related causes in a one-year period.²
- Families were four times as likely to receive information on community resources.²
- HealthySteps parents were:
 - Twenty-two percent less likely to rely on harsh punishment (e.g., yelling, spanking with hand)²
 - 1.5 times more likely to rely on someone in the practice for advice (rather than friend or relative)²
 - 1.8 times more likely to remain with the practice through 20 months³
- Mothers with depressive symptoms were 1.6 times more likely to discuss their symptoms.²
- Mothers were 24 percent less likely to place newborns on their stomachs to sleep, reducing the risk of sudden infant death syndrome (SIDS).²

Implementation

HealthySteps training and technical assistance helps practices implement the HealthySteps model tailored to the needs of their staff and the families they serve. Staff from new sites attend a two-to-three-day training program known as the HealthySteps Institute. The highly interactive training focuses on applying relationship-building strategies, practicing a strengths-based, family-centered approach, and working on case scenarios.⁴

Billing and Reimbursement

While there is currently no specific billing code in New York State for the entire HealthySteps program, there are individual codes for a number of the services that HealthySteps offers families. For more information, email the HealthySteps National Office Policy and Finance team at JTracey@zerotothree.org.

Resources

HealthySteps

Phone: 844-464-9811

Website: healthysteps.org

Email: healthysteps@zerotothree.org

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1. What is HealthySteps? (2016). Retrieved from: Healthysteps.org.
 2. Guyer B, Barth M, Bishai D, Caughy M, Clark B, Burkom D, Genevro J, Grason H, Hou W, Huang K, Hughart N, Jones AS, McLearn KT, Miller T, Minkovitz C, Scharfstein D, Stacy H, Strobino D, Szanton E, Tang C. Healthy Steps: The First Three years: The Healthy Steps for Young Children Program National Evaluation. *Johns Hopkins Bloomberg School of Public Health*. 2003. Retrieved from: https://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/publications/Healthy_Steps_Final_Reports/FR_COVCONT_030103FIN.pdf.
 3. Minkovitz CS, Strobino D, Mistry KB, Scharfstein DO, Grason H, Hou W, Ialongo N, Guyer B. Healthy Steps for Young Children: Sustained results at 5.5 years. *Pediatrics*. 2007; 120(3), e658-e668.
 4. HealthySteps: Our Training. (2016). Retrieved from: <http://healthysteps.org/our-training/>.

Description

Health Leads (HL) is an organization that helps practices address patient's basic needs (such as food, housing and transportation) as a standard part of quality care. HL shares their models and tools, and trains health care organizations. HL helps organizations integrate volunteers or staff, such as community health workers (CHWs), into a clinical team that helps patients find food, clothing, job training or heating assistance. Clinics using HL may screen their patients for social needs and connect them with an advocate who can help them find the right resources. Pediatric offices or community-based organizations can offer this service.

Evidence

- HL improves the living conditions of vulnerable people by addressing non-medical or basic needs as part of health care delivery.¹
- Almost 1,000 advocates helped nearly 9,000 patients and their families access basic resources, between 2011 and 2012, across 21 sites in six cities.²
- HL regularly serves as a health care sector thought leader on addressing the social determinants of health (the conditions in which people are born, live, learn, work, play, worship and age).²
- HL helped 50 percent of client families at one clinic access at least one resource – most often employment, health insurance or food – within six months.³ The HL model reduced unmet social needs for low-income families, and connected the medical home with community-based resources.
- In an urban clinic, more than 10 percent of families used the HL desk, a physical space where patients can connect with HL volunteers and staff to receive information about services they need. The HL desk helped address the social needs of more than 1,000 families.³

Implementation

HL supports organizations and clinical practices while they integrate social health into their systems, including their case management and resource database systems. HL offers Health Leads Reach (a cloud-based database and case management system), as well as staff training, implementation coaching and workshops.

Process

Practices typically launch their pilot social needs program three to six months after initial conversations with HL. The process includes designing the workflow plan, configuring the Health Leads Reach system, finding space, staff reassignment and adjustment and other logistical components. Health Leads also offers payment plans that best suit practice needs.

Decision Makers

Chairpersons, practice managers (including non-unionized, non-medical professionals and general hospital staff) and legal staff should take part in planning and implementation. However, this may vary with each practice.

Recruitment Process

Recruitment methods could include screening patients at the point of care to identify their needs, and waiting room presentations about what the program offers. Recruitment could also include a buy-in presentation for doctors, nurses and other medical professionals. The presentations can highlight how patients benefit from HL and how each staff member will address patient needs.

Billing and Reimbursement

There is currently no billing code for this program.

Resources

Patrick Maseo – Bronx Lebanon
pmaseo@bronxleb.org
Bronx Lebanon Hospital Center
1276 Fulton Ave.
Bronx, NY 10456

Chloe Green – Health Leads National
cgreen@healthleadsusa.org
Health Leads National
24 School St., 6th Floor
Boston, MA 02108

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1. Robert Wood Johnson Foundation: Health Leads. (2016). Retrieved from: https://www.rwjf.org/en/how-we-work/grants-explorer/featured-programs/health_leads.html.
 2. Social Impact Exchange: taking successful innovation to scale - Health Leads. (2016). Retrieved from: <http://www.socialimpactexchange.org/organization/health-leads>.
 3. Garg A, Marino M, Vikani AR, Solomon BS. Addressing Families' Unmet Social Needs Within Pediatric Primary Care: The Health Leads Model. *Clinical Pediatrics*. 2012; 20(10):1-3. Retrieved from: <http://www.socialimpactexchange.org/sites/www.socialimpactexchange.org/files/Clinical%20Pediatrics%20-%20The%20Health%20Leads%20Model.pdf>.

Fluoride Varnish

Description

Fluoride varnish is a protective coating applied to teeth to help prevent cavities.¹ Cavities are the most prevalent chronic childhood disease in the United States. Children of color between ages 2 and 17 experience more dental cavities than their White counterparts.² Fluoride varnish takes about one to two minutes to apply.³ This service can be performed in the pediatric office or in a community setting.

Evidence

- Fluoride varnish is easy to apply and can prevent, stop and even reverse early cavity formation.^{4,5}
- Fluoride varnish strengthens teeth, renews fluoride levels in superficial enamel and helps slow or reverse demineralization.⁶
- Fluoride varnish is well tolerated by infants and young children, has a prolonged therapeutic effect and can be applied by both dental and non-dental health professionals in various settings.⁷

Implementation

Fluoride varnish may be applied two to four times a year for children up to age 7, depending on the child's risk for cavities.⁸

For infants and children under age 3:

- Establish a knee-to-knee position with the caregiver. The child's head should be in your lap and the child's legs should be around the caregiver's waist. The caregiver can help by holding the child's hands on top of the navel.

For children ages 3 and older:

- Have the child either lie on an examination table or sit in front of the caregiver, while both face you, so that the caregiver can help position and steady the child.

Lift the lip to inspect soft tissue and teeth for:

- Inadequate oral hygiene, such as plaque and debris on the teeth
- On-time tooth eruption and loss
- Dental crowding
- Tooth decay signs, including white or brown spots, holes or cavitation
- Swelling, redness and irregularities, such as lesions, bumps or ulcers

After inspection:

- Remove excess saliva and plaque from the teeth with a sterile gauze sponge.
- Apply fluoride with disposable applicator on all tooth surfaces. The varnish will harden immediately once it comes in contact with saliva.

Billing and Reimbursement

Medicaid fee-for-service: Providers will be reimbursed up to \$30 per application. You do not need prior approval under Medicaid fee-for-service.⁹

- CPT code 99188 – Application of topical fluoride varnish by a physician or other qualified health care professional
- ICD-10 code z29.3

Resources

Many companies supply fluoride varnish, including:

- Cavity Shield, in single-dose units with built-in applicators (Omni Products at 800-634-2249)
- Duraphat (Colgate Oral Pharmaceuticals at 800-225-3756, 800-226-5428 or 800-2-COLGATE)
- VarnishAmerica (Medical Products Laboratories at 800-523-0191, or mplusa.com/public-health/varnishamerica.html)

Additional lists of fluoride varnish products and dental supply companies can be found on the American Academy of Pediatrics website. Go to aap.org and search for **fluoride varnish manufacturers**.

Fluoride Varnish Information:

- American Dental Association Evidence-Based Dentistry: Go to ada.org and search for **clinical practice guidelines**.
- New York State Department of Health, Oral Health: Go to health.ny.gov and search for **oral health**.

Training in Oral Health Assessment:

- A Health Professional's Guide to Pediatric Oral Health Management: Go to mchoralhealth.org and search for **pediatric oral health guide**.
- American Academy of Pediatrics (AAP) Oral Health: Go to aap.org and search for **oral health advocacy**.

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1. New York City Department of Health and Mental Hygiene. Fluoride Varnish: Frequently Asked Questions.
 2. Fisher-Owens SA, Isong IA, Soobader M-J, et al. An examination of racial/ethnic disparities in children's oral health in the United States. *J Public Health Dent.* 2013; 73(2):166-174.
 3. New York State Local Health Department Training Initiative 2016-2017: Fluoride Varnishing Integration into the Pediatric Primary Care Setting FAQ.
 4. American Dental Association Council on Scientific Affairs. Professionally Applied Topical Fluoride. Evidence-based clinical recommendations. *Journal of the American Dental Association.* 2006; 137(8):1151-1159.
 5. Weintraub JA, Ramos-Gomez F, Jue B, Shain S, Hoover CI, Featherstone JDB, Gansky SA. Fluoride Varnish Efficacy In Preventing Early Childhood Caries. *J Dent Res.* 2006; 85 (2):172-176.
 6. American Academy of Pediatrics. Oral Health Initiative. Oral health risk assessment: training for pediatricians and other child health professionals. www2.aap.org/ORALHEALTH/EducationAndTraining.html.
 7. Clark MB, Slayton RL. American Academy of Pediatrics Clinical Report: Fluoride Use in Caries Prevention in the Primary Care Setting. *Pediatrics.* 2014; 134:626-633 Retrieved from: <http://pediatrics.aappublications.org/content/pediatrics/134/3/626.full.pdf>.
 8. New York City Department of Health and Mental Hygiene. (2017). Fluoride Varnish Brochure Oral Health Booklet.
 9. The American Academy of Pediatrics (January, 2016). Oral Health Coding Fact Sheet for Primary Care Physicians. Retrieved from: https://www.aap.org/en-us/Documents/coding_factsheet_oral_health.pdf.

Developmental Screening

Description

Developmental screening identifies children who may have developmental delays or who may need a more comprehensive diagnostic assessment.^{1,2} Providers can screen children periodically with a brief, standardized tool. After screening, families receive information about any developmental delays identified by screening and information about services available to address developmental delays if their child needs early intervention (EI) services.³ Pediatric offices or other pediatric settings – such as a child care program or a Women, Infants and Children (WIC) office – may offer developmental screening.⁴

Evidence

- One in six children between ages 3 to 17 had a developmental disability, from 2006 to 2008.⁵
- Screening with a validated tool identifies far more children with developmental and social-emotional needs than surveillance alone. The American Academy of Pediatrics considers developmental screening to be integral to well-child care.²
- Children who participated in a developmental screening program were more likely to be identified with developmental delays, referred to EI and eligible for EI services sooner. Identifying developmental disabilities early allows children to receive intervention as soon as possible.⁶

Implementation

Developmental screening should be performed routinely during every well-child visit. The American Academy of Pediatrics recommends developmental screening at ages 9, 18, and 24 or 30 months, and autism-specific screening at ages 18 and 24 months. When administering a developmental screening tool, address all areas of a child's development, including language, cognitive, adaptive, social-emotional, and gross and fine motor skills. Ideally, the tool should be brief; easy to administer and score; low-cost to pediatricians; and available in various formats, including electronic or paper-and-pencil.⁷

Billing and Reimbursement

96110 – Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report⁸

96111 – Developmental testing; extended (includes assessment of motor, language, social, adaptive or cognitive functioning by standardized developmental instruments) with interpretation and report⁶

Resources

Selected Screening Tools

- Ages and Stages Questionnaire, Third Edition (ASQ-3): Ages 4 to 66 months^{9,10}
- Battelle Developmental Inventory Screening Tool, Second Edition (BDI-ST): From birth to age 95 months⁷

- Bayley Infant Neurodevelopmental Screener (BINS): Ages 3 to 24 months⁸
- Brigance Screens III: From birth to age 90 months⁸
- Child Development Inventories (CDI): Ages 18 to 72 months^{7,8}
- Infant Development Inventory (IDI): From birth to age 18 months^{7,8}
- Parents' Evaluations of Developmental Status (PEDS): From birth to age 8 years^{7,8}
- Survey of Well-Being of Young Children (SWYC): From birth to age 5 years⁸

New York City Early Intervention Program

- The New York City Health Department's Early Intervention Program (NYC EIP) provider information: Go to nyc.gov/health and search for **early intervention**.
- Clinicians' Guide: The EIP in New York City: Go to nyc.gov/health and search for **early intervention clinicians' guide**.
- NYC EIP referral form: Go to nyc.gov/health and search for **early intervention referral form**.

Tools for Integrating Screening Into Your Practice

- CDC Developmental Monitoring and Screening for Health Professionals: Go to cdc.gov and search for **developmental screening hcp**.
- Child Health and Development Interactive System (CHADIS): Go to chadis.com.

New York City Health Department Parent Education Materials

- Developmental screening poster for clinic waiting room (English and Spanish): Call 311.
- Developmental milestone handouts (by age): Call 311.
- Brochures for families: Call 311.

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1. Center for Disease Control (CDC). 2017. Developmental Monitoring and Screening. Retrieved from: <https://www.cdc.gov/ncbddd/childdevelopment/screening.html>.
 2. American Academy of Pediatrics Committee on Children with Disabilities. Developmental Surveillance and Screening of Infants and Young Children. *Pediatrics*. 2001; 108(1):192-196.
 3. Association of Maternal & Child Health Programs (2017). Early Childhood Developmental Screening and Title V: Build-ing Better Systems. Retrieved from <https://www.nichq.org/sites/default/files/resource-file/EarlyChildhoodDevelopmentScreening-Sept2017.pdf>.
 4. Pinto-Martin JA, Dunkle M, Earls M, Fliedner D, Landes C. Developmental Stages of Developmental Screening: Steps to Implementation of a Successful Program. *American Journal of Public Health*. 2005; 95(11):1928-1932. doi: 10.2105/AJPH.2004.052167.
 5. Boyle C, Boulet S, Schieve LA, Cohen RA, Blumberg SJ, Yearhin-Allsopp M, Visser S, Kogan MD. Trends in the Prevalence of Developmental Disabilities in US Children, 1997-2008. *Pediatrics*. 2011; 127(6):1034-1042. DOI: 10.1542/peds.2010-2989.
 6. Guevara JP, Gerdes M, Localio R, Huang Y V, Pinto-Martin J, Minkovitz CS, Hsu D, Kyriakou L, Baglivo S, Kavanagh J, Pati, S. Effectiveness of Developmental Screening in an Urban Setting. *Pediatrics*. 2013; 131 (1):30-37. Retrieved from: <http://pediatrics.aappublications.org/content/pediatrics/131/1/30.full.pdf> and <http://pediatrics.aappublications.org/content/131/1/30>.
 7. Perrin EC, Sheldrick RC. Development and Implementation of developmental screening tools in primary care. *American Psychology Association*. Retrieved from: <http://www.apa.org/pi/families/resources/primary-care/screening-tools.aspx>.
 8. NYS-Office of Mental Health: Appendix 3: Draft Clinic Services Billing Codes and Rules. Retrieved from: https://www.omh.ny.gov/omhweb/clinic_restructuring/appendix3.html.
 9. NYC-Department of Health and Mental Hygiene. 2016. Identifying and Referring Children with Developmental Delays or Disabilities to the Early Intervention Program. *City Health Information* 35(6):47-58.
 10. American Academy of Pediatrics: Developmental Screening Tools. Retrieved from: https://brightfutures.aap.org/Bright%20Futures%20Documents/Developmental_Screening_Tools.pdf.

Circle of Security

Description

The Circle of Security (COS) program helps families understand and respond to their children's emotions and behavior. COS classes focus on parent-child interactions, responding to children's needs and reflecting on parent strengths and challenges.¹ COS helps parents look beyond their child's immediate behavior, better understand their child's attachment needs, and recognize when their own reactions impede an appropriate response.² Pediatric offices or community-based organizations can offer this service.

Evidence

- COS decreases caregiver helplessness and stress.³
- COS helps parents consider their children's emotions more, and be more patient and less frustrated with their children.⁴
- COS helps parents increase their own emotion regulation capacity and demonstrate greater empathy for their children.⁵
- COS reduces insecure attachment and increases security for children between toddlerhood and early school years.⁶

Implementation

Providers can link parents to an existing COS class at a neighborhood community-based organization. They can also set up a COS class within their practice through Vibrant Emotional Health's Circle of Security Parent Coaching Department. To register for a class or host a class at your organization, contact the COS Parent Coaching Department at 646-532-3545 or pcd@mhaofnyc.org.

Billing and Reimbursement

This program does not currently have a billing code. MHA-NYC currently offers free COS classes.

Resources

Circle of Security International
circleofsecurityinternational.com/

The MHA-NYC Circle of Security Parent Coaching Department
2488 Grand Concourse
Bronx NY, 10458
646-532-3545

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1. COS Parent Coaching Program. Retrieved from: <https://www.vibrant.org/what-we-do/community-programs/parents-caregivers/circle-of-security/>.
 2. Zeanah CH, Berlin LJ, and Boris NW. Practitioner Review: Clinical applications of attachment theory and research for infants and young children. *Journal of Child Psychology and Psychiatry*. 2011; 52(8): 819-833.
 3. Kohlhoff J, Stein M, Ha M, Mejaha K. The Circle of Security Parenting (COS-P) intervention: Pilot evaluation. *Australian Journal of Child and Family Health Nursing*. 2016; 13, 3-7.
 4. Horton, GE. (2013). *The Impact of the Circle of Security-Parenting® Program on Mothers in Residential Substance Abuse Treatment: An Action Research Study* (Doctoral dissertation). Retrieved from ProQuest Dissertations Publishing (UMI No. 3609574).
 5. Cooper G, Hoffman K, Marvin R, Powell B. (2000). Circle of Security: Treatment Assumptions. Retrieved from: <http://circleofsecurity.net/treatment-assumptions>.
 6. Hoffman K, Marvin R, Cooper G, Powell B. Changing toddlers' and preschoolers' attachment classifications: The Circle of Security Intervention. *Journal of Consulting and Clinical Psychology*. 2006; 74, 1017-1026.

Co-located Services

Description

Co-location places multiple services in the same physical space. Co-location can involve shared space, equipment and staff for health and human services; coordinated care between services; and a partnership between health providers and human services providers.¹ Health care leaders support the medical home model to address children's complex needs, including obesity, chronic disorders, and developmental and behavioral issues. The medical home allows providers to coordinate a range of family and child health services in one physical space.¹ Co-located services are offered in the medical practice.

Evidence

- Co-location increases provider satisfaction.¹
- Co-location has contributed to better clinical outcomes as a result of more appropriate use of health services.¹
- Co-location of primary care and mental health services has reduced visits among people who formerly used services frequently.¹
- Infants were more likely to have better health results, higher immunization and age-appropriate weights if managed care sites offered Women, Infants and Children (WIC) services as part of co-location.¹
- Co-location increases family satisfaction with medical providers. Families are more likely to view the clinic as a medical home.¹
- Co-location improves access to care, streamlines billing and enhances care coordination.²
- Co-location creates an efficient system of referrals and increases access to care and communication between providers.³

Implementation

Before implementing co-location, consider how practices and services will be linked, what organizational arrangements (including financial relationships) should be developed and which incentives and other mechanisms best support the related entities. Co-locators need to consider both the actual amount of physical space required and how the space may be structured. Staffing arrangements depend on how the practices and services are integrated. In some cases, practices may employ individuals or contract their services. In other cases, there is no formal staff relationship across the services.¹ Ensure that co-located spaces look and feel integrated as one space.

Billing and Reimbursement

Billing and reimbursement varies by services offered to patients.

Resources

Resources vary depending on services offered to patients.

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1. Ginsburg, S. Issue Brief – Colocating Health Services: A Way to Improve Coordination of Children’s Health Care? *The Commonwealth Fund Publication*. 2008; 41:1-11. Retrieved from: <http://www.commonwealthfund.org/publications/issue-briefs/2008/jul/colocating-health-services-way-improve-coordination-childrens>.
 2. DeMaso, D, Martini, DR, Sulik, LR, Hilt, R, Marx, L, Pierce, K, Sarvet, B, Becker, E, Kendrick, J, Kerlek, AJ, Biel, M. A Guide to Building Collaborative Mental Health Care Partnerships In Pediatric Primary Care. *American Academy of Child and Adolescent Psychiatry*. (2010). Retrieved from: https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/guide_to_building_collaborative_mental_health_care_partnerships.pdf.
 3. Co-location of Services Model. Rural health Information Hub, Retrieved from: <https://www.ruralhealthinfo.org/community-health/services-integration/2/co-location>.

Food Insecurity Screening

Description

Food insecurity (FI) screening quickly identifies households with young children at risk for limited or uncertain access to food.¹ Screening enables providers to target services that improve the health and developmental conditions associated with food insecurity.² Pediatric offices or community-based organizations can provide this service.

Evidence

- Identifying FI and referring patients to appropriate nutrition and support services can help treat and prevent illness.³
- FI screening supports patients in chronic disease management.³
- FI screening is the least expensive and least invasive treatment with the fewest side effects in most cases.³
- Food insecurity experienced during the first five years of life, widely recognized as a key period of development during which the foundations for later cognitive and social functioning are laid, may be especially damaging because of possible indirect effects – through its influence on parental well-being and direct effects – through disruption of children’s brain growth and physical development.⁴
- Many studies have found links between food insecurity in the kindergarten or elementary school years and subsequent behavioral and self-regulatory competence.⁴
- According to one estimate, the direct and indirect health-related costs of hunger and food insecurity in the U.S. are more than \$160 billion a year.⁵

Implementation

The American Academy of Pediatrics (AAP) and Food Research and Action Center (FRAC) recommend the following steps for implementation.

1. To prepare for FI screening, educate and train leaders and staff on food insecurity and the importance of universal screening. Collaborate with the practice team to identify ways to screen for food insecurity.
2. Follow AAP’s recommendation and screen at scheduled health maintenance visits or sooner, if indicated.
3. Incorporate FI screening into the institutional workflow. For example, add a screening tool into existing registration or intake procedures, or into the electronic health record.
4. Show sensitivity when screening for food insecurity (e.g., inform patients that the practice screens all patients, normalize the screening tool questions).¹

By familiarizing themselves with community resources, pediatricians can quickly identify FI and refer patients to resources, including Women, Infants and Children (WIC); Supplemental Nutrition Assistance Program (SNAP); school nutrition programs; local food pantries; and summer and child care feeding programs.⁶

Billing and Reimbursement

The following diagnosis code can be used for positive screens: ICD-10-CM Diagnosis Code Z59.4 (lack of adequate food and safe drinking water).¹

Resources

Nutrition Programs:

FeedNYC: FeedNYC.org

USDA National Hunger Hotline
866-3-HUNGRY, 877-8-HAMBRE
Monday to Friday, 8 a.m. to 8 p.m.

Supplemental Nutrition Assistance Program (SNAP)
HRA info line: 718-557-1399
HRA website: nyc.gov/hra
Access NYC website: access.nyc.gov/
Centers are open Monday to Friday, 8:30 a.m. to 5:00 p.m.
SNAP brochure: www1.nyc.gov/assets/hra/downloads/pdf/services/snap/snap_need_to_know.pdf.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
WIC Info line: 800-522-5006
New York State Department of Health website: Go to health.ny.gov and search for **WIC program**.

WIC Participant Handbook: Go to health.ny.gov and search for **WIC handbook**.

WIC brochure: Go to health.ny.gov and search for **WIC ready set grow**.

The National School Breakfast and Lunch Program
Info line: 518-486-1086
Website: Go to usda.gov and search for **national school lunch program**.

Summer Food Service Program
Find nearby sites: 866-348-6479
Info line: 518-473-8781
Website: Go to usda.gov and search for **find summer meals** or **summer food**.

FoodFinder
Website: foodfinder.us
Download the FoodFinder app from the Apple (iOS) or Google Play (Android) store.

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1. Ashbrook A, Hartline-Grafton H, Dolins J, Davis J, Watson C. Addressing Food Insecurity: A Toolkit for Pediatricians. *American Academy of Pediatrics and Food Research and Action Center*. 2017; 1-39.
 2. Hager ER, Quigg AM, Black MM, Coleman SM, Heeren, T, Rose-Jacobs R, Cook JT, Ettinger de Cuba SA, Casey PH, Chilton M, Cutts DB, Meyers AF, Frank DA. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. *Pediatrics* 126:e26-e32.
 3. Feeding America - Health Care Provider Training: Screening for and Addressing Food Insecurity in Clinical Settings. Retrieved from: https://hungerandhealth.feedingamerica.org/wp-content/uploads/2014/05/FA_Clinical-Training_2017.pdf.
 4. Johnson AD, Marokowitz AJ. (2018) Associations Between Household Insecurity in Early Childhood Children's Kindergarten Skills. *Child Development*. Volume 89, Number 2, pages e1-e17.
 5. Cook JT, Poblacion AP. Estimating the Health-Related Costs of Food Insecurity and Hunger. *2016 Hunger Report* (2016).
 6. Schwarzenberg SJ, Kuo AA, Linton JM, and Flanagan P. Promoting Food Security for All Children. *Pediatrics*. 2015; 136(5): e1435-e1436.

CenteringParenting/ Well-Baby Group Care

Description

CenteringParenting is a model for group pediatric care where mothers, partners and other support people come together with similarly aged infants in a two-hour shared medical visit. Each visit consists of physical examination, immunizations and risk assessment for the baby. Because group visits are longer than individual visits, there is more time for education. Group care supports mothers with stress management and family planning, and encourages mothers to track their goals.

Because group care can continue until the infant is 2 years old, families can get to know each other and receive support from other families facing similar challenges. Groups cover topics such as attachment, safe sleep, breastfeeding, nutrition, early literacy, child development and safety issues.^{1,2} Groups typically include six to eight mothers with similarly aged infants. Pediatric offices can provide this service.

Evidence

- Parents who participated in CenteringParenting reported feeling more informed, confident and empowered to make healthier choices for themselves, their babies and their families.¹
- Group primary care offers more in-depth coverage of topics, as well as opportunities for parents to practice and integrate health behaviors. Group primary care may improve health outcomes (particularly in at-risk communities), while addressing social determinants of health. Group primary care builds support networks, fosters healthy relationships and promotes responsive parenting.³
- Additional time during visits allows providers to screen for developmental milestones and mental health concerns, which can lead to earlier intervention and referrals.¹
- Families have better attendance for their well-child visits, which leads to higher immunization rates, extended breastfeeding and more maternal mental health screening.¹
- Group primary care may lower rates of overweight or obesity in young children.³

Billing and Reimbursement

Group pediatric care visits are billable encounters incorporating all clinical components of routine well-child care (assessment, risk monitoring, immunizations and anticipatory guidance).

Implementation Resources

Implementation support can come from national and local resources.

National: The Centering Healthcare Institute offers training workshops, consultation and assistance with launching groups.

The Centering Healthcare Institute Headquarters
89 South St., #404
Boston, MA 02111
857-284-7570

Website: centeringhealthcare.org/what-we-do/centering-parenting

Local: The South Bronx Health Center and Center for Child Health and Resiliency provides well-baby group care, as well as guidance and technical support on implementation in the South Bronx community.

The Center for Child Health and Resiliency – Montefiore South Bronx
890 Prospect Ave.
Bronx, NY 10459
718-991-0605

Specific questions can be addressed to Dr. Hildred Machuca at hmachuca@montefiore.org.

1. Centering Healthcare Institute: CenteringParenting. (2017). Retrieved from <https://www.centeringhealthcare.org/what-we-do/centering-parenting>.

2. The South Bronx Health Center/Center for Child Health and Resiliency Team.

3. Machuca H, Arevalo S, Hackley B, Applebaum J, Mishkin A, Heo M, and Shapiro A. Well Baby Group Care: Evaluation of a Promising Intervention for Primary Obesity Prevention in Toddlers. *Childhood Obesity*. 2016; 12(3): 171-178.