


Integrating Parenting Support Within and Beyond the Pediatric Medical Home

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Abstract

Positive parenting programs, developmental support services, and evidence-based home visiting programs can effectively provide parenting support and improve health and developmental outcomes for at-risk children. Few models, however, have integrated referrals for on-site support and home visiting programs into the provision of routine pediatric care within a medical home. This article describes an innovative approach, through partnership with a community-based organization, to deliver on-site and home visiting support services for children and families within and beyond the medical home. Our model offers a system of on-site services, including parenting, behavior, and/or development support, with optional intensive home visiting services. Assessment included description of the population served, delineation of services provided, and qualitative identification of key themes of the impact of services, illustrated by case examples. This replicable model describes untapped potential of the pediatric medical home as a springboard to mitigate risk and optimize children's health and development.

Keywords

medical home, parenting, home visitation, early childhood, delivery of health care

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Background

A child's capacity to grow and develop is guided by social determinants of health, or the social, economic, and environmental factors that shape the health of individuals and communities.¹ Certain pediatric populations, including children living in poverty,^{2,3} children in immigrant families,⁴ children with teen parents,⁵ children born prematurely,⁵ and children in foster care,⁶ face particular developmental and behavioral risks. Multiple developmental risk factors may amplify one another.⁷ During the first years of a child's life, positive experiences, such as parents routinely reading with young children, and negative experiences, such as exposure to chronic stress (known as toxic stress), can critically affect development.^{8,9} Reinforcing young children's closest relationships may be uniquely protective against long-term, adverse consequences of stress—including developmental risk—imposed by environmental factors.¹⁰

The American Academy of Pediatrics recommends that children have 11 visits with primary care providers,

including routine developmental surveillance with periodic screening,⁷ literacy promotion,⁹ and attention to social determinants of health¹ during the first 2 years of life.¹¹ Pediatricians can access tools to screen for social determinants of health and connect children to relevant community resources.^{1,12-15} Referral to community resources can enhance receipt of other community resources for families.¹² In particular, “warm hand-offs,” or in-person transfer of care between health care team members with patients and families present,¹⁶ can help ensure linkage between providers and relevant resources. Yet implementing models that not only facilitate referral but also integrate overarching social factors into routine care may have the greatest potential to mitigate risk and build resilience among vulnerable families.

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Developmental disabilities are estimated to affect 1 in 6 children in the United States.¹⁷ Although the American Academy Pediatrics also recommends that all children with failed developmental screens be referred for further evaluation,⁷ referral rates are significantly lower in practice,^{18,19} and systematic tracking of referrals is infrequent and cumbersome.¹⁹ Among young children with developmental concern or delay, baseline estimates for receipt of early intervention (EI) services range from 20% to 40%.²⁰⁻²² In the United States, 72% of referrals to EI are evaluated for service eligibility, and 51% are ultimately served.²³ Significant disparities in parenting practices that promote early child development contribute to developmental risk among economically disadvantaged children.³ These same social risk factors may also jeopardize receipt of needed developmental support services. Family barriers to receipt of services may include funding and staffing issues, state and federal regulations, and limited communication between families, medical providers, and EI providers.²⁴ Providers report that office processes, family preferences, and perceived understanding of the developmental screening tool can affect EI referrals.²¹ Efforts such as enhanced screening and referral documentation in the electronic medical record (EMR) and subsequent phone follow-up may improve referral rates and completed evaluations.¹⁸

Evidence-based interventions, such as home visiting programs,^{25,26} offer developmental and parenting support to at-risk children and families. The medical home provides a natural opportunity to identify at-risk families and facilitate referral to evidence-based programs. Several initiatives have implemented integrated models that mitigate toxic stress, address developmental risk, and attend to social determinants of health within a family-centered medical home.²⁷⁻³⁰ One successful model has incorporated school readiness promotion with video observation of parent-child interactions.²⁷ Another successful model is the Parents as Teachers curriculum³¹ to successfully integrate home visitation into medical care of infants born to young, low-income mothers.²⁸ Despite progress in expanding services offered within the medical home, opportunities exist to adapt existing models based on community assets and existing resources.

Our unique collaboration and partnership between pediatric practices and a community-based organization is intended to integrate positive parenting, home visiting, and developmental support services within and beyond the pediatric medical home. In this article, we describe an approach to delivery of on-site parenting support and home visiting support initiated within the medical home, describe the population served by our integrated model, and identify themes regarding the

impact of services provided by the community-based organization.

Methods

Model Development and Implementation

Imprints Cares is a community-based, nonprofit organization intended to help children and families reach their full academic and future potential by enriching children's development and supporting parents. Imprints Cares is funded by a diversity of grants, organizations, and individual and business donors. Family educators for Imprints Cares have college degrees in relevant fields, and all are trained in the Parents as Teachers curriculum and most are bilingual and bicultural in English and Spanish. Family educators are also trained in a variety of evidence-based screening tools (eg, Keys to Interactive Parenting Scale [KIPS],³² the Life Skill Progression [LSP],³³ Ages and Stages Questionnaires [ASQ-3, ASQ-SE]³³) and programs and skills (eg, lactation consultation, positive discipline, infant massage, and Triple P³⁴).

In 2011, Imprints Cares partnered with 2 community-based private practices and 1 academic practice to identify referrals within the medical home. Our office-based model incorporates comprehensive consultation for parenting concerns, breastfeeding challenges, behavior problems, and developmental concerns with the option of on-site or intensive, home visiting services for relevant families.

Our current descriptive analysis is based on 179 children referred to Imprints Cares from the academic practice for 1 year, July 2015 through June 2016. The clinic serves one of the largest pediatric Medicaid populations in North Carolina; 89% of patients are Medicaid recipients, 2% are privately insured, and 9% are self-pay/charity care. The racial/ethnic composition is 54% Hispanic/Latino, 30% African American, 9% Caucasian, and 7% other/unknown; 53% of families prefer to speak Spanish. The majority of the clinic's pediatric providers are pediatric resident physicians. In our practice, all patients attending well visits at select intervals (6 months, 12 months, 18 months, 24 months, 3, years, 4 years, 5 years) are screened using the PEDS (Parents Evaluation of Developmental Status) developmental screening tool,³⁵ with the Modified Checklist for Autism in Toddlers Revised with Follow-Up (MCHAT-R/F)³⁶ to screen for autism.

Referrals to Imprints Cares are triggered when providers identify needs or family concerns relevant to the expertise of Imprints Cares family educators. Referrals are made in-person (to an on-site family educator), via

phone, or with a direct message in the child's EMR. A referral may result in immediate assessment by the family educator, a follow-up phone call, or a subsequent scheduled office-based evaluation.

When family educators receive a referral, they make 3 attempts to contact the family. If they make contact with the family, they assess the family's needs by interviewing the parent and evaluating the child. For children who have been identified as having developmental concerns, they perform an ASQ-3, developmental screening tool for children ages 1 month to 5½ years,³³ in the child's preferred language. If they are not able to make contact and the concern is related to developmental delay, family educators send a letter to the family and notify the medical provider.

Some families who are referred to Imprints Cares are enrolled in intensive services. Families are selected to receive intensive services based on age of parent (Imprints Cares receives additional funding to serve teen parents), parent preference, and needs and/or other circumstances identified by the family educator (eg, toxic stress and family receptiveness). Intensive services are based on the Parents as Teachers model. Parents receive 1 or 2 home visits monthly depending on the number of high need characteristics identified (ie, low income, teen parent, immigrant parent, and low education). During home visitation, family educators use a formal curriculum to assess the child, identify family strengths, address concerns, and engage the child and parent in age-appropriate topics. Family educators also provide an age-appropriate activity to promote parent-child interaction and a new or gently used book to promote literacy. After each contact, family educators record field notes. Parents of children who receive intensive services are also evaluated using the KIPS, used to measure parent-child interactions over time,³² and the LSP, an outcome measurement and intervention planning instrument used with low-income parents during pregnancy and early parenting.³³ Families receiving services through Imprints Cares are offered additional services, including monthly parenting groups, educational programs, personalized referrals to community resources, and tracking/follow-up of referrals.

Measures

In this study of program implementation, assessment included description of population served and services provided as well as a chart review to qualitatively evaluate the model of referral and service provision. The first and second authors reviewed the EMR (JML) and Imprints Cares record (MPS), respectively, for all 179 children referred to this program. Inclusion criteria for

medical record review included all Imprints Cares referrals ($n = 179$); of those receiving intensive services ($n = 52$), 20 were randomly selected for comprehensive review of all field notes by first author (JML). Descriptive measures included preferred language, parent age (teen parent or not teen parent), reason for referral, type of services provided, presence of developmental delay/concern, referral for EI, and engagement with EI services. Chart review included iterative review of medical records and Imprints Cares case notes to qualitatively identify common themes from medical charts (children receiving non-intensive services) and Imprints Cares case notes (children receiving intensive services). Additional qualitative measures incorporate conclusions from regular meetings with key collaborators, including staff and leaders of the clinic and Imprints Cares.

This research was conducted in accord with prevailing ethical principles and was reviewed and approved by the institutional review board of the Wake Forest School of Medicine.

Results

Characteristics of the 127 children who received on-site services and the 52 children who received intensive services through Imprints Cares are summarized in Table 1. Among children receiving intensive services, race/ethnicity was reported as follows: 55% Hispanic, 29% African American, 6% Caucasian, 6% multiracial, and 4% Asian. Forty-four percent of children receiving intensive services lived in single-parent families, and 27% of parents receiving intensive services had received a high-school diploma or GED. Sixty-five percent and 40% of children receiving non-intensive services and intensive services, respectively, preferred to speak Spanish. Eight percent of children in the non-intensive services group and 29% of children receiving intensive services had teen parents.

Among children receiving non-intensive services, the primary reasons for referral were breastfeeding (43%), parenting (38%), developmental concerns (16%), and need for referral to community resources (3%). For children receiving intensive services, primary reasons for referral included parenting (88%), breastfeeding (6%), and developmental concerns (6%). Examples of parenting concerns included tantrums, sleeping problems, toilet training, picky eating, or techniques for positive discipline. Breastfeeding referrals included challenges such as difficulty with latch, weight gain, or weaning. Developmental concerns included expressive and receptive language, fine motor difficulties (including lack of exposure to age-appropriate activities), and relationship building. Eighty-three percent of children

Table 1. Characteristics of Children Receiving Non-Intensive Services and Intensive Services.

Variable	Non-Intensive Services, n (%)	Intensive Services, n (%)
Total non-intensive referrals staffed	127 (71%)	52 (29%)
Preferred language of parent		
Spanish	83 (65%)	21 (40%)
English	43 (34%)	29 (59%)
Kinyarwanda	1 (1%)	
Karenni		2 (1)
Teen parent		
Yes	10 (8%)	15 (29%)
No	117 (92%)	37 (71%)
Primary reason for referral		
Parenting	48 (38%)	46 (88%)
Breastfeeding	55 (43%)	3 (6%)
Development	21 (16%)	3 (6%)
Resource referral needs	4 (3%)	
Child has developmental concern/delay	23 (18%)	12 (23%)
Children with developmental concern/delay who were evaluated for eligibility by early intervention	19 (83%)	11 (92%)
Well-child visits up-to-date (at least 75% of recommended visits during study period)		
Yes	116 (91%)	47 (90%)
No	11 (9%)	5 (10%)

who were identified by medical providers as having developmental concerns or delays and then referred, via Imprints Cares, to EI were subsequently evaluated for eligibility determination by EI services. Fifty-nine percent of children who were referred to EI were ultimately served by EI. By comparison, at the county level, 72% of referrals are evaluated for eligibility by EI services, and 51% are ultimately served.²³

Chart review revealed key strengths of this integrated approach and collaboration. Among children who received non-intensive services, the following themes were extrapolated: (1) families receiving breastfeeding support not only gained nutritional support but also gained parenting support services; (2) behavioral support services exceeded those that could be reasonably offered by medical providers; (3) children with developmental delay benefitted from successful referral tracking; and (4) family educators were able to recognize trauma and associated stress and supported parents and children with trauma-informed support and anticipatory guidance. Themes are illustrated by select case notes (Table 2).

For children who received intensive services, there were several notable benefits of the services rendered, elucidated by key themes and case examples (Table 2). First, families were provided in-depth anticipatory guidance that was both timely and relevant to their unique home environments. Second, fathers were more involved in this process than is typically feasible in the medical

setting, and family educators celebrated this involvement with strengths-based support. Third, family educators identified and followed-up referrals to relevant community resources, resulting in improved follow through with referrals and needed care. Finally, family educators integrated literacy promotion, supporting parent-child interactions and emphasizing school readiness.

Discussion

Our work adds to the emerging evidence base regarding enhanced parenting support within and beyond the medical home.²⁷⁻³⁰ Our model incorporated an existing community asset, in the form of a well-established community-based organization, into the pediatric medical home. This collaborative model offers mutual benefits for both the academic pediatric clinic and a community-based organization. For the community-based organization, a steady stream of referrals as well as the opportunity to interface directly with the medical team provided enhanced enrollment and communication. For the medical team, integrated services offered pediatric trainees opportunities to become familiar with positive parenting techniques and collaborate in advocacy efforts (eg, parenting classes for pregnant and parenting teens, car seat installation and education programs, family nutrition courses). The personal, “warm” hand-off between medical providers and community partners may foster enhanced referral effectiveness. Additional unique

Table 2. Themes Based on Qualitative Review of Non-Intensive Services and Intensive Services Interventions.

Theme	Illustrative Case Examples
<i>Illustrative case examples from the electronic medical record</i>	
Breastfeeding support as means of supporting mental health needs of parent/postpartum depression	The mother of a newborn was struggling with breastfeeding and bonding with her infant in the context of limited family support after recent immigration from Central America. Family educator worked closely with mental health provider and pediatrician to support mom. At the 2-month visit, the medical provider stated, "Mom's mood and affect are greatly improved, and she feels that talking with [family educator] and counselor has been helpful."
In-office behavioral support beyond capacity of pediatricians	A 2-year-old boy with history of dysphagia and poor weight gain was struggling to implement nutrition suggestions in home environment. Medical record noted, "Since last visit, mother has been visiting with [family educator], who says has been giving her good tips on structuring mealtimes . . . [mother] reports that [child] is eating more with this structure."
Successful referral tracking for children with developmental delay	A 3-year-old boy with expressive language delay who had been referred to early intervention without follow-up. After referral to Imprints family educator to assist with referral tracking and family engagement, child was successfully enrolled in Head Start and Early Intervention services, with improvement noted in expressive language.
Recognition of children's trauma	A 5-year-old girl who had been detained and separated from mother during immigration from Central America was exhibiting severe behavioral problems at home and in school. Family educator worked closely with mom to provide anticipatory guidance regarding trauma and to connect child to counseling services. Marked improvement in child's behavior and parent-child bonding were observed by family educator and medical team.
<i>Illustrative case example from family educator notes</i>	
Timely, relevant anticipatory guidance	"Family educator shared with mom the importance of the safety at home, safety with households and cleaning supplies, safety around toys, and things around the house. Toward the end of the visit, when mom's siblings got home from school, the children got distracted and stopped doing the activities they were doing. [30-month-old child] left the living room for a few seconds, and when she came back, mom noticed that [30-month-old child] had something in her mouth and found a marble inside. [30-month-old child] thought it was funny and would not release the marble, but mom finally got the marble out of her mouth. This was a great time to refer to mom again about safety around the house, including toys."
Celebrating father involvement	"Father took [child] to the patio and invited child to play with shadows. Father asked child if he can see his shadow. [Child] laughed and said yes. Child pointed to his daddy's shadow and said, "Your shadow is big, and mine is small." Father positioned his right side to the sun, and extending his arms started doing shadow shapes with his fingers and hands. He asked child if he could do it. Child tried to do shadow with his hands, and moving his fingers. Father then opened holes in a paper page and put it in front of the sun light, and the child watched how light passed through the paper holes. Father explained to the child how the shadow is formed."
Toxic stress intervention	"There was an incident at the home recently where someone tried to break in and was stopped by a family member. This has been traumatic for the family, and they are dealing with the aftermath. . . . I took mom information about child stress and things to look for so that she can support [child]. Mom is getting counseling to help her deal with this situation also."
Supportive, ongoing referrals to community-based referrals	Previous visit: "[Parent] is going to think about all of her monthly expenses so that we can make a budget next time. Subsequent visit: Budget was developed and included in notes, and follow-up to referral to community-based organization to support working parents.
Literacy promotion/parent-child interaction	"The parents told [the child] that they were going to create a space for book reading and story time. They asked the child, "Where do you think could be the place for reading books?" The child pointed to the corner . . . the father asked if they need something else to make the place comfortable. [The child] said that we wanted some pillows and a blanket, and the mother said that she wanted her rocking chair. The mother said, "Well, we now have a reading place."
School readiness	"[Child name] is ready for kindergarten, she has her physical done, all her immunizations are updated, she is registered, and the best part is that she is excited about school."

elements of this model include breastfeeding support as a parenting intervention, developmental referral tracking, and after-hours educational opportunities for engaged families.

This observational study has several limitations. First, there was no randomization for receipt of the intervention, nor was there a control group to systematically compare those who received the intervention with the general clinic population. The sample is relatively small, and data are from a single site. Manual chart review revealed inconsistencies in how referrals and follow-up communications were recorded in the EMR, which may have resulted in underreporting of outcomes. Although no longitudinal data exist to evaluate the impact of the program, preliminary findings suggest significant benefit based on themes identified and illustrative cases.

Our preliminary work has led to the identification of 3 primary next steps. First, identification of shared measures will facilitate more meaningful tracking over time of the impact of this intervention. Second, integrating Imprints Cares into the EMR for the medical practice will further improve communication and care coordination. Third, given the stress associated with parenting for the at-risk families referred to this program, integrated mental health triage as part of the collaboration will enhance support provided to parents.

Conclusion

Our model delivers on-site parenting support and offers evidence-based home visiting programs as part of a comprehensive pediatric medical home. Connecting medical providers with community-based organizations offers the ability to extend anticipatory guidance beyond that offered during a typical medical visit. Given the role of parents in ensuring the health and wellness of their children, innovative models that deliver evidence-based, family-centered services into the pediatric medical home offer promising opportunities to mitigate family stressors and to build resilience among at-risk children and families.

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Author Contributions

JML: Contributed to conception or design; contributed to acquisition, analysis, and interpretation; drafted the manuscript; gave final approval; agrees to be accountable for all aspects of work ensuring integrity and accuracy.

MPS: Contributed to acquisition, analysis, and interpretation; critically revised the manuscript; gave final approval; agrees to be accountable for all aspects of work ensuring integrity and accuracy.

BA: Contributed to acquisition, analysis, and interpretation; critically revised the manuscript; gave final approval; agrees to be accountable for all aspects of work ensuring integrity and accuracy.

SD: Contributed to conception or design; contributed to interpretation; critically revised the manuscript; gave final approval; agrees to be accountable for all aspects of work ensuring integrity and accuracy.

Declaration of Conflicting Interests

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References

1. Gorski P, Kuo A; American Academy of Pediatrics Council on Community Pediatrics. Community pediatrics: navigating the intersection of medicine, public health, and social determinants of children's health. *Pediatrics*. 2013;131:623-628.
2. AAP Council on Community Pediatrics. Poverty and child health in the United States. *Pediatrics*. 2016;137:e20160339.
3. Shah R, Sobotka SA, Chen YF, Msall ME. Positive parenting practices, health disparities, and developmental progress. *Pediatrics*. 2015;136:318-326.
4. Karoly LA, Gonzalez GC. Early care and education for children in immigrant families. *Future Child*. 2011;21:71-101.

5. Hoffman L, Bann C, Higgins R, Vohr B; Eunice Kennedy Shrive National Institute of Child Health and Human Development Neonatal Research Network. Developmental outcomes of extremely preterm infants born to adolescent mothers. *Pediatrics*. 2015;135:1082-1092.
6. Szilagyi M, Rosen D, Rubin D, Zlotnik S. Health care issues for children and adolescents in foster care and kinship care. *Pediatrics*. 2015;136:e1142-e1166.
7. American Academy of Pediatrics Council on Children with Disabilities; Section on Developmental Behavioral Pediatrics; Bright Futures Steering Committee; Medical Home Initiatives for Children with Special Health Care Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics*. 2006;118:405-420.
8. Garner AS, Shonkoff JP Committee, on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. Early childhood adversity, toxic stress, and the role of the pediatrician: translating developmental science into lifelong health. *Pediatrics*. 2012;129:e224-e231.
9. AAP Council on Early Childhood; High PC, Klass P. Literacy promotion: an essential component of primary care pediatric practice. *Pediatrics*. 2014;134:404-409.
10. National Scientific Council on the Developing Child. Excessive stress disrupts the architecture of the developing brain (Working Paper No. 3; Updated edition). <http://www.developingchild.harvard.edu>. Accessed March 29, 2018.
11. Bright Futures; American Academy of Pediatrics. Recommendations for preventive pediatric health care: periodicity table. https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed March 29, 2018.
12. Garg A, Toy S, Tripodis Y, Silverstein M, Freeman E. Addressing social determinants of health at well child care visits: a cluster RCT. *Pediatrics*. 2015;135:e296-e304.
13. Garg A, Butz A, Dworkin PH, Lewis RA, Thompson RE, Serwint JR. Improving the management of family psychosocial problems at low-income children's well-child care visits: the WE CARE project. *Pediatrics*. 2007;120:547-558.
14. Fazalullasha F, Taras J, Morinis J, et al. From office tools to community supports: the needs for infrastructure to address the social determinants of health in paediatric practice. *Paediatr Child Health*. 2014;19:195-199.
15. Kenyon C, Sandel M, Silverstein M, Shakir A, Zuckerman B. Revisiting the social history for child health. *Pediatrics*. 2007;120:e734-e738.
16. Agency for Healthcare Research and Quality. Design guide for implementing warm handoffs. <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfepriarycare/warm-handoff-designguide.pdf>. Accessed December 26, 2017.
17. Boyle C, Boulet S, Schieve L, et al. Trends in the prevalence of developmental disabilities in US children, 1997-2008. *Pediatrics*. 2011;127:1034-1042.
18. Talmi A, Bunik M, Asherin R, et al. Improving developmental screening documentation and referral completion. *Pediatrics*. 2014;134:e1181-e1188.
19. King TM, Tandon SD, Macias MM, et al. Implementing developmental screening and referrals: lessons learned from a national project. *Pediatrics*. 2010;125:350-360.
20. Brown CM, Beck AF, Steuerwald W, et al. Narrowing care gaps for early language delay: a quality improvement study. *Clin Pediatr (Phila)*. 2016;55:137-144.
21. Jimenez ME, Fiks AG, Shah LR, et al. Factors associated with early intervention referral and evaluation: a mixed methods analysis. *Acad Pediatr*. 2014;14:315-323.
22. Zimmer MH, Panko LM. Developmental status and service use among children in the child welfare system: a national survey. *Arch Pediatr Adolesc Med*. 2006;160:183-188.
23. Simpson B. Early Intervention Referral Source and Referral Disposition Data for FY 15-16. Electronic data request by JM Linton. 2016.
24. Little A, Kamholz K, Corwin BK, Barrero-Castillero A, Wang CJ. Understanding barriers to early intervention services for preterm infants: lessons from two states. *Acad Pediatr*. 2015;15:430-438.
25. Avellar S, Paulsell D, Sama-Miller E, Del Grosso P, Akers L, Kleinman R. Home visiting evidence of effectiveness review: executive summary. <http://homvee.acf.hhs.gov/About-Us/5/Executive-Summary/20/2>. Accessed March 29, 2018.
26. AAP Council on Community Pediatrics. The role of preschool home-visiting programs in improving children's developmental and health outcomes. *Pediatrics*. 2009;123:598-603.
27. Weisleder A, Cates CB, Dreyer BP, et al. Promotion of positive parenting and prevention of socioemotional disparities. *Pediatrics*. 2016;137:e20153239.
28. Paradis HA, Sandler M, Manly JT, Valentine L. Building healthy children: evidence-based home visitation integrated with pediatric medical homes. *Pediatrics*. 2013;132(suppl 2):S174-S179.
29. Shah R, DeFrino D, Kim Y, Atkins M. Sit down and play: a preventive primary care-based program to enhance parenting practices. *J Child Fam Stud*. 2017;26:540-547.
30. Minkovitz C, Hughart N, Strobino D, et al. A practice-based intervention to enhance quality of care in the first 3 years of life: the Healthy Steps for Young Children Program. *JAMA*. 2003;290:3081-3091.
31. Parents as Teachers. Home page. <http://www.parentsas-teachers.org>. Accessed November 8, 2016.
32. KIPS: Keys to Interactive Parenting Scale. Nurturing insights proving outcomes. <http://www.comfortconsults.com>. Accessed February 1, 2017.
33. Ages & Stages Questionnaires®, Third Edition (ASQ-3™). <http://agesandstages.com/products-services/asq3/>. Accessed February 1, 2017.
34. Triple P Positive Parenting Program. Triple P takes the guesswork out of parenting. <http://www.triplep.net/glo-en/home/>. Accessed February 13, 2017.
35. PEDStest.com. Tools for developmental-behavioral screening and surveillance. <http://www.pedstest.com/default.aspx>. Accessed February 13, 2017.
36. Modified Checklist for Autism in Toddlers, Revised with Follow-Up. M-CHAT general information. <https://www.m-chat.org/about.php>. Accessed February 13, 2017.