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# 7 chapters take part in QI project to identify, address families' social needs

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At the start of the COVID-19 pandemic, the AAP recruited seven chapters to embark on a national collaborative to facilitate practice transformation when addressing social-emotional health in young children. Each chapter, in turn, recruited 10 practices to participate in a quality improvement initiative to screen for perinatal depression, social drivers of health and social-emotional development in children from birth through age 5.

The project, called Addressing Social Emotional Health and Early Childhood Wellness (ASHEW), sought to enable pediatric practices to identify and address unmet social needs and support social and emotional well-being of children and families.

With support from national leadership, each chapter tailored a standard curriculum to fit regional needs. Chapter leaders, practice leaders and practice team members were trained to do the following:

- Prepare the practice environment for trauma- and resilience-informed care.
- Foster and continually expand referral networks.
- Utilize a family-centered, strength-based approach.
- Establish and maintain effective systems to support assessment, primary care intervention, referral and follow-up.
- Ensure care is delivered to advance racial and ethnic equity.

Monthly meetings were held for practices to share successes and challenges.

California Chapter 1's approach is an example of how the seven chapters involved in the program addressed social drivers of health. Following is a summary of their efforts.

The chapter relied on expertise and experiences from adopting California's mandate to screen all patients annually for adverse childhood experiences (ACES), https://www.acesaware.org/. In one of the learning sessions for pediatricians, Dayna A. Long, M.D., FAAP, provided an overview of the prevalence of ACEs and the rationale for screening, as well as resources for both clinicians and patients on trauma-informed care. One message that resonated was a reminder to ask about family strengths and protective factors.

Webinars were conducted to check in with chapter and practice leaders, share innovations and encourage one another. Participants shared experiences, data and plan-do-study-act tests of change; celebrated successes; and took moments for reflection, mindfulness, gratitude and solidarity.

Some practices decided to focus on adopting screening for social drivers of health. They felt screening was important, but they were not yet comfortable asking about sensitive issues and responding appropriately during the routine 15-minute well-child visits. In fact, the biggest barrier practice leaders reported was their own hesitation and lack of confidence in asking and responding. Once they started to ask, the discussions became easier, and many families expressed gratitude that they were asked about social-emotional needs, especially during the COVID-19 pandemic.

To track performance, each practice reviewed 10 or more patients seen for their 6-month, 15-month, 24-month and 48-month well-child visits every month for one year and entered into a database the numbers screened, counseled and referred.

In keeping with ASHEW's family-centered approach, each practice recruited a parent adviser. Parents in California Chapter 1 collaborated to identify and encourage best practices in incorporating parent perspectives. Many discussed the importance of clear role description and evidence that their voices were heard and their recommendations adopted. Many practices reported how vital parent involvement was in developing inclusive policies and sensitive procedures to address social-emotional health.

When the year-long project concluded, practices reported feeling encouraged that they were able to make changes in spite of the continuing pandemic. They agreed that screening for social-emotional health can be difficult and that the process works better when the entire practice is involved. This meant considering the wellness of all practice members and providing resources, including training on unconscious bias and anti-racism as well as personal, relational and group resilience workshops.

Practices also learned that families are key partners in practice transformation efforts,  and referrals work better when practices have mature relationships with community partners.

*Dr. Takayama is past president of AAP California Chapter 1.*

**Resource**

Information on the TRIADS Framework, which describes evidence-informed practices for screening, provider response and patient education about adverse childhood experiences in primary health care settings, is available at https://cthc.ucsf.edu/triads/.