Global Aim

All families with infants will receive high-quality, family-centered healthcare characterized by effective partnerships with the care team, family-centered communication, strategies to promote Protective Factors, developmental promotion through education in teachable moments, systematic identification of family strengths and HRSN, and family-led problem solving for linkage with resources within and beyond the healthcare system.

Acronym Key

RHC = routine healthcare visit
WCV = well-child visit
HRSN = health-related social need
IPV = intimate partner violence
EHR = electronic health record
FS = Family Specialist
EC = early childhood
PDSA = Plan-Do-Study-Act

Primary Drivers	Interventions
Comprehensive, strengths-based care enriched by FS engagement during and between WCVs *% of WCVs attended by FS (Aim = 90%)*	• FS present during WCVs • Between WCV support (in-person, telephone, text, email, etc.) • Systematic identification of families' strengths and reinforcement of Protective Factors (e.g., social connections) • Fortification of parent-child attachment and attunement via anticipation of periods of change/stress and support of parental process of mastery • FS integrated as essential member of primary care team (included in all team meetings, access to EHR, etc.) • Clinic protocols for enrollment, integrating FS into workflow • Formal, regular, face to face supervision for FS, including a) administrative supervision and b) individual reflective supervision
Systematic identification of families' strengths and health-related social needs and implementation of family-led problem-solving *% of families screened for nine HRSN (Aim = 95%)*	• Screening for nine HRSN using validated, standardized screening tools occurs in context of ongoing, caring relationship between FS and family • Solicitation and respect of families' desires and preferences for support • Protocols, procedures for communication with team about all identified HRSNs • Protocols, procedures for communication with team about urgent mental health needs, safety assessment, and intervention planning
Cross-sector team – that includes an early childhood system representative, legal partner, behavioral health clinician, clinic champion, clinic DULCE lead, and FS – **provides ongoing collaboration to improve families' access to benefits, services, and legal protections and to identify opportunities to effect policy change and systems improvements** *% of families with concrete supports needs (employment security, financial supports, food security, housing health & safety, housing stability, transportation, utilities) that receive support (Aim = 90%)* *% of families with caregiver depression or IPV needs that receive support (Aim = 75%)*	• Weekly case review with cross-sector team to review families' priorities and collaborate in problem-solving for all identified HRSN and clinical and behavioral health goals • Team-based, role-appropriate, family-centered support to access benefits, services and legal protections for all identified HRSN • Identification of commonly unaddressed needs and system gaps to 1) engage the EC system, healthcare system and legal community to redress DULCE families' needs and 2) use data to inform early childhood policy agenda and systems-building to improve population outcomes • The designated early childhood system lead serves as the local backbone organization for DULCE and brings a population health lens to learning from DULCE that can impact other families with young children
Families as partners in DULCE design and implementation	• DULCE teams create and sustain forums for families to provide feedback & share ideas
Continuous quality improvement: data-driven adaptation	• Monthly CQI meetings to promote iterative, data-driven adaptation via PDSA cycles to improve DULCE implementation and outcomes for children, families, and cross-sector partners