The third paper in this panel (presented by Pamela Morris, New York University) will discuss the integration of these two models infused with behavior economics and embedded in pediatric primary care.

As will be discussed in the first two papers in this session, in separate clinical trials, both VIP and FCU show evidence of efficacy in promoting positive parenting practices and enhancing children’s development across domains. Both models effectively engage low-income parents with infants and toddlers in public health settings. However, VIP, with relatively low intensity, is unlikely to fully close the gap for families with additional psychosocial stressors, suggesting an opportunity for synergy through the addition of FCU to provide more intensive services for higher risk families.

In addition to integrating primary and secondary prevention, a key aspect of our integrated approach is that it applies innovations from behavioral economics to increase parent engagement. The success of early childhood preventive interventions hinges on the parent having the available energy to fully participate, consistently engage, and follow-through with recommendations. However, parent engagement often varies substantially. Advances in behavioral economics suggest that the stresses associated with low and unstable income may interfere with parent engagement. Also, because of the lag between current program services and later benefits to children’s school readiness and educational achievement, parents may not correctly perceive the benefits to participation. We will discuss strategies we plan to use to minimize demands on attention, or more proactively offer rewards (such as those successfully used in other domains like nutrition and finance), which have not been employed to date in the context of preventive interventions.

Finally, our approach is unique in leveraging a pediatric primary care platform for population-level preventive intervention with low-income families. A number of existing models based in early childhood education settings (e.g., preschool or child care) and in the home environment (using home visiting) have shown promise in promoting children’s school readiness through enhanced parenting in the infant and toddler years. However, the high cost and logistical challenges of engaging at-risk families in these settings have prevented them from

---

being brought to scale at a population level. Pediatric primary health care platforms offer an innovative alternative for providing low intensity, preventive interventions for low-income families at scale that complements more intensive targeted interventions.\textsuperscript{19} Initiatives to increase health insurance for low-income children (i.e., S-CHIP, Medicaid expansion) and the 13 to 15 visits over the first 5 years of life recommended by the American Academy of Pediatrics provide an opportunity for near-universal, frequent contact with difficult-to-reach families during this critical early period. As such, this approach takes advantage of a fully developed existing health care infrastructure, dramatically reducing the cost relative to other platforms, while also utilizing already scheduled family travel and time related to health care visits, reducing cost and burden on participating families. The result is a model that has the potential for dramatically reduced costs compared to existing initiatives to prevent school readiness disparities.