Hope and the Science of Thriving
A Summit to Build the Field of Positive Health and Nurturance

Summary Proceedings and Next Steps
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in partnership with the Children's Hospital Association, the Center for the Study of Social Policy, and Prevent Child Abuse America

INTRODUCTION

On March 28-29, 2016, the Child and Adolescent Health Measurement Initiative (CAHMI) and Health Resource in Action collaborated to coordinate and convene a summit on *Hope and the New Science of Thriving. CAHMI and HRIA envisioned a summit to build the field of positive health to promote early and lifelong health and partnered with* the Children's Hospital Association, Prevent Child Abuse America and the Center for the Study of Social Policy to convene a small group around the need and possibility of establishing a purposeful effort (or campaign). The goal of the summit was to advance a positive construct of health and build common understanding in the field, and explore the formation of a purposeful consortium to coordinate and expedite the activities essential to advance the science and practice of promoting positive health and healing for children, youth and families. (See Attachment 1 for a list of participants, and Attachment 2 for the summit's agenda). Participants reflected a wide diversity of roles and perspectives, including researchers, providers, hospitals and health systems, federal, state, local and private sector policy leaders, philanthropic foundations, and the next generation of leaders.

This summit was an outgrowth of years of work by all involved, including a multi-year effort initiated by the CAHMI, and in partnership with AcademyHealth, to build a national child health services research, practice, and policy action agenda to address the problem of adverse childhood experiences (ACEs) and promote resilience and positive health.

The summit built on the extensive leadership of the Center for the Study of Social Policy and HRIA to define protective and promotive factors that strengthen families and promote safe, stable and nurturing relationships at the core of health child development and well-being.

Summit Goals:

The primary goal of the summit was to *establish an enduring positive construct for child, youth and family-centered health that better communicates the need, opportunity and new innovations in promoting optimal child development and health.* This goal built on existing models, such as the Health Outcomes from Positive Experiences *(HOPE) mode*l,[1] and leverages the CAHMI's articulation of a *new science of thriving.*[2]

Additional goals included:

- Develop a common language, set of assumptions, and principles to describe positive quality and experiences that promote optimal child health and development
- Establish a beginning venue for learning and resource-sharing to build awareness, capacity and innovation for families, clinicians, healthcare organizations and policy leaders.

Through these activities, we sought to specify longer-term actions and explore expanding partnerships.

SHARED ASSUMPTIONS, BELIEFS AND VALUES AND NEED FOR STRATEGIC ACTION

Participants came to this meeting with many shared assumptions, beliefs and values. A diverse array of frameworks and perspectives were also represented, and added a depth and richness to the discussion. Prior to the convening, a survey of participants was conducted. The overall response rate was 96% (n=25). The summary below reflects responses to the pre-meeting survey and subsequent dialogue. (See Appendix 3 for more information.) Participants were asked to rate their agreement with 15 statements on a scale of 1-10, with 10 being the highest level of agreement and 1 being the lowest level of agreement. (See Table 1, below, for the full list of statements.) While even small differences in view are essential to explore and integrate, for the purposes of guiding dialogue during the meeting, consensus was considered to be *strong* if 75% or more of respondents answered with agreement in the range of 8-10, *moderate* if 58%-74% of respondents answered in the range of 8-10; and *low* if less than 58% answered with agreement in the range of 8-10. While the meeting dialogue provided an important forum for affirming shared perspectives, areas identified in the survey as having less consensus were prioritized for discussion throughout the summit. The areas with the greatest consensus, moderate consensus, and least consensus are outlined below.

1. ***There is A Sense of Urgency to Foster Collaboration to Frame a Positive Health Agenda***: All participants completing the pre-meeting survey reported some level of urgency to *act now* to promote a positive construct for child well-being. (See Table 1.) Specifically, 71% of survey respondents felt that unless we took intentional action to cultivate shared perspectives and coordinated or complementary action, existing momentum could devolve into unproductive competition with commensurate inefficiencies and delays in progress. And, as the policy arena rapidly changes, there is a real need to organize parties and put a "stake in the ground" on this issue in a timely manner.

2. ***There is A Critical Need to Evolve the Current Language to Advance a Positive Construct of Health***: There was also concern that the emerging language for recognizing the importance of safe, stable, nurturing relationships (SSNRs) in child health—and the impact of adverse childhood experiences-- may exclude a positive health focus for all children. Particularly worrisome was the widespread use of the term "trauma-informed care", which emphasizes addressing and adapting to adversity, and does not include the proactive and simultaneous promotion of SSNRs, hope, optimism, and aspiration. Moreover, without attention, terms such as this may become buzz words without substance (87%), and we may see the consequent emergence of trauma-informed approaches which focus only on "highly complex" instances of childhood trauma interventions that do not transform culture or practice in ways that lead to the prevention of ACEs or the proactive cultivation of positive health and flourishing (79%).

Simply put, child development requires the affirmative presence of positive experiences, including safe, stable, and nurturing environments. The simple prevention or mitigation of adverse experiences cannot itself foster normal child development.

3. ***Measures are Needed to Inform, Anchor Action, and Track Progress***: There was strong consensus among participants that *common metrics and methods are essential* to build and grow the field of positive child health. Specifically, participants agreed that common metrics and methods are required for evaluating existing efforts and assessing positive health capabilities to promote learning, scaling and sustainability of programs and policy (96%). However, over half (56%) disagreed that we are ready to translate positive health measures into performance measures and accountability systems. While some foundational work is underway, this is a nascent area and requires more attention and support.

4. ***Progress Requires Robust Provider Training and Focus On the Adults in Children's Lives:*** A large majority of participants (96%) agreed *that providers do not have most of the knowledge and skills required to promote positive health* and need more than simply structural supports, such as more time with patients; and 88% agreed that *promoting positive social and emotional capabilities among children and families should be a standard of care* for all child and family serving organizations. To this end, training providers to promote positive experiences and prevent, identify, and respond to ACEs with the goal or promoting resilience of positive health was identified as a priority for most. There was less consensus regarding the belief that *providers need to understand and address their own trauma to be effective in promoting positive health with their patients* (50%). However, nearly all participants (92%) also agreed that *engaging adults in children's lives to develop their own positive social and emotional capabilities* and address their own trauma is also essential.

5. ***There is Agreement that Child Health Means Family Health:*** Reflecting the Center for the Study of Social Policy's "Strengthening Families" model, participants shared a common understanding that *promoting child well-being means working with families to improve their capacity and opportunities to raise healthy children*. Regardless of participants' perspectives, it was commonly believed that ACEs threaten to undermine the building blocks of what children, youth, and families need: (1) safe, stable, nurturing relationships and environments; (2) prevention of and building resilience to trauma and stress; and (3) policies and community norms that strengthen families, promote positive experiences and help children master essential social emotional skills. It was also commonly understood that positive experiences promote these building blocks, and allow children to thrive despite their exposure to adversity.

6. ***Creating a Road Map Is Limited by Divergent Views and Need for Innovation:*** Despite general agreement (76%) that the field is ready to embrace a common framework, model, and language to make progress in promoting a positive health focus in the US,

there was less consensus on the correct approaches for doing so. Some advocate that assessing positive health and protective factors in conjunction with ACEs and trauma among children and parents are critical to begin to advancing efforts to promote healing and positive health (60%). Yet, only about half of the participants agreed that:

(1) *we are ready to initiate a wide-scale and coordinated public education and policy advocacy campaign focused on positive health* (54%); and
(2) *sufficient evidence and methods exist to conduct wide scale education and training across child and family health sectors* (48%).

Participants also reported that although there is much we already know and evidence on trauma-informed and resilience-based interventions and programs abound; translation and scaling are not fully realized due to gaps in training, supportive financial arrangements and needs to address issues of capacity, coverage, credentialing, coding, and coordination of care.

Table 1: Pre-meeting Survey Results (presented from greatest common agreement to least common agreement)

Level of Consensus	% Agree	Statement
Strong (75%-100%)	96%	Common metrics and methods to evaluate efforts is essential to learning, sustainability and scaling
	96%	Common metrics to assess positive health capabilities and protective factors is essential to progress
	96%	Providers' (health care and community) DO NOT have most of the knowledge and skills required to promote positive health—they need more than structural supports (e.g. time, resources, etc.)
	92%	Engaging adults in children's lives to develop their own positive social and emotional capabilities and address their own trauma is a priority
	88%	Promotion of positive social and emotional capabilities among children and families should be a standard of care for all child and family serving organizations
	87%	Trauma informed approaches and resilience may become buzz words without substance
	79%	Approaches will become focused interventions that do not scale or transform culture or practice
	76%	We are ready and need to embrace a common framework, model and language to make progress in promoting a positive health focus in the US
Moderate (55%-75%)	71%	Devolution of existing momentum, organizations working at cross purposes; there will be competition instead of collaboration

	60%	Assessing for adverse childhood experiences, trauma, etc. among children and parents is a critical element to promote healing and positive health capabilities
	58%	Further fragmentation of funding for and/or response from systems within and across sectors
Low (Below 55%)	54%	We are ready to initiate a wide scale and coordinated public education and policy advocacy campaign focused on positive health promotion
	50%	Personal transformation (beyond skills building) and understanding their own trauma is needed for providers to be most effective in helping promote positive health capabilities
	48%	Sufficient evidence and methods exist to conduct wide scale education and training across all child health and related services organizations
	44%	We are ready to build evidence of promoting positive health capabilities into performance measurement and accountability systems

7. ***There is a Need to Balance Opportunities for Promotion, Prevention, and Healing Among All Children:*** Science supports the importance of the prenatal and early childhood years as a critical time for development of brain architecture, which then sets up future development opportunities or challenges.[3] [4] [5] Some participants were strongly focused on the prenatal and the 0-3 age groups as key targets for near-term action. However, there was no consensus on age targets as it related to policy actions. While all agreed a population-wide approach is essential, some felt that priority should be given to set in place policy and practice capacity on behalf of all children, while others viewed focusing on prenatal and early childhood as the right approach at this stage.

SUMMIT GROUP DIALOGUE: DISCUSSION ON GUIDING CONSTRUCTS, OPPORTUNITIES, AND CHALLENGES

The majority of discussion at the summit took place in smaller groups. Large group dialogue provided an opportunity to reflect on the insights gained and ideas generated within the smaller groups. Insights and ideas shared with the larger group could not reflect the depth and breadth of the smaller group discussions. However, several themes emerged across groups:

There is a Baseline Need to Put Children and Families on the Policy Agenda: A cross-cutting focus for all groups was on the need to prioritize efforts to gain public and policymaker attention for all children and families. While much is possible without policy action, policy changes are critical to enable effective action to support family well-being and the providers that serve them - especially since supporting providers requires broadening the current medical model of health). However, to get child wellbeing on the federal policy agenda has proven difficult, at best. Doing so will involve addressing concrete issues around health insurance

coverage, coding and credentialing, as well as contracting and performance measurement. Support for real-time innovation and learning across efforts will also be essential to advance assessment and support of healthy development and resilience; prevention, identification, and mitigation of adversity and toxic stress, and addressing social determinants during well child and routine healthcare visits. This effort will require leveraging existing public sector platforms to promote positive health, raise awareness through public health campaigns, use storytelling to engage families, and focus on community-level strategies.

There are Benefits to Embracing a Public Health Model to Build Awareness of ACEs, Resilience, and Positive Health: Participants affirmed that there is a clear and compelling case for a population-wide model in promoting positive health (vs. a high-risk model). Everyone, regardless of demographic, economic, and health status characteristics, needs to develop positive health and the social-emotional skills that form the basis of positive health. Data was shown that even in the absence of ACEs, only 55% of US children meet basic criteria for flourishing, as defined by the National Survey of Children's Health. Public health approaches to promoting positive health have a number of advantages.

First, some of the issues around fungible financing and reimbursement might be alleviated using the public health workforce. Second, using systems within the public health model - for example federally qualified health centers (FQHCs) and school-based health programs - will reach populations most in need. Third, public health models can normalize the need for awareness about the possibilities and requirements for well-being and how chronic and daily stress and trauma impact well-being.

Fourth, public health campaigns can also normalize messages about life-long impacts of childhood trauma and stress, the need for inclusion and avoidance of discrimination and marginalization, the need for help and the intergenerational nature of ACEs, and facilitate wide-scale efforts to eradicate the "shame and blame" mentality. Approaching positive health and well-being from the public health perspective fully aligns with efforts to create a culture of health, reduce disparities, and address health equity issues. Participants agreed that we need a common framework – tied to action steps, – a common set of messages and language, and that we should build on past successful public health campaigns such as smoking cessation and seat belt use. Some participants felt that we as a field are close to developing this language, and consensus could be achieved through a structured and iterative process.

There is a Need to Place Children at the Forefront of Congress: Further discussion ensued among participants around the best approaches for placing child well-being at the forefront of Congressional action, and saw this as a major opportunity for building and advancing the field. As noted, there was widespread understanding that children are not a high priority for Congress, in part because there are (mis)perceptions that children are predominantly doing well, child well-being is the primary domain of the parents, and children are not a high cost item for the national budget or in health care, particularly when compared to the Medicare and

chronic health conditions populations. Strategies for consideration to address those perceptions and the larger issues of promoting a positive health agenda included:

(1) undertaking a consistent and persistent public health awareness campaigns
(2) showing a positive return on investment (ROI) for the healthy development of children using a life course framework;
(3) involving the business community and creating a public-private initiative;
(4) using existing Medicaid, the Affordable Care Act, or tax structure platforms to leverage fiscal incentives;
(5) requesting an FOA from the Centers for Medicare and Medicaid Innovation targeting young children to accelerate practice innovation and diffusion of positive health and trauma-informed approaches to child and family services; and,
(6) creating and supporting policies that support safe, stable, nurturing environments and families as the "first responder" to a child's needs.

It was also noted that it would be important to help policymakers understand the concept of the "dual continuum"[6] – that positive health is not the absence of disease, but is a much larger frame than a medical model for understanding, assessing and measuring individual and collective well-being.

Participants also affirmed that any effort directed at Congress needs to be strongly bipartisan ("purple" policies), easy to understand, digestible and relatable (even perhaps oversimplified); precise and concrete with respect to outcomes and measures of improvement; well communicated; and fearless in terms of a request for funding.

Developing Common Measures and Metrics for Performance and Accountability is Needed:
While there is widespread agreement that the field needs a set of common metrics and methods to assess social determinants of health, ACEs, resilience and positive health, there are few resources and only a handful of experts dedicated to this goal. Among the resources that do exist,, the CAHMI recently undertook a major review and comparison of positive health, family well-being and protectives factors and ACEs assessment tools currently in the field (soon to be published).[7] Major federal initiatives such as the Maternal and Child Health Measurement Research Network, the Life Course Measurement Research Network, and the Pediatric Quality Measures Program are also key in identifying and promoting alignment of metrics across programs. Based on existing well-established measures for Quality-Adjusted Life Years (QALY) and Disability Adjusted Life Years (DALY), a new concept on *Well Being Adjusted Life Years (WEBLY)* has recently emerged, particularly with respect to cross sector comparisons of subjective well-being.[8] There was strong agreement that additional metrics focused on social determinants of health, intergenerational health and transmission of trauma and resilience, well-being across the life course, ACEs, resilience, and positive health need to be developed. Common metrics for positive health also need to be integrated into and aligned across performance and accountability systems. The measurement field for positive health and wellbeing is nascent, and requires continued support and cross program collaboration.

There Have Been Challenges in Translating and Scaling Evidence-Based Programs that Promote Positive Health: Participants agreed that we currently have a wide range of evidence-based interventions, programs, and strategies to promote positive health, address ACEs, teach social-emotional skill development, and train providers. However, while some have been translated or subject to some scaling – for example, Help Me Grow, Healthy Steps, Child FIRST, and Medical-Legal Partnerships - many have not, and the efforts to do so are still relatively nascent. Participants affirmed that translation and scaling are needed. Additionally, there were some basic questions raised regarding how to scale effective strategies for creating positive health for adults and children, and how to create optimal "pro-social" environments.

Participants also flagged that context is critical, and there is a delicate interplay between scaling what we already know works and having sufficient flexibility to tailor strategies to specific communities or populations. Additionally, lacking a strong mandate that we are "…ready to initiative a wide-scale and coordinated public education and policy advocacy campaign focused on positive health" (only 54% of participants agreed with this statement, as per Table 1), it is also unclear how to best create the common public health messages for ACEs and positive health that would drive this momentum.

Important Opportunities Exist to Engage Parents and Promote Intergenerational Approaches: "Your Being, Their Well Being": Participants widely agreed that healthy child development depends largely on the health and well-being of parents, reflecting the emerging research demonstrating the link between parental health and child outcomes. For example, data from the National Survey of Children's Health (NSCH) reveal several important facts. First, children are significantly more likely be resilient when they have a trusted parent or mentor, their parent talks to them about things that matter, when the parent knows who most of the child's friends are and attends the child's events, or when the parent is generally able to cope with the stress of parenting. Conversely, children are significantly less likely to be resilient when their parent is usually or always stressed or aggravated with the child.[9] The data further demonstrate that children with two or more adverse childhood experiences (ACEs) are more likely to have mental and behavioral problems, but that this is mitigated by demonstrating resilience, including having a healthy, attentive parent.[10] There is also some evidence demonstrating both resilience and adversity, and perhaps more importantly, the values and ancestral norms around having healthy behaviors and lifestyle, can be transmitted from one generation to another - creating either positive health and engagement with life or a cycle of trauma and adversity.[11 12 13]

There Has Been Increased Focus on Training Providers about Positive Health Development, ACEs, and Engaging Families: Participants also recognized the need, feasibility, and desirability of improving training for pediatric and primary care providers to promote positive health and address ACEs. These sentiments have been echoed in a series of articles recently published in Academic Pediatrics. One study found that less than 11% of survey respondents (out of a sample of 302 general practice pediatricians) were familiar with the original ACEs study and

only 4% asked about ACEs on a regular basis. The study also found that pediatricians' attitudes and beliefs about ACEs was a contributing factor, and concluded that emphasizing social-emotional risk factors may help increase early identification in pediatric practice settings.[14] A systematic review of primary care interventions to treat or prevent childhood stress found a wide diversity of approaches, including implementing screening programs or tools, providing practitioners with links to community resources, and training providers to identify and discuss social-emotional issues with families, and that these interventions are feasible and have positive outcomes for families.[15]

There has also been a recent focus on provider burnout and toxic stress, raising the question of how prepared and capable providers are to even ask the family questions about home life, parental stress, and how that may be impacting the child's development.[16] [17] [18] [19] Providers, health practices, and health systems need to know and address their own challenges (ACEs, toxic stress, risk factors) and strengths (resilience, protective factors) in order to help the children and families they serve. Additionally, participants recognized that pediatric providers will need to adopt a life course and intergenerational model of care, recognizing that parents' stressors and protective factors, parenting skills, knowledge, attitudes, and family context all have important implications for positive health and well-being of children and families.[20]

Participants also discussed, in detail, the ongoing debate in the field right now regarding screening for ACEs in pediatric practices. On the one hand, some feel that ACEs screening can open much-needed dialogue with the family, and can increase opportunities for both engagement and help families get the services they need. The counterpoint, and a large fear among providers, is that screening in the absence of knowledge or referral resources may not be productive. In addition, screening for ACEs may not address the most pertinent information about the need for safety, stability, and nurturing in the home environment. Other screening – for social determinants and for protective factors – may be more relevant to both identifying vulnerable families and starting the engagement process with them.

Providers' question of "what do I do when…?" and the absence of evidence-based clinical screening tools, are serious impediment to scaling universal ACEs screening. To this end, testing, training, and dissemination of available toolkits to assist providers and families would be useful. Additionally, there has been very little discussion in the field regarding best practices for screening for positive health and resilience. The utility of ACEs scores in the absence of the context of positive health and resilience is limited. On this point, several questions remain to be addressed, including what kind of training is needed to help providers address their own self-care and promote their own well-being, and what the characteristics of a "healing" encounter are.

Storytelling and Developing a Coherent Narrative is Crucial: Throughout the summit, the importance of storytelling and developing a coherent narrative emerged as a strong theme for participants – and as something they felt was important for themselves, their families, and their communities. Data demonstrate that a parent who has a coherent narrative about his or her

life is more likely to be able to promote positive health and resilience with his/her children, and that sharing one's story can improve immune function (ref). In addition, storytelling is a powerful vehicle for creating inspiration, creating connection, and healing families and communities. Participants agreed that it was important to continue "building the space for storytelling" to educate and create greater awareness of commonalities that we all share regarding thriving, and healing from traumatic experiences. Also discussed was the need to better understand how to use people's personal stories to help people connect, how to incorporate stories into "evidence", and how we might translate personal narratives into measures.

***Real Challenges Exist to Put Family and Provider Engagement into Action*:** Participants agreed that the degree to which we can teach our children how to develop a skill (in this case, healthy social-emotional and positive health skills) is dependent on our own skill set as adults. It is clear that more needs to be done to assist families in promoting positive health; however, in order to know what families actually need and want, it is essential to engage them in dialogue and partnership in achieving their own health goals. The power of family engagement to transform health and health care has been emphasized by health care leaders, researchers, and advocacy organizations for the past fifteen years. [21] [22] [23]

Despite calls for increased and improved family engagement, researchers and providers have identified barriers to family engagement in the health and well-being of children.[24] [25] [26] In particular, studies report that providers are concerned that engaging families in a true partnership will uncover needs and expectations that cannot be met, or at least addressed in the immediate visit.[27] [28] Underlying these concerns is a lack of beliefs, knowledge, skills and resources that would tend to support family engagement.[29] The ability to engage parents in partnership during an office visit requires that child and family service providers, regardless of sector, have strong positive health skills themselves in order to be present with, hear, and meet their clients' (often unstated) needs and expressed wishes. This concept also pertains to other non-medical providers who interact with children and families, including teachers, social service staff, community workers, and so forth. Developing positive health is a universal need in our society.

OUTSTANDING QUESTIONS

As we examined the importance of the themes above, a number of important questions arose:

(1) What are the best practices for family engagement? What skills and attributes do staff need to possess to be successful in engaging families?

(2) How do we best ensure that parental/family health needs are identified and met, and what are the opportunities for doing so (e.g.: screening parents as well as children during a child's routine visit)? How can we move beyond providing formal professional care to also

address family needs for supportive community environments and opportunities to participate and be included in community life?

(3) What kinds of training are needed to engage families and address their needs in addition to the child's need?

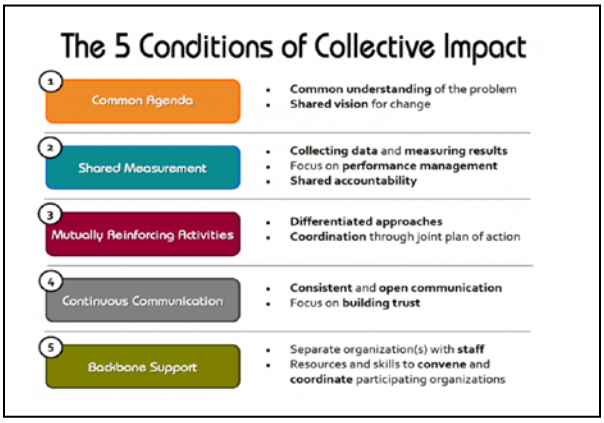
(4) What does positive health and resilience look like in the next generation?

(5) What policies are needed to address the intergenerational aspects of adversity and resilience? Promoting positive health for children is a keystone of successful parenting.

REQUIREMENTS FOR ADVANCING THE FIELD

Participants agreed that the time for strategic leadership is now. We have a unique window of opportunity to influence and take action. There is momentum in the field, but greater awareness in the general population and policy leaders is needed. The following themes emerged when summit participants discussed what is required to advance the field:

***Embracing Collective Impact Strategies*:** Among meeting participants, engaging in approaches that promote collective impact was considered to be a promising next step. Indeed, most if not all participants came to the meeting because of their belief in the need for and importance of collective impact. According to Kania and Kramer, Collective Impact "…is premised on the belief that no single policy, government department, organization or program can tackle or solve the increasingly complex social problems we face as a society."[30] They further outline five conditions for creating collective impact: (1) having a common agenda and shared vision for change; (2) having common data and metrics that are focused on performance and shared accountability; (3) having coordinated and differentiated but mutually reinforcing activities among organizations; (4) creating a learning platform where information can be shared in an open, mutually respectful way that builds trust in the field; and (5) having a backbone organization that has resources and skills to convene and coordinate the efforts of the participating collaborators. Participants stopped short of calling for the creation of a consortium or backbone organization, but did embrace the other four principles of Collective Impact.



Fostering Multiple Approaches to Build the Field: Building the field of positive health will require innovations and targeted efforts at all levels. *"Top down"* approaches and policies are needed to align financing and service delivery mechanisms from federal, state and local levels

of government - and this is no small feat. Government agencies are often constrained by program law, policies and regulations that limit the fungible use of resources and flexibility in financing, program eligibility, and type, level, location and mechanism of service delivery. Innovations to share data, merge funding streams, and create seamless systems of care are underway and need to be supported.

"Bottom Up" approaches are needed to engage families, consumers, and community residents to better understand what they need, what they want, and what may activate the will to be healthy. Efforts that have made family engagement a priority have been more successful and sustainable.

The *"Inside Out"* approach, central to healing trauma, is an individual- and internally-driven process that requires neuro-repair. There is a saying that "Neurons that fire together, wire together."[31] "Rewiring" our nervous systems to allow for functional and healthy responses to stress and adversity is the internal work we each need to do in order to be present for, create connections with, and be able to help and serve others.

Shifting the Collective Mindset: Perhaps the strongest point of consensus among participants was that accomplishing the goals of this summit and promoting a culture of positive health will require a major shift in how we think about our own health and the health of our children, families, communities, and organizations. Traditional paradigms in medicine have led to expectations that a health care system can "fix" our health problems, or at least our symptoms. This conventional thinking cannot address the deeper root causes of our distress, our disorders, and our dysfunctions – and does not address the strengths we bring that can contribute to our own and others' health. Additionally, this thinking does not show us where or why we may lack positive health, help us identify the consequences (at both the personal and societal level), or tell us what it means to lack a set of skills that lead to positive health and well-being. We cannot think or talk our way out of the deeper level work required to be fully healthy and engaged in life. Accomplishing these goals will require us to acknowledge the failures of both policy and culture: we must face the fact that as a society, we are not valuing health. We must own the (scientific) fact that we are wired to be social creatures; we have a "social brain" for which connection to others is in fact literally and physiologically a matter of life and death.

Promoting positive health requires that a person's will and desire to be healthy is activated. We then need the prevailing culture to support this will in its collective policies, programs, funding, behaviors, and values. This requires looking at health and health care from the life-course perspective. It also requires understanding how values and health behaviors can be transmitted across generations. In order to shift the prevailing mindset, we need multiple approaches, training, and a shift in our language – how we talk about trauma and resilience to ourselves, our children, in our schools, and in our communities.

Table 2: High-Level Summary of Key Summit Findings

Pre-Meeting Survey	**Key Findings**
The pre-meeting survey consisted of 15 questions posed to 25 summit participants. The response rate was 96%.	• There is a sense of urgency to **foster collaboration** to frame a positive health agenda • There is a critical need to **evolve the current language** to advance a positive construct of health • **Measures are needed** to inform, anchor action, and track progress • Progress requires **robust provider training** and **focus on the adults** in children's lives • There is agreement that **child health means family health** • Creating a road map is **limited by divergent views and need for innovation** • There is a need to balance opportunities for promotion, prevention, and healing **among all children**
Summit Group Dialogue: Opportunities and Challenges	**Key Findings**
The majority of discussion at the summit took place in smaller groups. Groups then returned to the larger group to reflect on the insights gained and ideas generated within the smaller groups. Several themes emerged across groups.	• There is a baseline need to **put children and families on the policy agenda** • There are benefits to **embracing a public health model** to build awareness of ACEs, resilience, and positive health • There is a need to **place children at the forefront of Congress** • Developing **common measures and metrics** for performance accountability is needed • There have been challenges in **translating and scaling evidence-based programs** that promote positive health • Important opportunities exist to **engage parents and promote intergenerational approaches** • There has been increased focus on **training providers** about positive health development, ACEs, and engaging families • **Storytelling and developing a coherent narrative** is crucial • Real challenges exist to put **family and provider engagement into action**
Summit Group Dialogue: Requirements to Advance the Field	**Key Findings**

Participants agreed that the time for strategic leadership is now. A few themes emerged when summit participants discussed what is required to advance the field.	The following is required to advance the field: • Embracing **collective impact strategies** • **Fostering multiple approaches** to build the field • Shifting the **collective mindset**

NEXT STEPS

While consensus was not reached on the creation of a consortium to facilitate coordination and collaboration, participants did affirm that a follow-up meeting would be highly beneficial. This next meeting is envisioned to widen the sphere of inclusion – for example, including representation from social service and justice agencies, family/consumer organizations[1], large payer organizations such as Kaiser, Aetna, Blue Cross/Blue Shield, and others.

It was also agreed that building the field is essential, and a query has been sought to better ascertain what participants want to do either individually or collectively going forward.

Participants also mentioned that while the field is being advanced, there is much we can do now. For example, we can disseminate a toolkit that provides examples to targeted audiences suggesting action steps and "the three things we can do right now". There was also some discussion of creating a working group to more fully and carefully define an "ask" of Congress.

PROLOGUE: A CASE FOR FULL COLLABORATION

In the interim few months since this Summit was convened, several additional meetings among stakeholders on thriving, positive health and/or ACEs have taken place or are being planned. This suggests that participants' concerns over increasing competition without a solid commitment to Collective Impact may occur. While in the short term it might seem as if carving out a niche – either for resources, leadership recognition or both – is an important focus for organizational survival, splitting the field will result in less than ideal results for children and families in the long term.

There is a significant amount of work to be done, requiring many different skill sets, and a number of organizations poised to take on the challenges outlined here. In fact, in the months since this summit, many participant organizations have made purposeful, significant strides in this field. (See Table 3 for examples of this work.)

This progress reflects the extreme momentum, interest, and promise in the promotion of positive health among children, youth, and families. Additionally, it continues to point to the

[1] Note: Family Voices was included in this meeting, but was unable to participate on March 28.

fact that even though organizations and individuals may have varying opinions -- indeed conflicts are likely to arise over details of how, where and when actions might be undertaken -- together we will be stronger and stand to be more impactful, speaking as one voice to promote positive health and well-being for us all.

Towards the Articulation of a New Science of Thriving

(from CAHMI's Thriving and Healing Children, Families and Communities statement):

The science of human development opens the door to unprecedented advances in human health and well- being. Breakthrough findings in neuroscience, epigenetics, biology, psychology, sociology and humanities point to a new science of thriving that illuminates largely untapped capacities for self, family and community-led healing and squarely places the locus of human health and development within the social, emotional and environmental context we create and live within. In contrast to the conventional focus on negative development, risk factors and pathology, this new approach concerns itself with the largely untapped capacities for positive human development. We seek to bring the research, education, innovation, advocacy and leadership capacity of existing partners together into a consortium effort to catalyze and advance a new integrated science of thriving into efforts to promote and assess and address childhood adversity in pediatric practices and other settings.

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