WHOLE CHILD HEALTH ALLIANCE

NEMOURS CHILDREN'S HEALTH

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About Whole Child Health Approaches

Whole child health approaches engage multisector partners (e.g., community-based organizations, schools, other child-serving organizations, and families) to support the developmental, physical, mental, behavioral and social needs of children and youth. These partners also foster healthy relationships with caregivers, through individual, family-based and community-level approaches. The goal is to create a supportive context to help children and youth thrive. Key elements of whole child health approaches include:

- Promoting health equity
- Integrating care delivery and social supports
- Aligning care for families
- Fostering healthy communities
- Supporting a diverse, multidisciplinary workforce
- Incentivizing cross-sector data partnerships
- $
- Promoting quality improvement performance [2]

There is a unique opportunity for providers to implement whole child health approaches for the youngest children (i.e., children under 3 years old), who the American Academy of Pediatrics recommends visit their health
of health and social needs, strengthening early relational health, and promoting health and prevention. [3] Research has shown that early experiences affect health across the life-course and effective interventions are needed in the early years and prenatal period. As described above, whole child health approaches take a multifaceted approach to pediatric care through child health transformation, which refers to transforming how pediatric care is practiced

Impact of Whole Child Health Approaches on Health Equity

As described above, whole child health approaches have the potential to play a critical role in advancing health equity and reducing disparities. Whole child health approaches should focus on improving health outcomes for historically marginalized populations who disproportionately experience suboptimal health outcomes and care.
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health disparities, and ensure data are collected and evaluated through an equity lens. Notably, the majority of
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Islanders (52%) who are 0–18 years old are covered by Medicaid or other public coverage. Therefore, there is a unique opportunity to address health disparities among children/youth through whole child health approaches driven by Medicaid policy.

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Value-Based Payment and Pediatrics

+HDOWK FDUH ²QDQFLQJ LV D NH\ FRPSRQHQW RI D ZKROH FKLOG KHDOWK DSSURD and delivery models with desired health and well-being outcomes for children. The implementation of value-based payment has lagged in pediatrics as compared to the adult population, especially those served by 0HGLFDUH ZKLFK KDV DGYDQFHG YDULRXV YDOXH EDVHG SD\PHQW WUDQVIRUPDW

Barriers WR ²QDQFLQJ SHGLDWULF YDOXH EDVHG SD\PHQW PRGHOV LQFOXGH ORZHU S savings time horizon, and a high probability of churn (i.e., when members switch between health insurance plans or lose coverage), which limits payers' opportunities for savings. Additionally,

Massachusetts

In September 2022, Massachusetts received approval from the federal government to implement a comprehensive suite of changes to the state's Medicaid and CHIP program ("MassHealth") as part of a Section 1115 waiver from CMS. One explicit goal of the waiver was to implement reforms and investments in pediatric care to expand access and move beyond fee-for-service health care. The pediatric reforms emerged from a set of recommendations compiled by a coalition of child advocates and built upon previous MassHealth reforms that addressed behavioral health and health-related social QHHGV GH²QHG E\ CMS as an individual's unmet, adverse social conditions that contribute to poor health. This original set of reforms GLG QRW VSHFL²FDOO\ IRFXV RQ FKLOGUHQ

Background

Massachusetts has been a pioneer in terms of expanding coverage and implementing health system reform efforts aimed at improving population health, including addressing health-related social needs among its members. Covering 40% of births and one-third of the state's children and youth, MassHealth serves as a critical resource to promote whole child health in Massachusetts.

Over the past decades, Massachusetts has used several strategies to implement key reforms to its MassHealth program, including an 1115 waiver, DSRIP, a CMS SIM model, and other strategies. In the Massachusetts' 2017 1115 waiver, the state implemented a number of approaches to address health-related social needs and promote behavioral health integration. These included:

- Creating accountable care organizations (i.e., groups of providers that collaborate to improve population health under value-based payment agreements)
- Supporting mental/behavioral health integration within primary care
- Requiring providers to screen for health-related social needs
- Implementing the Flexible Services Program, which allows MassHealth funds to be spent on targeted food instability and housing supports for those who meet certain medical and needs-based criteria
- Strengthening care coordination for people with chronic conditions

To ensure delivery system reforms adequately addressed the unique needs of children, a group of child providers and advocates came together through the Child and Adolescent Health Initiative to develop 10 recommendations focused on child health and deeply rooted in an advanced model of primary care. This group worked with MassHealth to inform an 1115 waiver request that CMS approved in 2022. This high level of community engagement was a key factor in catalyzing the pediatric segments of the 1115 waiver.

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Local Examples

The local examples below highlight a handful of providers exemplify elements of whole child health. Note this list is not exhaustive of all Massachusetts providers practicing whole child health.

Child Advocacy Community

North Carolina also has a robust child advocacy community working to advance child health and well-being. From 1999 through 2019, the North Carolina Assuring Better Child Health and Development Program,
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initiative that established developmental, autism and perinatal depression screening, brief intervention, and partnering with families for linkage and referral in primary care. With the transition to managed care, the Assuring Better Child Health and Development Program state advisory group transitioned to the EarlyWell project with an emphasis on social-emotional development. NC Child D F QRQSUR²W HQ SWKH EarlyWell Initiative, an advocacy effort aiming to strengthen North Carolina's system for promoting infant and early childhood mental health. By convening over 100 service providers, clinicians and advocates, EarlyWell has mapped the current landscape of social, emotional and mental health efforts for children from newborn to age 8 in the state. It is now developing the North Carolina Young Children's Social-Emotional Health Action Plan, which lays
RXW VWDWH SROLF\ VROXWLRQV IRFXVHG RQ SUHYHQWLRQ HDUO\ LGHQWL²FDWLRQ WU
effectively aligns care for families by partnering with local organizations that can facilitate receiving feedback directly from family members and caregivers. Such initiatives exemplify how North Carolina's child advocacy organizations collaborate with government leaders, families and other stakeholders to catalyze change.

Division of Child and Family Well-Being

,Q WKH 1RUWK &DUROLQD 'HSDUWPHQW RI +HDOWK DQG +XPDQ 6HUYLFHV WRRN
care delivery and social supports by establishing the Division of Child and Family Well-Being, which "works to promote healthy and thriving children in safe, stable and nurturing families, schools and communities." The division explicitly aims to promote whole child health by improving coordination and integration of services for children and families across physical health, behavioral health and other programmatic areas. Some of its focus areas include food and nutrition services, school and community-based services, and early intervention approaches.

North Carolina's Model for Promoting Whole Child Health

North Carolina has implemented numerous policies and practices that advance whole child health. These include an October 2018 Medicaid Section 1115 Demonstration waiver, the NC Integrated Care for Kids (NC InCK) model, various coverage extensions, innovative programs and funding sources, and technology platforms. [4] The sections below

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4. NC Integrated Care for Kids

In 2019, CMS published a notice of funding opportunity for the Integrated Care for Kids Model (InCK). CMS currently funds seven awardees across six states, including North Carolina.[5] The model aims to promote early LGHQWL²FDWLRQ DQG WUHDWPHQW RI FKLOGUHQ ZLWK PXOWLSOH SK\VLFDO E DQG ULVN IDFWRUV LQWHJUDWH FDUH FRRUGLQDWLRQ DQG FDVH PDQDJHPHQW payment models.

In January 2022, North Carolina launched NC InCK IRU 0HGLFDLG DQG &+,3 LQVXUHG FKLOGUHQ OLYLQ North Carolina counties. Partners include the North Carolina Department of Health and Human Services, Duke Health System, UNC Health System, and various child health leaders from the target region. NC InCK seeks to holistically understand the needs of children by implementing data integration across multiple sectors (e.g., health, education, juvenile justice) to identify children with physical, behavioral and social needs. Children with higher needs are offered integrated, longitudinal care management, which includes convening a cross-sector care team and connecting families to services such as early care and education, schools, food programs, housing, legal aid, and others. In addition, NC InCK DGYDQFHV ²QDQFLQJ UHIRUPV WKDW DOLJQ FHQWDOL] health and assesses quality improvement and performance through an alternative payment model that rewards participating providers for achievement on six child-centered process measures:

- Kindergarten Readiness Promotion Bundle
- Screening for Food Insecurity & Housing Instability
- Shared Action Plan [6]
- Depression Screening & Follow Up
- Emergency Department Utilization
- Racial and Ethnic Disparities in Infant Well-Child Visits

7KH 1& ,Q&. DOWHUQDWLYH SD\PHQW PRGHO ZDV FRGHVLJQHG ZLWK OHDGHUV IURP Prepaid Health Plans (i.e., North Carolina's Medicaid managed care organizations) and clinically integrated QHWZRUNV &,1V LQ 1& ,Q&. V²YH FRXQWLHV 7KH 1& ,Q&. DOWHUQDWLYH SD\PHQW LQFHQWLYH SURJUDP LQ WKH ²YH 1& ,Q&. FRXQWLHV WKDW ODXQFKHG LQ-DQXDU\ 2026. The alternative payment model includes AMH incentive payments through health plan contracts, which are linked to reporting and performance against benchmark targets.

NC InCK aligns care for families by convening a paid Family Council to advise program leaders on key strategic decisions, ensuring families play a role in the NC InCK program and policy design. The initiative seeks to inform practices about the health-related social needs of families by providing data on the kindergarten readiness rate, school attendance, housing instability, food insecurity and total cost of care. It is testing strategies like HPEHGGLQJ FDUH PDQDJHUV LQ SUDFWLFHV WR FRRUGLQDWH VHUYLFHV DQG FKLOG direct referrals from community partners, including schools and juvenile justice counselors. It promotes health equity in numerous ways, including its hiring processes and equity-focused measures. The state will evaluate results over several years and hopes to scale successful innovations statewide. NC InCK is an innovative approach aiming to serve the whole child by integrating services and addressing needs that can positively impact the health outcomes of children and families.

5. Medicaid Coverage Extensions

North Carolina has also adopted two important Medicaid policies to align care for families and promote continuity of coverage for mothers and children. It provides 12 months of continuous Medicaid eligibility for children enrolled in Medicaid and CHIP. In addition, the state recently extended Medicaid postpartum coverage to 12 months, recognizing the critical period for addressing maternal health needs after birth.

5 InCK awardees include Connecticut, Illinois (Egyptian Health Department, Lurie Children's), North Carolina, New Jersey, New York and Ohio.

6 A Shared Action Plan is a care plan developed collaboratively by a family and the child's cross-sector team.

6. Quality Improvement

Through CCNC and other initiatives, North Carolina has consistently demonstrated its commitment to improving children's health care while assessing quality improvement and performance. The state won a $9.2 million federal grant from the Children's Health Insurance Program Reauthorization Act (CHIPRA) between 2010–2015. This funded a partnership with the North Carolina Pediatric Society, North Carolina Academy of Family Physicians, and CCNC on various activities, including evaluating quality measures. North Carolina CHIPRA supported practice transformation for strengthening medical homes for children ZLWK VSHFLDO KHDOWK FDUH QHHGV VSHFL²FDOO\ WKRVH LQ IRVWHU FDUH and those with sickle cell disease with a focus on those with developmental, and/or mental health disorders. North Carolina was one of only two CHIPRA grant states to evaluate the pediatric electronic health record format.

7. Innovative Programs and Funding Sources

1RUWK &DUROLQD EHQH²WV IURP PXOWLVHFWRU FROODERUDWLRQV WR WHVW DQG create positive impact for children and families. In the late 1990s, pediatric practices in North Carolina began implementing the Reach Out and Read Program. In more recent years, the state utilized a CHIP Health Services Initiative to support the implementation of the program across all 100 counties. This evidence-based program fosters healthy social/emotional and language development through the promotion of shared reading and stories. Through this evidence-based intervention, parents and caregivers are supported at each checkup between birth and 5 years by their clinician. They are provided with guidance and a book to take home hoping to build into their daily routines. In June 2023, North Carolina announced plans to transition the Reach Out and Read funding to new initiatives, including a statewide breastfeeding hotline and a parenting intervention for caregivers with substance use.

North Carolina also has an active philanthropic sector focused on children and families that has made innovation in behavioral health, school-based care (including oral health and vision care) and telehealth possible in the state. For example, CaroNova — a health incubator that addresses the common needs of North and South Carolina, in partnership with the North Carolina Healthcare Association, the South Carolina Hospital Association, and the Duke Endowment — has focused on collaborating with the states to enhance youth behavioral health prevention programming and redesigning the system to support the behavioral health needs of children in the Carolinas.

Furthermore, the State Employees' Credit Union Foundation and UNC Health Foundation funded the University of North Carolina School of Medicine Department of Psychiatry to implement a pilot program to expand telehealth into schools to address the child/youth behavioral health crisis. These examples are

2. Value-Based Payment

VALUE-BASED PAYMENT THROUGH MEDICAID 115 WAIVERS

As authorized by the state's 2016–2022 and 2023–2027 Medicaid 1115 waivers, the Health Care Authority implemented a value-based payment VWUDWHJ\ WKDW DLPV WR PRYHH GKRH DOWDKWH ²QDQF care payments into value-based payment contracts. The state's nine ACH's have played a critical role in the implementation of value-based payment, having leveraged Medicaid Transformation Project funds to provide technical assistance, coaching and infrastructure investments to support regional providers as they transition to new payment models. ACH's can receive incentives if their regions achieve value-based payment participation targets.

Washington's Common Measure Set OLVWV VSHFL²F SHGLDWULF PHDVXU which are included in value-based payment contracts to measure provider performance. Examples of pediatric value-based payment metrics include child and adolescent well-care visits, childhood immunization status, immunization for adolescents, depression screening and follow up and remission/response for adolescents, follow up for children prescribed ADHD medication, as well as prenatal and postpartum care. In addition to supporting the state's ²QDQFLQJ reforms to incentivize optimal health, the common measure set helps Washington assess quality improvement and performance.

TRANSFORMING CLINICAL PRACTICE INITIATIVE

Prior to Washington's recent 1115 waiver, CMS awarded the state $16.3 million between 2015 to 2019 to participate in the Transforming Clinical Practice Initiative designed to support clinician practices to achieve large scale health care transformation, including transitioning to value-based payment models. Washington's Transforming Clinical Practice Initiative was one of only two pediatric transformation networks, which the Washington State Department of Health implemented in collaboration with the Washington Chapter of the American Academy of Pediatrics and Molina Healthcare. The initiative aimed to support pediatric primary care, specialty care and behavioral health providers to transition to family-centered care and value-based payment through the implementation of the Regional Care Coordination Project, which leveraged the Medical Home Neighborhood model of care for the pediatric Medicaid population. The initiative was implemented through each region's ACH and local health department via Regional Care Facilitators. The overarching goal of the initiative was to improve health outcomes for children covered by Medicaid and reduce costs.

3. Integrated Pediatric Medical Home

COLLABORATIVE CARE CODES

Washington has strengthened pediatric medical homes throughout the state by instituting new payment methods that leverage a multidisciplinary workforce to promote integrated physical and behavioral health care delivery and social supports. 6SHFL²FDOO\ :DVKLQJWRQ HQDEOHG collaborative care billing codes as a critical component of its Collaborative Care Model, an integrated care model developed at the University of Washington to treat mild and moderate mental health conditions in the primary care setting. Introduced by CMS in 2017 and adopted by Apple Health in March 2018 through legislative action, Collaborative Care Model services codes are billed for services provided in a calendar month with a maximum of 120 minutes of services a month, under the billing provider (i.e., behavioral health services provided by a therapist in the primary care setting are billed by physician or nurse practitioner). While uptake of the Collaborative Care Model has been limited to date due to administrative complexity and shortage of behavioral health providers, this payment has allowed primary care practices – LQFOXGLQJ 3HGLDWULFV 1RUWKZHVW SUR²OHG EHORZ § WR LQWHJUDWH EHKDYLRUDO LQ D ²QDQFLDOO\ VXVWDLQDEOH diverse, multidisciplinary workforce (i.e., associate therapists) to

Local Examples

The local examples below highlight a handful of local providers exemplifying elements of whole child health. Note this list is not exhaustive of all Washington providers practicing whole child health.

Seattle Children's Care Network

Seattle Children's Care Network has undertaken several initiatives that advance whole child health. One of Seattle Children's key initiatives includes implementing ²QDQFLQJ UHIRUPV including participating in value-based payment contracts with commercial, Medicaid and direct-to-employer plans. Seattle Children's was a "top performer" in its value-based payment arrangement with Regence BlueShield for three years (2019–2021), based on its performance on seven pediatric quality metrics, which include performance for well-child visits and immunizations. Seattle Children's Odessa Brown Children's Clinic DOVR H[HPSOL²HV D ZKROH FKLOG DSSU providing medical, dental, behavioral health, nutrition and other services on site, while also providing community SURJUDPV DQG FODVVHV RQ IRRG ²WQHVV HPRWLRQDO ZHOO EHLQJ VDIHW\ DQG

Other key initiatives advancing whole child health include the following:

- Seattle Children's Care Network's Pediatric Integrated Behavioral Health Initiative ZKLFKWEHZOLVKHG D ²QDQFLDO sustainable model in which behavioral health care is integrated into primary care practices, resulting in increased behavioral health screenings across all age groups
- Seattle Children's Care Network's Quality and Care Transformation program, which provides coaching and facilitation to support preventive care, immunizations, asthma, behavioral health, outpatient antibiotic stewardship and patient-centered medical home recognition
- Standardized data and reporting tools to increase transparency, provide real-time reports, and identify gaps in care
- Access to legal services via the Washington Medical-Legal Partnership, described above

HopeSparks and Pediatrics Northwest

Since 2018 HopeSparks Family Services, a behavioral health and family services provider in accountable care organizations and Pierce County, and Pediatrics Northwest, a comprehensive pediatric group practice serving the South Puget Sound region, have partnered to integrate behavioral health care into the pediatric care medical home, leveraging the Collaborative Care model from the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington. The care team is comprised of the primary care pediatrician, integrated therapist, and the pediatric psychiatric provider who provides routine case consultation. Through this model, the primary care provider universally screens children and youth ages 4 through young adult for behavioral health needs. An integrated therapist provides children with mild to moderate behavioral health conditions with behavioral health services via telehealth. Therapists leverage brief, evidenced-based interventions including the First Approach Skills Training (FAST) curriculum, which includes weekly 15- to 30-minute sessions with children and youth and their parent/caretaker (i.e., a two-generation approach) based on cognitive behavioral therapy. The providers use a registry to track progress. Pediatrics Northwest bills collaborative care codes to provide this integrated service.

Tubman Center for Health and Freedom

The Tubman Center for Health and Freedom, located in Seattle's Puget Sound region, is an example of a local community-based organization that advances whole child health as part of its mission addressing health and wellness through systemic and clinical approaches. Among a myriad of services and resources, the Tubman Center provides culturally appropriate clinical services and social services, while also leading policy and DGYRFDF\ ZRUN WR DGGUHVV KHDOWK LQMXVWLFH ,Q WKH 7XEPDQ &HQWHU Z whole family, expanding current operations beyond the Freedom Clinic school-based health center. The Freedom Clinic serves students through a whole child health approach that provides primary care, holistic preventive care and advocacy work.

Massachusetts, North Carolina and Washington serve as key examples of how states can implement the key elements of whole child health. Though each state implemented its own unique model, the case studies illuminate a common set of “facilitators” — circumstances that allowed the model to succeed, and “barriers” — circumstances that made implementation more challenging. The following section of this report outlines key facilitators and common barriers to whole child health model implementation. Finally, the report concludes with a set of policy recommendations to advance the implementation of whole child health approaches across the country.

Facilitators

$FURVV WKH WKUHH VWDWHV SURÀOHG FHUWDLQ IDFWRUV KHOSHG IRVWHU D SRVLWLYH whole child health reforms. Key factors gleaned from interviews included the importance of the following:

- Leveraging federal policy levers. Each state has leveraged underlying EPSDT authority to provide VFUHHQLQJ DQG SUHYHQWLYH VHUYLFHV LQ DGGLWLRQ WR RWKHU GHPRQVWUDO DXW (e.g., 1115 waivers, SIM awards, InCK awards, etc.). These core funds and policy levers help to catalyze and create an environment to sustain whole child health approaches.

The above examples highlight the important role federal and state policy plays in creating a supportive context for child health transformation efforts. The following recommendations, informed by these case studies and the prior work by Nemours Children's Health and the Alliance, could support state and provider readiness to adopt, spread and sustain whole child health approaches in additional jurisdictions. Note that all the policy recommendations below would apply to children and youth age newborn to 21. [8] If enacted, the recommendations would help spread existing best practices and provide incentives to further catalyze design and testing of whole child health approaches rooted in primary care transformation. [9]

Federal Executive Branch

Centers for Medicare and Medicaid Services (CMS)

- CMS, through CMMI and CMCS, could establish w prevention (mental health n add1)]TJ Etivinfrablish wructur5 (v)3csuppoli (olish10 (tshar5 (v)3ck)
  demonstration models that address upstream factors through prevention (omoties)1g4.9 (tims s(CM)30alth i.th prMassach[<0057004B0048005600
  prevention, health promotion and c.1 (omoti.th pr)2igrtifact ce Case Saremendatio

Other Executive Branch Opportunities

- The White House could develop cross-governmental coordinating entities that prioritize equity and whole child health. Options include:
  - Creating a :KLWH+RXVH2²FHRI&KLOGUHQDQG<RXWK, a Children's Cabinet and related guidance, with a focus on equity and whole child health. This entity should center health equity as directed by the Executive Order on Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government.
  - Building on the National Academies of Sciences, Engineering and Medicine's recent recommendations to establish an entity within the federal government charged with improving racial, ethnic and tribal equity across the federal government.[11] If established, this new entity should include a focus on children and youth.
- The White House could continue its leadership in addressing racial inequities in health, with an additional focus and emphasis on children.
- 7KH 2I²FH RI 0DQDJHPHQW DQG %XGJHW FRXOG LVVXH JXLGDQFH WR FODULI\ KR legally braid and blend funds from separate programs that serve a similar population or need.
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2XU QDWLRQ¬V LQYHVWPHQW LQ FKLOGUHQ UH³HFWV RXU FRPPRQ YDOXHV DQG RXU approaches health care transformation, the predominant focus remains on the adult population, where there are greater opportunities for short-term savings, but fewer opportunities for long-term impact on health and well-being.

The advancement of whole child health approaches has great potential to improve child health outcomes and reduce health disparities. To do so, the federal government, states, localities and health systems should incorporate the key elements of whole child.

A shifting mindset in pediatric payment and delivery reform needs to be coupled with adequate investment, training, workforce development and incentives. Federal and state programs can be important catalysts for sustainable change. Powered by strong multisector collaborations and leveraging federal and state Medicaid policy mechanisms and philanthropic funding, North Carolina, Massachusetts and Washington are among the early adopters of many of the core elements of whole child health approaches. The federal government, states, providers, and payers can learn from their approaches and continue to innovate in support of the healthiest generations of children.