



# Addressing Social Drivers through Pediatric Value-Based Care Models:

Recommendations for Policymakers and Key Stakeholders



**TABLE OF CONTENTS**

Introduction.....	4
Overarching Policy and Practice Barriers and Accelerators.....	5
Recommendations to Catalyze and Sustain Integrated Pediatric Models that Address Social Drivers.....	6
Building Block #1: Multi-Sector Partnerships with Shared Goals and Metrics and Financial Alignment across Sectors..	6
State and Federal Policy Recommendations to Enhance Alignment across Sectors.....	7
Building Block #2: Alternative Payment and Delivery Models that Address Social Drivers.....	7
State and Federal Policy Recommendations to Catalyze Pediatric Value-Based Care.....	9
Building Block #3: Cross-Sector Data Infrastructure.....	9
State and Federal Policy Recommendations to Promote Cross-Sector Data Sharing.....	10
Building Block #4: Workforce Redesign.....	11
State and Federal Policy Recommendations to Promote Workforce Redesign.....	12
Building Block #5: Patient and Community Engagement.....	12
State and Federal Policy Recommendations to Promote Patient and Community Engagement.....	13
Cross-Cutting Element: Health Equity.....	14
State and Federal Policy Recommendations.....	15
Conclusion.....	15

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## INTRODUCTION

This is the second in a two-part series that highlights existing and recommended policies and practices that communities, states, funders, payers, providers, and the federal government could adopt to accelerate the move toward integrated pediatric value-based payment models that address social determinants of health (SDOH) with a focus on Medicaid and the Children’s Health Insurance Program (CHIP). It builds on the framework of essential building blocks presented in Brief 1 that create a supportive context for transformation. This brief was informed by interviews with thought leaders (see Appendix of Brief 1); input provided in conjunction with a convening hosted by Nemours Children’s Health System and the Duke-Margolis Center for Health Policy (see Appendix); and themes emerging from a two-year [Collaborative on Accountable Communities for Health for Children and Families](#). The authors of this brief have synthesized the feedback, and the recommendations presented represent the authors’ views.

This brief identifies accelerators, barriers, and recommendations to promote transformative value-based care for children, including addressing SDOH and health disparities. The recommendations highlight existing policies and best practices that communities, states, providers and payers are currently doing that others could adopt, and additional polices that could further catalyze and sustain transformation.



## OVERARCHING POLICY AND PRACTICE BARRIERS AND ACCELERATORS

Policymakers, providers, payers, and communities face barriers to implementing and sustaining pediatric value-based payment (VBP) models that holistically address social determinants of health. Among the **barriers** are:

- Pediatric payment models that reinforce a focus on treatment instead of paying for health
- Under-resourcing and capacity challenges across sectors and providers
- “Wrong pocket” issues where investments from one sector create savings and benefits in another
- A lack of specialized approaches and intentional focus on child and family wellbeing among some states, communities, payers, and providers
- Lengthy time horizon for return on investment for pediatric care models
- Uncertainty about the future direction of health care/value-based care
- Lack of standard use of measures and metrics that are inclusive of holistic child health and SDOH
- Limited evidence demonstrating the feasibility, utility, and benefit of bringing evidence-based and efficacious care models to scale and impact.

Early innovators have begun to address these challenges, catalyzed by the following **accelerators**:

- High-level community, provider, and state leadership focused on the health of children and families, including strong relationships among the health, education, and child care sectors
- Metrics development from a multi-generational, holistic perspective that can drive practice change
- Engaged, cohesive child advocacy community with aligned, cross-sector strategies and investments
- State laws, funding, and contract provisions that prioritize child health and address SDOH
- Sharing of best practices, including through formal structures such as learning collaboratives
- Section 1115 Medicaid waivers and Center for Medicare and Medicaid Innovation (CMMI) models, especially State Innovation Model, Accountable Health Community model, and Integrated Care for Kids
- Foundation and other funding, including pooled investments, for pediatric practice transformation that advances exemplary practice and delivers enhanced primary, preventive, and developmental promotion services.



## RECOMMENDATIONS TO CATALYZE AND SUSTAIN INTEGRATED PEDIATRIC MODELS THAT ADDRESS SOCIAL DRIVERS

The recommendations presented below help address the barriers and promote the accelerators listed above. Given the complexity of the issues, they go into more depth for the alignment and value-based payment sections. They are organized through a framework of building blocks that create a supportive context for transformation. Please see Issue Brief 1 for further explanation and examples from each building block.

### Building Block #1: Multi-Sector Partnerships with Shared Goals and Metrics and Financial Alignment across Sectors

Multi-sector partnerships with aligned goals, metrics, and investments are essential to the establishment of integrated, pediatric value-based payment models that address social determinants of health. Barriers to achieving that alignment include competition among groups for limited resources, lack of trust and shared experience among partners, “wrong pocket” issues, and the fear that blending and braiding of funds will result in underfunding of other priorities or a violation of federal auditing rules. To address these barriers, communities and states have pursued the following strategies.

Best Practices from Providers, Payers, and Multi-Sector Community Stakeholders	Current Policies that More States Could Adopt
<ul style="list-style-type: none"> <li>• By leveraging foundation, private, and governmental funds, communities, payers, providers, businesses, and multi-sector partners can jointly invest in place-based and other targeted initiatives and align financial incentives and metrics, including leveraging community benefit dollars and braiding and blending funds to support child health.</li> <li>• Child health advocates can collaborate to provide policymakers with jointly endorsed, evidence-informed policy solutions and a shared vision to advance child health transformation.</li> <li>• Funders and policymakers can evaluate the impact of state-level coordinating entities/governance structures focused on children and families.</li> </ul>	<ul style="list-style-type: none"> <li>• States can make targeted investments in addressing SDOH through building up the capacity of community organizations, establishing formalized cross-sector collaborations, and supporting integrator entities (e.g. Washington’s Accountable Communities for Health, New Jersey’s Health Hubs).</li> <li>• States can work with partners, including payers and providers, to agree on common metrics (e.g. Washington’s common measure set) and outcomes across programs that serve a similar population through a single contract (e.g. Vermont’s Integrating Family Services Initiative).</li> <li>• Governors can explore coordinating structures that focus on child and family health and developmental issues to advance joint goals and address “wrong pocket” issues (e.g. Children’s/Family Cabinets in Delaware and Maryland, Arizona’s housing and homelessness program).</li> </ul>

## State and Federal Policy Recommendations to Enhance Alignment across Sectors

- The federal government and states should invest in children as a core value and should focus on long-term impact on child and family wellbeing and cost, including short-term indicators of long-term return on investment (ROI).
- The federal government should encourage, support, and incentivize states to create a dedicated, pooled source of funding for children (e.g. [wellness funds](#), children's budgets, First Five Years Fund). This could include required contributions from payers, health systems, and businesses, pooled with state funds, philanthropy, etc., and supported by [integrators](#), which are entities that play a convening role across sectors to achieve a common purpose for a geographic area.
- The federal government, states, and localities should structure coordinating bodies (e.g. Children's Cabinets) that can test approaches to identifying sources of funding with similar goals and populations, and which might then be blended or braided. This could include identifying shared metrics and outcomes across programs that could be used in child-focused joint funding announcements across agencies.
- The White House, governors, and federal and state cabinet secretaries should set an expectation for cross-departmental collaboration and work with key partners such as the Centers for Medicare and Medicaid Services (CMS), the Administration for Children and Families, the Department of Education, the National Quality Forum, and other key stakeholder entities to identify a core set of shared metrics on SDOH for children and families.
- The Office of Management and Budget should provide guidance on what is permissible regarding blending and braiding of funds from separate programs serving a similar population or need.

## Building Block #2: Alternative Payment and Delivery Models that Address Social Drivers

Transformed child health delivery models, supported by aligned payment models, include a holistic focus on addressing the health, wellbeing, and development of the child and family. Efficacious models that address social factors and relational health are critical to optimizing a child's development and wellbeing. More widespread adoption of these models would require financing that enables and incentivizes providers to work with partners to become high-performing health neighborhoods. Barriers to implementing transformative delivery and aligned payment models persist, including payer and provider reticence to fully commit to pediatric alternative payment models (APMs) that do not offer the same potential for cost savings as APMs that include high-cost adults; lack of experience with pediatric value-based care; and lack of standardized metrics across payers, making it difficult for providers to align with various requirements. However, through incentives and requirements, policymakers can help catalyze transformative models that address social and relational health.

Best Practices from Providers, Payers, and Multi-Sector Community Stakeholders	Current Policies that More States Could Adopt
<ul style="list-style-type: none"> <li>• Community integrator entities (e.g. health departments, nonprofits, health systems, community hubs, etc.) can help to organize providers, including small and large pediatric primary care practices, to test payment models that align with a focus on child health practice transformation that moves them from disease-oriented care to more holistic care; leveraging innovative and evidence-informed models such as Help Me Grow, Healthy Steps, Project DULCE, and home visiting.</li> <li>• Providers, payers, and community partners can pursue a multi-payer approach to the design of APMs, selection of SDOH screening questions, and aligned delivery models that address physical and behavioral health as well as social factors.</li> <li>• Core clinical quality measures can be refined to integrate strengths, family- and wellbeing-oriented measures, which will necessitate incorporation of child- and family-reported data.</li> </ul>	<ul style="list-style-type: none"> <li>• Through contracts with managed care organizations (MCOs) or legislation, states can: 1) require a certain percentage of contracts to be VBPs (e.g. New York); 2) require MCOs to invest in the community (e.g. Arizona); 3) require MCOs to use measures relevant to children and pregnant women in any model/contract where those populations are included (e.g. New York and Oregon); 4) offer incentives for MCOs to meet quality targets/metrics related to SDOH and kindergarten readiness (e.g. Oregon developed a kindergarten readiness metric and is developing a SDOH screening metric); 5) require MCOs and Accountable Care Organizations (ACOs) to screen for SDOH (e.g. Massachusetts) with appropriate referral and follow-up; and 6) consider SDOH risk adjustment (e.g. Minnesota, Massachusetts).</li> <li>• In the Medicaid and CHIP context, states can encourage or require in lieu of services, value-add services, and counting the investment in community resources in the numerator of the Medical Loss Ratio calculation, as North Carolina is planning to do.</li> </ul>





## State and Federal Policy Recommendations to Catalyze Pediatric Value-Based Care

- The Centers for Medicare and Medicaid Services should provide clarity, planning support, and funding and should disseminate best practices to states. This could include issuing and updating guidance on addressing social determinants of health in Medicaid and CHIP, including how to support integrator functions within an APM; disseminating model Medicaid State Plan Amendments and waivers; and providing technical assistance on contracting and innovative financing mechanisms to address SDOH interventions and infrastructure. Each of these actions should specifically include strategies related to the pediatric population and parent–child dyads.
- The Center for Medicaid and CHIP Services should develop two-generation demonstration models that focus on children, families, and SDOH, including infrastructure support and provider training on whole-child care models, and should mandate the use of two-generation health measures (e.g. maternal depression screening at pediatric well visit) in the demonstrations.
- The Center for Medicare and Medicaid Innovation should support additional models beyond Integrated Care for Kids (InCK) focused on the pediatric population to advance development of high-performing health neighborhoods for children with Medicaid or CHIP coverage. This could include adapting existing models like Primary Care First or Comprehensive Primary Care+ for children and ensuring inclusion of pediatric-specific measures and practice transformation components.
- States should fully leverage existing Medicaid authority available under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and CHIP Health Services Initiatives and disseminate best practices to spread and scale what works. This includes:
  - Leveraging the EPSDT benefit to finance care coordination and cross-sector supports for children/families with unaddressed social needs
  - Leveraging the EPSDT benefit to finance two-generation strategies that strengthen relational health, bonding, and attachment with parents/caregivers.

## Building Block #3: Cross-Sector Data Infrastructure

Access to individualized health, education, and social services data can help to create a more complete picture of a child’s health, support an integrated care team, and facilitate the provision of services to the child and family. Currently, there are real and perceived data-sharing restrictions resulting from federal laws such as the Health Insurance Portability and Accountability Act and the Family Educational Rights and Privacy Act. Beyond privacy limitations, communities face challenges related to limited resources, limited access to care coordination technology, limited training and infrastructure of social service providers to participate in cross-sector data-sharing platforms, lack of uniform SDOH screeners, as well as the existence of multiple closed-loop referral systems in a geographic area. Despite these barriers, states have made progress in implementing cross-sector data-sharing.

Best Practices from Providers, Payers, and Multi-Sector Community Stakeholders	Current Policies that More States Could Adopt
<ul style="list-style-type: none"> <li>• Stakeholders in a state or community can come together to jointly invest in a common resource platform/closed-loop technology system.</li> <li>• Communities can share tools and templates that enable cross-sector data sharing; providers and schools can leverage lessons from early innovators who have used these tools to share data among the education and health sectors.</li> <li>• Funders and payers can evaluate the impact of cross-sector data systems on child health outcomes and equity.</li> </ul>	<ul style="list-style-type: none"> <li>• States can pursue public–private partnerships to fund closed-loop technology systems that enable cross-sector data-sharing, including potentially leveraging Medicaid funds to support licensing fees (e.g. North Carolina &amp; New York) and/or including requirements in contracts with MCOs to utilize a common cross-sector resource platform across the state (e.g. North Carolina’s <a href="#">NCCARE 360</a>).</li> <li>• States can consider requirements in contracts with MCOs to utilize a common cross-sector resource platform across the state (e.g. North Carolina’s NCCARE 360).</li> <li>• States can adequately resource data collection and analysis from closed-loop systems to identify community needs and service gaps in order to inform policy and program design, including evaluating impact on health equity.</li> </ul>

## State and Federal Policy Recommendations to Promote Cross-Sector Data Sharing

- States should invest in helping schools and early care and education programs (e.g. preschools, child care, Head Start) operate on shared resource platforms, such as a closed-loop community care coordination system to promote child health and wellbeing efficiently.
- States and payers should invest in linking data across generations, starting with parent/caregiver–child dyads, including the ability to connect electronic medical records between a parent/caregiver and young child (with appropriate legal and privacy safeguards).
- The federal government should consider building upon recent interoperability and patient access rules to include standardized data on social drivers of health (e.g., food insecurity, housing instability).
- The federal government should establish an interdepartmental/interagency task force to provide guidance on federal privacy laws to promote robust exchange of data consistent with such laws.

## Building Block #4: Workforce Redesign

As clinical and community-based care models evolve, providers, payers, and communities must ensure that the workforce is also evolving, both in terms of the makeup of the workforce to ensure diverse representation from the community served, as well as the types of roles included. These roles range from navigators who assist children and families with addressing individual clinical and social needs, to integrators who build and sustain cross-sector partnerships to address upstream needs for the community. Current challenges include an unaddressed need for training programs to support these new roles (including community-based pipeline programs), as well as the fact that provider culture change can take time and be met with resistance.

Best Practices from Providers, Payers, and Multi-Sector Community Stakeholders	Current Policies that More States Could Adopt
<ul style="list-style-type: none"> <li>• Providers, payers, health systems, and communities can develop and implement comprehensive workforce redesign strategies and certification programs with multiple pathways to recruit and train a diverse workforce, including growing their own workforce from the community (including local schools), investing in internal training to create new opportunities for existing staff, and growing others' workforces through cross-sector training.</li> <li>• To address individual and community-level SDOH, providers and payers can ensure that training, practice transformation, and quality improvement incorporate an integrated workforce, including patients/families, providers, navigators, and integrators who coordinate policy and systems approaches.</li> <li>• Community colleges can offer courses to build the skills of a diverse care coordination workforce, including allied health professionals, ensuring that the workforce is skilled in addressing social and health needs.</li> </ul>	<ul style="list-style-type: none"> <li>• States can design two-generation workforce strategies and ensure training in the needs of the child and parent/caregiver (e.g. family-focused models to mitigate child abuse and domestic violence).</li> <li>• States can ensure equity training, cultural competency training, and diverse representation among their workforce (e.g Oregon's contractual requirements for Coordinated Care Organizations to provide and incorporate cultural responsiveness and implicit bias continuing education and training).</li> <li>• States can adopt certifications that recognize community health workers, peer navigators, and peer support to coordinate services across sectors (e.g. Massachusetts, Texas, and Pennsylvania).</li> </ul>

## State and Federal Policy Recommendations to Promote Workforce Redesign

- The federal government should consider authorizing and funding a program that trains a workforce to address patients' social needs and to help patients better understand and navigate the health care system (e.g. “Navigators for America”).
- Federal and state governments should prioritize funding for technical assistance and quality improvement to support provider culture change that more holistically addresses child and family health (e.g. how to support practice transformation and care model design for the family unit). This should include identifying currently available funding that could be used for technical assistance and seeking additional funding to address gaps.
- States should invest in cross-sector workforce development and develop an overarching roadmap using an equity framework with active engagement from families and communities.

## Building Block #5: Patient and Community Engagement

Engaging patients, families, and community residents is a critical foundational element to a sustainable value-based care model that addresses social determinants of health. Patients and communities provide unique insights into lived experiences that are important to consider in developing sustainable VBP models. Such engagement requires powerful stakeholders to cede some power, and it requires support (technical and financial) to promote meaningful participation among patients, families, and community residents. To address these challenges, policymakers and communities can pursue the following.



Best Practices from Providers, Payers, and Multi-Sector Community Stakeholders	Current Policies that More States Could Adopt
<ul style="list-style-type: none"> <li>• MCOs, providers, and other payers can ensure diverse, multi-sector community and resident representation on their boards and governing structures, including integration of their perspectives into data systems in real time as decision-making members.</li> <li>• Decision-making entities can define governance structures to ensure collaborative and equitable decision-making procedures and refine them as needed to meet the needs of stakeholders. Clear and distinct governance procedures are essential to ensuring appropriate oversight, resource allocation, and approach to achieving desired outcomes.</li> <li>• Funders can require that communities co-design grants, programs, care models, and metrics with community residents and families, and engage various sectors in shared problem-solving and decision-making.</li> <li>• Communities can focus on promoting social connectivity and reducing isolation.</li> <li>• Organizations can utilize various modalities to reach and engage a diverse, broad audience.</li> </ul>	<ul style="list-style-type: none"> <li>• States can identify and work with partners to disseminate best practices for engaging community residents such as having evening meetings with transportation and child care available for attendees and their children (e.g. Oregon’s best practices guide and Virginia’s Medicaid patient advisory boards).</li> <li>• States can convene Community Advisory Councils that review and comment on any patient-facing materials to increase inclusivity and engagement (e.g. New York).</li> <li>• States can require Medicaid health plans to convene Consumer Advisory Boards (e.g. California, Oregon).</li> </ul>

## State and Federal Policy Recommendations to Promote Patient and Community Engagement

- Federal and state governments should require meaningful engagement of families in the design and implementation of value-based care models. Federal and state governments should consult with community leaders in designing these requirements and ensure accountability once the requirements are implemented.
- Federal and state governments should make data dashboards transparent and publicly available to communities, following the lead of communities on what metrics should be included.
- State governments should identify the appropriate level of engagement on the continuum (consultation, involvement, or partnership/shared leadership) for each initiative to facilitate effective policy.

## CROSS-CUTTING ELEMENT: HEALTH EQUITY

Making progress towards health equity, defined as achieving social justice in health, involves improving the health of those who are economically and socially disadvantaged. Structural racism<sup>1</sup> continues to be a major barrier to achieving health equity. While there is a great need to promote health equity and reduce health disparities through a variety of strategies, including addressing SDOH, many states and communities are still in the nascent stages of developing a comprehensive approach. Focused efforts to engage and amplify the voices of community residents, to identify the strengths and assets in communities, and target resources and metrics to directly address equity are emerging strategies. It is critical that value-based care efforts intentionally promote equity and avoid posing additional risk to communities facing inequities.

Best Practices from Providers, Payers, and Multi-Sector Community Stakeholders	Current Policies that More States Could Adopt
<ul style="list-style-type: none"> <li>• All stakeholders can approach health equity through the lens of promoting dignity for children and families while ensuring that they have a voice at the table to 1) inform the strategies and approaches to address the social factors impacting their health; and 2) identify systems and processes that could have unintended consequences on exacerbating disparities.</li> <li>• Communities can frame their collective efforts around family and community assets and protective factors instead of deficits.</li> <li>• Providers, MCOs, and other payers can invest in training on equity and cultural competency and leverage learnings from health equity impact statements to guide their models.</li> <li>• Health systems and payers can ensure that their payment models take into account risk adjustment for populations experiencing inequities and multiple vulnerability factors (e.g. poverty, disability); and use metrics that assess the impact of the model on accelerating reductions in health inequities.</li> </ul>	<ul style="list-style-type: none"> <li>• States can make targeted investments and initiatives focused on equity (e.g. Rhode Island’s Health Equity Zones).</li> <li>• States can ensure that equity is a driver for pediatric quality and measurement (e.g. Connecticut’s Health Enhancement Communities as a key element of the State Innovation Model).</li> <li>• States can require that MCOs and Coordinated Care Organizations invest in equity (e.g. Oregon).</li> </ul>

<sup>1</sup> Structural racism is a “system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call ‘race’) that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources.” <https://pediatrics.aappublications.org/content/144/2/e20191765>

## State and Federal Policy Recommendations to Promote Equity

- The federal government and states should prioritize resources for promoting equity and address equity in APMs (e.g. financial incentives or risk adjustment for serving high-need populations).
- To avoid unintended widening of disparities that could result from the testing of value-based models, states should incentivize achieving health equity, including setting metrics and benchmarks by race/ethnicity and socioeconomic status on top of required metrics in contracts that explicitly measure equity.

## CONCLUSION

Assuring optimal health, development, and wellbeing for all children will necessitate sustained commitment, investment, and creativity from providers, payers, community-based partners, policymakers, the private sector, philanthropy, and community residents. The strategies and emerging best practices identified in this brief help to highlight early lessons that can inform comprehensive, integrated models.

The strategy to adopt these recommendations should be informed by each community's state and local context and should build on existing community assets. Incremental steps made across these areas can lead to meaningful impact, and evaluating short, intermediate, and long-term results and outcomes along the way will help yield important insights. Federal and state policymakers should consider ways to make progress in advancing the recommendations presented to help catalyze and sustain progress; and move from the current stage of early innovation to spreading and scaling transformative models that improve child health and wellbeing.

