

Whole Child Health Alliance

Key Elements

Introduction

The Whole Child Health Alliance (the “Alliance”) seeks to accelerate the adoption of whole child health delivery models supported by sustainable financing models. Whole child health models engage multisector partners to support the developmental, physical, mental, behavioral, and social needs of children and youth, and foster healthy relationships with caregivers, through individual, family-based and community-level approaches. Key partners include child health providers, payers, community-based organizations, families and other child-serving organizations such as schools. This document describes key elements of the whole child health models the Alliance will advance.

Taken together, the key elements represent essential components of holistic, family-centered child health approaches that support optimal health, development and well-being. They expand upon, but do not duplicate, existing work by other organizations (see Appendix). The Alliance will utilize this document to concretely assess whole child health models and policy proposals. In addition, the Alliance will expand upon the key elements with companion documents that lay out specific opportunities for action by policymakers.

Need for Whole Child Health Models

Not all children are thriving. The COVID-19 pandemic exacerbated many health conditions, including mental, emotional and behavioral health issues, as well as straining the social and economic conditions in which children live and grow. While the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit offers comprehensive coverage for the nearly 27 million children with Medicaid coverage, there is great unrealized opportunity for states to maximize the full potential of this benefit. In addition, many health, early intervention, social, child welfare, nutritional and other programs serving children and families are not optimally coordinated. Opportunities for early intervention are missed, and predominant reimbursement models do not incentivize integrated care that focuses on prevention and health promotion.

Key Elements

Whole child health models the Alliance advances should seek to incorporate the following elements to the degree possible and move the health care system along the value-based payment continuum over time.¹

Promoting Health Equity

Whole child health models should promote health equity and reduce health disparities.² The models should focus on improving outcomes for historically marginalized populations who disproportionately experience suboptimal health outcomes and processes of care. This could be done in [various ways](#) and should improve access to culturally responsive health care. Key strategies could include those listed below.

- Implement approaches explicitly designed to address health disparities and advance health equity.
- Invest in clinical workforce training focused on promoting access to equitable care. (*See Diverse, Multi-disciplinary Workforce section below*).
- Structure financial models to explicitly invest in and measure performance on equity. (*See Financing Models section below*).
- Advance the concept of [targeted universalism](#) in which approaches have overarching or population-based goals but include targeted processes to achieve those goals.
- Require data to be collected in such a way that equity issues can be studied (e.g., ensuring that key sociodemographic characteristics of patients and families are captured within the electronic health record and used to conduct stratified subgroup analyses to identify disparities consistent with findings from the research literature, incorporating indicators of socioeconomic deprivation across community or geographical regions as potential health related exposures).
- Encourage a role for families and community in decisions regarding the data collection methodology, including what data is collected and how it is used.
- Require rigorous assessment across sociodemographic characteristics to determine whether an algorithm or a source of data is appropriately redirecting investments towards populations with greatest need.

¹ The term “value-based continuum” refers to the [2017 Alternative Payment Model Framework](#) published by the Health Care Payment & Learning Action Network. As described in this document, the Alliance will support and develop models that transition away from fee-for-service payments (Category One) and toward population-based payment models (Category Four) centered around value over the long-term.

² In general, health disparities are unjust differences in health outcomes that are closely linked with economic, social or environmental inequities that tend to adversely affect historically marginalized groups disproportionately.

- Encourage whole child health models to pilot, as feasible, the use of standardized measures consistent with equity principles and best practices to assess equity as part of the outcome measures used in value-based contracts.
- Use measures such as the [Centers for Disease Control and Prevention's Agency for Toxic Substances and Disease Registry's Social Vulnerability Index](#), the [Area Deprivation Index](#), neighborhood poverty measures, or other indicators of community resources and concentrated disadvantage to identify and prioritize investments at a community as well as individual level.

Integrating Care Delivery and Social Supports

Whole child health models incorporate integrated delivery models of clinical care and social services that address various [social drivers of health](#) in addition to the developmental needs of children and their relationships with caregivers. Whole child health models should include the following features to promote strong multi-sector partnerships centered in families.

- Promote children's optimal health, development, and well-being by fully leveraging existing state authorities and enhancing investments in evidence-based programs rooted in primary care. This includes:
 - Sustaining and building upon Medicaid's Early and Periodic Screening, Diagnostic, and Treatment benefit, which finances prevention, early intervention, and treatment services for physical, mental, dental, and other health related needs.
 - Utilizing comprehensive clinical pathways and workflows that support care across the continuum for all children, regardless of medical complexity or social determinant of health (SDoH) factors, by building upon the guidelines established for patient-centered medical homes and well-child visits under [Bright Futures](#).
 - Promoting integration of evidence-based programs, such as Reach Out and Read, Medical-Legal Partnership, and HealthySteps, that support children's optimal health and well-being.
- Center efforts in the family, by supporting healthy and positive relationships with caregivers that build on family strengths and adopt multi-generational strategies for addressing social determinants of health. (See *the Centering Families section below*).
- Include diverse, interdisciplinary teams that collaborate effectively to achieve care coordination with closed-loop connections to social, mental and developmental services. This can be achieved, for example, by high-performing medical homes that partner with community-based organizations. (See *Diverse, Multi-disciplinary Workforce section below*).
- Invest in community-level (or other geographic level) interventions to address the needs of the patient population and broader community.

- Employ thoughtful use of stories, technology, data and analytics to better understand the needs of, and improve engagement and partnership with, children and families.
- Support ongoing two-way communication about the patient experience with clinical care and social services to advance process improvement efforts that focus on the child and family at the center of all patient care.

Aligning Care for Families

Families are a fundamental factor in the long-term health and development of children. Stable and nurturing relationships with parents, grandparents, siblings, and other family members provide a foundation for healthy development across [a variety of areas](#), including brain architecture. The health of [mothers](#) and [fathers](#), even prior to pregnancy, has a significant impact on child health. In addition, [two- or multi-generational approaches](#) are often the most effective strategies to promote child health and development. Models should consider the following factors.

- Partner with and be grounded in the lived experience of families to ensure their goals and needs are incorporated.
- Promote co-development of goals and agendas in a way that respects families, patients and community members as equal partners.
- Include parents and other caregivers in disease prevention and health promotion efforts focused on improving child health and development and supporting healthy pregnancies.
- Ensure connections to resources and programs that promote the [economic security](#) of families and address their social needs since families with greater economic security can better ensure the health and well-being of their children.

Fostering Healthy Communities

[Engagement from community members](#) with lived experience, patients, leaders, local organizations, residents, and other stakeholders is critical to building buy-in and ensuring approaches meet local needs. Community members, leaders and organizations should play a key role in the design and development of whole child health models. This includes a role in determining how funds will be used and an ongoing role in governance structures and evaluation.

- Models should provide the financial support to develop and sustain a community-based “backbone” or [integrator](#) organization(s) that can help address social and developmental needs, integrate programs, advance shared goals and optimize funding, for example, by pooling resources from various multi-sector sources.
- Health care, child care, education, public health, community leaders, payers and other sectors should agree on a set of shared goals and cross-sector measures of success. This effort could include criteria to define targeted

populations with key risk factors (e.g., targeting children with chronic absenteeism in families experiencing eviction, focusing upon high social vulnerability neighborhoods and communities, etc.).

- Community partners should reflect the continuum of needs of all children (e.g., children who are well, have unmet or unidentified needs, or experience medical complexity), including partners that might assist with addressing SDoH challenges.
- Models should provide for deep connections between the clinical models and community partnerships via governance, alliances and even technology sharing/data.

Supporting a Diverse, Multi-disciplinary Workforce

Whole child health models should support a diverse workforce with appropriate knowledge, skills, contextual understanding, and ability to establish trusting relationships with those served. This supports provision of culturally and linguistically appropriate services that are accessible, efficient, timely, effective, family-centered and equitable.

- Models should encourage investment, procurement, and hiring from the community, including investing in workforce strategies to increase diversity across disciplines and within positions of leadership. For examples, see the [Healthcare Anchor Network](#), [National Association for Community Health Workers](#), [InCK Marks](#), and [Penn Center for Community Health Workers](#).
- Models should invest in various training opportunities to support whole child health, prioritizing [cross-sector integrative activities](#) and the [non-traditional workforce](#). This includes [family](#) and [youth peer support specialists](#) who can help promote mental, emotional and behavioral health and empower youth and their caregivers to more effectively navigate and engage in services and supports. Training should include strategies to mitigate implicit bias and promote diversity, equity, inclusion and antiracism principles. Additionally, family members and youth should be integrated into decision-making, design, and evaluation processes to ensure resources are responsive to the needs identified by impacted communities.
- Models should recognize the contributions of the community-based workforce through fair and equitable compensation while promoting sustainable financing.

Incentivizing Cross-Sector Data Partnerships

Because whole child health models aim to address clinical, social, and other factors, it is often necessary to facilitate the exchange and integration of data across sectors. Connecting datasets can facilitate continuous improvement and evaluation activities. It can create opportunities to serve children and families more

comprehensively, and reduce burden (e.g., completing forms or applications repeatedly). Cross-sector data partnerships should promote the following features.

- Engage families and community members to ensure their goals are embedded in data systems.
- Include appropriate consent procedures and protection of individual privacy.
- Fund community organizations' capacity to collect, exchange and operationalize data from patients/clients, health information exchanges, and other health partners.
- Invest in population health data and analytics tools, including capacity for predictive analytics and risk stratification.
- Support the development or purchase of closed-loop referral systems.
- Standardize data across stakeholders to ensure monitoring and evaluation of whole child health models can track success and identify areas of opportunity.
- Engage all payers (government and commercial) with full claims transparency and cost modeling to ensure investments have a return on investment.
- Form legal agreements and partnerships with key child-serving sectors such as schools, child care, child welfare, and juvenile justice to enable data exchange, in compliance with various state and federal laws and with clear policies on information sharing.
- Enhance and expand public health data sharing (e.g., vaccines).
- Advance enhanced data infrastructure and policies that allow for systematic data collection and monitoring regarding the burden of unmet social needs within communities (e.g., eviction and housing instability rates, food insecurity, severe unmet housing needs) at a local level to better identify the extent of unmet need in social and human services sectors and the appropriate role for flexible health care funding vs. other investments.

Advancing Financing Reforms that Incentivize Optimal Health

Implementing the integrated delivery models necessary to improve equity and outcomes requires reevaluating the way we pay for care. Current financing models tend to perpetuate inequalities and do not optimally support the care delivery reforms necessary to improve care. Financing models should consider the unique needs and long-term developmental trajectories of children and youth while advancing along the value-based continuum.

Cost savings for pediatric populations generally take longer to accrue than is the case for adults. Savings often are distributed across multiple areas, resulting in the [“wrong pocket” problem](#) whereby investments from one sector accrue benefits across a variety of other sectors. [Few value-based payment models](#) have been implemented for the pediatric population at-large, with many focusing on specific

subsets of high-cost users. Whole child health financing models should promote optimal outcomes for all children, transition away from fee-for-service payments, and move towards population-based payment models centered around value over the long-term.

- Financing models should give providers appropriate flexibility to invest in and sustain activities to improve care, including testing the strategies below.
 - Include upfront cash flow to invest in delivery system changes.
 - Promote investment in safety net providers and enable access to high quality care among historically underserved communities.
 - Create clear financial incentives for the delivery of equitable, person centered, and high-quality care.
 - Provide flexibility to invest in upstream interventions and wraparound services.
 - Reduce administrative burden for families, providers, states and payers.
 - Provide appropriate time to implement necessary delivery and financing reforms.
- The financing approach should include Medicaid, at a minimum, but should strive for multi-payer alignment. If other health care payers are not included, there should be a pathway to include them over time with clear goals and metrics to achieve multi-payer engagement.
- Medicaid financing should include all the children in a state or target geographic area, as opposed to solely focusing on those who have special health care needs or are high risk due to social determinants of health. Interventions should be targeted to appropriately differentiate among these populations.
- To ensure that whole child health delivery models address issues that affect children's families, financing approaches should incorporate, or plan to cultivate, funding sources outside of child health.
- Clinical providers should receive financial incentives for adopting a whole child health approach and, over time, additional risk and reward payments for the improvement of the health status of their attributed patients and/or population health.
- States and community partners should attempt to incorporate costs and benefits of whole child models across sectors, such as health care, education, social services and juvenile justice.
- Financing models should have a graduated path to become financially sustainable in the long run, starting with the identified population in the model.

Assessing Quality Improvement and Performance

Quality assessment and improvement activities aim to measure how well various clinical or social delivery models improve key client or patient outcomes. The influential [Institute of Medicine framework](#) includes six aims: safe, effective, patient-centered, timely, efficient and effective clinical care. In the context of whole child models, these activities should also assess SDoH, health equity and the additional components below.

- Outcome measures should include areas of child wellbeing and development outside of health conditions and medical care. Examples include bonding, secure attachment, early self-regulation, absenteeism, kindergarten readiness, literacy, high school graduation, family safety, stability, and nurturing in the home environment.
- To the extent feasible, models should include at least one outcome or clinical quality indicator measure that spans generations or is applicable across multiple generations in a family, such as parental educational attainment, employment status or depression screening.
- Relative to clinical care delivery, quality measures that address chronic conditions, access to health care and prevention should be foundational. Measures should also consider children with social, familial, or medical complexity across the spectrum of severity. This may include children living with chronic medical conditions, neurodevelopmental challenges, behavioral health conditions, a history of trauma, or home and community vulnerability.
- Models should identify opportunities for screening measures and standardization of assessments in tools while also recognizing some traditional measures can “top out.”
- Measures should address SDoH, assess protective factors, and include patient experience measures linked to provider payment.
- Measures should be weighted sufficiently so providers will have an incentive to address them.

Appendix

Suggested Citation

Whole Child Health Alliance. *Key Elements of Whole Child Health Models*. Updated January 26, 2023. <https://www.nemours.org/content/dam/nemours/nemours-org/en/documents/whole-child-health-alliance-key-elements.pdf>

Foundational Resources

In addition to the resources linked throughout the document, the following resources provided foundational content for the key elements.

- Ascend at the Aspen Institute, BrunerChildEquity LLC, Center for Health Care Strategies, Center for the Study of Social Policy, Georgetown University Center for Children and Families, Johnson Group Consulting Inc, National Institute for Children's Health Quality, ZERO TO THREE. *Opportunities for Medicaid to Transform Pediatric Care for Young Children to Promote Health, Development, and Health Equity*. Consensus statement; September 2019. Accessed November 16, 2022. <https://www.nichq.org/resource/opportunities-medicaid-transform-pediatric-care-young-children-promote-health-development>
- Brooks T, Whitener K. *Leveraging Medicaid to Address Social Determinants and Improve Child and Population Health*. Georgetown University Center for Children & Families; 2018. <https://ccf.georgetown.edu/wp-content/uploads/2018/02/Leveraging-Medicaid.pdf>
- Counts NZ, Roiland RA, Halfon N. Proposing the Ideal Alternative Payment Model for Children. *JAMA Pediatr*. 2021;175(7):669. doi:10.1001/jamapediatrics.2021.0247
- Gratale DJ, Counts NZ, Hogan L, et al. Accountable Communities for Health for Children and Families: Approaches for Catalyzing and Accelerating Success. *NAM Perspectives*. Published January 13, 2020. doi:10.31478/202001b
- Gratale D, Wong C, Hogan L, Chang D, McClellan M. Addressing Social Drivers through Pediatric Value-Based Care Models: Recommendations for Policymakers and Key Stakeholders. Nemours Children's Health. Duke Margolis Center for Health Policy. <https://www.nemours.org/content/dam/nemours/wwwv2/childrens-health-system/documents/nemours-policymakers-stakeholders.pdf>
- Hogan L, Wong C, Gratale D, Chang D, Santanam T, McClellan M. Addressing Social Drivers through Pediatric Value-Based Care Models: Emerging Examples and Promising Approaches. Nemours Children's Health. Duke Margolis Center for Health Policy.

<https://www.nemours.org/content/dam/nemours/wwwv2/childrens-health-system/documents/nemours-emerging-examples.pdf>

- Johnson K, Bruner C. *A Sourcebook on Medicaid's Role in Early Childhood: Advancing High Performing Medical Homes and Improving Lifelong Health*. Child and Family Policy Center; 2018.
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- Johnson K, Bruner C. *Design and Key Operational Components for High Performing Medical Homes for Young Children in Medicaid*. InCK Marks; 2021.
- Mann C, Ferguson M. *Caring for the Whole Child: A New Way to Finance Initiatives to Improve Children's Health*. Manatt, Phelps & Phillips, LLP; 2020.
https://www.manatt.com/Manatt/media/Documents/Articles/RWJF-Manatt-Caring-for-the-Whole-Child-Issue-Brief_12-1-20.pdf
- Roiland R, Counts N, Pereira N, et al. *Alternative Payment Models to Support Child Health & Development: How to Design and Implement New Models*. Duke-Margolis Center for Health Policy; Mental Health America; UCLA Center for Healthier Children, Families, and Communities; 2020.
https://healthpolicy.duke.edu/sites/default/files/2020-06/apms_for_kids_final.pdf

The following resources are examples of principles developed by other organizations.

- *Alternative Payment Model Framework*. Health Care Payment Learning & Action Network; 2017. <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>
- Brundage SC, Shearer C. *Reforming Payment for Children's Long-Term Health*. United Hospital Fund; 2019.
https://uhfnyc.org/media/filer_public/da/51/da519808-cb2c-43e1-afcb-8d626b07d795/uhf-cmwf-childrens-vbp-20190822c.pdf
- Gears H, Casau A, Buck L, Yard R. *Accelerating Child Health Care Transformation: Key Opportunities*. Center for Health Care Strategies; 2021.
https://www.chcs.org/media/Report-Accelerating-Child-Health-Care-Transformation-Key-Opportunities-for-Improving-Pediatric-Care_8.24.21.pdf
- Guiding framework. InCK Marks. Published 2020. Accessed October 21, 2022. <https://www.inckmarks.org/GuidingFramework>
- Guiding principles. National Alliance to impact the Social Determinants of Health. Published 2021. Accessed October 21, 2022. <https://nasdoh.org/about-us/#guiding-principles>
- *Proposed Social Needs and SDOH Principles for CMMI Payment Models*. National Alliance to impact the Social Determinants of Health; 2022.
<https://nasdoh.org/wp-content/uploads/2022/06/NASDOH-Principles-for-CMMI-Payment-Models.pdf>