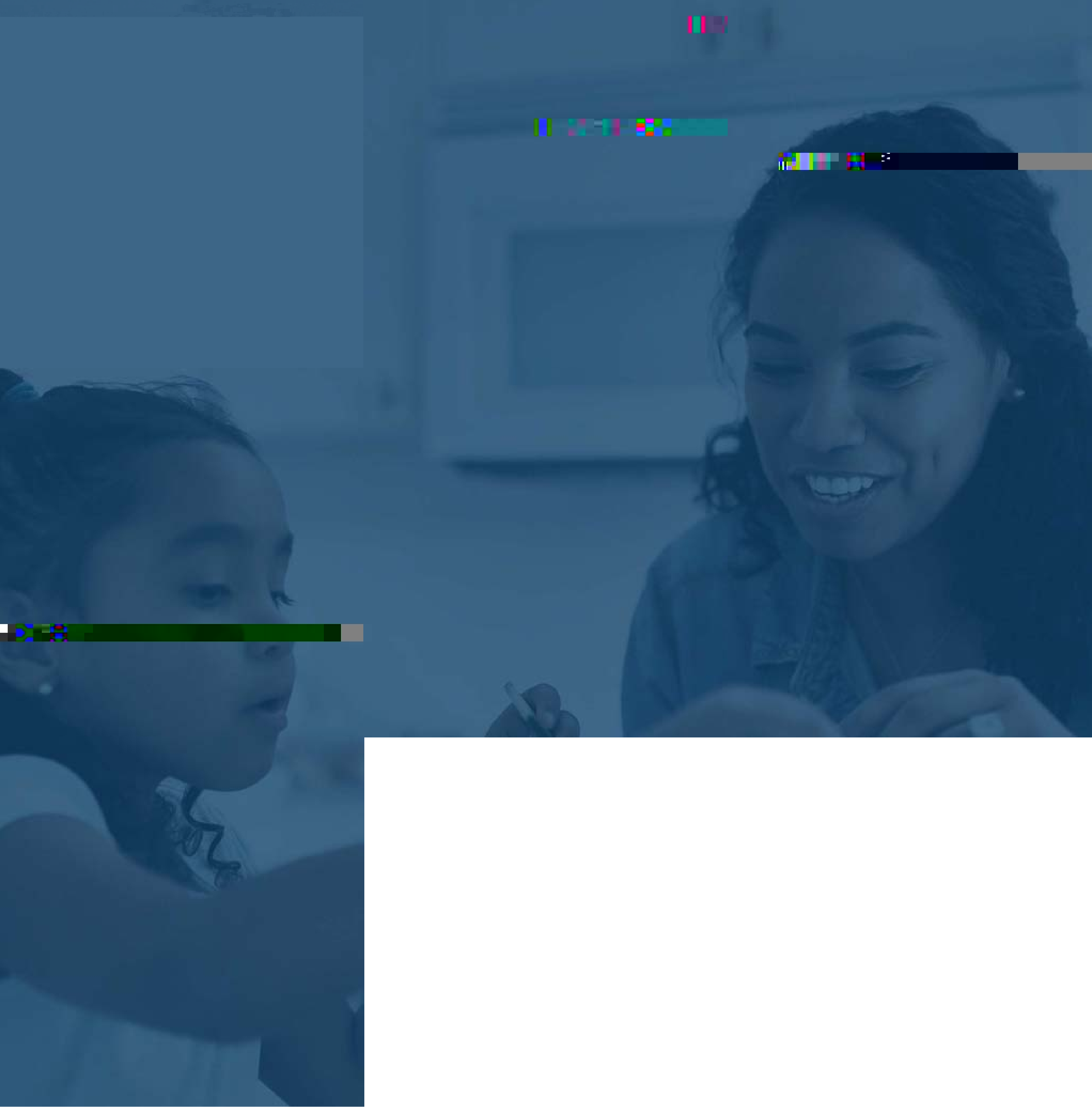
Addressing Social Drivers through Pediatric Value-Based Care Models:

Recommendations for Policymakers and Key Stakeholders



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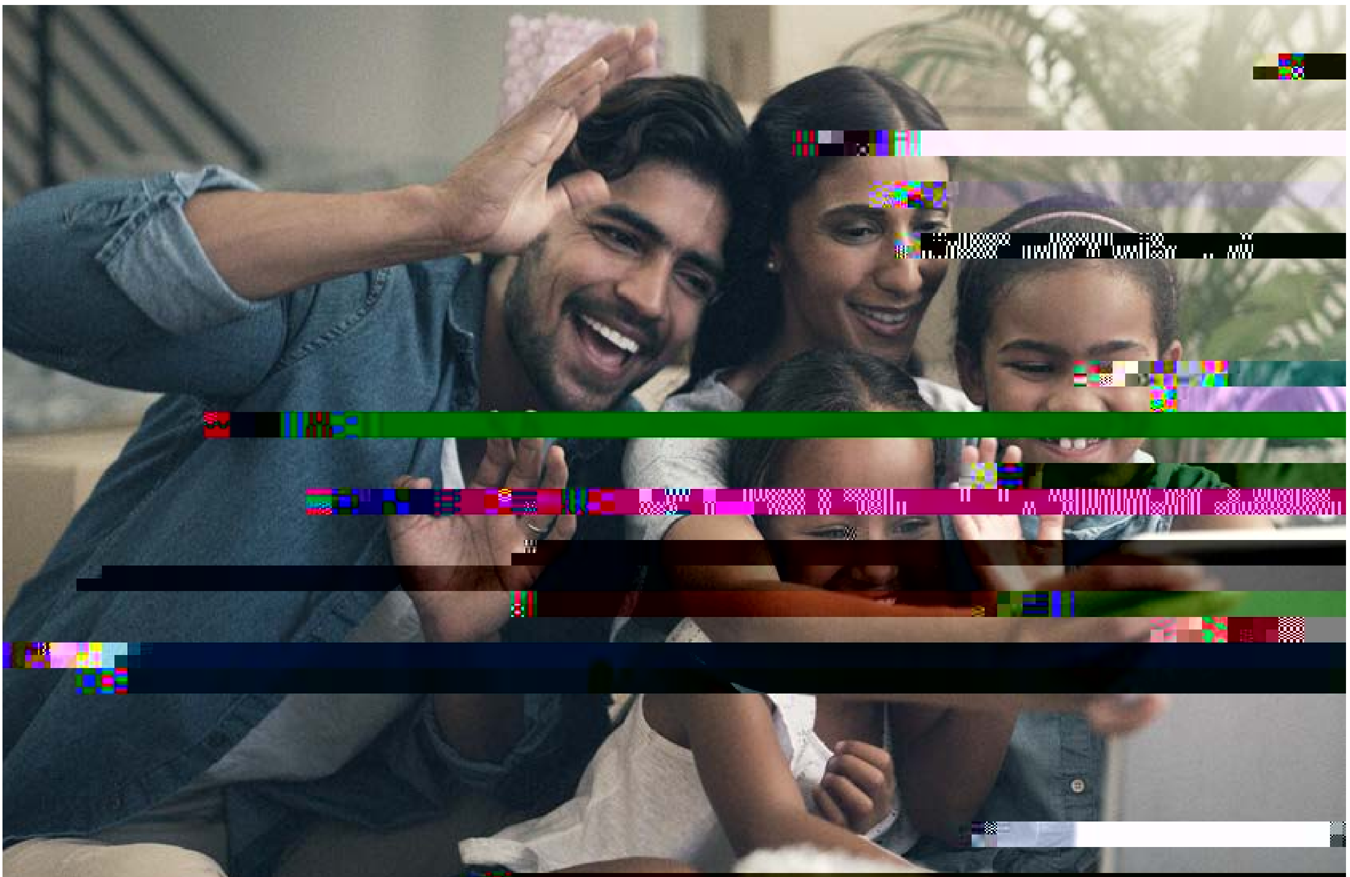
INTRODUCTION

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 identi es 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.



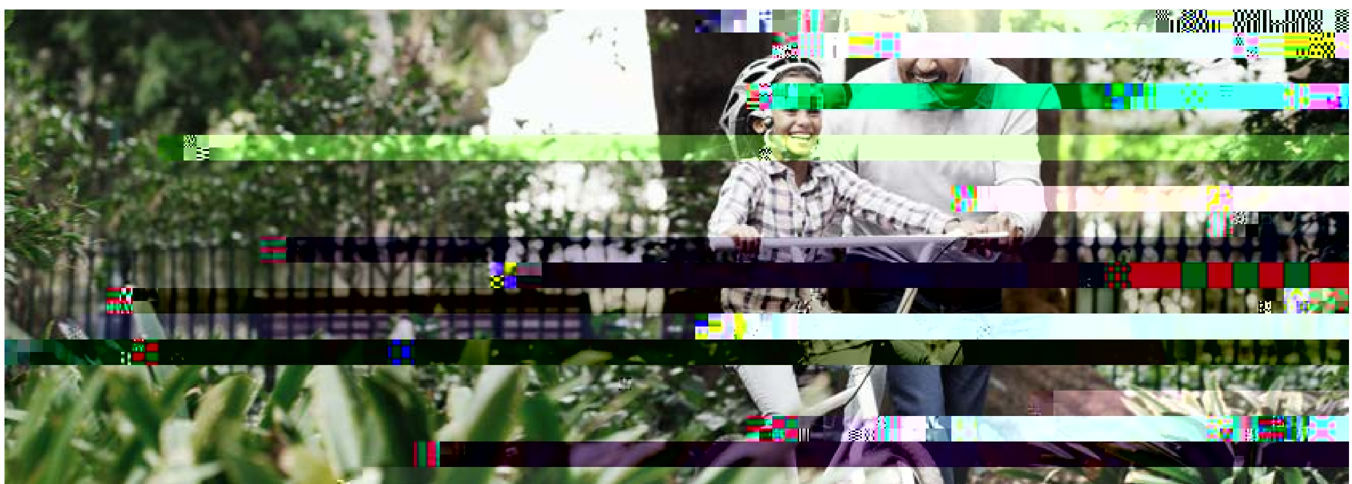
OVERARCHING POLICY AND PRACTICE BARRIERS AND ACCELERATORS

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 bene ts 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 bene t of bringing evidence-based and ef cacious 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.



S a e a d ede a P c Rec e da ha ce A g e ac Sec

- 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 Of ce 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: A e a e Pa e a d De e de ha Add e S c a D e

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. Ef cacious 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 nancing 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 dif cult 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
• Community integrator entities (e.g. health departments, nonpro ts, 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. •	

Building Block #4: f ce Rede g

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
(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
• Providers, payers, health systems, and communities can develop and implement comprehensive workforce redesign strategies and certi cation 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. • 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. • 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.	• 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). • 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). • States can adopt certi cations that recognize community health workers, peer navigators, and peer support to coordinate services across sectors (e.g. Massachusetts, Texas, and Pennsylvania).

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- The federal government should consider authorizing and funding a program that trains a workforce to address patients' technicaovnssiv2to needseek a prddi22onaovding a ptddress patgaps. 0.0-49 6T-26 TD 0225 wwwS5vtosould coninvestnin cross-sectorrk

Best Practices from Providers, Payers, and Multi-Sector Community Stakeholders	Current Policies that More States Could Adopt
• 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. • Decision-making entities can de ne governance structures to ensure collaborative and equitable decision-making procedures and re ne 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. • 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. • Communities can focus on promoting social connectivity and reducing isolation. • Organizations can utilize various modalities to reach and engage a diverse, broad audience.	• 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). • States can convene Community Advisory Councils that review and comment on any patient-facing materials to increase inclusivity and engagement (e.g. New York). • States can require Medicaid health plans to convene Consumer Advisory Boards (e.g. California, Oregon).

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- Federal and state governments should require meaningful engagement of families in the design and implementation of value-based care modelsinclusivi resource l24lansnodels5engagvn fe meani 0 TwJ 0 -1.a fasplans to conven(rnmentsm)]TJ T*[ )]TJ acc6.9

CROSS-CUTTING ELEMENT: HEALTH EQUITY

Making progress towards health equity, de ned as achieving social justice in health, involves improving the health of those who are economically and socially disadvantaged. Structural racism[1] 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
• 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. • Communities can frame their collective efforts around family and community assets and protective factors instead of de cits. • 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. • 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.	• States can make targeted investments and initiatives focused on equity (e.g. Rhode Island's Health Equity Zones). • 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). • States can require that MCOs and Coordinated Care Organizations invest in equity (e.g. Oregon).

[1] 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

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