



# Profiles in Integrated Family Care

Suzanne Brundage, Chad Shearer, Sarah Scaffidi, Lee Partridge

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## Introduction

In March 2019, United Hospital Fund published *Plan and Provider Opportunities to Move Toward Integrated Family Health Care* (see Figure A)<sup>1</sup>. The report described the nascent national phenomenon of child health providers pushing beyond the traditional patient-centered medical home model to pursue a more expansive model of care. Integrated Family Care aims to seamlessly meet the emerging physical health, mental health, and social service needs of families with young children who are at risk for poor outcomes across their lifetime due to significant adversity caused by structural discrimination, including structural racism, poverty, and challenges related to the inequitable distribution of the social and political determinants of health.

Since publication of that report, primary care providers and community-based providers of behavioral health and social services have been tested in unprecedented ways. The COVID-19 pandemic has been financially ruinous to some child and family-serving organizations and traumatic to frontline providers across the spectrum of care. This comes on top of the historical challenges faced by children's primary care and community-based organizations. The pandemic has also exacerbated family poverty, adding to the many other major life disruptions likely responsible for the parent-reported decrease in children's mental and emotional health and increase in child mental health service utilization.<sup>2</sup>

In this moment, it is reasonable to focus on how to protect and maintain the core infrastructure of essential child-serving providers, including the ability of health care to deliver the core components of patient-centered care. And yet, the moment also calls for a new vision of health services. The pandemic has illuminated the many ways in which our siloed systems of care often do not meet the needs of families who are underserved, particularly families of color, especially when faced with a disaster of either national or family-wide scope. The concept of Integrated Family Care is not a panacea for solving these challenges but does represent a possible future direction for health care. Innovators across the country are actively pursuing the model, recognizing even before the pandemic the need for a better model of care for families from underserved communities. This paper highlights five of these innovators.

Each provider featured below is working on a transformation effort of its own making, but all can loosely be organized under the rubric of "Integrated Family Care." We purposefully selected providers working in very different types of settings. **New York City Health+Hospitals** is the nation's largest public health care system, serving over 1.4 million patients a year, with a robust pediatric service network that cares for children in all five New York City boroughs. **Dartmouth-Hitchcock** is a private academic medical center that, while based in Hanover, New Hampshire, supports community-based pediatric sites across the state, including in many rural areas. **AsOne Healthcare IPA** is not a direct service provider, but rather a clinically integrated provider network of like-minded health and social service providers committed to delivering family-focused care together. New York-based **Strong Children Wellness Medical Group** is a new medical group, launched in 2020, using a "reverse integration" model, meaning that health providers would embed primary care services into established

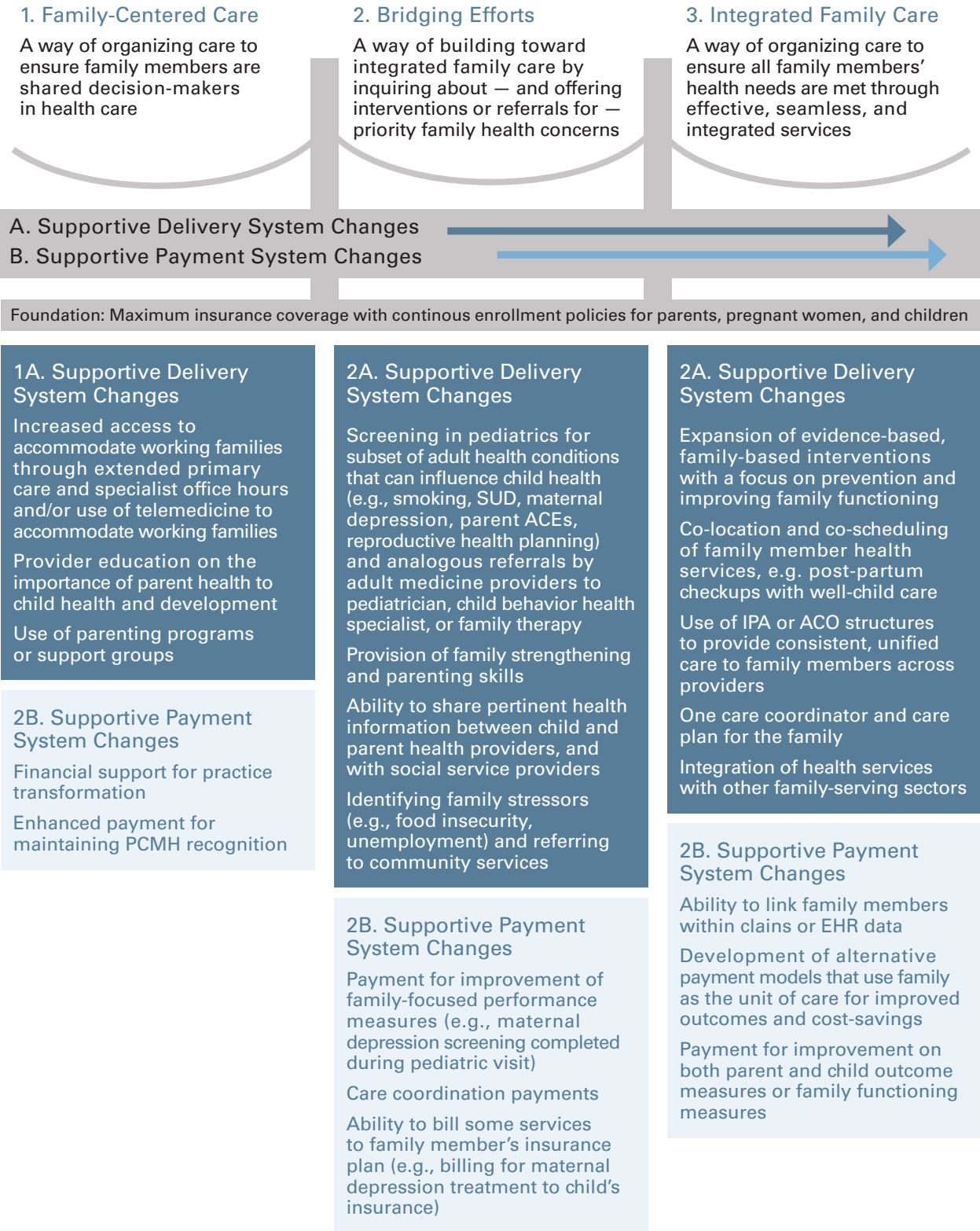
<sup>1</sup> Brundage S and Shearer C. March 2019. *Plan and Provider Opportunities to Move Toward Integrated Family Health Care*. United Hospital Fund. <https://uhfnyc.org/publications/publication/plan-and-provider-opportunities-move-toward-integrated-family-health/>

<sup>2</sup> Panchal N, Kamal R, Cox C, Garfield R, and Chidambaram P. May 2021. *Mental Health and Substance Use Considerations Among Children During the COVID-19 Pandemic*. Kaiser Family Foundation. <https://www.kff.org/coronavirus-covid-19/issue-brief/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic/>



# Figure A: Integrated Family Care Framework

## How to Bridge Family-Centered Care and Integrated Family Care



family-serving, community-based social service organizations rather than developing their own brick-and-mortar primary care sites. Conversely, **Starfish Family Services** in Michigan is a long-standing human services organization that in the past decade has developed a robust program to integrate behavioral health services into pediatric and OB-GYN settings.

Despite vast differences in the structure and resources of these five organizations, each is striving in its own way to pursue Integrated Family Care. This means coordinating care across three dimensions: physical health and behavioral health care; medical care and social care; and caregiver well-being and child well-being, in two-generational (2Gen) or multi-generational care (see Figure B). As was emphasized in the 2019 paper, Integrated Family Care is not a single approach, but rather an ongoing effort to harmonize care across these three dimensions. While the catalyst for this integration differs for each organization, they are all united in a desire to meet the holistic physical health, mental health, and social service needs of young families and to interrupt the intergenerational transmission of poor outcomes—a phenomenon often rooted in structural inequities and poverty.

Each of these organizations is on a pathway to Integrated Family Care that is wholly unique to its particular strengths, limitations, and history. As a result, they are making differential progress along the elements of the framework (Figure A). The organizations are leveraging trusted relationships with families to provide more consistent and coordinated care and are engaging families in strengths-based approaches to shared decision-making that address needs across the dimensions of integrated care. They are also butting up against substantial common barriers in advancing their work:

- Limited opportunities to evaluate the entirety of their integrated model, rather than individual interventions embedded in their model
- The inability to build data systems that enable them to view families as a constellation of members (especially caregiver and child) rather than siloed individuals
- Challenges in securing reimbursement under alternative payment mechanisms that would differentially and sustainably finance the health care components of their models

Overcoming these challenges will require the unique strengths of different agencies and national organizations.

The following profiles aim to bring the stories of these organizations to life. It is one thing to think conceptually about future integrated models of health care; it is another to place oneself on the clinic floor or in the social services office and understand what these abstract concepts mean for payers, providers, and families.

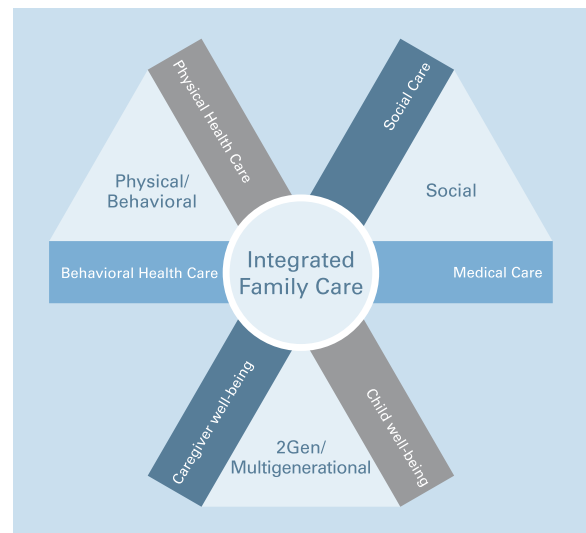


Figure B. Coordinating Three Dimensions of Family Care

## Strong Children Wellness Medical Group

Several years ago, Drs. Omolara Uwemedimo, Nicole Brown, and Suzette Brown were each working for different New York academic medical centers on innovative child health efforts. One was screening families for social determinants of health and referring them to a community-based partner to meet those needs; another was identifying developmental needs and assisting with the creation of New York's Health Homes; and the third was involved with Adverse Childhood Experiences screening and trauma-informed care. Each was growing disillusioned with their work. They felt that despite their efforts to collaborate with community partners, their referrals were often not leading to a satisfactory experience for families. Many families were not making it to follow-up care for mental health or social service needs. When families did make these critical connections, clinicians rarely received systematic feedback and often did not know whether the families' needs were being met.

In 2018, Dr. Uwemedimo had been partnering for the past two years with the Child Center of New York (CCNY), a long-established New York organization offering multiple social services as well as educational and counseling programs to children and families. As the partnership grew, Dr. Uwemedimo started working with a Head Start program in Corona, Queens, run by CCNY. During this experience she saw firsthand the benefits of bringing medical services directly into Head Start. This model allowed physicians to integrate health, education, and social services in one setting. Further, it allowed health professionals to develop closer ties with families by working with trusted community partners, an opportunity that had been limited by working inside academic medical centers. Dr. Uwemedimo worked with Dr. Nicole Brown and Dr. Suzette Brown to conceive how this could be transformed into a sustainable primary care model that avoids the challenges they had encountered in their existing practices. "The health care provider often doesn't know the needs of the patients beyond the clinic, and we wanted to flip that by bringing primary care into an organization that also provides mental health and social services under the same roof," said Dr. Brown. Thus, Strong Children Wellness Medical Group was born.

Launched in April 2020, the Group currently has one brick-and-mortar location providing comprehensive well-child care in Jamaica, Queens with CCNY, and is expanding to additional community partner locations, including a foster care agency and a perinatal behavioral health center. Through physical integration with their community partner, they can also offer mental health services, parenting programs, health and wellness classes, and other services that support and strengthen families. A family physician has joined the medical group to bolster a 2Gen approach to parental and child health, with a special emphasis on helping identify and address parents' mental health challenges.

"The health care provider often doesn't know the needs of the patients beyond the clinic, and we wanted to flip that by bringing primary care into an organization that also provides mental health and social services under the same roof."

## Bidirectional screening and referrals

The founders of Strong Children Wellness Medical Group knew that for the model to succeed they would need to maximize family use of pre-visit screenings. By sending families screening questions about social and behavioral needs prior to the visit, the primary care team (including a nurse educator) gets as much of a view of the family as possible before meeting with them. This enables the team to get a better sense of the family's needs and maximizes visit time for explaining services CCNY can provide. If the family consents to services for behavioral health or social needs, a shared health coordinator (i.e., one who is hired by CCNY but works with Strong Children Wellness) then makes a “warm handoff” to CCNY services. The shared health coordinator is highly knowledgeable of CCNY's robust and diverse programmatic offerings and can help the family navigate enrollment into services for both parent and child.

From the other direction, all CCNY clients who enroll in one of the community organization's programs receive an intake form—the Child Center Health and Well-Being Questionnaire, co-created by Dr. Uwemedimo and CCNY leadership. The questionnaire includes two questions about whether the child or the caregiver has had a physical health checkup in the last year or any physical health concerns in the last month. The process then works in reverse, with the shared health coordinator connecting with the family and providing referrals back to SCW. The SCW team prioritizes discussions with families about collaborative care for social needs and mental health as well as seeking the family's understanding of, and consent for, services. This is particularly important when working with families who, because of discrimination based on race or poverty, “often don't have their consent elicited,” says Dr. Uwemedimo.

The doctors note that co-location of services does not automatically mean integration, and SCW is working with a consultant to help educate all professionals and departments at CCNY about what collaborative care means. “We learned early in this process about the need to talk often, often, often with CCNY,” said Dr. Nicole Brown, noting that case management is traditionally not reimbursed through insurance dollars. The team is also working through the implications of integrating a family physician into their practice. This includes updating their scheduling process to allow for co-scheduling of parent and child primary care visits, and lengthening visit times to enable additional warm handoffs to adult mental health providers.

## Technology and Information-Sharing

SCW prides itself on using a technology-enabled system of care. All pre-visit screenings can take place on the family's mobile device. SCW can also make digital handoffs to CCNY through telehealth—which became a necessity when SCW launched during the first wave of New York City's COVID-19 pandemic—but the group still prefers in-person visits and handoffs when possible. In addition to frequent case management meetings with CCNY staff, “records are mutually accessible between the health care provider and the community social services and mental health partner,” Dr. Brown said. “Counselors and social workers can access relevant medical records in a HIPAA-compliant manner, and a physician could review mutual patients with relevant caseworkers,” she said. All information sharing, however, is preceded by discussions with the families to ensure their understanding and to obtain consent.

Technology that enables 2Gen health care has been slower to materialize. While Strong Children Wellness does not currently have the capacity to link family members within its electronic health record,



the leadership expressed interest in engaging with its vendor to build this capacity. In the interim period, the new family medicine provider will chart notes about parent health in the child’s record.

## Outcomes and Payment

SCW and CCNY leadership meet weekly to discuss progress in defining and achieving shared outcomes for families. To date they have focused most on “what matters to the family,” and “erasing boundaries in health care,” says Dr. Uwemedimo. Among the potential outcomes SCW would like to evaluate are school absenteeism, family employment, socioeconomic empowerment, and parental stress. The group has also discussed evaluating patient activation measures (e.g., does the family feel in charge of their health?). But this process has been stymied by a limited set of measures that appeal to potential funders. Most health care payers are interested in Healthcare Effectiveness Data and Information Set (HEDIS) measures, which are a narrow set of circumscribed health care measures; most philanthropic funders focus on 12- to 18-month outcomes, but that’s often not a realistic timeframe for showing concrete improvements in a child’s life.

Closely related to the issue of outcomes is a desire to partner with health care payers in alternative payment mechanisms that would reimburse on the basis of outcomes rather than the current fee-for-service system. SCW has engaged in conversations with one Medicaid managed care plan about potential value-based reimbursement that provides a set fee per patient (capitation) or bundles payment for a defined set of services. Dr. Nicole Brown shared that the group is “trying to be thoughtful about how to make the case for capitation—in particular, the collaborative care piece or meeting bimonthly with CCNY to discuss mutual patients is unfunded.” Ultimately, the group knows they will not be able to sustain technology-enabled, high-touch care that is integrated with community-based organizations through the dominant fee-for-service model. Moving toward value-based payment arrangements with payers is their “north star” goal.

## Starfish Family Services

Michelle Duprey, LMSW, has worked at Starfish Family Services for more than 20 years. The nonprofit human services organization in Inkster, Michigan, primarily provides children’s mental health and early education services. Now Director of Integrated Health Care at Starfish, Ms. Duprey has seen a lot of changes during her time. One of the most significant has been a recognition that family health is as critical to child well-being as school success and family empowerment—the other two priorities in Starfish’s comprehensive strategy.<sup>3</sup>

Improving family health for the community Starfish serves has been a challenge. Western Wayne County in Michigan has a diverse mix of socioeconomic backgrounds with a few small, affluent pockets. Much of the community faces challenges similar to neighboring Detroit. Approximately one in three residents of Inkster lived in poverty in 2019, and its infant mortality rate was nearly triple the U.S. average in 2017.<sup>4</sup> It was in this context, nearly a decade ago, that a local Federally Qualified Health Center (FQHC) reached out to Starfish and requested assistance providing mental

<sup>3</sup> *About Us: Starfish Family of Services.* <https://www.starfishfamilyservices.org/about/>

<sup>4</sup> Quick Facts, Inkster city, Michigan. United States Census Bureau. <https://www.census.gov/quickfacts/fact/table/inkstercitymichigan/PST045219>; Kids Count Data Center, The Annie E. Casey Foundation. <https://datacenter.kidscount.org/>

health services for children. Starfish made a therapist available to work in the FQHC two days a week—a strategy that didn't lead to increased services for children. The next step was to “send [the therapist] there full-time—it still didn't work,” Ms. Duprey said. Starfish had learned a critical lesson in the integration process: co-location of services does not necessarily mean integration, and a process for implementation is critical.

### **Integrated Pediatric Care Moves Upstream for a 2Gen Approach**

As a next step, Ms. Duprey herself joined the FQHC full-time in a dual role as therapist for children and adults, and as a behavioral health consultant to help the Center's primary care practitioners. Fortuitously, the FQHC had just hired a chief operating officer with a doctorate in psychology, and together the new COO and Ms. Duprey set out to create a fully integrated behavioral health practice within the community health center. The team learned many lessons over this year-and-a-half journey—chief among them was the importance of having an embedded behavioral health consultant (such as Ms. Duprey) with deep knowledge of available community-based services for families. The advantage, says Ms. Duprey, is that the FQHC's families “got all of Starfish's services” because we could establish a “really strong one-way linkage back to Starfish services.” This consisted of children's mental health services as well as parenting programs, including a fatherhood group, programs for pregnant teenagers and expectant teen fathers, and educational programs in personal finance and professional development.

Aided by a Systems of Care federal grant, Starfish began developing expertise on how to integrate behavioral health services into pediatric primary care services and create seamless connections to community services. Beyond adding professionals or interventions, the process requires knowing how to directly connect families to community service organizations, get people into the specific services they desire, and “transfer patients in a way where they [don't] feel like they [are] transitioning,” says Ms. Duprey. “It's a process, a transformation, an attitude change.”

At first, there was a lot of resistance from pediatricians, some of whom claimed that having a professional available to address family mental health needs “sounded too good to be true.” Much of this was driven by a fear that funding would dry up and leave the pediatric practice with uncovered costs. Yet at the same time, the Michigan Department of Health and Human Services became interested in pediatric integrated health after realizing children weren't getting screened for behavioral problems, such as attention-deficit/hyperactivity disorder (ADHD) and anxiety. In partnership with the Ethel and James Flinn Foundation, the state launched a pediatric integrated health care pilot program—Services for Kids in Primary Care Plus (SKIPP)—that would evaluate and accelerate the adoption of pediatric integrated health.

In the course of this work, Starfish realized that “we always like to go upriver—and that meant we

“Beyond adding professionals or interventions, the process requires knowing how to directly connect families to community service organizations, get people into the specific services they desire, and transfer patients seamlessly.”

needed to work with OB-GYNs.” Using state-endorsed mental health therapists trained in supporting attachment and prenatal bonding, and specializing in home visiting, Starfish designed a program in which these specially trained infant mental health therapists are embedded part-time in OB-GYN offices, while continuing a half-caseload of home visits. The mental health therapist supports OB-GYN preconception screening and screening of pregnant women for depression, anxiety, domestic violence, substance use, and trauma. The therapist also provides physician consultation and patient psychoeducation. What is particularly unique, however, is that the in-office therapist can also offer patients home visitation services through the traditional infant mental health home visiting program. Ms. Duprey explains: “Home visiting is by definition pretty intrusive, and cold referrals are often denied. But when the [behavioral health] consultant in the OB-GYN practice says, ‘What if it’s me?’ that is more appealing.” Later, Starfish added an evidence-based home visiting program—Nurse Family Partnership—to the integrated team to meet increasing demand.

Ms. Duprey is particularly optimistic about the potential for integrated behavioral health services in OB-GYN settings to make a meaningful and lasting impact on children’s health. First, she observed that OB-GYNs seemed much more willing to onboard mental health specialists because they were spending so much time with stressed patients and were having trouble meeting efficiency targets. Meeting a woman in the OB-GYN office with trusted clinical staff also allows the therapist to work with her prior to a child’s arrival, enabling an early start in preventing second-generation problems due to the parent’s trauma, toxic stress, substance use disorder (SUD), or domestic violence. Notably, Starfish President/CEO Ann Kalass is a former Aspen Ascend Fellow; this national program was designed to help leaders advance two-generational programs to break cycles of poverty, and Ms. Kalass’s experience has further cemented the 2Gen approach in Starfish’s strategic plans.

## Critical Role of Transformation Support and Integration Infrastructure

In support of the SKIPP pilot, Starfish secured additional grants to provide technical assistance and consultation services to help other pediatric medical clinics become integrated, using what they have learned over the years and using the Pediatric Integrated Health Care Implementation Manual that Ms. Duprey developed.<sup>5</sup> To date they have helped over 20 medical clinics in Michigan learn how to provide integrated health care. In addition to the local medical clinics, Starfish has also done national work in collaboration with the National Council for Behavioral Health. Ms. Duprey was invited to head up their pediatric integrated health care learning collaborative, which served participants from 20 different states. Starfish is also currently training MSW interns and medical residents in one of the nearby health systems to help develop the workforce for integrated health care in a family medicine clinic. As someone who literally wrote the manual for Wayne County on how to integrate behavioral care, Ms. Duprey sees a few barriers to further integration for families.

Her biggest concern is access to integrated care for community physicians who normally can’t obtain large federal or state grants. These physicians often serve populations that need integrated care yet struggle to find easy transformation support. “Your average physician,” says Ms. Duprey, is “going to look around and ask, ‘Where do I go for this support?’” The second issue is adequate payment for the infrastructure that makes the integration process work. This includes data collection, trained

<sup>5</sup> Duprey M. 2016. *Pediatric Integrated Health Care Implementation Model – One Location, One Visit: A Manual for Integrating Mental Health Services Into a Pediatric Practice*. Starfish Family Services. [https://www.starfishfamilyservices.org/wp-content/uploads/2020/11/STARFISH\\_K38101-IM-Manual\\_6.pdf](https://www.starfishfamilyservices.org/wp-content/uploads/2020/11/STARFISH_K38101-IM-Manual_6.pdf)

professionals, and transformation assistance. Michigan Medicaid allows for reimbursement of collaborative care codes—an advancement over many states—but the payment rate is too low to cover the costs of a full-time professional.

Ideally, Ms. Duprey would love for health plans to strive to include all members in integrated health care, then build out the mechanisms to support their provider networks in accessing transformation assistance to provide those services. Once providers can demonstrate that they have the appropriate infrastructure—including trained professionals, pathways to community services, and attention to social determinants of health—the health plans would pay a value-based, higher rate for ongoing costs.

## Outcomes and Payment

Starfish and their partners have two promising evaluation efforts that they hope will pave the way for sustainable financing. The University of Michigan is evaluating the use of infant mental health professionals in OB-GYN settings to see whether the integrated program yields better health outcomes for mom and baby compared to traditional OB-GYN services alone. Michigan Medicaid provided a matching grant to help pay for the evaluation.

The second evaluation is of the pediatric behavioral health consulting program, with a focus on the actual costs and outcomes of implementation.<sup>6</sup> Through the evaluation, Starfish sought to identify the specific activities necessary to move a practice from non-integrated care to fully integrated care and, in so doing, make the case for adequate financing in the future.

Not in the works yet but in Ms. Duprey's ideal vision is also financial support to help community-based human service organizations create the infrastructure to establish linkages back to health care. Starfish's linkages with health care providers are a "one-way street"—the behavioral health consultant can send families to Starfish for programs such as Head Start. This capacity does not exist in reverse. While Head Start has an obligation to provide families with choices of a medical home, there is no funding or support to provide a warm handoff to primary care to facilitate these referrals. Similarly, when patients are discharged from community mental health programs, such as Starfish's, with medications, there is no mechanism to firmly link those patients to a primary care practice with integrated behavioral health that can help manage their care.

## Dartmouth-Hitchcock

As a primarily rural state, New Hampshire has long had to grapple with access to health care and health promotional services. Health care professional shortages and transportation barriers are widespread. For families with substance use disorders (SUD), a significant population given the opioid epidemic's foothold in the state, these challenges combine with other barriers to care, such as stigma, that limit access to care. This was particularly challenging prior to New Hampshire's Medicaid expansion in 2014, when access to prenatal care for women with SUD was limited. Many providers did not accept Medicaid, had a multi-month wait list, or charged cash. As a result, many pregnant women with substance use challenges would forgo treatment altogether or enter prenatal care late.

<sup>6</sup> Duprey M, et al. March 2021. *One Location, One Visit - Pediatric Integrated Health Care in Wayne County: A value proposition for sustainability*. Center for Health and Research Transformation. <https://www.starfishfamilyservices.org/wp-content/uploads/2021/04/BHC-Implementation-Model.pdf>



The state's rate of neonatal abstinence syndrome increased 10-fold in 15 years.<sup>7</sup>

To better assist these women with their behavioral health needs, the Dartmouth-Hitchcock psychiatry department—with key guidance from nurse-midwife Daisy Goodman—created a “moms group” with five women in fall of 2014. The women seemed to enjoy it. In fact, the program worked almost too well—the women started attending the moms group every week and stopped going to prenatal care. The psychiatry department asked a prenatal clinician to

come to the group practice to provide integrated care. This was the first programmatic move toward women's health and behavioral health integration at Dartmouth-Hitchcock and, given the patients it aimed to serve, was directly focused on supporting women and their recovery, thereby preventing adverse childhood experiences (ACEs) and ending the cycle of intergenerational SUD. Soon after, Dartmouth-Hitchcock's obstetrics department established two models of care:

“Key to making this model work is focusing on the strengths, not the deficits, of parents in recovery.”

- **Moms in Recovery:** An intensively resourced, fully integrated model of care for pregnant women with SUD. Women in this model receive behavioral health group counseling, individual therapy, and psychiatric medication management, as necessary. They are also treated as needed by infectious disease experts for Hepatitis C (a common comorbidity for people with SUD), receive evidence-based parenting interventions, and are given resources, such as job training, cooking classes, and a food pantry for unmet social needs. Well-child care and play groups for children are also available onsite.
- **Recovery-friendly obstetrics:** A lower-intensity, integrated model of care focused on appropriately caring for pregnant women with SUD. Across Dartmouth's obstetrics clinics, women with SUD (identified through universal screening) receive care from a “purple pod” team (named for the color of their workstation) that includes a recovery coach and community health worker to support women through the prenatal and SUD care process. Additional case management supports allow for connections to community resources for unmet social needs.

## Pediatrics Takes Notice

As this work in the obstetrics department unfolded, Dartmouth-Hitchcock's General Pediatrics Clinic, led on the clinical side by Dr. Steven Chapman, began to take notice. The pediatricians suspected they were too frequently calling Child Protective Services on families with SUD due to a dearth of options for supporting parents in recovery who are raising young children; weren't collaborating or talking with OB-GYN colleagues about how to care for these highly vulnerable families; and in general weren't adequately meeting the needs of families. They also realized that if they were facing these challenges, it was likely that other pediatric practices across the state who partner with Dartmouth-Hitchcock's Community Health team were as well.

<sup>7</sup> Smith K. December 2017. *As Opioid Use Climbs, Neonatal Abstinence Syndrome Rises in New Hampshire*. University of New Hampshire Carsey School of Public Policy. <https://carsey.unh.edu/publication/opioid-nas-nh>

To better understand the scope of the problem, the Dartmouth-Hitchcock Community Health team conducted a community stakeholder assessment; they would use the results to guide a system redesign that could interrupt the intergenerational cycle of SUD. The assessment revealed there was little communication across women’s providers and pediatric teams about supporting family members, little knowledge among providers of community resources, a need to know how to share community resource information with families, and a desire to improve cross-sector partnerships for families. These challenges persisted despite providers stating they were spending up to half of their time with patients focused on social determinants of health. Additionally, parents clearly stated in the assessment that “parents in recovery could be great parents, too!” but they needed help from pediatrics. They had common questions, such as: “If I need assistance with childcare or food, where should I go?” and “How do I talk to my child about recovery?” They wanted to discuss these issues with their pediatrician but feared being judged. The stakeholder assessment results prompted the pediatrics department (enabled by support from the Couch Family Foundation) to start “recovery-friendly pediatrics.” Modeled after the obstetrics program, this approach was considered a better way to serve moms with SUD after delivery.

### **Recovery-Friendly Pediatrics Relies on Strong Communication, Care Handoffs, and Co-Designing Care with Parents**

The recovery-friendly pediatrics model features enhanced communication pathways with prenatal providers, multidisciplinary staff collaborations to support connections to community services, additional developmental screenings and supports, and strength-based care to support parenting skills and family functioning.

Given that the model is built to continue supporting women who have received recovery-friendly OB-GYN care, recovery-friendly pediatrics is designed to mirror and build upon the support provided in the prenatal period. The goal is to provide as seamless a transition for women as possible. The pediatric team engages early with the prenatal team to ensure a warm handoff and seamless transition in care for mom and baby. After delivery, new moms and their babies are greeted at the pediatric visit by the same community health worker who supported them on the obstetrics unit. The family is then handed off to the pediatric support team, which is named the “pediatric purple pod” to signify to moms in recovery the continuity in approach and shared values with the obstetrics “purple pod.”

A major focus of the pediatric visit for these families is to ensure families with SUD continue to receive supportive services that successfully keep moms in recovery. Most of these supports have been identified by the obstetrics team during the prenatal period as part of the families “plan of safe care.” The pediatric team views its role, especially that of the community health worker, as ensuring a successful hand-off into their care and continuing to support connections to vital community resources. The pediatric clinics mostly refer to family resource centers, which are community hubs—the “heartbeat of the community,” Dr. Chapman says—for navigating programs such as the Women and Infant Care nutrition program, home visiting, and job training resources.

Key to making this model work is focusing on the strengths, not the deficits, of parents in recovery. While the pediatric team continues to screen for essential issues such as maternal depression and unmet social needs, the pediatrician also asks new moms about their strengths, supports that are available to them, goals, how their recovery program is going, and if they need help finding care for themselves. The approach has been co-designed with women experiencing

SUD and relies heavily on patients and families as advisors. Such co-designed care is a constant process of listening to families, as well as educating pediatric staff on stigma reduction and the recovery process.

## Outcomes and Payment

For the recovery-friendly model creators, what is missing from their work is the “financial model that reinforces the clinical model.” Part of the appeal, Dr. Chapman hopes, is that recovery-friendly pediatrics was designed with sustainability in mind. While Dartmouth-Hitchcock’s Moms in Recovery model is well suited for an academic medical center, the staff acknowledges that it is a “Cadillac” integration model. By comparison, recovery-friendly pediatrics is more modest in scope and an achievable transformation goal for community-based practices.

Thus far there have been modest gains toward sustainability. One part of the recovery-friendly team—the recovery coach community health worker—has been integrated into the pediatrics operations budget. Community health workers, however, are still grant-funded. Also now funded in the operations budget are an MSW, as well as an integrated behavioral health clinician. Parts of these salaries have been grant-funded, and the team hopes that ongoing evaluation of their model will help make the case. The team measures a wide range of outcomes in evaluating the model’s success, including maternal outcomes, child outcomes, and family functioning. Family outcomes include foster care use; cases opened by the State’s Division for Children, Youth and Families; the father’s involvement in the child’s life; the number of trauma-based parenting classes attended; whether there is an employed guardian in the household; and enrollment in child care. Additionally, as part of ongoing quality improvement work, the team tracks access to services, including monitoring no-show rates for well-child care visits and successful connections to family resource centers. Both have steadily improved since the model began.

Despite this model being developed for families with SUD, much of the model can be applied to families who are at high risk for other reasons. Dr. Chapman’s “north star” for his own practice is a universal statement for his approach to health care, not just caring for families with SUD: “We must move away from stigmatizing and judgment, and see the strength in recovery and what good parents they can be with the proper support.”

## 3-2-1...IMPACT! at NYC Health+Hospitals

In New York, Dr. Jennifer Havens has spent over 30 years leading children’s mental health service systems at NewYork Presbyterian and Bellevue/NYU. She was tired of seeing mental health problems too late and of only receiving referrals for children with externalizing behaviors, while children who were suffering quietly slipped through the cracks. She knew that early detection and intervention were crucial to serving families with behavioral health needs and that something needed to be done to make this possible. Her NYC Health + Hospitals (H+H) colleague Dr. Mary McCord, Director of Pediatrics for Gotham Health (the H+H network of community health centers), was frustrated by the lack of consistent, multi-generational, family-centered care integration for children aged 0-3 across their system. She co-chaired New York State’s First 1,000 Days on Medicaid Preventive Pediatric Care Clinical Advisory Group, which had recommended the adoption of a pediatric population health model that integrates

care for parents and caregivers into primary care for children.<sup>8</sup> Buoyed by the State’s embrace of that model, she and Dr. Havens seized the unique opportunity to put the recommendations of that group into action.

With support from H+H leadership and The Robin Hood Foundation, in Spring 2019 they launched 3-2-1...IMPACT!, an Integrated Model of Parents and Children Together. The approach brings together in one setting the three disciplines of women’s health, pediatrics, and behavioral health, for a two-generational approach. All H+H facilities were invited to apply to be pilot sites.

“Our biggest opportunity for population health is in strengthening social-emotional outcomes.”

Three sites—Bellevue, Gouverneur, and Queens—are participating in the first cohort. The sites were selected from a pool of eight applicants and were chosen for their demonstrated focus on screening for social determinants of health and for the level of need in patients they serve, a majority of whom are Medicaid beneficiaries. Many components of the program are being implemented at other sites, with some structural elements rolled out system-wide. The goal is to establish this model of pediatric primary care and prenatal care across H+H, the largest public health care system in the U.S.

### Universal Delivery of 2Gen Programs to Families

3-2-1...IMPACT! Has an explicit 2Gen focus. Services are provided to all mothers starting at their first prenatal visit. Family needs are assessed and addressed by in-house social work or behavioral health staff or a referral to community resources. If needed, IMPACT also provides a community health worker to assist in referrals and care coordination. After delivery, there is a coordinated handoff to pediatrics, where the staff continues to monitor the health and well-being of the mother as well as providing care for her child. In addition, pediatrics sites also incorporate three evidence-based programs designed to help parents:

- Reach Out and Read, which emphasizes the importance of parents reading with their child
- Video Interaction Project, which coaches parents on how to read and play with their child
- HealthySteps, a team-based primary care program that promotes the health, well-being, and school readiness of babies and toddlers

While there is a warm handoff between prenatal care and pediatrics, documenting health information across provider types remains a challenge. The dominant barrier is a concern over recording the parent’s mental health in the baby’s medical record, particularly for families from underserved communities who are at a higher risk of Child Protective Services involvement. In addition to the privacy concerns, complexities remain with building and refining data systems with the capacity to document needs, track referrals, and measure performance quality. This becomes even more complex when the parent and child have different insurers.

<sup>8</sup> *Final Report of the First 1,000 Days Preventive Pediatric Care Clinical Advisory Group*. October 2019. New York State Department of Health. [https://health.ny.gov/health\\_care/medicaid/redesign/1000\\_days/2019-10-01\\_final\\_report.htm](https://health.ny.gov/health_care/medicaid/redesign/1000_days/2019-10-01_final_report.htm)



## Risk Stratification and Care Coordination

3-2-1...IMPACT! takes a risk stratification approach to match families with services that meet their intensity of need. Risk stratification is based on clinical assessments, mental health screenings, and social needs screenings in both women's health and pediatric settings. Mental health workers and social workers are embedded in the practice to address short-term needs, assess more complex needs, and provide some management of the highest-need families while trying to get them into care. Ultimately, patients are assigned to one of three risk tiers based on the totality of their family's circumstance, including social complexity, parent health, and child health. Families at the "universal" level (i.e., the lowest-risk tier) receive a referral to community agencies, while families at moderate- and high-risk levels receive a higher degree of care coordination support, with bidirectional communication between social service agencies serving these families and H+H.

The model emphasizes integrated behavioral health across developmental stages, including dyadic therapy in pediatrics when needed to support the parent-child bond. While behavioral health services for parents are not provided in the pediatric clinic, efforts are made to connect moms with a suitable provider or psychiatric program if severe mental illness is suspected. Early identification and treatment of post-partum depression is largely responsible for the estimated positive return on investment from the model.

## Outcomes and Payment

In emerging payment conversations with plan partners, H+H is focusing on initial research to demonstrate the efficacy and sustainability of 3-2-1...IMPACT! These conversations center on successful implementation and fidelity to the core program elements, with a focus on meeting the relative needs of prenatal and pediatric primary care families consistent with their risk tier while sustaining and improving performance on quality measures. H+H is also assessing the improved systemic links between pediatrics, women's health, and behavioral health. "Our biggest opportunity for population health," said Dr. McCord, "is in strengthening social-emotional outcomes."

H+H received grant funding to develop an initial return on investment model and is using the model as the starting point to engage managed care plan and state partners in discussions around alternative payment mechanisms to support the program. The financial challenges facing a model like 3-2-1...IMPACT! are not new. The HealthySteps components of the model, which include staffing requirements for a child development specialist and a community health worker, are not fully funded by existing payment mechanisms. The HealthySteps specialist works with the clinical staff and assists with the Video Interaction Project, observing child and parent interactions and then coaching the parent, while the community health worker helps the parent by making appointments and coordinating care and social services. Because this is a new model, it is also difficult to accurately estimate the total cost of the services and potential savings. H+H is partnering with a local health plan and an academic Medicaid data research team to better understand baseline utilization and costs, and to assess potential savings for children and families receiving the model intervention. The goal is to leverage this ongoing research to support the design of a Medicaid alternative payment model that could both sustain the 3-2-1...IMPACT! model and its expansion at H+H—and also act as a model for other integrated care reimbursement arrangements across the state.

## AsOne Healthcare IPA

A group of New York City area organizations made up of three multi-service community-based organizations (including two with a child-and-family focus), one of the largest behavioral health providers, one of the largest Federally Qualified Health Center networks, and a youth development services organization came together to create an organization focused on leveraging new payment models to expand access to family-based care. These providers were consistently frustrated with disjointed care delivery that didn't fully meet the needs of the children and families they served. Historically, there would have been little reason for these organizations to collaborate, and in some cases they would even have considered themselves competitors in the increasingly zero-sum game of procuring government and philanthropic support for providing services. That all changed in 2011 as the New York State Medicaid program began a multi-year push to transform the way care was delivered to enrollees and how it was paid for through new value-based payment approaches.

Building on collaborations started under the State's Medicaid Delivery System Reform Incentive Payment (DSRIP) program 1115 Waiver, in 2018 the State recognized the need to support behavioral health providers and community-based social service organizations in the ongoing transition to value-based payment. With this, the state issued a grant to support the creation of Behavioral Health Care Collaboratives, and the six founding organizations came together and were awarded funding to launch the AsOne Healthcare Independent Practice Association (IPA). The network currently has 16 participating providers that deliver mental health, substance use, primary care, care management, and social services. While the concept of IPAs as networks of providers working together to negotiate value-based payment arrangements with managed care organizations isn't new, what makes AsOne different is the unique model of care and adjoining alternative payment models the network is promulgating.

Conceptually, the model is simple: provide all the services a whole family needs to get healthy and stay healthy, preventing future costly health care utilization. The IPA seeks "to improve the health and lives of not only one client or patient at a time, but entire families at once, in an effort to break the cycle of a myriad of co-occurring illnesses and ailments that often afflict high-risk families and communities... addressing the health and social needs of an individual's loved ones and safety-net."<sup>9</sup> Delivering on the model in a way that attracts the envisioned value-based payment contracts necessary to fully support the innovative model of care is anything but easy.

"Conceptually, the model is simple: provide all the services a whole family needs to get healthy and stay healthy, preventing future costly health care utilization."

### Acting "As One" to Provide Unified Family-Based Care

Bringing together primary care, behavioral health services, care management, and social determinants of health support is complicated for even the most vertically and horizontally integrated delivery system. Doing so in a way that treats the family as the unit of care is a unique approach that strives

<sup>9</sup> About AsOne Healthcare IPA. <https://myasone.org/about>

to break the intergenerational cycle of complex health and social needs so common for New York Medicaid enrollees in high-risk families and communities. The AsOne model begins by identifying a “high-utilizer” index patient, most likely an adult with chronic health conditions and behavioral health comorbidities, and then engages that patient to identify other family members—including their children—to take part in the services. The index patient acts as both an entry point into the model, and a strategic value-based payment target that managed care organizations would easily identify as having the opportunity to improve outcomes and save money.

In addition to addressing the individual health and psychosocial needs of each member of the family, the model provides family-based therapy and care management, leveraging a care team of social workers, nurses, and care coordinators. Together they “meet the family where they are at,” according to AsOne executive director Caroline Heindrichs. A multi-month, intensive, in-home, family-based intervention works to strengthen the family dynamic, preparing the family unit to support one another in achieving their individual and collective well-being goals. Current high utilization is reduced by meeting otherwise unmet needs and better coordinating care, while also ideally preventing future high utilization by reducing the intergenerational transfer of stress, chronic health conditions, and substance use disorders. This therapeutic intervention may also reduce the incidence of adverse childhood experiences that have life-long effects on children’s health and well-being.

Beyond just negotiating with managed care organizations, the IPA backbone infrastructure provides network members with the support necessary to carry out the mission and work. AsOne provides shared information technology, data, and analytics to support the IPA’s quality efforts and to identify and generate the list of target index patients for engagement in the model of care. AsOne trains and oversees at a high level the teams carrying out the model and also coordinates the exchange of data with the managed care organizations and the flow of funds between providers that are collaborating on staffing the care teams. It also supports all network providers in ongoing measurement of quality and performance with an eye toward metrics of most interest to managed care organizations for value-based payment arrangements. These efforts include a special focus on eliminating the gaps in care that often occur between physical health and behavioral health providers.

## Outcomes and Payment

AsOne is currently planning to launch a pilot program with a major Medicaid managed care payer in September 2021. The goal is to demonstrate proof of concept with both the clinical model and the alternative payment model. Initially, managed care organizations seemed most interested in the utilization and cost associated with the index patient, raising the ever-present issue of realizing savings from any longer-term family outcomes when family members are enrolled in different plans or members are churning on and off of plans. Recognizing this reality, AsOne will evaluate the outcomes and cost impact both on the individual index patient and for the group as a whole. This will require utilizing the data and technology tools the IPA has built to compile the data in a single warehouse, group family data together from many different sources, and apply measures (HEDIS, Centers for Medicare and Medicaid Services measures, and others) to the data in order to visualize and contextualize the outcomes.

# Action Agenda for the Field

## Financial Sustainability

Providers continue to express a need for support in preparing the evidence base and rationale for integrated family care interventions, identifying capacity or financial “gaps” that need payer support, and educating senior leadership of payers on the history and value of integration. The financial needs of the partnering community organizations must also be considered in this work. Advances in Medicaid payment for parent-child dyadic therapy in a number of states may provide a pathway for sustaining some elements of the integrated family care model, but alone are insufficient to support fully integrated models.<sup>10</sup> Government payers, managed care organizations, and providers working together to agree on the costs and potential savings from integrated family care and develop standard or alternative payment mechanisms that fully recognize those costs and reinvest the benefits in the integrated models of care from whence they are derived, could achieve this aim.

## Measuring Outcomes

How do we document that integrating care makes a difference—for the child and family, for the providers, and for the payers? Measure development and testing are currently lacking for all three dimensions. “Payers” in this instance include not only costs or savings for the health sector but impact on other payers as well, including foster care, juvenile justice, and educational systems, as well as workforce capability. Additional research to evaluate the nearer-term health costs and outcomes of integrated family care programs and also the longer-term effects on the health and financial well-being of those served as well as the related costs and savings to other sectors would provide crucial answers in this effort.

## Harnessing Data Systems

The providers profiled here have often had more success in sharing information across organizations (from clinical settings to community social service providers) than viewing family connections and common family challenges within their own clinical and administrative data. The one provider (AsOne) that has been able to see family ties within their own data built their system upon technology used by human service organizations. Other providers (e.g., Strong Children Wellness) are discussing this capability with their electronic medical record (EMR) provider, potentially leading to an individual workaround and modification that is playing out countless times across the country. Additional data standards and improved data interoperability across sectors would allow providers and payers to fully harness the power of integrated family care. State governments could consider leveraging all-payer databases and health information exchanges to connect the administrative and clinical records of children and families. Providers may need EMR developers to create additional capabilities for real-time care management and coordination at the clinical level. The connection of community-based social service organizations to these data systems will

<sup>10</sup> North Carolina’s Medicaid Reform Demonstration Special Terms and Conditions. April 2019. <https://www.medicaid.gov/Medic-aid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf>; Medi-Cal Psychological Services Manual. September 2020. California Department of Health Care Services. <https://files.medi-cal.ca.gov/pubdoco/publications/masters-mtp/part2/psychol.pdf>



be vital for getting a full picture of the needs of and resulting services delivered to children and families. In the longer term, the connection of all this data to data from other sectors, such as child welfare, juvenile justice, and education would maximize the ability to evaluate cross-sector outcomes, and also to coordinate integrated service delivery across these siloed sectors.

## **Recovery and Transformation Post-Pandemic**

As the U.S. emerges from what is hopefully the worst of the COVID-19 pandemic, it is a perfect moment to consider the current state of child and family health services and how integrated family care could help address both the long-term physical and behavioral health consequences of the pandemic and address the ongoing needs of families disparately affected by the crisis. States and providers leveraging federal relief funds could consider how 2Gen approaches that integrate physical, behavioral, and social care needs can act as protective factors against the potential longer-term health and behavioral health consequences of the pandemic. Providers must recognize the trauma and stress of the pandemic on families, especially those from underserved communities, and provide trauma-informed care that focuses on the most pressing needs. Children and families may benefit from significant financial relief through the enhanced child tax credit in the American Recovery Plan Act. At this time, the credit is temporary, and it is unclear whether it will be extended. Long-term child poverty reduction that could reduce economic and social stresses for children and families may require other actions.

Especially for children and families in underserved communities, the pre-pandemic system of siloed services that treated individuals often irrespective of broader family needs was not meeting their needs. This unique moment in history presents an opportunity to rethink care delivery for children and families, integrating physical and behavioral health services in a 2Gen approach that also addresses the underlying social needs responsible for the myriad health inequities further laid bare by the pandemic.