



# Plan and Provider Opportunities to Move Toward Integrated Family Health Care

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# Introduction

Family dynamics affect the health of individual family members, especially children, in multiple and profound ways. Beyond families sharing genetic factors, social interactions between family members and common environmental influences can influence familial health. Families can mitigate risks to an individual's health—for example, as caregivers during illness and as buffers to external stressors that can lead to a decline in health. But family members can also pose risks to one another's health, such as when one's smoking exacerbates another's asthma or other respiratory conditions of those in the household. Third, common social determinants of health can have adverse consequences and lead to other negative effects (e.g., adult unemployment can limit opportunities for accessing high-quality child care). The role of the family is especially important in influencing children's health—strong, supportive relationships with a caregiver are the foundation for a young child's physical and mental well-being. Individual health is therefore rooted in the family.

Focusing on these dynamics yields an opportunity to invest in supporting families as an effective means for improving population health. For several decades, the concept of family-centered care (recognition of family members as partners) has been a standard for high performing health care. Much of the focus has been on family involvement in making care decisions and shaping a plan for treatment. Concurrently, an evidence base on the importance of family dynamics in influencing health has grown. Some evidence suggests that positively changing outcomes for family members of several generations, particularly for historically disadvantaged populations, requires not only partnering with families but also building integrated approaches that simultaneously meet the different health and social needs of several immediate family members. The import of these findings, however, has not been widely incorporated into population health strategies.

As health systems and insurers, including state Medicaid programs, seek to improve health outcomes, control rising health care costs, and reduce the impact of poor health outcomes on the nation's economy, it is time to think about how a family-based approach to care can contribute to population health strategies. Several leading child health experts recommend pursuing integrated care for families by focusing on the interruption of the causal pathways that can lead to long-term and multigenerational health conditions.<sup>1,2</sup> This would require embracing and expanding the concept of family-centered care to include family-based interventions as a key component of an overarching population health strategy.

The brief presents a conceptual framework for using family-centered care as a launch pad for pursuing a goal we call “integrated family care”—systematically ensuring that all family members' health needs are met through effective, seamless, and integrated services. This framework is similar to approaches that have been used to conceptualize other important shifts in health care, including behavioral health integration into primary care<sup>3</sup> and children's health system transformation<sup>4</sup> that is inclusive of community and social service organizations. The brief concludes with pragmatic strategies for payers and providers to move toward “integrated family care” as part of their population health work.

<sup>1</sup> Bonney J and Chang DI. February 2017. Realizing The Promise of Medicaid Prevention and Population Health. Nemours. [https://www.movinghealthcareupstream.org/wp-content/uploads/2018/06/whitepaper\\_final7a.pdf](https://www.movinghealthcareupstream.org/wp-content/uploads/2018/06/whitepaper_final7a.pdf)

<sup>2</sup> Bruner C, Counts N, and Dworkin P. November 2017. “Alternative Payment Models for Pediatrics: Operationalizing Value-Based Care Over the Life Course.” In CK Marks. <http://www.inckmarks.org/docs/keyissues/ALTPAYMENTMODELSjointMHAHMGCFPC.pdf>

<sup>3</sup> Chung H, Rostanski N, Glassberg H, Pincus HA. June 2016. Advancing Integration of Behavioral Health into Primary Care: A Continuum-Based Framework. United Hospital Fund. <https://uhfnyc.org/publications/publication/advancing-integration-of-behavioral-health-into-primary-care-a-continuum-based-framework>

<sup>4</sup> Halfon N, DuPlessis H, and Inkelas M. March 2007. Transforming the U.S. Child Health System. *Health Affairs* 26(2):315-30. <https://www.healthaffairs.org/doi/10.1377/hlthaff.26.2.315>



# Why Focus on Families?

There are three reasons why health insurers, in particular, should deepen their knowledge of and support for family health care strategies: improved health outcomes; an emerging business case; and pressure from medical societies and physician champions for delivery system reform.

## Health Outcomes

The Institute of Medicine's landmark 2001 report, "Crossing the Quality Chasm," highlighted the importance of patients and their families as key drivers in achieving optimum outcomes in health treatment. They are better equipped than clinicians to identify family circumstances and preferences that must be considered in shaping a plan of care for the patient. Over the years, health care providers and payers have followed this approach and actively supported changing primary care practice to incorporate an emphasis on patient and family "centeredness": the most widespread example is the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) recognition program.

In parallel, the last two decades have ushered in a new understanding of how family relationships and dynamics directly affect health and have a critical impact on the child—especially during the early years of life—through a combination of genetic, environmental, and social factors. Family members tend to learn and reinforce healthy and unhealthy behaviors between one another.<sup>5</sup> Chronic physical and mental health disorders can be alleviated or exacerbated by family functioning, and poor family interactions in early childhood can result in changes to multiple organ systems that make chronic illness more likely.<sup>6</sup> Social disadvantage—which can include factors commonly referred to as social determinants of health—is also found in families across multiple generations, leading to intergenerational cycles of poor health and inequity.<sup>7</sup> These dynamics partially explain why children have about three-and-a-half times the odds of having very

## A Word About This Paper's Approach

"Family" can have broad and varying definitions, most often understood to include both biological and "chosen" family. This paper is written from a child-centric perspective, and, as such, examples focus primarily on the relationship between caregiver and child health—but family dynamics can include siblings, three-generation families, and other configurations. The paper also takes a primary care orientation because primary care is preventive in nature and offers opportunities to present family-based interventions in a non-stigmatized setting. Children's primary care, however, is not the only segment of health care that could benefit from a family orientation. Adult medicine providers and specialists, especially behavioral health providers, have an equally important role to play in the evolution toward "integrated family care."

<sup>5</sup> Pachucki MA, Jacques PF, Christakis NA. 2011. Social network concordance in food choice among spouses, friends, and siblings. *AM J Public Health* 101(10): 2170 – 2177.

<sup>6</sup> Shonkoff JP et al. January 2012. The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics*: 129 (1) e232-e246. <https://pediatrics.aappublications.org/content/129/1/e232>

<sup>7</sup> Cheng TL, Johnson SB, Goodman E. Breaking the Intergenerational Cycle of Disadvantage: The Three Generation Approach. *Pediatrics*. 2016; 137(6):e20152467.

good or excellent health if their parents have very good or excellent health themselves, although more research is needed.<sup>8</sup>

Many of the nation's most pressing—and costly—health issues are rooted in childhood. Collectively called cognitive, affective, and behavioral (CAB) health problems, these conditions include many prevalent and costly issues, such as substance use disorders and overdoses, obesity, autism spectrum disorders, and premature birth.<sup>9</sup> While the causes of these conditions are complex, factors such as poor family functioning and hindered parent-child interaction have frequently been linked to their emergence.<sup>10</sup> For example, a parent's untreated depression may hamper his or her ability to carry out a treatment plan to address a child's aggressive behavior.

Evidence currently suggests that, unlike usual care, family interventions can simultaneously improve outcomes for children by better preventing or managing these conditions and can improve outcomes for their caregivers as well. For example, a review of clinician-led family support programs for adolescents with mental health conditions found “positive benefits on caregiver mental health, parenting knowledge, and parenting strategies, as well as improvements in child mental and behavioral health.”<sup>11</sup> Similarly, interventions that focus on better birth outcomes often benefit both the newborn and the mom. The totality of the science should not be interpreted to justify blaming caregivers for these conditions—rather, it should be seen as evidence of the need for family-focused interventions in the prevention and management of these conditions.

### Emerging Business Case

It is well established that public investments in early childhood health and development can yield a significant return on investment over the long-term through better health, educational, and social outcomes. There is also promising evidence that family-based strategies can produce a short- and medium-term economic return on investment for health plans and payers.

The National Business Group on Health, a national non-profit organization that helps large employers with health care decision-making, issued a report in 2007 on the business imperative of investing in maternal and child health. The report cites four main advantages for companies that use their insurance benefit packages and other tools to maximize maternal-child health: lower health care costs, increased employee productivity, improved retention, and a healthier future workforce. The group specifically calls out the need to better support families of children with special health care needs.<sup>12</sup>

Public insurers, such as Medicaid and Children's Health Insurance Programs, also stand to gain from the broader societal benefits that can result from family-based interventions. The Washington State Institute for Public Policy catalogues benefit-cost analyses of interventions of interest to

<sup>8</sup> Murphy D, et al. October 2018. The Health of Parents and Their Children: A Two-Generation Inquiry. Child Trends. Publication #2018-4. [https://www.childtrends.org/wp-content/uploads/2018/10/AECFTwoGenerationHealth\\_ChildTrends\\_October2018.pdf](https://www.childtrends.org/wp-content/uploads/2018/10/AECFTwoGenerationHealth_ChildTrends_October2018.pdf)

<sup>9</sup> Counts NZ, et al. April 2018. Redesigning Provider Payments to Reduce Long-Term Costs by Promoting Healthy Development. National Academy of Medicine.

<sup>10</sup> Counts NZ *ibid*, Cheng TL *ibid*.

<sup>11</sup> Kuhn, E. S., & Laird, R. D. (2014). Family support programs and adolescent mental health: review of evidence. *Adolescent health, medicine and therapeutics*, 5, 127-42. doi:10.2147/AHMT.S48057

<sup>12</sup> Campbell KP, editor. 2007. Investing in Maternal and Child Health: An Employer's Toolkit. Washington, DC: Center for Prevention and Health Services, National Business Group on Health. <https://www.businessgrouphealth.org/pub/?id=f3004374-2354-d714-5186-b5bc1885758a>

policymakers. Numerous family-based interventions are included (across domains such as child and adult mental health, health care, substance use disorders, and child welfare), and many show a cumulative benefit within one-to-three years. For example, an analysis of child-parent psychotherapy estimates a considerable monetary benefit (\$15 for every \$1 invested) for taxpayers, participants, and others (including employer-paid insurers). Given the significant anticipated payoff for this program, it is reasonable for public insurers to expect a return on investment, possibly even in health care savings alone.<sup>13</sup>

### Demand for Delivery System Reform

The pediatric community has increasingly urged its members to become aware of these family relationships and circumstances and to view them as central to caring for children. The American Academy of Pediatrics' 2012 policy statement, *Patient and Family-centered Care and the Pediatrician's Role*, and its March 2016 paper, *Poverty and Child Health in the United States*, both address the importance of recognizing family stressors in caring for children. Additionally, the fourth edition of the Bright Futures Guidelines states that pediatricians should take a "2-generation" approach, i.e., helping children and parents simultaneously.

Some payers are responding to this new focus on family issues. Most state Medicaid programs now cover dyadic (parent-child) mental health interventions.<sup>14,15</sup> In May 2016 guidance from CMS encouraged state Medicaid officials to cover maternal depression screening as part of a well-child visit and pay for it under the child's Medicaid. Montefiore Medical Center's implementation of HealthySteps, an integrated model of pediatric behavioral health, includes mental health supports for parents; it has yielded outcomes of interest to payers and health systems, including improvement on Healthcare Effectiveness Data and Information Set (HEDIS) measures, improved family satisfaction, and medium-term cost savings.<sup>16</sup> This model is particularly illustrative because it demonstrates the feasibility of integrating family interventions into routine clinical operations while also highlighting the need to provide primary care offices with technical assistance and financial support to help them integrate family interventions into their work.

While the pediatric and family medicine professions have driven much of this work, the internal medicine community could also improve primary care for adults through a greater integration of family approaches. Adults who take on caregiving responsibilities, often for aging parents, can experience detrimental health effects.<sup>17</sup> Parents caring for children with developmental disabilities are more likely to report depressive symptoms.<sup>18</sup>

<sup>13</sup> Washington State Institute for Public Policy. 2018. Child-Parent Psychotherapy. <http://www.wsipp.wa.gov/BenefitCost/Program/263>

<sup>14</sup> Several commonly cited, evidence-based therapies include: Parent-Child Interaction Therapy (PCIT), Child Parent Psychotherapy (CPP), Attachment Biobehavioral Catch-up (ABC), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

<sup>15</sup> Burak E and Rolfes-Haase K. November 2018. Using Medicaid to Ensure the Healthy Social and Emotional Development of Infants and Toddlers. Georgetown University Health Policy Institute Center for Children and Families. [https://ccf.georgetown.edu/wp-content/uploads/2018/12/Medicaid-and-IECMH\\_FINAL.pdf](https://ccf.georgetown.edu/wp-content/uploads/2018/12/Medicaid-and-IECMH_FINAL.pdf)

<sup>16</sup> Guyer B et al. 2003. Healthy Steps: The First Three Years. Nancy Hughart and Janice Genevro, eds. Women's and Children's Health Policy Center, Department of Population and Family Health Sciences, Johns Hopkins Bloomberg School of Public Health. Baltimore, Maryland. [https://ztt-healthysteps.s3.amazonaws.com/documents/139/attachments/2003\\_HS\\_National\\_Evaluation\\_Report.pdf?1539967824](https://ztt-healthysteps.s3.amazonaws.com/documents/139/attachments/2003_HS_National_Evaluation_Report.pdf?1539967824)

<sup>17</sup> Pinquart M, Sorensen S. Correlates of physical health of informal caregivers: a met-analysis. J Gerontol B Psychol Sci Soc Sci. 2007;62(2):P126–P137.

<sup>18</sup> For example, many families of children with autism spectrum disorder (ASD) report feeling isolated and describe their reaction to a new diagnosis of ASD as a grieving process similar to having lost a child, which can increase depressive symptoms. Conversely, having positive parent-child relationships can protect against depression.

## Framework

The graphic on page 7 illustrates how payers and providers can form a bridge between family-centered care and an expanded goal of “integrated family care.” It is intended to help payers and providers conceptualize the types of changes they can introduce to become more family-oriented without being prescriptive about the precise steps. The illustration is not exhaustive, but it can hopefully encourage further exploration of delivery system and payment reforms that reflect family influences on health.

**Foundation:** Strengthening family-centered approaches to care and pursuing “integrated family care” requires a strong foundation of health insurance coverage for both children and their parents. Research shows that insuring children without insuring their parents is insufficient for getting children the health services they need. Insured children with uninsured parents are more likely to experience insurance coverage gaps, not have a usual source of care, have unmet health care needs, and miss preventive care services.<sup>19</sup> Uninsured parents are also less likely to receive care for their own medical conditions, such as mental health disorders, that when left untreated can adversely affect their child’s health. After declining for a decade, the child uninsured rate increased in 2017,<sup>20</sup> underscoring that progress on coverage for families cannot be taken for granted.

**Family-centered care:** The concept of “patient and family-centered care” originated with the pediatric community in the 1990s.<sup>21</sup> It was incorporated in a set of principles that became the basis of the Patient Centered Medical Home (PCMH) model adopted in 2007 by four health care primary care provider organizations: the American Academy of Pediatrics, the American College of Physicians, the American Osteopathic Association, and the American Academy of Family Physicians. The model stresses partnership with families and a continual effort to be responsive to their needs. The primary care team is expected to encourage and support the patient and his or her family in making decisions about treatment and in developing and implementing the plan of care. The PCMH practice also takes on a major responsibility for coordinating care with other providers on behalf of its patients. Several national organizations—NCQA, The Joint Commission, URAC—develop and regularly update sets of standards for the PCMH model and recognize practices that meet them.

Numerous state Medicaid programs and commercial payers incentivize PCMH recognition by financially rewarding providers who attain the certification or by giving preference to them when the plan auto-assigns members to a primary care provider.<sup>22</sup> Despite the widespread support for the PCMH model, its adoption is far from universal. Family-centered care is critical to any effort to integrate family care.

**Bridging Efforts:** In recent years, a growing number of providers have begun using the platform of patient and family-centered care to seize opportunities for identifying health conditions of

<sup>19</sup> Georgetown University Health Policy Institute Center for Children and Families. March 2017. Health Coverage for Parents and Caregivers Helps Children. Washington, DC. <https://ccf.georgetown.edu/wp-content/uploads/2017/03/Covering-Parents-v2.pdf>

<sup>20</sup> Alker J and Pham O. November 2018. Nation’s Progress on Children’s Health Coverage Reverses Course. Georgetown University Health Policy Institute Center for Children and Families. Washington, DC. [https://ccf.georgetown.edu/wp-content/uploads/2018/11/UninsuredKids2018\\_Final\\_asof1128743pm.pdf](https://ccf.georgetown.edu/wp-content/uploads/2018/11/UninsuredKids2018_Final_asof1128743pm.pdf)

<sup>21</sup> The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child’s medical records. Beginning in the 1990s, this concept began to be formally defined and broadened to include concepts of patient and family-centeredness.

<sup>22</sup> The federal Medicare program, beginning in 2019, will also give a PCMH-recognized practice the maximum points allowed for the Clinical Practice Improvement Activities element of its MACRA score.

family members that impact their patient's own health and development, and strengthening family relationships. Ideally, providers can build a bridge between family-centered care and “integrated family care” by inquiring about—and offering interventions or referrals for—priority family health concerns that are pertinent to their main client.

The best-known example of “bridging efforts” may be the implementation of maternal depression screening during well-child visits and the billing for such services under the child's insurance plan. Other clinical interventions akin to this include detection of parental substance use disorder or significant parental stress. Additionally, by recognizing that safe, stable interactions between children and caregivers is a protective factor for child health, some providers may incorporate programs designed to promote positive parenting and nurture the parent-child bond (e.g., Parenting Journey and Reach Out and Read). Providers may also offer interventions directly aimed at reducing family stress, such as screening for social determinants of health that affect the entire family or strengthening family members' interactions. Indeed, the NCQA's 2017 PCMH edition requires practices to document medical and social needs for the entire family—this suggests that the medical home model itself is evolving toward more integrated family care.

Many of these efforts have been funded by grants, although some health plans and state Medicaid programs have supported such endeavors through billing changes and demonstration programs. New quality improvement initiatives, such as maternal depression screening during the first six months of life, also support the transition.

***Integrated family care:*** “Integrated family care” is a label we are introducing to represent the desired goal of systematically ensuring that all family members' health needs are met through effective, seamless, and integrated services. Moving toward this goal requires a significant shift in how providers and payers view families. It also necessitates a transformation of health care delivery structures and payment incentives that encourage family-based approaches and reduce unnecessary silos between care for family members.

While this paper does not offer a formal definition of “integrated family care,” it shares many elements that could belong to this model. These include strategies that are primarily emerging outside of health care under the banner of “two-generation approaches” and reflect a particular need to use and be accountable for outcome measures for all family members.<sup>23</sup> A resolute focus on improving family outcomes will likely require not just greater integration of health care services between individual family members, but also between physical and mental health care and social services. When asked, youth and families with mental health conditions have expressed a desire for an “outcomes-focused delivery system that holds all stakeholders accountable, regardless of which service system the children and families are in.”<sup>24</sup> The Accountable Communities for the Health of Children and Families is a notable attempt to bring these elements together under one organized service delivery rubric.<sup>25</sup>

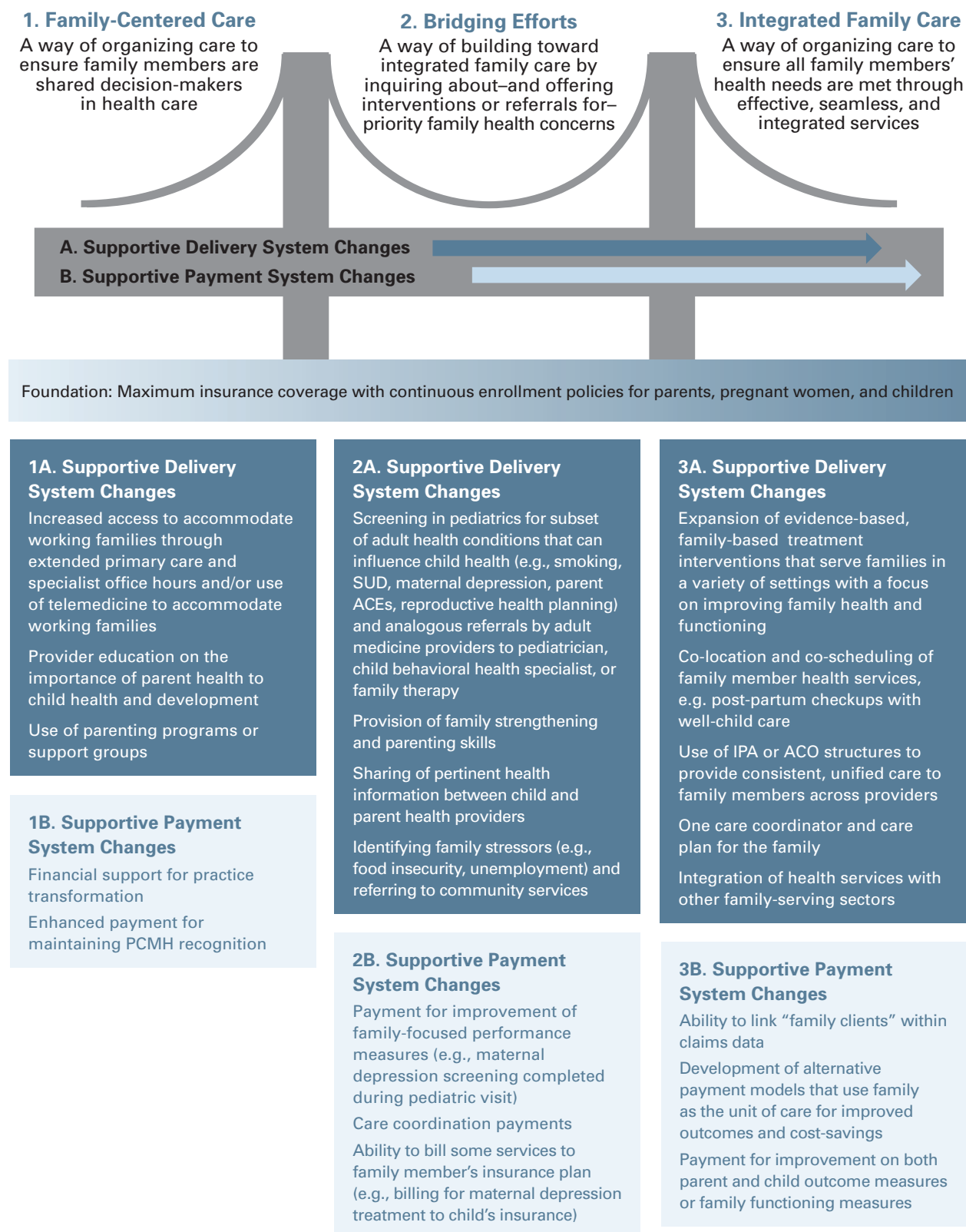
<sup>23</sup> Ascend at the Aspen Institute. March 2016. Making Tomorrow Better Together: Report of the Two-Generation Outcomes Working Group. Washington, DC. <http://ascend.aspeninstitute.org/resources/making-tomorrow-better-together/>

<sup>24</sup> Dababnah S and Cooper J. July 2006. Challenges and Opportunities in Children's Mental Health: A View from Families and Youth. National Center for Children in Poverty. New York, NY. [http://www.nccp.org/publications/pdf/text\\_673.pdf](http://www.nccp.org/publications/pdf/text_673.pdf)

<sup>25</sup> Gratale D and Chang D. October 2017. Defining an Accountable Community for Health for Children and Families. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC. doi: 10.31478/201710e



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



## Barriers to Pursuing Integrated Family Care

The nation is still a long way from integrated systems of care for families. Like all shifts in health care delivery and payment, pursuing integrated family care will require overcoming significant barriers. The concept is in its infancy, and further development is necessary; family-centered care, on the other hand, is a well-established model but not universally implemented.

One barrier that exists at a systemic level is the absence of clinical care coordination structures, quality measures, and incentives focused on families—despite the proliferation of individual-focused reforms in these domains. Currently, practices have limited means to share pertinent family health information across provider types (e.g., from Ob/Gyn to pediatrics, or pediatrics to women’s health providers) or to deploy care coordination resources focused on family members. This problem may be particularly acute for behavioral health providers, who are frequently less connected to other health services and sometimes left out of broader health system transformation efforts. Quality measures tend to focus on individuals and do not yet adequately account for integrated family processes or desired outcomes for children and families.<sup>26</sup>

Health care data systems typically track individuals, not families. Many electronic medical record systems lack the ability to link family members, and Medicaid programs (unlike some commercial products) are also often unable to establish family connections through claims data. The challenge of linking family members is exacerbated when children and parents are served by different insurance plans.<sup>27</sup> Furthermore, the use of different plans by one family makes it harder for payers to decide to invest in an intervention because health care-related return on investment may not accrue to the plan paying for the treatment. Consider this example: a young child has a diagnosed behavioral disorder for which the recommended treatment is behavioral parent training—a category of treatment programs that aims to change parenting behaviors as a method for improving a child’s behavioral problems (such as aggression). The child’s plan, however, may not pay for mom and dad to receive the intervention because the barriers described above obscure the financial return on investment for the plan.

Implementation of integrated family care also raises key ethical issues. Providers and payers moving in this direction will need to be clear about how they define “family” and be aware that provider organizations, payers, and individuals in care may differ on their own definitions. This is particularly important to recognize for vulnerable populations that may have been rejected or abused by traditional notions of family—for example, among LGBTQIA persons. Protecting family member privacy, especially in the documentation and sharing of medical information, will also need to be addressed. For those providers willing to innovate, questions about medical liability—Who is the patient from an accountability standpoint? What is the clinician’s responsibility?—will need to be resolved. Finally, providers will need to develop a familiarity and comfort with family-oriented approaches. Primary care providers already have a lot on their plates, and any new effort perceived as increasing their scope of work may understandably be viewed as adding to an already unmanageable to-do list. Prioritization of practice-based changes is important and should be limited to family-oriented approaches that can be linked to improved outcomes.

<sup>26</sup> Counts NZ et al.

<sup>27</sup> This phenomenon may be exacerbated by the decline in dependent coverage through employer-sponsored insurance and consumer protections that limit directing families into specific Medicaid plans.

## Opportunities for Pursuing “Integrated Family Care”

Despite barriers to pursuing more integrated family care, insurers and providers that recognize the critical role family plays in achieving population health goals can pursue several opportunities to make modest but meaningful progress. Insurers, especially public insurance programs, have multiple levers available. These include the scope of benefits, reimbursement policies, better utilization of existing data, quality incentives, plan guidance, and member education. State Medicaid programs have additional levers, including the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirement and federal waivers. Below are some immediate opportunities insurers and providers can pursue.

1. **Increase awareness of existing evidence-based family interventions and explore braided funding opportunities.** High-quality, evidence-based health interventions for families exist. They tend to have limited spread, are generally not well known beyond child development experts, and are often supported via grants or public health rather than funded through insurance dollars. As a starting point for becoming more family-oriented, insurers should educate themselves and their provider networks about these interventions. The Blueprints for Healthy Youth Development database is a good starting point. Insurers can consider demonstration projects of these interventions through a targeted benefit package for families identified for heightened risk of poor outcomes. State Medicaid programs, with a public government lens on cost-savings, can explore opportunities for braided funding for these programs, including the use of Maternal and Child Health and block grants from the federal Substance Abuse and Mental Health Services Administration. Joint information released by the Center for Medicaid and CHIP Services and the Human Resources and Services Administration in March 2016 on how to fund home visiting services may provide a building block.<sup>28</sup>
2. **Use federal and American Academy of Pediatrics guidance to encourage maternal depression screening in children’s primary care.** Intense focus by the American Academy of Pediatrics and others on maternal depression as an influencer of child health outcomes, followed by May 2016 guidance<sup>29</sup> by CMS, has led to 32 state Medicaid programs covering maternal depression screening in pediatric and family medicine settings under the child’s Medicaid plan.<sup>30</sup> Payers in all states should broadly embrace this opportunity to ensure universal uptake among pediatric providers. Additionally, payers and providers can explore expanding on this precedent in three ways:
  - **Include payment for mental health services for the child based on family risk factors and pay for treatment for parental depression under the child’s Medicaid plan.** Nine state Medicaid programs pay for home-based mental health services for children based on family risk factors (such as maternal depression), meaning that a child does not need to have developed a mental health condition in order for important infant and early childhood mental health services to be provided.<sup>31</sup>

<sup>28</sup> Wachino V and Macrae J. March 2016. Coverage of Maternal, Infant, and Early Childhood Home Visiting Services. CMCS and HRSA Joint Information Bulletin. Baltimore, MD. <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf>

<sup>29</sup> Wachino V. May 2016. Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children. Baltimore, MD. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf>

<sup>30</sup> Smith, S., Granja, M.R., Nguyen, U., Rajana, K. 2018. How States Use Medicaid to Cover Key Infant and Early Childhood Mental Health Services: Results of a 50-State Survey (2018 Update). New York: National Center for Children in Poverty, Mailman School of Public Health, Columbia University. [http://nccp.org/publications/pdf/text\\_1211.pdf](http://nccp.org/publications/pdf/text_1211.pdf)

<sup>31</sup>Smith S *ibid*.

- **Use maternal depression screening as a model for identifying additional high-priority parental health conditions in a pediatric setting.** Bright Futures encourages pediatricians to screen and counsel parents for possible additional parental health issues, such as substance use disorder, anxiety, family trauma, and unmet family planning needs.<sup>32,33</sup> Screening for social determinants of health may also fall under this rubric. Payers can follow the maternal depression screening model to cover these screenings under the child's insurance plan. Guidance from CMS on this topic could encourage states to explore this option.
  - **Encourage adult medicine primary care providers to screen for family issues.** Though a lesser-explored option to date, adult medicine providers can also be encouraged to inquire about child or other family member dynamics that may influence the care recipient's health. For example, parents of children with medically complex conditions face stress and caregiving demands that may be detrimental to their own health. Providers may provide referrals to supportive services, and payers may fund respite care for these families.
3. **Compile and analyze state data on complex families.** Most states have significant data about complex families, but it is usually focused on the individual and kept in discrete state-program silos; it is rarely connected to create a composite portrait of a family. In 2015 the Minnesota Department of Human Services released a study of family risk factors among children enrolled in the Minnesota Medicaid or MinnesotaCare program. Working with data collected by the state's Medicaid, food support, and cash assistance programs—both eligibility files and claims—the study paints a stunning portrait of the frequency with which children in Minnesota families experience multiple factors associated with risk of poor outcomes. For example, 13 percent of Medicaid-enrolled children had a parent treated for serious mental illness within an 18-month period. Armed with this data, the state is now studying potential payment and quality initiatives that would target these high-risk families.<sup>34</sup>
  4. **Offer planning grants for providers that want to explore the development of integrated family care through new partnerships or contracts.** Commercial insurers, state Medicaid programs, or Departments of Health can make needs assessment and planning grants available to providers that want to explore the feasibility of developing integrated family care structures. For example, under New York's shift to value-based payment in Medicaid, groups of behavioral health providers (known as Behavioral Health Care Collaboratives) were awarded grants to increase readiness for value-based payment. One of these groups, the AsOne Independent Practice Association, was created specifically to provide family-based treatment across primary care and behavioral health specialists for adults and children alike, with a special emphasis on evidence-based, family-focused interventions for complex families.

<sup>32</sup> Zuckerman B. Jan 2016. Two Generation Pediatric Care: A Modest Proposal. *Pediatrics* 137 (1) e20153447; DOI: 10.1542/peds.2015-3447

<sup>33</sup> Cheng TL, Johnson SB, Goodman E. Breaking the Intergenerational Cycle of Disadvantage: The Three Generation Approach. *Pediatrics*. 2016; 137(6):e20152467.

<sup>34</sup> Minnesota Department of Human Services. April 2015. How prevalent are family risk factors among Minnesota children who receive Medical Assistance or Minnesota care, Office of the Medical Director, Office of the Assistant Commissioner, Health Care, Minnesota Department of Human Services. [https://earlysuccess.org/sites/default/files/website\\_files/Edwall\\_Family%20Risk%20Factor%20Report-Final.pdf](https://earlysuccess.org/sites/default/files/website_files/Edwall_Family%20Risk%20Factor%20Report-Final.pdf)



5. **Clarify or enhance State “patient-centered medical home” standards and incentives to include family-focused interventions and coordination.** Some states are creating their own patient medical home standards that build upon and customize the NCQA PCMH model. This approach offers an opportunity to encourage more family-oriented care. For example, care coordination requirements under PCMH could be broadened to encourage information-sharing between child and adult practitioners treating the same family. While there is no known example of this, such an approach has been recommended by the New York Preventive Pediatric Care Clinical Advisory Group. North Carolina’s Pregnancy Medical Home Model is also the type of state-driven PCMH approach that could be expanded to include family-oriented features.
6. **Leverage the Center for Medicare and Medicaid Innovation’s Integrated Care for Kids and MOM demonstration projects to test family integration models.** In fall 2018 the Center for Medicare and Medicaid Innovation announced two upcoming funding opportunities for state Medicaid programs to plan and test new delivery systems to integrate physical health, mental health, and social services for children and pregnant women. The Integrated Care for Kids model addresses care of all Medicaid-covered children up to age 21; the maternal opioid misuse model focuses only on pregnant and postpartum Medicaid beneficiaries and their infants. Family approaches are emphasized in both opportunities—a feature that should not be lost during a state’s planning and implementation efforts. Commercial insurers can also learn from these demonstration projects.
7. **Pilot alternative payment models that support integrated family care.** One emerging idea: health plans (with appropriate state and federal approval if using Medicaid dollars) can partner with providers to test new payment models that foster collaboration between providers caring for different members of the same family.<sup>35</sup> Under such models, the providers would assume financial risk, and their performance would be evaluated collectively for all attributed family members. While numerous designs are possible, two possible avenues to explore include:
  - **Maternal and child bundle that begins in the prenatal period and extends to the child’s first or second year of life.** The stage extending from the prenatal period through a child’s first birthday should be a joyous time in the lives of families. But, sadly, this formative phase is too often marred by serious injury or health conditions, or even death, for newborns and moms. Like many poor outcomes, these are high-cost conditions for payers. Maternity bundles focused on prenatal care and labor and delivery already exist in many states. Typically, the maternity care bundle episode ends at 30-days post-discharge for the newborn and 60-days post-discharge for the mom. Under a pilot that expands the bundle, the episode would be extended to the child’s first birthday to include services for mom and child, with some exclusions. The bundle would contain evidence-based interventions for improving maternal and child health outcomes, such as those in the infant mortality prevention toolkit from the National Institute for Children’s Health Quality.<sup>36</sup> Such a bundle, extending for a full year

<sup>35</sup> New York State Department of Health. September 2017. Value-Based Payment for Children: Report to the NYS Medicaid VBP Workgroup. Albany, NY. [https://www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/vbp\\_library/docs/2017-09-12\\_child\\_cag.pdf](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/docs/2017-09-12_child_cag.pdf)

<sup>36</sup> National Institute for Children’s Health Quality. 2017. Infant Mortality CoIIN Prevention Toolkit. Boston, MA. <https://static.nichq.org/prevention-toolkit/?submissionGuid=38cc6a15-7706-4965-8aff-fded9a6fad24>

postpartum, would encourage collaboration between women's health and child health providers on critical interventions that reduce maternal mortality and infant mortality; it would also improve parent-child attachment and overall family health.

- **Shared-risk or full-risk arrangement for families with complex needs.** This kind of pilot would test the feasibility of pursuing shared savings through evidence-based interventions focused on treating families with complex social, physical, or behavioral health needs. Under this arrangement, children and their caregivers would be treated as a single unit of care so that benchmark expenditures would be established and one or two-year cost-savings would be calculated. The theory is that by aligning families under a single payment arrangement, interventions can be targeted to all family members and the return on investment for high-cost family members (most likely adults) can be used to justify the cost of the intervention for the entire family. This would potentially overcome a common barrier: failure to make a strong business case for the interventions due to the inability to demonstrate a sufficient near-term return on investment for prevention activities, particularly for children. Data strongly suggest that such an approach for behaviorally complex families—if used to support evidence-based interventions—would yield both improved outcomes for families and a return on investment for payers; more research is needed to test such a concept with families with physically complex conditions.

Any pilot would need to work through the following design issues:

- *Target population:* One approach to defining a target population could be focusing on a specific set of child or parental diagnoses (e.g., obesity, substance use disorder) or family characteristics (e.g., multi-system involved families, parent under age 21). Alternatively, the pilot could be structured to test a specific evidence-based family intervention for its precise return on investment potential.
- *Tracking families in data:* Pilot implementation will require the ability to identify and link family members within the health plan's data. Most commercial, and some Medicaid, health plans have a family ID that allows them to identify all family members on the same policy. If a plan does not have this function, a more feasible option for a pilot stage may be to first recruit families for participation and then collect their insurance numbers so data for family members can be tracked. The risk of this latter approach, however, is that family members may not belong to the health plan(s) willing to participate in the pilot. If this is the case, it might be necessary to migrate family members into the same product—but only if consumer choice can be guaranteed. One option: attract families to an insurance plan due to the additional benefits that come with participation in the pilot.
- *Services and benefit package:* The care delivery model to be supported by the payment pilot must be defined. This should include the evidence-based services that will be supported by payers as part of the effort to improve outcomes for families, as well as the general insurance benefits for enrolled families.
- *Cost:* Payers and providers will need to agree on the estimated cost of delivering the above benefits and services to families in order to set a shared-risk or full-risk benchmark and encourage efficient care. To see if the new pilot structure results in savings at the end of the pilot period, payers will want to compare expenditures

for families in the pilot to either a control group or historical expenditures for attributed members.

- *Expected outcomes:* The plan and provider group must agree on what success should look like. This could include a variety of outcomes: a combination of expected cost benefits (either savings or cost neutrality) driven by reduced hospitalizations or emergency department use, or improved disease management (e.g., better control of type II diabetes or asthma); progress on HEDIS measures; and improved outcomes for families, such as those being deliberated by the *Collaborative on Vital Signs for the Health and Well-Being of Children and Families* led by The National Academies of Sciences, Engineering, and Medicine.

## Conclusion

Population health strategies would be stronger if providers and stakeholders paid greater attention to families and intergenerational transmission of health disparities. While often discussed in the context of children's primary care, all segments of health care—including payers and adult medicine—can benefit from, and contribute to, a more family-oriented health system. All health players can work toward this goal by reinforcing their commitment to family-centered care, learning from the innovators building upon this approach, and seizing health transformation and redesign opportunities to pursue and test integrated family care.