FINAL REPORT

of the
First 1,000 Days Preventive Pediatric Care Clinical Advisory Group

New York State Department of Health
Office of Health Insurance Programs

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NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Summary

New York State's (NYS) First 1,000 Days on Medicaid Initiative recognizes that the earliest years of life greatly influence long-term health and well-being. Optimal growth and development in early childhood have been scientifically proven to have sustained impacts on health, educational achievement, and economic productivity. Many children are at risk for not achieving their full potential due to individual and community-based disparities in health and available services. The Preventive Pediatric Care Clinical Advisory Group (CAG) understands that the primary care practitioner's office is the ideal setting to support optimal outcomes for NYS's children and families, identify children and families at risk, and link children and families to appropriate services.

The Preventive Pediatric Care Clinical Advisory Work Group is committed to a comprehensive Model of Pediatric Population Health, one that integrates care for parents and other caregivers into primary care for children. This Model of Pediatric Population Health[1] requires (1) practice transformation to address social determinants of health related to poverty, racism and other environmental influences, and (2) integrates behavioral health[2] care while continuing to address biomedical factors. We envision a future where all New York primary care practices that provide health care to children comprehensively support the growth, development, and wellness of *all* children and families. This vision of practice transformation addresses systemic disparities, fosters trust between families and medical providers, promotes community linkages, and provides 2-generational, trauma-informed, culturally competent, and integrated primary and behavioral health care for all. Practice transformation in pediatric care is the cornerstone of this model, with the goal to achieve health equity among all children and families.

The NYS Model of Pediatric Population Health will build on Bright Futures (4th edition), the patient- and family-centered medical home model of care, and New York State's nationally recognized investment in the First 1,000 Days on Medicaid Initiative. The vision of pediatric population health will be accomplished by:

- focusing resources, trainings, and practice transformation assistance from the New York State Patient-Centered Medical Home program on child health and development, including developmental and psychosocial screening, screening for family needs, cross-agency care management, and integrated data systems specific to this Model of Pediatric Population Health;

[1] "Pediatric" is used throughout this document to refer to all providers of primary care for children, including family medicine providers.

[2] Integrated behavioral health is inclusive of care for mental health and care related to substance use disorder, for the purposes of this document.

- equipping primary care practices and Managed Care Organizations (MCOs) with the necessary skills and resources to promote optimal development of the child, including multi-generational behavioral health care integrated into practices providing primary care for children and families;
- fostering family resiliency and strengthening protective factors, and focusing health promotion efforts on these goals;
- securing agreement on trackable, cross-agency population health measures for optimal developmental and social-emotional outcomes that focus on long-term health, education, and wellness; and
- developing payment models linked to the health and developmental outcomes that effectively support primary care practices to achieve this vision.

Recommendations

Transforming children's primary care in New York so it can significantly advance children's health and well-being is within reach. Strong consensus has emerged around a NYS Model of Pediatric Population Health and its vision for primary care for children and families. Many core elements of the model are already operational in select primary care practices across the state. The challenge is to strategically integrate these elements into advanced primary care practices for children across the state, ensure this model achieves desired outcomes for children, support the model's financial sustainability, and develop the transformation pathway to help all primary care practices move toward this vision. If the below actions are taken, New York will take a giant step forward in securing a better future for its children:

1. **Embrace the NYS Model of Pediatric Population Health.** The NYS American Academy of Pediatrics supports this vision of primary care for children and families, and the NYS Department of Health should formally endorse this vision and support the dissemination and implementation of these recommendations.

2. **Continue to invest in the core programs that comprise the NYS Model of Pediatric Population Health and fill funding gaps.** Current investments in effective children's health programs and primary care transformation efforts must be sustained.

    - To aid the State in supporting these programs, the NYS First 1,000 Days Preventive Pediatric Care CAG will develop a list of existing, evidenced-based and evidence-informed, effective NYS efforts that currently support care consistent with this Model of Pediatric Population Health. Gaps in funding streams for programs, infrastructure, and training needs will also be identified. The list should be provided to the NYS Department of Health no later than February 2019 to inform efforts to secure transformation resources for 2019. (*See Appendix*)
    - **NY State should sustain the HealthySteps model, continue funding for sites funded by the NYS Office of Mental Health HealthySteps pilot, and allow the model to expand to more practices in NY state.** HealthySteps is a unique, evidence-based pediatric primary care program committed to healthy early childhood development and effective parenting so that all children are ready for kindergarten and for success in life. **The**

HealthySteps[3] **program has broad support and provides mental health prevention and some short-term treatment for children and families. Other states have adopted HealthySteps as a statewide model and there is good evidence to support its financial viability in the current environment. Future discussions, including planning for proposed pilots, should include serious consideration of funding to expand the scope of this model to integrate parental mental health treatment into advanced pediatric practices.**

3. **Pilot the NYS Model of Pediatric Population Health with the goal of defining an alternative payment model that supports this population health-based model of primary care for children.**

    - A subcommittee of the NYS First 1,000 Days Preventive Pediatric Care CAG should be charged with helping to design a pilot of the NYS Model of Pediatric Population Health, built on HealthySteps and related approaches, no later than December 2019. This pilot would establish the feasibility and financial viability of this model of advanced primary care for children (as outlined in "Care Model Features" portion of this report below). At least two parent representatives should be invited to join the subcommittee.
    - The Office of Health Insurance Programs, upon receipt of design plans from the NYS Preventive Pediatric Care/Value-Based Payment CAGs, should launch 2 – 4 pilots of the NYS Model of Pediatric Population Health across a combination of rural, urban, suburban, upstate and downstate health systems. A combination of state, federal (e.g. Integrated Care for Kids demonstration project) and private funding should be considered. The focus of the pilots should be to (1) test the feasibility of combining all core model components – including integrated child and family behavioral health care - into individual primary care practices caring for children, (2) assess transformation and ongoing operating costs of the model to inform development of a pediatric Value-Based Payment (VBP) approach, and (3) define a set of process/outcome measures that would be used to measure success of the model in pilot phase and when it is expanded to scale. A parent/peer advisory council should advise the pilot. Measures of equity in outcomes and of the strength of the family-provider relationship must be included among the measures.
    - As part of the pilot, the Office of Health Insurance Programs, building on the MCO Kids Quality Agenda effort under the First 1,000 Days on Medicaid Initiative, should convene Medicaid managed care organizations and providers to define a core set of screenings, based on Bright Futures, 4th edition, that could be paid for as an all-or-nothing, standardized suite of screenings and reporting beyond what is currently included in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Enhanced payment could be made available to participating providers or considered in VBP contracting. This effort could, over time, be expanded to include other model components that required enhanced payment.

[3] https://www.healthysteps.org

4. **Interpret primary care patient-centered medical home (PCMH) standards for pediatrics, and advance health and education collaborations to improve the baseline performance for all NYS pediatric practices.**

    - The NYS Department of Health should review NYS PCMH standards with attention to care for children and involve members of the NYS First 1,000 Days Preventive Pediatric Care CAG in developing a guide to interpreting those standards for use in practice, so they best support this model of pediatric care. These standards, with corresponding technical assistance and resources to support practice transformation (funded from the State Innovation Model through 2019 or an alternative source), should be integrated into the NYS PCMH certification process. Funds awarded to Performing Provider Systems as part of the DSRIP Program would also be appropriate to support transformation of pediatric practices and pediatric-focused DSRIP projects.
    - The NYS Department of Health and State Education Department (SED), aligned with the SED Early Childhood Workgroup Blue Ribbon Committee's recommendations, should explore solutions for improving communication and data sharing between practices providing primary care for children and related systems, including but not limited to: schools, maternity/obstetric providers, and early intervention providers in a manner consistent with HIPAA[4] and FERPA[5]. This would include clarifying existing policy and exploring areas where policy change might be needed. Additionally, NYS Department of Health and SED should address and resolve any potential issues of scope of practice raised by the 2-generation model of care to make it clear that this model of primary care for children is supported by NY State.

5. **Track progress toward implementing the NYS Model of Pediatric Population Health and its impact on children's health, development, and well-being.**

    - The NYS Department of Health should evaluate how its existing Maternal and Child Health Dashboard might be enhanced to track population-level outcomes and kindergarten readiness for the NYS Model of Pediatric Population Health.
    - The Office of Health Insurance Programs should designate a pediatric advisory group – a combination of the First 1,000 Days Pediatric Preventive Care CAG and the Children's VBP CAG – to provide advice to NY State on Pediatric Value Based Care and to assess progress toward achieving implementation of the NYS Model of Pediatric Population Health.

[4] Health Insurance Portability and Accountability Act.

[5] Family Educational Rights and Privacy Act.

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The Vision

We envision a future where all New York practices providing primary care for children are medical homes that improve population outcomes in children and effectively address racial and other disparities, while also delivering care in a way that engenders trust and respect from the families they serve. This means each practice is equipped to support families by focusing on both the biomedical and social-emotional elements that affect child development and are essential to achieving health equity. Institutional racism and other system-level barriers, along with larger community concerns such as poverty and incarceration, should be addressed as we work to support 2-Generation family care.

To achieve this, we will:

1. build on NYS's nationally-recognized investment in the First 1,000 Days on Medicaid Initiative, focusing resources and technical assistance from the New York State Patient-Centered Medical Home program on the transformation of primary care practices that care for children;
2. equip primary care practices and MCOs with the skills, resources, and access to information necessary to promote optimal development of the child, focusing health promotion efforts on these goals;
3. actively assist caregivers to meet their own needs, foster family resilience, address structural racism and poverty at the practice level, and provide practices and MCOs with the training necessary to achieve these goals;
4. build tiered support for families into primary care practices – including integrated behavioral health interventions for parents and children, with intensity of support based on risk stratification;
5. secure cross-agency agreements, including but not limited to the State Education Department, on trackable, multi-agency population health measures for optimal developmental and social-emotional outcomes;
6. develop payment models linked to health and developmental outcomes that effectively support primary care practices to achieve this vision, moving from a disease-based model to one that acknowledges equity in both biomedical and social-emotional outcomes as a primary outcome of interest for pediatric primary care; and
7. develop integrated, information-sharing systems that allow meaningful information exchange between families, medical practices, and community agencies, including early childhood programs and schools.

The Rationale

Supporting scientific evidence is overwhelming: optimal growth, nutrition, health, and wellness in early childhood, especially in the first three years of life, can improve a broad range of health, social, and educational outcomes.

- Because pediatric primary care provides nearly universal, frequent access for children and families during early childhood, pediatric primary care is well positioned to promote optimal childhood growth and development, identify and mitigate risk factors for families, and promote protective factors. As such, primary care for children should be considered health care's frontline strategy for improving population health and achieving health equity.
- Despite its potential to improve individual health and broader societal outcomes, primary care for children has historically been underinvested and is at risk of continuing to be underinvested as Medicaid transitions to value-based payments. Additional investment in early childhood development and wellness through pediatric primary care transformation can yield substantial cost savings for Medicaid and other parts of government (education, child welfare) in the long run. There is growing evidence that some short-term savings are possible, but substantial savings, both in health care expenditures and additionally across sectors, are expected in the medium and longer terms. Primary care for children must transform to a population health delivery system model where investment in longer term outcomes is included in the model.
- An effective program of interventions in early childhood can have an impact on disparities throughout life, reducing both traditionally defined health disparities and significant disparities in social-emotional health among children in NY State.
- Many structural factors, including racism and poverty, negatively impact optimal growth and development of children and are the primary cause of disparities in health outcomes in children. Many health disparities in adults have their roots in childhood, and the majority of children in NY State are children of color. Children impacted by these factors are seen in both safety net clinics and private practices.

Care Model Features

The proposed New York State Model of Pediatric Population Health supports an integrated system of child health, building on the traditional patient-centered medical home model in three fundamental ways:

1. higher standards for comprehensive well-child care that call for the integration of evidence-based interventions to support optimal growth and development;
2. care coordination/case management capacity for navigating across medical services and social determinants of health to include other supporting roles such as community health workers and peer navigators, and engagement with faith-based organizations; and
3. integrated behavioral health care that is sensitive to the relationship between the health care practitioner and family, culturally sensitive, age-appropriate, and 2-generational.

Higher standards and better tools for comprehensive well-child care and panel management include:

- use of pre- and post-visit planning;

- integrated technologies that allow for efficient administration of structured screening tools, pre-visit information-sharing, and post-visit linkages and communication between referral sources;
- team-based care that includes social workers, case managers, care coordinators, community health workers, and/or parent partners, as examples, focusing on 1) trauma-informed/culturally competent care, 2) shared decision-making, 3) risk stratification incorporating psychosocial determinants of health, and 4) provision of care coordination;
- increased mutual understanding, trust, and respect between provider and family/child achieved through increased visit times for improved dialogue; and
- use of at least one evidence-based primary prevention strategy aimed at promoting child development (e.g. systematic referral to home visiting programs; Reach Out and Read).

Care coordination/case management capacity (not necessarily practice-based) that can navigate across health services and social determinants of health includes:

- personnel – either peer navigator or Community Health Worker – with the ability to link families across relevant educational organizations and community-based social service and mental health providers, and with expertise in early childhood-focused services (e.g. WIC, childcare enrollment, home visiting programs, maternal family planning and medical care, Early Intervention and Committee for Preschool Special Education services, parenting programs, breastfeeding supports);
- coordinated transitions for families from prenatal to infant care with transition processes that address both medical and social-emotional health needs; and
- use of a risk-stratification approach that is inclusive of medical and social-emotional/developmental needs, supports effective connection to services for those with elevated risk and fosters effective communication between agencies serving these families.

Tiered behavioral health interventions, able to address needs across developmental stages, should be integrated into practices providing primary care for children.

Tier 1 – Services received by all children.

- Screening – Age-appropriate child development, Maternal Depression and Adverse Childhood Experiences (ACEs), social-emotional development, Social Determinants of Health, Interpersonal Violence
- Culturally sensitive Anticipatory Guidance focused on social-emotional/family health (e.g. Reach Out and Read, Vroom, lactation counseling, parent access for questions)
- Information about community resources (e.g. Head Start)

Tier 2 – Services received when a child or parent has an identified need. These needs, in their severity or singularity, are not considered "complex." Examples include developmental delay, housing or other concrete service needs, sleep or feeding issues, tantrums, mild postpartum depression, or maternal anxiety.

- Short-term counseling by Early Childhood Mental Health-trained professional in practice
- Care coordination knowledgeable about early childhood services to facilitate connection with community resources

- Follow up and escalation to Tier 3 if needed
- Care delivered in collaborative care model by the primary care provider, with support from mental health professionals either in the practice or remotely via tele-health model.

Tier 3 – Services received when a more complex need is identified for a child or parent.

- Therapeutic intervention (e.g. dyadic therapy, parental mental health and substance use treatment) in the practice
- Referral to community-based mental health services when needed
- Case management (with early childhood skills) for all needs, including navigation across services

Staffing Needs for tiered behavioral health services (for a practice with approximately 2000 children age 0-3 and approximately 250 families getting Tier 3 services):

- **Tier 1 and 2 needs can be addressed through the HealthySteps model – adding an Early Childhood-trained advanced degree professional.**
- **Addressing Tier 3 needs would require an additional 0.5 FTE of a psychologist (with parent-child mental health skills) and 0.2 FTE of a psychiatrist. This extra staffing would be necessary to address parental mental health needs within the practice. In addition, case management support, well versed in early childhood needs, would be essential. Health Homes with training and experience relevant to this model may be able to provide this case management, or a community health worker could provide care coordination support.**

Financing Integrated Behavioral Health Model:

We estimate that 50% of Tier 1 and Tier 2 services can be reimbursed based on diagnoses and fee-for-service. Higher percentages have been achieved in the Federally Qualified Health Center environment and when parental mental health services are included (parental mental health care that is diagnosis-based and billed on their insurance, can be supported through reimbursement). A capitated model, however, would be more effective and is justifiable given recent evidence of some expected short-term savings.[1] **For tier 3 services, payment models could parallel adult collaborative care models. This would include mental health care and other support for more complex cases, until children/families could be successfully linked to long-term care, if needed.**

Health Outcome Orientation & Metrics

New York's transition to value-based payment has raised awareness of the importance of accountability for achieving improved outcomes for populations. Children – as a population – have relatively few acute healthcare needs, so there is limited opportunity for short-term savings

[1] Buccholz, Barnett, Margolis, Miller and Talmi (2018). *Clin Prac in Ped Psych* (6), 2: 140-151.

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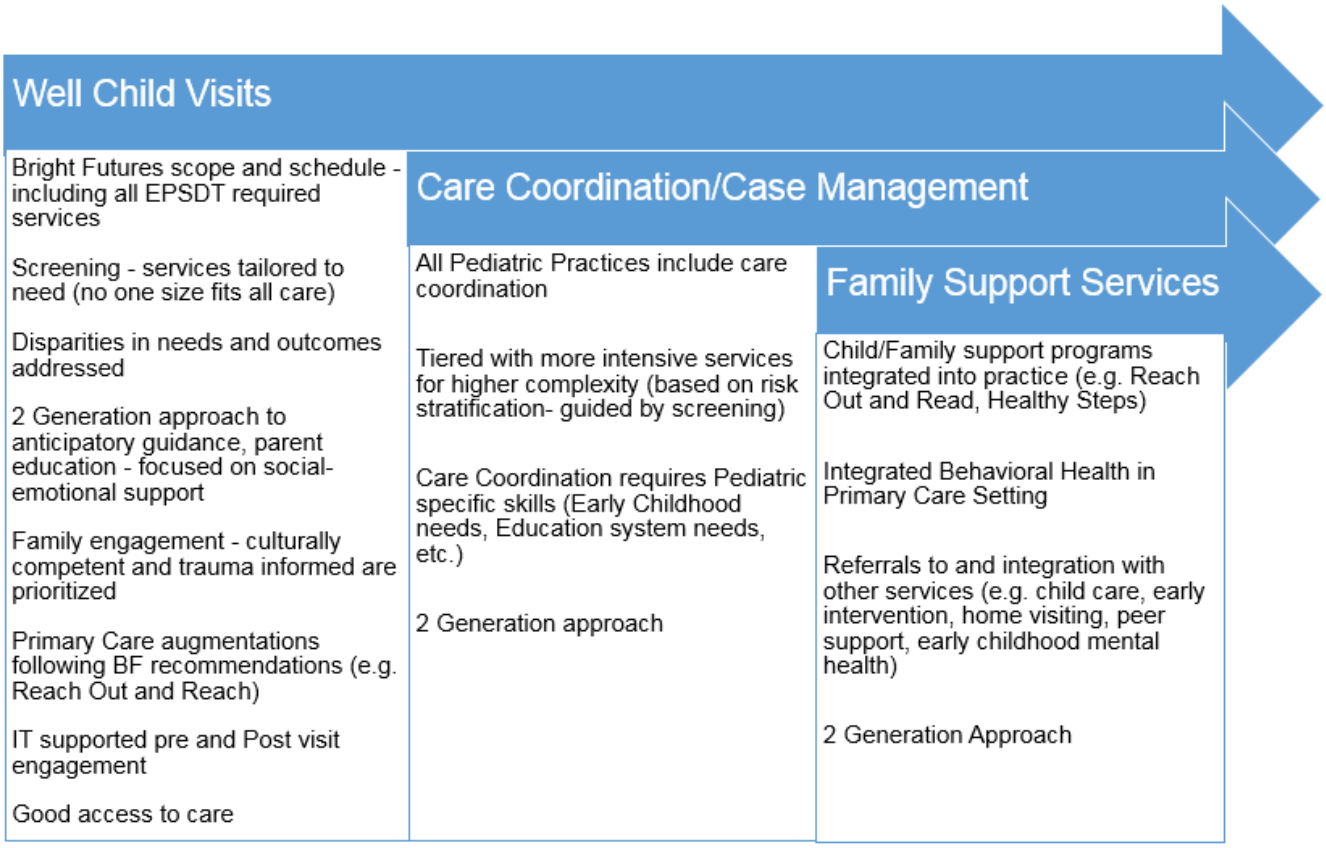
through improving health outcomes. While investment in short-term savings related to health outcomes should be explored, investment in a child's optimal growth and development has the best potential to improve long-term health outcomes. However, this benefit is found in improvements across a wide range of sectors over time.
Optimal child development and wellness are important population health outcomes to track for practices providing primary care to children. These outcomes are not adequately captured by traditional health care quality measures such as well-child visits or immunization rates. The proposed NYS Model of Pediatric Population Health would be assessed at a regional or county level by its cumulative effect on family-based outcomes, and could include:

- improved maternal depression outcomes;
- healthier birth spacing;
- decreased cardiovascular disease risk as youth enter adulthood;
- caregiver smoking cessation;
- decreased intimate partner violence (IPV);
- optimization of social-emotional health outcomes through effective, integrated behavioral health services;
- improved kindergarten readiness (optimal social-emotional-intellectual-medical outcome at age 5);
- improved High School graduation rates;
- improved adult employment rates;
- decreased criminal justice and child welfare system involvement; and
- reduction and amelioration of disparities in service provision and developmental outcomes.

Additionally, individual provider groups engaged in the New York State Model of Pediatric Population Health would be held accountable for process measures toward these outcomes (e.g. routine developmental screening, early engagement in Early Intervention and special education, including elimination of disparities), in addition to quality measures selected by VBP contractors from the NYS Medicaid VBP measure sets.

New York State Model of Advanced Primary Care for Children



Creating a Supportive Environment

Successful pediatric primary care transformation will not occur unless the broader health and health care environments are conducive to supporting the model of care. For the New York State Model of Pediatric Population Health to be viable and sustainable over the long term, all health care partners, including payers within NYS, must:

- undergo Anti-Racism training so as to include an *Undoing Racism*® perspective in policies and recommendations across administering departments and advisory councils that address Pediatric Population Health;
- understand and prioritize pediatric primary care transformation with a focus on optimizing developmental outcomes;
- develop VBP payment models that support the NYS Model of Pediatric Population Health, including the integration of behavioral health, with financing for practice transformation. Pediatric primary care capitation models should link maternal and pediatric care.
- recognize the need for a statewide increase in child and family mental health treatment capacity within pediatric practices and in the community;
- provide meaningful technical support, akin to practice transformation support for NYS PCMH efforts, from transformation consultants with a skill set focused on the needs of this model;

- invest in information technology upgrades that effectively connect families, community-based organizations, schools, and primary care practices, and should include solutions to address HIPAA/FERPA issues in building inter-sector and practice-family connections;
- invest in and prepare child and family-serving community-based organizations to function in a value-based environment – if community agencies are not prepared, the linkages will not happen; and
- consider collective impact approaches that offer a good model for improving support for families across sectors.

Recommendations

Transforming children's primary care in New York so it can significantly advance children's health and well-being is within reach. Strong consensus has emerged around a NYS Model of Pediatric Population Health and its vision for primary care for children and families. Many core elements of the model are already operational in select primary care practices across the state. The challenge is to strategically integrate these elements into advanced primary care practices for children across the state, ensure this model achieves desired outcomes for children, support the model's financial sustainability, and develop the transformation pathway to help all primary care practices move toward this vision. If the below actions are taken, New York will take a giant step forward in securing a better future for its children:

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[3] Health Insurance Portability and Accountability Act.

[4] Family Educational Rights and Privacy Act.

APPENDIX

List of Current New York State-supported Programs Critical to the Success of the Vision of Advanced Pediatric Primary Care

New York State is a leader in supporting a broad vision of child health. In addition to New York's robust Medicaid benefits for children and its recent First 1,000 Days on Medicaid Initiative, many innovative regional and statewide efforts serve as vital building blocks for the NYS Model of Pediatric Population Health. Key features of these efforts will need to be drawn upon as we develop and pilot this new model of primary care for children and families, with the aim of integrating New York's innovative programming under one cohesive system of primary care.

Some existing efforts that provide Advanced Pediatric Primary Care model support are listed below. These programs have varied sources of funding. Identifying gaps in funding and potential models for long-term support should be a priority for any pilots of an Advanced Pediatric Primary Care model. This list provides important examples of existing programs, but it is not meant to be all-inclusive.

- Practice-based support for promoting early childhood social-emotional development, e.g. NYS Office of Mental Health's HealthySteps pilot
- Support for promoting early literacy and school readiness, e.g. Reach Out and Read
- Enhanced primary care physician access to mental health providers in community and pediatric settings, e.g. NYS PCMH, Project TEACH, and Children's behavioral health redesign
- Home visiting programs, e.g. Nurse Family Partnership, Healthy Families, and Title V/DOH efforts to coordinate intake and referral
- Initiatives supporting parental mental health assessment and treatment in pediatric settings, e.g. post-partum depression screening and treatment support through NYS Maternal Mental Health initiative and NYC THRIVE
- Initiatives supporting cross-sector integration for early identification of developmental delays and linkage to services, e.g. Help Me Grow and Early Childhood Comprehensive Systems initiatives
- First 1000 Days on Medicaid Managed Care Performance Improvement Projects to address specific infant/children screenings
- Enhancements to pediatric and Ob/Gyn services, e.g. NYS PCMH and CenteringPregnancy pilots

- Leverage of existing data systems to facilitate information-sharing between practices and systems, e.g. Qualified Entities (formerly called Regional Health Information Organizations), the Statewide Health Information Network for New York (SHIN-NY), the All Payer Database (APD), and the New York State Immunization Information System (NYSIIS)
- Health and education collaborations promoting better health, educational outcomes, and cost-savings across sectors, e.g. Albany Promise, ROC the Future, and the Kindergarten Developmental Skill Inventory project under the First 1,000 Days on Medicaid Initiative