



Whole-Family Wellness for Early Childhood: A New Model for Medi-Cal Delivery and Financing



FIRST 5 CENTER FOR
CHILDREN'S POLICY

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The California Children’s Trust was established to transform the administration, delivery and financing of our child-serving systems to ensure that they are equity driven and accountable for improved child health outcomes. It is a statewide initiative that seeks to improve child wellbeing through policy and systems reform. Learn more at www.cachildrenstrust.org.

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FIRST 5 CENTER FOR CHILDREN'S POLICY

ABOUT FIRST 5 CENTER FOR CHILDREN'S POLICY

Grounded in the experience of First 5s around the state, the Center studies and disseminates best practices and solutions in early childhood development; convenes experts inside and outside the early childhood space to inform policy; and evaluates solutions within and outside California that can be adapted for the state. Learn more at www.first5center.org.

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Executive Summary

Whole-Family Wellness for Early Childhood: A New Model for Medi-Cal Delivery and Financing outlines a new approach for California to conceptualize, deliver, and fund a system of care for Medi-Cal eligible infants and toddlers that is grounded in family wellness. At present, California is not adequately addressing the needs of young children on Medi-Cal, allowing millions to miss out on important preventive care each year because Medi-Cal health plans do not meet the whole family's needs.

The need for family- and community-centered care is particularly critical in pregnancy and the first five years of life, when the architecture of the brain is established and neural connections grow at the fastest rate of a person's lifetime. During this period, the brain shapes key abilities for long-term wellness, such as forming trusting relationships, being open to learning, and regulating emotions. Healthy, loving caregivers promote healthy development in young children; thus, the whole-family context is vital.

Currently in California, the Medi-Cal system focuses on delivering individual services for children, outside the context of their families and communities. For example, healthcare providers and systems must determine a young child's "psychopathology" before they offer mental health care or are reimbursed for it. Yet many clinicians do not receive training in early childhood mental health, and the diagnostic criteria are based on adult symptoms, calling accurate diagnosis into question. At the same time, young children in genuine distress due to family conflict, community violence, economic hardship, and parental mental illness may not fall under a diagnosis, but still need support.

The proposed new model of care, the Whole-Family Wellness Hub-and-Spoke Model, recognizes the importance of early prevention, identification, and support to mitigate adversity, and to bolster protective factors and family resilience. Providers would include community-based organizations, county-operated clinics, Federally Qualified Health Centers, and primary care practices, working together to provide peer support and age-appropriate models for attachment and bonding (Hubs), as well as resources to address broader social needs (Spokes). This family-centered model of care and parenting support is preventive, need-based, and therapeutic; it focuses on supporting children and families in community settings that build social connections and directly address the social determinants of health. The model would be financed by accessing and leveraging multiple sources of funding (e.g., Early and Periodic Screening, Diagnostic and Treatment [EPSDT], Realignment, Mental Health Services Act [MHSA] dollars).



To bring the model to life, three transformations in the Medi-Cal system are needed:

1. Ensuring access to *Whole-Family Wellness Hubs* that support family wellbeing through peer support, attachment and bonding, and understanding of social determinants of health. Hubs would focus on social and emotional support, as well as linkages to community-based services and supports, from the onset of a child's life.
2. Prioritizing the training and retooling of the early childhood wellbeing workforce to understand and address issues in the context of community, social justice, and family wellbeing.
3. Creating a financing model with a capitated rate that supports providers to address children based on need in the context of their family, their extended family, and their community.

Our administrative delivery and financing systems must support child wellness in the overall context of family and community. The Whole-Family Wellness model is a starting point, and provides the backbone for California to ensure that we address root causes of suffering and promote healing and wellness to enable California's children and youth to thrive. Together we can find the will, skill, and process to re-center our system on the needs of families, involve them in future decision-making, and pave the new road ahead.

We need a new vision for early childhood healthcare.

This brief proposes a paradigm shift in how California conceptualizes, delivers, and funds a system of care for Medi-Cal eligible infants and toddlers and their families. The current healthcare system for children was organized and built on an individualized and diagnostic adult model of care, and it is not working. Young children and their families need family-centered models of care and parenting support that are both preventive and need-based, and which primarily focus on supporting children and families in community settings that build social connections and directly address the social determinants of health.

We propose a single system of wellness and a new administrative and financing model that works in a “Hub-and-Spoke” fashion. This model would reform the way Medi-Cal is operationalized to ensure a comprehensive wellness benefit during early childhood to all Medi-Cal eligible children and families in California. Whole-Family Wellness Hubs and Spokes would include community-based organizations, county-operated clinics, Federally Qualified Health Centers (FQHCs), and primary care practices. Hubs would provide peer support and age-appropriate models for attachment and bonding, while Spokes would provide resources to address broader social needs. The model as a whole would assure preventive and therapeutic supports for families; and would be coordinated, accountable, and reflective of the culture and context of individual families. It would be delivered by a variety of professionals and experts, including family and peer support specialists.

A “whole-family” wellness model in early childhood is crucial.

Children’s physical health, as well as their social, emotional, and cognitive competence, require secure attachments to emotionally invested and protective adults who have the knowledge and psychological readiness to provide safe, stable, and developmentally appropriate care. Decades of empirical research confirm the importance of parental care in predicting child outcomes.^{1,2,3} The need for emotionally invested, protective care is particularly critical during pregnancy and the first five years after birth, when the architecture of the brain is being established and neural connections grow at the fastest rate of an individual’s lifetime.⁴ Data show there is a sensitive period early in development when the brain is most susceptible to environmental influences that shape the circuitry of key areas of the brain associated with three pillars of mental health: affect regulation, trusting relationships, and readiness to learn.⁴ Research also shows that investing in the first five years of life produces positive returns over a child’s lifetime in the form of decreased medical and mental health costs,⁵ greater educational achievement,^{6,7} higher likelihood of employment,^{8,9} and lower likelihood of incarceration.⁹

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- 1 National Scientific Council on the Developing Child. (2015). Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience [PDF file]. Retrieved from <http://developingchild.harvard.edu/wp-content/uploads/2015/05/The-Science-of-Resilience.pdf>
 - 2 Strathearn, L. (2007). Exploring the neurobiology of attachment. In: Mayes, L., Fonagy, P., & Target, M, (Eds). *Developmental science and psychoanalysis*. London: Karnak Books.
 - 3 Boyce, W., Essex, M., Alkon, A., Goldsmith, H., Kraemer, H., & Kupfer, J. (2006). Early father involvement moderates biobehavioral susceptibility to mental health problems in middle childhood. *American Academy of Child Adolescent Psychiatry*, 45(12), 1510–1520. DOI:10.1097/01.chi.0000237706.50884.8b
 - 4 Harvard Center on the Developing Child. (2007). In Brief: The Science of Early Childhood Development [PDF File]. Retrieved from <https://46y5eh1lfhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2007/03/InBrief-The-Science-of-Early-Childhood-Development2.pdf>
 - 5 Campbell, F., Conti, G., Heckman, J., Moon, S., Pinto, R., Pungello, E., & Pan, Y. (2014). Early childhood investments substantially boost adult health. *Science*, 343(6178), 1478–1485. doi:10.1126/science.1248429
 - 6 Luo, Y., Héту, S., Lohrenz, T., Hula, A., Dayan, P., Ramey, S. L., ... Ramey, C. (2018). Early childhood investment impacts social decision-making four decades later. *Nature Communications*, 9(1). <https://doi.org/10.1038/s41467-018-07138-5>
 - 7 Laura & John Arnold Foundation. (2017). Evidence Summary for the Perry Preschool Project. Retrieved from <https://evidencebasedprograms.org/document/perry-preschool-project-evidence-summary/>
 - 8 Masse, L., & Barnett, W. (2002). *Cost-effectiveness and educational policy*. Levin H., & McEwan, P. (Eds). Larchmont, NY: American Education Finance Association.
 - 9 Laura & John Arnold Foundation. (2017). Evidence Summary for the Perry Preschool Project. Retrieved from <https://evidencebasedprograms.org/document/perry-preschool-project-evidence-summary/>



Compelling evidence suggests healthy parents and caregivers promote healthy development in children.¹⁰ Child wellbeing is strengthened when caregivers are healthy and possess protective factors, including parental resilience, social connections, access to basic necessities, and resources to address mental health and substance use issues.¹¹ These requisite needs are sorely missing for too many parents and their young children and, in some cases, they have been taken from families through systemic and pervasive inequities and discrimination. Supporting the healthy development of young children necessitates supporting their parents' ability to provide adequate care. Effective funding and delivery of children's services must involve a whole-family wellness approach that includes systematic attention to the parents' wellbeing and psychological needs; remedies to sources of discrimination; and the fostering of dignity, love, and healing within the context of empowered communities.

¹⁰ Newland, L. (2014). Supportive family contexts: Promoting child wellbeing and resilience. *Early Child Development and Care*, 184, 9–10. doi: 10.1080/03004430.2013.875543

¹¹ Center for Study of Social Policy. (2018). Strengthening Families Framework [PDF File]. Retrieved from <https://cssp.org/wp-content/uploads/2018/11/About-Strengthening-Families.pdf>

California's current system of care is not aligned with the realities and needs of young children and their families.

California currently ranks near the bottom of the nation in most standard measures of child wellbeing and access to care.¹² A recent audit by the California Office of the State Auditor reported that 2.4 million children in Medi-Cal miss out on important preventive care each year because of poor access to primary care providers and an inability of Medi-Cal managed care health plans to meet whole-family needs.¹³ California's children and families face a number of barriers to receiving family-centered (or whole-family) wellness supports:

- » **In order to offer and receive reimbursement for care, healthcare providers and systems are driven to assess a young child's individual "psychopathology."** In our state, few children receive timely developmental screenings and those that do must then demonstrate a diagnostic impairment under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit to receive a covered service. This prerequisite encourages premature and/or inaccurate labels for some children while completely ignoring others, particularly those whose needs do not meet strict clinical criteria. Young children in families experiencing economic stress, family conflict, parental mental illness or substance use, community violence, or exposure to structural inequities like underperforming schools don't qualify for comprehensive social-emotional care and supports under EPSDT (see sidebar, page 8).
- » **The harmful effects of requiring a diagnosis as a prerequisite for services are particularly challenging during the early stage of development when children are experiencing rapid changes in biological, cognitive, and social-emotional functioning.** Both specialty and non-specialty mental health services require a provider to label a young child with a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis in order to provide a them with services and supports. Yet the clinical criteria used to diagnose many impairments were developed for adults and adolescents. Consequently, we lack clinical criteria adept at identifying a range of social-emotional and developmental issues, as well as mental illness, during early childhood. Moreover,

¹² Children Now. (2019). 2018-19 California County Scorecard of Children's Wellbeing. Retrieved from <https://www.childrennow.org/publiccharge-2-2/>

¹³ Auditor of the State of California. (2019). *Department of Healthcare Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services*. Retrieved from: <https://www.auditor.ca.gov/pdfs/reports/2018-111.pdf>

the DSM has been criticized for its sociocultural bias, reflecting a clinical model that is neither sensitive nor reflective of the experiences of communities that have been marginalized.^{14 15} Furthermore, though families may need support, parents are often hesitant to label their children at a young age, nor should they be required to.

- » **Many clinicians do not receive training in early childhood mental health.** This results in an under-appreciation of the significance of young children’s affective and behavioral expressions of psychological distress, under-diagnosis,¹⁶ and a lack of critical supports. We also know that peer-to-peer supports can be effective, yet our current system unnecessarily limits who can be reimbursed by Medi-Cal as a provider of care.

14 Chow, J. C.-C., Jaffee, K., & Snowden, L. (2003). Racial/Ethnic Disparities in the Use of Mental Health Services in Poverty Areas. *American Journal of Public Health*, 93(5), 792–797. <https://doi.org/10.2105/AJPH.93.5.792>

15 Whaley, A. L., Smith, M., & Hancock, A. (2011). Ethnic/Racial Differences in the Self-Reported Physical and Mental Health Correlates of Adolescent Obesity. *Journal of Health Psychology*, 16(7), 1048–1057. <https://doi.org/10.1177/1359105311398683>

16 Gleason, M., Egger, H. L., Emslie, G. J., Greenhill, L. L., Kowatch, R. A., Libermann, A. F., ... Zeanah, C. H. (2007). Psychopharmacological treatment for very young children: Contexts and guidelines. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46(12), 1532–1572. <https://doi.org/10.1097/chi.Ob013e3181570d9e>

17 California Children’s Trust and Children Now. (July 2019). The California Children’s Trust Initiative: Financing New Approaches to Achieve Child Wellbeing. Retrieved from <https://go.childrennow.org/financingnewapproaches>

MEDICAL NECESSITY AS DEFINED BY MEDICAID’S EPSDT

Medicaid’s Early & Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit was purposely constructed with broad eligibility criteria to treat health conditions and to prevent future negative health outcomes. By federal statute, EPSDT’s definition of medical necessity is broad. Unlike adult definitions of medical necessity, children are eligible for services that “ameliorate” a condition or prevent a condition from worsening or leading to additional health problems. Virtually all medical and health services are covered for children – health education, home visiting, preventive health counseling for families, case management, and other early interventions are all reimbursable claims under EPSDT. For example, EPSDT can be used to cover relationship-based, parent-child therapy for families at risk and for families who have already entered the child welfare system. All states, however, are given discretion to define what constitutes medically necessary treatment. States are able to restrict or approve what is considered medically necessary, what constitutes a “qualifying condition” that is eligible for treatment, and what type of treatment qualifies for reimbursement.¹⁷ California state law has taken a restrictive definition of medical necessity, resulting in fewer children receiving the broad set of screenings included in the benefit. California can promote healthy, safe, and supportive parenting and caregiving by redefining EPSDT to serve its original purpose.

- » **Young children are also not able to use language to describe their internal experiences, and as a result, adults may be unaware of children’s psychological distress** unless they have specialized training in early childhood assessment and treatment. Young children also have a limited behavioral repertoire to express distress, usually through frequent and prolonged crying, aggressive behavior, and other forms of behavioral dysregulation that can be understood by adults as misbehavior. As a result, different emotional or developmental problems may be manifested through the same behaviors, leading to misdiagnosis. A classic example of this phenomenon is the misuse of ADHD as a diagnosis for symptoms of impulsivity, inattention, and difficulty concentrating that are actually the result of unidentified trauma exposure.¹⁸ Co-morbidity of different diagnoses is the norm across the lifespan and is particularly salient in children and adults exposed to multiple traumatic stressors, with childhood stressors predicting more complex multiple diagnoses in adulthood.¹⁹
- » **Our system is based on individually focused services for the child instead of delivering care based on a whole-family approach.** Presently, the system of care and service delivery to support a child’s social and emotional health are not designed nor implemented to be consistent with an understanding of child development, family influences, and community connections. Consequently, many family supports do not qualify for reimbursement under current policies and practices. Three examples of evidence-based treatment modalities – Child-Parent Psychotherapy, and Attachment Vitamins, and Infant and Early Childhood Mental Health Consultation (see page 11) – provide the necessary supports to ameliorate the negative effects of toxic stress and adverse childhood experiences (ACEs) on children, and bolster the child-parent relationship in the context of adversity. These evidence-based and promising interventions are not currently eligible for reimbursement in California for all children ages 0 to 5 because of the focus on diagnosis as a prerequisite to care.
- » **Our individual-focused, downstream approach also misses an opportunity for early prevention.** Early access to appropriate family interventions for children is critically important for healthy and optimal development. We have a “wait and see” approach to early childhood risks as opposed to a “seek and support” model focused on predicting and preventing the risks that contribute to biological, psychological, social, educational and spiritual distress and challenges.
- » **A bifurcated system in California divides children into those considered to have significant behavioral health problems (Specialty Mental Health) and those who have mild or moderate problems (Non-Specialty Mental Health).** The result is a fragmented approach to early childhood wellness with limited accountability or demonstrated improved outcomes. Without an integrated system, it is currently difficult

¹⁸ Crusto, C., Whitson, M., Walling, S., Feinn, R., Friedman, S., Reynolds, J., ... Kaufman, J. (2010). Posttraumatic stress among young urban children exposed to family violence and other potentially traumatic events. *Journal of Traumatic Stress*, 23(6), 716–724. <https://doi.org/10.1002/jts.20590>

¹⁹ Putnam, K., Harris, W., & Putnam, F. (2013). Synergistic Childhood Adversities and Complex Adult Psychopathology. *Journal of Traumatic Stress*, 26(4), 435–442. <https://doi.org/10.1002/jts.21833>



to assess who is being served and what types of supports children are receiving. Using current reports, only an estimated 5% of California’s children enrolled in Medi-Cal receive any type of care to address social and emotional needs.²⁰ This low penetration rate fails to reach a large number of children, especially black and brown children, and children exposed to adverse childhood experiences as the result of family poverty, discrimination, and marginalization.

- » **In our current finance model, public healthcare expenditures place the greatest burden of risk on counties and providers.** This leads to either an overutilization of state and county general fund dollars, or an underutilization of federal dollars. This practice is reinforced by regressive and punishing auditing policies and practices. Agencies are challenged to spend their allotted dollars or do not focus on care for the 0–5 population. The result is a mismatch between appropriate care and the needs of the population.

²⁰ California Department of Healthcare Services. (2019). Performance Outcomes Systems [PDF File]. Retrieved from <https://www.dhcs.ca.gov/services/MH/Documents/00-20190304-Statewide-SUP-Final.pdf>

PROMISING FAMILY-BASED INTERVENTIONS FOR A NEW MODEL

Family Wellness Interventions using empirically tested practices that support the emotional and social development of children exist but are not currently eligible for reimbursement in California for all children using Medi-Cal.

Three examples of evidence-based practices used by the authors are described below, though there are many other promising and/or community-based practices that could be reimbursable under the new model.

CHILD-PARENT PSYCHOTHERAPY

Child-Parent Psychotherapy (CPP) is an intervention model for children ages 0 to 5 who have experienced traumatic events and/or are experiencing mental health, attachment, and/or behavioral challenges. CPP supports and strengthens the child-parent relationship by incorporating relational, developmental, trauma, social learning, and cognitive behavioral theories in a therapeutic context. CPP has been proven to support children who display maladaptive behaviors as a result of developing within a context of neglect and abuse. The effectiveness of CPP is supported by five randomized studies, and it has been listed in the SAMHSA National Register of Evidence-Based and Promising Practices and Programs (NREPP). A randomized control trial that evaluated the effects of CPP on preschoolers who had four or more ACEs found the treatment group had significantly greater improvements in Post-Traumatic Stress Disorder, depression symptoms, and behavioral problems compared to the control group.

ATTACHMENT VITAMINS

Attachment Vitamins is an educationally based 10-week parenting class designed to help parents and caregivers of children ages 0 to 5 learn about child development and the impact of stress and trauma. The goal is for caregivers to better understand and reflect on the possible meanings of children's behaviors, and promote secure bonding and safe socialization practices. The class teaches parents about emotional development and supports emotional attunement to their children; emphasizes mindful awareness of positive parent-child interactions; and emphasizes the importance of reflective rather than reactive parenting skills. Attachment Vitamins grounds the parent-child relationship in a framework that is attachment oriented, trauma informed, culturally informed, and context responsive.

INFANT AND EARLY CHILDHOOD MENTAL HEALTH CONSULTATION

Infant and Early Childhood Mental Health Consultation (IECMHC) is a multi-level preventive intervention that joins mental health professionals with people who work with young children and their families to improve their social, emotional, and behavioral health and development. IECMHC builds the capacity of providers and families to understand the powerful influence of their relationships and interactions on young children's development. Children's wellbeing is improved and mental health problems are prevented and/or reduced as a result of the IECMHC's partnership with adults in children's lives. IECMHC includes skilled observations, individualized strategies, and early identification of children with and at risk for mental health challenges.

The Whole-Family Wellness Hub-and-Spoke Model would address the current realities young children and their families face.

Given this set of realities, we propose organizing care for families with young children according to their needs. The proposed paradigm shift in the design and funding of a whole-family wellness care benefit would create a community “Hub-and-Spoke” model supported by an alternative payment structure. This model is influenced by provider collaborations developed in Accountable Care Organization (ACO) pilots and other collaborations currently being piloted across the nation. The goal of the Whole-Family Wellness model is to reformulate available services, understand the gaps in context of the available resources, and radically increase federal contribution to help build a more robust set of needed, proximate, accessible, coordinated, and culturally relevant services for children’s wellbeing. While we are providing the framework for the model, California must take the next step and bring together families enrolled in Medi-Cal, providers, advocates and policymakers, to design an implementation plan for this model.

We propose a new system that would include three transformations:

1. A focus on access through Whole-Family Wellness Hubs that support family wellbeing through peer support, attachment and bonding, and an understanding of social determinants of health. Hubs are focused on social and emotional support and linkages to community-based services and supports (“Spokes”) from the onset of a child’s life.
2. A focus on training and retooling the early childhood wellbeing workforce to understand and address issues in the context of community, social justice, and family wellbeing.
3. A financing model that involves a capitated rate that supports providers to care for children based on need in the context of their family or extended family system and/or community.

THE WHOLE-FAMILY WELLNESS HUB-AND-SPOKE SERVICE DELIVERY MODEL

Whole-Family Wellness Hubs would be located in places where families show up (i.e., within Family Resource Centers, pediatric and family practice settings, public health and WIC programs, wellness centers in child care and preschool programs, and/or community centers) and the model would be administered under managed care organizations. Staffing and services would be co-located or easily accessible to pediatric primary care. Hubs would use capitated reimbursement from Medi-Cal to conduct family assessments, provide direct services, and contract with community-based family support organizations and resources provided by Spokes. Hubs would establish a legal network of sharing information and data agreements, with the parents' consent, among the parties responsible for providing care. Medi-Cal beneficiaries (parents and caregivers) would co-create the service arrays and providers in accordance with their needs.

Each Whole-Family Wellness Hub would be responsible for a panel of children for whom they would provide care coordination, screening, assessment, and some interventions within their scope of practice. This panel would help lead and define the services the hub provides, and help evaluate their effectiveness. To ensure that families and children receive the quality and type of care needed, the hub would use a three-tiered system of care to determine the immediate level of services ranging from preventive, to targeted education and intervention, to intensive services focused on treating complex and multifaceted problems. A tiered system of care would provide a way of projecting both core services and costs. Parent partners and peer supports would be an integral and required component of each tier of service. Capitation would be risk adjusted and based on projected utilization in each tier.

Each family would have a Hub Family Care Manager who would ensure coordination between Hub and related Spoke agencies, and regularly solicit and reflect beneficiaries' experience and evaluation of the services and supports offered. Spoke agencies would have formal agreements and relationships with the Hub, be required to participate in regular care coordination meetings, and be accountable to the care plans developed by the Family Care Managers. For example, a Hub could develop MOUs with community nonprofits, adult health and behavioral health services, housing, legal, and social supports representing the continuum of care families need to grow and develop. The Hub and Family Care Manager also would provide relational care management, and be responsible for the ecosystem of the child and family and their health outcomes. This responsibility would inspire innovation around care management and shared care plans, eliminating multiple assessments and thus the need for families to tell their stories to multiple agencies. Incentives for participation in the Spoke network could include providing staffing at Spoke agencies and/or infrastructure support using flexible dollars from the capitated rate.

The Whole-Family Wellness Hubs would provide and support proven programs to prevent behavioral health concerns in children and families. Centers could sponsor home visiting programs, and work in partnership with county Maternal and Child Health Departments and First 5 programs to reach out to new families and families in need of support. New and ongoing group programs, such as well baby group appointments, developmental playgroups, parent support groups, and child care and preschool programs, could be supported with regular information and curriculum about healthy behavior and development for young children.

WHOLE-FAMILY SCREENINGS AND ASSESSMENTS

Screening is important but not sufficient without a system of care that can respond. In the Whole-Family Wellness model, a Hub within a primary care practice or Family Resource Center would be responsible for ensuring that every child and family receives regular whole-family care screening and assessments, as prescribed by the American Academy of Pediatrics (AAP) Bright Futures guidelines.²¹ Similar to the Whole-Person Care model, this would include screenings and assessments for adversity, protective factors, cultural and spiritual practices, and wellness needs through a whole-family, systems lens. A whole-family screening, assessment, and care plan mechanism would bring the multitude of existing screenings, assessments, and care plans together and coordinate them in one centralized system. Resources and peer support would be offered to families, based on an understanding of the educational, psychological, spiritual, and health needs and context of the parent/caregiver and community.²² For example, Native American sweat lodges may be the most relevant and healing practice for some Native Americans who should not be referred only to Western medical model practices for healing. Hubs need to be located in the community, in locations where families want to go and feel comfortable going. Our approaches need to go beyond the current medical model, which uses only certain types of therapeutic supports that may not be perceived as therapeutic by every culture and community.

Family assessments also would provide the necessary comprehensive data to determine which families fall into tiers 1, 2, and 3. These tier levels are tied to both level of need, level of service, and reimbursement rate, and are based on the Multi-Tiered Systems of Support (MTSS) model adopted by and used in schools.²³ The framework recognizes that families may not stay in their original tier level as family circumstances change.

FAMILY CARE PLANS

The child and family would co-construct their care plan with Hub Family Care Managers who have relevant lived experience. The care plan would integrate the collected assessments for a coherent understanding of the family's strengths and needs, and would outline the planned sharing of information among the partners who, with parental consent, would allow them to work together. The Hub Family Care Manager would oversee the family care plan and coordination and would refer to Spoke agencies for those services not available or better served by partner agencies (e.g. housing supports, substance abuse services, vocational training, child care support, afterschool programs). For children and families with more severe concerns, a more intensive and integrated care plan would be developed, compared to families in tier 2 who would require or ask for less intensive supports, or those in tier 1, who do not need or want any additional supports. The plans would be coordinated in the context of a facilitated family conference, designed to ensure authentic family engagement and choice.²⁴ Care plans would be developed by family voice and choice rather than used as a compliance mechanism. This process repositions decisions about services and utilization from external reviewers to the core team, including the family, with the goal of healing root causes of harm and proactively building on assets.

²¹ Hagan, J. F., Shaw, J. S., & Duncan, P. M. (Eds). (2017). *Bright Future: Guidelines for Health Supervision of Infants, children, and adolescents* (4th ed.). Elk Grove Village, IL: American Academy of Pediatrics.

²² Demarco, R., & Healey-Walsh, J. (2019). *Community and Public Health Nursing*. Philadelphia, PA: Wolters Kluwer.

²³ California Department of Education. (n.d.). Definition of MTSS. Retrieved from <https://www.cde.ca.gov/ci/cr/ri/mtsscompri2.asp>

²⁴ Oxford Bibliographies. (2016). *Family Group Conferences*. DOI:10.1093/obo/9780195389678-0240

WORKFORCE AND CAPACITY BUILDING

The Hub-and-Spoke model requires a major cultural shift for the medical world and many more service providers from what we have today. Hub-and-Spoke agencies would promote collective development and oversight of a whole-family model, including providing training and ongoing coaching to providers that is culturally relevant to families. This model involves care coordination and support through an expanded workforce that does not yet exist in a robust form—and which needs to be developed using new policies—a workforce that can deliver services and be reimbursed by Medi-Cal. This workforce development opportunity is a way to bolster employment in communities and train a team of peers, caregivers, neighbors, and people who reflect the populations served by Medi-Cal. These new child-focused practitioners can join with existing practitioners to establish an approach that champions whole-family care, trauma-informed care, and healthy attachment. Training and core practices should be developed by experts in various content areas and people with lived experience. While the development of a statewide workforce plan is beyond the scope of this brief, the Hub infrastructure and Spoke expertise could be leveraged to hire and train community members, who would reflect that the community is central to all aspects of the care delivery system.

CASE STUDY OF KARA AND HER FAMILY: CHILD WELLBEING THROUGH A WHOLE-FAMILY APPROACH

Kara's story illustrates the type of support that can be realized with a whole-family approach.

Reason for the referral: Kara was a 36-month-old referred for treatment by her pediatrician because of intense tantrums and aggression towards her child care provider and peers, including biting and hitting. She could not sit still during circle time at daycare, had difficulty paying attention, and was easily distracted. The pediatrician diagnosed her with ADHD and suggested psychotropic medication, but her parents were not comfortable with giving her a diagnosis, and worried about the effects of medication. The pediatrician then referred Kara for mental health services.

Initial assessment: Kara's parents had complex issues affecting their parenting. The father was overwhelmed, as the mother had left the home three days earlier after relapsing in her use of opioids, which were originally prescribed to relieve pain from a car accident she experienced while pregnant with Kara. Opioids had contributed to the mother repeatedly disappearing for days and returning home tired, irritable, and emotionally disconnected. She often yelled at Kara and slapped her when the child did not comply with requests. The parents fought often, with loud arguments and mutual verbal insults. The father began to feel hopeless, had difficulty sleeping, and worried that his state of mind and chronic fatigue were impairing his work at his job.

Subsequent assessment: There were individual meetings with the father and the mother; a joint meeting with both parents; a cognitive assessment of Kara; and a meeting with Kara and her parents to assess the quality of her relationship with her parents, as well as her parents' ability to join forces on behalf of the child. This comprehensive assessment revealed that Kara had been exposed to five traumatic events: 1) physical abuse by the mother; 2) verbal abuse by the mother; 3) unpredictable separations from the mother; 4) witnessing marital discord; and 5) Maternal Substance Use Disorder. Screenings of Kara revealed the following symptoms: aggressive outbursts; tantrums and emotional dysregulation; distractibility; difficulty persisting in age-appropriate activities; difficulty falling asleep; night terrors; repeatedly asking whether the parents were angry at her; frequent sadness and listlessness; staring off into space; fear of the dark; fear of loud noises; fear of separation; fear of getting lost; accident proneness; and refusal to go to school.

Treatment plan: Kara was treated within a whole-family model that understood Kara's wellbeing as a function of her parent's wellbeing, and the parents' impaired ability to attach to and bond with Kara. Kara's treatment plan included Child-Parent Psychotherapy.²⁵ The treatment included helping the family co-construct a trauma narrative that gave meaning, as opposed to blaming, to the mother's erratic and angry behavior; the father's efforts to protect the child and his anger at the mother; and the child's fear that her behavior was the reason for the parents' fights and the mother's periodic disappearances. This plan showed the importance of understanding and supporting a young child's functioning in the context of her familial relationships.

In a well-functioning system, the risks in Kara's family would have been identified earlier and services would have been provided before Kara was so symptomatic. Still, Kara's family was able to access and receive treatment, while many families cannot or do not have services available, flexible, and proximate enough to meet their needs. The support Kara and her family needed and received from the Child Trauma Research Center at the University of California, San Francisco could not be billed to Medi-Cal under current policies and practices; instead, the services were funded through philanthropy.

In our proposed Hub-and-Spoke model, the policies and practices in the Medi-Cal system of care would allow the Whole-Family Wellness Hub to identify risk early, and work towards engaging a family like Kara's to receive flexible, coordinated, and publicly funded services to address the child's needs in the context of the whole family.

²⁵ Lieberman, A.F. & Van Horn, P. (2004). *Don't hit my mommy: A manual for child parent psychotherapy with young witnesses of family violence*. Washington, D.C.: Zero to Three Press

We have the tools to finance a whole-family system of care.

The key to financing the Hub-and-Spoke model is the utilization of multiple sources of siloed funding for services and coordination—including but not limited to EPSDT funding (from both managed care organizations and county Mental Health Department resources), Realignment funding, state General Fund dollars, and Mental Health Services Act (MHSA) Dollars—and by leveraging the Care Management responsibilities and Mild and Moderate Behavioral Health Benefit managed by Medi-Cal managed care organizations (MCOs). Optimally, payment could be made through either mental health plans (MHPs) or MCOs under existing state regulations to construct a Whole Family Capitated Rate. These funding sources and details on increasing federal and state dollars through Medi-Cal can be found in our policy brief *Financing New Approaches to Achieve Child Wellbeing*.

Specifically, under the current Medi-Cal reform landscape, an enhanced capitated rate could be paid to providers via MCOs to bolster their existing care management capacity. Similar to the Health Home Program model which has been implemented in California for adults with complex health problems and high utilization, plans can connect primary care providers to community-based organizations that hire peers, focus on social and emotional development in whole-family models, focus on the social determinants of health, and have access to or directly employ behavioral health professionals with early childhood expertise. This model, focused on bolstering access to early intervention/prevention for children and their families, will prevent tomorrow's high utilizers. The community-based organizations will provide care management, care coordination, and health promotion; address social determinants of health through community referrals; and deliver behavioral health services.

The existing state regulations allow for capitation for both MCOs²⁶ and MHPs²⁷ and rates could be developed using Realignment, MHSA, or Proposition 64 funds as the non-federal share. There are four specific strategies that could be used:

- 1. Implement a Well Family Provider Incentive** payment to providers via MCOs to bolster EPSDT behavioral health screening and timely care coordination of services, and promote appropriate utilization of services covered under the Mild and Moderate Behavioral Health Benefit—obligations under their current contract with DHCS.
- 2. Amend existing Proposition 56 VBP Initiative for Behavioral Health** to allow for investments consistent with this model. Currently, the proposed behavioral health integration metrics are limited to Healthcare Effectiveness Data and Information Set (HEDIS) outcomes and do not target social-emotional outcomes.

²⁶ Title 9, section 1810.438

²⁷ 42 CFR §438.5(c) (2016)

3. **Use the MHP capitation allowances of Title 9** and amend MHP contracts to scale this behavioral health funding model in all California counties using MHSA or allowable Realignment funding as the non-federal share. Medical care would remain a separate capitated benefit.
4. **Use the upcoming 1915b/1115 Waiver negotiations** to propose a dedicated Early Childhood and Family Wellness pilot and directly fund the Hubs as a component of a broader Behavioral Health Delivery System Reform Incentive Program (DSRIP) or advance a Health Homes-like model for children, to bolster the ability of community-based providers to offer care management services (navigation, support, health education) to families.

Migrating from our current Certified Public Expenditure (CPE) process to a capitated payment system for behavioral health will provide significant flexibility and orient Medi-Cal resources towards prevention. Capitated financing structures are used by a number of states, including California, to help coordinate care associated with providing treatment and promoting flexibility in treatment modalities to meet the needs of individuals.²⁸ Capitation does not mean a limit or restriction on services or capping expenditures for children; it is a way to distribute the financial burden across a population. A capitated rate can serve as a limitation if it is set up as a goal to reduce costs. However, unlike a diagnosis-driven system, capitation can be a population health strategy. A focus on equity and outcomes as opposed to services should define funding for hubs.

Multiple models exist that can inform the setting of a capitated rate, including the Family Mosaic Project in San Francisco and Wrap Milwaukee. Research would need to be conducted to identify the correct capitated rate, and risk pools would need to be developed to ensure implementation does not bankrupt the provider. For example, an initial rate of \$2,400 per year might be a base capitated rate provided for all Medi-Cal children. This initial rate would be used to fund prevention, screening, assessment, family conferencing, and family care management as well as provide flexible funding to support specific interventions or collaborations with Spoke support agencies.

The capitated rate model would mitigate some of the risk and challenges of our current model. Re-appropriating and re-proportioning dollars would allow us to fund a more coherent, developmentally appropriate and family-centered system of care. Similar to how managed care operates for physical health, risk would be part of the delivery system and the Hub would share risk. A Hub would have a budget based on its panel size and possible risk adjustment. This would assure yearly funding for the number of children and families a Hub serves, create more robust staffing of peer Hub Family Care Managers, afford flexibility to hire diverse staff from different disciplines, and provide the ability to build an array of services that ranges from prevention to intervention.

²⁸ Urban Institute. (2016). Payment Methods and Benefit Designs: How they Work and How They Work Together to Improve Healthcare. Primary Care Capitation [PDF File]. Retrieved from <https://www.urban.org/sites/default/files/publication/80301/2000776-Payment-Methods-How-They-Work.pdf>

A healthier California is within our reach.

Early childhood wellness is dependent upon the ability to foster, maintain, and sustain healthy caregiver attachments within the context of a healthy ecosystem and available and culturally reflective coordinated services. The proposed new model of care supports caregiver and child attachment and bonding during the critical early stages of life by honoring the importance of early prevention, identification, and support to combat adversity and bolster protective factors and family resilience. Our administrative delivery and financing systems need to be able to support child wellness in the overall context of family and community. Building upon protective factors and an understanding of child wellbeing as a product of whole-family wellbeing and structural and systemic factors, the Whole-Family Wellness model provides the backbone for California to ensure that we address root causes of suffering and promote healing and wellness to enable California's children and youth to thrive. This early childhood model is consistent and reflective of the national recommendations found in the comprehensive report, *A New Vision for Whole-Family, Whole-Community Behavioral Health*.²⁹

As systems leaders, advocates, and policymakers, it is our job to ensure effective access and delivery of needed supports and services. In order to achieve this vision in California, we recommend that:

1. The leadership and choices of families and caregivers of young children enrolled in Medi-Cal be at the forefront of designing a new early childhood system of care.
2. California establish a workgroup with families and caregivers to further design a Whole-Family Wellness Hub-and-Spoke model that includes a timeline for piloting and implementation.
3. California use implementation science and quality improvement models to support early adopters and build practices that can effectively spread and be coordinated across the state.
4. California hold itself accountable to improving outcomes for children—the next generation of Californians—instead of protecting the status quo.

Healthcare systems need to be accountable to those they serve, and a process for including families in the design of this system is what we need to realize this vision. The Whole-Family Wellness Hub-and-Spoke model is a starting point for a redesign of our system. Together we can find the will, skill, and process to re-center our system on the needs of families, involve them in future decision-making, and pave the new road ahead.

²⁹ Georgetown Center on Poverty and Inequality. (2019). Reimagining Behavioral Health: a new vision for whole-family, whole-community behavioral health. Retrieved from <http://www.georgetownpoverty.org/issues/health-human-services/reimagining-behavioral-health/>