

Achieving Whole Person Care in the Postpartum Period Through Partnership Between Medical Providers and Community Organizations

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Introduction

Whole person care is the client-centered coordination of diverse health care resources to deliver the physical, behavioral, emotional and social services necessary to improve health outcomes. Whole person care acknowledges that wellness is more than physical health. This concept can also be referred to in literature as *patient-centered care*, *holistic care*, or *primary psychosocial care*¹. When community partners and health care providers work together in an expansive way to provide whole person care, they meet both the medical and psychosocial needs of individuals. Towards the aim of providing comprehensive care of every patient, the doors of the medical home must open in new ways to these innovative partnerships. Viewing care via the whole person paradigm creates a much broader and inclusive picture of health, including how people are cared for, where people are cared for, and who is part of the care team. In this new world, essential psychosocial supports that influence health stand on parity with medical care as being essential to an individual's overall well-being. The services and supports that meet an individual's psychosocial needs can come from both within (such as healthcare systems that prescribe fresh fruits and vegetables and offer a free farmer's market) and beyond the walls (such as through connecting a family to a local food pantry or home visiting program) of the medical office.

The need for whole person care is especially poignant in the postpartum period when health concerns for the birthing person or newborn may be heightened and the support systems within a community may seem overwhelming and complicated to access for a family with a newborn. This paper explores one example of an innovative whole person care collaboration between medical providers and a community partner (an evidence-based newborn nurse home visiting program intended to maximize a shared vision of whole person health with the goal of supporting children and families from the very start). This paper also encourages policymakers to provide funding to both incentivize and evaluate broader medical provider-community partner collaboration.

The Impact of Social Determinants and Adverse Childhood Experiences on Health

A groundbreaking shift in our understanding of maternal and child health has emerged from examining the economic and social conditions that influence differences in health status. Models derived from basic science, translational, and clinical research, as well as the social sciences, describe the complex interplay between stressful environmental exposures, genetics, and resilience factors²⁻⁴.

As defined by the Centers for Disease Control and Prevention (CDC), social determinants of health (SDOH) are the conditions in the places where people live, learn, work, worship, age, and play which affect a wide range of health, functioning, and quality-of-life risks and outcomes. Per the Office of Disease Prevention and Health Promotion, SDOH can be broken down into 5 domains⁵:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

Social determinants of health include intangible factors such as political, socioeconomic, and cultural constructs, as well as place-based conditions, including accessible health care and education systems, safe environmental conditions, well-designed neighborhoods, and availability of healthful food⁵. SDOH includes poverty, racism, and adverse childhood experiences (ACEs), all of which have profound impacts on health outcomes².

ACEs are potentially traumatic events that occur in childhood (0-17 years). Examples of ACEs are having a family member attempt or die by suicide or experiencing abuse or neglect. Per the CDC, ACEs can also include “aspects of the child’s environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with substance misuse, mental health problems or instability due to parental separation or household members being in jail or prison.”⁶

ACEs experienced in childhood can have enduring impact on health and well-being in adulthood. Adults who have experienced ACEs, stressors related to SDOH or poverty, are also at an increased risk of poor health outcomes. Numerous studies have shown that SDOH account for 30-55% of health outcomes.⁷

It is well-recognized that ACEs and detrimental social factors are not equitably distributed. Lower income families and racial/ethnic minorities are more likely to experience these stressors, further potentiating well-known health disparities.^{8–13} When it comes to health inequities based upon race, we also acknowledge the *structural determinants of health*, since it is *racism* and not race that is the root cause. We cannot separate racial health disparities from racism. Institutional policies and practices in the U.S. designed to disenfranchise people of color (for example Jim Crow laws and “redlining”) continue to have an impact on access to health-promoting resources.¹⁴

Children exposed to psychosocial stimuli that result in frequent or sustained activation of stress responses are at greater risk of a range of physical and socio-emotional problems throughout their lifespans (for example, asthma exacerbations, obesity, cardiovascular disease, mental health disease, behavior disorders)^{15–20}. Moreover, chronic exposure to these factors in the critical periods of infancy, childhood, and adolescence may result in toxic stress which can lead to potentially permanent changes in the developing brain⁴. These physiologic changes have been linked to delayed achievement of early developmental milestones, decreased educational attainment and decreased ability to cope with subsequent stressors.²¹

When it comes to clinical care, SDOH is typically siloed. The array of social service providers outside of the medical office can appear to be a complex and fragmented web to both the patient and provider. In a recent American Academy of Pediatrics (AAP) policy statement²², the AAP noted that while toxic stress defines the problem, the promotion of early relational health strategies which focus on promotion of the safe, stable, and nurturing relationships (SSNRs) that buffer adversity and build resilience, may be the solution. The AAP calls on pediatric providers to “adopt a public health approach that builds early relational health by partnering with families and communities with integration both vertically (by including primary, secondary, and tertiary preventions) and horizontally (by including public service sectors beyond health care)”.

As such, there is considerable necessity for collaboration between health care providers and community service programs to work together to deliver strength-based, patient-centered, whole person care. The urgency is so great that some health policy scholars recommend novel alternative payment models that incentivize health care providers to collaborate with a wide array of community service and education programs²³.

Challenges with Current SDOH Strategies: The Need for Screening Paired with an Informed and Effective Referral

There are significant assets and strengths that lie within communities and within families. The positive exists in every community and culture, and it can be fostered and grown to mitigate negative exposures. Strategies, such as the Montana Institute’s *Science of the Positive* and Dr. Robert Sege’s *Health Outcomes from Positive Experiences* (HOPE), can support approaches to recognizing and fostering the positive in individuals, communities and systems²⁴. The HOPE framework recognizes the protective impact of positive childhood experiences²⁵. Even in the face of adversity, a relationship with a nurturing and attuned caregiver can support a child’s health and development.

A recent large-scale John Hopkins study identified the mitigating impact of Positive Childhood Experiences (PCEs) in countering the impact of ACEs, including on adult mental health²⁶. The authors posit “PCEs may have a greater influence in promoting positive health, such as getting needed social and emotional support or flourishing as an adult. In turn, these positive health attributes may reduce the burden of illness even if the illness is not eliminated. This is consistent with prior research demonstrating a dual continuum of health whereby flourishing is found to be present for many adults despite concurrent mental health conditions.”

The concept of a *Pair of Aces*, as developed by Ellis and Dietz, acknowledges the interconnectedness of **Adverse Community Environments** (ACEs) – the soil in which some children’s lives are rooted – and **Adverse Childhood Experiences** (ACEs) – the branches on which children bud and grow²⁷.



(Graphic used by permission)

Traditional health care is very important to health and longevity, but it must be broadened to attend to not only identifying SDOH and ACEs but also engaging in the systemic work to foster positive and protective experiences that promote early relational health and drive future health outcomes²⁸. The recognition of the impact of SDOH on overall health has led to a growing use of screens for SDOH during the patient visit in a step forward towards whole person care.

When medical providers who are part of systems that delivers whole person care meet certain criteria, they may be described as being *high performing medical homes*. An example of the design of a high performing medical home for children in Medicaid is described as:

1. *Improvements in primary care and well-child visits to respond better to social determinants, build on family strengths, and support and engage parents.*
2. *Enhanced care coordination to ensure authentic engagement and two-generation support and access to and use of community resources to meet child and family needs and*
3. *Integration within or linkages to other health, developmental, and family support services that advance health and development.*²⁹

The American Academy of Pediatrics recommends a maternal depression screen for the birthing person postpartum, and regular screenings for SDOH in its *Bright Futures*³⁰ guidelines. The American College of Obstetrics and Gynecology recommends screenings include ongoing screens for anxiety and interpersonal violence in its *Women's Preventative Service Initiative*³¹. The American College of Physicians, and the American Academy of Family Physicians³² have also endorsed the importance of screening for SDOH within their respective areas of the health care system^{20–22}. States and payers are also increasingly requiring medical providers to screen families for SDOH as a standard procedure with reimbursement tied to completing a patient screen.

A 2019 study documented that while most medical professionals support social needs screening in clinical settings, a minority of clinicians expressed confidence in their ability to address social needs.³³ Medical providers in this study, which included a range of clinicians, expressed discomfort with conducting screenings for a range of reasons, including worry about patient discomfort, lack of time and inability to offer resources to address identified patient needs³⁴.

Reasons cited by clinicians for hesitancy related to routine screening for SDOH included being overworked, not knowing how to ask about SDOH, not knowing what to do about it once it is found out, questioning if this is part of their role, and lacking role models or support in helping patients to address identified needs.³⁵

In a 2019 report from *Public Agenda*³⁶ regarding caregiver perspectives about SDOH screenings, caregivers cited “a broad range of social stressors that affected their children’s health and well-being, including some that screening tools for social determinants of health may not currently include,” such as intimate partner violence, parental mental health and legal issues. Caregivers identified several concerns about social determinant screening, including “worries about being judged and discriminated against, fear of intervention by a child welfare agency, lack of time during appointments and frustration at the prospect of disclosing sensitive information without getting help.” To abate these concerns, caregivers encouraged providers to: 1) only ask these sensitive questions within a trusted parent-physician relationship, 2) indicate that the screeners are universally completed as standard protocol to decrease stigma, 3) articulate transparency regarding confidentiality and what findings would incur a referral to social services, 4) ensure that resources can be provided for the needs that may be identified through screening, and 5) not conducting screenings for SDOH in front of children.

In terms of ACEs screenings, providers cite a number of barriers to screening including “confidence in ability to advise parents”, inability to bill, unfamiliarity with screening tools, and lack of training.¹² Some have argued that without evidence-based interventions to address high ACE scores, there may be unintended risks associated with implementation of routine screening and that these screening tools do not meet U.S. Preventive Services Task Force (USPSTF) requirements for effective screening.^{37–39} Others have cited fears about caregiver perceptions of screening as a barrier to implementation despite some evidence to suggest that caregivers see their pediatrician as a trusted and safe person with whom to discuss these issues.^{39–41}

Finally, the findings from screening require a response from the health care provider. Child health leaders who convened in 2020 through the Child and Adolescent Health Measurement Initiative proposed that primary care providers draw from a set of “6R responses” when a concern or risk is identified through screening.⁴²

The 6Rs include:

1. **Respect.** *Show respect for the family’s right to feedback and engage in a respectful discussion related to the results of the screening.*
2. **Reinforce.** *Give feedback about the family’s strengths and opportunities to take action regarding concerns and risks.*
3. **Resource.** *Provide resources and information through both oral and written communication, including handouts, Internet content, etc.*
4. **Return.** *Ask the family to make a return visit in near future, particularly if the status of risk and needs are unclear based on the screen results.*
5. **Refer.** *Make a specific referral to another provider, service agency, or community resource.*
6. **Resolve.** *Complete the process, with follow-up continuing until the immediate need is resolved, referral completed, or additional services secured.*

One of the challenges that medical providers face in addressing identified needs is the lack of a coherent network of community resources to which a family can be referred. Some larger health systems may use an information and referral system that can help make referrals. However, the creation and maintenance of such a network cannot be financed by smaller medical practices and clinics. This challenge requires a population health approach that distributes costs across all members of the population (and their payers or the community) and partners with similarly purposed community-based initiatives.

Without the infrastructure to respond, medical providers risk “exacerbating existing mistrust between patients and families, contributing to an individual’s trauma from unmet needs, negatively impacting the patient provider relationship, and overburdening staff who do not have the time nor the training to provide meaningful follow up” according to the policy brief *Screening for Social Needs in Pediatrics* recently released by PolicyLab at the Children’s Hospital of Philadelphia. The brief also notes that there should be sensitivity to the perceptions of harm or stigma that can arise when screening for social needs.⁴³ Privacy in disclosing sensitive needs should be taken into consideration, and families should also be able to indicate their priority needs, including those for which they do not desire assistance.⁴³

With these findings in mind, screening for cognitive and social-emotional development, maternal depression, ACEs, and SDOH is strongly needed but requires a clear process that is conducted by qualified and well-trained professionals with subsequent health care provider response. The screenings should be conducted with a process that values a family’s assets, strengths and partnership on the journey toward wellbeing.

Collaboration for Whole Person Care

We propose that whole person care can and should be a collaboration between medical providers and community partners that is structured to be patient-centered, collaborative, built to ensure communication flow between partners, and ensures that the 6 Rs are addressed.

The idea of whole person care has been criticized as a lofty but unrealistic goal given financial constraints, the siloed health care system, and often dizzying array of community social services. We also note that in rural communities the social services can be limited and hard to locate and there is often effort required to identify the informal supports that community families may be accessing to meet social needs.

Below, we share one example of a successful partnership that connects health care with community resources in a financially feasible way. This example focuses on a collaboration between medical providers and a universal newborn nurse home visiting program known as [Family Connects](#) that is offered to all families within a defined community at a point in time when there is risk (the birth of a newborn)⁴⁴.

The Universal Newborn Nurse Home Visiting Model

The Family Connects universal newborn nurse home visiting program is an evidence-based model that combines engagement and alignment of community service providers with short-term nurse home visiting. The Family Connects model is designed to be offered to all families with newborns within a defined community. It is a voluntary program and is provided at no cost to families.

The Family Connects model uses a “targeted universal” approach. That is, while delivered universally, the program quickly triages and customizes the intervention based on screening to target a family’s unique needs. This approach is similar to primary medical care in pediatrics, in which the primary care provider delivers universal care, screens for medical issues, and (when necessary) refers a child for specialist diagnosis and intervention.

A registered nurse connects with a family in their home shortly after birth to: share the joy of the birth; assess the child’s and birthing person’s physical health status (as applicable); assess unique family strengths and challenges; and respond to immediate family needs. The program is also available in the case of adoption, foster or kinship care. Working together with the family and building on identified strengths, the nurse connects the family with local community resources based on individually identified needs, priorities and preferences. And in turn, the caregiver connects with their child’s needs, supporting caregiver and child health, caregiver-child relationship, child development, and long-term family adjustment.

By offering Family Connects to all families within a community, Family Connects improves health outcomes at the population level and establishes a new norm for how families of newborns are welcomed and supported in the community.

The model has 3 central components that work together:

1. Integrated Home Visit
2. Community Alignment
3. An Integrated Data System

1. The Integrated Home Visit: Registered nurses offer a home visit to all families with newborns within a community to provide a high-inference health assessment of family strengths, challenges and needs (based on nursing queries, nursing observations, and validated screening tools) to offer supportive guidance about maternal and infant health, and to connect the family to community resources. The visit typically occurs at 3 weeks after discharge from the birthing hospital and lasts approximately 90 minutes-2 hours.

Research has consistently shown that the birth of a baby is a time of vulnerability and opportunity for every family. In a rigorous trial of the Family Connects model in 4 low-income rural counties in North Carolina, 94% of families regardless of income welcomed the partnership from a Family Connects nurse via provision of additional education or connections to community resources.²³

The core of the Integrated Home Visit, the *Family Support Matrix*, was created to assess the family across 12 factors that are empirically linked to maternal, family, and child health and well-being. The nurse uses the Family Support Matrix to guide the home visit; to summarize the assessments, observations and discussions; and to document the infant's, caregiver's and family's strengths and needs. Each factor reflects:

- 1) health and psychosocial risk factors in early childhood;
- 2) parenting concerns about caring for a newborn; and
- 3) family needs for which the nurse makes recommendations and referrals to community resources.

Family Support Matrix

Support for Health Care	1. Maternal Health
	2. Infant Health
	3. Health Care Plans
Support for Infant Care	4. Child Care Plans
	5. Parent-Child Relationship
	6. Management of Infant Crying
Support for a Safe Home	7. Household Safety/Material Supports
	8. Family and Community Safety
	9. History with Parenting Difficulties
Support for Parent(s)	10. Parent Well Being
	11. Substance Abuse in Household
	12. Parent Emotional Support

Key health areas covered during a Family Connects nurse visit include:

- A systematic discussion about the family's supports, strengths, vulnerabilities and needs using the 12 factors of the Family Support Matrix.
- Health assessment for postpartum birthing person (as applicable) and infant. The health assessment includes a blood pressure check and limited physical exam, if indicated, for birthing person and weight/length/head circumference, and physical exam for infant.
- Screening for SDOH and ACEs through Nurse query regarding mental health history, substance use history, previous parenting history, interpersonal violence exposure, incarceration of parent or partner, history of abuse/neglect and involvement of Child Protective Services as a child or adult.
- Validated written screening tools to allow another opportunity to query about level of concern, including postpartum mood disorders, substance misuse, and intimate personal violence.
- Support and guidance about topics relevant to all newborns and caregiver health needs, including:
 - o Reinforcement of connection to the medical home for caregiver(s) and infant to reduce unnecessary emergency department visits.
 - o Breastfeeding support.
 - o Safe sleep practices and Sudden Infant Death Syndrome (SIDS) prevention.
 - o Postpartum care, including scheduling postpartum appointment as needed.
 - o Caregiver-child interaction assessment and coaching.
 - o Dialogue regarding the growing relationship between caregiver(s) and child.
- Specific education and demonstrations in response to caregivers' questions and concerns or those that arise from observations during the home visit.

- A collaborative plan for recommendations and referrals to community services as identified by nurse visitor and caregiver(s) including:
 - o Perinatal mood disorder referrals.
 - o Postpartum care, including scheduling postpartum appointment as needed.
 - o Tobacco cessation referrals.
 - o Intimate partner violence referrals.
 - o Assistance with obtaining health insurance coverage/enrolling in Medicaid, childcare, and social services.
 - o Family networking, social support building and "who do you call when you need support?"
- Signed agreements for releases of information to health providers and referral agencies, as needed.
- Plans for follow-up home visit(s) and/or telephone contacts.

Nurses can make up to three home visits to a caregiver's home, as needed, although most families receive only one visit. At 4 weeks after the last home visit, a Family Connects staff member contacts the caregiver to assess satisfaction with the program, to determine if any new needs have arisen, and to follow up on all community referrals to ensure successful connection.

2. Community Alignment: The community level outcomes are dependent on the program's ability to make appropriate and timely connections to effective community resources. In many communities, numerous agencies exist to address diverse needs, but they are not known to primary care providers and are isolated from each other with no coherent organization. This fragmentation makes it difficult, if not impossible, for the individual provider to connect a family with the most-appropriate agency. A primary goal of Community Alignment is to improve the accuracy and efficiency of connecting families with the right service, at the right time, in the right amount. This work uses a system of feedback loops to ensure the nurses have access to updated contact and capacity information for community agencies. These timely connections are facilitated by feedback loops that are created through relationships with community programs and collaborations and inform daily operations. These processes allow program staff to identify gaps in support for families and collaborate with partners to help address those needs.

In the absence of a comprehensive "catalog" of community resources to support families with young children, a community is vulnerable to having gaps in some kinds of services and surpluses in other services. The Family Connects Community Alignment Specialist will build a comprehensive resource catalog which is known as an Agency Finder.

In some communities, there has been investment in organized systems of community resources such as Help Me Grow⁴⁵ or 211⁴⁶. There are also multiple intake and referral services operating across the country, many of which can integrate with electronic health record systems and all of which can support referrals for SDOH needs. In some communities, Family Connects programs incorporate use of these systems in addition to their Agency Finder.

A second goal of Community Alignment is to optimize the array of services available in a community by matching the measured needs of families (aggregated from individual families' reports during home visits) with available services. This level of intervention occurs outside of the individual primary care provider, but at the community level.

Community Alignment can be described as a wheel with 6 spokes that all work together:

- The **Community Advisory Board** offers an opportunity to incorporate stakeholder processes and feedback by working closely with community agencies and existing community collaborative, such as early childhood coalitions or infant mortality reduction task forces that focus on system-wide strategies that may already exist in a given community.

- The **Agency Finder** is a searchable directory of all community agencies that is used by nurses to make referrals. While creating the Agency Finder it is important to identify other community systems for referrals that may already exist to establish partnerships to share information that will help ensure collective success.

- **Engagement** is the process of connecting and relationship building with key stakeholders including the medical provider community, community partners, and additional champions, as well as ensuring family voice is at the center of the work.

- **Case conference** is a weekly meeting for nurses to discuss clinical concerns and to report referral data and qualitative feedback regarding ease of access for clients, needed resources, and connections into the community. The Community Alignment Specialist attends these meetings as well to obtain this feedback and troubleshoot service delivery for clients.

- **Post Visit Connection** calls are staff-initiated calls to families to assess program effectiveness in connecting to resources. These calls are a standard part of the model, taking place four weeks after the last visit.

- **Data review** includes analyzing visit completion rates as well as community referral trends.

Often this is an opportunity to discover a gap in services or resources that may exist within a community for a particular need. The resultant data can often be utilized to justify funding requests to support these needed services

3. Integrated Data System: While the Family Connects program collects data to ensure program implementation with quality and fidelity, a connection with the family’s medical provider (and patient consent) can allow for bi-directional flow of information. With caregiver consent, the Family Connects data system can send a summary report after the home visit to the family medical providers, including the identified needs and connections made to community resources.



Impact of Family Connects

Randomized controlled trials of Family Connects published in *Pediatrics*, the *American Journal of Public Health*, and *JAMA Network Open* have shown positive effects for families in several key areas^{44,44,47–51}, including:

- In contrast with control infants, those randomly assigned to Family Connects had significantly lower rates of infant emergency room visits and hospital overnight stays in the first year of life; these results were sustained through the fifth year of life.
- In contrast with control families, those randomly assigned to Family Connects were less likely to be investigated for child maltreatment.
- Family Connects mothers were less likely to report possible postpartum clinical anxiety.
- Family Connects mothers reported significantly more positive parenting behaviors, such as hugging, comforting and reading to their infants.
- Home environments were improved — homes were safer and had more learning materials to support infant development.
- Community connections were higher for Family Connects families.
- When using out-of-home childcare, Family Connects families used higher quality care.
- Family Connects families were more likely to use out-of-home childcare.
- Family Connects mothers were more likely to complete their six-week postpartum health check but also had more emergency department visits. (*The manuscript noted that the difference in emergency department visits might be due to an effect of Family Connects on mothers' increased awareness of their own health needs in the fourth trimester period*).

Medical Provider Partnership with Family Connects

The authors acknowledge that collaboration between the pediatric and maternal care practices with a community partner, such as a universal newborn nurse home visiting program, will not address the overall systemic challenges that contribute to SDOH and ACEs. These partnerships can happen while at the same time the high priority, essential and complex work to address systemic racism continues. We want to be very clear that the work to address systemic racism is of the utmost priority.

Broadening the definition of the medical home to intentionally use coordinated community partnerships should find a place at the center of child and maternal health transformation. These types of innovative partnerships can be steps forward towards building a new system of *whole person care*. Partnerships between medical providers and their local Family Connects program can help deliver whole person care at one point in the overall life course by helping to build positive health foundations.

One potential innovative approach for whole person care would be through an intentional, formalized agreement between pediatric care practices, maternal care practices and Family Connects programs that **delegates the screening in the postpartum period to the local Family Connects program**. Family needs are uncovered through a sensitive, trust-building dialogue between the Family Connects nurse and the caregiver(s) that identifies family strengths, vulnerabilities and preferences. A formalized partnership with health-care providers and Family Connects programs benefits families by eliminating multiple, duplicative screenings in the immediate postpartum period.

In this collaboration, the Family Connects Integrated Home Visit would serve as a comprehensive SDOH/ACEs screening with all parties working together to take an approach that is mindful of the “6 Rs.”

This type of health care integration would be narrowly focused on the important and foundational interactions of the immediate postpartum period. Because the Family Connects nurse will loop back with the family’s medical providers, this integration carries the important message of the medical providers’ commitment to the well-being of the family, the infant and their growing relationship. With patient consent, the medical providers will receive a post-visit report after the Family Connects visit that will detail the identified strengths, opportunities and referrals.

Medical providers have an important role to play in this partnership because they will follow up with the family at their next medical appointment. The information from the Family Connects visit allows the provider to begin the next visit with an understanding of the families’ specific needs, offering an opportunity to deepen trust and further support those needs. The family may have new psychosocial needs to share with their provider at their medical appointment. Additionally, coordinated partnership between the healthcare provider and the local Family Connects program’s Community Alignment Specialist may help to ensure that the provider is knowledgeable about available community resources and able to more adeptly respond to future needs as they arise outside of the postpartum period.

An essential element for both consideration and innovation is how this type of whole person care integration is funded. Providers of both medical care and psychosocial care have the health of their patients and the health of their community as their mission. However, this innovation will require new or different funding streams from the approaches that currently operate within the United States. Ideally, public and private payers would be (and in some states are) reimbursing Family Connects programs for the valuable assessments, education, and support with referrals that make up the complete Family Connects Integrated Home Visit. Funding from the Federal level, for example via the United States Department of Health and Human Services, could incentivize these types of partnerships. Funding could also be generated via demonstration waivers from the Centers for Medicare and Medicaid Services (CMS) to support health care integration for Medicaid-eligible families. Finally, these types of projects could be supported by philanthropy as “beta tests” to demonstrate impact and advance larger policy shifts with a focus on upstream prevention, whole person care, and high-performing medical homes.

Funding for both qualitative and quantitative evaluation should also be prioritized to determine the overall effectiveness of this type of health care integration.

Conclusion

In conclusion, there is considerable opportunity for medical providers and community partners to work together to deliver whole person care that extends beyond the walls of the medical provider’s office and embraces community partners. These partnerships require collaboration and coordination between health care services and community programs and must be built with patients at the center. Innovative funding streams that incentivize partnerships and build bridges for data exchange must be developed. Public funds must be leveraged at federal, state and local levels, and the donor community must share a long-term vision and commitment to whole person care.

By building and incentivizing an infrastructure that is founded upon a universal system of coordinated supports for all families and linking that system with the medical home, we ensure family-centered

access to needed and desired referrals. We also move one step closer to connecting every caregiver and child to the healthy futures that they deserve.



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