

# Whole Person Care Collaborative

## Background

The North Central Accountable Community of Health (NCACH) Governing Board selected whole person care as the primary project under the State Innovation Model (SIM) grant program in 2015, in order to improve the quality of health care in the region and prepare for fully integrated Medicaid contracting by 2020. A Primary Care Transformation Workgroup was formed, and in the fall of 2016 the workgroup adopted a broad vision of whole person care and formed the Whole Person Care Collaborative (WPCC). The goal was to promote Whole Person Care in a way that achieves the triple aim of better quality, better service, at a lower cost. The term *collaborative* was modeled after “Learning Collaboratives” sponsored by the Institute for Healthcare Improvement (IHI) and others where multiple organizations participate in a series of structured process improvement efforts involving collaborative learning, process redesign, implementation, measurement, sharing results, and continued improvement. Because of the unique nature of the North Central Washington delivery system and the willingness of provider organizations to support this approach, the NCACH board approved the creation of the Whole Person Care Collaborative as the most effective means to advance the triple aim in the region.

## Charge

The Whole Person Care Collaborative (WPCC) will promote alignment of provider transformation efforts in the North Central Region with a shared vision of whole person care. The region’s vision of whole person care is for patients to receive care that focuses on the overall health of individuals and the population at large, including integrating behavioral and physical care. The goal is to promote Whole Person Care in a way that achieves the triple aim of better quality, better service, at a lower cost. The work of WPCC will also strive to deliver Whole Person Care in a way that is financially sustainable for provider organizations.

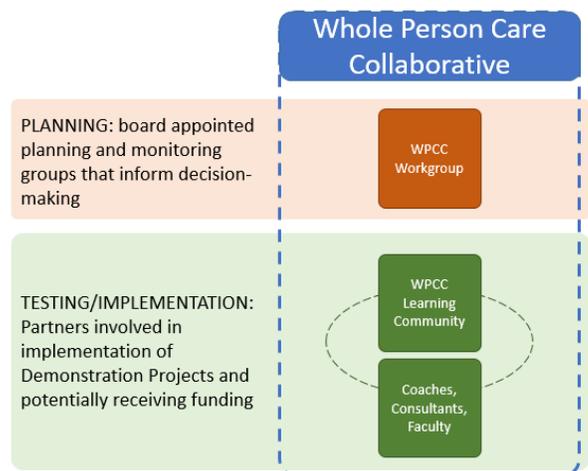
## Whole Person Care Vision

At a two-day summit in January 2017, regional partners convened and began articulating a vision of whole person care ensuring patients receive care that focuses on the overall health of individuals and the population at large, including integrating behavioral and physical care. *See Appendix A for the Vision Statement and Overview document that was drafted.*

## WPCC Evolution

In January 2017, Washington State’s Medicaid Transformation Project Demonstration grant was approved by the federal Centers for Medicare & Medicaid Services (CMS) and the NCACH began planning for regional health improvement projects as part of this 5-year contract initiative.

As our region moves from planning to implementation in 2018, we are finding a need to delineate between roles and functions of the Whole Person Care Collaborative moving forward (as shown in diagram). These roles and function are further defined in the following documents. *See Appendix B for a visual of how this structure fits into the greater whole.*



# WPCC Workgroup Charter

## Background

On January 9th, 2017 the Washington State Health Care Authority (HCA) signed an 1115 Waiver, now known as the Medicaid Transformation Demonstration Project. The goal of the Demonstration is to improve care, increase efficiency, reduce costs and integrate physical and behavioral health into Medicaid contracting. To align clinical aspects of behavioral and physical health with payment integration, HCA developed the [Medicaid Demonstration Project Toolkit](#) to provide tools, resources and guidance for these efforts.

As the North Central Accountable Community of Health (NCACH) began planning for regional health improvement projects under this 5-year contract initiative, the Whole Person Care Collaborative (WPCC) was seen as a natural fit for the Bi-Directional Integration and Chronic Disease projects, whose objectives (as described in the toolkit) are as follows:

- **Bi-Directional Integration of Physical and Behavioral Health through Care Transformation:** Through a whole-person approach to care, address physical and behavioral health needs in one system through an integrated network of providers, offering better coordinated care for patients and more seamless access to the services they need. This project will support and advance Healthier Washington's initiative to bring together the financing and delivery of physical and behavioral health services, through MCOs, for people enrolled in Medicaid.
- **Chronic Disease Prevention and Control:** Integrate health system and community approaches to improve chronic disease management and control.

The WPCC Workgroup was conceptualized as a distinct advisory body in late 2017, in order to guide the planning and implementation of these two projects. The WPCC Workgroup may also provide input into mechanisms that assist provider organizations in contributing to and supporting NCACH's four other projects; Community-Based Care Coordination, Transitional Care, Diversion Interventions, and Opioid Use Public Health Crisis.

## Charge

The WPCC Workgroup is tasked with providing oversight of a process for partnering providers to collaborate on and receive funding to support the two Demonstration projects described above. The WPCC Workgroup will work with NCACH staff to ensure that the NCACH region implements effective evidence based practices that align with the milestones and approaches described in the HCA Toolkit. Specifically, planning and implementation guidelines outlined by the WPCC Workgroup will:

- Enable primary care and behavioral health providers in the NCACH region to better integrate behavioral health and medical care,
- Better integrate and coordinate care activities with organizations addressing social determinants of health,
- Achieve the population-based clinical outcome goals of the Medicaid Demonstration projects as outlined by the HCA in the Demonstration Project Toolkit, and;

- Support partnering providers in delivering effective whole person care that is financially sustainable under evolving reimbursement models (value-based payment) beyond the Demonstration period.
- Provide recommendations to the NCACH Governing Board and staff on approaches to take for the Bi-Directional Integration and Chronic Disease projects.
- Ensure Bi-Directional Integration and Chronic Disease projects align with all other NCACH projects, as much as possible.
- Ensure projects effectively connect patients with resources to mitigate the negative consequences of the social determinants of health
- Help identify how Domain 1 (*IT, workforce, and value-based payment*) strategies can support WPCC projects.

## Composition

The WPCC Workgroup will include representatives from Grant, Chelan, Douglas, and Okanogan Counties. Membership on the WPCC Workgroup is not a prerequisite to receiving funding through the Demonstration. The NCACH Executive Committee will recommend to the Governing Board workgroup members from a list of interested parties, assuring representation from:

- Primary Care
- Behavioral Health
- Managed Care Organizations (Operating in all 4 NCACH counties after Jan. 1, 2018)
- Emergency Medical Services
- Community-Based Organizations
- Tribes

Additional representation will be added to the WPCC Workgroup by the NCACH Executive Director if it is deemed necessary. A WPCC Workgroup Chair may be appointed by the Executive Director, if needed. The WPCC Workgroup is a sub-committee of the NCACH Board, and as such must have a minimum of two board members serving on the committee.

## Meetings

WPCC Workgroup meetings will be held once per month, with additional meetings scheduled as necessary. Meetings will be held in Chelan, Douglas, Grant, and Okanogan Counties; locations will vary and an effort will be made to hold meetings in each of the Local Health Jurisdictions throughout the year. Whenever possible, members will have an option to participate via teleconference or audioconference for those unable to attend in person, although in-person participation is encouraged. NCACH's Director of Whole Person Care and the WPCC Workgroup Chair shall be responsible for establishing the agendas. Notes for all meetings will be provided to the Workgroup by NCACH staff within two weeks of each meeting. Monthly meetings will be open and meeting minutes and materials will be posted on the NCACH website ([www.ncach.org](http://www.ncach.org)).

## Membership Roles and Responsibilities

1. Attend at least 75% of regular meetings of the WPCC Workgroup and actively participate in the work of the Workgroup.
2. Sign a Membership Agreement (attachment A).
3. Review data to recommend target population(s), to guide project planning and implementation, and to promote continuous quality improvement.
4. Help develop and recommend processes associated with the Bi-Directional Care and Chronic Disease projects, including change plan templates and scoring, design of learning activities, funding levels, reporting methodology, and data and outcome tracking.
5. Assist in identifying, recruiting, and securing formal commitments for participation from implementation partners via a written agreement specific to the role each organization and/or provider will perform in the selected approach.
6. Recommend to the Board a project implementation plan adhering to project approaches outlined in Toolkit, including a financial sustainability model and how projects will be scaled to full region in advance of HCAs project implementation deadline.
7. Provide input on mechanisms for measuring performance of the ACH, sub-regions, and funded organizations to track progress over time.
8. Evaluate and recommend improvements in shared systems as necessary to improve care across organizations (e.g. 24/7 nurse advice systems, health information exchange/interoperability, care management systems, other IT solutions).
9. Monitor project implementation plan, including scaling of implementation plan across region, and provide routine updates and recommended adjustments of the implementation plan to the NCACH Governing Board.
10. Collaborate with NCACH staff on the application of continuous quality improvement methods in projects.
11. Promote strategies that advance equity and reduce disparities in the development and implementation of the Bi-Directional Care and Chronic Disease projects.

## Authority

The WPCC Workgroup is an advisory body that will inform decision-making by the NCACH Governing Board and ensure regional priorities and local considerations are incorporated in program design decisions. Recommendations and input developed by the Workgroup will be shared in regular monthly progress reports to the NCACH Governing Board.

# WPCC Learning Community Charter

## Background

During the summer of 2017, primary care and behavioral health providers involved in the Whole Person Care Collaborative (WPCC) completed an evaluation process conducted by a coach/consultant from Qualis Health to determine their current state of operations relative to an idealized model for population health as defined by the Patient-Centered Medical Home Assessment (PCMH-A) guideline for primary care or the Maine Health Access Foundation (MeHAF) rating scale. These baseline assessments established current operational state and identified improvement opportunities to be addressed in the transition to whole person care and value-based payment.

Building on these evaluations, the WPCC Learning Community is being organized to drive systemic change in clinical practice by focusing on basic operational processes needed to move from an acute, episodic model of care to a proactive, population-based model. Participation in the WPCC Learning Community is the primary means of engaging qualifying clinical providers as implementation partners of NCACH's Bi-Directional Integration and Chronic Disease projects for the Demonstration.

## Eligibility

To be eligible to participate in the WPCC Learning Community, partners must:

- Be a primary care and/or behavioral health provider
- Serve a significant volume of Medicaid Beneficiaries (based on parameters set by the WPCC Workgroup prior to contracted work)
- Complete a MeHAF/PCMH-A baseline assessment to establish current operational state relative to the PCMH model (organizations may use Qualis or another consultant of their choice)
- Sign a Memorandum of Understanding indicating willingness and ability to be involved in the learning activities and agreeing to meet the expectations outlined below

## Expectations

Commitment to writing a change plan is a pre-requisite for engagement in the WPCC Learning Community. The Learning Community will offer Learning Activities (*see next section*) specific to change plan development in order to promote partner success. Primary care and behavioral health organizations also may choose to work with a consultant of their choice (or internal experts if available) to develop a Change Plan using a pre-established template. Each organization participating in the WPCC Learning Community will:

- engage in learning activities,
- develop and implement change plans to undertake improvement processes,
- measure and evaluate progress,
- share results with each other, and
- pursue further improvements.

## Learning Activities

The WPCCL Learning Community will offer implementation partners opportunities to share and learn from each other and take action to achieve common goals. **Learning activities will be designed with partnering organizations** and may include:

- Sprints
- Learning & Action Networks
- Affinity Groups
- Skill building opportunities
- Breakthrough Series Collaborative
- Idealized Design Projects
- Coaching Support
- Quarterly Meetings

Drawing on these structured peer-based learning activities, the WPCCL Learning Community will take each organization at its own starting point and move it further along the continuum of bi-directional integration and whole person care.

## Team Members

While team size is variable depending on size of clinical site, an ideal team might include the following members:

- *Clinical champion:* for primary care, this is a primary care provider. For BH this is a therapist, psychologist or substance use counsellor
- *Day-to-day leader:* someone who is familiar with the QI structure and methods of the organization. Will have ongoing responsibility to organize the team and make sure reporting happens, tracking tasks and activities.
- *Front line staff:* (1-3) people who are involved in the processes and have on-the-ground knowledge of the way the organization functions. Depending on the topic and goal of the team, this could be a medical assistant, a care manager, a community health worker, primary care psychologist, a peer support worker.
- *Senior leader:* The person who can clear the way for the team to do their work. They can influence the resources and processes of the broader organization.

Note that in smaller organizations, some people may hold more than one role.

## Funding

Funding will be provided to participating organizations that have signed a Memorandum of Understanding. It is the intent that members of the Learning Community will receive funding throughout the demonstration project, provided they meet the ongoing requirements as outlined below:

Funding Stage	Time Period	Basis for funding
Stage 1	2018 Q1	<ul style="list-style-type: none"> <li>• Signed MOU with funding based on historical encounters</li> </ul>
Stage 2	2018 Q3	<ul style="list-style-type: none"> <li>• Submitted Change Plan based on quality and comprehensiveness of the plan</li> </ul>

Stage 3	2019-2020	<ul style="list-style-type: none"> <li>• Successful implementation of a change plan based on reporting of milestones identified in the plan</li> </ul>
Stage 4	2021-2022	<ul style="list-style-type: none"> <li>• Reported improvement in quality metrics over baseline</li> </ul>

Recognizing the time commitment involved, and the fact that provider organizations already feel stretched thin, funding is primarily intended to support practice team involvement in meetings and activities in their setting, which may require backfill, per diems, locums, or temporary staff to continue to meet patient needs.

In addition to supporting practice team engagement in the WPCCL Learning Community to share best practices, engage in peer learning, and leverage available statewide practice transformation resources, Demonstration funding may be used to secure needed training and coaching to advance organizational change and clinical practice improvement, beyond what is being provided through the Learning Community.

While there are no specific prohibitions in the use of funds other than proscribed by State guidelines, the NCACH does not encourage their use to add resources that cannot be sustained beyond the Demonstration period.

### Reporting

Continued funding will be contingent on demonstrated effort and progress as outlined in required progress reports to the NCACH. An NCACH portal will provide a centralized and efficient method of reporting (user licensing will be covered by the NCACH). The portal will also facilitate sharing of resources – including trainings, calendars, listservs, change plan templates, reporting templates – related to the WPCCL Learning Community activities.

# WHOLE PERSON CARE VISION STATEMENT AND OVERVIEW

## Vision Statement

The vision of Whole Person Care is for a patient to reach a state of complete physical, mental, and social well-being by creating healthcare systems that will improve the patient experience of care, improve population health, reduce the per capita cost of health care, and improve job satisfaction for those involved in providing care. (The Quadruple Aim)

## What is it?

We define health (based on the World Health Organization definition) as a state of complete physical, mental, social, and spiritual well-being and not merely the absence of disease or infirmity.

Whole Person Care recognizes that a person's state of health is influenced by much more than the health care they receive. According to the Institute of Medicine, health is determined:

- 10% by health care
- 20% by genetics
- 30% by environmental factors, (such as housing, employment, etc.)
- 40% by personal behaviors, (such as diet, exercise, substance abuse, etc.)

Since health is affected by all of the factors above, Whole Person Care, to the extent possible, must address all of them. An important difference between Whole Person Care and other care is that Whole Person Care more effectively connects patients with resources outside the clinic which help address health-related social issues such as housing, education, and other social determinants of health. Whole Person Care also eliminates the divide between behavioral health and medical care.

## How does it work?

In a primary care setting, Whole Person Care involves a Primary Care Provider (PCP) acting as the leader of a multi-disciplinary team that would address the medical/behavioral issues as well as the health-related social issues affecting a patient. It has been shown that the keys to success are resources, such as Care Coordinators, who contact and make arrangements for services at the direction of the PCP. It is important that all of this coordination is done in partnership with the patient to encourage patients to take ownership of their own health.

For patients receiving care mainly from specialists or others outside the framework of primary care, effective care coordination is a key element enabling patients to cope with multiple health care providers, while also connecting patients to community resources needed to address health related social issues.

## What resources/services are required?

The social determinants of health suggest the following resources/services should be part of the Whole Person Care toolkit available to providers, whether in the clinic itself or through care coordinators whom providers can call on to connect patients with community resources:

- Care Coordinators, often Community Health Workers but may be nurses or others with credentials needed for more complicated patients. Care coordination must itself be coordinated to avoid multiple silo-ed care coordinators attempting to help the same patient.
- Behavioral Health Counselors and Prescribers, ideally co-located with medical providers.
- Patient consultations with Pharmacists
- Oral health resources
- Health Educators
- 24 hour/7days per week Nurse-staffed health information phone line
- Medical Interpreters
- Telehealth resources (especially important in rural areas)
- Housing specialists/resources
- Transportation services
- Nutrition education and access to healthy foods
- Employment Services
- ...and others depending on patient needs.

These resources would be linked together into a “system” through a combination of formal and informal agreements and proactively developed relationships.

### Who would need which resources?

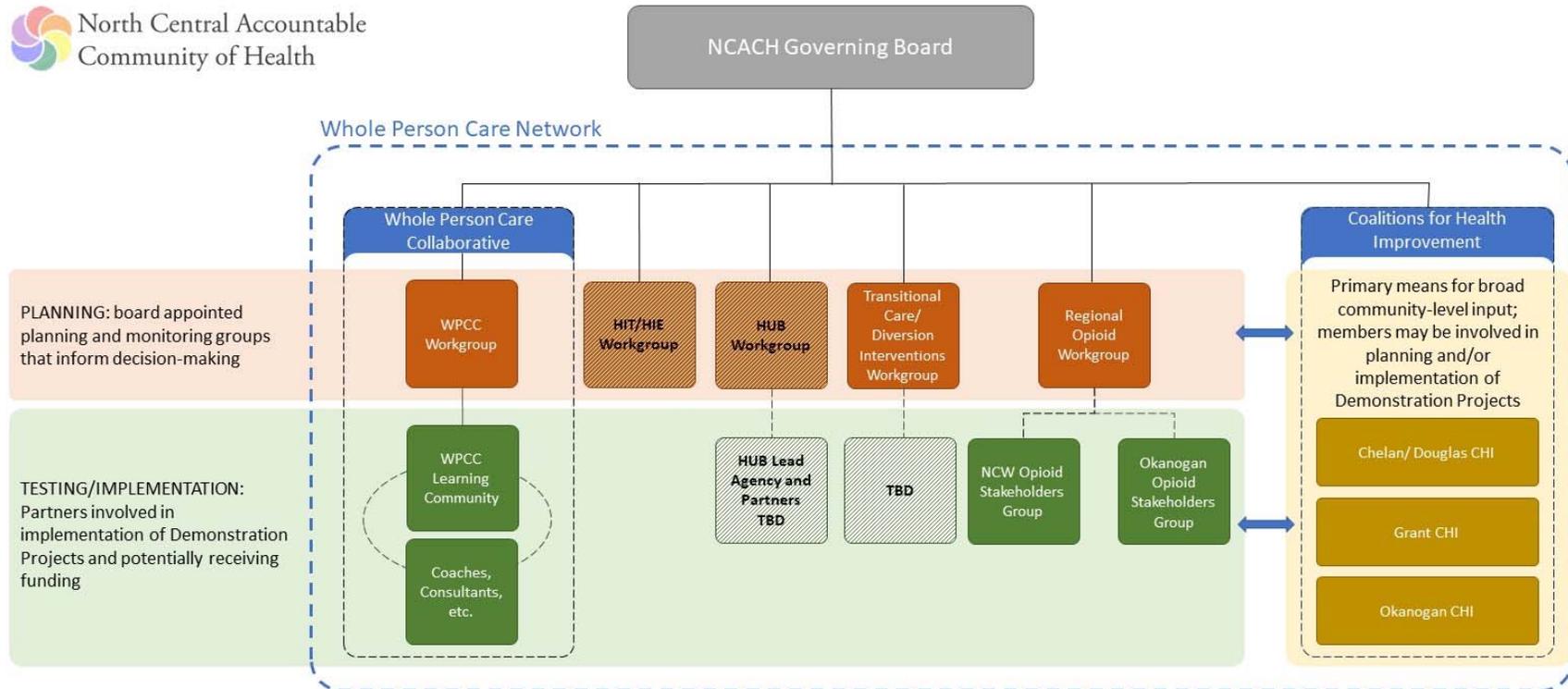
The services required for a given person depend on their state of health. In primary care settings the PCP Team, led by the PCP, would identify gaps in needed services and connect the patient with the necessary resources in the clinic, or with care coordinators to meet needs addressed by community resources outside the clinic. Though the PCP will take a leadership role in this work, Whole Person Care is a team effort.

When presenting to the PCP Clinic, people generally fall into one of following three categories of health and therefore resource need:

- Healthy with no chronic conditions: This group typically needs care for acute conditions, preventive services for monitoring their continuing health, and review to ensure all their non-medical determinants of health are met.
- Healthy with controlled chronic conditions: This group typically needs preventive services/monitoring of their condition(s), education, prescription drugs and other services on an episodic basis. It is important to ensure all their non-medical determinants of health are met to avoid these individuals falling into the “chronic conditions” category of patient care.
- Chronic conditions: Uncontrolled or advanced: This group is the most resource intensive in terms of health care services, accounting for approximately 70% of total healthcare costs. It is also expected this group would have the greatest needs for other services over a long period of time as well. As a result, this group provides the largest potential for both improving quality and reducing costs.

**When Whole Person Care is fully developed and operational, patients in North Central Washington will experience the following:**

1. Every patient who wants one will have a primary care provider (PCP) who knows the patient and his/her family, and is supported by a competent team of health professionals to assist the patient in developing a plan of care appropriate to his or her health needs.
2. The PCP team coordinates the patient's care both within the clinic and wherever the patient is referred for services (e.g. specialty care, hospital care, or any number of community based non- medical services which support the patient in achieving his/her health goals).
3. In accordance with their care plan, patients will receive routine reminders about preventive screening and immunizations, which will prevent unnecessary illness and lead to early detection, cure, or appropriate management of more serious disease.
4. Patients will have online access to important health information in their medical record to assist in managing their own care. Patient Health Information comes from all sources (inside and outside the clinic) and is part of an integrated and comprehensive medical record accessible to all providers in the region authorized to care for the patient. (e.g. EMS, Emergency Room, Primary Care, Specialty Care, etc.)
5. Patients will be treated with respect, informed, cared for, and involved in decisions about their care at every step of the way. They will see themselves as important members of their own health care team and the ultimate decision makers regarding their own care.
6. Patients will have same or next day access to an appointment with their primary care team if desired. They will also have the option to communicate with their PCP via e-mail or phone if more convenient than a face-to-face visit. In addition, they will be able to call a nurse advice line 24/7 which has access to their electronic health record to help them make important decisions about whether and where to seek care.
7. New reimbursement models (e.g. value-based payment) will compensate Primary Care (including Behavioral Health) for services, many unrelated to a visit to a provider that support the quadruple aim. Insurers, employers, and other agencies will recognize that some increases in primary care and social services may be required to reduce unnecessary medical and social costs that occur widely across our community.



This diagram is a visual representation of the various governing, planning, and implementation elements involved in NCACH’s six Medicaid Demonstration projects. For the sake of presentation and simplicity, many linkages among planning workgroups and implementation partners have not been drawn, though those intersections should be assumed. Some workgroups and partners have yet to be identified, and more workgroups may be formed if needed.

The “Whole Person Care Network” illustrates our region’s commitment to whole person care, which has been a priority for a number of years and is now being reinforced through our Medicaid Demonstration projects. This network is made up of planning, implementation, and advisory partners including local government agencies, tribal representatives, community-based organizations, physical health providers, and behavioral health providers. Achieving whole person care depends on partnerships with both clinical and social service agencies who are critical to the success of our region’s health improvement efforts.