Introduction to the Whole Person Integrated Care Model

Excerpts from a note of encouragement and hope from Derek Feeley, President and CEO of IHI (the Institute for Healthcare Improvement):

“Together, we must make care safer and more equitable, populations healthier, and costs more affordable. We feel a particular responsibility to those people who lack access to care or who experience inequity or social injustice....

Now is a time to be bold and innovative and to demonstrate resilience and resolve.”

Training Objectives

As a result of this training, participants will:

1. Learn about Partners’ Whole Person Integrated Care (WPIC) model and how it is structured;
2. Become familiar with current research and policies that support the WPIC model as best practice;
3. Become familiar with how Partners’ Care Coordination is adopting complementary WPIC strategies; and,
4. Learn about the comprehensive evaluation framework of the WPIC model.
The pivot toward achievement of the Triple, and now the Quadruple Aim requires us to re-envision the components and processes of health delivery.

- Integration of research in neuroscience, social epidemiology, public health & the behavioral sciences create new opportunities to advance Whole Person and Value Based Care.

- The Whole Person Integrated Care (WPIC) model leverages these advances to create a new model of comprehensive care.

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**The Quadruple Aim**

- Better Care
- More Satisfied Members
- Lower Total Health Costs
- More Satisfied Providers

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**The WPIC model**

- Focuses on helping people become & stay healthy—rather than focusing more narrowly on “managing” diseases or conditions;
- Includes, but is not limited to strategies such as integrated care, which has typically focused on integration of healthcare services (hospital, primary care, & specialty services such as behavioral health); and,
- Expands the concept of integration beyond the health sector to include the broad range of services & approaches now known to positively & negatively impact overall health, reduce health disparities & optimize public & private resources.
WPIC Ingredients

- Public Health Approaches
  - Health promotion for all citizens
  - Prevention & early intervention
  - Population orientation
- Peer engagement – support – active care facilitation
- Individual/family owned resiliency-based Health Plan & Team
- Systematic community support infrastructure & resources to support those delivering care
- SDOH remedies via community-wide Health Network & Timebanking

INFRASTRUCTURE TO ADVANCE, SUPPORT & SUSTAIN WHOLE PERSON INTEGRATED CARE

Tier 3
The larger community + Time Bank to address SDOH

Tier 2
A community forum/learning collaborative that links to and supports Tier 1 partners

Tier 1
Health Providers moving to best practices with customized support (HUBs, PCPs, etc.)
Tier 2: Advancing the Quadruple Aim

Local Health Forum

Medical Practices, Human Service & Community Partners

Collective Impact Emergence Model

Informed by Data, Research, Lived Experience

Developing the Community's Health Network

Seeing resources through a new lens via a collective vision

Vision is defined by strengths & needs of the population

Broadening resources, the range of solutions and opportunities through a lens of shared understanding

POPULATION

Seeing resources through a new lens via a collective vision

Vision is defined by strengths & needs of the population

Broadening resources, the range of solutions and opportunities through a lens of shared understanding

TIER 3: Engaging All in a Culture of Health

HEALTH PROMOTION through raising awareness about Health and Wellness via signage, publications and use of de-stigmatizing language related to behavioral health

General Public

Community Service System (T2)

Health Delivery Practices: Health Homes, PCPs (T1)

ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Time Series

+ giving back
+ resiliency
+ health
+ social
+ connectivity
+ community investment in health
+ isolation
+ depression

The Community Health Network = The Sum of Services + Resources Known to Advance the Wellbeing of each Health Home's Population X the Number of Health Homes Participating in WPIC

OUR POPULATION

Partnerships among consumers, their health home & the community shape the range of resources necessary to advance the health and wellbeing of each health home's unique population

Increased Population Rate

Array of informal supports & services to address social determinants

40% Impact on Health

60% Impact on Health

General Public

Community Service System (T2)

Health Delivery Practices: Health Homes, PCPs (T1)
Common sense and a growing body of research tell us that having social support networks is essential to achieving & maintaining health. It is also clear that Social Determinants of Health (SDOH) are increasingly understood as a key driver of virtually all aspects of health.

An approach that can actively create solutions to SDOH challenges is the Time Bank. Timebanking builds social networks of people who give & receive support from each other based upon time as currency, enabling people to share their unique strengths & interests to help others, while at the same time ‘withdrawing’ the resources they need to improve their own wellbeing.

Time Banks operate all over the world & have grown in number in the US since the Great Recession.
Contributing Research, Best Practices & Common Sense Informing WPIC

Tier 1
- Brain Plasticity & Epigenetics
- Public Health Approaches
- The power of Pears
- Resiliency
- The EBP Collaborative Care Model (UW/AIMs Center)
- Maslow

Tier 2
- Collective Impact Emergence Model
- Medical/Health Homes essential linkages to Community

Tier 3
- Public Health Promotion Approaches
- Time Banks

MHSU Care Coordination
Whole Person Integrated Care Team

Care Coordination History
- Collaboration between Care Coordination and CCNC Care Managers since 2013
- Burke Integrated Health Care Team 2015
- Gaston County ED Focus Care Team 2015
- Nurse Care Coordinator designated CCNC Liaison and Health Educator
**Moving Forward...**

- Partners Care Coordination staff partnering with HUB providers and CCNC to implement Collaborative Care Model
- Whole Person Care Teams inside MHSU Care Coordination
- Adaptation of Transitional Care Management Model (Naylor)

**WPIC Care Team**

Team Approach
- Team Lead
- Licensed Clinicians
- RN
- Qualified Professionals
- Family Partner

3 Teams
- 2 Adult
- 1 Youth

**Impacting Care**

- Intentional transition from ED
- High touch interventions
- Facilitate client engagement in services
- Decrease rapid readmissions
- Increase percentage of individuals managing both behavioral health and comorbid physical conditions
Expected Outcomes

- Improve care and outcomes for individuals
- Improve collaboration among individuals, families, local hospitals, providers, stakeholders, community
- Address Social Determinants of Health

THE WPIC EVALUATION FRAMEWORK

Evaluation is an essential part of planning and implementing a program design. The WPIC evaluation design for implementation is important because it:

- Helps ensure fidelity to the WPIC framework from the beginning
- Improves program design and implementation on an ongoing basis
- Assesses activities of implementation to ensure they are as effective as possible
- Helps identify areas of success (in meeting goals/outcomes) and areas needing improvement in a timely fashion so that successes can be supported and replicated, and challenges can be quickly addressed
Developmental Evaluation

Tier 1
- Complete white paper integrating research from the multiple perspectives included in the WPIC.
- Finalize peer support measures and fidelity protocols.
- Develop "rapid, short and continuous" methods for consistently (at least weekly) contact with all providers, HUBS, Local Health Forums, Time Banks and other stakeholders.
- Develop procedures for Collective Impact framework to provide rapid response to successes and barriers detected.

Tier 2
- Determine/Develop to assess progress of integration and implementation of WPIC within DPHD and Local Health Forums.
- Utilize qualitative methods (e.g. in-depth semi-structured interviews, focus groups) to assess consumer and provider experiences, satisfaction, and suggestions for WPIC improvement.

Tier 3
- Include Time Bank as a focus for Developmental Evaluation.
- Develop fast assessment practices to track Time Bank users.
- Integrate multiple data points into an integrated structure to determine WPIC efficacy on social determinants, providers, teams, staff, peers, and clients.

FORMATIVE & IMPLEMENTATION EVALUATION

Tier 1
- Finalize data collection processes, data points and fidelity measures.
- Track development of HUBS and medical homes.
- Assess data collection processes and advise.
- Complete process interviews of key staff and selected clients.

Tier 2
- Assess impact of Wellness Guide and other tools on workflow and client outcomes.
- Develop a detailed evaluation process for Local Health Forums.
- Finalize data tracking/storage of Time Banks.
- Assess fidelity of implementation within/between HUBS.

Tier 3
- Assess integration and impact of Local Health Forums in community.
- Track changes in community services, supports and resources.
- Track coverage and satisfaction with Social Marketing.
- Complete hierarchical analysis of practice, HUB, Local Health Forum and Time Banks on individual outcomes and social determinants.

Outcome Evaluation

Tier 1
- Develop a shared measurement system.
- Define client level output/outcomes and assessment measures.
- Prevention care rates.
- Client costs.
- Well-being/wellness.
- Quality of life.
- Patient satisfaction.
- Define provider level outcomes (e.g. medical homes, teams, satisfaction).
- Update outcomes as needed via the emergency framework.
- Recruitment/retention analysis to assess client, provider, support longevity and barriers to retention.
- Define and develop social determinants data points for Tier 3.
- Define HUB/Community integrated outcomes to assess satisfaction and impact of WPIC.

Tier 2
- Evaluate outcomes related to Time Banks, linking with social determinants.
- Continue to enroll clients/families into WPIC and assess outcomes across cohorts.
- Assess impact of WPIC on social determinants.

Tier 3
- Continue to enroll clients/families into WPIC and assess outcomes across cohorts.
- Assess impact of WPIC on social determinants.
Collaborative Evaluation

**Tier 1**
- Develop infrastructure for cross partner collaborative evaluation.
- Train Peer Staff to assist in brief evaluation contacts.
- Develop/Integrate collaborative measures for Tiers 2 and 3.
- Assess collaborative partners for the 5 core conditions of Collective Impact.
  - Developing and using a shared agenda.
  - Capacity/willingness for shared measurement.
  - Ability to operationalize mutually reinforcing activities.
  - Willingness/capacity to engage in continuous communication.
  - Support the Backbone Organization (Partners).

**Tier 2**
- Train Local Health Forums in collaborative evaluation based on CI principles.
- Track decisions and activities of Local Health Forums.
- Track resources, contacts, services delivered... analyzing for gaps, satisfaction and perceived impact.

**Tier 3**
- Assess implementation and impact of Local Health Forums.
- Link analysis with Time Banks and assist Local Health Forums in supporting the Time Banks.
- Assess social determinants to estimate changes in population health.

Case Studies

**Tier 1**
- Collaboratively develop a case study protocol.
- Develop a case selection process based on TBD factors (e.g. risk, family composition, etc.)
- Determine no more than three levels and have 2-4 cases per level.

**Tier 2**
- Select, recruit, consent and retain case study participants.
- Incentivize contacts to complete online surveys, monthly check in calls and quarterly interviews.
- Use case study data to provide context for outcome and impact evaluations.

**Tier 3**
- Continue and potentially start new case studies annually.

Impact Evaluation

**Tier 1**
- Define a comparison group from HUB, Partners, or other sources.
- Collaboratively define Impact Evaluation outcomes/objectives, limiting to outcomes that will support WPIC longevity and expansion.
- Complete a pilot analysis to check data integrity and data collection efficiency.

**Tier 2**
- Finalize data collection processes.
- Design the analytic plan, collect data for intervention and comparison cases.
- Complete and report findings after 12- and 24-months of implementation.

**Tier 3**
- Finalize in Year 3 or 4, using best methods of repeated measures and comparison analysis.
To determine whether there are significant changes on key outcomes and measures of knowledge, attitudes, beliefs or behaviors that can be linked (associated) with components of the WPI-Care program.

Utilize already existing Partners data (ED visits, Hospital re-admissions, Penetration rate, etc.), as well as new surveys for evaluation of WPI-Care (e.g. Wellness Guide, SF-12, PHQ-2, PHQ-9, QOLS and others as determined) linked to specific outcomes TBD collaboratively.

To be able to make data supported statements on program activity, participants and benefits:

1. Evaluation and analysis plan and bi-annual outcome evaluation reports.

WHAT WILL BE MEASURED & HOW IS IT RELEVANT? MEASUREMENT TOOL & PROCESS

1. The Healthy Days Measure is related to self-reported chronic diseases (diabetes, breast cancer, arthritis, hypertension) & their risk factors (body mass index, physical inactivity, smoking status).
   - Measuring HRQOL can help determine the burden of preventable disease, injuries.
   - It will help monitor progress in achieving health objectives.
   - Analysis of the data can identify subgroups with relatively poor perceived health and help guide interventions to improve their situations and prevent serious consequences.
   - Interpretation and publication of these data can help identify resources based on current needs, aid development of strategic plans, and monitor the effectiveness of broad community interventions, etc.

2. The Optum 12-Item Short Form Health Survey (SF-12) captures practical, reliable and valid information about functional health and well-being from the patient’s point of view.
   - It was developed for a multi-year study of individuals with chronic conditions.
   - It is used to measure changes in individual health and well-being, as well as population health and well-being over time, (e.g., mental and physical health status of adults), and to measure the outcomes of health services.

Projected Outcomes

- Lowers costs, improved care, clinical outcomes and patient/consumer satisfaction, lower rates of ED visits, increased use of preventative care, higher rates of treatment initiation and completion
- Increased patient/member and practitioner satisfaction, improved quality of life
- Decreased social isolation, improved community participation, reductions in Social Determinants of Health barriers to wellness
- An enhanced delivery system capable of addressing key factors influencing health and defining health outcomes

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