Whole Person Integrated Care

Partners Behavioral Health Management

The Whole Person Integrated Care Model: Advancing the Quadruple Aim and Community Wellness

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Summary of the Problem

Health costs, barriers to access, obstacles to incorporating evidence-based practices, and low consumer and provider satisfaction have all been cited as issues for poor health outcomes and low quality of life. More specifically, barriers that impede health care and affect positive behavioral and medical health outcomes include:

1. Low penetration rates, especially for behavioral health care wherein one in five U.S. adults have a mental illness and one in twenty-five has a serious mental illness. This high prevalence is coupled with inadequate access to care, insurance discrimination, and medical comorbidities that confound treatment systems, individuals, and providers alike.
2. Over-utilization of high cost services, especially for persons with serious behavioral health issues and complex medical conditions, resulting in crisis contacts and emergency department visits that are inappropriate to the service need. This is exacerbated by the lack of health care coverage, poor health education (how to access, what to do), and the compounding factor of scarcity of community resources and supports.
3. A focus on a limited definition of health that excludes either physical or behavioral health, while emphasizing diagnosis and symptom reduction absent a holistic focus on wellness.
4. A fragmented service system operating in siloes without a common agenda or voice.
5. Difficult or non-existent data sharing capacity to manage and track outcomes across providers or to aggregate or evaluate performance.
6. Poor integration of behavioral health and the primary care of medical conditions frequently resulting in co-location only, limited referral options, and rarely true integration. When they are combined, social, organizational and community health and wellness are often excluded. The resulting focus on crisis results in a reactive versus proactive system.
7. Failure to incorporate social determinants of health (SDOH) as part of a comprehensive model, considering that sixty percent of health impact results from behavioral, environmental and social conditions.
8. Disproportionate focus on intervention with limited attention to prevention and promotion, in essence supporting the ballooning of health costs by not attempting to limit and reduce the number of individuals in need of intervention and potentially high cost services.
9. Individuals are often provided prescriptions and interventions with limited health education and implementation support. Lack of follow-through on provider recommendations is a key contributor to negative health outcomes.
10. A lack of defined outcomes to evaluate clinical and program impact can result in wasted resources or insufficient emphasis on critical and successful outcomes.

High prevalence of mental illness coupled with inadequate access to care and insurance discrimination create the current low penetration rates.

Source: Substance Use and Mental Health Services Administrative (SAMHSA)

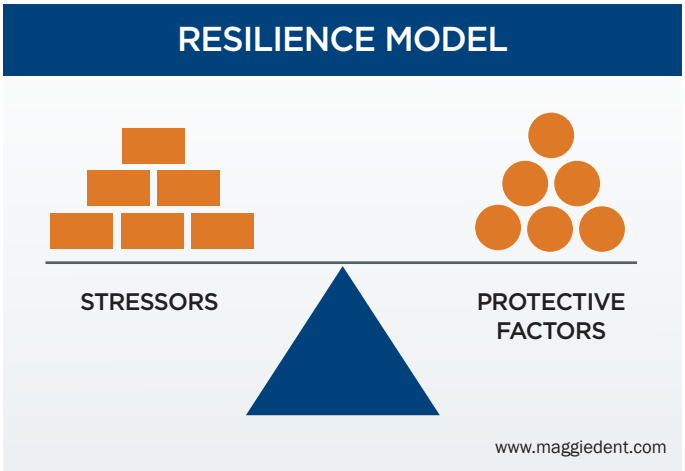
In summary, the primary barriers for integrating behavioral and physical health is the inability of providers to adhere to a common agenda, share data, and organize their efforts for maximum impact on the individual, family, and community. A great deal of what contributes to the burden of disease and low quality of life remains unaddressed.

An Integrated Systemic Solution

The Whole Person Integrated Care (WPIC) comprehensive model addresses health and wellness via a public health continuum from promotion to prevention and intervention. This includes discrete models synthesized into WPIC at three tiers of integrated implementation, evaluation and ongoing support/ technical assistance. The model is designed to address the ten barriers listed above in a collaborative and holistic manner, leveraging local efforts and resources.

A **Public Health Approach** with a key focus on SDOH is critical to WPIC. The WPIC model embraces promotion, prevention and intervention to lower overall disease burden, support access to community and resources, and for improved social networks through addressing SDOH. Individuals often bring issues into treatment offices that behavioral and medical interventions are not equipped to address. Addressing health/wellness holistically by including SDOH makes sense for an approach targeted to enhance and improve quality of life.

Viewing mental health on a continuum ranging from optimal to minimal allows the use of a low-cost population based promotion framework with appropriate strategies that foster individual strengths including resilience. The three tiers of the WPIC model incorporate strength- and trauma-based approaches while respecting culture, equity, social justice and personal dignity. The emphasis on resilience also targets protective factors while being mindful of risk factors. The concept of wellness naturally emerges from viewing both risk factors, with the emphasis on symptoms and pathology, via attending to personal, familial, organizational and community protective factors. Genetic and environmental variables play a role in the development and manifestation of behavioral health disorders. Because many environmental variables can be acted upon, there are opportunities for preventing behavioral health problems by implementing practices that are designed to reduce malleable risk factors and enhance malleable protective factors.



> "I diagnosed abdominal pain when the real problem was hunger; I mislabeled the hopelessness of long-term unemployment as depression and the poverty that causes patients to miss pills or appointments as noncompliance. My medical training had not prepared me for this ambush of social circumstance. Real-life obstacles had an enormous impact on my patients' lives, but because I had neither the skills nor the resources for treating them, I ignored the social context of disease altogether."
>
> **Laura Gottlieb, MD**

The WPIC Comprehensive Model

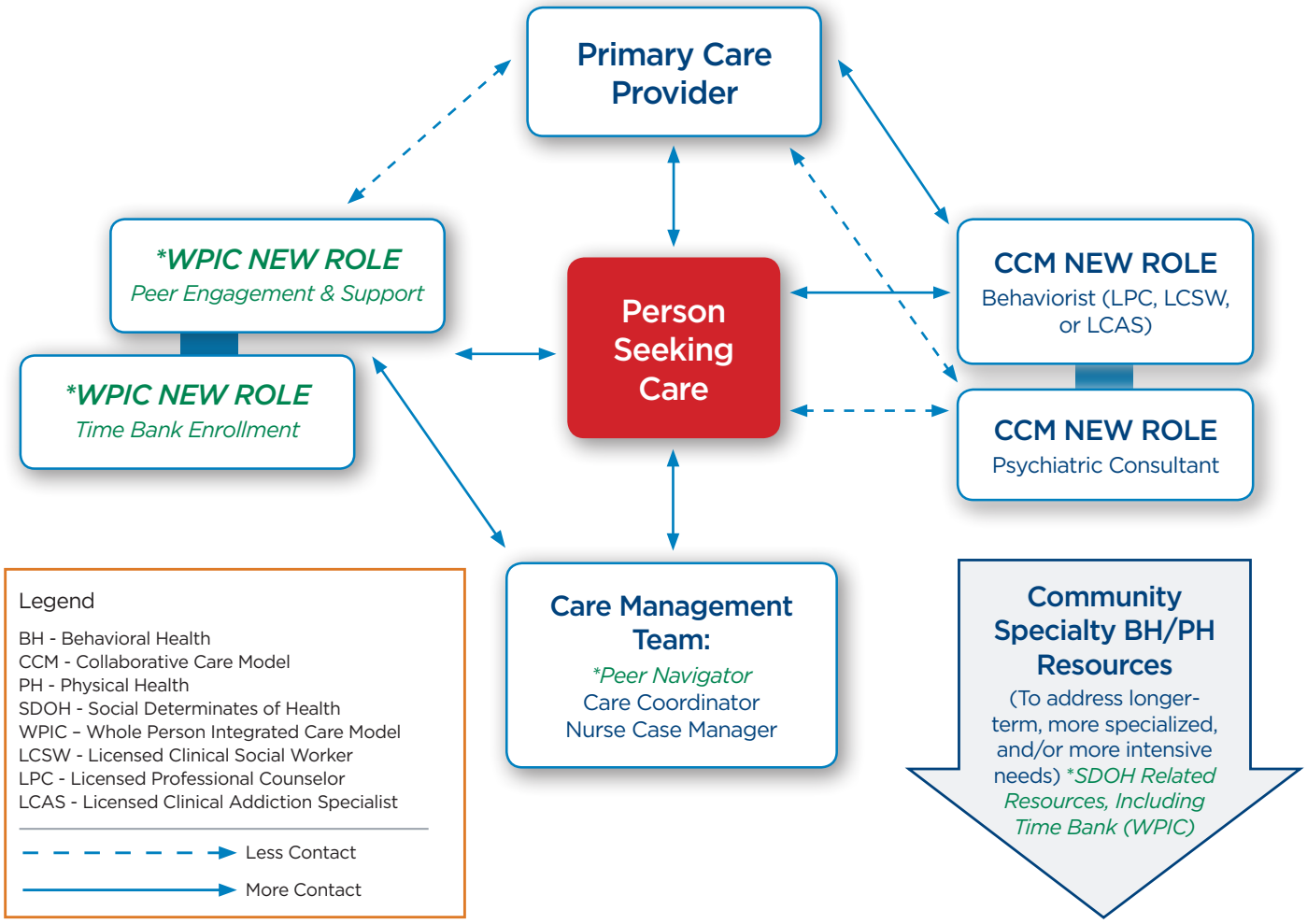
The WPIC model will address the barriers listed on page 2 using a three tier integrated model of service delivery, sustainable resource stewardship, and community development. A comprehensive evaluation ensures tracking of individual and population health outcomes, fidelity to the model, and data-driven decision making in implementation of WPIC. Table 1 (below) summarizes each tier.

For Tier 1, the key feature is the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Institute Collaborative Care Model (CCM). The CCM is a researched and proven evidence-based system for delivering physical and behavioral integrated care. This model has been adopted as a key component of WPIC and adapted to include peer supports/navigators to strengthen continuity of care, and a priority on inclusion of community resources (e.g. time banks) to address SDOH. These additions enhance the model while maintaining fidelity to the core components of the CCM. The facilitating member of the CCM is the Care Manager that ensures psychiatric consultation, medical care via the primary care provider, other consultations as needed, linkage with the peer support to assist with integration and follow through with medication and behavioral prescriptions, and linkage to additional resources affecting quality of life. Figure 1 on page five summarizes the Adapted Collaborative Care Model.

Table 1. Summary of the WPIC Three Tier Comprehensive Model

Tier 1	**Health Providers Moving to Best Practices with Customized Support** • Community health homes, Integrated Care Centers, primary care practices, medical homes, Federally-Qualified Health Centers • Collaborative development of a shared agenda and targeted shared measurement that is outcome specific • Implementation of the Adapted Collaborative Care Model • Peer engagement, support and active care facilitation • An individual/family owned resiliency-based Health Plan and Team • A Public Health approach (promotion, prevention, intervention) • Integration of the Quadruple Aim
Tier 2	**A Community Forum/Learning Collaborative Linking to and Supporting Tier 1 Partners** • Development/support of a community health forum based on the Collective Impact Model • Resource development and sustainability • Feedback system and systematic vigilance to detect emergent issues and scale up successes • Expanded shared agenda and support for shared measurement and collective activity • Development of a learning based environment to support an outcome based approach • A Public Health approach (promotion, prevention, intervention) • Integration of the Quadruple Aim
Tier 3	**The Larger Community, Time Banking and Focus on Social Determinants of Health** • Community integration development via the Collective Impact Model to increase social and organizational network density and flexibility (e.g. local government, businesses) • Time Banks to directly address social determinants of health • Evaluation system to link SDOH with Integrated Care Center, provider, and individual level outcomes • A Public Health approach (promotion, prevention, intervention) • Integration of the Quadruple Aim

Figure 1. Adapted Collaborative Care Team Structure



Green italics denote functions adapted from the original Collaborative Care Model

Adapted from the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Institute Collaborative Care Model (CCM).

Collective Impact

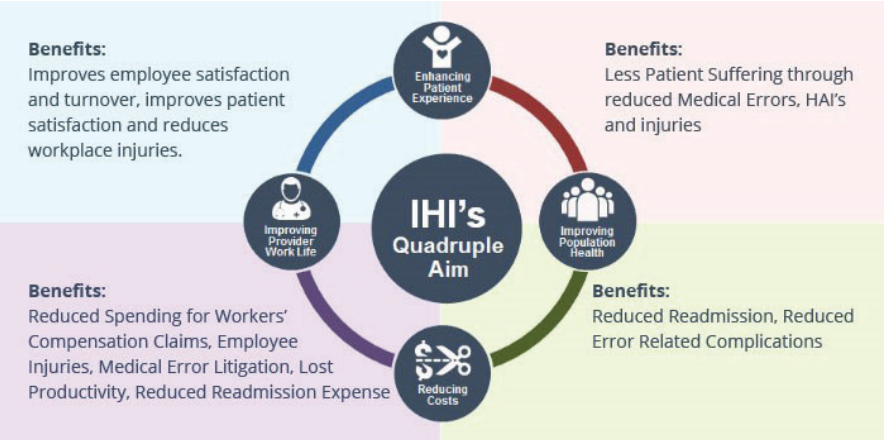
The Collective Impact approach is premised on the belief that no single policy, government department, organization or program can tackle or solve the increasingly complex social problems we face as a society. The approach calls for multiple organizations or entities from different sectors to supplement their own agenda to include a common agenda, shared measurement and alignment of effort. There are five conditions that drive collective impact (Table 2). Implementation of the conditions is a priority in each tier of WPIC. Process outcomes related to each principle have been developed. A sample outcome is included in Table 2 as well.

Table 2. Collective Impact Principles for Design, Implementation and Evaluation	
Backbone Support	An independent, funded staff dedicated to the initiative provides ongoing support by guiding the initiative's vision and strategy, supporting aligned activities, establishing shared measurement practices, building public will, advancing policy, and mobilizing resources
	Sample Outcome: 80% of participants endorse that the Backbone Organization (Partners Behavioral Health Management) has sufficiently guided the vision and strategy of WPIC
Common Agenda	All participants share a vision for change that includes a common understanding of the problem and a joint approach to solving the problem through agreed-upon actions
	Sample Outcome: 80% of participants will agree that the development of a common agenda includes sufficient diversity in members from multiple sectors
Shared Measurement	All participating organizations agree on the ways success will be measured and reported, with a short list of common indicators identified and used for learning and improvement
	Sample Outcome: 80% of participants agree that the shared measurement system is used to make decisions collaboratively
Continuous Communication	All players engage in frequent and structured open communication to build trust, assure mutual objectives, and create common motivation
	Sample Outcome: 80% of participants agree that communication was sufficient to support their participation in WPIC
Mutually Reinforcing Activities	A diverse set of stakeholders, typically across sectors, coordinate a set of differentiated activities through a mutually reinforcing plan of action
	Sample Outcome: 80% of participants agree coordination of activities to meet the common agenda are sufficient or have improved

The Quadruple Aim

The development of WPIC, its implementation and its evaluation have kept the Quadruple Aim (QA) (Figure 2) as a central organizing concept. The QA has been essential for selecting components (e.g. the CCM) and for developing outcomes (next section). Table 3 (page 6) summarizes the Quadruple Aim and why it is an essential part of WPIC.

Figure 2. Quadruple Aim (QA)



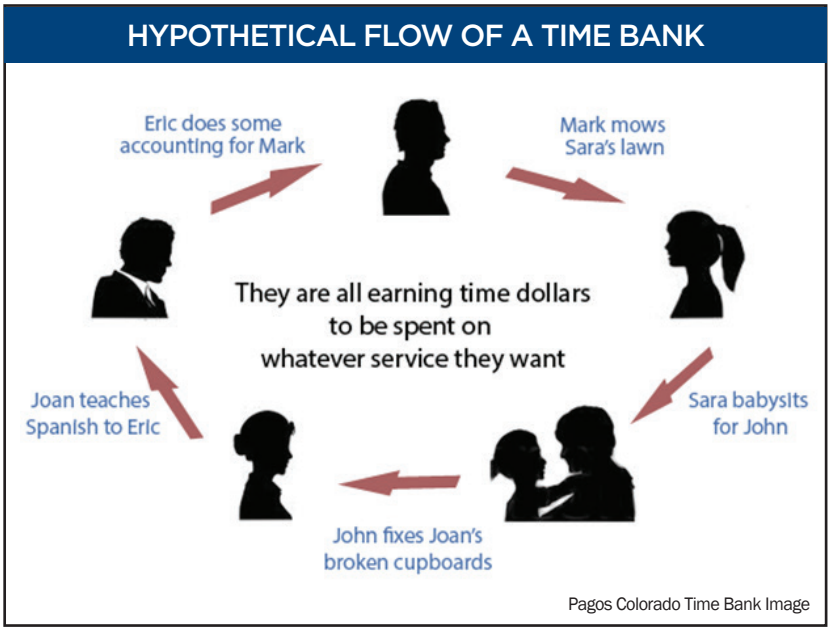
Source: Institute for Healthcare Improvement

Table 3. Summary of Quadruple Aim	
The Quadruple Aim:	**Why it is important:**
Improves the health of the population	Increases penetration rates
Improves the experience and quality of care	Increases overall quality of life
Reduces the per capita cost of health care	A systems-based approach to maximize resources, detect and address high costs contributors, and detect and fill gaps
Increase provider satisfaction and retention	Improves collaboration and shared agenda

Time Banks and Social Determinants of Health

A Time Bank (Figure 3) is a form of community currency that rewards informal volunteering by paying one "'hour'" for each hour of commitment, which can at any time be "'cashed in'" by requesting an "hour" of work in return from the system. Everyone's time is worth the same and the time credits earned can have their value underpinned by local authorities or concerned businesses making goods available in return for them – reinforcing reciprocity and trust. Time banks have been evaluated as successful in addressing social isolation, improving social integration, and reducing depression. Participants in time banks become more engaged with their communities, trend toward more stable housing and employment, and report higher quality of life.

Figure 3. Time Bank



Hierarchy of Integrated Outcomes

An outcome evaluation has been designed for the WPIC implementation. This includes a focus on 25 total outcomes that address Integrated Care Center, patient, provider and community outcomes. These outcomes target key areas to assess efficacy, impact and cost efficiency while being consistent with the Quadruple Aim. These outcomes are in the process of being reviewed with Integrated Care Center leadership and finalized for verbiage and target percentages. Most, if not all, of these outcomes will be included in the final evaluation with some potential additions pending Integrated Care Center input. Table 4 (pages 8 and 9) summarizes the outcomes in current form.

Table 4. Summary of Outcomes and Measurement Across Four Outcome Levels		
#	Outcome	Measurement/Method
	Integrated Care Center Level Outcomes	
1	WPIC will result in lower overall costs to providers and to persons served. The degree of cost savings will be determined after initial data analysis	Partners data Integrated Care Center data
2	Rates of emergency department visits will decline by twenty-five percent compared to a similar time frame from a previous year	Partners data
3	Rates of hospitalizations will decline by fifteen percent compared to a similar time frame from a previous year	Partners data
4	Changes in penetration rate after establishment of WPIC will increase by five percent of the available population	Partners data
	Individual Level Outcomes	
5	Fifty percent of enrolled persons served will increase involvement in preventative care related to diabetes, breast cancer, arthritis, hypertension, weight, activity and tobacco use	CDC Healthy Days Measure Integrated Care Center data (e.g. BMI)
6	Eighty percent of persons served will endorse that access to service (treatment initiation) have increased/improved for those that, at baseline, noted access to service issues	Evaluation team generated survey Interviews Case studies
7	Person served completion of services will improve by twenty percent compared to a similar time frame from a previous year	Evaluation team generated survey Possible Integrated Care Center data
8	Eighty percent of persons served will report increased knowledge of the health related issues surrounding the recommended behavior change or course of treatment	Evaluation team generated survey Interviews Case studies
9	WPIC will improve the experience of care for 70 percent of persons served through a focus on wellness and planning for family health	Evaluation team generated survey Interviews
10	Eighty percent of persons served will increase knowledge regarding wellness as a lifestyle option	Evaluation team generated survey Interviews
11	Sixty percent of persons served will report increased confidence regarding their participation in the recommended behavior change or course of treatment	Evaluation team generated survey Interviews Case studies
12	Eighty percent of persons served will improve in clinical outcomes related to behavioral health indicators	Duke 8 [2] PHQ-9
13	Eighty percent of persons served will improve in clinical outcomes related to medical health indicators	Integrated Care Center clinical data Duke 8 [3] PHQ9

2 - Pending approval by Duke Community and Family Medicine
3 - Pending approval by Duke Community and Family Medicine

Table 4. Summary of Outcomes and Measurement Across Four Outcome Levels		
#	Outcome	Measurement/Method
14	Eighty percent of persons served will endorse improved quality of life	Healthy Days Measure Interviews Case studies
15	Sixty percent of persons served with a substance use issue will improve the condition as evidenced by reduced or eliminated use, reduced cravings, reduced drug seeking behavior, recovery engagement	Gaston Complete Health substance use questions approved for use
16	Seventy percent of persons served will endorse improved social networks with a decrease in social isolation	Evaluation team generated survey Interviews
17	Eighty-five percent of persons served will endorse the experience with Peer Navigators as satisfying or highly satisfying	Evaluation team generated survey Interviews
18	At least ninety percent of persons served will indicate satisfaction with involvement with WPIC	TBD satisfaction survey, e.g., Global questions from US CAHPS or How's Your Health surveys
	Provider Level Outcomes	
19	At least eighty percent of practitioners will indicate satisfaction with the WPIC service delivery model	Evaluation team generated survey Interviews
20	Eighty percent of practitioners will endorse that involvement with WPIC has improved quality of the work environment specifically related to reducing job fatigue (a.k.a. burnout)	Evaluation team generated survey Interviews
21	Ninety percent of Peer Navigators will endorse satisfaction with the WPIC model and their employment as Navigators	Evaluation team generated survey Interviews
22	Eighty percent of practitioners will endorse improved clinical outcomes for persons served based on involvement with WPIC	Evaluation team generated survey Interviews
23	Seventy percent of practitioners and managers will be able to name at least two WPIC innovations, foci, or activities that have improved/energized practitioners and/or communities	Evaluation team generated survey Interviews
	Community Level Outcomes	
24	Evaluation data and Time Bank data will endorse improvements on TBD indicators of SDOH for fifty percent of the population served in WPIC and Time Banks (other than social support and health care access addressed in other outcomes)	Project specific online survey Time Bank data Duke 8 Population Health Survey
25	Time Bank data will endorse improvement in community participation from baseline for seventy percent of Time Bank WPIC members	Project specific online survey Time Bank data Duke 8 Population Health Survey

Closing Comments

The pivot toward achievement of the Quadruple Aim requires us to re-envision the components and processes of health delivery. Intentional integration of research in neuroscience, social epidemiology, public health, and the behavioral sciences create new opportunities to advance Whole Person and Value Based Care. The three tiers of the WPIC model leverage these advances to harness the best in scientifically-supported best practices, results-based collaboration to promote wellness for all, and a wide-lensed perspective that embraces innovation to foster community health.

The health care reforms that guide the WPIC model are not entirely unfamiliar. However, there is a trio of needs related to each person seeking care that we must authentically address in order to reach them: relevancy, trust, and hope. Grounded in lived experience, the Whole Person Integrated Care model envisions a service delivery structure that begins with entrance through the medical or health home. Like in our own homes, we are welcomed to our health visit by someone who has had similar life experiences to our own–a peer. Over time, we come to know that this person will hear us and not judge, and will explain things to us that we may be embarrassed to ask about, such as complex forms and how the health care system really works. The peer is part of a health and wellness team that includes our physician, a behavioral health specialist, and an individual who concentrates on helping us coordinate our care among those who provide it. We too are a member of the team; we learn how to address daily living issues that can interfere with our health and hope such as food insecurity, lack of transportation, unemployment, unreliable child care, isolation, and fear based in underlying trauma.

When we go for our "doctor appointment", we no longer see it as one more stressor, but as a place where we are welcomed and have a voice, where people make it a priority to understand and respect our strengths as well as our needs, a place that we trust to be a partner in our search for wellness with care and support that is truly relevant to our everyday lives. No longer wrestling with health challenges alone, we find the hope to take on new opportunities to manage our health and improve our well-being, and that of our community. We now know what it is like to have a health home.

Martha Kaufman, WPIC Founder

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