

## **Discussion Draft: Functions of the Whole Person Care Collaborative**

April 2, 2017

We need a framework that defines what the Whole Person Care Collaborative (WPCC) will do and the major steps that must be taken to do it. This is a discussion draft on those points.

**Primary Functions** The Whole Person Care Collaborative has several purposes related to the Triple Aim and other high level goals, but what is it supposed to do? Its primary functions are to:

1. Enable primary care and behavioral health providers in North Central Washington to better integrate BH and medical care, and;
2. Enable them to adapt successfully to Value Based Payments, which will also help them with similar initiatives in Medicare such as MACRA. Successful adaptation means that the provider organizations are able to deliver effective Whole Person Care while surviving economically under the changing incentives created by changes in payment methods.

### **Notes on Demonstration Funding**

The ACH will help define, allocate funding for and oversee Demonstration projects, but funding received for the projects will flow from the state's Financial Executor (an HCA contractor) directly to provider organizations, except for small amounts that go to the ACH for oversight functions.

HCA is expected to provide better information on Demonstration funding over the next two weeks, but we do have some hints. We have been informed that our region will receive incentive payments because we are a mid-adopter region and are taking on the challenges associated with that. We are told this incentive will total \$5.4M. Presumably, such an incentive would make up only a small part of our overall Demonstration funding. This suggests that during the 4 years of Demonstration implementation (2018-2021) the region will be eligible for several million dollars a year for projects – the bulk of which is expected to go to the care transformation effort.

Because Demonstration funds are expected to end in 4 years, the ACH's firm policy is to fund activities which create lasting changes in our regional health care system, as opposed to funding services that will fade away (or require rescue with new funding) at the end of the Demonstration.

### **Steps for WPCC Member Organizations**

1. Every WPCC member organization will conduct its own baseline assessment (using Qualis or the consultant of their choice) to establish a starting point and help define issues that must be addressed in the transition to Whole Person Care and Value Based Payment. Several of these assessments are under way now. The ACH may be able to provide help in paying for consultants if necessary.

2. Every WPCC member organization will work with the consultant of its choice (or its internal experts if available) to develop its own Transformation Plan. WPCC will provide a Transformation Plan template and may be able to help pay for outside consultants if needed, but each organization must develop its own internal plan. This plan should be as specific as possible in identifying necessary changes in arrangements for behavioral health integration, changes in staffing patterns, IT changes, care coordination arrangements and other measures that will be needed to provide Whole Person Care under Value Based Payment. The plan must explicitly address how the organization will engage front-line providers in the difficult process of bridging from today's configuration and practice patterns to those required for sustainability under Value Based Payment and other foreseeable changes. The plan should include a budget reflecting the costs of this transition and an implementation plan identifying who in the organization will be involved in shaping and implementing these changes. The Transformation Plan will be submitted to the WPCC. Medicaid Demonstration funds will be used to support the development of Transformation Plans.
3. WPCC will evaluate transformation plans and allocate Medicaid Demonstration funds to support the implementation of high quality plans. WPCC will work with organizations as needed to improve suboptimal plans, using Demonstration funds if needed to enable the organization to acquire needed consultations.
4. NC ACH performance on HCA's Demonstration metrics will determine the amount of Demonstration funding available. In early implementation years, funding will be earned by reporting on plans and other process indicators. In the middle years, actual achievements in implementing plans will be used as indicators. In the final year or two, transformation plan objectives, clinical metrics and other impact measures will be used.

#### **Related Regional Activities**

1. North Central ACH will develop a regional Pathways HUB to provide coherent and self-sustaining care coordination services available to all providers in the region. This will have to be done in a phased manner, but should eventually be available to any interested provider organization. (Note: selection of this project is still subject to Governing Board decisions based on partner input.)
2. To support development of provider Transformation Plans, and in response to issues that emerge from the work to implement those plans, the WPC Collaborative will function was a learning collaborative that enables sharing of expertise among participants and brings in relevant expertise from outside the region. One very helpful side effect of this activity would be to foster openness among provider organizations about successes and setbacks they encounter over the next few years. One role of the ACH will be to organize and foster the learning collaborative.
3. North Central ACH may attempt to form a regional data repository or other mechanism to facilitate sharing of patient information among providers in the region. This is an ambitious goal at which

others have failed before, and would require significant help from the IT effort at the state level, but Healthier Washington may create conditions in which this would be possible.

4. There may be need for a regional effort to help establish cooperatives of smaller providers to create a 24/7 nurse call line.
5. There may be a regional role to facilitate establishment of telehealth services, especially for behavioral health care. The issues with telehealth are no longer technical but revolve mainly around agreements among providers to provide, receive and pay for such services. For BH, this does not involve only telepsychiatry but, especially in small remote clinics, access to any credentialed mental health professionals. Other medical specialties (notably dermatology) have also demonstrated the effectiveness of telehealth in extending specialty care to very small communities.

### **Operational Challenges**

There are many challenges involved, but some that stand out include:

- Establishment of a Pathways HUB that is self-sustaining will require financial agreements from the very beginning, in which parties which benefit economically from improved care coordination agree to share some of those benefits in the form of support for care coordination services and the HUB. Current revenue streams for care coordination could also support sustainable services.
- WPCC will be in the position of evaluating the Transformation Plans of member organizations and allocating funds in support of the transitional efforts. This will require a defensible and transparent evaluation and funding mechanism.
- A lot of “social determinants” service providers seem to expect to share in revenues for their work on Whole Person Care. How would that happen? Will provider organizations or the HUB pay for the services of a housing specialist or for a transport service for one of their patients? Would MCOs create programs to pay for such services? Or is the provider’s responsibility just to use the HUB to connect patients with such services, and let those services fend for themselves (using whatever payment sources they have now)? The instability of our social services network suggests that the ACH should look for ways to support it as an integral part of Whole Person Care.

### **Assumptions**

- So far WPCC members are primary care provider organizations. BH organizations must soon be brought into the Collaborative as members. Membership must soon be more formalized, based on a written commitment to the steps described here.
- PCMH and similar approaches to advanced primary care are important starting places, but are in themselves insufficient to achieve sustainable Whole Person Care. (“PCMH” is used here as shorthand for the various approaches to optimal primary care, including “Advanced Primary Care.”) It is not that optimal PCMH could not produce Whole Person Care, but it must be acknowledged after decades of work on PCMH and similar approaches that only a minority of organizations are

able at any one time to achieve and sustain a high level of PCMH functioning (as distinct from certification or “checking the boxes”). If PCMH was the answer, we would not have the problem. The use of PCMH and comparable approaches does not in itself address the WPCC’s function, although they have a place.

- Even practices that do not achieve a high level of PCMH functioning can provide better care through specific Whole Person Care measures. These include:
  - BH-medical integration. Patients of a mediocre primary care office are better off with telehealth links or other connections with behavioral health care, or co-located mental health providers who are used effectively by PCPs, even if the clinic never achieves PCMH excellence.
  - Care Coordination. A person with diabetes and depression, who attends a primary care clinic that falls short of PCMH excellence, is still better off if he or she gets basic care coordination that connects the patient with mental health care, diabetes education (even at the simple level of instruction on how and when to monitor blood glucose and some basic nutrition advice) even if the clinic never achieves PCMH excellence. Similarly, a patient facing domestic abuse and the risk of homelessness will be better able to address medical issues if he or she has a Pathways HUB care coordinator who can help connect the patient with outside-the-clinic services to help address those social issues.
  - 24/7 Access to Health Advice. A patient attending a mediocre practice (in PCMH terms) is still better off if he or she has 24/7 access to a nurse and/or pharmacist who has access to the patient’s records and can answer many of the patient’s questions – even if the clinic never achieves PCMH excellence.
  - It is not that principles of primary care excellence are unimportant. The point is that in a region where levels of excellence must inevitably vary in PCMH terms, Whole Person Care measures can still meaningfully improve the overall care patients receive. It is not true that a high level of PCMH functioning must be achieved in a clinic before these and other Whole Person Care measures can have beneficial effects.
- Clinical organizations in the region face a serious gap. Most practices still function to a significant extent in a fee-for-service payment environment. This dictates certain specific approaches to the staffing and organization of clinics, and to the operation of IT systems. These same arrangements, however, will be dysfunctional and financially unsustainable when Value Based Purchasing and capitation are the norm. If clinics do not change, they will not survive the new regime. But if they change now, they will suffer financially in today’s payment environment. Furthermore, it costs money to make the change from one system to the other. WPCC (in part by using Demonstration dollars) could assist provider organizations in bridging this gap.