

## **SUMMARY**

The work of primary care providers (PCPs) and their organizations is being incented to change, because the payment methodology used by Medicaid (and increasingly by Medicare and private payers) will be changing significantly in the very near future. These incentive changes recognize the value of “whole person care,” which refers to care that better meets the needs of patients by addressing not only acute medical problems but also chronic health conditions, the provision of preventative health services, addressing behavioral health needs and the social problems often associated with medical problems. This broader approach has been shown to improve care by overall improving a patient’s health and quality of life, as well as reducing unnecessary office visits, ER visits, hospital admissions and specialty referrals.

The new payment models will emphasize health care entity accountability for high value care (outcomes divided by cost) by using capitated and “bundled” payments, rather than current fee-for-service payment models. Many primary care organizations will find it a challenge to provide the needed care while surviving financially under these new conditions.

We are using the term Whole Person Medical Home (WPMH) for a primary care organization or practice that has successfully adopted such an approach. We are proposing the creation of a North Central Washington Primary Care Transformation Collaborative that will utilize a collaborative approach to implementation of this care model in North Central Washington, in different legal entity practices.

## **WHAT IS A WHOLE PERSON MEDICAL HOME?**

A homeless diabetic patient is unlikely to successfully manage diabetes without a stable living situation, and appropriate nutrition. A patient facing domestic violence, untreated substance abuse, food insecurity or many other health-related social problems is in a similar dilemma. The PCP cannot solve all of these health determinants, but is in a unique position to be able to guide the patient to a team capable of providing the appropriate assistance, including community health workers, housing specialists, mental health providers and others. With the requirement for face-to-face encounters lifted under payment methodologies other than FFS, PCPs would have the ability to use their time, as well as the rest of the team’s efforts in the patient’s best interest. Only patients requiring face to face visits with the PCP to meet their needs would be seen in person; more would be in touch via email and phone, and the PCP would have an increased opportunity to assure that health related psychological and social issues are addressed more appropriately. This approach has much in common with the Patient Centered Medical Home, but goes well beyond it. There is substantial evidence that this approach does improve value in healthcare. In addition, PCPs and their staff find that this is a more satisfying way to practice. But the transition is not easy.

## **HOW WOULD THE PRIMARY CARE COLLABORATIVE HELP?**

Preparing for these changes is both complex and risky. Everything from compensation plans and PCPs’ work flow, to IT systems and the physical arrangement of offices may have to change. Organizations that move away from fee-for-service care to prepare for new payment systems will need to invest resources in this change process, and will likely have an added penalty in the form of reduced fee-for-service reimbursement during the transition. Organizations that delay the transition to value based payments, and the associated work process adjustments, until the new payment measures are instituted risk a significant disruption of their business model when the new system is implemented.

While each organization or practice must work out these adjustments for itself, collaborative efforts across organizations in North Central Washington can reduce the risks to individual organizations. We

can share the positive learnings, and the failures, producing a better care system for all the area's residents. There are many options for collaboration, while maintaining business and financial data confidentiality. All rural primary care providers will need to work collaboratively with other organizations to address whole person service needs. These cannot be met independently. We need to establish a common processes for care coordination with hospitals, specialists, behavioral health organizations, and social service organizations. There is no other way to have a successful, long term viable health care system in North Central Washington.

As examples, the Collaborative may address the following:

1. Access to after-hours phone or on-line advice from a nurse (who can utilize the patient's medical record, and is usually backed by a PCP and often by a pharmacist) helps patients succeed with their treatments while avoiding unnecessary ER visits. But small clinics often cannot afford to do this on their own. Cooperative efforts to implement such services can be developed by the Collaborative.
2. Well over a dozen organizations in the state already have special grants to provide consultation and training to providers, but they are not well coordinated. The Collaborative can be a mechanism through which these training and consultation resources can be matched to the needs of Collaborative members, without each provider organization having to deal with a dozen transformation projects. More effective sharing of training and consultation services will result.
3. Primary care organizations can collaborate to develop IT capabilities they will need to track Whole Person Care screening data, activities such as Community Health Worker home visits, and metrics/standards such as those that come with integrated Medicaid contracts.
4. Developing transition plans and dealing with change management issues will be important for every provider organization. Without straying into business issues that must remain confidential, Collaborative members will have opportunities to learn from each other in developing and refining these efforts.
5. By covering a large proportion of the region's population, the Collaborative will be well positioned to attract outside funding to support the transition.

#### **BECOME A PART OF THE COLLABORATIVE**

Join this effort, or learn more about it, by contacting one of these founding members:

Peter Rutherford, CEO, Confluence Health, [peter.rutherford@confluencehealth.org](mailto:peter.rutherford@confluencehealth.org)

Peter Morgan, Board Member, Family Health Centers, [ptrmrgn@gmail.com](mailto:ptrmrgn@gmail.com)

Patrick Bucknam, CEO, Columbia Valley Community Health, [pbucknum@cvch.org](mailto:pbucknum@cvch.org)

Kevin Abel, CEO, Lake Chelan Community Hospital, [kabel@lcch.net](mailto:kabel@lcch.net)

Other?

*Administrative support and staffing for the Collaborative will be provided by the North Central Accountable Community of Health. At this point no costs or fixed obligations have been established for membership, though we expect that members will hold one another to some level of accountability for participation and progress toward transformation objectives.*

## RESOURCES

---

Alternative Payment Model Framework and Progress Tracking (APM FPT) Work Group. (January 12, 2016). Alternate Payment Model Framework and Progress Tracking (APM) Final White Paper.

<https://hcp-lan.org/workproducts/apm-whitepaper-total.pdf>

Bitton A<sup>1</sup>, Schwartz GR, Stewart EE, Henderson DE, Keohane CA, Bates DW, Schiff GD.

Off the hamster wheel? Qualitative evaluation of a payment-linked patient-centered medical home (PCMH) pilot.

Bodenheimer, T., Ghorob, A., Willard-Grace, R., Grumbach, K. The 10 Building blocks of High-Performing Primary Care. (2014). Annals of Family Medicine.

<http://www.annfammed.org/content/12/2/166.full>

Dudgeon, Kate. Understanding the Whole Patient: A Model for Holistic Patient Care. **BOSTON 06.03.15, 09:20AM**

<http://continuuminnovation.com/understanding-the-whole-patient-a-model-for-holistic-patient-care/#.VuiS4dlrLcs>

Health Care's Blind Side. The Overlooked Connection Between Social Needs and Good Health. (December, 2011). Robert Wood Johnson Foundation.

[http://www.rwjf.org/content/dam/farm/reports/surveys\\_and\\_polls/2011/rwjf71795](http://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2011/rwjf71795)

Heyworth L, Bitton A, Lipsitz SR, Schilling T, Schiff GD, Bates DW, Simon SR. Patient-centered medical home transformation with payment reform: patient experience outcomes. Am J Manag Care. 2014;20 (1) :782-5. Abstract:

[http://scholar.harvard.edu/asaf\\_bitton/publications/patient-centered-medical-home-transformation-payment-reform-patient](http://scholar.harvard.edu/asaf_bitton/publications/patient-centered-medical-home-transformation-payment-reform-patient)

Luff, Michael. Public, Private Help Smooth Transition to Medical Home. (January 21, 2015).

<http://www.aafp.org/news/practice-professional-issues/20150121RI-PCMH.html>

Joint Principles of the Patient-Centered Medical Home. (February, 2007). Patient Centered Primary Care Collaborative.

[http://www.aafp.org/dam/AAFP/documents/practice\\_management/pcmh/initiatives/PCMHJoint.pdf](http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf)

Milbank Q. 2012 Sep;90(3):484-515. doi: 10.1111/j.1468-0009.2012.00672.x.

Abstract: [http://scholar.harvard.edu/asaf\\_bitton/publications/hamster-wheel-qualitative-evaluation-payment-linked-patient-centered](http://scholar.harvard.edu/asaf_bitton/publications/hamster-wheel-qualitative-evaluation-payment-linked-patient-centered)

Nielson, M., Buelt, L., Patel, K., Nichols, L. (February, 2016). The Patient Centered Medical Home's Impact on Cost and Quality: Annual Review of Evidence, 2014 – 2015. Patient-Centered Primary Care Collaborative.

<https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality-2014-2015>

Teeter, Dorothy. (March 1, 2016). The State's Perspective: What Purchasing for Value Means Dorothy Teeter Director, Washington State Health Care Authority Moving the Health Care Market to Value Workshop.

[http://wahealthalliance.org/wp-content/uploads.php?link-year=2016&link-month=03&link=Dorothy-Teeter\\_Washington-State-Health-Care-Authority.pdf](http://wahealthalliance.org/wp-content/uploads.php?link-year=2016&link-month=03&link=Dorothy-Teeter_Washington-State-Health-Care-Authority.pdf)

Ziebarth, Deboarah J. (2/19/16) Wholistic Health Care: Evolutionary Conceptual Analysis. Journal of Religion and Health.

Abstract available at : <http://link.springer.com/article/10.1007/s10943-016-0199-6>

## SOME ASPECTS OF A WHOLE PERSON MEDICAL HOME

