CIN Partners Share:

Whole-Person Care

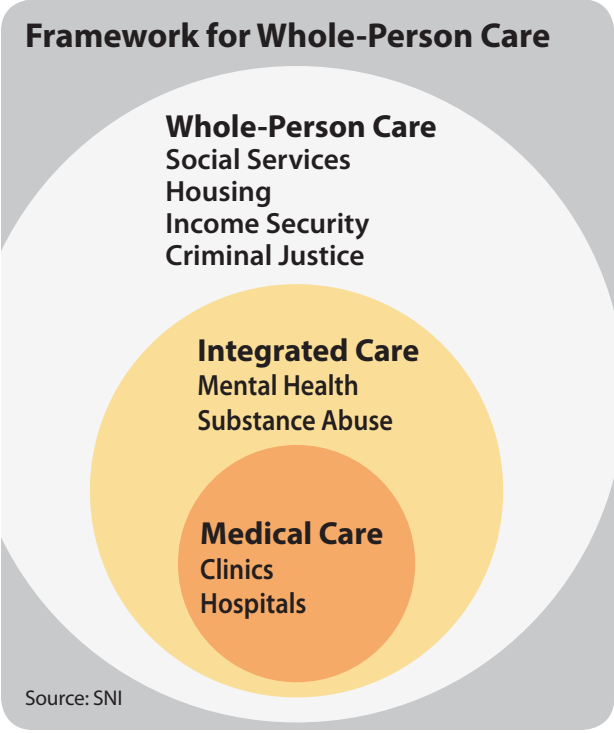
The California Improvement Network (CIN) partners — public and private health care organizations actively engaged in improving care delivery — meet quarterly to share experiences and to learn from one another. Following are highlights from the partners' November 2013 meeting, which focused on whole-person care. The meeting included presentations from the California Health Care Safety Net Institute (SNI), AltaMed Health Services Corporation (AltaMed), and Rishi Manchanda, MD, MPH, founder of HealthBegins.

Main Take-Away:
To be successful at whole-person care, organizations need to be creative in developing programs that address upstream social determinants of health — but the financing mechanisms to support these new models are only in their infancy.

The California Health Care Safety Net Institute: Defining Whole-Person Care

www.safetynetinstitute.org

Who: SNI is the quality improvement affiliate of the California Association of Public Hospitals and Health Systems (CAPH), representing 21 public hospital systems and academic medical centers and their 150 primary care clinics and numerous specialty care clinics across the state. The public hospital systems serve 2.6 million patients who are primarily low-income, uninsured, or publicly insured.



What: Over the past few years, SNI's member hospitals have shown an increased interest in whole-person care. Many are expanding services beyond the hospital walls, partnering more closely with community-based organizations, and linking patients to social services. Based on the experiences of these hospitals, SNI offered a framework for defining and thinking about the evolving field of whole-person care (see figure).

The concept arose from the realization that the traditional medical system is not only expensive but that it is also ineffective at addressing the social determinants of health. Whole-person care includes a wide range of services: medical, public health, mental health, substance abuse, and social services. As a starting point for this new care model, public hospital and health systems have targeted the most vulnerable and expensive population of patients. These patients typically have multiple chronic medical conditions, significant mental illness, substance abuse issues, and/or are homeless. Their needs are met in multiple locations — hospitals, primary care settings, mental health agencies, substance abuse organizations, social service agencies, homeless shelters, and the criminal justice system — highlighting the importance of care coordination and of addressing basic needs, such as housing, alongside medical needs.

Whole-person care is not easy to implement. It blurs the boundaries between services that have traditionally existed in silos. For example, providers focus on medical conditions, community-based organizations focus on social conditions, and the typical payer only pays for services that are medically necessary. The lack of alignment in a common goal and the lack of financing mechanisms that work across organizations are significant obstacles to delivering whole-person care.

SNI outlined key components to effective whole-person care:

- Development of close working relationships between organizations that may not be accustomed to working together
- Provider access to valid, real-time data to identify the target population, coordinate care across organizations, and help assess the impact of whole-person care
- Processes and technologies to facilitate communication of individualized care plans among providers, and across institutions
- Flexible policy and financing mechanisms that support investment in nonmedical solutions that reduce health care costs downstream

"The good news is that there are a lot of resources for this population; the bad news is that these resources are hard to coordinate."

There is increased interest in whole-person care from both a program and a policy perspective outside of California as well. Efforts such as Hennepin Health, an accountable care community effort in Minnesota, and the multi-stakeholder Michigan Primary Care Transformation Project, the largest patient-centered medical home project in the country, were highlighted at the annual CAPH conference in December 2013. In addition to raising awareness about these national innovations, SNI and CAPH are embarking on a research effort to identify and share innovative efforts by California counties to implement care delivery and policy changes that support whole-person care.

AltaMed Health Services Corporation: Offering Whole-Person Care at an FQHC

www.altamed.org

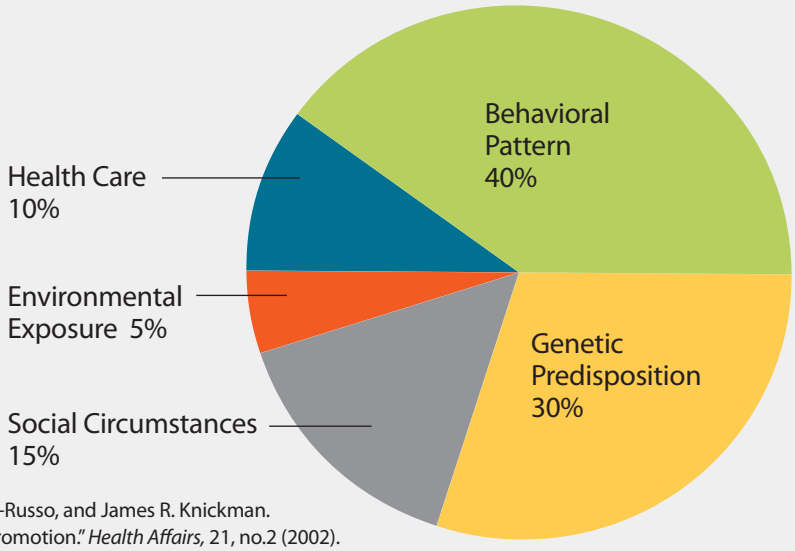
Who: Founded in 1969, AltaMed is the largest independent Federally Qualified Health Center (FQHC) in the United States, operating 43 sites in Los Angeles and Orange Counties and delivering more than 930,000 annual patient visits. AltaMed also manages an independent practice association (IPA) with 153 contracted primary care physicians and 471 specialists.

What: AltaMed uses a whole-person care approach with their entire patient population and provides supplemental services to a targeted population of elders who participate in its Program of All-inclusive Care for the Elderly (PACE) — a program for nursing home–eligible elders who live in the community. Among the whole-person care services offered at at AltaMed are: medical care, transportation to medical appointments, assessment of the home environment, and health literacy (see figure). As part of this approach, AltaMed offers a number of additional services, such as parenting classes, a college prep program, an adolescent/teen clinic, an obesity program, and ACA enrollment support, all of which are designed to position AltaMed as a community resource.

Whole Person Orientation

Health

- Health Literacy
- Medical Care
- Transportation
- Air Quality
- Home Environment
- Food Environment
- Economic Conditions



Source: AltaMed; J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman. "The Case for More Active Policy Attention to Health Promotion." *Health Affairs,* 21, no.2 (2002).

AltaMed's PACE program for older patients provides transportation to and from appointments, adult day care, and social programming. Since AltaMed accepts financial risk for the full cost of care for PACE program patients, justifying the expense of whole-person care for this patient population is easier than for others.

" We want to think of ourselves as a community center, an integrator of resources that are centrally located and offered to the whole community."

Health education is a key component of AltaMed's approach to whole-person care. Free classes and individual counseling sessions are offered to AltaMed patients and community members. Classes are offered on nutrition, chronic conditions, stress and depression, weight management, exercise, and healthy cooking. These services are promoted through an online calendar, with class flyers, and by word of mouth, and are offered at 22 sites in Los Angeles and Orange Counties. The program has 24 staff members and has 1,615 patient encounters per month.

Health education services are provided by a team of health educators and health promoters, also called *promotores*. During a health education session, which typically lasts 45 to 60 minutes, the patient is encouraged to create a realistic self-management goal. To accommodate varying literacy levels in their patient population, AltaMed has developed visual aids as well as written health education materials. Patients may also be referred to other departments and community resources. Patients complete a pre- and post-test and/or a class evaluation.

AltaMed has documented the following results from its health education program:

- Enhanced patient self-management skills
- Improved health behaviors
- Improved health outcomes (blood pressure, adult BMI, and hemoglobin A1c levels)
- Lower rate of emergency department visits compared to a control group

Although health education visits are not reimbursable, AltaMed includes these services in their prospective payment system rate. For each health education visit, AltaMed submits a non-billable code. Since AltaMed can only bill for face-to-face provider visits, the organization plans to combine health education with provider visits in the future.

HealthBegins: Training Care Providers to Become Upstreamists

www.healthbegins.org

Who: Rishi Manchanda, MD, MPH, is the author of *The Upstream Doctors*, published by TEDBooks, and founder of HealthBegins, an online, 640-member learning collaborative. HealthBegins focuses on the unhealthy social conditions that play a role in disease and health disparities, and trains clinicians to address them. The goal of HealthBegins is to equip 25,000 "upstreamists" — clinicians who are addressing the upstream factors that impact health — with the tools to transform care and improve the lives of 25 million Americans by 2020.

"Treating people without tackling the conditions that make them sick is a losing proposition."

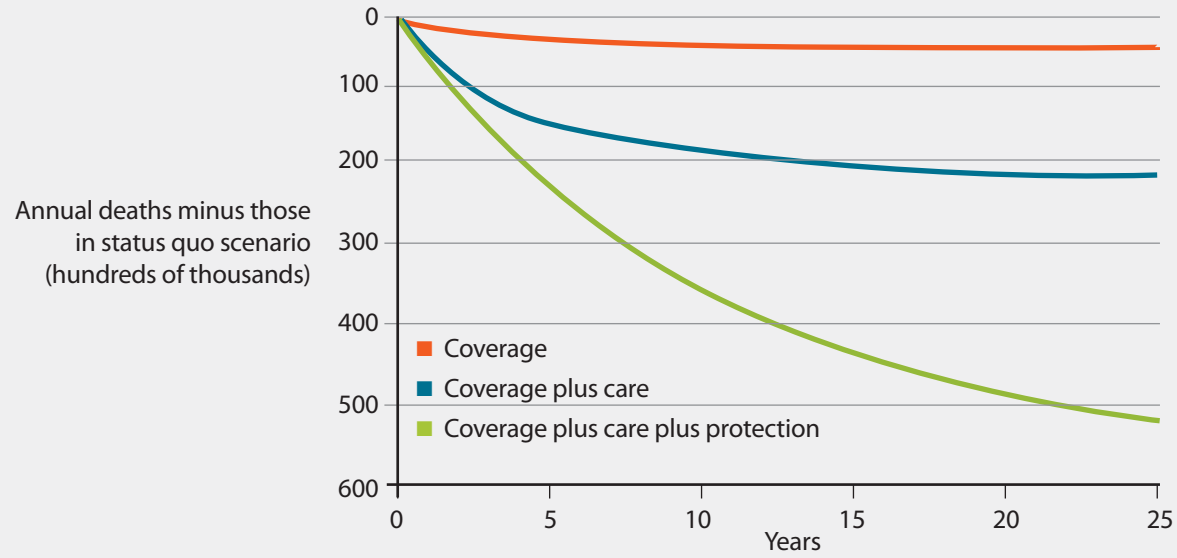
What: To illustrate the role of the upstreamist, Dr. Manchanda shared the story of a patient in South Los Angeles who had chronic and severe headaches. Over the course of three years, this patient had numerous interactions with care providers and medical interventions designed to diagnose and treat her headaches, including repeated primary care visits, three emergency department visits, two CT scans, a lumbar puncture, and numerous blood tests. As a result, the patient experienced pain and discomfort, missed work, lost income, paid out-of-pocket charges, and came away without a clear diagnosis or treatment plan. After a medical assistant screened her for housing-related risks (using seven questions from the American Housing Survey) that identified exposure to water leaks, cockroaches, and mold, the physician was able to correctly diagnose her condition and set an appropriate treatment plan, which included connecting her to a healthy housing program that could help her advocate for improvements such as mold remediation.

Upstreamists identify the root causes of health problems by asking patients about where they live, work, eat, and play; address upstream problems at the patient, clinic, and population levels; and build bridges with organizations outside of health care to improve the quality of care and the social determinants of health. This approach can help improve health outcomes and reduce health care costs. See charts below for estimates of lives and money saved by improving coverage and care, and by addressing social factors.

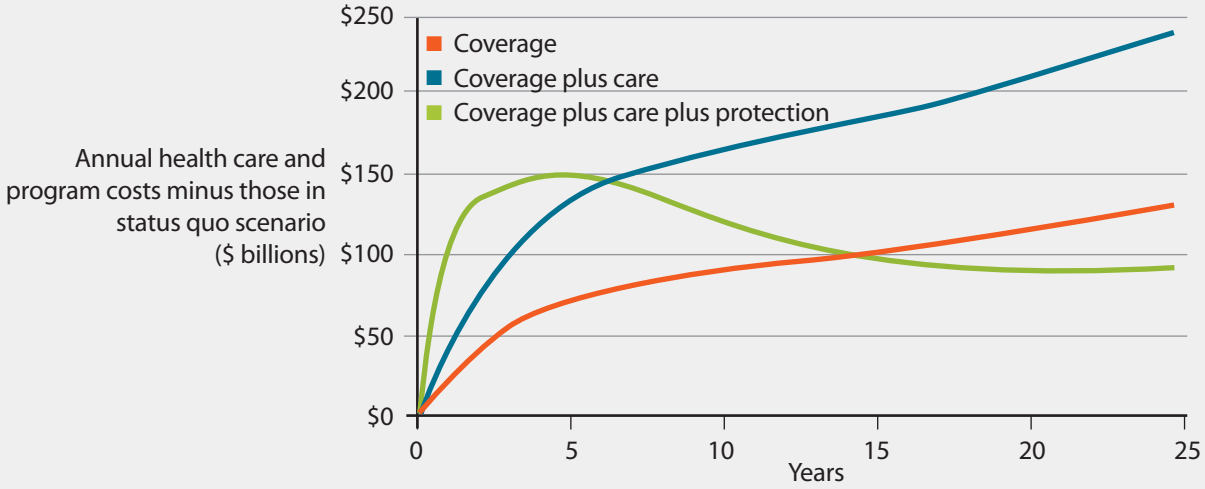
Upstreamists, however, cannot work alone. They partner with "partialists" (sub-specialists, trauma surgeons, emergency department doctors, and other clinicians focused on downstream issues) and "comprehensivists" (primary care providers who may be responsible for coordinating patient care) to deliver quality care.

HealthBegins has developed online tools to support upstreamists. One tool uses a community-powered "Yelp for Health" that helps providers assess community-based service organizations based on peer feedback. (See http://healthbegins.ning.com/page/hsa-resource-search.)

Addressing Social Factors Can Save More Lives



The Cost Curve Only Bends by Improving Care, Coverage and Social Factors



Note: "Coverage" is availability of health insurance; "care" is delivery of preventive and chronic care; and "protection" is promotion of healthy behavior and safe environments.

Source: Bobby Milstein, Jack Homer, Peter Briss, Deron Burton, and Terry Pechacek. "Why Behavioral and Environmental Interventions Are Needed to Improve Health at Lower Cost." *Health Affairs*, 30, no.5 (2011).

Quick Takes

- **Building a business case is critical to advancing whole-person care as a new approach.** Capitated environments offer greater opportunity to provide incentives for whole-person care than traditional fee-for-service models. New models of care delivery, such as accountable care communities and medical neighborhoods — where finances and risk are shared across social service and health care entities — provide patients with the services they need, without dividing up medical and nonmedical services among multiple organizations not working in concert.
- **Physicians are often so focused on the clinical issue at hand that they can lose sight of the whole person.** To combat this tendency, build surveys on social determinants of health into the check-in process, involve physicians in health education classes so they feel engaged, identify physician champions to advocate for whole-person care, and simplify the process for physicians to refer patients to health education or community services.
- **Adequate workforce capacity is needed to deliver effective whole-person care.** While clinicians (mostly physicians and nurses) are currently informally acting as upstreamists, other professionals, such as social workers, could also fill this role.
- **Effective whole-person care involves coordination with community-based organizations.** Online tools and other technologies can help facilitate this collaboration.

Resources

The Case for More Active Policy Attention to Health Promotion www.hdassoc.org/pdf/Active_Policy_Attention.pdf

Why Behavioral and Environmental Interventions Are Needed to Improve Health at Lower Cost http://content.healthaffairs.org/content/30/5/823.abstract

Health Care's Blind Side: The Overlooked Connection Between Social Needs and Good Health www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2011/rwjf71795

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California Improvement Network Better Ideas for Care Delivery