



The Whole Person Care Approach: How Using Technology Can Impact Quality Improvement and Population Health Monitoring

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Advantages of Whole Person Care



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WPC will eliminate siloed treatment and work together to create an overarching network of care.



WPC coordinates health, behavioral health and social services needs in a patient-centered manner. This helps with the goal of improved and synchronized beneficiary care.



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Introduction



**California's
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California's Section 1115 Medicaid waiver which will run through December 2020, Medi-Cal 2020, includes a \$3 billion pilot program to improve care for Medi-Cal beneficiaries by supporting local efforts that embrace the Whole Person Care (WPC) philosophy. The WPC system is a holistic approach to healthcare that looks at vulnerable individuals through a "whole person" lens to address complex needs within their full spectrum. This approach extends far beyond traditional healthcare services as it considers social determinants to health for low-income communities, including poor nutrition, lack of safe and stable housing, incarceration, and unemployment. These factors and current services should not be isolated in individual siloes, like they are currently, but rather should all work together to create an overarching network of care. WPC coordinates these health, behavioral health, and social services needs in a patient-centered manner. This lends itself to the goal of improved and synchronized beneficiary care resulting in better health and wellbeing for our most vulnerable populations. This newfound approach will require current systems to break down barriers and to join into partnerships, creating an unprecedented system of integration. Greater care coordination also enables safety net providers to more efficiently and effectively use their resources, maximizing their ability to improve patient health outcomes and making limited resources go further to help more people in the community.

The WPC approach stemmed from the fact that oftentimes, low-income individuals have unmet health needs that are exacerbated by their social and economic issues, and to receive appropriate help, they need to go through several different, fragmented channels which can be difficult to navigate. Different types of service providers do not regularly communicate or coordinate care, even though they may be serving the same individuals and families. While the need to better coordinate services has long been recognized, progress has been challenging due in part to this fragmented nature of the organizational structures in our current healthcare system. The result is that vulnerable individuals who have the greatest health, behavioral health, and social service needs often find themselves having to navigate systems that have different structures and practices, programmatic goals and financial incentives. To ease these barriers and difficulties, the WPC approach provides tailored support and coordinated services for high-risk Medi-Cal beneficiaries who have been identified as repeat users of multiple systems who continue to have poor health outcomes.

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California State decided that the best way to trial this approach was via 25 monitored pilot programs across the state. Once the pilot regions were identified, elements have been established to focus their efforts, ensuring that the target population has a collaborative leadership structure in place that is headed by a group of public and private entities that have agreed upon WPC's common purpose. In order to think differently about how agencies and providers work together, a coordinated approach is needed where a more effective and navigable experience is available at the individual, patient level. This requires new and improved infrastructure of communication and data sharing, which is often seen as the greatest area of challenge and opportunity for WPC pilots. Data is needed at all stages of care, from targeting high-risk populations, to coordinating care across sectors, to evaluating the impact of the pilots, to correctly reporting their progress. To provide the necessary care that includes all social determinants to health, creativity is needed throughout the entire care process, which is particularly true with regards to the technology and IT needed to harness these WPC elements by the most efficient and productive means.

The technology needed to successfully instill the WPC approach is highly important with regards to the successful implementation of a coordinated and innovative platform of care. The ability to share data is seen as a huge barrier to integrative, holistic health, and the technologies that address this barrier are vital—they provide an opportunity for actionable solutions.

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An open architected web-based Care Tracking and Coordination Platform is required to coordinate care across systems and to enable electronic referrals. It is needed to consolidate assessments and care plans from diverse system providers. It should incorporate functions to provide telemedicine consultation system and require real-time secure messaging that allows providers to share confidential health information with all parts of the system. To store and consolidate all of this information, a well-defined data warehouse is essential for quality improvement and population health monitoring purposes.

Providers and agencies can prepare for the WPC approach by determining who the other local key-players in their region are so that they have a foundational grasp of who they will be collaborating with to address the patient's holistic needs. The pilots are focused on some core strategies and interventions that can help with this. One element that WPC focuses on is supportive housing services, such as house navigators, financial assistance for security deposits and move-in fees, as well as support maintaining relationships with landlords. Community re-entry after jail is another important element to focus on so that parolees are efficiently transitioned into the community by being effectively connected to case management, medical care and housing options. Each patient should also be screened for behavioral health needs to connect them to appropriate detox and rehabilitation centers, medication assisted treatment, and intensive outpatient services.

Each client is required to have a single, comprehensive care plan that is streamlined by WPC, and is accessible to all involved care team partners via real-time web-based technology. Lastly, and perhaps most importantly, a workforce of local community health workers and peer navigator's is needed to foster trust and connection with vulnerable patients throughout their whole care process.

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Conclusion



The WPC program has already seen some great successes with their pilot projects that demonstrate organizations from across fields partnering to coordinate care for enrollees. It is allowing new ideas, perspectives and priorities to be brought to the forefront of discussion and can begin to lead the way to a holistic and patient-centered approach on a more universal scale. Health involves so much more than primarily physical health; it is wellness in all facets of life and should be treated that way.



6-point checklist for achieving Whole Person Care:

Target Population

- Identify particularly vulnerable Medi-Cal beneficiaries who are high users of multiple systems and continue to have poor health outcomes.

Collaborative Leadership

- Create a group that consists of both public and private entities that partner together towards WPC common purpose.

Coordinating Services Across Sectors

- Create a more effective and efficient, navigable experience for target population
- At the individual, patient level—care coordinated across services.
- At the systems level—new and improved infrastructure for communicating and working together.

Interoperable Data Sharing

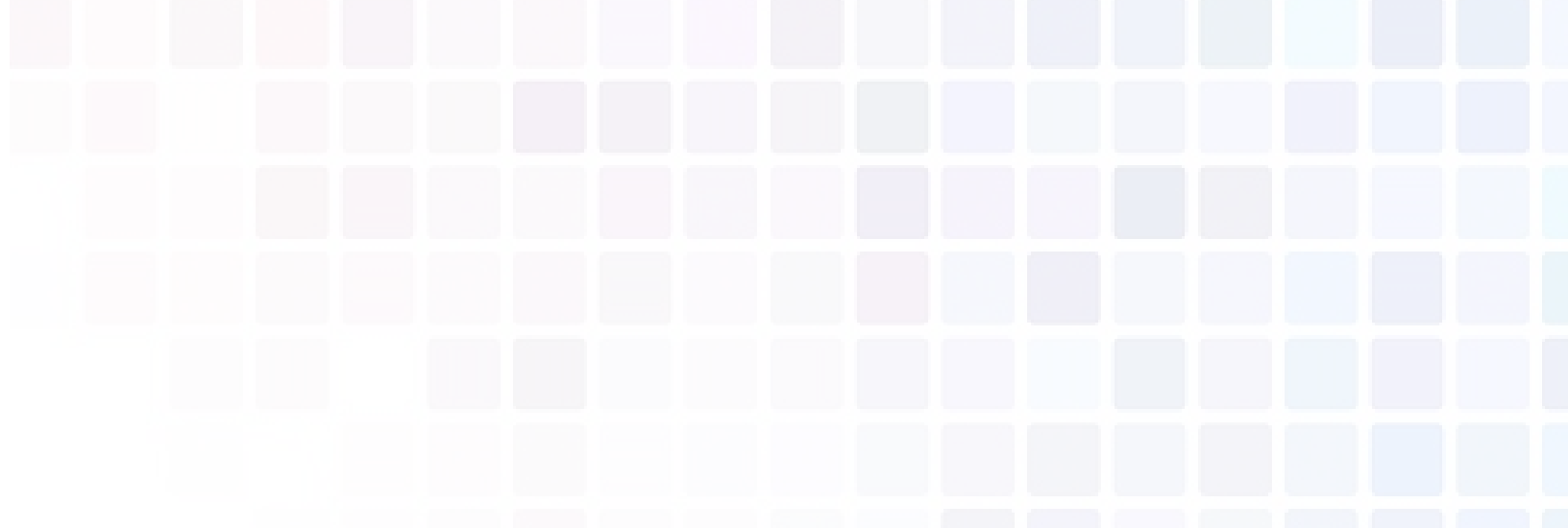
- Create a software that allows data sharing across partnering entities.

Financial Flexibility

- Commit to investing in new infrastructure development and services that are not already paid for by the Medi-Cal program to expand services accordingly.

Meeting Patient Needs

- Provide the necessary care to meet the social, physical and behavioral health needs of each targeted individual.
- through referrals.
- by identifying gaps in the system to develop new services.



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Resources

California Association of Public Hospitals and Health Systems

<http://caph.org/wp-content/uploads/2019/04/wpc-4.11.19.pdf>

<https://caph.org/wp-content/uploads/2016/09/caph-sni-issue-brief-wpc.pdf>

<http://caph.org/wp-content/uploads/2018/07/wpc-brochure-7.20.2018.pdf>