The Journey To Whole Person Care

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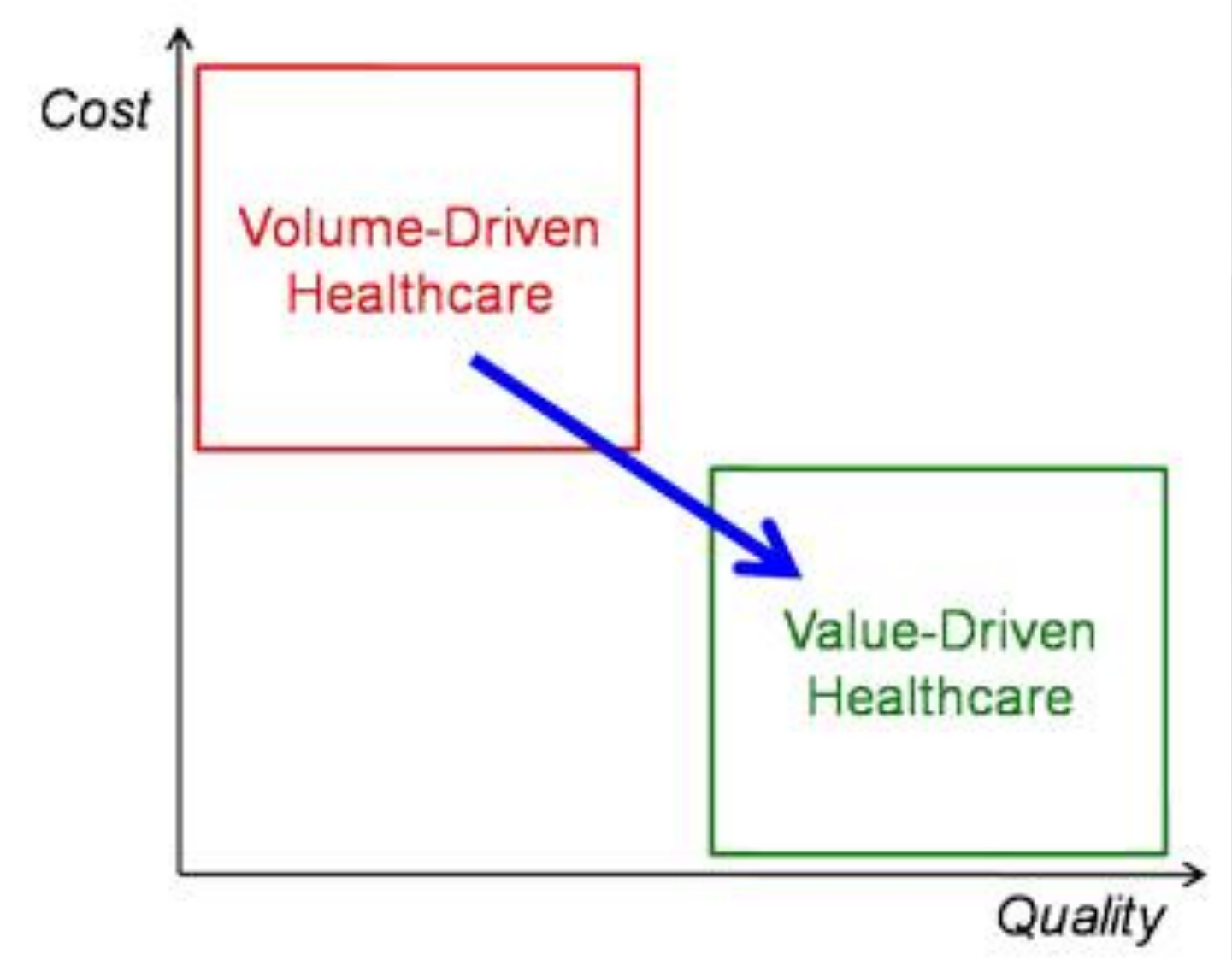
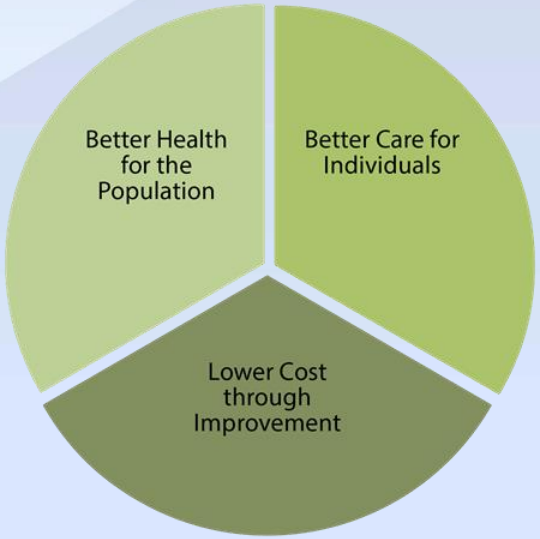
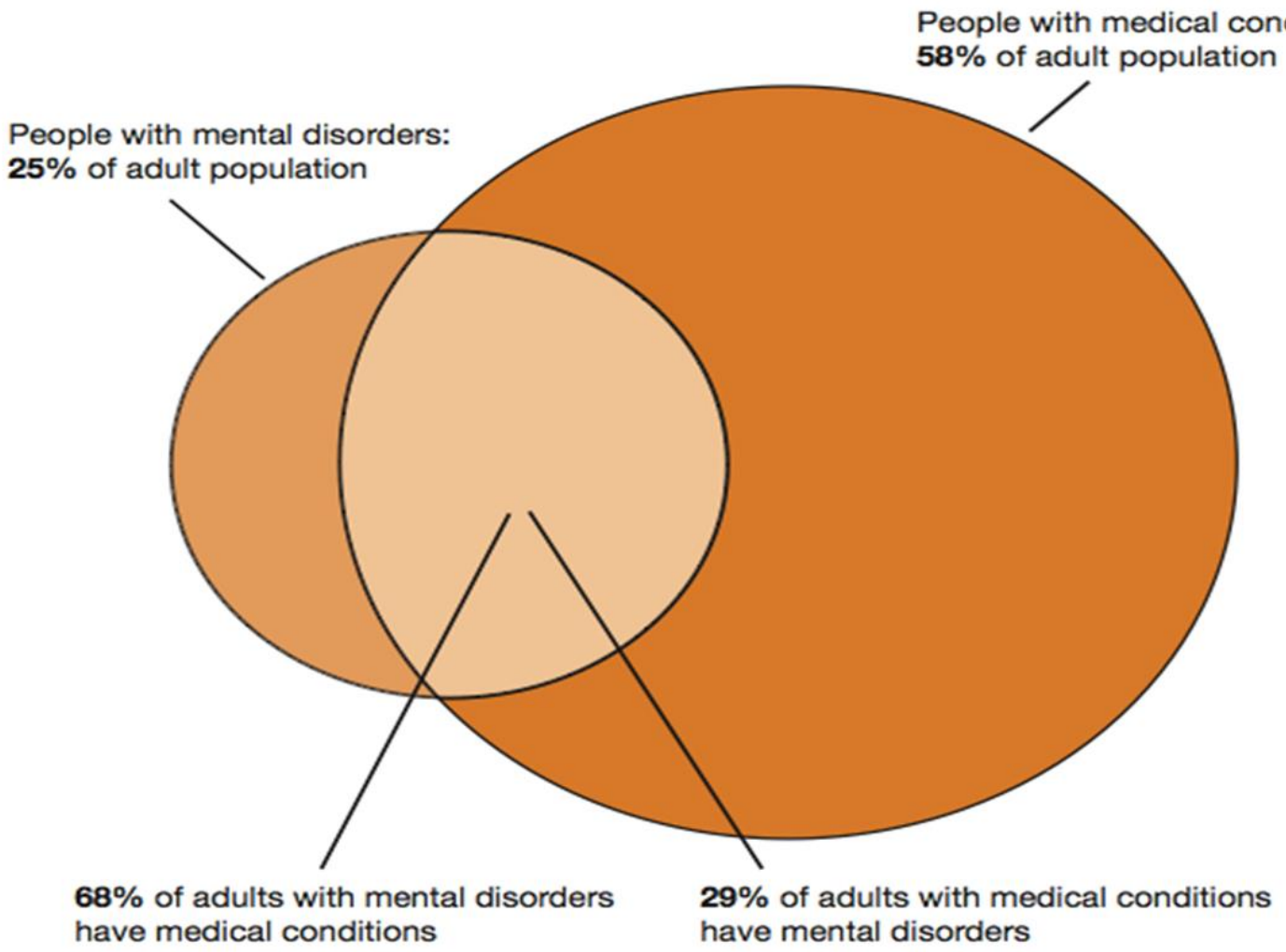

Cost
Volume-Driven Healthcare
Value-Driven Healthcare
Quality

In the new world of healthcare…

- Silos of care will no longer be tolerated
- Payments & budgets must be predictable and care will be provided at-risk
- Achieving the Triple Aim





Source: Adapted from the National Comorbidity Survey Replication, 2001–2003 (3, 83)

What is Integrated Care?

Integrated care is “care that results from a practice team of [medical] care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care...”

(Peek, 2013)

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understanding of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet ill-defined team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth understanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Heath B, Wise Romero P, and Reynolds K. A Review and Proposed Standard Framework for Levels of Integrated Healthcare. Washington, D.C.SAMHSA-HRSA Center for Integrated Health Solutions. March 2013

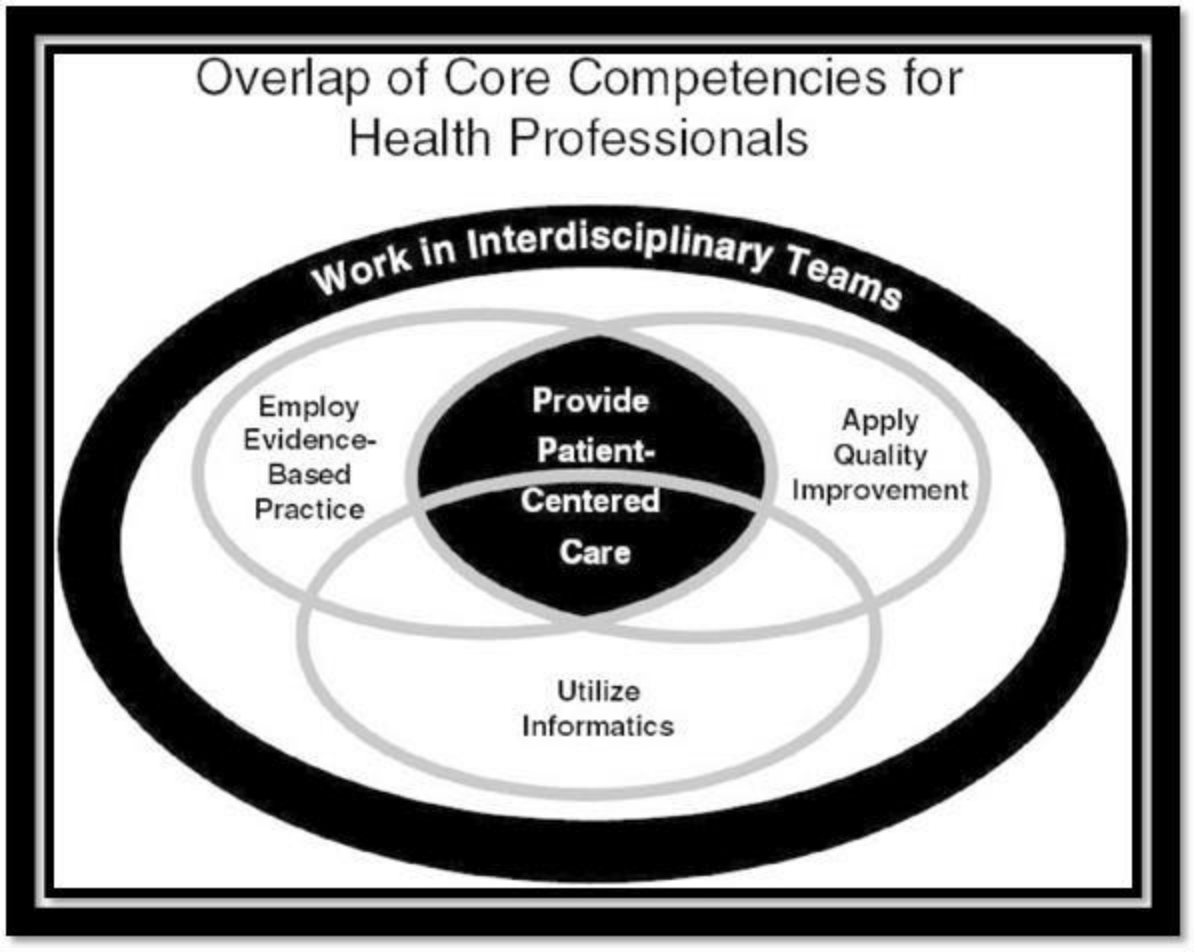
Moving Along the Continuum

- Not all at the same place to begin with
- Not all have the same resources
- Not all have the same needs
- STARTING WHERE YOU ARE, AND HELPING YOU TO ADVANCE

Vaya Health's Integrated Care Strategic Plan

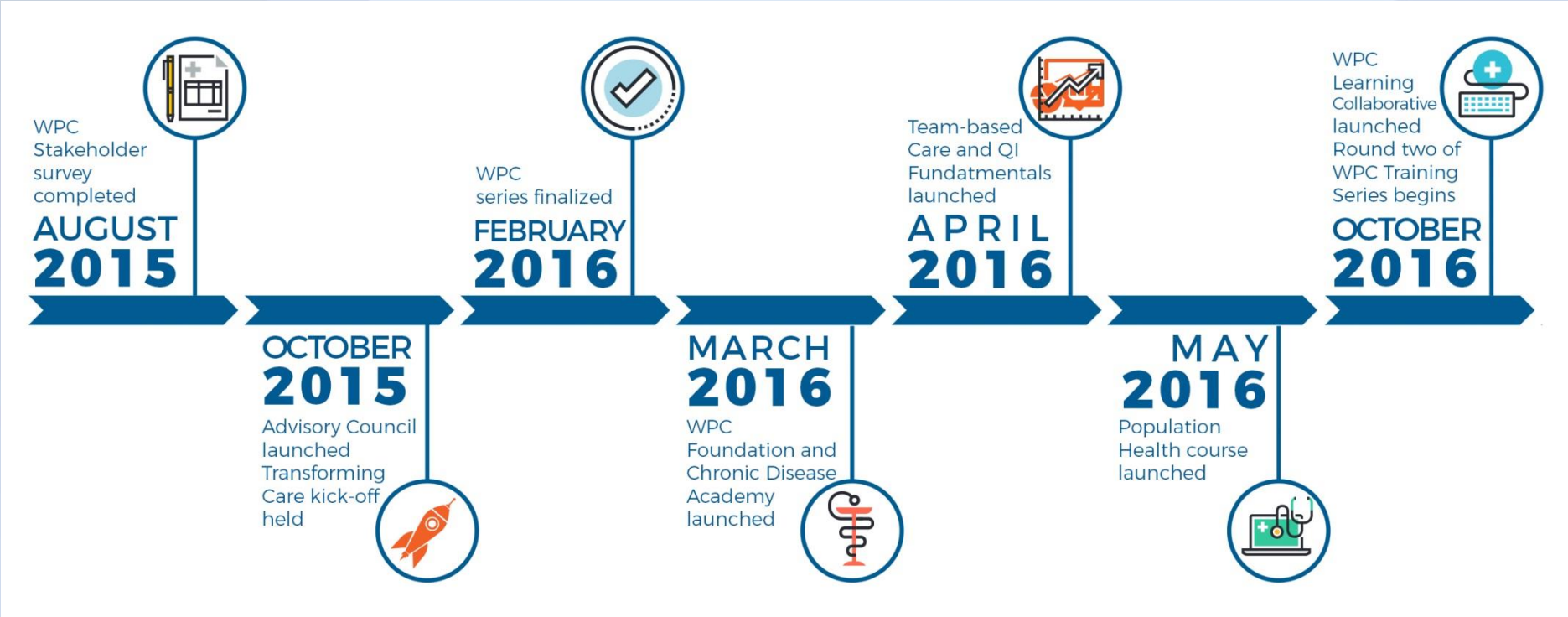
- Developing and Training the Regional Workforce
- Enhancing Care Coordination
- Eliminating Barriers and Creating Supports
- Managing the Behavioral Health and Intellectual Disabilities Network
- Measuring Progress

Workforce Development: The ability to provide integrated care is becoming a core set of competencies



Healthcare Professions Education: A Bridge to Quality, Ann C. Greiner and Elisa Knebel, Editors; Committee on the Health Professions Education Summit; Board on Health Care Services; Institute of Medicine

Workforce Development
What is Vaya Health Doing?



Whole Person Care: The Learning Curriculum

- Foundations of Whole Person Care
- Chronic Disease Care Academy
- Fundamentals of Quality Improvement
- Team Based Care
- Population Health

In 2016…

- Over 800 session participants took 7,000 hours of training.
- They demonstrated statistically significant learning across a wide variety of integrated care learning objectives

Vaya Health's WPC Learning Collaborative

Launch and Learning Session #1
(Face to Face and Video Conference in 4 Locations)

Meet with Your Team

Write Your Change Plan; Begin First Experiment

Check-in on progress
Phone webinar

Meet with Your Team and Conclude First Experiment

Purpose

To provide behavioral health and primary care teams with a structured learning framework in which they:

- experiment with improvements
- collect data
- make decisions about how to advance integrated care

In 2017…

- We launch the first blended virtual learning approach in the history of MAHEC (Mountain Area Health Education Center)
- Now participants can take eLearning courses at their desk and then participate via webinar or in person for fast paced practice sessions
- The next Transforming Care Conference will be held in early June

And that’s not all…

Driving the Future:
Vaya Health Whole Person Care Initiatives

QUADRUPLE AIM

- *Improving Individual Experience of Care*
- *Improving the work life of healthcare providers*
- *Improving Population Health*
- *Reducing per capita costs*

Wilkes Collaborative Care Partnership

- Formed in early 2015 to be a Learning Lab
- Daymark, Northwest Community Care Network of CCNC, Vaya Health & Wilkes Regional Medical Center ED
- Established communication pathways
- Evaluating member and staff satisfaction and areas to improve coordination of care
- Next Step to include primary care champions

CMT
(Care Management Technologies)

- Tool used for population health management
- Based on paid claims data
- Two projects
  - For Comprehensive Providers
    - Metabolic Screenings
    - Quality Improvement Project
  - For IDD Providers
    - Quality Improvement Project

Vaya's Action Plan

- Encourage participation in workforce development series
- Encourage questions/collaborations
  - Share with us what you are doing
  - Learning from each other
- Encourage providers to make organizational change

Considerations

- What are you doing to train your staff?
- What are you doing to train yourself? Your board? Your consumers?
- Is integration reflected in your organizational mission, goals and strategies?
- How can Vaya help?

Vaya Health is *advancing Integrated Care through partnerships*

VAYAHEALTH

Community Care of North Carolina

MAHEC

Center of Excellence for Integrated Care

Foundation for Health Leadership & Innovation

Moving people and ideas into action.

Contact

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QUESTIONS?

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