Medicaid Demonstration Public Forum

$4 Billion Dollars: Spent on health care in our region

With poor health status

19% of adults report smoking in Ferry County

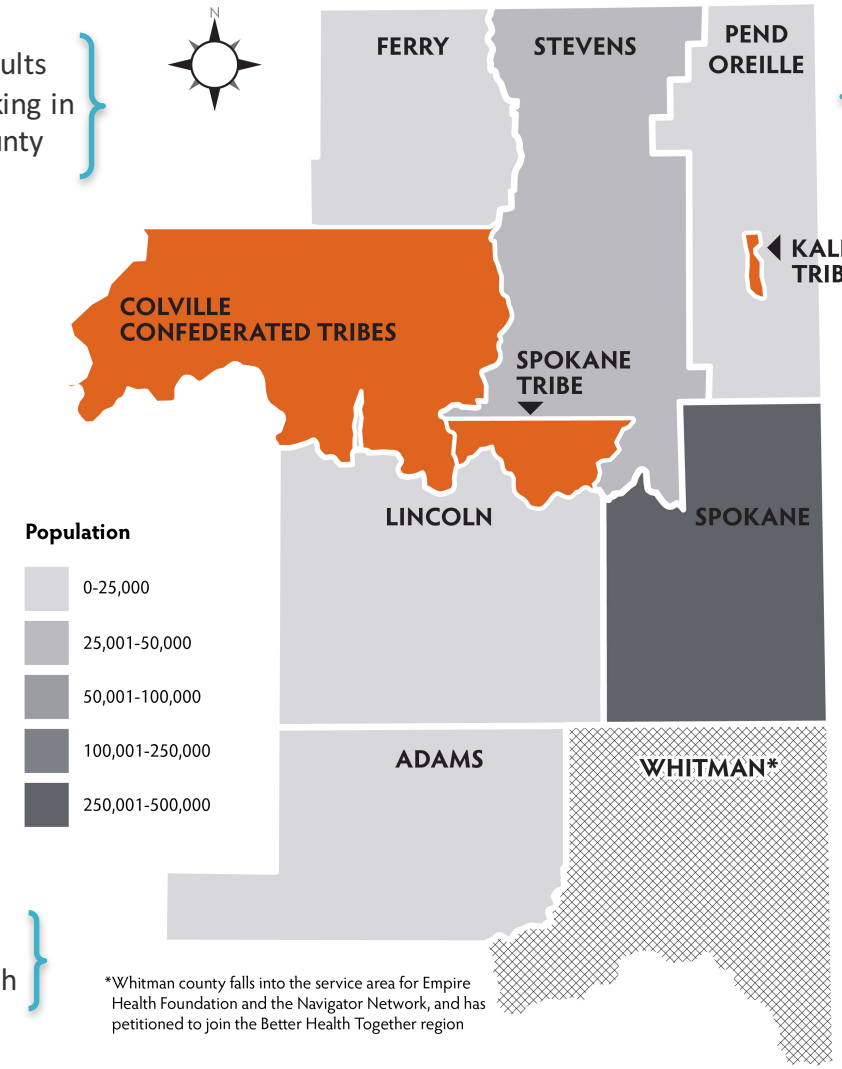
37 of 39 in overall health outcomes in Pend Oreille

AI/AN men and women have lowest life expectancy of any population in WA

21% of adults report excessive drinking in Spokane County

33% of adults are obese in Lincoln County

25% of adults report poor health



*Whitman county falls into the service area for Empire Health Foundation and the Navigator Network, and has petitioned to join the Better Health Together region

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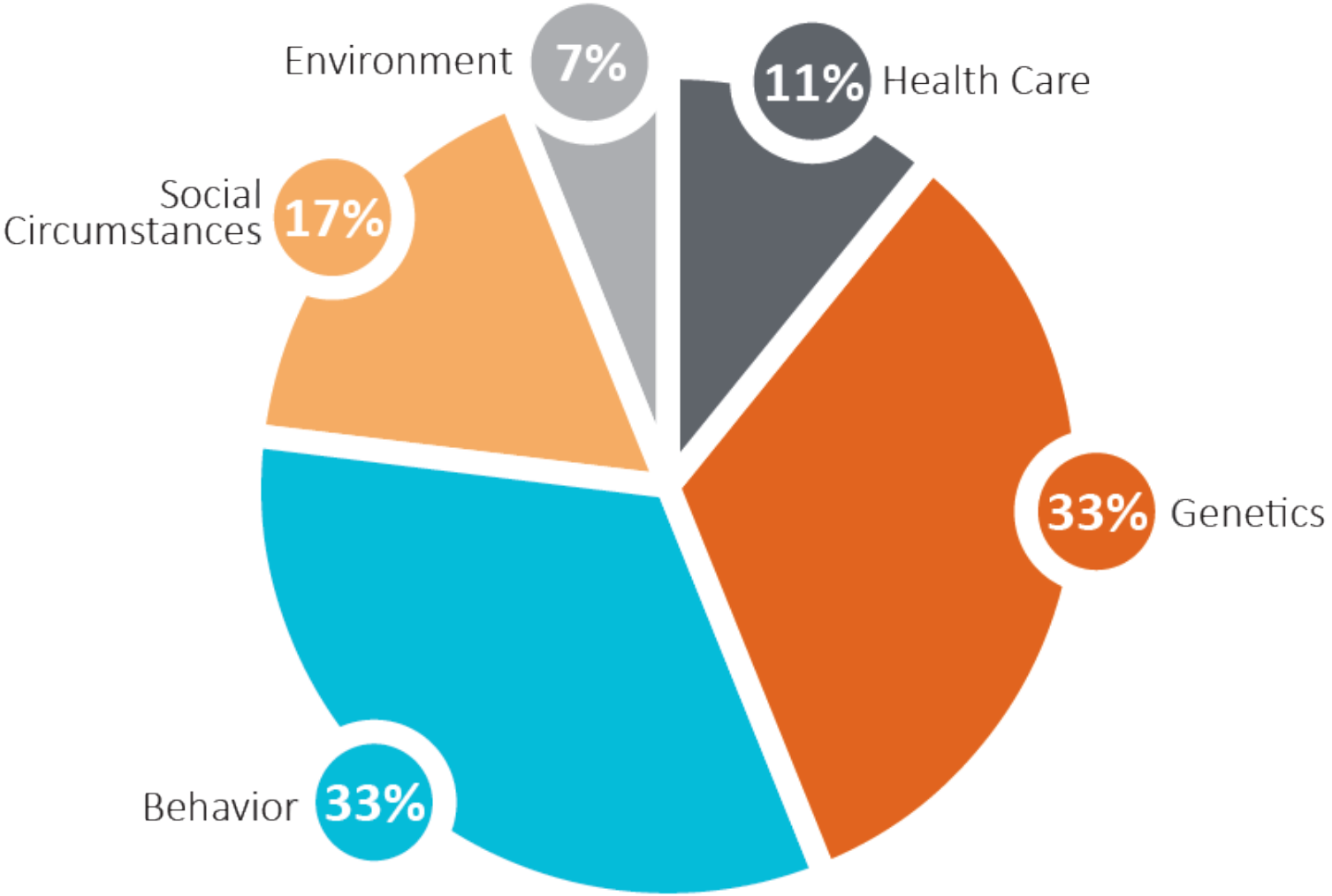
What determines Health?



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Social Determinants of Health

- Obesity Rates
- Life Expectancy
- Poor Mental Health Days
- Substance Use Disorder
- Oral Decay

- Education
- Neighborhood
- Culture
- Occupation
- Race/Ethnicity
- Socioeconomic Status/Income

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ACH Guiding Principles

- Truly effective health and community systems care for the whole-person and are utilized and accessible to all.
- The best solutions and implementation are local and originate from within the community.
- Prudent and efficient use of community resources and the health care system ensures lower costs and better health.
- To realize our audacious health goals we must approach this as a movement requiring each of us to lead, collaborate and orchestrate our work in creative and new ways.

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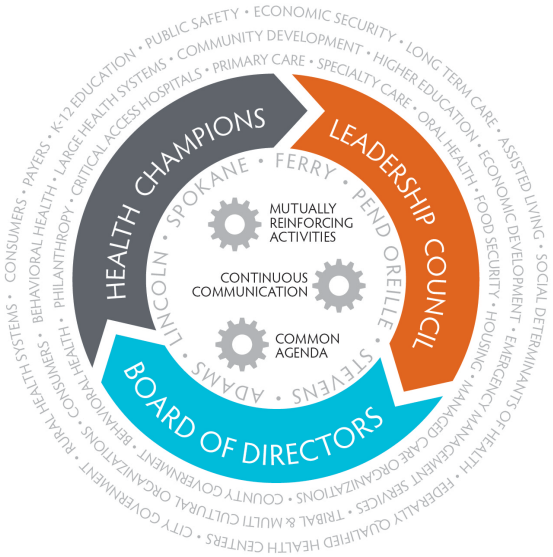
ACH Governance Structure



ACH Leadership Council is the strategic synthesizer for ACH; 75 members representing 7 counties and key stakeholders. Meets 6-10x a year.

BHT Board of Directors is the Governing Body of the ACH; 17 Board members representing key stakeholders and Co-investment in programs. Meets monthly.

Health Champions, Rural County-Based Coalitions, "mini ACHs" and Community Strategy teams and developing Regional Health Improvement Action plans

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Better Health Together ACH

VISION: everyone will have a longer, more productive, higher quality lives by ensuring access to:

- Stable housing, nutritious food and transportation.
- Opportunity to attain post secondary education and training to allow for meaningful employment that pays the bills with some left over for savings.
- Community resources and opportunities for recreational and leisure-time activities.
- Social support networks that allow for emotional, social and psychological well-being.

PRIORITIES:

- Dramatically improve whole-person care through the integration of behavioral, physical and oral health systems.
- Expand oral health access.
- Develop strong community systems that link housing, food security and income stability.
- Dramatically decrease obesity rates across all populations through prevention.
- Scaling community-based care coordination to improve health.

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Community Action Strategy Maps

Aim

The BHT Region is the healthiest region in Washington State

METRICS

For children ages 20 and under:

- Childhood immunization status (combo 10)
- Well- child visits in the 3rd, 4th, 5th, and 6th years of life
- Medication management for people with Asthma

For Adults age 21 and up:

- Controlling high blood pressure
- Comprehensive Diabetes Care (HbA1c) Poor control
- Comprehensive Diabetes Care: Blood Pressure Control
- Antidepressant Medication management: effective acute phase treatment, and effective continuation phase treatment

IDEAL STATE

STRATEGIC AIM

①

INTEGRATED CARE:

Our community experiences whole-person health through integrated efforts of behavioral, physical, and oral health systems.

» Integration of Behavioral, Physical, and Oral Health systems
» Link community services with health care services
» Accelerate the transition to Value-Based Purchasing
» Scale community based care

②

POPULATION HEALTH:

Our Community invests in upstream prevention efforts to improve all aspects of health for the whole population.

» Disrupt the intergenerational transfer of ACEs
» Control and prevent Type 2 Diabetes
» Improve oral health
» Increase age appropriate immunization rates
» Prevent asthma
» Prevent unintended pregnancies
» Prevent usage of tobacco, marijuana, and eCigarettes

③

COMMUNITY DETERMINANTS:

Our community benefits from a health system with strong linkages between community and health care services.

» Housing
» Transportation
» Income Stability
» Food
» Education
» Community Support

Population Health

STRATEGIC AIM

Invest in upstream prevention efforts to improve all aspects of health for the whole population.

RESULT: Disrupt the intergenerational transfer of Adverse Childhood Experiences (ACEs)

INDICATORS:
- » % of adults reporting 3-8 ACEs
- » % population aware of ACEs concept
- » % of adults with high protective factors

STRATEGIES:
- » Educational campaign to raise awareness of ACEs and their effects
- » Champion Trauma Informed Care practices
- » Work with pregnant mothers with high ACEs

RESULT: Control and prevent Type 2 Diabetes

INDICATORS:
- » # Adults without Diabetes who have been told they have prediabetes
- » Adults with adequate access to opportunities for physical activities
- » Controlling high blood pressure
- » Comprehensive Diabetes Care (HbA1c) Poor control
- » Comprehensive Diabetes Care: Blood Pressure Control

STRATEGIES:
- » Advocate for policy which supports healthy choices, like a tax on sugary beverages
- » Increase opportunities for physical activities
- » Increase nutritional literacy

RESULT: Improve Oral Health

INDICATORS:
- » Adults missing 6+ teeth from decay
- » % of parents with a dental home
- » % Adults who received routine care
- » % High Risk - Caries Risk Assessment

STRATEGIES:
- » Establish "prevention pool" for non-emergent dental needs
- » Increase parent enrollment in dental home

RESULT: Increase age appropriate immunization rates

INDICATORS:
- » % of Adults who receive flu immunization in last 12 months
- » % of Children 19-35 Months with complete vaccination record on file
- » % of K-12 students with exemption from immunizations

STRATEGIES:
- » Implement school based education for parents who do not immunize
- » Increase place-based immunization opportunities

RESULT: Prevent unintended pregnancies

INDICATORS:
- » % of unintended pregnancies
- » % of schools with comprehensive sex ed
- » % of birth control use
- » % with access to all types of birth control
- » % of teen's pregnant

STRATEGIES:
- » increase # of schools with comprehensive sex ed
- » Increase access and awareness of all types of birth control
- » Educate about healthy relationships

RESULT: Prevent eCig, Tobacco, and Marijuana usage, and increase cessation support

INDICATORS:
- » % pregnant women using products
- » % Youth in grades 6,8,10,12 who smoke one or more times a day
- » % of minors with access to Triangulum substances

STRATEGIES:
- » Increase opportunities and supports for cessation, and coordinate efforts between providers and clinics.
- » Decrease access youth access and exposure to Triangulum substances
- » Target parents who use Triangulum substances for education about having products in home and the health effects for kids

RESULT: Prevent Environmentally Induced Asthma

INDICATORS:
- » % of hospitalization, ER, and/or urgent care visits from asthma
- » % diagnosed asthma cases resulting from environment
- » TBD Housing Quality Metric

STRATEGIES:
- » Home visits for asthma to check housing quality
- » Reduce rates of parents who smoke in home
- » Housing rehab for patients with asthma

Social Determinants of Health

STRATEGIC AIM

Develop strong community systems that link the social determinants to health care, to improve community health.

RESULT: Increase access and placement to stable and safe housing

INDICATORS:
- » # Homeless in our region
- » % recidivism rate for individuals in housing placement services
- » % Vacancy rate
- » % Rent Burden

STRATEGIES:
- » Diversion Programs
- » Education campaigns for tenant and landlord rights and responsibilities
- » Advocate for mandatory rental inspection criteria
- » Advocate for anti-income discrimination act
- » Link vocational training programs to rehab of old units
- » Target population transitioning out of jail
- » Scale community based care utilizing CHWs and Supportive Housing model

RESULT: Increase opportunities to stabilize income

INDICATORS:
- » % people living under federal 300% poverty level
- » % of adults who increase employment gains or non-employment cash income over time
- » % households with savings account

STRATEGIES:
- » Financial literacy classes in K-12 education
- » Increase opportunities for adult financial education
- » Increase supportive employment opportunities
- » Scale Community Based Care – link folks with a CHW who can navigate

RESULT: Increase access to transportation through innovative partnerships

INDICATORS:
- » % public transportation use
- » # missed appointments due to transportation,
- » # traffic related accidents, injuries, and death
- » % streets walkable or bikable
- » % ADA accessible

STRATEGIES:
- » Complete Street road planning which welcomes non-car transportation and ADA accessibility.
- » Integrate individual and family transportation assessment at all points of care
- » Collaborate with transit partners across the region to ensure transportation patterns reflect geographical health access

RESULT: Improve education attainment

INDICATORS:
- » % Graduation rates
- » % School discipline rates
- » # Teacher-to-student representation ratios

STRATEGIES:
- » Champion education for school providers in trauma informed care
- » Place nurses and/or CHWs in school to assess children and families and link to services
- » Increase before and after school supportive services
- » Increase cultural competency trainings in school, and advocate for school leadership that is representative of student population

RESULT: Increase access to healthy, affordable food

INDICATORS:
- » # of people entering hospitals as malnourished,
- » % living in food desert
- » % average sugar intake

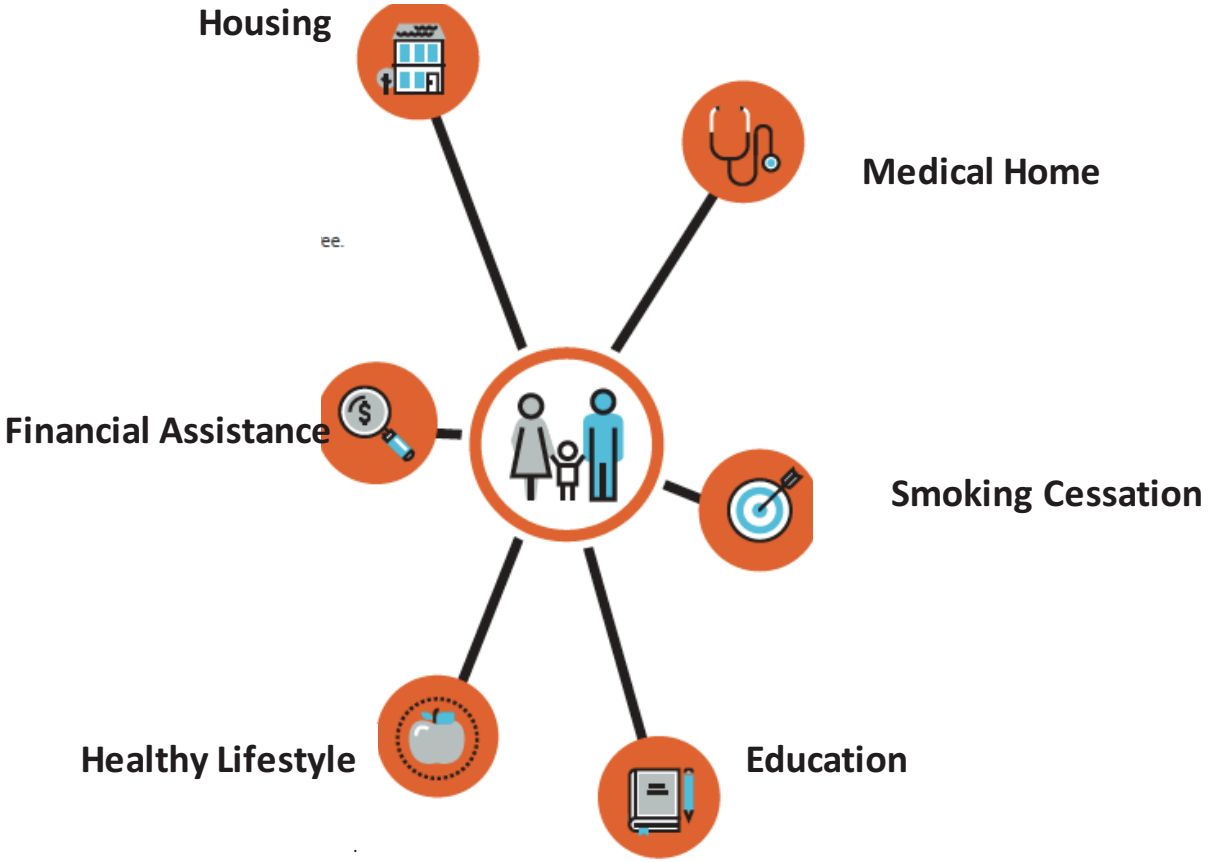
STRATEGIES:
- » Mobile markets bring healthy food to food deserts
- » Scratch cooking in all schools
- » Increase opportunity for meal prep education, for kids and adults
- » Increase community gardens and greenspaces to integrate food production in urban centers
- » Scale community based care using CHW to link folks to food service and meal support

RESULT: Increase community access to socially supportive peer-groups.

INDICATORS:
- » % with feeling of support (Community Survey)
- » # funding for community events
- » % households close to community gathering space

STRATEGIES:
- » Increase opportunities for "Meet Your Neighbors"
- » Increase community gathering spaces
- » Directory of community support venues and groups
- » Increase civics education to increase community knowledge of policy process

ACH Projects: Pathfinder Community Hub



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How does it work?

Meet Kathy

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Ferry County Pilot

Long Term Outcomes by December 2018:

(Ferry County Pilot)

Recidivism

- Reduction in recidivism in Ferry County Jail by 20% by December 2018 Ferry County recidivism rate is 62% (Ferry County data 2015) National statistics show that 43% of all inmates return to prison within three years of their release (Pew, 2011) Ferry County is 274% higher incarcerated than Washington State average (Vera.org, 2013)

Cost

- Reduction in cost of providing jail health services in Ferry County by 20% by December 2018 Annual County Budget $2million / Annual Jail Budget $800,000 / Annual Jail Health Services $45,000 (Ferry County data 2015)

ED Diversion

- Reduction of emergency department utilization for ambulatory sensitive conditions in target population in Ferry County from 20% to 16% of all ED visits by December 2018 (both inmates and their families) National emergency department overuse is $38 billion in wasteful health care spending; 56% or roughly 67 million visits, are potentially avoidable. Significant Savings, average cost of an ED visit is $580 more than the cost of an office health care visit (National Quality Forum, 2016)

Pathways:

- *Adult Education*
- *Behavioral Health*
- *Developmental Screening Pathway*
- *Education Pathway*
- *Employment Pathway*
- *Family Planning Pathway*
- *Health Insurance Pathway*
- *Housing Pathway*
- *Immunization Referral Pathway*
- *Medical Home Pathway*
- *Medical Referral Pathway*
- *Medication Management Pathway*
- *Smoking Cessation Pathway*
- *Social Service Referral Pathway*

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Questions?