better health together

Theory of Action

OUR VISION: An integrated community health system, accountable to improving health through delivering culturally competent, whole person care to all community members

Statewide Drivers of Systems Transformation

- Healthier Washington Initiative
- Shift to 90% Value Based Contracts by 2021
- Shift to Integrated Managed Care by 2020
- Upcoming changes to Medicare via MACRA/MIPS

Strengthen the Foundation

align energy and investment around regional strategies needed to support Whole Person Care, and success in Value Based care.

- Align with regional and statewide workforce development activities to increase capacity of the region's health workforce
- Effectively link health care transformation efforts with community services to support whole person care
- Integrate behavioral health and physical health payments through Integrated Managed Care
- Link and leverage data to monitor improvement and guide activities with a focus on health equity
- Retain less than a 5% uninsured rate, to ensure access to Whole Person Care

Improve Population Health

transformation activities build community infrastructure and scale best practice to support responsive, sustainable, systems improvement.

- Develop a Community Dashboard to monitor key population health priorities regionally across multiple payers, providers and measurements.
- Align ACO efforts throughout the region to leverage investment in Medicaid Transformation efforts and MACRA/MIPS reporting
- Align regional funders around a Community Resiliency Fund to address social determinants
- Reinvest shared savings with a focus on upstream prevention
- Connect siloed services into a continuum of care with "no wrong door" for patients
- Boost culturally competent and trauma informed care practices

Medicaid Transformation Projects

Demonstrate the Value of Whole Person Care

PROJECT	IMPACT POPULATIONS
Bi-Directional Integration of Behavioral and Physical Health	• Medicaid patients with both a Behavioral Health issue and chronic disease
Community Based Care Coordination	• People transitioning of jail • Pregnant women on Medicaid • Foster youth & youth exiting or aging out of foster care
Opioid Responses	• Medicaid beneficiaries who use, misuse, or abuse prescription opioids and/or heroin
Chronic Disease Management	• Medicaid adults with diabetes • Medicaid children with asthma • Medicaid beneficiaries with chronic behavioral health issues

COLLABORATIVE ACTIVITIES:

- Build and scale linkages between physical, oral, behavioral, and social determinant of health providers
- Prepare providers for value based payments
- Support population health management through proactive use of data to track progress and identify areas for improvement among partners
- Implement Care Coordination strategies to help complex patients overcome risks
- Align disparate community strategies into community based plans to improve population health outcomes around regional priorities

DESIRED REGIONAL IMPROVEMENTS

- ☑ 90% of Medicaid contracts are Value Based in 2021
- ☑ Implement regional plan to be ready for Integrated Managed Care by 2019
- ☑ Reduce Medicaid emergency department utilization by 6%
- ☑ Reduce hospital readmission rates for Medicaid by 2%
- ☑ Increase % of Medicaid residents who have their mental health treatment needs met by 10%
- ☑ Increase % of Medicaid residents who have substance use disorder needs met by 10%
- ☑ Train 25 Care Coordinators to the Pathways Hub model by December 2019
- ☑ Reduce # preventable hospital admissions for diabetes and asthma by 10%
- ☑ Increase % effective contraceptive use among Medicaid women by 50%
- ☑ Increase health workforce to meet health care demands
- ☑ Decrease jail recidivism by 20%
- ☑ All children in foster care will have at least one annual primary care visit
- ☑ 10% of Medicaid children receive fluoride varnish in a primary care setting
- ☑ Develop data sharing agreements amongst 90% of Collaborative members