Healthier Washington
Health Innovation Leadership Network Quarterly Meeting
9 a.m. to noon, Monday, January 30

Cambia Grove | Suite 250 | 1800 9th Avenue | Seattle
Public listen-only webinar access: https://attendee.gotowebinar.com/register/3885236866589909508

Agenda

Meeting Objectives:

- Reflect on Health Innovation Leadership Network accomplishments and role as accelerators and ambassadors over the last two years;
- Agree on HILN priorities and action for the next year.

9:00 a.m. Welcome and Introductions
Rick Cooper, Health Innovation Leadership Network Co-chair

9:30 a.m. Healthier Washington Update
Nathan Johnson, Healthier Washington Coordinator

10:00 a.m. Spotlight On: Healthier Washington Accelerator Committee Recommendations

- Clinical Engagement Accelerator Committee | *Paul Hayes, committee co-champion & Ginny Weir, committee staff*
- Communities & Equity Accelerator Committee | *Antony Chiang & Winfried Danke, committee co-champions*

10:30 a.m. Break

10:40 a.m. Spotlight On: Healthier Washington Accelerator Committee Recommendations

- Rural Health Innovation Accelerator Committee | *Nicole Bell & Andre Fresco, committee co-champions*
- Collective Responsibility Accelerator Committee | *Kathleen Paul & David Wertheimer, committee co-champions*

11:15 a.m. Spread, Perform, Sustain: HILN's Evolving Acceleration Role
Rick Cooper & Nathan Johnson

- Accelerator Committee recommendations

11:45 a.m. Next Steps
Rick Cooper

- Items for the good of the order
- HILN 2017-2019 membership and meetings
- Meeting evaluation and agenda topics for future meetings

12:00 p.m. Adjourn

Thank you to Cambia Grove for hosting today's Health Innovation Leadership Network meeting.

Health Innovation Leadership Network Roster

Name	Organization
Dorothy Teeter, Co-Chair	Health Care Authority
Rick Cooper, Co-Chair	The Everett Clinic
Chris Ackerley	Ackerley Partners, LLC
Peter Adler	Molina Healthcare Washington, Inc.
Teresita Batayola	International Community Health Services
Randi Becker	Washington State Senate
Nicole Bell	Cambia Grove
Diana Birkett Rakow	Group Health Cooperative
Brian Bonlender	Department of Commerce
Marty Brown	State Board of Community and Technical Colleges
Antony Chiang	Empire Health Foundation
Ann Christian	Community Mental Health Council
Eileen Cody	House of Representatives
Sean Corry	Sprague Israel Giles, Inc.
Bob Crittenden	Office of the Governor
Winfried Danke	CHOICE Regional Health Network
Regina Delahunt	Whatcom County Health and Human Services
Greg Devereux	Washington Federation of State Employees
Sue Elliott	Arc of Washington
Michael Erikson	Neighborcare Health
Andre Fresco	Yakima Health District
Nancy Giunto	Washington Health Alliance
Mike Glenn	Jefferson Healthcare, Port Townsend

Health Innovation Leadership Network Roster

Name	Organization
Amy Morrison Goings	Lake Washington Institute of Technology
Paul Hayes	Harborview Medical Center
Ross Hunter	Department of Early Learning
Uriel Iniguez	Washington Commission on Hispanic Affairs
Nancy Johnson	Colville Business Council
Mike Kreidler	Office of the Insurance Commissioner
Patricia Lashway	Department of Social and Health Services
Pam MacEwan	Health Benefits Exchange
Tom Martin	Lincoln Hospital and North Basin Medical Clinics
Todd Mielke	Spokane County
Peter Morgan	Family Health Centers
Steve Mullin	Washington Roundtable
Diane Narasaki	Asian Counseling and Referral Service
Dan Newell	Office of the Superintendent for Public Instruction
Diane Oakes	Washington Dental Service Foundation
Richard Pannkuk	Office of Financial Management
Gail Park Fast	Educational Service District 105
Kathleen Paul	Virginia Mason Medical Center
Chris Rivera	WA Biotechnology and Biomedical Association
David Rolf	SEIU 775 NW
Joe Roszak	Kitsap Mental Health Services
Bill Rumpf	Mercy Housing Northwest
Peter Rutherford	Confluence Health, Wenatchee
Joel Sacks	Department of Labor and Industries

Health Innovation Leadership Network Roster

Name	Organization
Marilyn Scott	Upper Skagit Indian Tribe
Jill Sells	Reach Out and Read Washington State
Preston Simmons	Providence Regional Medical Center
Diane Sosne	SEIU 1199 NW
Aren Sparck	Seattle Indian Health Board
Hugh Straley	Dr. Robert Bree Collaborative
Jurgen Unutzer	University of Washington, Department of Psychiatry
Joe Valentine	North Sound Accountable Community of Health
Janet Varon	Northwest Health Law Advocates
Ron Vivion	Washington State Council on Aging
Rick Weaver	Central Washington Comprehensive Mental Health
David Wertheimer	Gates Foundation, Pacific Northwest Initiative
Caroline Whalen	King County
John Wiesman	Department of Health

Health Innovation Leadership Network Accelerator Committees Update

Health Innovation Leadership Network (HILN) Accelerator Committees focus on specific and timely efforts that directly impact and drive toward the achievement of Healthier Washington's measures of success.

HILN Accelerator Committees:

- Accelerate the goals and objectives of Healthier Washington versus advising on policy and operational components of the initiative.
- Evolve, expand and disperse over time as Healthier Washington itself evolves in response to rapid-cycle learning and improvement.
- Build upon existing efforts and groups already in place.
- Are championed by HILN members, with membership including leadership from HILN and non-HILN organizations.

One year after the creation of the Accelerator Committees, this update provides an overview of lessons learned, proposed next steps, and activities and efforts of each Accelerator Committee.

Healthier Washington Accelerator Committees: 2016 Themes and Lessons Learned

Key to success in achieving Healthier Washington's aims is the public-private HILN, comprised of providers, business, health plans, consumers, community entities, governments, tribal entities and other key sectors to accelerate the initiative's efforts. Transformative, lasting changes requires focused and collaborative engagement of the public and private sectors working toward mutual goals.

In addition to HILN's overarching role as accelerators of culture change and Healthier Washington ambassadors, the Leadership Network created HILN subcommittees, called "accelerator committees." The HILN Accelerator Committees focus on specific and timely efforts that directly impact and drive toward the achievement of Healthier Washington's aims.

The Accelerator Committees formed in 2016 were:

- **Healthier Washington Clinical Engagement Accelerator Committee**: Accelerate provider commitment to and adoption of Healthier Washington aims and strategies.
- **Healthier Washington Communities and Equity Accelerator Committee**: Ensure Healthier Washington's guiding principle to improve health equity is a focus in community health improvement activities. Support and implement state- and community-level strategies, particularly as Accountable Communities of Health are in early phases of development.
- **Healthier Washington Integrated Physical and Behavioral Health Accelerator Committee**: Accelerate the transition to fully integrated care systems by leveraging cross-sector action.
- **Healthier Washington Rural Health Innovation Accelerator Committee**: Accelerate the uptake and spread of value-based payment and delivery models in the state's rural communities, and influence the uptake of rural health innovations that support these models.

- **Healthier Washington Collective Responsibility Accelerator Committee**: Promote the concept of shared accountability and collective impact in achieving the aims of Healthier Washington.

In 2016, each of the Accelerator Committees had a cross-cutting purpose foundational to the success of all Healthier Washington efforts. Given the systems change envisioned under Healthier Washington, elements such as equity and whole-person health, and engagement of specific populations or sectors are key in the achievement of better care, smarter spending and healthier populations. Additionally, each Accelerator Committee ensured statewide and community foci for their proposed audiences and action. As noted below in each of the Accelerator Committee activity summaries, a lot of focus was placed on supporting those participating in Accountable Communities of Health as well as statewide organizations such as associations. Other discussion themes include:

- **Collaboration**. There is need to identify, invest in and empower thought leaders. This is impactful in all forums, e.g. from technological innovation and implementation to provider training and support. Policies that give flexibility to and encourage virtuous cycles of collaborative efforts should be explored and invested in.
- **Data**. The more we can advance integration, transparency and interoperability, the better. Underlining many conversations across Accelerator Committees was the need for data. Fundamentally, even when data is accessible it is often not in the form of information, the cost and technical expertise required to make data usable is a large barrier many populations and sectors.

The first year of Accelerator Committee activity revealed several learnings around committee process and structure, which can guide HILN in determining next steps for Accelerator Committees. The Accelerator Committee model was developed as a test with the intention to evolve, expand and disperse committees over time. One of the more significant takeaways from Accelerator Committee activity is that a project-based effort may not be the most effective mechanism for cross-sector leadership acceleration of health system transformation. While all Accelerator Committees produced valuable outputs, the committees that likely will endure as accelerator groups identified gaps in current efforts that require public-private, multisector engagement, and identified existing avenues to individually and collectively address those gaps. Additionally, in order to effectively and consistently engage leaders with competing priorities across the state, significant resources are required to staff the committees and provide materials and tools to serve as ambassadors and accelerators.

The deliverables each Accelerator Committee provided, as outlined below, advance the state's efforts in achieving a healthier Washington. Beyond these outputs, the benefit of all of the committees was a structure that allowed for a greater level of leadership connecting. Accelerator Committee members noted that this forum advanced their levels of knowledge and agility in connecting with other leaders across the state to advance their own organizations' efforts and mutual goals under Healthier Washington. In extending this forum beyond HILN membership, an extended network of leaders across the state were connected and activated. This extended sub-committee model allowed sectors that may not normally work together to do so, and revealed leaders critical to the Healthier Washington effort who may not have been actively engaged to date.

Moving forward, it is recommended that HILN and the extended leadership network of Accelerator Committee members consider, take action on and continue to promote the recommendations and work of all committees. HILN should consider continuing to support a formal, evolved committee structure for those Accelerator Committees filling critical gaps in the Healthier Washington effort and that have identified strategies to collectively address those gaps. For Accelerator Committees not filling this

evolved role, it is recommended that HILN collectively proceed with the recommendations and messages of those committees while dispersing the formal committee structure. All Accelerator Committee members should be considered for continued leadership roles as accelerators and ambassadors of Healthier Washington.

Healthier Washington Clinical Engagement Accelerator Committee

Co-champions: Hugh Straley, Bree Collaborative, and Paul Hayes, Harborview Medical Center

The intent of the Healthier Washington Clinical Engagement Accelerator Committee is to engage clinical leadership and providers in Healthier Washington opportunities to advance the development of integrated, value-based delivery systems linked to community supports to improve population health.

Goals of the committee are to engage providers across Washington state in Healthier Washington initiatives that:

- Integrate the delivery of physical and behavioral health;
- Link clinical practice systems to community-based services to provide care that focuses on the whole person;
- Better engage patients and families in health care decisions through shared decision making strategies;
- Build organizational capacity to move to a value-based delivery system; and
- Support the shift away from traditional health system methodologies to the adoption of evidence-based and innovative practices that allow for the delivery of high-quality, value-based health care.

In 2016 the committee developed and dispersed a survey among committee members to identify current practices at their respective organization to identify overlap, gaps, and areas of opportunity. The results were used to identify key areas where the committee felt they could provide direct/indirect support to engage providers in practice transformation activities. Those areas are:

- Identifying gaps between current clinical practices and pathways to the adoption of recommended innovative practices, including strategies to reduce barriers to implementation of integration of behavioral/physical health and value-based purchasing. Some of the key gaps/barriers include:
    - Universal understanding of VBP
    - Need for adequate data
    - Initial resources needed to build infrastructure
- Supporting practices during transition to new value-based payment structures.
- Sharing best practices to assist clinics integrating behavioral health into primary care.

The committee is in the process of drafting materials for use by communities, statewide partners, committee members and the HILN to demonstrate the barriers practices may be facing that may cause challenges to implementing new payment models or integration of care. The materials may include:

- A fact sheet of the Clinical Engagement Accelerator Committee, talking points for members, and a list of committee members the ACHs could reach out to in their region to attend events to speak to providers. The committee discussed the concept, expressing interest but agreed this provides an opportunity for recruitment of broader membership to ensure adequate representation within ACHs.

- Other fact sheets and visual materials that address the three priority areas of the Practice Transformation Support Hub – Journey to VBP – what are enablers/barriers and what are common needs; BH integration – what are the enablers, clinical-community linkages

In 2017, it is recommended that the committee continue to meet, as they can fill a key role of helping providers engage with practice transformation activities through the Practice Transformation Support Hub and ACHs. The committee recognizes the need to coordinate with Hub activities, as well as other practice transformation activities co-occurring in order to avoid provider "transformation fatigue." The committee feels they can provide assistance/resources to providers to help them make sense of how all of these initiatives align and what the value add is for them.

Clinical Engagement Accelerator Committee

Name	Organization
Hugh Straley, Co-Champion	Bree Collaborative
Paul Hayes, Co-Champion	Harborview Medical Center
Chris Barton	SEIU Nurse Alliance NW
Richard Bryan	Overlake Medical Center
Tony Butruille	Washington Academy of Family Physicians
Phyllis Cavens	Child and Adolescent Clinic, Longview
Eileen Cody	House of Representatives
Lori Cohen	Community Health Plan of Washington
Sharon Eloranta	Qualis Health
John Espinola	Premera BlueCross
Bob Farrell	CHC of Snohomish County
Charissa Fotinos	Health Care Authority/DSHS
Ingrid Gerbino	Virginia Mason Medical Center
Holly Greenwood	Rural Health Collaborative
James Kaech	WACMHC
Lynn Kimball	Aging and Long Term Care of Eastern Washington
Sarah Koca	CHAS Health
Michael Maples	Community Health of Central WA
Hiroshi Nakano	UW Medicine/Valley Medical Center
Bob Perna	Washington State Medical Association
Donna Poole	Kitsap Mental Health
Jeanne Rupert	Public Health – Seattle and King County
Bruce Smith	Regence BlueShield
Sarah Stacy	Community Health Plan of Washington
Sean Trafficante	Mt. Baker Planned Parenthood
Carol Wagner	Washington State Hospital Association
Dylan Dressler	Lower Elwha Klallam Tribe
Laura Pennington, Committee Staff	Health Care Authority
Ginny Weir, Committee Staff	Bree Collaborative

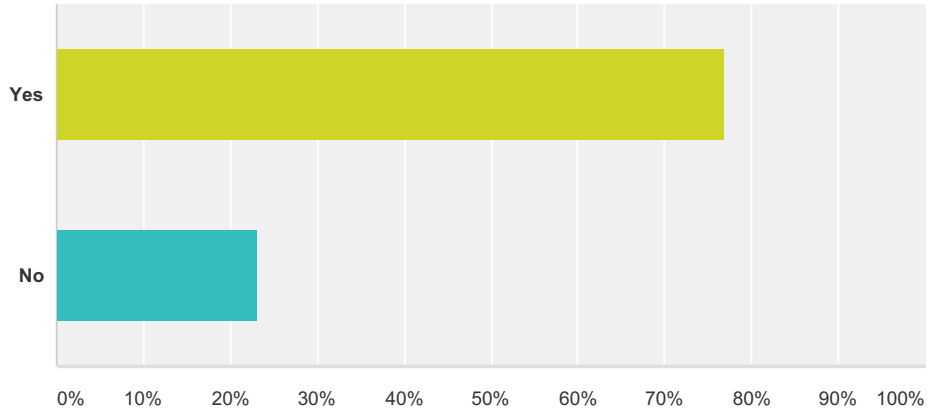
Q1 Please provide the name of your organization and names of affiliates and facilities under your ownership.

Answered: 14 Skipped: 0

#	Responses	Date
1	CHC of Snohomish county	8/2/2016 4:36 PM
2	Aging & Long Term Care of Eastern Washington	8/2/2016 2:58 PM
3	Virginia Mason Medical Center	7/27/2016 3:20 PM
4	Virginia Mason Medical Center	7/27/2016 3:08 PM
5	Cascade Medical, Leavenworth	7/26/2016 2:09 PM
6	Kitsap Mental Health Services	7/25/2016 3:06 PM
7	Qualis Health	7/25/2016 2:46 PM
8	Community Health Plan of Washington	7/19/2016 1:39 PM
9	Washington State Hospital Association	7/12/2016 8:39 PM
10	James Kaech WACMHC	7/11/2016 8:57 AM
11	Harborview Medical Center. Owned by King County, staffed and managed by the University of Washington.	7/11/2016 8:27 AM
12	Mt Baker Planned Parenthood Bellingham Mt Vernon Friday Harbor	7/10/2016 10:06 PM
13	Overlake Medical Center Overlake Medical Clinics Overlake Provider Network	7/9/2016 11:32 AM
14	Community Health of Central Washingtion: Central Washington Family Medicne and CWFM Residency; Yakima Pediatrics; Naches Medical Clinic; CHCW Ellensburg Clinic; Ellensburg Dental Care; Highland Clinic; Senior & Residential Care; Senior Smiles	7/8/2016 7:51 PM

Q2 Are clinicians a part of your organization's leadership structure?

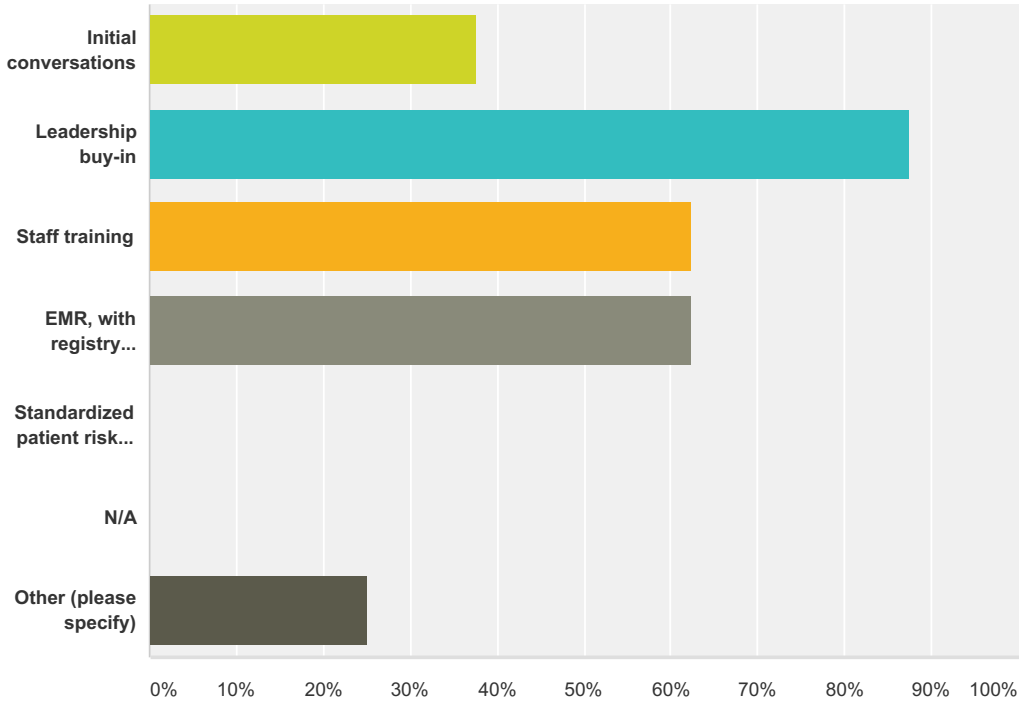
Answered: 13 Skipped: 1



Answer Choices	Responses	
Yes	**76.92%**	10
No	**23.08%**	3
Total		**13**

Q3 Infrastructure: What investments in infrastructure has your organization made to prepare for practice transformation (e.g., new payment systems, behavioral health integration)

Answered: 8 Skipped: 6

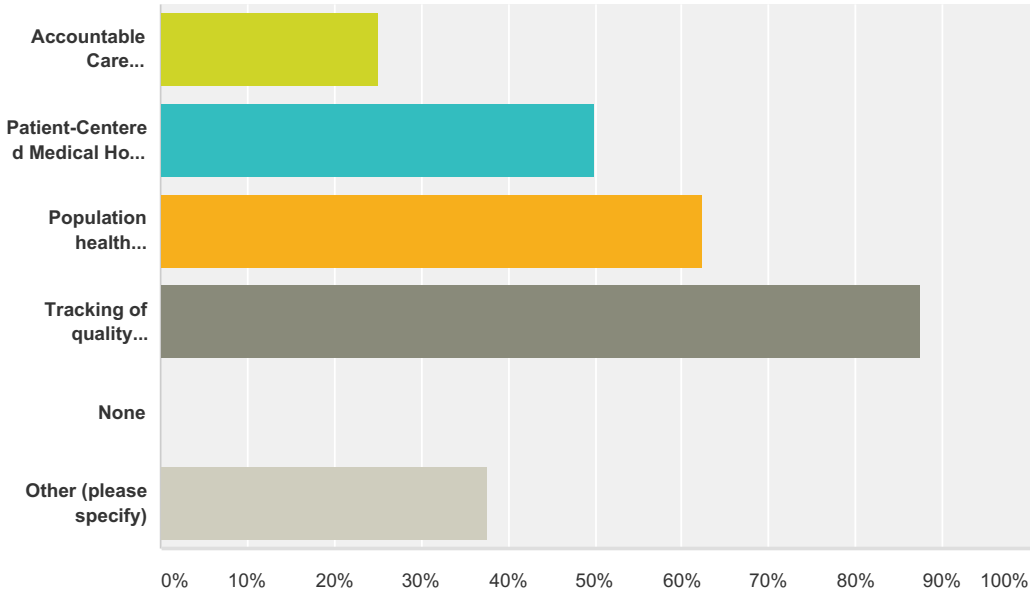


Answer Choices	Responses	
Initial conversations	**37.50%**	3
Leadership buy-in	**87.50%**	7
Staff training	**62.50%**	5
EMR, with registry feature to track population health and quality indicators	**62.50%**	5
Standardized patient risk assessment (e.g., of social determinants of health)	**0.00%**	0
N/A	**0.00%**	0
Other (please specify)	**25.00%**	2
Total Respondents: 8		

#	Other (please specify)	Date
1	Clinical Integration Solution (claims & EHR) to drive analytics	7/19/2016 1:39 PM
2	Part of our strategic plan	7/12/2016 8:39 PM

Q4 Process: Is your organization participating in the following to prepare for new payment systems that provide incentives for demonstrated improvement in patient health outcomes:

Answered: 8 Skipped: 6

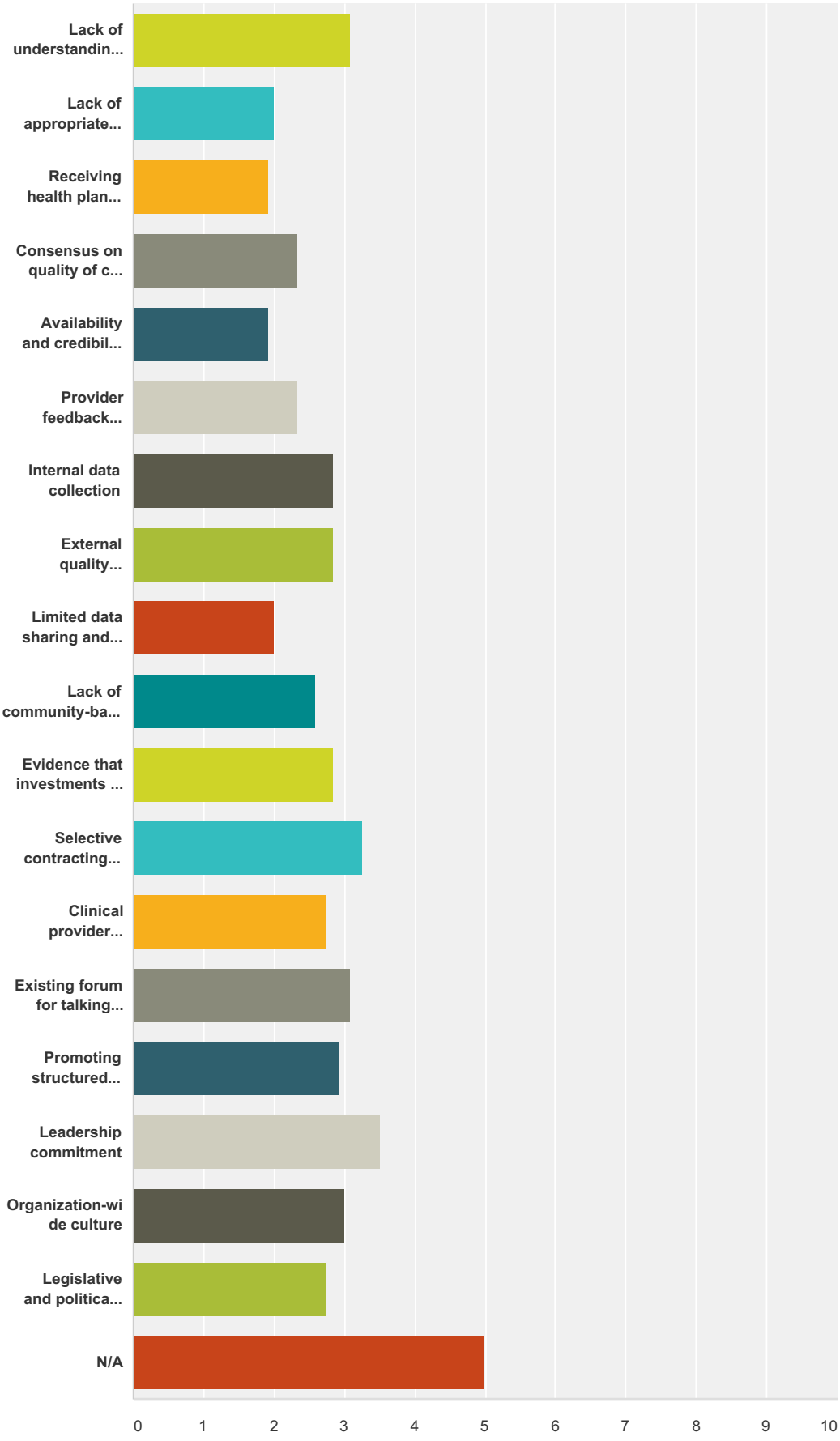


Answer Choices	Responses	
Accountable Care Organization or Program	**25.00%**	2
Patient-Centered Medical Home Model (PCMH)	**50.00%**	4
Population health management	**62.50%**	5
Tracking of quality indicators	**87.50%**	7
None	**0.00%**	0
Other (please specify)	**37.50%**	3
Total Respondents: 8		

#	Other (please specify)	Date
1	early stages of above, working with Healthy Hearts NW	7/26/2016 2:12 PM
2	We were on track for population health management until financial barriers	7/25/2016 3:12 PM
3	MACRA, CMS Value Based Purchasing	7/12/2016 8:44 PM

Q5 Barriers: From the following list please rank each of the following as barriers to adoption of value-based purchasing

Answered: 13 Skipped: 1

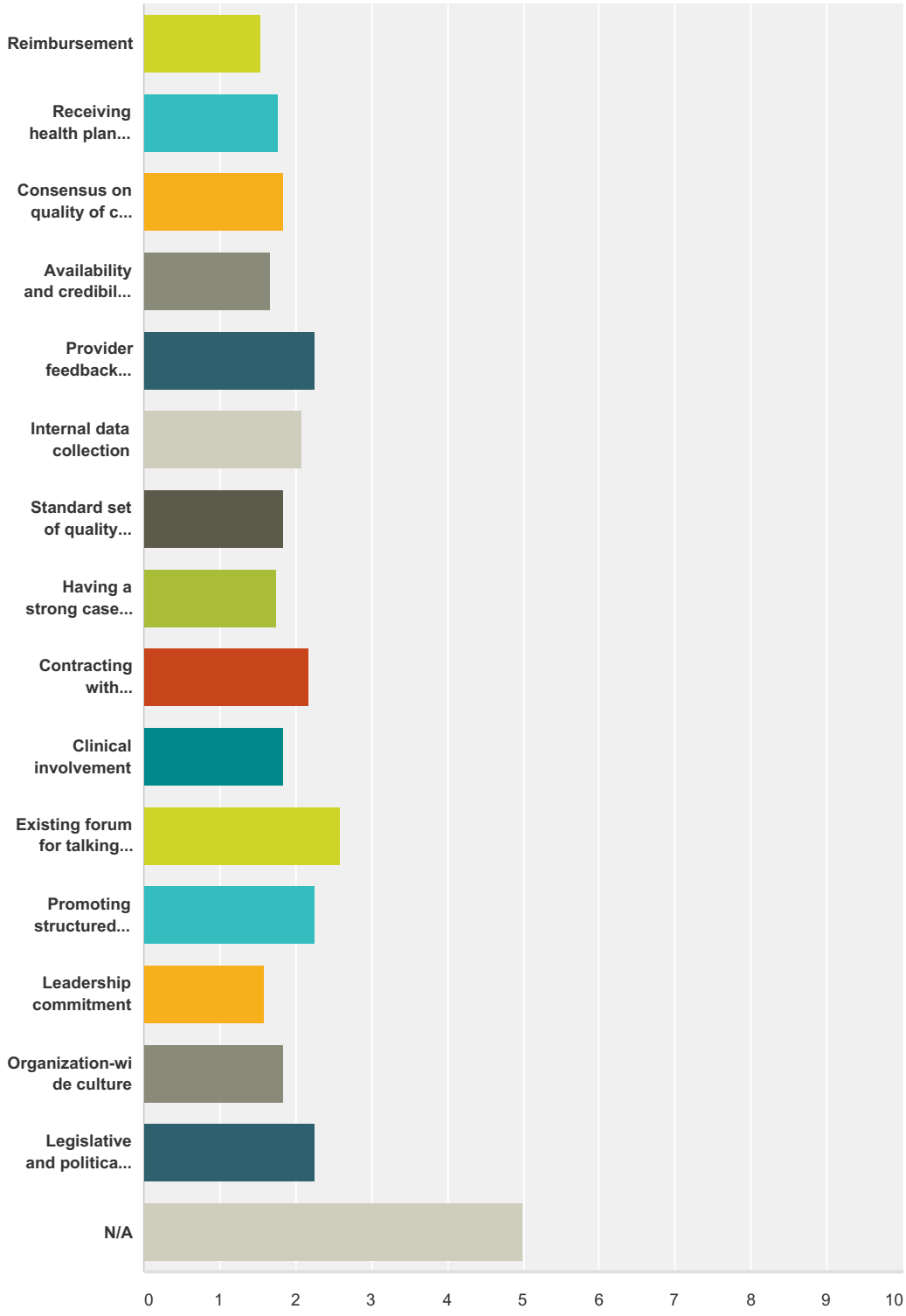

Lack of understandin...
Lack of appropriate...
Receiving health plan...
Consensus on quality of c...
Availability and credibil...
Provider feedback...
Internal data collection
External quality...
Limited data sharing and...
Lack of community-ba...
Evidence that investments ...
Selective contracting...
Clinical provider...
Existing forum for talking...
Promoting structured...
Leadership commitment
Organization-wide culture
Legislative and politica...
N/A
0
1
2
3
4
5
6
7
8
9
10

	1-strong barrier	2-medium barrier	3-slight barrier	4-not a barrier	N/A	Total	Weighted Average
Lack of understanding of VBP	**0.00%** 0	**16.67%** 2	**58.33%** 7	**25.00%** 3	**0.00%** 0	12	3.08
Lack of appropriate reimbursement mechanism	**41.67%** 5	**33.33%** 4	**16.67%** 2	**0.00%** 0	**8.33%** 1	12	2.00
Receiving health plan data/Giving health plan data to clinics	**30.77%** 4	**46.15%** 6	**23.08%** 3	**0.00%** 0	**0.00%** 0	13	1.92
Consensus on quality of care definitions	**25.00%** 3	**25.00%** 3	**41.67%** 5	**8.33%** 1	**0.00%** 0	12	2.33
Availability and credibility of data	**41.67%** 5	**33.33%** 4	**16.67%** 2	**8.33%** 1	**0.00%** 0	12	1.92
Provider feedback mechanisms	**16.67%** 2	**50.00%** 6	**16.67%** 2	**16.67%** 2	**0.00%** 0	12	2.33
Internal data collection	**0.00%** 0	**33.33%** 4	**50.00%** 6	**16.67%** 2	**0.00%** 0	12	2.83
External quality indicator reporting	**0.00%** 0	**41.67%** 5	**33.33%** 4	**25.00%** 3	**0.00%** 0	12	2.83
Limited data sharing and interoperability	**38.46%** 5	**30.77%** 4	**23.08%** 3	**7.69%** 1	**0.00%** 0	13	2.00
Lack of community-based nurses	**25.00%** 3	**25.00%** 3	**25.00%** 3	**16.67%** 2	**8.33%** 1	12	2.58
Evidence that investments in VBP worthwhile	**0.00%** 0	**25.00%** 3	**66.67%** 8	**8.33%** 1	**0.00%** 0	12	2.83
Selective contracting with high-quality partners	**8.33%** 1	**8.33%** 1	**50.00%** 6	**16.67%** 2	**16.67%** 2	12	3.25
Clinical provider involvement in planning VBP activities	**8.33%** 1	**33.33%** 4	**33.33%** 4	**25.00%** 3	**0.00%** 0	12	2.75
Existing forum for talking about quality and VBP.	**16.67%** 2	**0.00%** 0	**41.67%** 5	**41.67%** 5	**0.00%** 0	12	3.08
Promoting structured programs for minimizing errors and waste.	**0.00%** 0	**33.33%** 4	**41.67%** 5	**25.00%** 3	**0.00%** 0	12	2.92
Leadership commitment	**0.00%** 0	**25.00%** 3	**0.00%** 0	**75.00%** 9	**0.00%** 0	12	3.50
Organization-wide culture	**0.00%** 0	**33.33%** 4	**33.33%** 4	**33.33%** 4	**0.00%** 0	12	3.00
Legislative and political limitations (e.g., HIPAA)	**8.33%** 1	**41.67%** 5	**25.00%** 3	**16.67%** 2	**8.33%** 1	12	2.75
N/A	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**100.00%** 1	1	5.00

#	Other (please specify)	Date
1	So many organizations doing Value Based Purchasing differently.	7/12/2016 8:44 PM
2	time and $$	7/8/2016 7:57 PM

Q6 Enablers: From the following list please rank each of the following factors as “enablers” or factors that help with adoption

Answered: 13 Skipped: 1

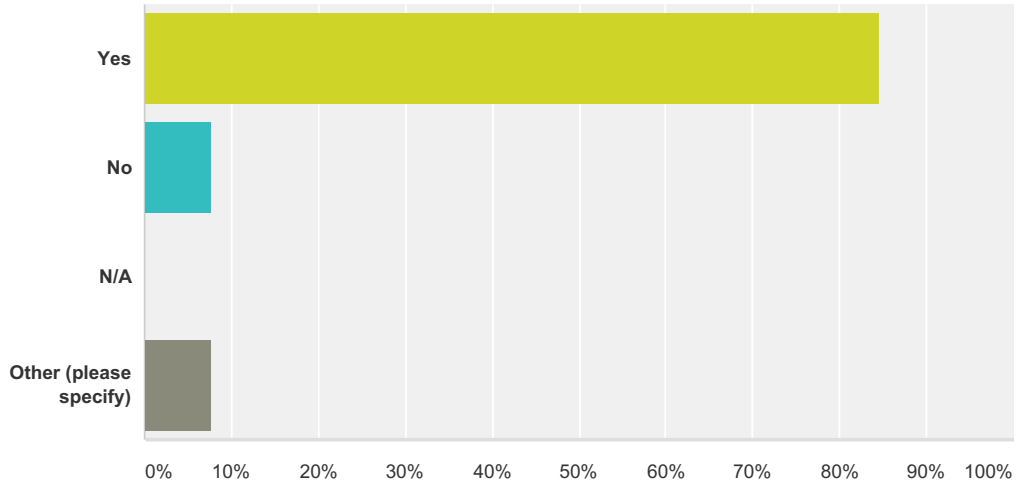


	1-strong enabler	2-medium enabler	3-slight enabler	4-not an enabler	N/A	Total	Weighted Average
Reimbursement	**76.92%** 10	**0.00%** 0	**15.38%** 2	**7.69%** 1	**0.00%** 0	13	1.54
Receiving health plan data/Giving health plan data to clinics	**46.15%** 6	**38.46%** 5	**7.69%** 1	**7.69%** 1	**0.00%** 0	13	1.77
Consensus on quality of care definitions	**41.67%** 5	**41.67%** 5	**8.33%** 1	**8.33%** 1	**0.00%** 0	12	1.83
Availability and credibility of data	**58.33%** 7	**25.00%** 3	**8.33%** 1	**8.33%** 1	**0.00%** 0	12	1.67
Provider feedback mechanisms	**25.00%** 3	**33.33%** 4	**33.33%** 4	**8.33%** 1	**0.00%** 0	12	2.25
Internal data collection	**25.00%** 3	**41.67%** 5	**33.33%** 4	**0.00%** 0	**0.00%** 0	12	2.08
Standard set of quality measures for external reporting	**33.33%** 4	**50.00%** 6	**16.67%** 2	**0.00%** 0	**0.00%** 0	12	1.83
Having a strong case that investments are worthwhile	**41.67%** 5	**41.67%** 5	**16.67%** 2	**0.00%** 0	**0.00%** 0	12	1.75
Contracting with high-quality partners	**33.33%** 4	**33.33%** 4	**16.67%** 2	**16.67%** 2	**0.00%** 0	12	2.17
Clinical involvement	**33.33%** 4	**50.00%** 6	**16.67%** 2	**0.00%** 0	**0.00%** 0	12	1.83
Existing forum for talking about quality and VBP	**8.33%** 1	**25.00%** 3	**66.67%** 8	**0.00%** 0	**0.00%** 0	12	2.58
Promoting structured programs for minimizing errors and waste	**16.67%** 2	**41.67%** 5	**41.67%** 5	**0.00%** 0	**0.00%** 0	12	2.25
Leadership commitment	**58.33%** 7	**33.33%** 4	**0.00%** 0	**8.33%** 1	**0.00%** 0	12	1.58
Organization-wide culture	**33.33%** 4	**58.33%** 7	**0.00%** 0	**8.33%** 1	**0.00%** 0	12	1.83
Legislative and political support	**33.33%** 4	**25.00%** 3	**33.33%** 4	**0.00%** 0	**8.33%** 1	12	2.25
N/A	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**100.00%** 1	1	5.00

#	Other (please specify)	Date
1	Need vision and direction for value based purchasing which is consistent at state and national level. It needs to link to the MACRA.	7/12/2016 8:44 PM

Q7 Is your organization producing and using timely data at the group/provider/patient level (quality, patient experience, utilization and cost) to continually evaluate and improve care?

Answered: 13 Skipped: 1

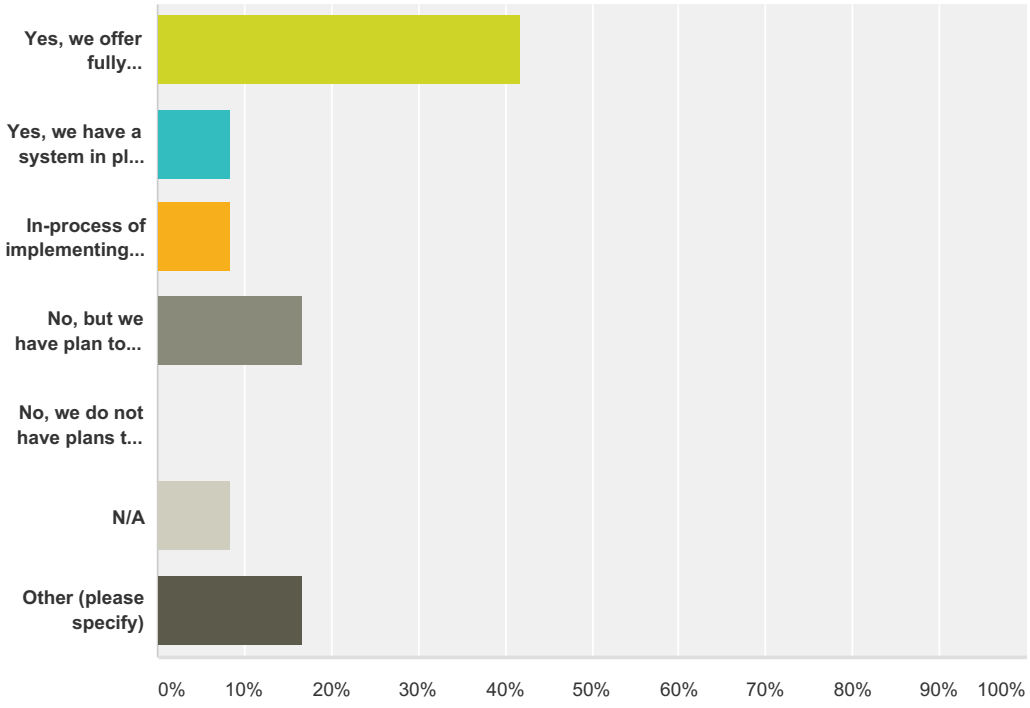


Answer Choices	Responses	
Yes	**84.62%**	11
No	**7.69%**	1
N/A	**0.00%**	0
Other (please specify)	**7.69%**	1
Total		**13**

#	Other (please specify)	Date
1	only timely data is internal data, so not always accurate as patients often receive care from providers outside of our system. payor data often lags and not timely enough to make meaningful clinical intervention. limited access to utilization and cost data.	7/27/2016 3:16 PM

Q8 Has your organization made steps to integrate behavioral health care into primary care or primary care into behavioral health care?

Answered: 12 Skipped: 2

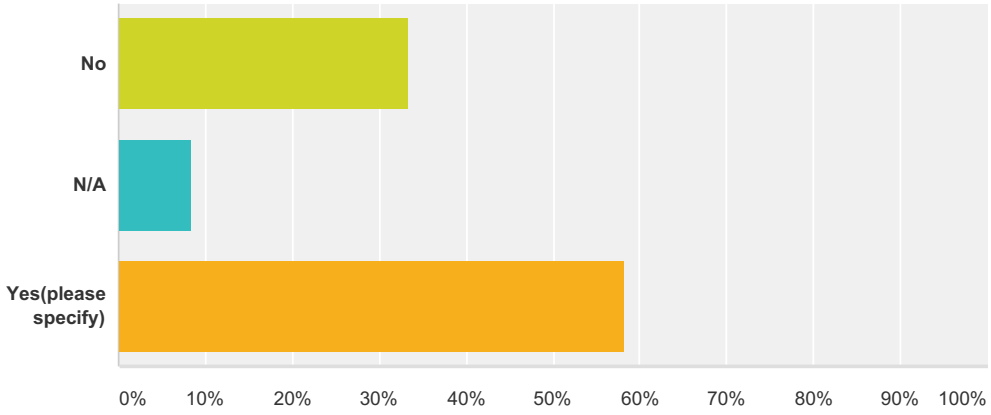


Answer Choices	Responses
Yes, we offer fully integrated (one treatment plan with behavioral and medical elements), co-located (medical services and behavioral health services located in the same facility) care	**41.67%** 5
Yes, we have a system in place to coordinate care outside of our organization	**8.33%** 1
In-process of implementing behavioral health integration plan	**8.33%** 1
No, but we have plan to move toward an integrated behavioral health model in the future	**16.67%** 2
No, we do not have plans to move toward an integrated behavioral health model	**0.00%** 0
N/A	**8.33%** 1
Other (please specify)	**16.67%** 2
Total	**12**

#	Other (please specify)	Date
1	Through our care management programs and support for PCMH, we provide services and education about how to integrate BH into PC and vice versa.	7/25/2016 3:09 PM
2	We have supported boards, CEOs, and clinicians to do behavioral health integration	7/12/2016 8:50 PM

Q9 Do you have an organizational definition for behavioral health integration?

Answered: 12 Skipped: 2

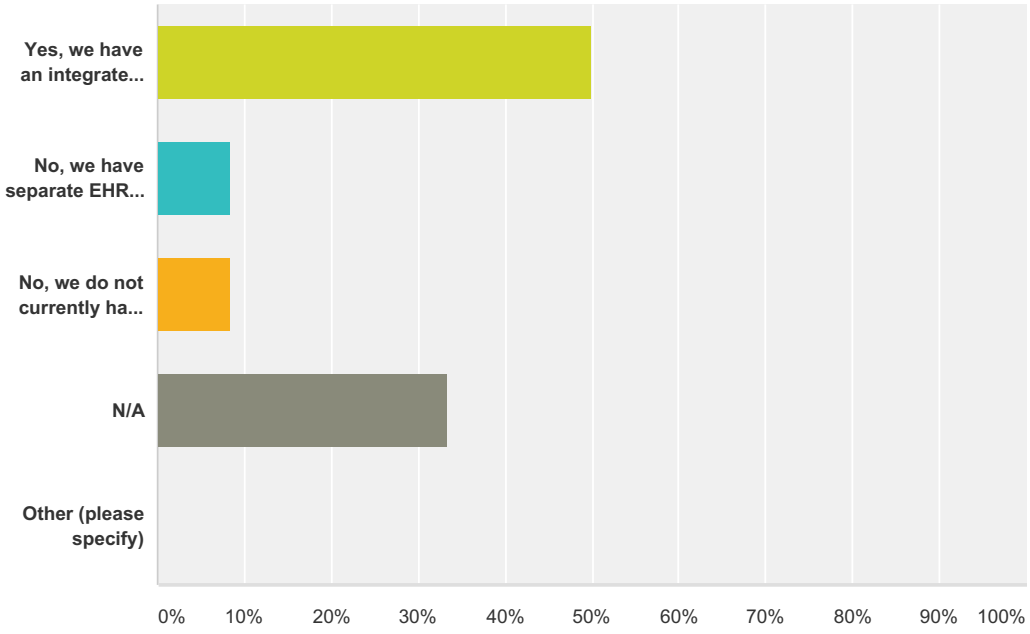


Answer Choices	Responses	
No	**33.33%**	4
N/A	**8.33%**	1
Yes(please specify)	**58.33%**	7
Total		**12**

#	Yes(please specify)	Date
1	colocate behavioral health specialists with primary care providers	7/27/2016 3:16 PM
2	right care, right place, right time to meet the Triple Aim	7/25/2016 3:20 PM
3	Pretty close to the one stated above - that BH and physical health cannot be separated in the true person centered medical home, as behavioral health affects physical health and vice versa. Services should be co-located if at all possible in the most efficient manner - e.g., use of BH liaison in the primary care practice, with availability of a psychiatrist for consults/backup. In BH setting, an ARNP or PA could be located in the clinic to manage physical health problems during a single visit.	7/25/2016 3:09 PM
4	Care and payment for behavioral and physical health services.	7/19/2016 1:43 PM
5	Delivery of care which supports mental and physician health.	7/12/2016 8:50 PM
6	Our definition includes routine screening and intervention with mental health professional who is imbedded within the clinic. Additonally development of telepsych is underway.	7/11/2016 8:39 AM
7	instant availability of warm hand-off to BHC, and closure	7/8/2016 8:01 PM

Q10 Does your organization have an integrated electronic health record (EHR) that includes both the medical record and behavioral health record?

Answered: 12 Skipped: 2

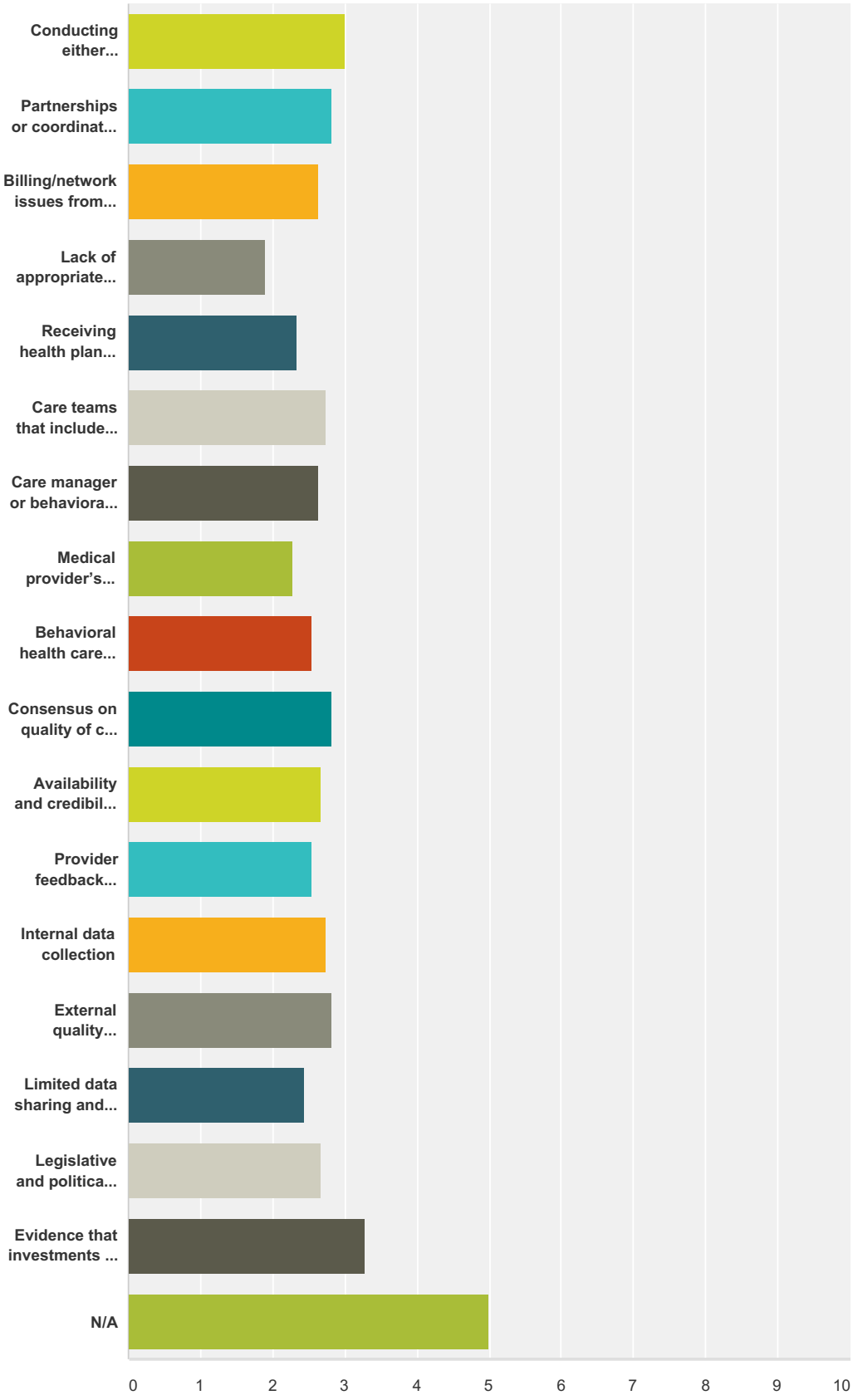


Answer Choices	Responses
Yes, we have an integrated EHR that allows us to share bi-directional information between both primary care and behavioral health providers in real time	**50.00%** 6
No, we have separate EHR systems, however we have a process for sharing information that we manually input into patient records	**8.33%** 1
No, we do not currently have a process for sharing patient information between both primary care and behavioral health providers	**8.33%** 1
N/A	**33.33%** 4
Other (please specify)	**0.00%** 0
Total	**12**

#	Other (please specify)	Date
	There are no responses.	

Q11 Barriers: From the following list please rank each of the following as barriers to integration of behavioral health

Answered: 13 Skipped: 1



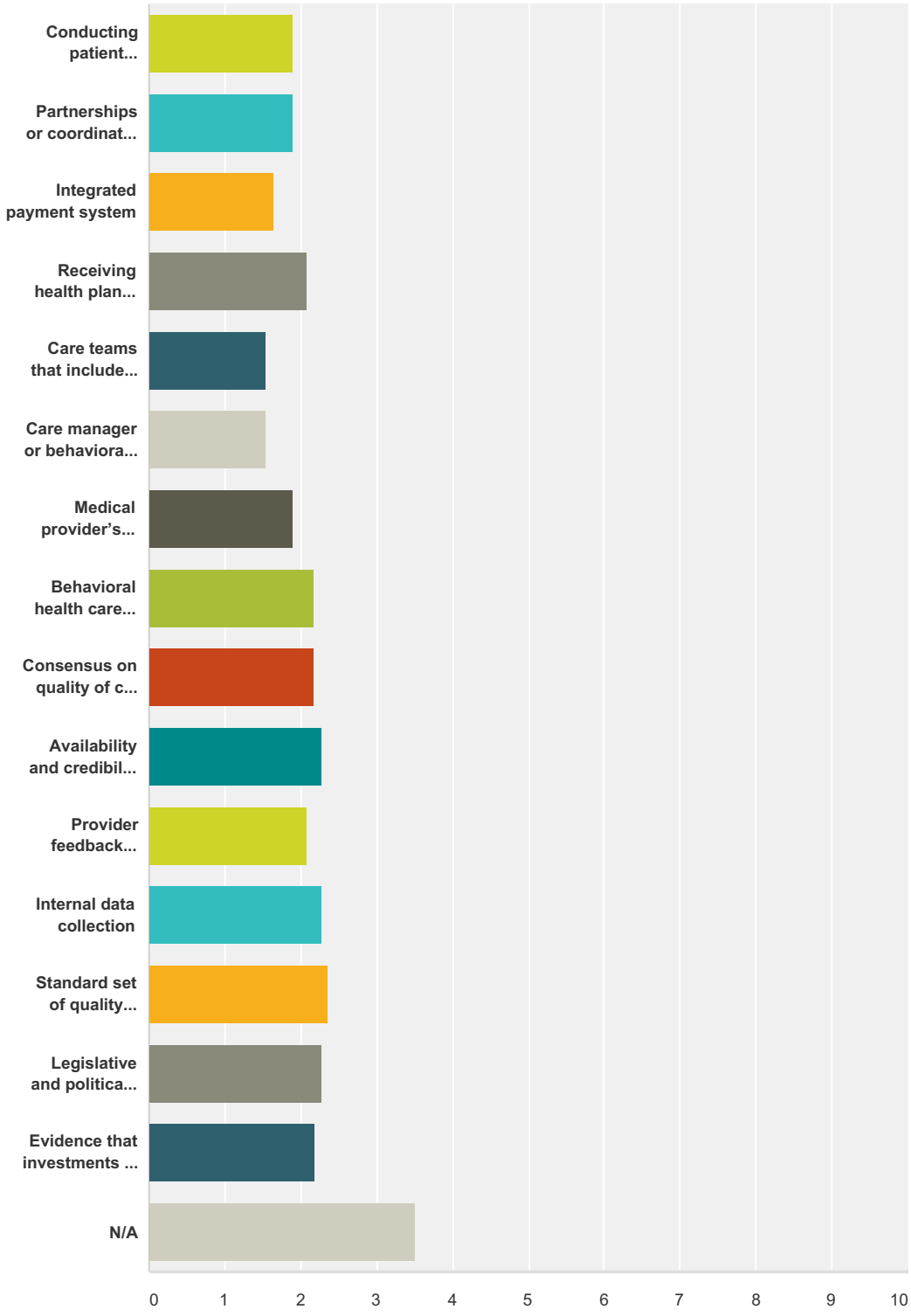
	1-strong barrier	2-medium barrier	3-slight barrier	4-not a barrier	N/A	Total	Weighted Average

Conducting either behavioral and physical health screening assessments	**0.00%** 0	**36.36%** 4	**36.36%** 4	**18.18%** 2	**9.09%** 1	11	3.00
Partnerships or coordination with community resources	**0.00%** 0	**45.45%** 5	**36.36%** 4	**9.09%** 1	**9.09%** 1	11	2.82
Billing/network issues from health plans	**36.36%** 4	**9.09%** 1	**18.18%** 2	**27.27%** 3	**9.09%** 1	11	2.64
Lack of appropriate reimbursement mechanism.	**54.55%** 6	**27.27%** 3	**0.00%** 0	**9.09%** 1	**9.09%** 1	11	1.91
Receiving health plan data/Giving health plan data to clinics	**25.00%** 3	**41.67%** 5	**16.67%** 2	**8.33%** 1	**8.33%** 1	12	2.33
Care teams that include behavioral health personal	**18.18%** 2	**18.18%** 2	**45.45%** 5	**9.09%** 1	**9.09%** 1	11	2.73
Care manager or behavioral health specialist to follow-up with patients	**18.18%** 2	**27.27%** 3	**36.36%** 4	**9.09%** 1	**9.09%** 1	11	2.64
Medical provider’s ability to deal with behavioral health care issues	**27.27%** 3	**45.45%** 5	**9.09%** 1	**9.09%** 1	**9.09%** 1	11	2.27
Behavioral health care provider’s ability to deal with medical care issues	**36.36%** 4	**9.09%** 1	**27.27%** 3	**18.18%** 2	**9.09%** 1	11	2.55
Consensus on quality of care definitions	**18.18%** 2	**18.18%** 2	**36.36%** 4	**18.18%** 2	**9.09%** 1	11	2.82
Availability and credibility of data	**16.67%** 2	**33.33%** 4	**33.33%** 4	**0.00%** 0	**16.67%** 2	12	2.67
Provider feedback mechanisms	**18.18%** 2	**27.27%** 3	**45.45%** 5	**0.00%** 0	**9.09%** 1	11	2.55
Internal data collection	**9.09%** 1	**36.36%** 4	**36.36%** 4	**9.09%** 1	**9.09%** 1	11	2.73
External quality reporting	**9.09%** 1	**36.36%** 4	**27.27%** 3	**18.18%** 2	**9.09%** 1	11	2.82
Limited data sharing and interoperability	**27.27%** 3	**27.27%** 3	**27.27%** 3	**9.09%** 1	**9.09%** 1	11	2.45
Legislative and political limitations (e.g., 42 CFR)	**33.33%** 4	**16.67%** 2	**25.00%** 3	**0.00%** 0	**25.00%** 3	12	2.67
Evidence that investments in behavioral health Integration are worthwhile	**0.00%** 0	**27.27%** 3	**27.27%** 3	**36.36%** 4	**9.09%** 1	11	3.27
N/A	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**100.00%** 1	1	5.00

#	Other (please specify)	Date
1	Payment for services related to: drug addiction, homelessness,	7/12/2016 8:50 PM

Q12 Enablers: From the following list please rank each of the following factors as “enablers” or factors that help with integration of behavioral health

Answered: 11 Skipped: 3

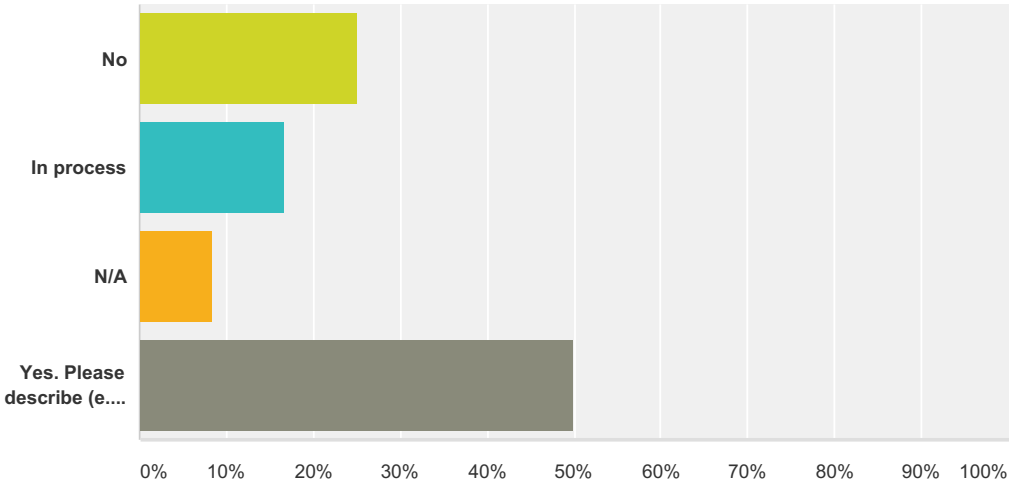


	1-strong enabler	2-medium enabler	3-slight enabler	4-not an enabler	N/A	Total	Weighted Average
Conducting patient assessments (either behavioral health assessments within primary care or physical health assessments within behavioral health care)	**54.55%** 6	**18.18%** 2	**18.18%** 2	**0.00%** 0	**9.09%** 1	11	1.91
Partnerships or coordination with community resources	**54.55%** 6	**18.18%** 2	**18.18%** 2	**0.00%** 0	**9.09%** 1	11	1.91
Integrated payment system	**72.73%** 8	**9.09%** 1	**9.09%** 1	**0.00%** 0	**9.09%** 1	11	1.64
Receiving health plan data/Giving health plan data to clinics	**36.36%** 4	**36.36%** 4	**18.18%** 2	**0.00%** 0	**9.09%** 1	11	2.09
Care teams that include dedicated behavioral health personal	**72.73%** 8	**18.18%** 2	**0.00%** 0	**0.00%** 0	**9.09%** 1	11	1.55
Care manager or behavioral health specialist to follow-up with patients	**81.82%** 9	**0.00%** 0	**9.09%** 1	**0.00%** 0	**9.09%** 1	11	1.55
Medical provider’s ability to deal with behavioral health care issues	**36.36%** 4	**54.55%** 6	**0.00%** 0	**0.00%** 0	**9.09%** 1	11	1.91
Behavioral health care provider’s ability to deal with medical care issues	**27.27%** 3	**45.45%** 5	**18.18%** 2	**0.00%** 0	**9.09%** 1	11	2.18
Consensus on quality of care definitions	**36.36%** 4	**27.27%** 3	**27.27%** 3	**0.00%** 0	**9.09%** 1	11	2.18
Availability and credibility of data	**27.27%** 3	**36.36%** 4	**27.27%** 3	**0.00%** 0	**9.09%** 1	11	2.27
Provider feedback mechanisms	**36.36%** 4	**36.36%** 4	**18.18%** 2	**0.00%** 0	**9.09%** 1	11	2.09
Internal data collection	**27.27%** 3	**36.36%** 4	**27.27%** 3	**0.00%** 0	**9.09%** 1	11	2.27
Standard set of quality measures for external reporting	**18.18%** 2	**45.45%** 5	**27.27%** 3	**0.00%** 0	**9.09%** 1	11	2.36
Legislative and political support	**27.27%** 3	**45.45%** 5	**9.09%** 1	**9.09%** 1	**9.09%** 1	11	2.27
Evidence that investments in behavioral health Integration are worthwhile	**40.00%** 4	**30.00%** 3	**10.00%** 1	**10.00%** 1	**10.00%** 1	10	2.20
N/A	**0.00%** 0	**50.00%** 1	**0.00%** 0	**0.00%** 0	**50.00%** 1	2	3.50

#	Other (please specify)	Date
1	strong enablers above not in place at this time	7/26/2016 2:14 PM
2	Payment for services related to: drug addiction, homelessness,	7/12/2016 8:50 PM

Q13 Does your organization have a dedicated staff person who provides care coordination services both internal and external to your clinical sites?

Answered: 12 Skipped: 2

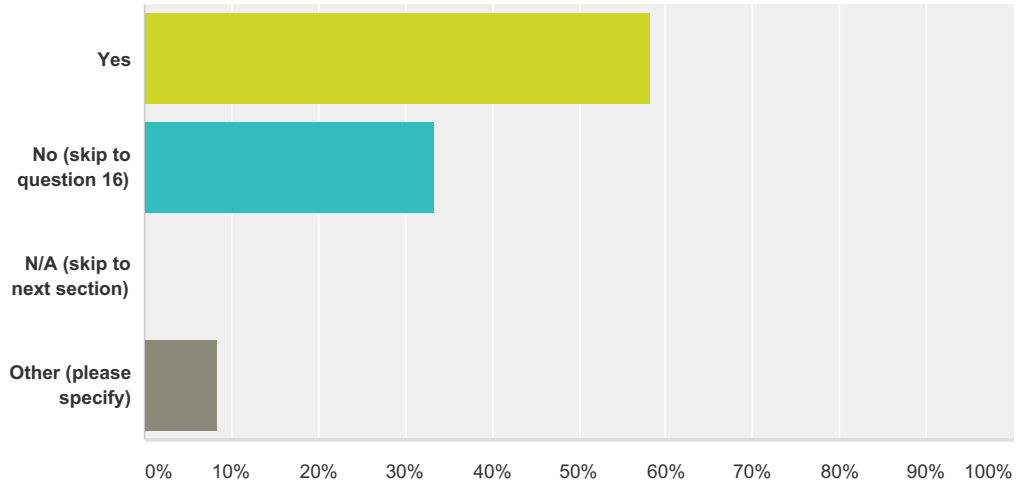


Answer Choices	Responses	
No	**25.00%**	3
In process	**16.67%**	2
N/A	**8.33%**	1
Yes. Please describe (e.g., main duties, including any coordination with community-based services):	**50.00%**	6
Total		**12**

#	Yes. Please describe (e.g., main duties, including any coordination with community-based services):	Date
1	Social Worker and outreach staff coordinate pt needs	8/2/2016 4:42 PM
2	Health homes care coordinators - home visits with patients and coordination with providers and case managers	8/2/2016 3:11 PM
3	coordination of care post hospital discharge	7/27/2016 3:22 PM
4	Care management services coordinate with medical and behavioral health providers.	7/25/2016 3:10 PM
5	Health Homes and Mental Health Integration Project (MHIP) Care Coordinators at Community Health Centers. Also Community Health Worker program for high risk members.	7/19/2016 1:45 PM
6	comprehensive care coordination and management	7/8/2016 8:02 PM

Q14 Do providers in your organization have an opportunity to regularly interact with other providers of health care services in community-based settings?

Answered: 12 Skipped: 2

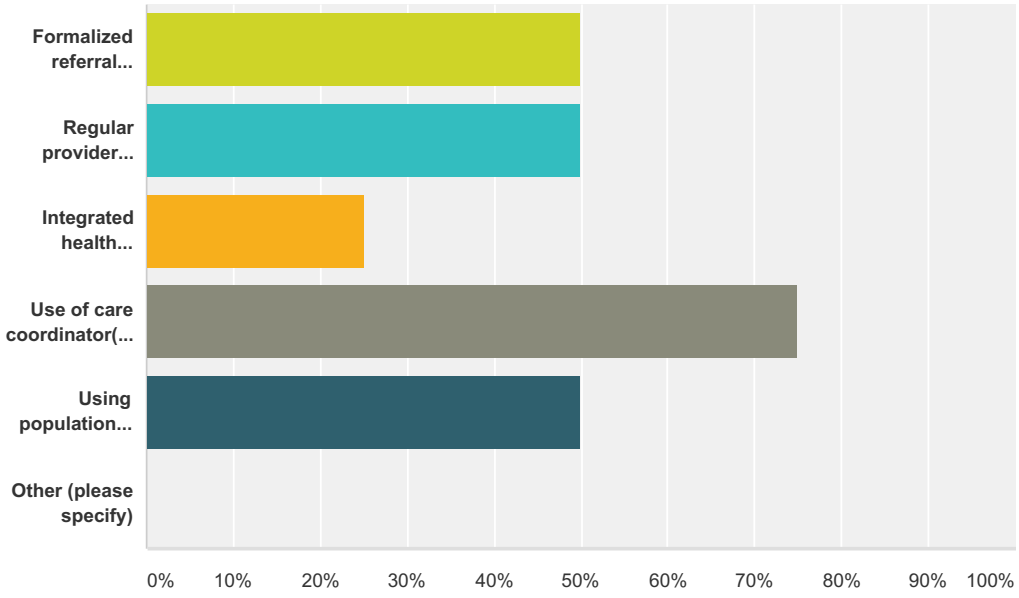


Answer Choices	Responses	
Yes	**58.33%**	7
No (skip to question 16)	**33.33%**	4
N/A (skip to next section)	**0.00%**	0
Other (please specify)	**8.33%**	1
Total		**12**

#	Other (please specify)	Date
1	Yes, to a certain degree	7/9/2016 11:41 AM

Q15 If so, what are some strategies that help you facilitate these interactions? (end of section)

Answered: 4 Skipped: 10

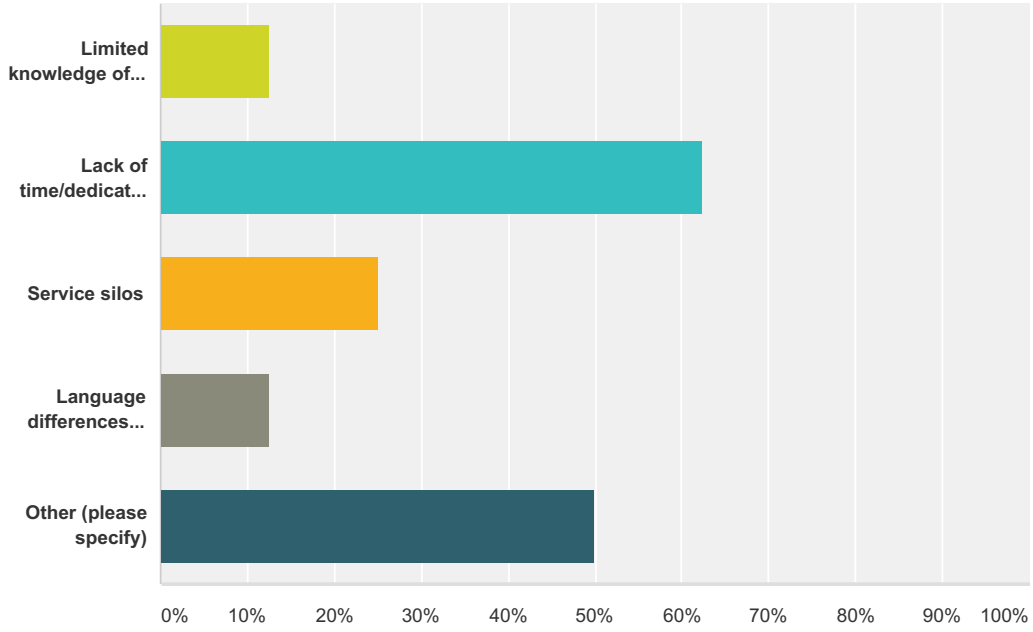


Answer Choices	Responses	
Formalized referral processes	**50.00%**	2
Regular provider networking opportunities	**50.00%**	2
Integrated health information technology	**25.00%**	1
Use of care coordinator(s) or community health worker(s)	**75.00%**	3
Using population level data to identify high risk clients	**50.00%**	2
Other (please specify)	**0.00%**	0
Total Respondents: 4		

#	Other (please specify)	Date
	There are no responses.	

Q16 If not, what are the barriers?

Answered: 8 Skipped: 6

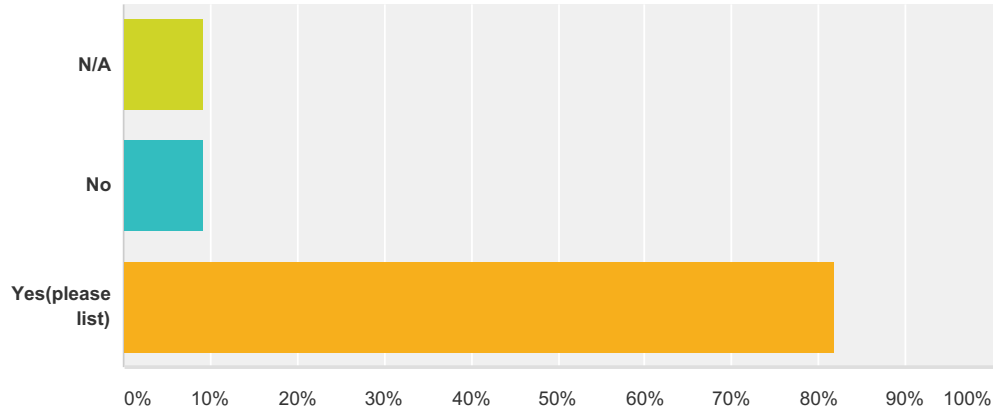


Answer Choices	Responses	
Limited knowledge of community resources	**12.50%**	1
Lack of time/dedicated staff person to coordinate services	**62.50%**	5
Service silos	**25.00%**	2
Language differences between different types of providers	**12.50%**	1
Other (please specify)	**50.00%**	4
Total Respondents: 8		

#	Other (please specify)	Date
1	Lack of community infrastructure for quality/performance tracking and system interoperability	8/2/2016 3:11 PM
2	Coordinating schedules of diverse providers--Who is going to pay for that?	7/25/2016 3:24 PM
3	N/A	7/25/2016 3:10 PM
4	EDIE and the care plans are not in all primary care settings.	7/12/2016 8:52 PM

Q17 Does your organization participate in local or state-wide quality improvement programs or collaboratives (not internal programs) such as with the Foundation for Health Care Quality?

Answered: 11 Skipped: 3

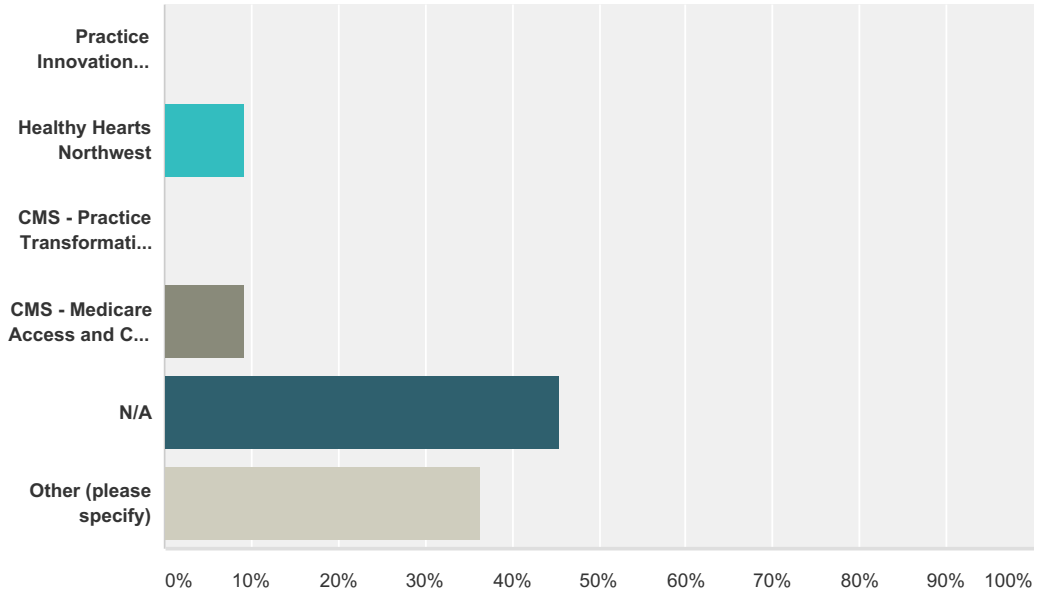


Answer Choices	Responses	
N/A	**9.09%**	1
No	**9.09%**	1
Yes(please list)	**81.82%**	9
Total		**11**

#	Yes(please list)	Date
1	SCOAP, COAP, AHRQ	7/27/2016 3:18 PM
2	HHNW	7/26/2016 2:16 PM
3	National Council for Behavioral Health	7/25/2016 3:28 PM
4	WPSC, WSHA, Bree, HILN	7/25/2016 3:13 PM
5	Bree Collaborative; DOH kids Health; WA Health Alliance	7/19/2016 1:46 PM
6	WSHA has many programs.	7/12/2016 8:54 PM
7	Participate in Bree Collaborative as well as national-UHC .	7/11/2016 8:42 AM
8	O	7/10/2016 10:13 PM
9	NCQA PCMH certification	7/8/2016 8:04 PM

Q18 Please indicate if your organization is part of the following practice transformation grants or programs

Answered: 11 Skipped: 3

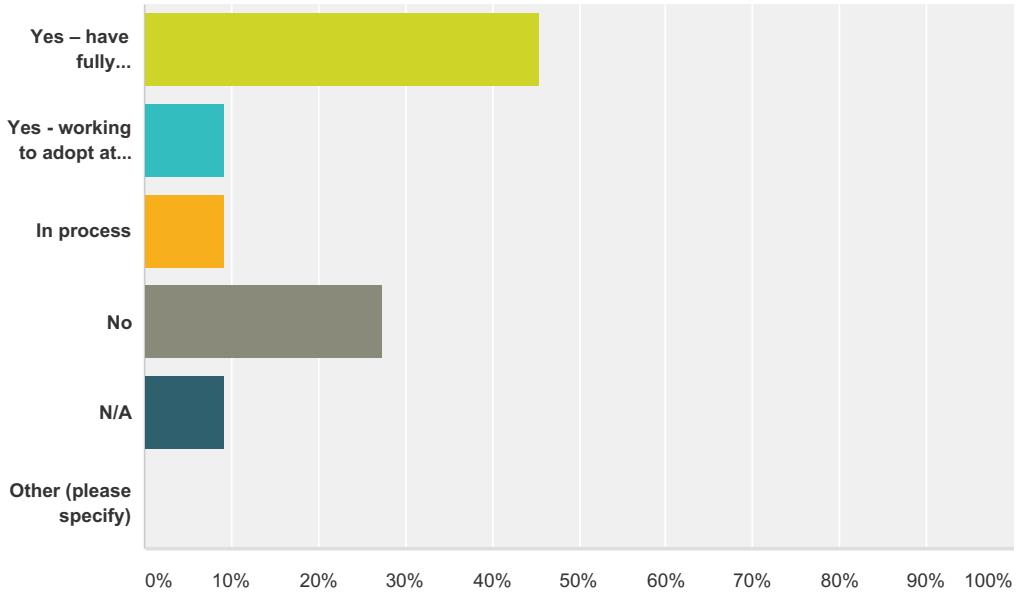


Answer Choices	Responses	
Practice Innovation Network (e.g., Cardiac learning and action network, PQRS reporting/meaningful use support)	**0.00%**	0
Healthy Hearts Northwest	**9.09%**	1
CMS - Practice Transformation Networks	**0.00%**	0
CMS - Medicare Access and CHIP Reauthorization Act (MACRA) Quality Improvement Direct Technical Assistance (MQIDTA)	**9.09%**	1
N/A	**45.45%**	5
Other (please specify)	**36.36%**	4
Total		**11**

#	Other (please specify)	Date
1	All of the above plus PCMH consultation and work to improve diabetes self-management and immunization rates	7/25/2016 3:13 PM
2	All Washington hospitals are part of CMS HEN.	7/12/2016 8:54 PM
3	Currently in Phase I of CMMI grant	7/11/2016 8:42 AM
4	NCQA PCMH	7/8/2016 8:04 PM

Q19 Has your organization implemented recommendations developed by the Bree Collaborative?

Answered: 11 Skipped: 3

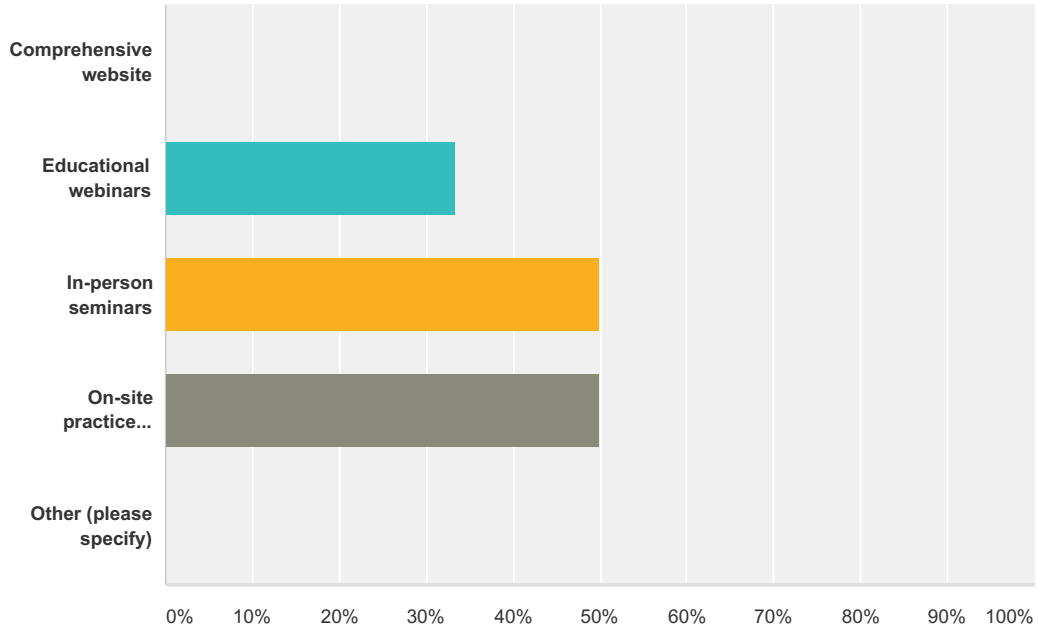


Answer Choices	Responses	
Yes – have fully implemented at least one recommendation	**45.45%**	5
Yes - working to adopt at least one recommendation	**9.09%**	1
In process	**9.09%**	1
No	**27.27%**	3
N/A	**9.09%**	1
Other (please specify)	**0.00%**	0
Total		**11**

#	Other (please specify)	Date
	There are no responses.	

Q20 What type of education, training, consulting or other support would you find beneficial to your organization to assist with other transformation activities?

Answered: 6 Skipped: 8



Answer Choices	Responses	
Comprehensive website	**0.00%**	0
Educational webinars	**33.33%**	2
In-person seminars	**50.00%**	3
On-site practice coaching	**50.00%**	3
Other (please specify)	**0.00%**	0
Total Respondents: 6		

#	Other (please specify)	Date
	There are no responses.	

Healthier Washington Communities & Equity Accelerator Committee

Co-champions: Antony Chiang, Empire Health Foundation, and Winfried Danke, CHOICE

The Healthier Washington Communities and Equity Accelerator Committee promotes the concept of health equity through work done by community members. The Accelerator Committee identified four focus areas. The criteria for focus areas were areas the committee felt sufficient knowledge and influence, both to the internal organizations represented by the committee, but also external to the committee.

The four areas are:

- Voices Included in Decision Making
- Equity Lens
- Data Disaggregation
- Workforce

Voices Included in Decision Making

Potential problem statement: Authentic community voices are not sufficiently engaged in ACH decision-making.

Questions for consideration: How do you meaningfully engage those most affected? Committee or subcommittee, equal opportunity to influence the outcome, each group having an equity lens so understanding the community?

Example: Pierce County ACH has decided to have a Community Advisory Board (CAB). Good example, also raises the question regarding how to have meaningful work for the CAB and how to integrate the work if it is a different group.

Equity Lens

Potential ask: ACHs adopt an equity lens, recognizing one size does not fit all and ACHs might need suggestions for a tool.

Other examples of actions: Sponsor a community member, a pool where funds would be available for community engagement, ACH learning session, ACHs co-creating an equity lens and all adopting it.

Data Disaggregation

Potential Problem Statement: There is insufficient data and data disaggregation, so it is a collection, reporting, analysis and utilization problem.

Local example: Kitsap Mental Health, supported by a significant CMS investment in their system.

Potential Ask for HILN: Ask MCOs and provider systems to agree on voluntary common standards for data collection that provide more nuanced data on health disparities (e.g., racial, ethnic and language categories). Potentially start with a smaller pilot project to determine feasibility, utility, and impacts.

Workforce

Potential Ask for HILN: Willingness of employers to sign on to statement regarding the importance of a diverse workforce to reduce disparities?

Potential Ask for HILN: support the data collection to test our hypothesis of the diversity of the workforce and develop a pipeline for greater workforce diversity?

Questions for HILN:

How does the value of equity move out of a single workgroup to a foundational value for organizations who influence health? How does the value of equity permeate community?

With all the work happening currently and the taxation of organizational resources, how do we make equity a priority for investment of resources?

Communities & Equity Accelerator Committee

Name	Organization
Antony Chiang, Co-Champion	Empire Health Foundation
Winfried Danke, Co-Champion	CHOICE Regional Health Network
Sofia Aragon	Washington Center for Nursing
Shelley Cooper-Ashford	Center for MultiCultural Health
Gail Fast	ESD 105
Jay Fathi	Coordinated Care
Victoria Fletcher	Ebony Nurses Association of Tacoma
Sybill Hyppolite	SEIU Healthcare 1199NW
Uriel Iniguez	Washington State Commission on Hispanic Affairs
Michael Itti	Washington State Commission on Asian Pacific American Affairs
Bertha Lopez	Yakima Valley Memorial Hospital
Diane Oakes	Washington State Dental Foundation
Chris Phillips	PeaceHealth
Tanya Riordan	Planned Parenthood of Greater Washington and North Idaho
Torney Smith	Spokane Regional Health District
Aren Sparck	Seattle Indian Health Board
Zosia Stanley	Washington State Hospital Association
Tommy Thombs	Mason County Public Hospital District 2
Janet Varon	Northwest Health Law Advocates
Kim Williams	Providence Regional Medical Center Everett
Lena Nachand, Committee Staff	Health Care Authority
Maria Courogen, Committee Staff	Department of Health

Healthier Washington Integrated Physical & Behavioral Health Accelerator Committee

Co-champions: Teresita Batayola, International Community Health Services, and Joe Roszak, Kitsap Mental Health Services

The Healthier Washington Physical & Behavioral Health Integration Accelerator Committee formed to build upon existing efforts and collaborations to achieve whole-person care. The committee aimed to engage connections with Washington's public and private partners to harness innovations and promote the spread of integrated service delivery models. The intent of the committee was to support providers in the ongoing transition to integrated delivery models through the mastering of challenges, distribution of best practices, and sharing of practice transformation support resources.

The Accelerator Committee met early in 2016 to scope its work, and then went on hiatus as members of the committee focused attention on ensuring a successful statewide transition to Behavioral Health Organizations (BHOs) or full integration in Southwest Washington. The committee did not convene again primarily due to an inability to identify its specific and unique purpose amid a plethora of similar multisector, committee-based efforts focused on physical and behavioral health integration, in which many of the Accelerator Committee members were engaged. The committee staff and co-champions designed the July HILN meeting focused on physical and behavioral health integration from three key angles: 1) financial integration, 2) clinical integration, and 3) inclusion of social determinants of health.

Healthier Washington Rural Health Innovation Accelerator Committee

Co-champions: Nicole Bell, Cambia Grove, and Andre Fresco, Yakima Health District

The Rural Health Innovation Accelerator Committee sought to encourage rural communities to shift to value-based payment and delivery models by removing barriers to innovation that exist in current payment systems. The committee has served as a forum wherein public and private partners have a role in helping shape a sustainable future for Washington's rural providers.

Over the course of 2016, the Rural Health Innovation Accelerator Committee had strong engagement from cross-cutting private-sector innovators and entrepreneurs, providers and public-sector contributors. The goal of the group is to inform our colleagues and policy makers of the current reality of rural health and present the opportunity for rural health investment and innovation.

Prefacing the committee's final deliverable, during the past year the committee has met to discuss both the barriers and the opportunities for rural health delivery. These discussions have led to several conclusions. First, there are a host of issues that make rural health delivery challenging and unique. Second, there is the need and potential for fundamental rural health delivery transformation, and Washington state is poised to be a leader. These sentiments were articulated by the committee's problem statement:

The sustainability of rural health care delivery depends on fundamental transformation and must consider the unique nature of rural and isolated constituents, and scarce resources. The transformation must pragmatically embrace health resource availability and redesign the system with enhanced patient engagement, innovative healthcare interventions and population health strategies, all leveraging modern technology platforms.

Recognizing the barriers to engaging in rural health issues and to support this problem statement, the committee has elected to develop a playbook that can be used to guide engagement of policy leaders, entrepreneurs and innovators, providers and other colleagues. The playbook will be a clear articulation of the reality rural health barriers and issues, give the committee's vision for rural health delivery, outline how to engage in rural health innovation and transformation, and offer up a set of several policy recommendations that would help to accelerate a shift from the current paradigm. The core of the playbook itself will give several specific recommended actions that can be taken to support rural health delivery transformation.

The hope is that the playbook will inform and encourage stronger rural health engagement, and HILN ownership of implementation of recommended actions.

Rural Health Innovation Accelerator Committee

Name	Organization
Nicole Bell, Co-Champion	Cambia Grove
Andre Fresco, Co-Champion	Yakima Health District
Jacqueline Barton True	Washington State Hospital Association
Dawn Bross	Samaritan Healthcare
Ralph Derrickson	Carena
Daryl Edmonds	Amerigroup
Laura Flores Cantrell	Delta Dental
Linda Gipson	Whidbey General Public Hospital District
Candace Goehring	Department of Social and Health Services
Mark Johnston	Amazon
Eric Moll	Mason General
Brian Myers	Empire Health Foundation
Ken Roberts	WSU College of Medicine
Phil Skiba	Hewlett Packard
Mark Stensager	Washington Health Benefit Exchange Board
Karina Uldall	Virginia Mason
Keith Watson	Pacific Northwest University
Gary Swan, Committee Staff	Health Care Authority

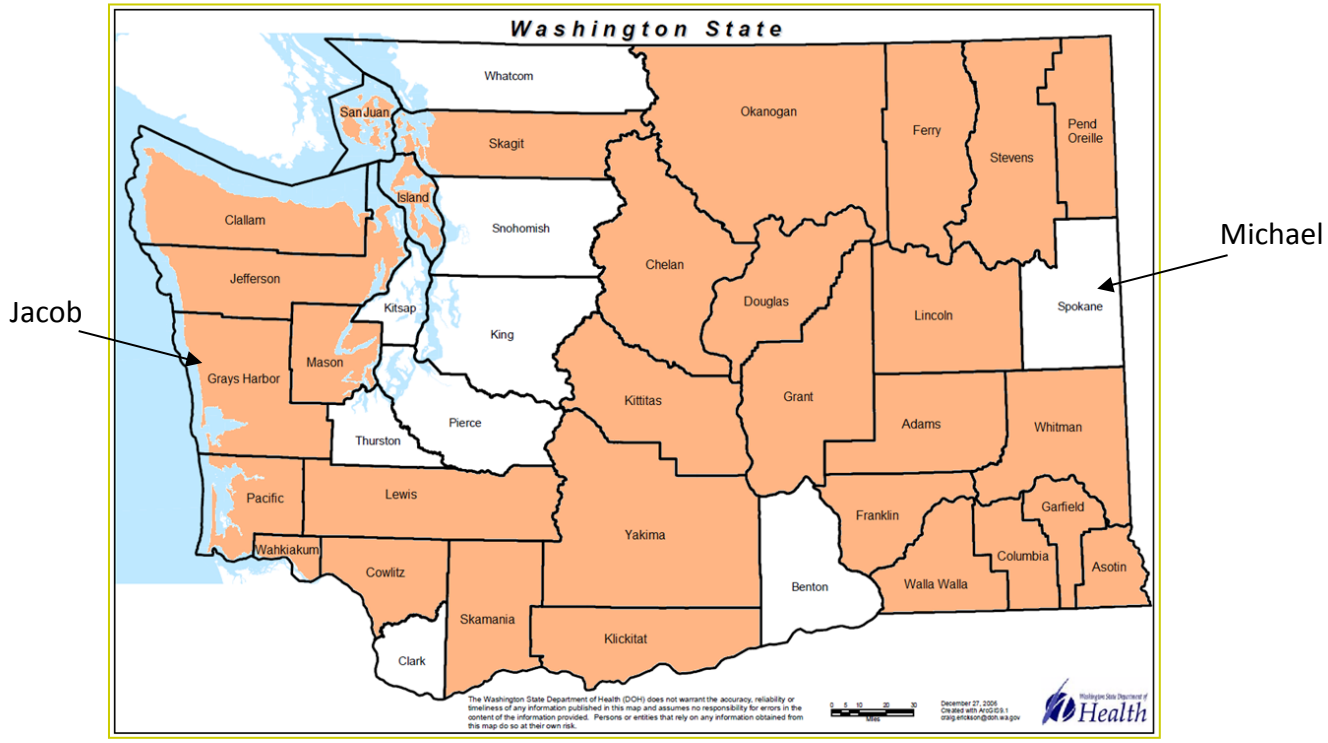
Rural Health Innovation Accelerator Committee

Rural Health Problem Statement

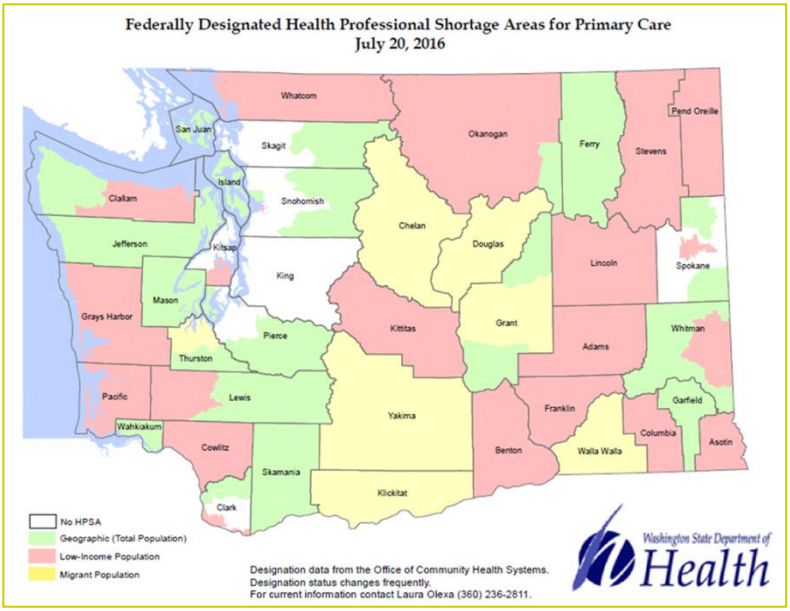
The sustainability of rural healthcare delivery depends on fundamental transformation and must consider the unique nature of rural and isolated constituents and scarce resources. The transformation must pragmatically embrace health resource availability and redesign the system with enhanced patient engagement, innovative healthcare interventions and population health strategies, all leveraging modern technology platforms.

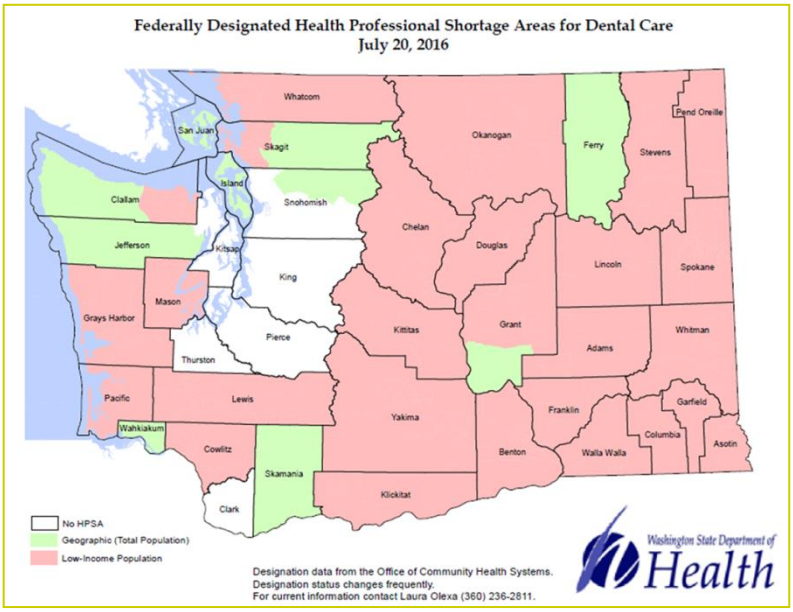
Growing up: Jacob vs. Michael

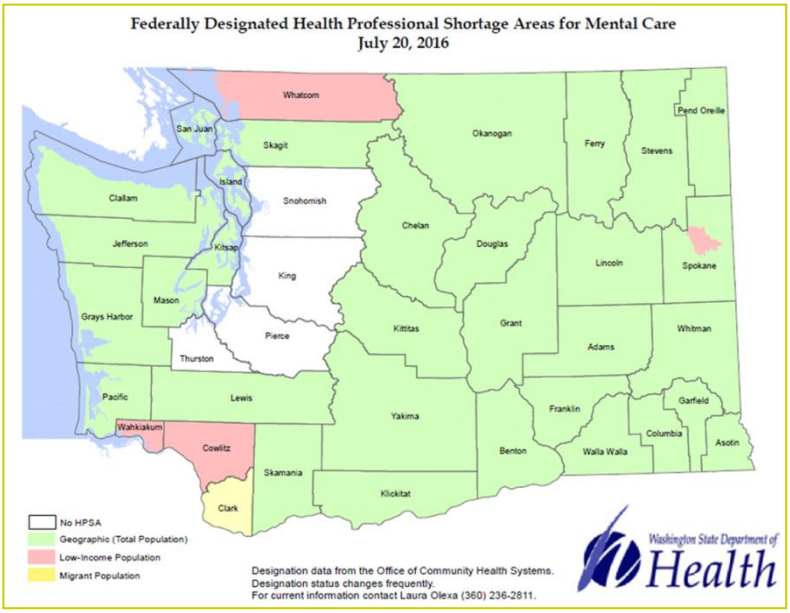
- Jake's home town will have fewer kids and more older people than Michael's.
- Jake's family will make less money than Mike's.
- Jake is less likely to graduate high school and even less likely to attend college than Mike.
- Jake is more likely to be unemployed than Mike
- Jake is more likely to become obese, get diabetes, and to smoke than is Mike
- Jake's family is less likely to have health insurance then Mike's
- Jake is likely to die younger than Mike



*County Health Rankings, http://www.countyhealthrankings.org/app/washington/2016/downloads







Current reality of rural healthcare

- There is a lack of primary care physicians.
- Operating margins continue to be very low to negative.
- Electronic medical records are expensive and slow to come to rural communities.
- Tele-medicine remains an unrealized opportunity in most rural areas.
- There is a high reliance on emergency room use.
- It will be a challenge to maintain the current system in the long term.
- There are pockets of innovation, but this is far from universal.

Discussion questions

- **Do we believe that funding innovation can balance the inequality?**

- **Can we demonstrate leadership in our state, and do we want to serve as a beacon for a national/international problem, and are there alternate funding mechanisms to demonstrate viability in an initially targeted community?**

- **Do we believe that we should demonstrate initiatives in the next two years, if so where and how?**

Contact information

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Healthier Washington Collective Responsibility Accelerator Committee

Co-champions: Kathleen Paul, Virginia Mason Medical Center, and David Wertheimer, Bill & Melinda Gates Foundation

The Healthier Washington Collective Responsibility Accelerator Committee promotes the concept of shared accountability and collective impact in achieving improved community health. Through mutually identified priorities and action, the committee in 2016 helped shape messaging, identified key partners across multiple sectors in the promotion and sustainability of Healthier Washington, and served as champions of the concept of collective responsibility. The committee:

- Highlighted common indicators of success across a broad range of constituencies in communicating the value proposition of improved community health;
- Articulated and prioritized activities around the concept that all have a role to play across the system in service to mutual action and goals; and
- Served as "connective tissue" to help those working in the field and across the Accountable Communities of Health move from theory to practice, as well as make the vision of collective responsibility more palatable.

The committee's value statement and objectives are as follows:

Value statement: Accelerate collective responsibility for improving community health.

Objectives:

- Gather and share information. Understand and theme the full spectrum of community needs related to improving health outcomes as defined by each community, and share emerging and best practices related to key determinants of success.
- Identify common indicators. Propose indicators of success related to collective efforts to realize shared activities and outcomes, and promote dialogue with and across communities and sectors to address concerns and refine common indicators.
- Communicate, advocate and activate. Develop strategies to educate and communicate with targeted audiences, with a goal of changing the public dialogue by applying lessons learned to communicate with local and state-level systems and policy makers.

The committee drafted three items of communication collateral for use by communities, statewide partners, committee members and the HILN to demonstrate the importance of a multisector, public-private approach to improve community health:

- A graphic visualizing the "bright spots" around the state where actions to improve health and health care are occurring. This will leverage the data gathered in the August 2016 *Healthier Washington Collective Responsibility Accelerator Committee Report on Education and Advocacy Strategy.* This graphic could be housed on the Healthier Washington website, and shared with partners to embed in their materials.
  Purpose: Tool to help demonstrate the powerful work already happening around the state, and help multisector partners think across social determinants.
- A fact sheet to help Accountable Communities of Health participants explain their work and how it links with others working on social determinants of health. Includes a clear call to action to participate in the ACH.
  Purpose: Advocacy tool to support communities in articulating why social sectors are important to the ACH table.

- A fact sheet to help HILN and other partners reach out to boards, leaders, and community members to share the message of a Healthier Washington. Clearly articulate the linkage between health transformation and others who may not see the clear link between their work (in education, housing, or other areas) and health. The first draft fact sheet focuses on early learning to test the messaging and approach.
  Purpose: Clearly articulate the linkage between health system transformation and others who may not see the clear link between their work (in education, housing, or other areas) and health.

Moving forward, the committee advocates for ensuring more intentional linkages between the health care delivery system and social determinants of health. A system that supports the health of populations engages all sectors in achieving health for people and their families. While the health care system has an important role in supporting health outcomes, so does the education system, business, the housing system, social institutions and community support. Providers, frustrated with their lack of reach to help patients beyond the clinic walls, often say, "I have no place to send these people." But that is not universally true. Across communities, there are myriad resources to address the social needs of people and their families. In addition to educating provider teams and creating capacity for insight into community resources, Healthier Washington must address the system, policy and financial levers necessary for linking clinical practice to community.

The committee recommends to HILN and HCA that the following levers be considered to ensure effective clinical-community linkages:

- **Role definition**. Providers, community-based organizations, payers, public health and other partners all have a role to play in ensuring the factors for whole-person health are addressed. It is necessary to identify and understand the resources in a community or region, and how they complement one another.

- **Common language**. While health sectors and social sectors often have common goals for people and their families, vocabulary and approach often differ. Determinants of health and determinants of social success are largely identical. Identifying linkage opportunities and complementing one another in service to the person and family requires some common language or mechanism for translation between these sectors.

- **Data**. Common data aid in identifying opportunities for clinicians and community resources to link toward a common purpose. Furthermore, data that follow the person, as opposed to existing exclusively within payer systems or organizations' databases, support all systems in understanding and identifying the comprehensive needs of a person and their family. Data linkages across health, housing, education, criminal justice and more must be addressed.

- **Financing**. Financial systems must be aligned to adequately address health care needs as well as upstream components of health. Financing mechanisms must be built to incentivize alignment and ensure accountability for the whole health of a population.

Collective Responsibility Accelerator Committee

Kathleen Paul, co-champion	Virginia Mason
David Wertheimer, co-champion	Bill & Melinda Gates Foundation
Jennifer Allen	Planned Parenthood Votes Northwest and Hawaii
Abigail Blue	Washington Association of Community & Migrant Health Centers
Doug Bowes	United Healthcare
Alison Carl White	Better Health Together
Ed Dwyer-O'Connor	Harborview Medical Center
Dan Ferguson	Washington State Allied Health Center of Excellence
Connie Kline	Pierce Co. Community Connections - Aging & Disability Resources
Ben Lindekugel	Association of Washington Public Hospital Districts
Michael McKee	International Community Health Services
Peter Morgan	Family Health Centers
Teresa Mosqueda	Washington State Labor Council, AFL-CIO
Sallie Neillie	Project Access Northwest
Andrew Over	Regence BlueShield
Sherry Reynolds	Alliance4Health
Bill Rumpf	Mercy Housing Northwest
Martin Valadez	Greater Columbia ACH
Caroline Whalen	King County
Greg Williamson	Washington State Department of Early Learning

Healthier WASHINGTON

BETTER HEALTH. BETTER CARE. LOWER COSTS.
THE FACTS

ACHs: Inviting early learning professionals to the table

The key goals of the state early learning system—giving all children the social, emotional and academic support in their first years of life to thrive in school and life—closely mirror the goals of Healthier Washington.

We all are focused on ensuring the health and vitality of our residents, regardless of zip code or income. We are focused on making people healthier in their communities, and that includes what happens outside health clinic walls.

Accountable Communities of Health are expected to engage with non-clinical, non-payer participants. How can you, as an Accountable Community of Health, engage with the early learning system?

- **Find common ground.** Early learning can be an important partner as ACHs address community priorities. For example, your community is focused on physical and behavioral health integration. Early learning can be a key partner in that because home visiting programs and other early learning interventions are designed in part to promote social/emotional health and mitigate adverse childhood experiences.

- **Reach out.** Talk with your a local Child Care Aware office, child care association or early learning program to start the conversation.

- **Understand the science.** We know that children who are physically and emotionally healthy are better prepared to learn and thrive. For example, research tells us that:

    - Exposure to toxic stress impacts the development of a child's brain, cardiovascular system, immune system, and metabolic regulatory controls. [1]

    - Children who have tooth decay are more likely to struggle in school. [2]

[1] Harvard University Center on the Developing Child, http://developingchild.harvard.edu/science/key-concepts/toxic-stress/

[2] National Maternal & Child Oral Health Resource Center, http://www.mchoralhealth.org/PDFs/learningfactsheet.pdf

The aligned goals of early learning and Healthier Washington

Early learning focus	Accountable Communities of Health focus
• ECEAP promotes school success by providing high-quality preschool education that focuses on academics as well as emotional health. • Home visiting provides essential support for parents and children in building strong attachment and health from the start. • ESIT focuses on early intervention for infants and toddlers with disabilities, reducing the need for services in the K-12 system. • High-quality child care provides a strong start for young children.	Healthier communities through: • Physical and behavioral health integration • Care coordination, sometimes leveraging community health workers • Access to care • Equity • Prevention • Adverse Childhood Experiences prevention • Opioid response

Fact sheet produced by the Washington State Health Care Authority, October 2016
Healthier Washington is Governor Inslee's multi-sector partnership to improve health, transform health care delivery, and reduce costs. The Health Care Authority provides strategic oversight for this initiative. The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Healthier WASHINGTON

BETTER HEALTH. BETTER CARE. LOWER COSTS.
THE FACTS

Early learning and Healthier Washington: Joining forces for Washington kids

We know that children who are physically and emotionally healthy are better prepared to learn and thrive. For example, research tells us that:

- Exposure to toxic stress impacts the development of a child's brain, cardiovascular system, immune system, and metabolic regulatory controls. [1]
- Children who have tooth decay are more likely to struggle in school. [2]

With Healthier Washington, we have an opportunity to work together as a state to address the factors that put children on the path to lifelong health. We are working to move the focus on health "upstream" from health care, addressing and taking strategic action on the social determinants of health such as housing, employment, nutrition and education.

Building healthy communities supports lifelong health. And by starting early—prenatal to age 8—we can get our next generation off to the healthiest possible start.

By addressing the whole person—physical and emotional—Healthier Washington has many of the same goals in many of our state's early learning programs, including the Early Childhood Education and Assistance Program (ECEAP) and Head Start, home visiting, and Early Support for Infants and Toddlers (ESIT).

How can *you*—as an early learning professional—help?

If you are an early learning professional and want to make an impact at a local level, have a conversation with your Accountable Community of Health (ACH). This regional collaborative body brings together people, organizations and systems focused on working across siloes to support healthy communities, using community resources to address social determinants and health disparities. ACHs are focused on many of the same issues that support successful early learning: Quality education, stable housing, access to care, and stable income.

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[1] Harvard University Center on the Developing Child, http://developingchild.harvard.edu/science/key-concepts/toxic-stress/

[2] National Maternal & Child Oral Health Resource Center, http://www.mchoralhealth.org/PDFs/learningfactsheet.pdf

At the ACH table, you can bring the early learning lens to the conversation, making sure we consider the resources early learning brings to health systems. Visit www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach to learn more.

The aligned goals of early learning and Healthier Washington

Early learning focus	Accountable Communities of Health focus
• ECEAP promotes school success by providing high-quality preschool education that focuses on academics as well as emotional health. • Home visiting provides essential support for parents and children in building strong attachment and health from the start. • ESIT focuses on early intervention for infants and toddlers with disabilities, reducing the need for services in the K-12 system. • Early Achievers, Washington's quality rating and improvement system for child care and preschool, focuses on nurturing environments, family engagement, and healthy children.	Healthier communities through: • Physical and behavioral health integration • Care coordination, sometimes leveraging community health workers • Access to care • Equity • Prevention • Adverse Childhood Experiences prevention • Opioid response

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