Healthier Washington
Health Innovation Leadership Network Quarterly Meeting

9 a.m.-noon Friday, July 29

Cambia Grove | Suite 250 | 1800 9th Avenue | Seattle
Webinar access: https://attendee.gotowebinar.com/register/6756113399666086146

Agenda

Meeting Objective:

- Understand our multisector leadership role in accelerating the shared goal to provide integrated physical and behavioral health care that serves the whole person.

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

9:15 a.m. Spotlight On: Healthier Washington and Physical-Behavioral Health Integration
Teresita Batayola & Joe Roszak, Physical & Behavioral Health Integration Accelerator Committee Co-Champions
Bob Crittenden, Office of the Governor
Kay Roberson, Clark County Crisis Services

10:00 a.m. Spotlight On Physical-Behavioral Health Integration | Purchasing and Payment
Peter Adler, Molina Healthcare of Washington
Vanessa Gaston, Clark County Community Services
Bunk Moren, Community Services Northwest

10:35 a.m. Break

10:45 a.m. Spotlight On Physical-Behavioral Health Integration | Care Delivery
Joe Roszak, Kitsap Mental Health Services
Jurgen Unutzer, University of Washington (invited)
John Wiesman, Department of Health

11:20 a.m. Spotlight On Physical-Behavioral Health Integration | Community Linkages
Graydon Andrus, Downtown Emergency Service Center
Elya Moore, Olympic Community of Health

11:50 a.m. Next Steps
Dorothy Teeter

- Items for the good of the order
- Meeting evaluation and agenda items for next meeting
- Healthier Washington Symposium October 24 in SeaTac – please plan to attend

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

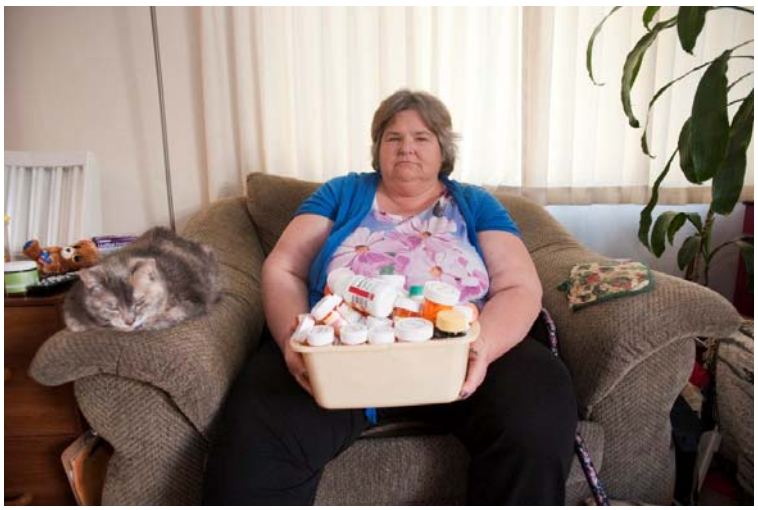
Name	Organization
Amy Morrison Goings	Lake Washington Institute of Technology
Paul Hayes	Harborview Medical Center
Ross Hunter	Department of Early Learning
Uriel Iniguez	Washington Commission on Hispanic Affairs
Nancy Johnson	Colville Business Council
Mike Kreidler	Office of the Insurance Commissioner
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
Andi Smith	Office of the Governor, Legislative Affairs
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

Clark, Skamania counties early adopters of integrated Medicaid services

New approach allows providers to collaborate on patients' physical and behavioral health



(http://16749-presscdn-0-94.pagely.netdna-cdn.com/wp-content/uploads/2016/04/412666-early-a
1024x682.jpg)

Kay Roberson, at her Vancouver home with her cat Sophie, holds a box of medications she's been prescribed for
health issues and several chronic health issues. Roberson spent most of her life on Medicaid. (NATALIE BEHRIN

By **Marissa Harshman (/author/mharshman)**, Columbian Health Reporter
Published: April 3, 2016, 6:07 AM

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Kay Roberson didn't want anyone to know she had been diagnosed with mental illnesses — not even her medical providers.

So when the Vancouver woman found herself in the local emergency department, she kept her diagnoses a secret. The physicians treating her had no idea she was on powerful medications for dissociative identity disorder, bipolar disorder and anxiety disorder.

"It was dangerous because some of those meds can interact," Roberson said.

But, at the time, Roberson was more concerned about how she would be treated by medical providers. She was a Medicaid member diagnosed with mental illnesses. She wanted to believe providers wouldn't judge her, but she knew some doctors would attribute her physical issues and concerns to her mental illness.

Fortunately for Roberson, her decision to hide her diagnoses and medications never had negative health repercussions. But Roberson would like to see that decision taken out of the hands of patients. She wants to see psychiatrists talking with cardiologists and primary care providers and substance abuse counselors. She wants health care to be about caring for the whole person, not one set of providers caring for the head, while another set cares for the body.

The state Health Care Authority — which oversees the Medicaid program, Apple Health — Medicaid health plans and county providers want to see that, as well.

That's why this month, Clark and Skamania counties became the first in the state to fully integrate Medicaid services. As of Friday, Medicaid clients in Southwest Washington have just one organization managing their physical health, mental health and chemical dependency services. The rest of the state will follow suit over the next four years, with every county in the state providing integrated care to Medicaid clients by January 2020.

In the meantime, all eyes are on Southwest Washington.

"Clark and Skamania counties should be really proud of the fact they're going first with this," said Peter Adler, president of Molina Healthcare of Washington, a Medicaid-managed care provider. "That doesn't mean there won't be some bumps in the implementation of this. But this is the future of managed care, of Medicaid."

Unifying systems

For years, two state agencies — the Health Care Authority and the Department of Social and Health Services — oversaw Medicaid services. The agencies contracted with various regional organizations, counties and health plans that, in turn, contracted with local providers to serve Medicaid clients.

That meant Medicaid patients had to navigate multiple systems to receive medical, mental health and chemical dependency treatment. It also meant providers worked in silos, unaware of what other services and treatments their patients were receiving, unless the patients told them.

Once Roberson felt confident enough with herself and her mental health diagnoses, she began asking her primary care provider and her psychiatrist to talk. She gave permission for them to share information about her, offered to sign a waiver, whatever it took to get her care team communicating.

"It was a brick wall," she said. "The Medicaid system, I don't believe they're set up to communicate."

Two years ago, the state took the first steps to try to break down those silo walls.

During the 2014 legislative session, the Legislature passed two bills that, in part, created regional service areas across the state and required full integration of the financing and delivery of Medicaid services by January 2020.

The 10 regional service areas in the state had two choices to move toward Medicaid integration. They could first integrate mental health and chemical dependency services by April 1, 2016, and then integrate physical health in 2020. Or regions could choose to be an early adopter and pursue full integration by April 1, 2016.

The Southwest Washington region, which includes Clark and Skamania counties, was the only region to pursue early adopter status.

The region did have incentives to move forward with the early adopter model. Not only would the counties be able to help craft how the new system operates, but the region will also receive 10 percent of the savings realized through care integration. It's unclear how much — and when — that money will come to the region.

So now, for the first time, the county's two health plans — Molina Healthcare of Washington and Community Health Plan of Washington — are responsible for the whole-person care of local Medicaid clients, rather than just their physical health care. A third organization, Beacon Health Options, will handle behavioral health crisis services.

The goals of the integration effort are better health outcomes, better care and lower health care costs. The theory is those goals can be achieved through better coordinated care.

"It's better care, better outcomes in terms of health and treating the whole person, and it's better stewardship of the public dollars," Adler said. "It's much more expensive to provide fragmented care with lots of redundancies than it is to provide integrated care."

Preparing for change

In Southwest Washington, Molina has nearly 82,500 Medicaid clients and Community Health Plan has about 15,900 members. The vast majority of those members live in Clark County.

Since the Health Care Authority awarded the contracts to the plans in mid-November, both plans have been preparing to take over the management of mental health and chemical dependency services.

Health plan officials have had regular meetings with state officials and representatives from the organizations that previously administered behavioral health services to ensure electronic patient records are transferred and to share information about how programs are funded and operated.

Molina officials have also been expanding the plan's provider network, adding all of the mental health and chemical dependency providers who had contracts with the previous organizations managing those services. That means Molina Medicaid members won't have to change providers and won't see any interruptions in care under the new integrated system, Adler said.

Molina has also focused on community outreach to inform members of the upcoming changes. Molina has worked with schools to sponsor family nights and food banks during distribution events, where Molina officials can explain the new system and answer questions.

In addition, Molina opened a Vancouver service center and retrained call center representatives and case managers to be better equipped to address mental health and chemical dependency service needs. All member materials have been redesigned — and translated to several languages — to include information about the additional services.

Community Health Plan of Washington also opened a Vancouver office and has contracted with the predominant behavioral health providers in the region, which means members should have access to their previous providers. Those who are seeing a provider outside of the network will have a grace period during which they can continue to see their previous provider before they need to switch to an in-network provider, said David DiGiuseppe, Community Health Plan's vice president of population health.

The county's behavioral health providers also have been preparing for the change.

Columbia River Mental Health, which provides mental health and substance abuse services, months ago started reaching out to primary care providers to begin building relationships, said CEO Craig Pridemore.

Earlier this year, Columbia River Mental Health and Rose Medical Groups opened their first joint office in Battle Ground. There, patients can access primary care and mental health services — and, soon, substance abuse services — under one roof.

The office, Pridemore said, is ground zero for integration efforts. Sharing the space allows providers to get to know each other and understand each others' work, he said.

“Primary care has very little understanding of behavioral health, and behavioral health has very little understanding of primary care,” Pridemore said. “So getting those cultures to interact is very advantageous to integrated care.”

Opening up the lines of communication between providers and the health plans has also been beneficial, said Bunk Moren, executive director of Community Services Northwest, which provides mental health and substance abuse services.

Moren said he’s looking forward to working with the health plans to the benefit of patients, particularly those with complex needs. In the past, it was difficult getting service payers to understand complicated cases — such as people with behavioral health needs, as well as ongoing health issues and social needs — because they were only responsible for funding one aspect of the patient’s care, Moren said.

“These (health plans), they’re gonna see the whole thing,” he said. “They’re gonna see the complexity of the picture through the claims.”

Bumps expected

But while most involved are optimistic, everyone acknowledges the transition is likely to come with hiccups.

“When you make any major change like this, there’s going to be bumps in the road,” said MaryAnne Lindeblad, the Health Care Authority’s Medicaid director.

The state and health plans have an early warning system in place to monitor key indicators that could point to problems so resolutions can be found quickly, Lindeblad said.

But the work doesn’t end with the early adopter launch, said Vanessa Gaston, director of Clark County Community Services, which administered substance abuse services under the old system.

“Early adopter is the first step, but it’s not the final step,” she said.

The next step is to get social services agencies involved to address Medicaid members’ social needs, such as housing and transportation, to make addressing their health needs easier, Gaston said. State officials agree.

“People with serious mental illness die sometimes up to 25 years earlier” than someone without mental illness, Lindeblad said. “They don’t die from the mental illness. They die from diabetes and high blood pressure and other health issues that go unaddressed.”

Roberson, who works as a peer mentor for Clark County Crisis Services, hopes those efforts shift more toward prevention, catching people before they reach crisis and their care becomes more complex and more expensive.

“My concern is they’re not there yet,” Roberson said. “They don’t get it.

“What they’re doing is great and longtime needed,” she added, “but they need to do 30 percent more.”

Marissa Harshman (/author/mharshman)

Columbian Health Reporter

360-735-4546

@MarissaHarshman (https://twitter.com/MarissaHarshman)

Send an Email (mailto:marissa.harshman@columbian.com)

Facebook (https://www.facebook.com/reporterharshman)

Southwest Washington Early Adopter Update

July 2016

Current Status

On April 1, the Health Care Authority (HCA) launched fully-integrated managed care (FIMC) in Clark and Skamania counties (SWWA). The Regional Support Network (RSN) in SWWA has ceased operations, and Medicaid beneficiaries have transitioned to coverage by one of two fully-integrated managed care plans of their choosing: Molina Health Care of Washington or Community Health Plan of Washington (CHPW). Additionally, HCA and Beacon Health Options launched a regional crisis response system to replace and improve upon the prior mental health crisis system managed through the RSN.

Highlights

- 100,982 Medicaid beneficiaries were enrolled in the FIMC program with Molina or CHPW, meaning they receive the full continuum of physical and behavioral health benefits through the MCO.

- Additionally, 14,631 clients are enrolled in the behavioral health services only (BHSO) program and receive specialty mental health and substance use disorder services through either CHPW or Molina. The BHSO program was designed to provide behavioral health coverage to clients who receive physical health coverage through the Medicaid FFS system or have other coverage (foster children, dual-eligibles, etc.).

- All behavioral health providers that had been under contract with the county (SUD) or the RSN (MH) opted to sign contracts with the MCOs and Beacon – BH provider network remained intact.

- CHPW and Molina have worked collaboratively to standardize authorization processes/requirements as well as billing instructions/codes for providers, to the extent possible.

- Through the month of April, HCA held daily calls with providers, county staff and MCOs to troubleshoot any implementation issues as they arose. In May these calls continued 3 days per week. HCA has been able to rapidly resolve issues such as:
    - Access to interpreters in BH provider settings
    - Authorization requirements for CD services and clarity on use of ASAM criteria and medical necessity definitions
    - Address issues impacting client eligibility and plan enrollment
    - Care coordination issues w/ DOC and instances when E&T beds are unavailable, etc.

- After 2 months of implementation, early metrics indicate that crisis calls are being triaged effectively, with 98.2% of calls being answered in less than 30 seconds, and average speed of answer at 13 seconds. Of clinical calls received by the hotline, 85.7% of callers during the month of April were stabilized by a clinician and connected to community resources. Of the 110 crisis incidents referred to mobile crisis outreach, 58% required an ITA investigation, with 34% ultimately being involuntarily detained. Of the total crisis calls in April, 3% resulted in an involuntary detention.

Case Examples and Anecdotes

Western State Hospital

Western State Hospital (WSH) discharge planners and social workers have reported that they are very pleased with the 3 hospital liaisons who have replaced the Regional Support Network hospital liaison and that all liaisons are extremely responsive and diligent in working to find placements and establish discharge plans. In the first 2 months since implementation, SWWA liaisons have facilitated the discharge of 5 people.

This month, Molina and CHPW will facilitate the discharge of 12 people from WSH into a new DSHS Home and Community-Based Services Enhanced Services Facility (ESF) in Clark County. MCOs and Beacon are working collaboratively with WSH, DSHS, HCA and outpatient providers to ensure a smooth transition into the ESF.

For comparison, the RSN discharged 27 individuals between April 2015 – April 2016, or a rate of 2.25 per month.

The region has remained 4-5 beds under its WSH census since April 1, in contrast to an average of 3-4 under census during the RSN system.

Molina Member #1

27 year old female, was either admitted to the hospital or in the ER 24 out of 31 days in March. Molina Case Manager was assigned the case on March 10th. By March 24th, the Case Manager had organized a multi-disciplinary care team meeting with Mental Health provider staff, Community Connectors (CHW), Health Homes care coordinator, and Hospital Psychiatric Liaisons, identifying strengths and barriers and creating an action plan and plan for follow up communication with the team. She was dismissed from 2 different PCP clinics in the first 2 weeks of March so the Case Manager also worked with her to find a new PCP and establish care. Molina's Community Connector, has assisted this client in forming productive relationships with her new providers. She was also connected to a provider for ongoing pain management.

In April, she decreased her inpatient and ED utilization to only 8 total visits (1/3 of previous months). As of May 4th, she has not accessed the ED in almost three weeks (since 4/15/16). Molina's Case Management team currently talks to this client 2-3 times a day, and between the community connector and CM, Molina has remained an integral piece of ensuring this member's many services providers are connected, integrated and working together as one team.

Molina Member #2

53 year old female, had been waiting months to get electroconvulsive therapy (ECT) after suffering nearly a year long intractable major depressive episode. As Molina assumed the FIMC role, our Case Manager was able to work with her providers and with Molina Provider Contracting to obtain ECT services at a Medical Center. A true benefit of FIMC is to be able to coordinate care for this member and to work closely with Molina's contracting team. This client hadn't been seeing a mental health counselor, so the Case Manager worked with a mental health provider agency in SWWA to ensure she had access to her therapist and appointments were arranged. This client was also eligible for the Health Homes program as was assigned a Health Home Care Coordinator who is starting to on board the client into the HH program. The member has also been accessing Physical Therapy services for TM. She also was connected to a provider for pain management. Additionally, a Molina Community Connectors, is assisting the client with forming relationships with the new providers.

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September 9, 2016

Get ready to connect to your community like never before at the 2016 Edge of Amazing conference Sept. 9, 2016 at the Tulalip Resort Casino. Join more than 450 local and state innovators advancing our community's health in the fields of nonprofits, healthcare, business, government and social services, at this one-of-a-kind health summit in Snohomish County.

Last year, attendees laid out a vision and priorities for a healthier future in Snohomish County. This year, see the results, including some of the most challenging and innovative work being done locally and across the state and country in the fields of 22nd century healthy community designs, and community connections.

After attracting statewide attention last year, we're partnering with Healthier Washington to offer 2016 attendees a track focusing on local and statewide efforts to transform the health system.

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THE FACTS

Save the Date: October 24, 2016 in SeaTac

2016 Healthier Washington Symposium: An Overview

As we embark look to year three of Healthier Washington, we move from planning into action and continued momentum. This fall, we will bring together key partners around the state for one day to learn, collaborate and engage. Partners will be invited to bring new ideas and proposals for strengthening Healthier Washington efforts, with opportunity for reaction and dialogue. Specifically, the agenda will include:

- Celebrating and reflecting upon Healthier Washington progress to date.
- Sharing successful health system reform strategies that can be replicated in other systems.
- Activating additional partners in the important work of building a healthier Washington.

Key discussions include

- What are next steps for the "watchful waiters" who have not yet engaged in health transformation efforts?
- Integration of physical and behavioral health: What can we learn from Clark and Skamania counties?
- How are communities advancing better care, smarter spending and healthier populations?
- Paying for value: Where are we on the path to 80 percent value-based payment statewide?
- What's the status of Medicaid Transformation Waiver implementation?

Attendees

Participants will include:

- Health systems
- Purchasers
- Insurers
- Community organizations
- Tribes
- Legislators
- State agency leaders
- Public health
- Business
- Provider organizations
- Consumers
- National leaders
- Other key partners and stakeholders

Fact sheet produced by the Washington State Health Care Authority, July 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.

Health Innovation Leadership Network Accelerator Committees Update

July 2016

HILN Accelerator Committees focus on specific and timely efforts that directly impact and drive toward the achievement of Healthier Washington's aims.

HILN Accelerator Committees:

- Accelerate the goals and objectives of Healthier Washington versus advise 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.

This update provides HILN with information on activities of the Accelerator Committees over the last quarter. More information on the Accelerator Committees can be accessed via the Healthier Washington website.

Healthier Washington Communities and Equity Accelerator Committee

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

The Healthier Washington Communities and Equity Accelerator Committee promotes the concept of health equity through work done by community members. The committee held its first in-person meeting April 18 at Coordinated Care in Tacoma. At this meeting, the group broadened the scope of its work beyond the focus on data collection and disaggregation and formed four sub-committees to tackle identified priorities. The sub-committees subsequently held calls and identified action steps as follows:

- *Voices Included in Decision Making* - This group focused on community/consumer participation in Accountable Communities of Health, including ways to make meetings more accessible both physically and in terms of language and knowledge. A potential site visit is being planned to a Robert Wood Johnson Culture of Health site to identify best practices to engage communities.
- *Workforce* - This group focused on building a pipeline to the health care workforce that creates diversity. Next steps include leveraging HILN to influence health professions schools and departments to set a goal of a significant number of them making improvement to policies or goals related to diversity in applicants/students/graduates.
- *Data Disaggregation* - This group focused on identifying a pilot site (or sites) to improve data collection and disaggregation, as well as clinical sites that are already doing this and could share lessons learned and best practices.

- *Equity Lens* - This group focused on researching and identifying an evaluation tool regarding equity that Accelerator Committees and HILN organizations could use to establish a baseline in their equity work and then progress up a "ladder" of engagement and readiness.

The committee's next in-person meeting takes place immediately following the July HILN meeting.

Healthier Washington Clinical Engagement Accelerator Committee

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

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. Informed by an environmental scan, the committee will coordinate and leverage resources and opportunities to engage in adopting and advancing transformation initiatives, including new and innovative systems of care that are aligned across Washington.

This may be as simple as aligning vital resources, or identifying tools already in existence and putting them into action. Or, it may be as broad as leveraging resources to promote the spread of shared decision making and implementing evidence-based recommendations. The committee will be encouraged to identify and prioritize the areas where they will have the most impact.

The 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.

The committee has met four times in 2016, identifying a few initial focus areas. Those areas include:

- Identify 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;
- Supporting practices during transition to new value based payment structures; and
- Sharing best practices to assist clinics integrating behavioral health into primary care.

The committee recently developed a survey (attached) to disperse among committee members to begin to identify current practices at their respective organization in order to identify overlap, gaps, and areas of opportunity for the committee to begin to focus on across the state. The survey is currently being administered and the results will be shared at an upcoming in person meeting in September to inform the development of an action plan.

Healthier Washington Physical & Behavioral Health Integration 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 will build upon existing efforts and collaborations to achieve whole-person care. The committee will 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 is 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 has been on hiatus in recent months, as members of the committee focus attention on ensuring a successful statewide transition to Behavioral Health Organizations (BHOs) or full integration in Southwest Washington. In the meantime, the committee staff and co-champions have worked to organize a Health Innovation Leadership Network (HILN) meeting on July 29, 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.

Following the July HILN meeting, the Accelerator Committee champions and staff will reconvene to determine potential deliverables for the Accelerator Committee, and to refocus the committee based on HILN dialogue and feedback during the July 29 meeting.

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 seeks 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 sought to provide a forum wherein public and private partners have a role in helping shape a sustainable future for Washington's rural providers. Aligned with the dynamic balance of recognizing the issues faced by rural providers and the opportunity presented to create new tools and innovative strategies, the committee has elected to conceptualize new systems of care for rural health providers going into the future.

The committee has continued to focus on three main structural challenges facing rural providers: people, systems and processes, and technology. Over the last several months the committee has begun to draw clarity around these structural issues and has started to outline potential solutions to challenges faced. In order to guide this effort, the committee has elected to review these structural challenges and solutions posed within the context of a targeted problem statement. The problem statement will be used to focus on the vision and opportunity presented, and outline expectations. This scoping exercise will occur in the next several months.

In the coming months, the committee will work toward the review and development of materials that will provide the vision of the group. The committee will clearly articulate the distinct nature of rural health delivery and the issues faced and potential solutions that would help to address these problems. The ultimate outcome of this work will frame up actionable steps that could be taken now or in the near term that would help to help to build a sustainable future for rural providers.

The committee has met in two in-person working sessions and will be convening three additional times: September 9, October 28 and December 16. The committee has also been meeting in regularly scheduled conference calls on the first Tuesday of the month.

Healthier Washington Collective Responsibility Accelerator Committee

Co-champions: Kathleen Paul, Virginia Mason, 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 will help shape messaging that resonates, identify key partners across multiple sectors in the promotion and sustainability of Healthier Washington, and serve as champions of the concept of collective responsibility. It will:

- Highlight common indicators of success across a broad range of constituencies in communicating the value proposition of improved community health;
- Articulate and prioritize activities around the concept that all have a role to play across the system in service to mutual action and goals; and
- Serve 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 meets monthly via conference call to make progress on its value statement and objectives, 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 has spent much of the second quarter developing an inventory of activities that reflect examples of multi-sector work (draft attached). Over the next month, the inventory will be analyzed to identify key shared elements, identify and organize lessons learned, identify key partnership and collaborations required to mobilize efforts, and define pathways to replication. This will result in a product that provides an overview of the themes, issues and approaches that can be shared with and applied at the community or state levels across sectors.

Organizational Structure

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

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

- ◯ Yes
- ◯ No

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

- ☐ Initial conversations
- ☐ Leadership buy-in
- ☐ Staff training
- ☐ EMR, with registry feature to track population health and quality indicators
- ☐ Standardized patient risk assessment (e.g., of social determinants of health)
- ☐ N/A
- ☐ Other (please specify)

Value-Based Purchasing

Definition: Paying health care providers, hospitals, and systems based on measures of quality and value, such as structure, care process, outcomes, access, patient experience, and cost or resource use and away from volume, fee-for-service-based care. These types of models can include pay for performance/quality, shared savings models typically in the form of accountable care organizations, and bundled payments for episodes of care.

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

- [ ] Accountable Care Organization or Program
- [ ] Patient-Centered Medical Home Model (PCMH)
- [ ] Population health management
- [ ] Tracking of quality indicators
- [ ] None
- [ ] Other (please specify)

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

	1-strong barrier	2-medium barrier	3-slight barrier	4-not a barrier	N/A
Lack of understanding of VBP	○	○	○	○	○
Lack of appropriate reimbursement mechanism	○	○	○	○	○
Receiving health plan data/Giving health plan data to clinics	○	○	○	○	○
Consensus on quality of care definitions	○	○	○	○	○
Availability and credibility of data	○	○	○	○	○
Provider feedback mechanisms	○	○	○	○	○
Internal data collection	○	○	○	○	○
External quality indicator reporting	○	○	○	○	○
Limited data sharing and interoperability	○	○	○	○	○
Lack of community-based nurses	○	○	○	○	○
Evidence that investments in VBP worthwhile	○	○	○	○	○
Selective contracting with high-quality partners	○	○	○	○	○

	1-strong barrier	2-medium barrier	3-slight barrier	4-not a barrier	N/A
Clinical provider involvement in planning VBP activities	○	○	○	○	○
Existing forum for talking about quality and VBP.	○	○	○	○	○
Promoting structured programs for minimizing errors and waste.	○	○	○	○	○
Leadership commitment	○	○	○	○	○
Organization-wide culture	○	○	○	○	○
Legislative and political limitations (e.g., HIPAA)	○	○	○	○	○
N/A	○	○	○	○	○

Other (please specify)

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

	1-strong enabler	2-medium enabler	3-slight enabler	4-not an enabler	N/A
Reimbursement	○	○	○	○	○
Receiving health plan data/Giving health plan data to clinics	○	○	○	○	○
Consensus on quality of care definitions	○	○	○	○	○
Availability and credibility of data	○	○	○	○	○
Provider feedback mechanisms	○	○	○	○	○
Internal data collection	○	○	○	○	○
Standard set of quality measures for external reporting	○	○	○	○	○
Having a strong case that investments are worthwhile	○	○	○	○	○
Contracting with high-quality partners	○	○	○	○	○
Clinical involvement	○	○	○	○	○
Existing forum for talking about quality and VBP	○	○	○	○	○
Promoting structured programs for minimizing errors and waste	○	○	○	○	○
Leadership commitment	○	○	○	○	○
Organization-wide culture	○	○	○	○	○
Legislative and political support	○	○	○	○	○
N/A	○	○	○	○	○

Other (please specify)

7. 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?

- ◯ Yes
- ◯ No
- ◯ N/A
- ◯ Other (please specify)

Behavioral Health Integration

Definition: Care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.[i]

[i] Peek CJ and the National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.p

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

- ◯ 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
- ◯ Yes, we have a system in place to coordinate care outside of our organization
- ◯ In-process of implementing behavioral health integration plan
- ◯ No, but we have plan to move toward an integrated behavioral health model in the future
- ◯ No, we do not have plans to move toward an integrated behavioral health model
- ◯ N/A
- ◯ Other (please specify)

9. Do you have an organizational definition for behavioral health integration?

- ◯ No
- ◯ N/A
- ◯ Yes (please specify)

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

- ◯ 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
- ◯ No, we have separate EHR systems, however we have a process for sharing information that we manually input into patient records
- ◯ No, we do not currently have a process for sharing patient information between both primary care and behavioral health providers
- ◯ N/A
- ◯ Other (please specify)

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

	1-strong barrier	2-medium barrier	3-slight barrier	4-not a barrier	N/A
Conducting either behavioral and physical health screening assessments	◯	◯	◯	◯	◯
Partnerships or coordination with community resources	◯	◯	◯	◯	◯
Billing/network issues from health plans	◯	◯	◯	◯	◯
Lack of appropriate reimbursement mechanism.	◯	◯	◯	◯	◯
Receiving health plan data/Giving health plan data to clinics	◯	◯	◯	◯	◯
Care teams that include behavioral health personal	◯	◯	◯	◯	◯

	1-strong barrier	2-medium barrier	3-slight barrier	4-not a barrier	N/A
Care manager or behavioral health specialist to follow-up with patients	○	○	○	○	○
Medical provider's ability to deal with behavioral health care issues	○	○	○	○	○
Behavioral health care provider's ability to deal with medical care issues	○	○	○	○	○
Consensus on quality of care definitions	○	○	○	○	○
Availability and credibility of data	○	○	○	○	○
Provider feedback mechanisms	○	○	○	○	○
Internal data collection	○	○	○	○	○
External quality reporting	○	○	○	○	○
Limited data sharing and interoperability	○	○	○	○	○
Legislative and political limitations (e.g., 42 CFR)	○	○	○	○	○
Evidence that investments in behavioral health Integration are worthwhile	○	○	○	○	○
N/A	○	○	○	○	○

Other (please specify)

12. Enablers: From the following list please rank each of the following factors as "enablers" or factors that help with integration of behavioral health

	1-strong enabler	2-medium enabler	3-slight enabler	4-not an enabler	N/A
Conducting patient assessments (either behavioral health assessments within primary care or physical health assessments within behavioral health care)	○	○	○	○	○

	1-strong enabler	2-medium enabler	3-slight enabler	4-not an enabler	N/A
Partnerships or coordination with community resources	○	○	○	○	○
Integrated payment system	○	○	○	○	○
Receiving health plan data/Giving health plan data to clinics	○	○	○	○	○
Care teams that include dedicated behavioral health personal	○	○	○	○	○
Care manager or behavioral health specialist to follow-up with patients	○	○	○	○	○
Medical provider's ability to deal with behavioral health care issues	○	○	○	○	○
Behavioral health care provider's ability to deal with medical care issues	○	○	○	○	○
Consensus on quality of care definitions	○	○	○	○	○
Availability and credibility of data	○	○	○	○	○
Provider feedback mechanisms	○	○	○	○	○
Internal data collection	○	○	○	○	○
Standard set of quality measures for external reporting	○	○	○	○	○
Legislative and political support	○	○	○	○	○
Evidence that investments in behavioral health Integration are worthwhile	○	○	○	○	○
N/A	○	○	○	○	○

Other (please specify)

Clinical-Community Linkages

Definition: Creating sustainable, effective linkages between the clinical and community settings can improve patients' access to preventive and chronic care services by developing partnerships between organizations that share a common goal of improving the health of people and the communities in which they live. These linkages connect clinical providers, community organizations, and public health agencies.[i]

[i] Clinical-Community Linkages. June 2015. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html

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

- ◯ No
- ◯ In process
- ◯ N/A
- ◯ Yes. Please describe (e.g., main duties, including any coordination with community-based services):

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

- ◯ Yes
- ◯ No (skip to question 16)
- ◯ N/A (skip to next section)
- ◯ Other (please specify)

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

- ☐ Formalized referral processes
- ☐ Regular provider networking opportunities
- ☐ Integrated health information technology
- ☐ Use of care coordinator(s) or community health worker(s)
- ☐ Using population level data to identify high risk clients
- ☐ Other (please specify)

16. If not, what are the barriers?

- [ ] Limited knowledge of community resources
- [ ] Lack of time/dedicated staff person to coordinate services
- [ ] Service silos
- [ ] Language differences between different types of providers
- [ ] Other (please specify)

Other Transformation Initiatives

17. 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?

- ◯ N/A
- ◯ No
- ◯ Yes (please list)

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

- ◯ Practice Innovation Network (e.g., Cardiac learning and action network, PQRS reporting/meaningful use support)
- ◯ Healthy Hearts Northwest
- ◯ CMS - Practice Transformation Networks
- ◯ CMS - Medicare Access and CHIP Reauthorization Act (MACRA) Quality Improvement Direct Technical Assistance (MQIDTA)
- ◯ N/A
- ◯ Other (please specify)

19. Has your organization implemented recommendations developed by the Bree Collaborative?

- ◯ Yes – have fully implemented at least one recommendation
- ◯ Yes - working to adopt at least one recommendation
- ◯ In process
- ◯ No
- ◯ N/A
- ◯ Other (please specify)

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

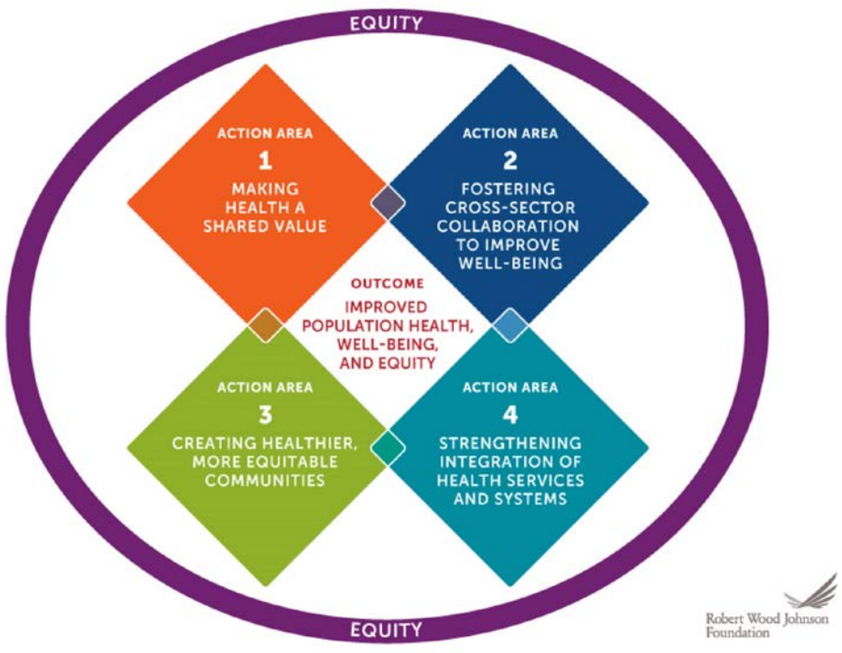
- ☐ Comprehensive website
- ☐ Educational webinars
- ☐ In-person seminars
- ☐ On-site practice coaching
- ☐ Other (please specify)

DRAFT – JULY 2016

Framework for the Healthier Washington Collective Responsibility Accelerator Committee members to map out actions their sector/organization is taking to improve health and health care in Washington. This work will help members better understand how we each conceptualize the roles we play to improve health, and from there inform an education/advocacy strategy (as well as indicators of success).

The creation of this inventory advances the Accelerator Committee's strategies to "Gather and Share Information" and "Identify Common Indicators" through the compilation of learnings, opportunities, indicators of success and best practices in collective responsibility to identify key audiences, common themes and potential strategies, as well as through the development of a product that identifies existing resources and compiles common indicators of success for collective action and responsibility.

Framework is from Robert Wood Johnson Foundation: http://www.cultureofhealth.org/



Making health a shared value: Making Health a Shared Value emphasizes the importance of individuals, families, and communities in prioritizing and shaping a Culture of Health. Everyone should feel engaged with their community's decisions and believe that they have a voice in the process.

Fostering cross-sector collaboration: Are individuals, institutions, and communities doing all they can to prevent illness and promote health? For well-being to flourish, we need to work together. This Action Area focuses on collaborations that include sectors typically seen as outside health and health care. Cooperation across sectors like education, business, transportation, and community development can play an essential role in building a Culture of Health.

Creating healthier, more equitable communities. The places where we live, learn, work, and play all contribute to our ability to become and stay healthy. How effective are our environments in fostering the healthy development of our children or in adapting for older adults so they can age in place? Do our neighborhoods offer access to nutritious and affordable food, recreational facilities, lifelong learning environments, and active transportation methods such as bike trails and sidewalks?

Strengthening integration of health services and systems. Imagine high-quality, efficient, and affordable health care to everyone living in the United States – where, when, and how they need it. This action area aims to strengthen a system of coordinated, quality care that integrates and better balances medical treatment, public health, and social services. It calls for a care delivery system that rewards value over volume and increased consumer engagement, shared decision-making, and transparency of data showing cost and quality of care.

Actions to Improve Health and Health Care: Mapping examples from across our sectors and organizations

YOUR SECTOR / ORGANIZATION	1. Making Health a Shared Value	2. Fostering Cross-Sector Collaboration to Improve Well-Being	3. Creating Heathier, More Equitable Communities	4. Strengthening Integration of Health Services and Systems
Local government (county); local public health **King County** In each area, we highlight actions we take both as the county government for the region's 2 million residents, and those that we take as a major regional employer and health care purchaser. Our external and internal actions are interconnected and mutually reinforcing: actions we take that affect the whole county also support our employees and their families; and actions we take as an employer have the ability to leverage larger health care system change that can deliver improved value for the larger community. *HILN Committee Rep: Caroline Whalen*	Equity and Social Justice (ESJ) commitment and plans Coverage is Here King County Champion of Health and Human Services Transformation initiatives - - - - - - *As an employer:* Comprehensive employee health and well-being strategy Best Run Government - engaging employees and fostering workplace culture of innovation	Best Starts for Kids levy Local Food Initiative Confronting climate change All Home – homelessness partnerships (housing/health) Gun violence prevention Accountable Community of Health convener King County Hospitals for a Healthier Community convener Transit-oriented development Collaboration across Orca Lift (reduced bus fare) enrollment and health coverage enrollment - - - - - - *As an employer:* Collaboration across county departments (Parks, Public Health, Transportation, etc.) to support employee health and well-being Financial well-being program being piloted, to address employee stress associated with financial issues.	Building healthier places through: - Communities of Opportunity - Healthy Housing - Partnerships to Improve Community Health - Smoke-free environments - Comprehensive plans / healthy community planning - Community Resilience & Equity Program (Preparedness coordination) - - - - - - *As an employer:* Fostering healthy physical environment: - On-site activity centers and classes - Wellness and lactation rooms - On-site CSA deliveries Policies that support flexibility and work-life balance	Behavioral health organization (BHO); physical and behavioral health integration design Heroin and Opiate Task Force convening Familiar Faces Mental Illness-Drug Dependency Action Plan Programs for community health workers (e.g., asthma) Support for clinical practices (family planning, communicable disease prevention, etc.) - - - - - - *As an employer/health care purchaser* Change agent moving toward value-based purchasing Benefit designs to incentivize prevention Empowering employees to become more actively engaged as shoppers and consumers of health care

YOUR SECTOR / ORGANIZATION	1. Making Health a Shared Value	2. Fostering Cross-Sector Collaboration to Improve Well-Being	3. Creating Heathier, More Equitable Communities	4. Strengthening Integration of Health Services and Systems
Health care; rural health **WSHA/AWPHD** *HILN Committee Rep:* *Ben Lindekugel*	Cosponsored with public health, WSMA, UW Population Health summit Engage hospitals in outreach and enrollment of patients in state health insurance exchange	Serving as sponsor/host for King County Hospitals for Healthier Communities	Worked with state to develop new payment model for vulnerable rural hospitals Created collaboration among 14 rural hospitals, public health, FQHC, etc. to form north central ACH Secured $100 million for mental health funding and $32 million for new mental health facilities Founding member of Health Coalition for Children and Youth Partnering at the local and statewide levels with the Accountable Communities of Health Working with all WA hospitals to simplify, standardize and translate charity care application process	Brought hospitals together to achieve 94% reduction in early elective deliveries before 39 weeks, allowing 3200 babies to mature Created Partnership for Patients, a hospital/physician relationship to increase safety and quality—resulted in 23,000 fewer harms per year. Created tools for hospitals to reduce readmissions and achieved a 27% reduction in readmissions Shared best practices among hospitals to achieve a 35% reduction in hospital mortality due to sepsis shock Worked with ER physicians, state Medicaid and hospitals to create “ER is for Emergencies” resulting in 9.9% reduction in ER visits, 10.7% reduction in “frequent visitors”, 14.7% reduction in visits with scheduled drug prescription

YOUR SECTOR / ORGANIZATION	1. Making Health a Shared Value	2. Fostering Cross-Sector Collaboration to Improve Well-Being	3. Creating Heathier, More Equitable Communities	4. Strengthening Integration of Health Services and Systems
				Championed state telemedicine legislation to expand access to specialty and primary care in urban and rural areas Through the safety net assessment, providing funds to the UW AIMS project to train more psychiatrists and other practitioners in integrative care model
Philanthropy **King County/Washington State** The Pacific Northwest Initiative of the Bill & Melinda Gates Foundation is committed to increasing access to educational success and attainment of a post-secondary degree for youth and young adults in our communities who are furthest from opportunity, including low income youth of color, homeless unaccompanied youth, and homeless and unstably housed families. *HILN Committee Rep: David*	We agree that there is a fundamental congruence between social determinants of health and social determinants of educational success. When we are discussing the social, cultural and systemic supports that are essential to increasing educational achievement, these supports are inextricably connected to the health-related supports and activities that promote individual and family well-being. The innovations that we seek to fund and support as a foundation	We are actively supporting efforts to promote integration of the key data sets that allow us to both identify the most important at-risk populations, track the relationship between key outcomes across multiple systems, and identify those interventions that can have the most positive impact on the social determinants of educational success (and health). This includes funding work in the field to enable the integration of data sets from multiple systems, including: • Health outcomes data (HCA) • Social services data related to social & emotional development (DSHS/ICDB)	With access to integrated data systems, we can track specific outcomes across multiple key measures that relate to the physical & social determinants of educational success and health, including: • Health care system enrollment and engagement • Receipt of primary care and related health services • Housing status (in public or subsidized housing) • Involvement with full range of social service, criminal justice and related systems	Informed by the data, systems that provide housing, health care, social & emotional learning and education can effectively work together to: • Plan and implement the most effective & efficient interventions that promote health, well-being and educational success for Washington State's most vulnerable children and families. • Measure the impact of shared, collective efforts to provide holistic services and supports in the context of the overall environment in which children and families

YOUR SECTOR / ORGANIZATION	1. Making Health a Shared Value	2. Fostering Cross-Sector Collaboration to Improve Well-Being	3. Creating Heathier, More Equitable Communities	4. Strengthening Integration of Health Services and Systems
Wertheimer	are seen as contributing not only to the educational success of our state's most vulnerable youth, but to the well-being of families, communities and learning environments as part of the bedrock of a healthy Washington.	• Housing data (PHA, WBARS) • Education data (OSPI/ERDC) Data integration requires addressing confidentiality challenges presented by HIPPA, FERPA, and other statutes that regulate the sharing of information across systems.	that inform social & emotional learning (in the DSHS ICDB) • Key markers of educational success, (e.g., absenteeism, disciplinary issues, 3rd grade reading, 5th grade math, HS graduation, post-secondary success, etc.)	live, work and play. • Target interventions to maximize use of limited resources to achieve health outcomes (writ large) in communities that are furthest from opportunity and most in need.
Local government (county); Area Agency on Aging; Care Coordination Organization (CCO) **Pierce County Aging & Disability Resources** Area Agencies on Aging (AAA) operate within a statewide and national framework, embedding goals, objectives and strategies focused on healthy aging, livable communities, and service integration / system coordination within local Area Plans *Collective Responsibility Committee member: Connie Kline*	**WA State Health Home Program** Implemented by DSHS Aging & Disability Administration and the Health Care Authority in partnership with Health Home leads and Care Coordination Organizations (CCOs) A Healthier WA health system transformation initiative funded by CMS under the Affordable Care Act A voluntary, person-centered program addressing health activation and improved overall health	State-contracted lead Health Home entities, including Managed Care Organizations (MCOs) and Community Based Organizations (CBOs) in turn contract with CCOs to provide a network of services and supports to eligible individuals CCOs can include Area Agencies on Aging, behavioral health organizations, etc. CCO Care Coordinators provide intensive person-centered support and utilize community partners (medical care, long-term services and supports, and behavioral health) to assist and engage individuals to improve their health	Reducing costs and improving health of Medicare/Medicaid beneficiaries with multiple chronic conditions through: - Comprehensive care management - Care coordination (medical and social services) - Transitional care and follow-up - Health promotion and health action planning - Patient and family support - Referral to community and social support services	Health Home network provides coordination of primary medical and behavioral health services and social supports to address the comprehensive needs of individuals CMS preliminary report of Demonstration Year 1 found: - Reduction of $21.6 million savings in Medicare costs - Some performance metrics trending in the direction intended - Approx. half of focus group participants reported achieving a health-related goal or improved overall health / quality of life while on the program

YOUR SECTOR / ORGANIZATION	1. Making Health a Shared Value	2. Fostering Cross-Sector Collaboration to Improve Well-Being	3. Creating Heathier, More Equitable Communities	4. Strengthening Integration of Health Services and Systems
WA State Allied Health Center of Excellence **WA State Community and Technical College System** In 2009, Washington became the first and only state in the nation to codify Centers of Excellence into state statute (HB1323) Ten Centers across the state represent a sector strategy to serve as economic development drivers for industries that help grow the state's economy. The Allied Health Center of Excellence, with regional and statewide leadership activities, serves as a resource to all 34 community and technical colleges, K-12 Health Science, business / industry partners, plus identified government entities to ensure a continuous pipeline of new healthcare professionals. *HILN Committee Rep:*	Support health workforce training across all Washington State community and technical colleges. The Center provides policy updates and education to faculty and administrators re: Healthier Washington Initiatives and actively encourages colleges to pursue community engagement to support public health and wellness. The COE assists with planning and facilitating the interdisciplinary health care futures conference. The focus of the conference is health care reform and the implications for multiple sectors including Health Care Education, Health Information Technology, Biotechnology, Community Health and the Integration of Primary Care and Behavioral Health.	Promoting a workforce that is team based and interprofessional across all health workforce training programs. The Center represents the community college system on the Yakima Valley Interprofessional Practice and Education Collaborative which was established to promote the highest quality health care in the region through a culture of inclusive and collaborative interprofessional education, practice, and scholarship. Participating institutions include Pacific Northwest University of Health Sciences, Heritage University, Central Washington University, Washington State University and the Allied Health Center of Excellence, hosted at Yakima Valley College. The Collaborative has a robust Advisory Council which includes multiple community partners including K-12 education, hospitals, community business leaders, the workforce development council, community health centers, the agriculture industry and a number of non-profit community based service	Advocating participation by the community college system in regional efforts for population health and the Accountable Communities of Health. Member of the Community Health Worker taskforce Education and Training Committee; Roles Skills and Attributes Committee. The Center Director is a member of the Leadership Council for the Greater Columbia Accountable Community of Health and participates on both the strategic issues and oral health subcommittees.	Support CTC system Hospital Employee Education Training grants to develop care navigation and coordination curriculum. The certificate program prepares individuals interested in professional care navigation, coordination, and advocacy roles in the health and human services systems. This certificate is based on the concept of integrated care for the whole person and focuses on strategies to navigate care to achieve wellness outcomes. The Center creates opportunities for college faculty and administrators to share best practices of examples of innovation in programming to integrate behavioral health and primary care training programs. The COE created a resource guide for K-12 students to use as an all in one “clearinghouse” for information on finding organizations that promote careers in health care. The “clearlinghouse” is a “central hub”

YOUR SECTOR / ORGANIZATION	1. Making Health a Shared Value	2. Fostering Cross-Sector Collaboration to Improve Well-Being	3. Creating Heathier, More Equitable Communities	4. Strengthening Integration of Health Services and Systems
Dan Ferguson		organizations		for Washington state's CTC allied health programs, allied health internships, allied health scholarships and allied health student leadership development opportunities. It give's K-12 students and counselors a research tool they need to access career information in the allied health field.
Nonprofit health care provider **Virginia Mason** Virginia Mason, founded in 1920, is a nonprofit regional health care system based in Seattle that serves the Pacific Northwest. In the Puget Sound region, the system includes 336-bed Virginia Mason Hospital; a primary and specialty care group practice of more than 500 physicians; regional medical centers in Seattle, Bainbridge Island, Bellevue, Federal Way, Kirkland, Issaquah and Lynnwood; Bailey-Boushay House, the first skilled-nursing and outpatient chronic care	**EnviroMason – Virginia Mason's Sustainability Program** EnviroMason, Virginia Mason's sustainability program, empowers team members to reduce the environmental impact of their daily work. Climate change is one of the greatest human health challenges of our generation. As an organization dedicated to preserving health, Virginia Mason is reducing carbon footprint in operations through: • Energy conservation • Commute trip reduction • Landfill diversion activities,	**Bailey-Boushay House Housing Stability Project** Bailey-Boushay House's housing stability project addresses the complex needs of homeless individuals living with chronic disease, chemical dependency and mental illness. In exchange for attending skill-building classes, clients are offered incentives such as grocery gift cards, sleeping bags, ponchos and volunteer furniture movers. These incentives inspire clients to focus on housing plans by completing applications and meeting with outside resources. In addition to nursing care, multidisciplinary assistance includes	**King County Hospitals for a Healthier Community Participant** In 2013, Virginia Mason partnered with other King County hospitals and Public Health - Seattle & King County to form Hospitals for a Healthier Community. This hospital collaborative developed a 2015 Community Health Needs Assessment (CHNA), and is developing collaborative community programs to comprehensively address community health issues. The joint CHNA provides the foundation for Virginia Mason's CHNA, which drives community work and serves as a guideline to achieve three basic goals:	**Puget Sound High Value Network (PSHVN)** The PSHVN, a clinically integrated network, was developed in response to one of three core strategies in the State Innovation Plan: *Pay for Value* **Goals:** • Build healthier communities and people through prevention and early attention to disease. • Integrate care and social supports for individuals who have both physical and behavioral health needs. • Reward quality health care over quantity, with state

YOUR SECTOR / ORGANIZATION	1. Making Health a Shared Value	2. Fostering Cross-Sector Collaboration to Improve Well-Being	3. Creating Heathier, More Equitable Communities	4. Strengthening Integration of Health Services and Systems
management program in the U.S. designed and built specifically to meet the needs of people with HIV/AIDS and Benaroya Research Institute, which is internationally recognized for autoimmune disease research. *HILN Committee Rep:* *Kathleen Paul*	such as recycling, composting and food donation • Buying local goods and services Since 2011, energy conservation projects have saved almost 4.5 million kilowatt hours per year and water conservation projects have saved more than 7 million gallons of water per year. Virginia Mason also led a statewide effort to engage businesses on climate change policy. As a result more than 250 businesses have signed on to the Washington Climate Declaration, calling for action on climate change.	social work, legal and payee services. This professional assistance, combined with attention to short-term needs such as clean and dry clothes, increases participant independence in obtaining and maintaining housing. Representatives from Bailey-Boushay House, Lifelong AIDS Alliance, Harborview/UW/ Madison Clinic and Country Doctor are planning regular meetings to develop solutions for specific client challenges. This collaborative approach will help meet the needs of homeless individuals who have fallen through our community's safety net.	• Improve the community's health status and overall quality of life • Reduce health disparities within the community • Increase access to preventive services Programs include: Subsidized health services at Virginia Mason and at Bailey-Boushay House. Graduate Medical Education Program partnership with Public Health - Seattle & King County to provide services at community clinics. Community health education, such as diabetes prevention programs at the Mexican Consulate and the Nutrition and Fitness for Life pediatric program; Nutrition and fitness education at Mary's Place; Healthy cooking demonstrations at Plymouth Housing Group. Free flu shots and health screenings for uninsured/underinsured and the	government leading by example as Washington's largest purchaser of heath care. A new insurance product, UMP Plus, includes: Edmonds Family Medicine, EvergreenHealth Partners, MultiCare Connected Care, Overlake Medical Center, Seattle Children's and Virginia Mason. Supported by Regence BlueShield as the third-party administrator. Large geographic footprint with more than 600 primary care providers, 2600 specialists, 400 clinics and 11 hospitals. Offered in five counties for 2016 and will expand to three additional counties in 2017. Multiple quality initiatives focus on the care of the Complex Care Patient and the implementation of Bree Collaborative recommendations. Integrated information systems and data analytics. Financial performance tied to bending the cost curve.

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			homeless.	
Healthcare **International Community Health Services (ICHS)** ICHS is a federally qualified health center providing comprehensive, integrated health care to over 25,000 patients in 2015. We operate 4 primary care clinics (2 in Seattle, 1 in Bellevue, and 1 in Shoreline), 1 school based health center at the Seattle World School, a weekly primary care clinic at Asian Counseling Referral Service, and a Mobile Dental Clinic serving 12 Seattle and Shoreline Schools, as well as community partners. Our mission is to "provide culturally and linguistically appropriate health services to improve the health of	ICHS has an active civic engagement strategy with staff, BOD, patients, and community members. We partner with other community based organizations to implement voter registration and education efforts, as well as get out the vote activities. We believe strongly that all people, regardless of their citizenship status can be civically engaged and should understand that they have important insights to contribute to share where they live, learn, work and play – the social determinants of health. ICHS' vision is "Healthy People, Stronger Families, Vibrant Communities." We have recently adopted a strategic plan that includes addressing the social	As a sponsor of a school based health center serving refugee and immigrant youth and young people, we are actively engaged with the school and its partners, including other non-profits and individual volunteers. ICHS is an active member of several key community planning groups that support cross-sector collaboration. - BUILD Health Initiative, a Chinatown/International District place based project that aims to improve the health of the C/ID residents by addressing key community issues. This work involves community development associations, hospital, health department, other non-	ICHS has active partnerships with community centers, local YMCAs, several key ethnic specific community based organizations (e.g. Filipino Community Center, Chinese Information Service Center, Asian Counseling Referral Service, Korean Women's Association, faith based organizations, Vietnamese Friendship Association, Somali Health Board, etc.). ICHS has developed several digital stories that address various social determinants of health (e.g. food insecurity, access to parks and green spaces, importance of community centers, etc.). These digital stories are used as tools to raise community awareness and to advocate for policy changes with	ICHS is actively engaged in providing high quality, integrated, comprehensive primary care, including medical, dental, behavioral health, and critical enabling services such as health education, health insurance enrollment, interpretation, and financial counseling. As an accredited health care facility, recognized as a patient centered medical home, ICHS works across health systems to ensure that our patients' data and electronic health record is appropriately accessible to providers serving our patients. As a leader in health care innovation, ICHS is involved in two

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Asian Pacific Islanders and the broader community." We currently serve a significantly diverse, low-income, refugee and immigrant patient populations. *HILN Committee Rep:* *Michel McKee*	determinants of health and recognizes the importance of social justice and equity in achieving health.	profits, city officials, and several key city departments (e.g. law enforcement, transportation, parks, etc.). - Eastside Human Services Forum member - North Urban Human Services Association member - Chinatown/International District Safety Task Force member	elected officials and decision-makers. Three of ICHS' clinics operate Women, Infant, and Children (WIC) programs, which supports nutrition and access to healthy vegetables and fruits through food vouchers, including local farmers' markets. ICHS has long term plans to open a PACE (Program for the All-inclusive Care of the Elderly) program in collaboration with other local non-profits. ICHS employs 12 community advocates, which function as community health workers, serving ethnic/language specific communities with supportive community health education, engagement, and health and human services system navigation support.	separate data warehouses that seek to improve how data is captured and used to better serve our patients, focused on wellness and prevention, and aimed at reducing the cost of care in the long-term. ICHS has been actively engaged in meeting Meaningful Use requirements for our Health Information Technology initiative, which includes inter-operability with other health systems and providers.

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Homeless Health Care Services **Harborview Medical Center** **Seattle, WA** *HILN Committee Rep:* *Edward Dwyer-O'Connor*	Harborview Mission Statement Harborview Medical Center is owned by King County, governed by the Harborview Board of Trustees, and managed under contract by the University of Washington. The following groups of patients and programs will be given priority for care within the resources available as determined by the Board of Trustees: • Persons incarcerated in the King County Jail • Mentally ill patients, particularly those treated involuntarily • Persons with sexually transmitted diseases • Substance abusers • Indigents without third-party coverage • Non-English speaking poor • Trauma • Burn treatment • Specialized emergency care	Homeless health Partnerships and contractual agreements with; Seattle/King County Public Health, King County Mental Health and Chemical Dependency Services and the King County Jail. Agreements and partnerships with Plymouth Housing Group, Downtown Emergency Services Center, Compass Housing Group, Catholic Community Services, Chief Seattle Club, Angeline's Day Center, 1811 Eastlake the REACH Program and Evergreen Treatment Services, Seattle Housing Authority HUD], Union Gospel Mission, Chief Seattle Club. Created partnerships with DESC and Plymouth to bring housing and health care together for this vulnerable population. Developed Medical Respite program to provide integrated care [physical and psychiatric] for homeless patients who are too sick for the streets but not sick enough for the hospital. Intentional Harm Reduction program that serves a large number of patients addicted to heroin. Connect	Created better data gathering on homelessness throughout the hospital and started tracking and connecting patients with care designed for homeless through Hospital to Home Program. Created Homeless Palliative Care program to follow patients after life-limiting diagnoses. Worked closely with Coordinated Entry in development of system to prioritize housing for this vulnerable population.	Developed programs for homeless that integrate behavioral and physical health on a larger scale including; medical clinics based in DESC mental health center and DESC main shelter. Data is shared across data systems between the two entities. Clinics developed in coordination with Health Care for the Homeless. Health care from clinics outreaches to housing when needed. Medical clinic imbedded in Harborview Mental Health and Addiction Services. Behavioral Health Care integrated into Pioneer Square Clinic and Third Ave Center in downtown Seattle.

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	• Victims of domestic violence • Victims of sexual assault While maintaining this priority commitment to patients and programs in the above categories, Harborview also serves a broad spectrum of patients to maintain a balanced clinical program and fiscal viability. Harborview plans and cooperates with other hospitals, public health providers, and the University of Washington to provide programs and services and avoid unnecessary duplication.	patients to treatment and housing whenever possible. Developing new Intensive Care Management program for jail high utilizers in Seattle in partnership with the county and community providers.		
Housing and health care **Washington Housing-Health Partnership** *HILN Committee Rep:* *Bill Rumpf*		We've met for about 18 months and had good involvement from HCA and DOH at the state, Public Health Seattle & King County, Gates Foundation and Boeing, Building Changes, Foundation for Healthy Generations, Global to Local and the public housing authorities from Seattle, King County, Tacoma and		

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		Spokane. The common goal is to develop a sustainable and scalable business model for affordable housing-based, or low-income community based health interventions. MHNW and several other organizations are employing Community Health Workers.		
Health Plan **United Health Care** *HILN Committee Rep:* *Doug Bowes*	**United Culture** Managers are required to go through three days of training on the culture which is somewhat self-exploring and intense. The training is conducted by senior executives from the company. Below is that basis for our culture: Our United Culture: Our Mission is to help people live healthier lives. Our Goal is to make health care work for everyone. Integrity: Honor commitments. Never compromise ethics. Compassion: Walk in the shoes of people we serve and those with whom we work.			

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	Relationships: Build trust through collaboration. Innovation: Invent the future and learn from the past. Performance: Demonstrate excellence in everything we do.			

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Health care: charity care and Medicaid **Project Access Northwest and other similar access efforts including free clinics** *HILN Committee Rep:* *Sallie Neillie*	Mission is to collaborate with the health care community to open doors to medical and dental care for low income individuals with limited access. Partner with all hospital systems, multi-specialty groups and community health centers in King, Kitsap and Snohomish counties.	Partner with all hospital systems and multi-specialty groups in King, Kitsap and Snohomish Counties to assure access to organized, efficient donated charity care to uninsured and provide, when requested by specialists, same care coordination for Medicaid patients to assure efficient use of providers time. Collaborate with community health centers and free clinics to assure their patients have appropriate access to needed specialty care services. Work with the Washington Healthcare Access Alliance (membership organization of free clinics in WA state) to assist in creating relationships and access as needed.	Collaborating in pilot program to assist uninsured and Medicaid in-patients make and keep a primary care appointment within 5 days of discharge. Collaborating in pilot program to link uninsured and Medicaid ED users to needed resources (including family practice clinics, food insufficiency, housing resources, etc.). Providing access to Silver Level health care insurance in partnership with funders to low income households who can't afford remaining premiums after tax credits are applied.	Prior to the ACA, brought the donated distributed care programs in the state together to collaborate and share best practices (most similar efforts are no longer in existence).

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Early Learning The **Department of Early Learning** is responsible for offering programs and services that support healthy child development and school readiness for the approximately 90,000 children born in Washington each year. Our work includes helping ensure high-quality, safe and healthy learning environments, offering comprehensive preschool education to vulnerable children, providing family support and information, overseeing services for infants and toddlers with disabilities and developmental delays, and supporting early learning professionals. *HILN Committee Rep:* *Greg Williamson*	Equity and Social Justice commitment and plans Healthiest Next Generation Initiative	Child Abuse and Neglect Prevention Home Visiting Healthiest Next Generation Initiative- 3 state agencies Child Care Subsidy Homeless Child Care ECLIPSE (Early Childhood Intervention Prevention Services) Early Support for Infants and Toddlers *As an employer:* State supported SMART Health	Health and Safety are the foundations of child care licensing regulations. Currently revising regulations to include some best practice standards from Caring for Our Children, 3rd edition—including areas promoting healthy eating and physical activity. Infant/Toddler consultation system which includes opportunities for health, nutrition, and mental health consultation for early learning programs that serve infants and toddlers. *As an employer:* Fostering healthy physical environment: - Wellness and lactation rooms Policies that support flexibility and work-life balance	Head Start, Early Head Start and ECEAP provide comprehensive services for young children, including health screenings and promotion of well child health and dental exams and family support. Working to re-establish a system of child care health consultation (nursing, mental health, nutrition, and environmental health) in the state. Developing a comprehensive Prenatal to 3 health system.

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Greater Columbia ACH The Greater Columbia ACH is a collaboration of community leaders from a variety of sectors with a common interest in improving health. The Board of Directors represents over 17 sectors within our 10 County geographic region. The Leadership Council is a 40+ "think tank" with subject matter experts in our 5 priority areas: obesity/diabetes, oral health, healthy youth & equitable communities, care coordination, and behavioral health. The Strategic Issues Committee (SIC) has developed our Regional Health Improvement Plan with help from our Consultant, Deb Gauck using the Culture of Health Framework. The Strategic Issues Committee identified and prioritized 3 strategic issues through 3 different survey methods: #1 Foster Cross-Sector Collaboration and Integration	• School-based assessment • Early ID of needs • School-based health centers • Worksite wellness	• School access for purchasing fruits/veg (rural) • Purchase healthy foods for schools • Safe neighborhoods or perception of safety (metropolitan/urban) • Access to parks • Community design - connectivity of sidewalks/trails • Marketing/environmental • Policy changes (SNAP--EBT by rock star for example, WIC is doing whole grain, etc.) • Neighborhood Safety & Perception of Safety • Safe routes to schools • Access to parks, areas to walk, bike, pools • Farmers' markets • Community gardens • Food security • Second Harvest • Breastfeeding promotion • Information on food banks and community gardens on public transit • Second Harvest mobile food	• Access to Baby and Child Dentistry • Smilemobile • Spanish medical interpretation • Health fairs and demonstrations • Translators • Transportation • More education about health for families/communities • Education for parents in hospital labor and delivery • Meet community where they are, e.g., where people live, work, worship, etc. • Dental clinics at ER • BHT DENTS program: Apple Health patients at ER referred by CHWs to dentists • Nursing Pathways • Integrate some CHW model in with dental health • Dental workforce • Use dental workforce in existence and recommend changes to practice such as dental hygienists • Train residents in rural areas • Need trusted resources in communities, e.g., CHWs	

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#2 Creating Healthier, more Equitable Communities #3 Strengthening Integration of Health Services and Systems *HILN Committee Rep: Martin Valadez*		pantry • Child and adult food care program • Summer meal program for kids, FISH food bank • Farm to school program • WIC • Youth sports scholarships • Early learning • Child Care Aware Early Achievers Infant/Toddler Consultation • Reach Out and Read • Elementary outreach • 21st Century Community Learning Centers • Supplemental Education Services • Yakima Valley College Access Network • English as a Second Language classes • GED classes • YouthBuild • Community Jobs • Academic Youth Employment Program	• Develop region-wide expertise so we have a "No Wrong Door" for all community members with behavioral health needs • Raise the level of expertise among community primary care, education, and social service systems to identify, screen, and provide ACES and BH screening. Includes prevention, identification of need • Trauma informed care/practice • Mental health first aid (model after Red Cross First Aid) for lunch ladies, EMTs, and small schools • Mental Health Integration Program (embedding BH into primary care) • Crisis intervention training • Housing inventory for mental health • ACES performance measures • Care delivery model (adding behaviorist, nutritionist, and pharmacists in each provider office) • Inpatient psychiatric unit	

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			• Outpatient mental health services • Parents as Teachers • Applied behavioral analysis • Mental health consultation to Head Start • Respite adult day center • Residential mental health services • Inpatient services • Chemical dependency services/treatment/recovery • Children with special health care needs • County mental health • Behavioral health integration • Behavioral health integration program • Housing services • School nurse corps program • Counseling center employment specialist • Children's summer day program • Therapeutic riding • Community paramedicine program • ACES work • School-based mental health competency training	

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			• Bright Beginnings • Community training • Shared value of cultural imperative to look for risk • Understand the path of where to go (hospital system, police, school, courts, EMS, etc.) • Integrated system (informed PCPs, BHIP, PC to MH, hospital, clinic, other settings • Permeation of well-being awareness • Awareness of healthcare resources • Common screening tool • Community awareness—destigmatize • Pathways predetermined • Proximity of MH (addiction) & PCPs • Fluid connections • Core competencies within professions • Lower activation level to access appropriate care • Models – could be other types of providers, not necessarily doctors • We need more opportunities	

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			for people to access care over the phone • Supportive Housing • Effective affordable transportation • Primary Care, as a factor for ER diversion • Basic knowledge of healthcare system, when to use ER or not • Support network, systems that help the member in two different categories • Direct and related to the individual; family, relatives, friends • Community Support; Agencies providing services for the individual • Existence of a clearly identifiable diversion agent • 100% intervention for people who use the ED for primary care • All ED users who seek care and are being discharged with these codes will have an intervention with an MSW/BSW or other life skills coach (possibly community health worker) prior to discharge from ED	

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			• Care coordination is promoted as the individual is assisted to connect with social services to promote health • If the hospitals are profiting from additional Medicaid volumes into the ED we need all of them to make a commitment to redirect non-emergent patients for future visits • Expand Consistent Care to all counties in our region and link their efforts and communication-- consistent treatment, consistent policies, etc. I'd like to see the Consistent Care program coordinate the use of ED by those with mental health diagnoses. We can build on the success of the current program to include other high use, high risk individuals • Promote state-wide policies that help in the effort to communicate "100% ER for Emergencies!" • Consistent Care (inappropriate use of hospital EDs) • Community	

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			paramedic/paramedicine program • Home visiting program • Housing and recovery through peer support • Health Home • Medical respite care • Coordinated discharge planning team • Permanent/supportive housing • Care transitions/transitional care • Senior and Residential Care Program • Care management • Palliative care • Dental case management • Connection between/integration of medical and dental • Diabetes and pregnancy efforts should include oral health • Case management could send people out to talk with parents about why they should bring their kids in for dental care • Prevention programs focused on life skills • Resiliency training for kids and	

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			caregivers • Parenting skills • Foster teen programs • Foster care • Foster grandparent • Prepares (mentoring) • Evidence-based parenting • Los Ninos Bien Educados (parenting) • Incredible Years • Nurse-Family Partnership • Medicaid treatment child care ECLIPSE • Child care coordination • Prenatal oral health initiative • Incredible Years • Screening for oral caries by primary care providers • More screening programs in schools • Shared value of prevention • General knowledge Health literacy Diabetes Prevention Program • Cultural awareness of food preparation/cooking methods	

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			• Life skills, e.g. planning meals • Walk the walk, talk the talk diabetes prevention program • Yakima childhood obesity program • Youth advocates for health • Support network • Food nutrition education program • Pathways • Diabetes management and control • Low-cost cooking classes • Pathways to diabetes self-care • Nutrition education plan • Diabetes wellness, Diabetes Prevention Program, and Chronic Disease • Pediatric yoga • ACT! Obesity prevention program • International diabetes management • Eating Smart, Being Active • Chronic Disease Self-Management • Healthy for life cooking classes	

Health Innovation Leadership Network

Quarterly Meeting | April 15, 2016

Summary

The first quarterly meeting for 2016 included a discussion about the importance of understanding the multisector leadership role in accelerating our shared goal to incentivize and deliver quality and value in Washington's health and health care systems. Additionally, there was a spotlight on the Paying for Value investment area, and the Leadership Network received an update on the design and early results of the Healthier Washington evaluation.

Opening remarks

John Wiesman, Healthier Washington Executive Governance Council

- Healthier Washington recently had a successful site visit with CMMI, which was a great opportunity to interface with the leadership. HCA Director Dorothy Teeter and Everett Clinic CEO Rick Cooper passed along their reflections regarding the visit:
    - We heard loud and clear that we cannot noodle around with incremental change. People are really looking to scale value-based care and hit the critical tipping point in incentivizing quality and value.
    - Accountable Communities of Health need to demonstrate their return on investment and early wins.
    - It was humbling to see all the hard work going into initiatives such as the early adoption of fully integrated care in Southwest Washington, the Accountable Care Networks in the Puget Sound region, and the Accountable Communities of Health.
    - We cannot lose focus on sustainability and must place importance on figuring out how we can sustain all of these things after the grant period ends.

Nathan Johnson, Healthier Washington Coordinator, provided a status update.

- Since we last met, we have entered Year 2 of the State Innovation Model grant, which is one of the drivers of Healthier Washington. That means we are transitioning from a design policy development era to one focused on action and implementation.
- This means that the Health Innovation Leadership Network, and the accelerator committees that are attached to it, are transitioning together from a method of education and informing to one as change agents.
- A Healthier Washington symposium was mentioned at the last meeting that would gather some of the sectors represented in the Health Innovation Leadership Network to engage on several focused topics. This was originally planned for a spring timeline, but has now

moved to fall. This event would help us all focus on the new phase of Healthier Washington and around three major topics and outcomes that we're aiming for. These agenda items include:

  - Celebrating and reflecting the work of Healthier Washington
  - Want an opportunity to share successful strategies that are working at a regional or state level and that can be replicated in other systems, whether that be Accountable Communities of Health, individual efforts around integrated care like we're seeing develop in Southwest Washington. Scale and spread is a theme in Healthier Washington and the symposium will provide a forum for that.
  - We want to active additional partners in the important work of building Healthier Washington, as many sectors are required to make this work sustainable. This will not be another health policy conference, but rather a more focused, and actionable discussion opportunity.

- We will have an opportunity to engage our regional CMS partners on the symposium timeline we have proposed. We hope to have a strong national presence at this event so that we can better link the federal and state efforts.

Paying for Value Spotlight

Hugh Straley, Dr. Robert Bree Collaborative

- The system right now is getting uneven quality, higher costs, and poor population outcomes and thus, we are not achieving the triple aim. Any system is designed to get the outcomes that it does and we need to change our current system and value-based payment is how we do that. The Bree Collaborative was created in 2011, in an effort to bring together stakeholders to improve quality and reduce costs.
- We will hear today the value-based payment foundational elements, which are aligned incentives, measurement of outcomes, patient-centered coordinated care, and transparency.

Al Fisk, The Everett Clinic

- There are three critical aspects to moving to the paying for value structure: transparency, the right clinical components, and the incentives and benefits structure. Healthcare is currently way too expensive, the quality is extremely variable, and it's bankrupting the country and we would like to think that there should be rewards for those who deliver quality care.
- Purchasers and providers want the same thing. Purchasers want high quality, affordable care that keeps their employees healthy. Patients want high quality, affordable care that keeps themselves and their families healthy. Providers want high quality, affordable care that keeps their patients healthy.
- Purchasers should demand transparency. If there is transparency in cost and quality, purchasers and patients can make more informed decisions. Healthy competition among

providers and clinics will also help drive down prices if patients can see those costs in advance.

- One of the right clinic models include integrated behavioral health—however, the high copays for behavioral health services is an enormous barrier and should be the same cost as more affordable primary care copays. Another successful clinic model is prescription management which means booting the drug representatives, and letting science influence prescribing, rather than marketing. This model also uses generic drugs for over 92% of their prescriptions, which has saved Everett Clinic customers more than $100 million a year. Imaging management is another clinic model. This includes using an evidence-based system where protocols must be met prior to order imaging. At the Everett Clinic, unnecessary scans were reduced by 29%, saving the clinic approximately $3.2 million annually. Additionally, care programs for complex patients should be considered. These innovative care programs improve outcomes and prevent unnecessary trips to the hospital.
- To summarize, those who pay the bill should also be demanding the right incentives and the right benefit design. Benefit design should be aligned with value-based reimbursement, out of pocket costs and selection of tiered networks. Behavioral health needs to be part of primary care benefits. Innovative care programs for complex patients need to be part of benefit design. The purchasers of care need to collaborate and change the system. To change how providers get paid, we need to move away from payment system based on volume, pilot contracts that pay providers for vale, and incentivize for reaching highest quality standards.

Diana Birkett Rakow, Group Health Cooperative

- Value based purchasing and value based insurance design can mean different things to different people. Value based purchasing includes making sure we're supporting providers in making the right decisions for people and delivering the best care. Value based insurance design includes supporting consumers in making it easier and cheaper to make those same decisions that deliver the best care and deliver care where they most need it.
- David Rolf and Chris Barton are both partners that have worked with Group Health to design benefits that create the type of structure we're talking about, but also then help people get the right information so that they can make great decisions around it.

David Rolf, SEIU 775

- The mission of the SEIU 775 group serves home care aides, and is to transform health care for their members and beneficiaries, and for the clients and consumers they serve. When operating on a fee-for-service system, there were escalating prices and double digit inflation, due to high-level emergency room visits, and low use of primary care services. With Group Health as the key sponsor, the Engaged Sponsor Program was created that created mutual incentives for the union, the health plan, and for the beneficiaries to get a handle on prevention and cost. By increasing price incentives for the members, and

engaging them more actively about integrated care, they program has seen many successful wins.

Chris Barton, SEIU Nurse Alliance Northwest

- In 2008, Group Health began working with union partners to negotiate a value-based insurance design health plan. Through this design, they incentivized and integrated preventative care, chronic care management and wellness into one plan and developed a culture of responsibility to utilize health care in the smartest way.

Jeff White, The Boeing Company

- You don't have to be a large employer to begin having conversations with the health care systems directly. There is a role, however, that the employer community needs to play in the system design. Boeing tries to align their goals around the triple aim, by making sure their health systems model is incentive online, maintains employee choice (providing options), and preserves a simplified approach. Boeing provides a strong incentive to their employees to choose an ACO, which is to receive better care and better outcomes. ACOs are then provided higher patient volume, and Boeing also provides them with a shared savings opportunity, as well as a branding win.

Rachel Quinn, Health Care Authority

- The Health Care Authority purchases health care for over 2.2 million people through Medicaid and PEBB, spending $10 billion annually. In 2014, HCA received a mandate from the legislature to increase value-based payment models. We need to get away from the fragmented, uncoordinated, volume-based systems, and move to an integrated care, engaged, value-based payment system. This system will also have standardized performance measurement, with clinical and financial accountability, and transparency for improved health and outcomes. Purchasing goals to reach by 2019 are:
    - 80% of state-financed health care and 50% of commercial health care will be value-based payment arrangements
    - Washington's annual health care cost growth will be 2% less than the national health expenditure trend
- Key strategies include: purchasing high-value care for Medicaid and PEBB members, engage purchaser, provider and payer partners to accelerate transformation, and align with federal efforts.

Quarterly Update

Healthier Washington Coordinator Nathan Johnson announced some recent successes of the Paying for Value: Early Adopter of Medicaid Integration. These included:

- Successful launch of fully integrated managed-care on April 1. Over 120,000 Medicaid clients enrolled in fully integrated plans in Southwest Washington.
- Released a timeline and memo in February setting forth key milestones for regions to pursue fully integrated managed care between now and 2020.

- Received a non-binding letter of intent in April from Chelan, Grant, and Douglas Counties to pursue fully integrated managed-care prior to 2020. HCA will begin engaging the counties to transition planning.
- HCA is working with Federally Qualified Health Centers and Rural Health Clinics on a new payment model that would free them from focusing exclusively on encounters as a revenue basis, and allow them to be rewarded for quality and allow them some flexibility to innovate within their delivery system models.

Healthier Washington Evaluation

Erin Hertel, Center for Community Health and Evaluation

- ACHs have spent the last year coming together to become regional multi-sector coalitions with the operational capacity, and the collaboration necessary, to move to action. Action is starting to implement the regional strategies and projects necessary to change healthcare in their region.
- Key Findings from Year 1:
    - All nine regions were formally designated as ACHs. HCA encountered community-driven development, which resulted in variation.
    - All ACHs have built the basic infrastructure and foundation needed to move forward, through governance structures or backbone organizations.
    - ACHs brought together a rush multi-sector representation as part of their group.
    - An ACH member survey was conducted, where participants were able to rate their perception of what kind of progress was taking place. The highest rated was how the backbone organizations were performing. The lowest rated was community engagement and feel strongly that this is an area that needs to keep moving forward and learn how to do better moving forward.
- Progress and next steps for Year 2:
    - Regional health priorities are being identified and preparing for regional health improvement plans.
    - ACHs are undertaking regional projects to achieve "early wins," to demonstrate ACH value and aid sustainability. As ACHs move forward into developing their projects, the evaluation framework will walk alongside them. The evaluation approach is to be a partner—to provide both formative evaluation along the way and conduct an impact evaluation at the end.

Doug Conrad, University of Washington

- The overall scope of work for the UW SIM evaluation team is to conduct formative and overall impact evaluation of SIM, leading the evaluation of the practice transformation support hub, and leading the evaluation of three different payment redesign models.
- There are a variety of sub-interventions within the SIM—the ACHs, the Hub, payment reform, and AIM. From those interventions, we hope to measure and see environmental

and system changes, and based off those changes, we hope to see changes in individual behavior and individual changes around health and resolving unmet need, and greater use of evidence-based services—both by providers and consumers in terms of demanding that type of transparency and shared decision making.

- Outcomes: improvement in the overall level of population health, improved quality of care, reduced cost growth.

David Mancuso, Department of Social and Health Services

- Will be focusing on working collaboratively on Payment Redesign Model 1—Adoption of Medicaid Integration of Physical and Behavioral health. Behavioral health risk factors are really critical drivers of health outcomes, especially in the Medicaid environment.
- We will be testing and comparing the fully integrated implementation in Clark and Skamania. The expectation is that we will be focusing on measurement areas around access to behavioral health services, greater engagement and quality of care, impacts on utilization of ED services and in-patient care. Are we seeing impacts on quality of life that could impact outcomes in the areas of employment, housing stability, criminal justice involvement?
- We will be rounding up data sources such as state agency administrative data, Provider One, and some external agency sources.

Tao Kwan-Gett, University of Washington

- UW is conducting an evaluation of the Practice Transformation Support Hub, which is an area focused primarily on how to help practices change their daily work in primary care and behavioral health in pursuit of the triple aim.
- Some of the evaluation questions are related to clinical community linkages, physical and behavioral health care integration, and value-based payment. Our strategy will be to conduct a survey of a sample of practices measuring their state of development in each of these areas, then track the use of Hub services by practices in the state over two years. And then repeat the process and see what changes have occurred.

Next Steps

John Wiesman

- Going from the design to the test phase, we have arrived at a real level of detail and can now proceed with rich discussions about transforming the health care system. As accelerators, we have an opportunity in the circles we participate in, to press the need for purchasers and others to demand and ask for value-based payments and to have those value-based insurance plans design. In the networks we're in, we can raise this as an issue to accelerate the conversation about where Washington is going.
- Folks are now talking about the "quadruple aim," which includes the work life of the Provider and trying to preventing burnout, which can happen to providers who are delivering care in these changing systems.

- Potential next agenda items:
    - Social determinants of health
    - Using technology to make services more convenient
    - Bringing value-based care to marginalized populations and communities