Aim

The BHT Region is the healthiest region in Washington State

METRICS

- 100% of eligible people have health insurance.
- Reduce Medicaid spending by xx%.
- Decrease obesity rates by 10%
- 50% reduction in people experiencing chronic homelessness
- 10% increase in high school graduation rates
- Food metric
- Economic metric

IDEAL STATE	STRATEGIC AIM
① **INTEGRATED CARE:** Our community experiences whole-person health through integrated efforts of health care, community.	» Integration of Behavioral Health, Physical Health, Oral Health » Community services are linked to health care services » Value Based Payments drive integrated care delivery
② **POPULATION HEALTH:** Our community invests in upstream prevention efforts.	» Obesity » Diabetes » Hypertension » Preventable diseases » Chronic diseases and cancer
③ **COMMUNITY DETERMINANTS:** Our community provides strong linkages between housing, food, education, and income stability to improve the health of everyone.	» Housing » Food » Education » Transportation » Income Stability

① Integrated Care

STRATEGIC AIM

Dramatically improve whole-person health through integration of behavioral, physical, and oral health systems.

METRICS

- Uninsured rate in our region is under 5%
- X % of Medicaid enrollees have a Medical Home
- 50% reduction of Emergency Room utilization
- X% increase in screening for clinical depression and follow up
- X% decrease in Alcohol and drug misuse
- Oral health metric
- X% increase in trauma informed care training

GOALS	ACTIVITIES	
Scale Community Based Care	» Develop and nurture an informed, well-trained, culturally competent network of care coordinators available to rural and urban community members 24/7. » Implement a community referral hub model with established best practices protocols, a technology platform and broad set of partner services that is available to health care and community service providers. » Create and utilize a community dashboard to measure, monitor and improve population health, demonstrate cost savings and highlight critical issues.	» Establish internal tracking, support systems, and measures to support and guide ongoing support and improvement for the network of care coordinators. » Design and implement efforts to inform community members and providers of care coordination services. » Utilize schools, churches, athletic teams and community leaders to promote healthy lifestyles.
Reduce ACEs by Trauma Informed Care	» Champion educating providers, schools, communities, and families about effect of ACES.	» Champion educating providers, schools, communities and families in trauma-informed care best practices.
Integrate Behavioral Health, Oral Health, & Primary Care	» Accelerate efforts to integrate provider teams to include physical, behavioral, oral health teams with community resources. » Pursue innovative initiatives to accelerate health transformation. » Increase usage of protocols to assess health risk at intake process.	» Increase capacity to facilitate connections between providers and community resources. » Increase the number of health care providers who serve Medicaid and Medicare populations.
90% of All Health Care is Value Based Payments	» Accelerate efforts to move providers and payers to value based payments. » Accelerate adoption of full integration of Behavioral Health, Oral Health, and Primary Care systems.	» Increase reimbursements for behavioral health and oral health for Medicaid Patients.
Increase Patient Engagement	» Design integrated care that is person-centered, culturally sensitive and balances evidence based and cultural norms, and emphasizes personal choice, responsibility and prevention. » Advocate for best practice for patient access to data, and ensure users ability to connect technologically across all data.	» Engage patients across community in determining health philosophies, policies and practices.

② Population Health

STRATEGIC AIM

Invest in upstream prevention efforts to improve population health.

METRICS

- BMI metric
- Developmental screening in the first 36 months of life
- Adolescent well-care visits
- Controlling high blood pressure
- Diabetes: HbA1c poor control
- Patient-Centered Primary Care Home (PCPCH) enrollment
- Access to Care: Getting Care Quickly
- Satisfaction with Care: Health Plan Information and Customer Service
- Electronic Health Record adoption
- Prenatal and postpartum care: timeliness of prenatal care
- Elective delivery before 39 weeks

GOALS	ACTIVITIES
Scale Community Based Care	» Develop and nurture an informed, well-trained, culturally competent network of care coordinators available to rural and urban community members 24/7. » Implement a community referral hub model with established best practices protocols, a technology platform and broad set of partner services that is available to health care and community service providers. » Create and utilize a community dashboard to measure, monitor and improve population health, demonstrate cost savings and highlight critical issues. » Establish internal tracking, support systems, and measures to support and guide ongoing support and improvement for the network of care coordinators. » Design and implement efforts to inform community members and providers of care coordination services.
Reduce ACEs by Trauma Informed Care	» Champion educating providers, schools, communities, and families about effect of ACES. » Champion educating providers, schools, communities and families in trauma-informed care best practices. » Educate providers, schools, communities, and families about philosophies of trauma-informed interaction.
Control & Prevent Diabetes	» Healthy food is available and affordable in all communities; schools, stores, etc. » Communities and schools provide education to kids and families about healthy eating, food and cooking. » Activities exist at no cost for people of all ages and abilities. » Community Health Workers perform health assessments and identify at-risk kids at every school. » All Providers are encouraged, supported, and compensated to engage in conversations about diabetes prevention and healthy eating. » Prevention efforts across Payers, Providers, Employers and Communities are Integrated.
Smoking Cessation	» TBD
Immunizations	» TBD
Prevent Health Care Associated Infections	» TBD
Prevent Unintended Pregnancies	» TBD
Control Asthma	» TBD

③Community Determinants

STRATEGIC AIM

Develop strong community systems that link housing, food, education, and income stability to improve community health.

METRICS

- Housing metric
- Food metric
- Graduation metric
- Transportation metric
- New business start up?
- Unemployment rate?

GOALS	ACTIVITIES
Scale Community Based Care Coordinatinon	» Develop and nurture an informed, well-trained, culturally competent network of care coordinators available to rural and urban community members 24/7. » Implement a community referral hub model with established best practices protocols, a technology platform and broad set of partner services that is available to health care and community service providers. » Create and utilize a community dashboard to measure, monitor and improve population health, demonstrate cost savings and highlight critical issues. » Establish internal tracking, support systems, and measures to support and guide ongoing support and improvement for the network of care coordinators. » Design and implement efforts to inform community members and providers of care coordination services.
Reduce ACEs by Trauma Informed Care	» Champion educating providers, schools, communities, and families about effect of ACES. » Champion educating providers, schools, communities and families in trauma-informed care best practices.
Increase Access to Safe Housing	» Utilize a community referral hub to link community services with providers and individuals seeking housing. » Utilize Pay for Success models to increase funding options. » Explore alternative pathway models. » Utilize Medicaid Waiver dollars. » Align community efforts to ensure increasing housing stock is available for vulnerable individuals, families and seniors.
Increase Access to Healthy, Affordable Food	» Utilize a community referral hub to link community services with providers and individuals seeking food supports. » Align community efforts to ensure increasing food resources available for vulnerable individuals, families and seniors. » Champion healthy eating, active living activities. » Utilize food tables in food desert areas.
Improve Graduation Rates	» Support community efforts to increase graduation rates.
Innovate New Access to Transportation	» Utilize a community referral hub to link community services and with providers and individuals seeking transportation supports. » Align community efforts to ensure increasing transportation resources available for vulnerable individuals, families and seniors.
Opportunities for Stable Income	» Utilize a community referral hub to link community services and with providers and individuals seeking TANF, SSI or other employment training opportunities. » Work in partnership with EDCs and Chambers of Commerce to incubate new business opportunities throughout the region. Include brokerage functions to facilitate connections for Providers and individuals seeking employment. » Support local, state and federal efforts to increase economic development efforts in key communities including The Zone and rural Counties.