

HealthierHere

The Accountable Community of Health of King County

MIDD Committee Briefing

February 22, 2018



Vision for a Healthy King County

Health and Human Services Transformation

By 2020, the people of King County will experience significant gain in health and well-being because our community worked collectively to make the shift from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention, embraces recovery, and eliminates disparities.

Shifting the focus

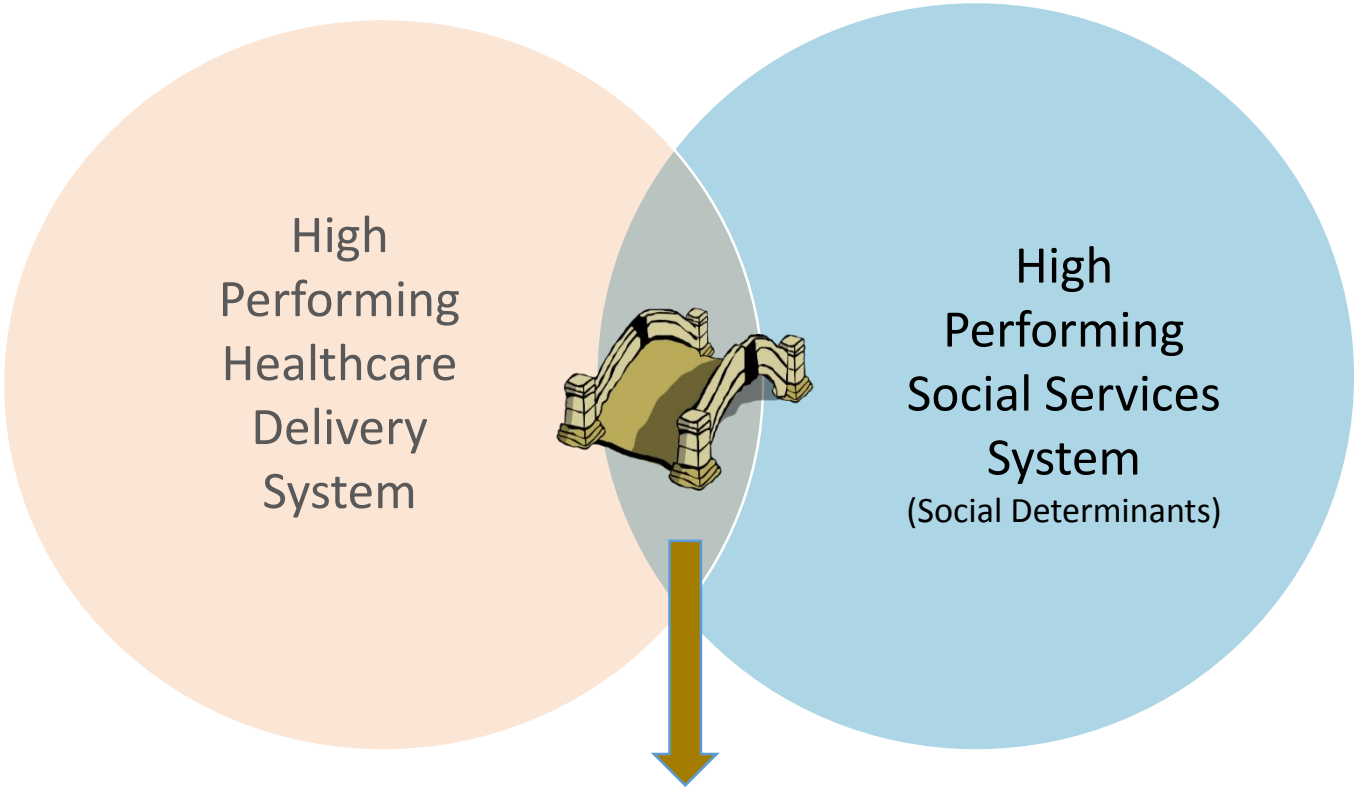
Move the conversation about **sustainable change** from <u>incremental changes within organizations</u>…

…to people and populations:

"Did you get the service you need and did it help?"

Ensure that all people can access the same opportunities for health & experience similar outcomes

Strong Community Services that Support Health



Strong bi-directional partnership between delivery system and community resources

Core Leave Behinds

Collaboration between the health care system and social services, evidenced by an **inter-connected HIT/HIE system** connecting providers from both systems and payment models that incorporate social service providers.

Access to person-centered, **multi-disciplinary, culturally competent care teams** -- inclusive of social services -- in health homes for everyone, regardless of where a person enters the system.

An infrastructure that provides an effective mechanism for **meaningful community and consumer involvement and voice** in the continuous improvement of the delivery system.

HealthierHere Transformation Portfolio

HealthierHere Project Portfolio

Integrated whole person care

Opioid use disorder prevention and treatment

Chronic disease prevention and control

Transitional care

Community-based Care Coordination

Social Determinants of Health

Equity and Reducing Disparities

Managed Care Organization value-based payment metrics

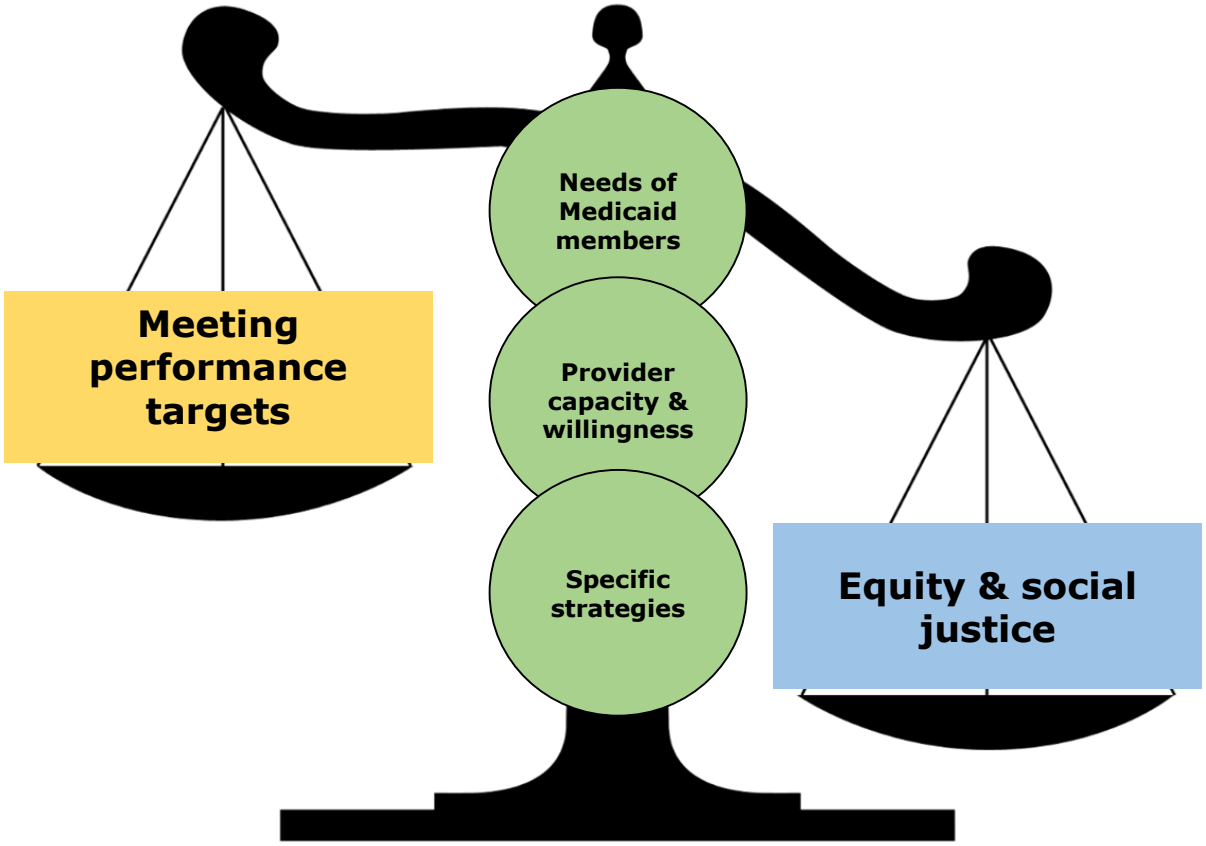
Project P4P measure

Some overlap with MCO value-based payment work

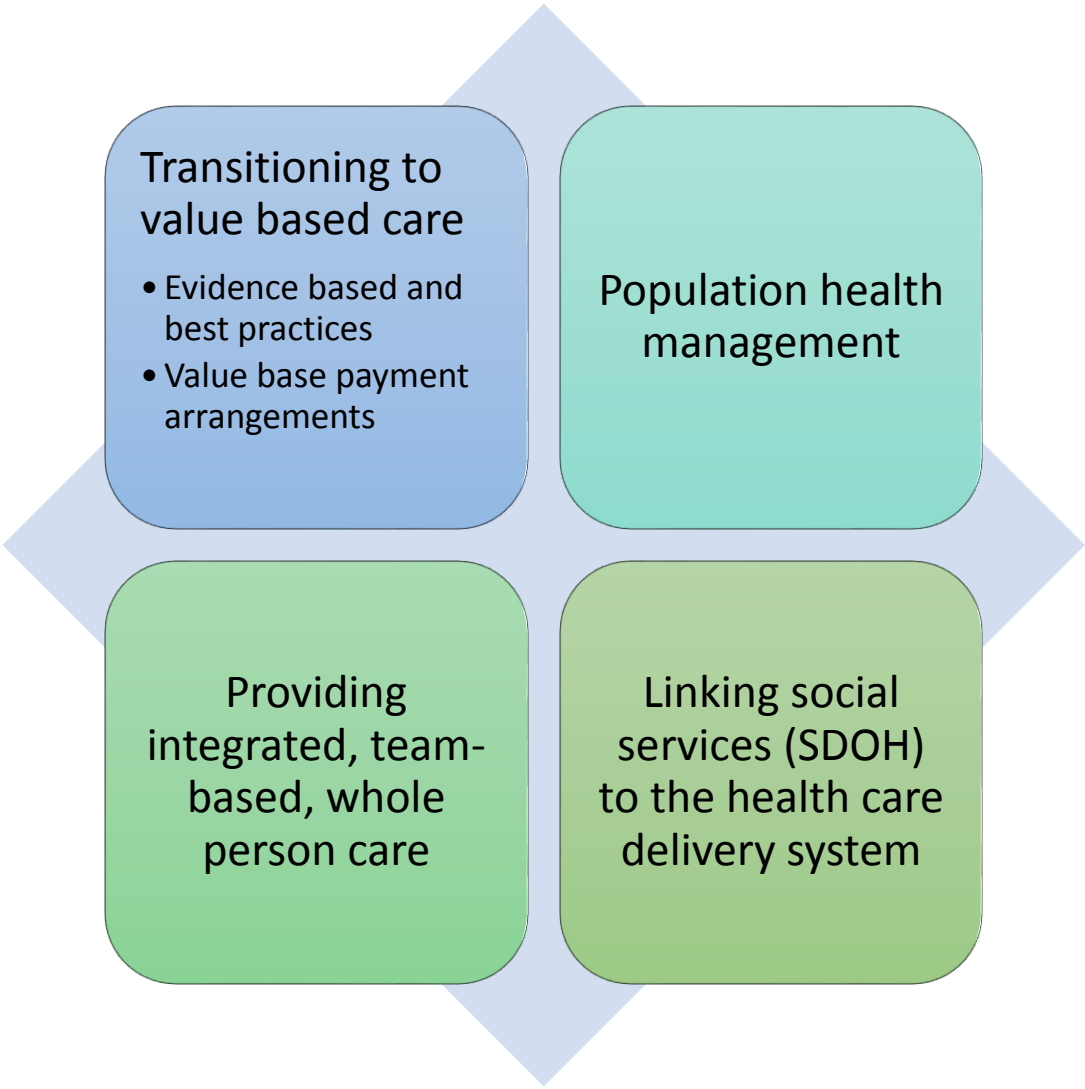
Measure	Age range	Bi-directional integration	Transitional care	Opioid use	Chronic disease	MCO VBP alignment
All-cause ED visit rate	10+	■	■	■	■	
Medicine & surgery inpatient hospital utilization[1]	18+	■	■	■	■	
Follow up ED visit for chemical dependency	13+	■	■			
Follow-up ED visit for mental illness[2]	6+	■	■			
Follow-up hospitalization for mental illness[2]	6+	■	■			
All-cause hospital readmission rate[3]	18-64	■	■			
Child and adolescent access to primary care	1-19	■			■	
Diabetes care: Eye exam	18-75	■			■	
Diabetes care: Hemoglobin A1c testing	18-75	■			■	
Diabetes care: Kidney screening	18-75	■			■	
Asthma medication management	5-64	■			■	
Percent homeless	All ages		■			
Mental health treatment penetration	12+	■				
Antidepressant medication management	18+	■				
Patients on high-dose chronic opioid therapy	All ages			■		
Patients with concurrent sedatives prescriptions	All ages			■		
Statin therapy for heart disease[4]	21-75				■	
SUD treatment penetration	12+	■				
SUD treatment penetration, opioid use disorder	12+			■		

[1]Excludes hospitalization for behavioral health concerns, birth, maternity (pregnancy, labor, delivery), newborn care, and stays during which a patient dies
[2]Note, this does not include hospitalizations for chemical dependency concerns
[3]Excludes hospitalization for pregnancy and perinatal conditions
[4]Male age range 21-75, female age range 40-75
ED, emergency department; SUD, substance use disorder

The balancing act of identifying target populations



Remember what this is about



Bi-directional Integration of Physical and Behavioral Health

Project Objectives

- Improve access to behavioral health through enhanced screening, identification, and treatment of behavioral health disorders in primary care settings.
- Improve access to physical health services for individuals with chronic behavioral health conditions through increased screening, identification, and treatment of physical health disorders in behavioral health care settings.
- Improve active coordination of care among medical and behavioral health providers and address barriers to care.
- Align new bi-directional integration with successful existing community efforts, including addressing social determinants of health.

Transitional Care

Project Objective

- Improve transitional care services to reduce avoidable hospitalization and ensure beneficiaries are getting the right care in the right place.
  - Individuals transitioning from inpatient hospital settings
  - Individuals transitioning from inpatient psychiatric facilities
  - Individuals transitioning from jail

Addressing the Opioid Crisis

Project Objective

- Support the achievement of the state's goals to reduce opioid-related morbidity and mortality through strategies that target prevention, treatment, and recovery supports.

Chronic Disease Prevention and Control

Project Objective

Integrate health system and community approaches to improve chronic disease management and control.

- Children and adults with chronic respiratory diseases (including asthma)
- Adults with chronic cardiovascular diseases (including diabetes)

Community Based Care Coordination and Addressing the Social Determinants of Health

- Rationalize and build off of current care coordination activities/infrastructure
- Invest in mechanisms for shared care planning
- Support strong two-way partnerships between health care delivery system and social service organizations
- Ensure two-way referral and tracking mechanisms
- Support sharing of information across provider types



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