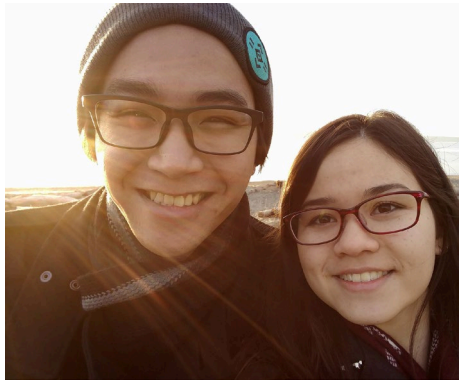
HealthierHere



Health Care for the Homeless Network

March 16, 2020

HealthierHere is a Non-Profit Organization

Dedicated to improving the health and well being of people in King County, through innovative, cross sector collaborations. We work…

in partnership and collaboration with providers and community organizations

on behalf of people here, especially the most vulnerable

to catalyze and test new and better ways to respond to health and social problems

so that the system can work better for everyone

Organizational Overview: **A Regional Partnership**

- 26-member, cross-sector, multi-stakeholder board
- Multidisciplinary backbone staff
- Contracted Accountable Community of Health (ACH) for the King County region
- Initial funding through Healthier Washington; long-term through grants, community support, and philanthropic investment

Medical Providers

Behavioral Health Providers

Hospitals

Tribes

Community Organizations

Payers / MCOs

City & County Government

Foundations

Advocates

Consumers

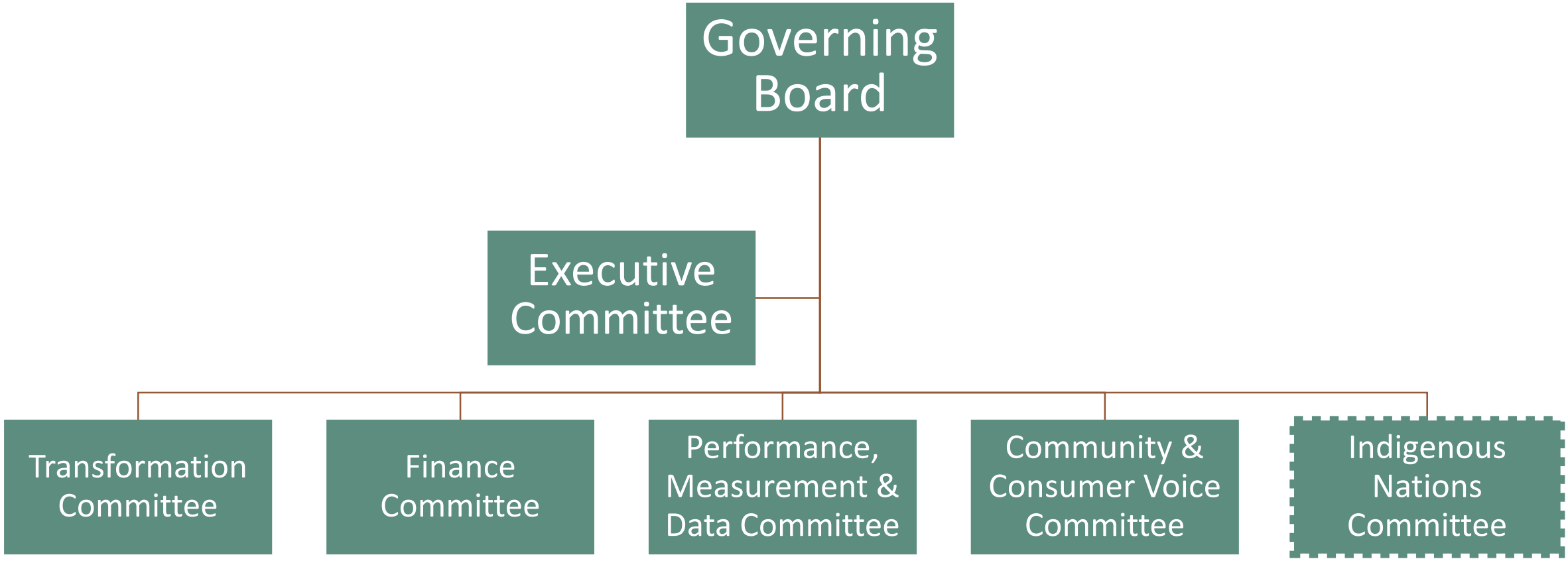
What are Accountable Communities of Health?

ACHs act as "change agents" for the Healthier Washington Initiative / Waiver:

9 regional multi-sector coalitions, aligned with Medicaid regional service areas

Responsible for developing and overseeing Medicaid Transformation Project to **improve health and health equity** in their region

A Shared Stewardship



Medicaid Transformation Project: **Three Initiatives**

Transformation thru Accountable Communities of Health

Up to $1.1 Billion

Long-term Services and Support

$175 Million

Foundational Community Support Services

$200 Million

HealthierHere Funds Flow

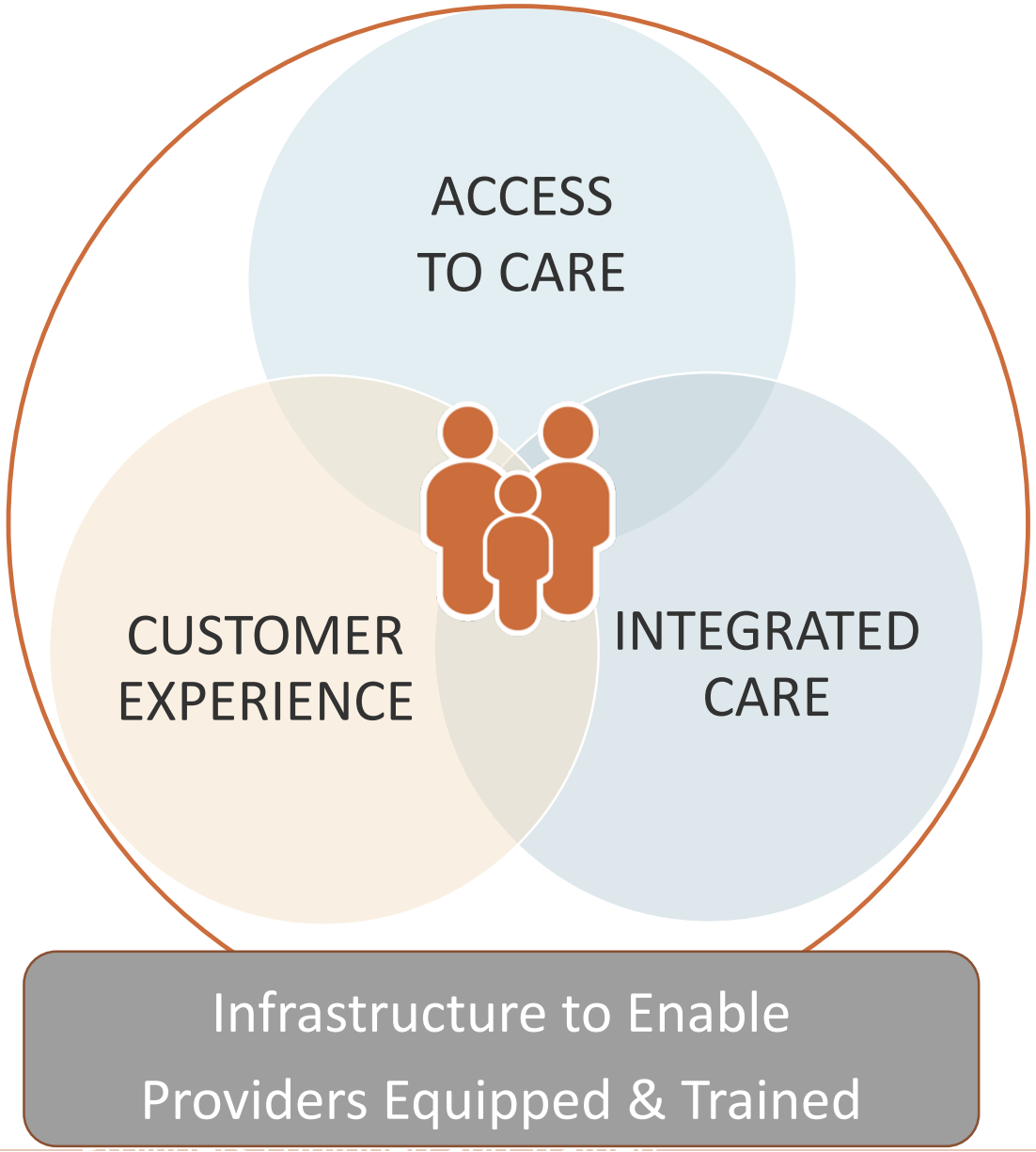
This is Pay-for-Performance at the Systems Level

Funds flow from Federal Government to State Government to a Fiscal Intermediary

HCA measures whether milestones have been met

HealthierHere uses earned incentives to invest in innovations

Building an Ecosystem for Whole-Person, Integrated Care



Roles of HealthierHere in Transformation

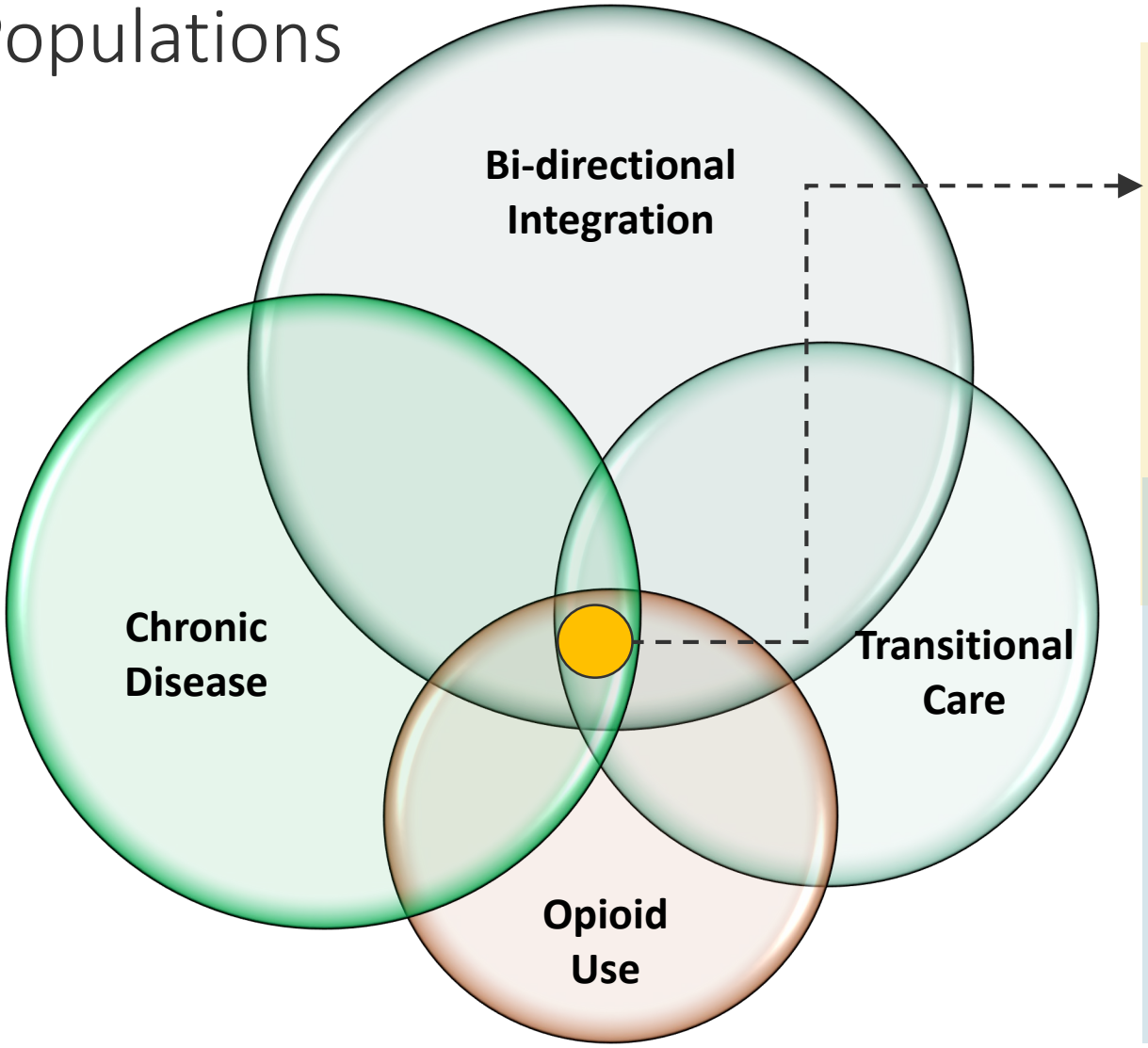
Investing	Convening	Policy	Sustainability
Invest in strategies that lead to a transformed system **Examples:** • Training and TA • Community support specialist staff capacity • Clinical Information Exchange • Optimizing PreManage	Convene partners and stakeholders around specific topic areas **Examples:** • Shared Care Plans • SDOH Screening • Data governance	Participate in local and statewide policy making related to transformation goals **Examples:** • Participate in defining MCO contract requirements • Work with HCA to obtain 90/10 funding to support providers' connectivity to HIE • Participate in removing regulatory barriers to integration	Identify mechanisms to sustain MTP investments and strategies **Examples:** • Work with MCOs and HCA to identify VBP structures that support care models • Identify alternative or additional funding sources to implement and sustain MTP investments

P4P Metrics

Measure	Ages	Bi-directional integration (56%)	Transitional care (23%)	Opioid use (7%)	Chronic disease (14%)
All-cause ED visit rate	All ages	■	■	■	■
Acute 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	6+	■			
Antidepressant medication management	18+	■			
Patients on high-dose chronic opioid therapy	All ages			■	
Patients with concurrent opioids & sedatives prescriptions	All ages			■	
Statin therapy for heart disease[4]	21-75				■
SUD treatment penetration	12+	■			
SUD treatment penetration - opioid use disorder	18+			■	

[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 dependencyconcerns [3]Excludes hospitalization for pregnancy and perinatal conditions [4]Male age range 21-75, female age range 40-75

Blending Performance and Equity Considerations to Determine Focus Populations



HOT SPOTS:

- Small population with most complex health and social needs
- Disproportionately high amount of ED and hospital utilization (and cost)
- Heavily under-served by fragmented health & social service systems
- **Blend of performance and equity focus**

WARM SPOTS: *Overlapping areas*

COLD SPOTS: (Hidden Populations)

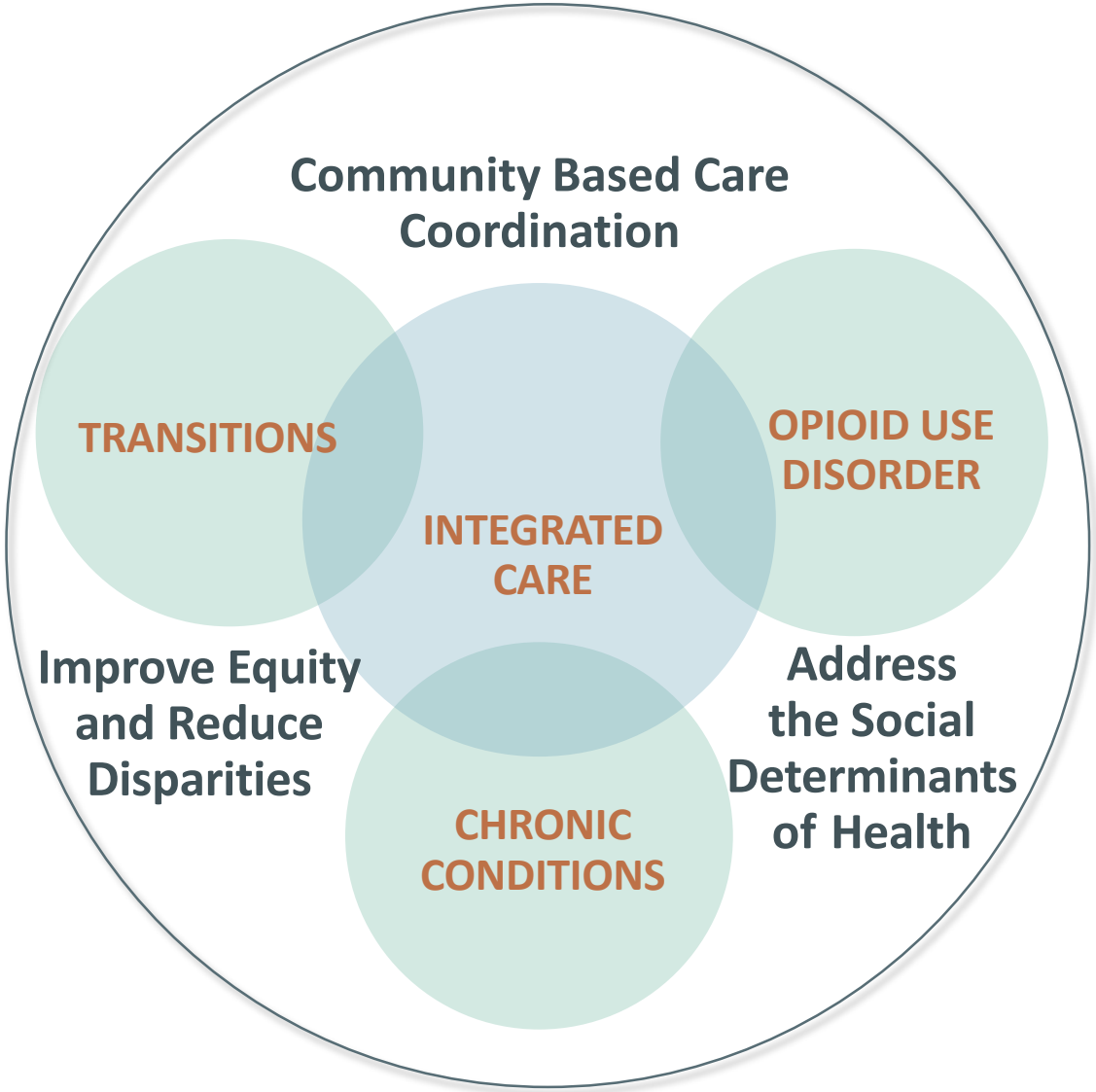
- Populations not utilizing or under-utilizing traditional preventive health care services *(e.g. homeless, immigrant/refugee populations, Medicaid expansion adults)*
- Populations under-represented in hot spots (e.g. reproductive health)
- **Equity focus**

Social Equity Framework

Shift the focus from what works for organizations to what works for people and populations

"Did you get the care/service you need?"

"Did it help you?"



Long-term: What Success Looks Like

Inter-connected HIT/HIE system supporting collaboration between health care and social service providers

Effective mechanisms for **meaningful community, tribal and consumer involvement and voice** in ongoing improvement of the system.

Multi-disciplinary, culturally competent care teams accessible from every entry point

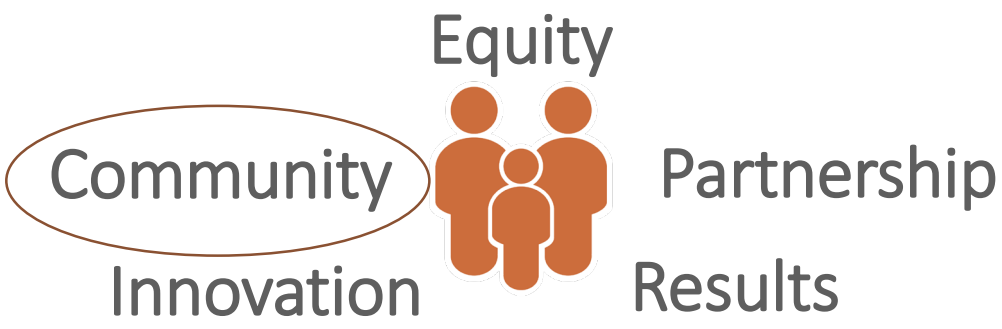
Payment models that incorporate and compensate social services

Community Grants Program Overview and Update

Presented by: Marya Gingrey

Equity and Community Partnerships Director, HealthierHere

Background: HealthierHere Values



- Community Engagement: the voices that drive our work are those who are impacted by health disparities, including
  - *People who are Medicaid beneficiaries*
  - *People who work with community members who are Medicaid beneficiaries (i.e. Community Based Organizations and Trusted Advisors)*

Community Grants Program Overview: 2018

- 18 Grantees
- 908 Surveys Completed
- 5 Key Leaders Focus Groups Conducted
- 11 Languages
- 22 Ethnic communities

Community Grants Program Overview: 2019

- 16 Grantees
- 1,952 Surveys Completed
- 3 Languages
- 9 communities

Housing Status of 2019 Survey Respondents – Medicaid Members + Housing Status

Community Grants 2018 | Community Grants 2019 | Notes

Return to HealthierHere.org

HealthierHere Community Grants Survey, 2019
Survey portion: Main portion | Survey cohort: Medicaid members

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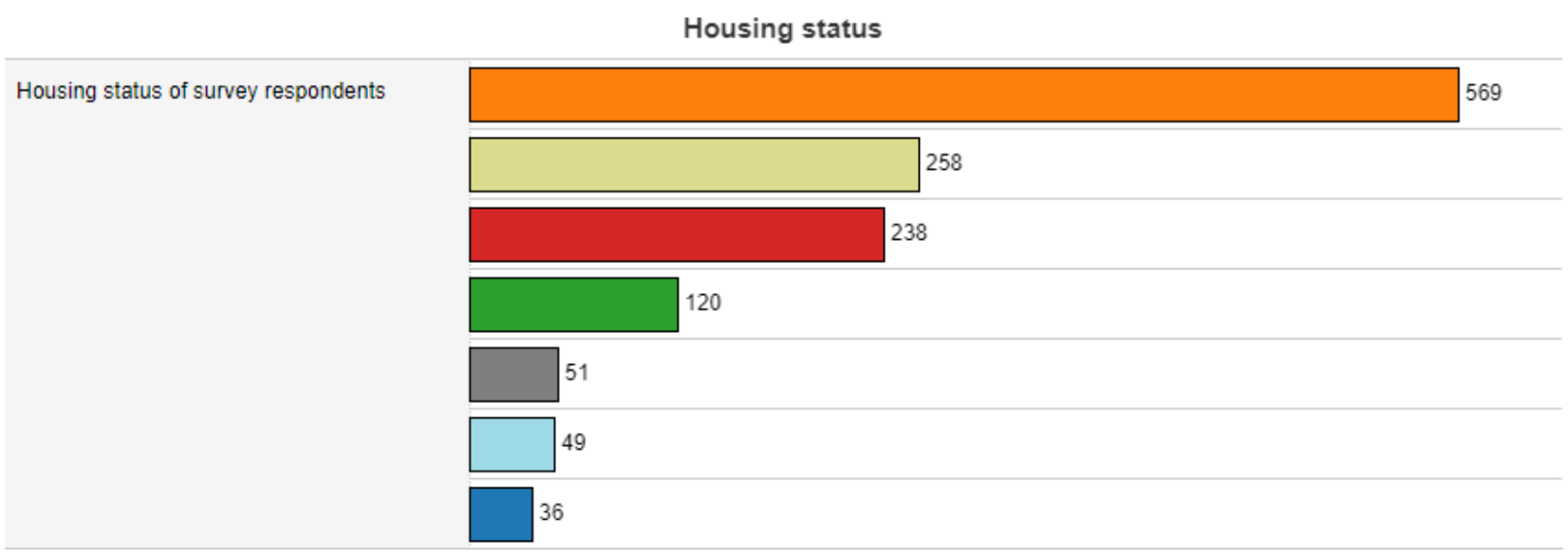


Survey portion
Main portion

Survey cohort
Medicaid members

Question
30: Housing status

Show data as
Respondent counts

Sort data
Descending

Response
- I am houseless/homeless
- I live in a home that I own or rent
- I live in a home that is owned/rente...
- I live in temporary housing
- I live outside
- Other
- Skipped

394 of 1,321 Medicaid Member respondents (30%) indicated that they were houseless/homeless, lived in temporary housing or lived outside.

2019 Survey Respondents – Medicaid Members - Mental Health Diagnosis + Housing Status

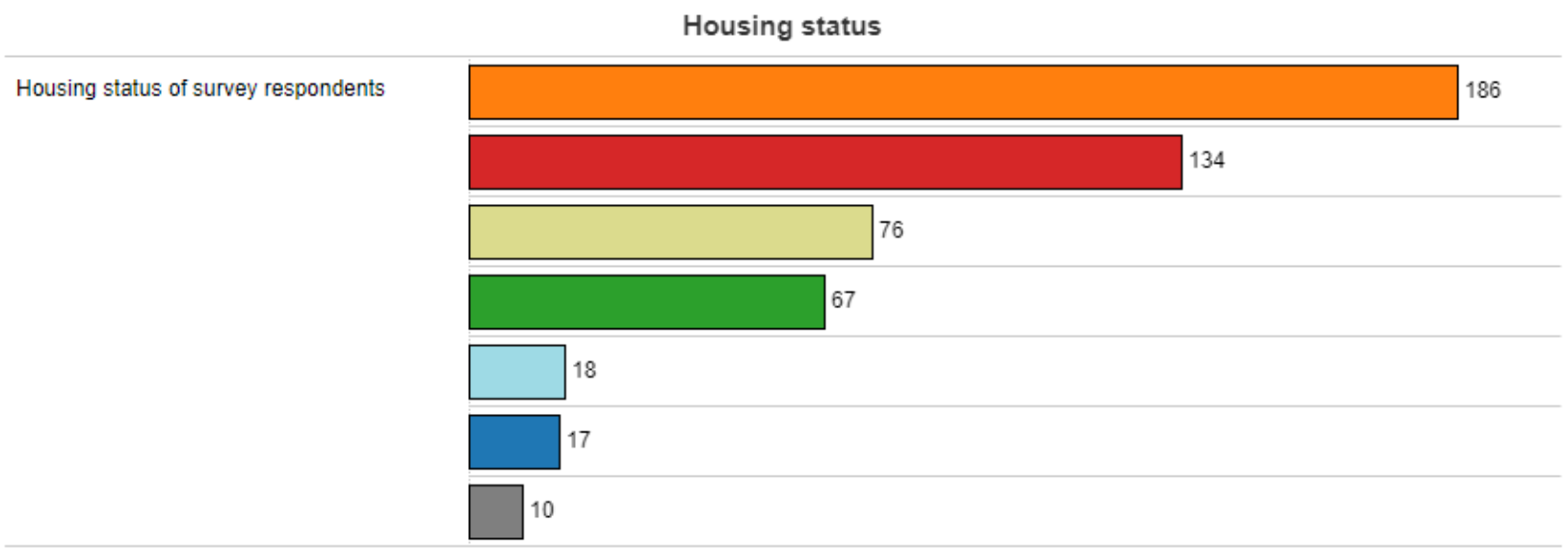
Community Grants 2018 | Community Grants 2019 | Notes

Return to HealthierHere.org

HealthierHere Community Grants Survey, 2019

Survey portion: Main portion | Survey cohort: Medicaid members with mental health condition

HealthierHere



Survey portion
Main portion

Survey cohort
Medicaid members with mental health...

Question
30: Housing status

Show data as
Respondent counts

Sort data
Descending

Response
- I am houseless/homeless
- I live in a home that I own or rent
- I live in a home that is owned/rente...
- I live in temporary housing
- I live outside
- Other
- Skipped

218 of 394 survey respondents (55%) who self-identified as being homeless/houseless, living in temporary housing or living outside also indicated that they had a mental health diagnosis.

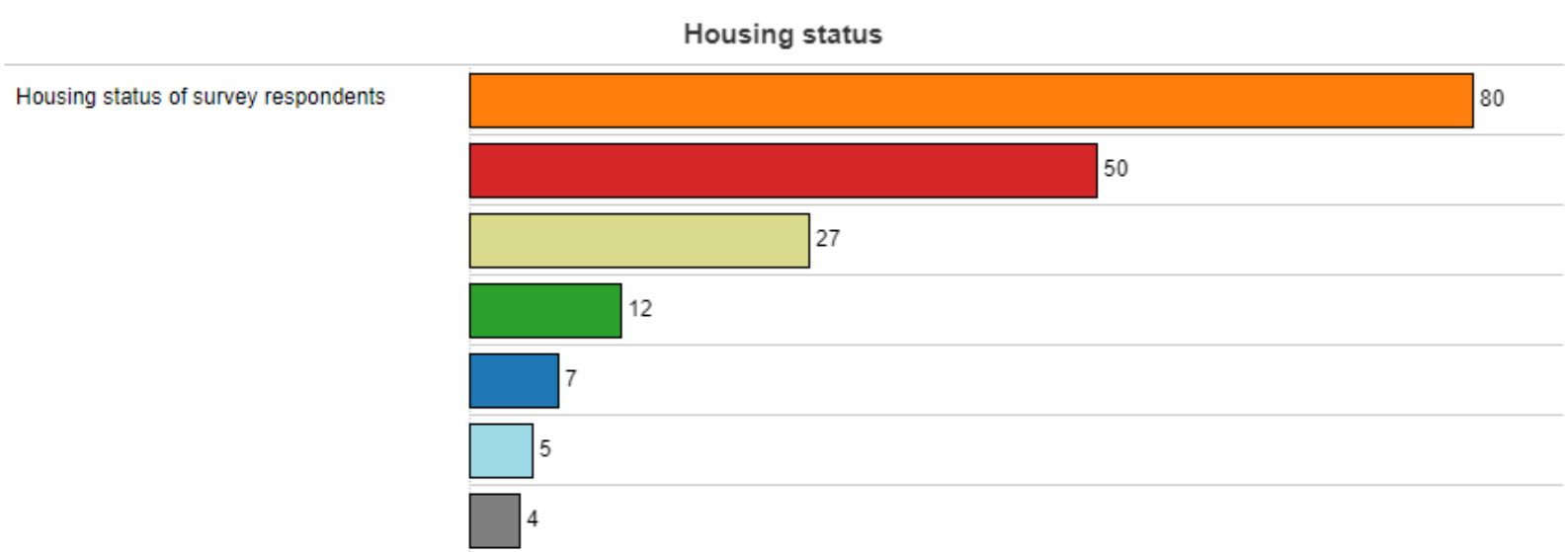
2019 Survey Respondents – Medicaid Members – Housing + Asthma

Community Grants 2018 | Community Grants 2019 | Notes

Return to HealthierHere.org

HealthierHere Community Grants Survey, 2019
Survey portion: Main portion | Survey cohort: Medicaid members with asthma

HealthierHere



Survey portion
Main portion

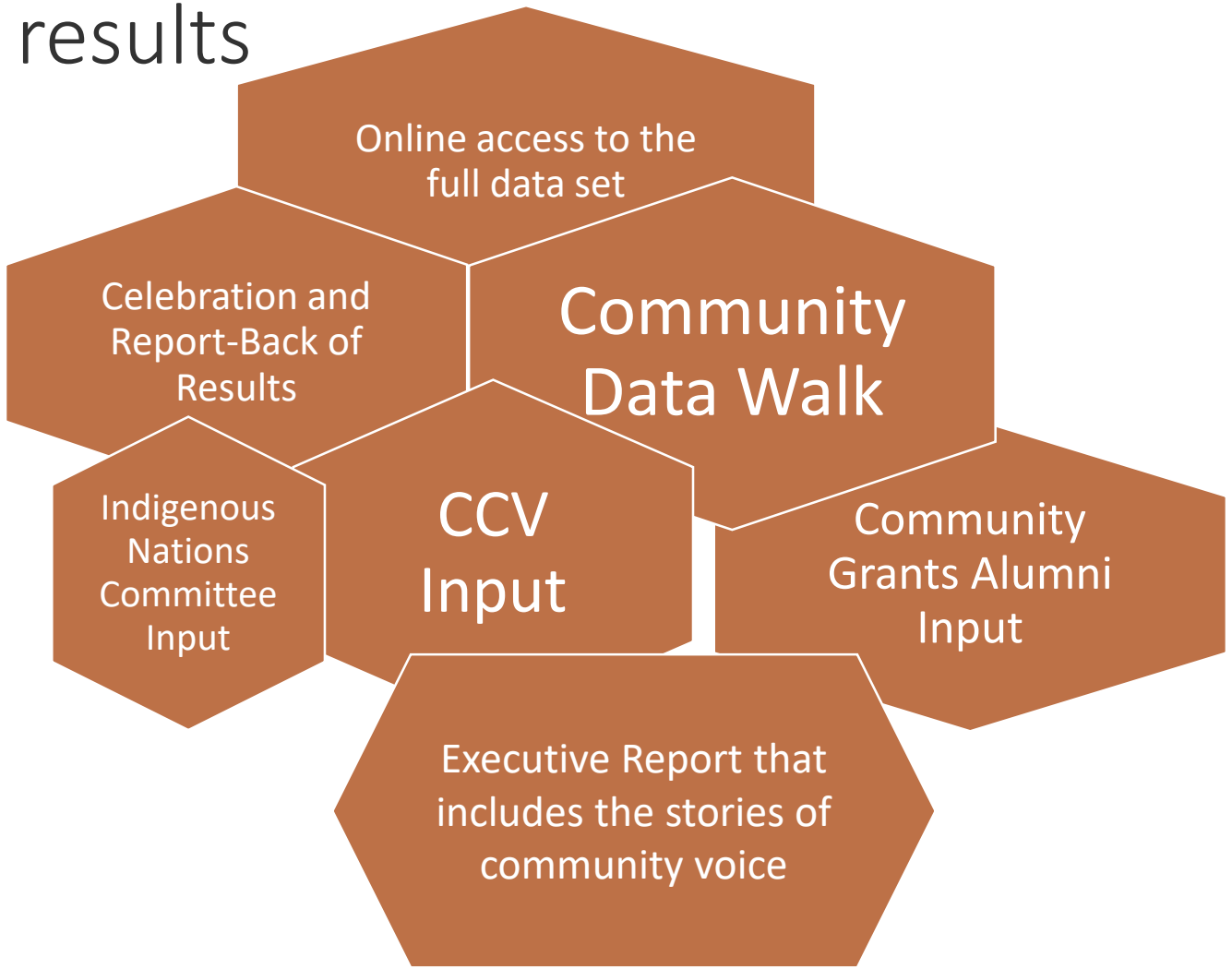
Survey cohort
Medicaid members with asthma

Question
30: Housing status

Show data as
Respondent counts

Sort data
Descending

Response
- I am houseless/homeless
- I live in a home that I own or rent
- I live in a home that is owned/rente...
- I live in temporary housing
- I live outside
- Other
- Skipped

66 of 394 survey respondents (17%) who self-identified as being homeless/houseless, living in temporary housing or living outside also indicated that they had asthma.

How we plan to engage the community around the results