

# Public Health – Health Care Delivery System Homework Compilation

Public Health – Health Care Delivery System Homework Compilation	Levels			Conditions			
	State	Regional	Local	Obesity	Diabetes	CVD	Mental Health
<b>FOUNDATIONAL BUILDING BLOCKS – State Health Care Innovation Plan</b>							
<b>1. BUILD A CULTURE OF ROBUST QUALITY AND PRICE TRANSPARENCY</b>							
Create a statewide health services database from HIE and/or claims data that ACH’s can use to assess needs and evaluate actions							
<b>2. ACTIVATE AND ENGAGE INDIVIDUALS AND FAMILIES IN THEIR HEALTH AND HEALTH CARE</b>							
<b>3. REGIONALIZE TRANSFORMATION EFFORTS</b>							
<p>Regional Health Entities: Entities like the Accountable Community of Health develop regional CHW cadres. Each Regional Health Entity will be incentivized to: create the following:</p> <ul style="list-style-type: none"> <li>• Create a cadre of CHWs that will be deployed throughout the region to promote primary prevention and screening.</li> <li>• Provide technical assistance to other local organizations within the region that are developing CHWs into their workforce to primary prevention and screening</li> </ul>							
<b>4. CREATE ACCOUNTABLE COMMUNITIES OF HEALTH</b>							
<p>Assure that public health has a role in providing understandable data for local communities to identify their priorities.</p> <ul style="list-style-type: none"> <li>• The public health system must have sufficient resource to provide the assessments needed to both identify priorities &amp; to monitor progress.</li> </ul>							
Provide funding to Accountable Communities of Health to foster connections between healthcare professionals and resource providers such as WIC programs, mental health providers, and evidence based-community programs (such as speaker/networking events that bring a broad range of providers together around a cross-cutting topic, such as obesity							
<p><b>Targeted Efforts:</b></p> <ul style="list-style-type: none"> <li>• Identify targeted health issues for communities of health. The health issues should correlate with high resource utilization with specific health management practices to achieve better health and lower resource consumption.</li> <li>• Prioritize service provision for substance use, mental health treatment, housing support and other concrete family needs for pregnant women and families with young children</li> <li>• Provide a menu of priorities</li> </ul>							

**5. LEVERAGE AND ALIGN STATE DATA CAPABILITIES**

Create a way to easily ‘mash up’ data from different agencies – e.g. see maps of health indicators with layers for education, housing, crime, air quality. (state recommendations- data partnership)							
Include measure(s) relevant to prevention of ACEs (e.g. proportion of children who meet developmental milestones of kindergarten readiness in all domains (physical, social-emotional, cognitive, language, literacy, math)							
Incorporate nonmedical health measures/Measures of community attributes/features not just those related to individual health <ul style="list-style-type: none"> <li>• Food and beverage environment / policy assessment</li> <li>• Physical activity environment / policy assessment</li> <li>• Accessibility of evidence based community programs such as DPP and CDSMP</li> <li>• Breastfeeding support and policies in communities, hospitals, worksites, early learning and community health clinics</li> </ul>							
Create a ‘dashboard’ that all ACH’s can use to track health indicators, and compare indicators to statewide indicators. Data/measures infrastructure – dashboards (e.g., <a href="#">Healthy Communities Institute</a> ) and GIS activity/initiative mapping.							
Data Sharing - Building on the data-sharing work that DSHS and the three largest housing authorities in the state have recently completed, so that there is an on-going database and workable data sharing arrangements would greatly enhance the effectiveness of housing-based health partnerships.							
Include ROI calculations as a capability							

**6. PROVIDE PRACTICE TRANSFORMATION SUPPORT**

<p><b>Create a statewide community health ‘learning commons’ that would include:</b></p> <ul style="list-style-type: none"> <li>• Establish statewide learning networks (working with WSHA, WSMA, public health association and others) to share best practices in these areas.</li> <li>• Create a common needs assessment and evaluation framework or “toolkit,” and provide low-cost web-based services and/or consultation services so that ACHs can instead share those capabilities instead of each one having to recreate their own capabilities.</li> <li>• A menu of evidence based interventions for prevention and chronic disease management</li> <li>• Business case justification and ROI estimates from the medical literature for prevention measures and community level interventions</li> <li>• Links to data sources, toolkits, resources, and consultants</li> <li>• Technical assistance</li> <li>• Supporting a platform or clearinghouse where examples, models, evidence-based tools, and metrics can be found and shared.</li> </ul>							
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<p>Building capacity to offer cross-sector training to increase mutual understanding of each field’s approaches, business models, strengths and weaknesses, and uses of financing and policy.</p> <p>Developing skills needed for successful collaboration, including ways to engage the community in planning; coalesce around aims; negotiate across vested interests; and tackle policy</p>							
<p>Establish Best Practices in Supportive Housing for High Needs Families and Develop Viable Funding Models</p>							
<p>Develop of a Technical Assistance Center (similar to that of the Early Psychosis and the Early Assessment and Support Alliance (EASA) in Oregon), which serves to write practice guidelines and fidelity tools, develop, provide, and facilitate training, supervision, and credentialing, develop written materials, media outreach, articles and publications, facilitate program development and access sustainable funding, and evaluate and coordinate research activities, data collection, reporting and analysis – all for the early identification and treatment for improved long-term health outcomes. Twelve years after its inception in five counties in Oregon, EASA has established a process for program establishment, training, supervision, and program development that has been successfully implemented in an additional thirteen counties and that could be modeled with state-level support.</p>							
<p>Trauma-Informed Care: Model and teach about ACES and trauma informed care and the creation of trauma informed environments and organizations to community service providers. (Includes but not limited to PCMH’s). Draw from the success of Nurse Family Partnership model to address and potentially prevent adverse childhood experiences in broader population.</p>							
<p>Ensure providers and other healthcare workers are trained in addressing weight management and the importance of pre-diabetes and pre hypertension diagnoses and follow</p>							
<p>Replicate promising, integrated models for creating more resilient, healthier communities. Invest in innovation</p>							
<p>Community Health College and Innovation Center becomes the statewide training and technical assistance CHW hub that serves as a clearinghouse of CHW tools, standards for training and supervision, training and technical assistance, and augmented resources. Provide support and technical assistance to help Accountable Communities of Health or ‘like regional designee’ to support CHWs to address</p>							
<p>Support partnerships between clinical system and housing systems in given geographic area. Bridging this can help to further expand role of housing in the ‘community’ domain actions as well – e.g. smoke free policies, more availability of units for people with complex needs, more features to support people aging in place, tenant mobilization for policy changes affecting their neighborhood environments, etc.</p>							
<p>Deploy HIT assistance to primary care as a core service in addition to primary care extension centers</p>							
<p>Provide a stipend for free or low cost access to HIT technical assistance to operationalize population level measures.</p>							
<p>Mental Health First Aid – training across the state to various entities</p>							

**7. INCREASE WORKFORCE CAPACITY AND FLEXIBILITY**

Convene as a public/private task force for the purpose of applying diverse perspectives and experiences to the examination of the issues facing successful deployment of a CHW workforce across the state. Assist in developing the definition of a CHW, their scope of work, training and standards that identify the continuum of CHW roles including primary prevention and screening.

State Board for Community and Technical Education and Dept. of Health would convene colleges and stakeholders to develop a consistent statewide curriculum for training community health workers. This process should recognize the work history of current, experienced CHWs and create a low cost, easily accessible road to certification to encourage ideal CHW candidates.

**Community Health Workers**

- Strategies such as Community Health Workers and Health Leads show great promise and should be supported. Exactly how these strategies might be implemented in different communities may well vary.
- Require (mandate) that Community Health Workers are deployed across the state to improve the health of the population, provide better care for individuals and lower health care costs
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- Use core CHWs functions to promote both community based prevention and improved chronic illness care that result in the creation of more effective linkages between communities and healthcare systems,
- Use core CHWs functions to promote both community based prevention and improved chronic illness care. (1) Provide health education and information, (2) Assist and advocate for underserved individuals to receive appropriate services, (3) Provide informal counseling, (4) Address basic needs (5) Build community capacity to address health issues and (6) Assure people get the services they need
- Increased use of Peer Specialists and Community Health Workers- to engage under-served communities and those who have not engaged through traditional services.
- Use community health workers to conduct education and outreach to increase use of preventive health services, particularly by ethnic and limited English proficiency communities. **Example:** Global 2 local conducts health outreach to immigrant communities in SeaTac and Tukwila
- CHWs functions to promote both community based prevention and improved chronic illness care.
  - Provide health education and information,
  - Assist and advocate for underserved individuals to receive appropriate services(increase use of preventive health services)
  - Provide informal counseling
  - Address basic needs
  - Build community capacity to address health issues
  - Assure people get the services they need

<p>Shared staffing models between health care delivery and social services can create a care coordination team that effectively leverages staff strengths across a broad spectrum of need, which will require less time of providers who typically charge more for service. Specifically, look into shared staffing of an individual qualified to lead case management and care coordination in the hospital, preferably with experience in the inpatient setting.</p>									
<p>Develop a Community Health Worker Regional Network through the following regional actions:</p> <ul style="list-style-type: none"> <li>• Coordinate, fund, and recruit a multi-disciplinary training for the region.</li> <li>• Provide strategic oversight, technical support, and leadership development to existing programs in the region.</li> <li>• Provide training opportunities to learn about the tools and techniques of coordinated discharge planning through scholarships and training grants.</li> <li>• Support multi-level system data integration with shared software and analytics to enhance coordination and communication between entities.</li> </ul>									
<p>CHW Network is non-governmental Network that becomes the backbone convener of the state’s many CHW efforts. It provides backbone services to loosely affiliated, grassroots, regional CHW networks and can coordinate mutually reinforcing CHW activities. The Network:</p> <ul style="list-style-type: none"> <li>• Develops CHW leadership across the state enabling the CHW collective voice to encourage community appropriate primary prevention and screening.</li> <li>• Identifies mutually reinforcing activities for community-based prevention and system changes that address primary prevention and screening.</li> <li>• Work with the Innovation Center to create the baseline information about the CHW field (e.g., ground-up information about what CHWs do, need, and want, populations served, etc.) and identify training and technical assistance needs across the state.</li> <li>• Represents CHW’s on the CHW TF and informs the TF of emerging policy priorities and strategies and develops the framework for defining the CWH scope of work, training standards, and potential financing models.</li> <li>• Support development of systems and plan for implementation of healthy competitive foods guidelines.</li> <li>• Promote and encourage collaboration of farmers markets across the region accepting SNAP.</li> </ul>									
<p>Expand the use of EMTs to provide screening and other supports in the community. Use the EMTs or home health nurse providers for follow up on patients discharged from the hospital.</p>									
<p>Expand the use of Emergency Medical Services response options permitting the ability to redirect individuals to detox centers or mental health agencies.</p>									
<p>SBIRT -- identifying those in need of treatment and beginning to engage them through supported referral to treatment. This needs to then be linked with adequate treatment capacity (sorely lacking due to historical lids on Medicaid-funded CD services). There needs to be a comprehensive strategy that address community education/prevention, identification and engagement, and treatment</p>									
<p>Expand capacity within the Birth to Three Early Intervention system to address the needs of children experiencing toxic stress. This would include provisions to serve children at risk of delays due to exposure to toxic stress and the inclusion of infant mental health as an intervention vehicle.</p>									

**PREVENTION FRAMEWORK STRATEGIES**

**1. REORIENT HEALTH AND OTHER SYSTEMS TO IMPROVE HEALTH, QUALITY, REDUCE COST AND IMPROVE EXPERIENCES FOR BOTH PEOPLE AND PROVIDERS**

<p>Adopt non health ‘vital signs’ for clinics to assess and refer to nonmedical indicators for health. Utilized in clinical settings to support triggering of referrals and connections to non-medical services in the community.</p>						
<p>Adopt/create an E- Referral system - Health homes would integrate and interface with all available agencies and resources to optimize the health and wellbeing of the local population.</p>						
<p>Develop a robust reminder recall system</p>						
<p>Provide access to EDIE (Emergency Department Information Exchange) to primary care providers across the state. It is currently unavailable to most primary care providers due to cost and not available for inpatient visits but would provide key information for patient follow up appointments</p>						
<p>Ensure that school wellness policies are implemented to ensure physical activity and sound nutrition: Implement high quality physical education, play and physical activity. Coordinate with cafeteria and wellness staff to ensure healthy foods are purchased and promoted in ways that encourage children to eat healthy. Eliminate sponsorship by companies that market unhealthy foods and drink.</p>						
<p>Increase participation in the School Breakfast Program (SBP). School breakfast improves nutritional intake and protects against obesity. A study found that low-income children who eat breakfast at school have better diet quality than children who skip breakfast or eat breakfast elsewhere. In a time of constrained budgets, the state could take advantage of federal funds that support the SBP. Washington State would receive an additional \$14.5 million if 60 free or reduced-price eligible students participated in the SBP for every 100 of these students who participated in the National School Lunch Program. Some existing opportunities for PSE changes include:</p> <ul style="list-style-type: none"> <li>• Include the SBP as a service on the Washington Connection website to enable parents and students to check for eligibility and securely apply online.</li> <li>• Utilize Washington Connection to enhance the direct certification process, which automatically enrolls students who are receiving Basic Food and TANF in the SBP.</li> <li>• Assist DOH in a breakfast promotion campaign, including flyers, a webpage, and Twitter, that contains consistent messaging (Fuel Up – Eat Breakfast Washington).</li> <li>• Advocate for the funding and implementation of universal free breakfast in school districts with 80 percent or more free or reduced-price eligible students to reduce the stigma associated with the SBP.</li> </ul>						
<p>Healthy food procurement: Organizations, agencies, institution and others make a variety of healthful, competitively priced food and beverage options available to employees, clients and the general public.</p>						
<p>Include healthy eating and active living in municipal and transportation planning through zoning ordinances, city ordinances, comprehensive plans, and transportation plans.</p>		x	x	x	x	x

<p>Creating and strengthening standards for high-quality early childhood development programs. Implement best practice standards for healthy eating and active living in childcare: Childcare providers and organizations implement healthy beverage guidelines, reduce screen time, increase active time and provide healthy foods for meals and snacks.</p>						
<p>Farm-to-School programs, operated within schools, have the potential to create immediate and long-lasting impacts on the health of thousands of students, while simultaneously benefitting Washington’s farmers and economy. FTS activities vary depending on the community’s resources, needs, and priorities, but generally, FTS programs connect schools with local farms in order to (1) serve healthy meals in school cafeterias, (2) improve agriculture, health, and nutrition education, and (3) support local and regional farmers</p>						
<p>Increase food recovery opportunities. In Washington State, 18% of all municipal solid waste (by weight) is food. Some of this food is perfectly edible and could be recovered for food banks, meals programs and shelters. Opportunities may exist to:</p> <ul style="list-style-type: none"> <li>• Create a regional food recovery system so that businesses have one contact point for food donation. This system could also have dedicated staff members who are available to quickly collect and distribute perishable food.</li> <li>• Create an online exchange that links restaurants, farmers, and supermarkets to non-profits seeking food, making it easy for small businesses to announce food surpluses to others in their region.</li> <li>• Partner with existing distribution and advocacy networks, such as Northwest Harvest, Washington Food Coalition, and Anti-Hunger &amp; Nutrition Coalition, to find ways to strengthen their efforts.</li> </ul>						
<p>Limit the marketing of unhealthy foods and drinks, which leads to unhealthy purchases and consumption, which in turn contributes to the obesity epidemic and the rise of chronic diseases. According to the CDC, if trends continue, one in three U.S. adults will have diabetes by 2050. In Washington State, the adult obesity rate could reach 55.5% by 2030. Potential strategies span state, regional and local arenas:</p> <ul style="list-style-type: none"> <li>• Require that checkout lanes contain healthy food and beverages.</li> <li>• Regulate the pricing of unhealthy foods and beverages.</li> <li>• Limit the total amount of store window space that can be covered by signs.</li> <li>• Enact regulations that place high-calorie, low-nutrient foods at the back of the store, behind the counter, or in locations other than at the end of aisles or checkout lanes.</li> <li>• Require shelf signage near sugary drinks and other unhealthy foods to alert consumers of health effects of the product.</li> <li>• Ensure restaurant meals marketed to children are healthy.</li> <li>• Prohibit new fast food restaurants from opening near schools or other locations with a youth population.</li> <li>• Support regulation that prohibits toys from being given away with unhealthy fast food meals. See NPLAN’s model ordinance for healthier toy giveaway meals.</li> <li>• Prohibit the acceptance of food/beverage industry sponsorships by schools.</li> <li>• Promote the adoption of school district policies that prohibit the advertising of unhealthy foods and drinks on school grounds. See NPLAN’s sample policy.</li> <li>• Ban unhealthy food and beverage advertising on school buses.</li> </ul>						

<ul style="list-style-type: none"> <li>• Prohibit the advertising of sugary drinks and unhealthy foods on or near schools, playgrounds, youth centers, and other facilities used by youth.</li> <li>• Support a study on the profitability of selling of healthy products in schools and at checkout lanes.</li> <li>• Ensure that vending contracts limit the sale and advertising of unhealthy food and beverages in parks and other venues visited by children and adolescents.</li> <li>• Ban all commercial billboards except those located on the site of the advertised establishment.</li> </ul>							
<p>Increase Access to tap water for children and adults in schools. Tap water consumption in schools has been declining for various reasons: infrastructure has fallen into disrepair, making water unsafe to drink; competition with the sale and marketing of bottled water; &amp; student preferences &amp; perceptions of tap water. Opportunities may exist to increase access to tap water, such as:</p> <ul style="list-style-type: none"> <li>• Advocate for federal legislation that provides grants to municipal water systems and individual schools for tap water infrastructure repairs and improvements.</li> <li>• Support state legislation requiring all schools to provide free, safe tap water to students during the entire school day, not just during meal time</li> <li>• Advocate for the use of state capitol budget funds to support necessary infrastructure for clean and safe tap water in schools.</li> <li>• Advocate for stronger state, regional, or local competitive beverage laws that (1) prohibit the advertising/marketing of sugary drinks and bottled water in schools by companies that sell these beverages, and/or (2) limit or ban the sales of sugary drinks and bottled water in schools, especially those with clean, safe tap water fountains.</li> <li>• Advocate for the inclusion of food and beverage nutrition literacy education into school curricula.</li> </ul>							
Implement Breastfeeding Friendly WA voluntary recognition program for hospitals and community health clinics – in clinics, hospitals, childcare and worksites	x	x	x	x	x	x	x
Ensure proper reinforcement of breastfeeding laws in WA							
Adopt and promote smoke free environments in health care providers, business, colleges, parks, housing authorities (supportive housing)							
Tobacco cessation in Supportive Housing: Supportive Housing providers, shelters and mental health agencies bring tobacco cessation assistance to population receiving services.							
Improve public safety to encourage more walking, biking and community connectedness: Improve environmental determinants of public safety such as lighting, safe routes, building codes. Incorporate DDACTS (Data driven approaches to crime and traffic safety). Improve safe storage of firearms (co-benefit injury and violence).							
Zoning and design for community health: Healthy zoning policies attract retailers that will promote healthy foods with emphasis on underserved areas. Enact zoning policies and comprehensive plans to ensure active transportation, physical activity and healthy eating are encouraged and designed to make the healthy choice the easy choice.							

<p>SBIRT -- identifying those in need of treatment and beginning to engage them through supported referral to treatment. This needs to then be linked with adequate treatment capacity (sorely lacking due to historical lids on Medicaid-funded CD services). There needs to be a comprehensive strategy that address community education/prevention, identification and engagement, and treatment</p>									
<p>Trauma-Informed Schools: Community service providers implement and spread ACES- and trauma-informed care and create trauma informed environments. (Includes but not limited to PCMH's). Draw from the success of Nurse Family Partnership model to address and potentially prevent adverse childhood experiences in broader population.</p>									
<p>Increase the number of Healthy Zones in WA Communities:</p> <ul style="list-style-type: none"> <li>• Municipalities may pass local zoning ordinances that create zones where schools cannot be near specific sensitive land uses (retail alcohol outlets, medical marijuana dispensaries, gun shops, retail tobacco outlets, and retail stores with high percentages of products that sell junk food and sugary drinks). See NPLAN's Model Healthy Food Zone Ordinance, which prohibits new fast food restaurants within a certain distance from schools and other locations where children are likely to visit.</li> <li>• Promote community gardens near schools through zoning policies and grants.</li> <li>• Provide guidance and tools for communities to understand the current landscape by mapping locations of schools, parks, and other youth-friendly areas in relation to fast food restaurants, retail alcohol and tobacco outlets, marijuana dispensaries, gun shops, etc.</li> <li>• Ban all commercial billboards except those located on the site of the advertised establishment</li> </ul>									
<p>Healthy housing ordinances and codes: Cities adopt local housing ordinances or code to create healthier housing environments including abating hazards in the house, reduce pollutants that infiltrate the house, and the relationships between housing costs and health.</p>									
<p>Implement temporary rental assistance pilot with integrated supportive services for families experiencing housing instability who have children enrolled in school (such as the McCarver Elementary School Special Housing Program in Tacoma, and the Student Family Support Services Initiative (SFSI) in Chicago). Opportunities exist to:</p> <ul style="list-style-type: none"> <li>• Create specific targeting for the temporary rental assistance pilot around chronic absenteeism, school mobility, behavioral issues, or other school issues related to housing instability.</li> <li>• Promote school-based and community-based health and mental health services for children and families experiencing homelessness.</li> <li>• Provide vocational training, employment services, and financial management services for families experiencing housing instability to achieve economic self-sufficiency.</li> <li>• Use a mentorship/community health worker model to assist schools in supporting students (and their parents) experiencing housing instability.</li> </ul>									

Support Health-Housing Partnership created to implement CHW collaborations in 3-4 communities around the state, based in affordable housing communities and serving residents and surrounding neighbors. Focus the collaborations on population based programs for prevention and management of chronic diseases through education, prevention and self-management efforts to promote healthy eating, physical activity, smoking cessation and reduction of obesity.							
Local cross-sector programs that target housing insecure populations with chronic illnesses can improve health and reduce costs to the system may succeed through combining targeted case management and housing resources. One successful program model – the Chicago Housing for Health Partnership (CHHP) worked with two Chicago hospitals to provide case management, medical respite, temporary housing after hospital discharge, and referral to permanent supportive housing to participating patients. A third-party evaluation of the project found that participants who were provided permanent housing with case management had one-third fewer inpatient hospital days and one-quarter fewer ED visits than their peers who relied on the usual care system.							
Use supported employment services with transition age youth- with behavioral health disabilities.							
Employment Security’s Rapid Response Teams (currently respond to workplaces where people are being laid-off to provide info re: unemployment insurance application, WorkSource info, etc.) Recommendation is to wrap comprehensive and integrated BH information for soon-to-be laid-off workers. This could include info re: signs of depression/anxiety/substance use to prevent these conditions and Health Benefit Exchange info.							
Support increased connection of young families to concrete supports (housing, food, jobs, etc.)							
Community Programs: Community partners and decision makers collaborate to implement policies and practices to prevent domestic violence and promote protection through the justice system.							
A comprehensive hospital discharge plan that coordinates follow-up medical care in appropriate settings while also connecting super-utilizers to the social support services they need, such as stable and permanent housing, ongoing behavioral health treatment, transportation services, medication management, and patient education may be developed through collaborative effort between health care delivery systems and social service communities. This solution requires a multidisciplinary team of health care and social support professionals who work together to develop an individualized care plan that is monitored based on the specific needs of the individual.							
Expand family-oriented substance use and mental health treatment provider capacity in local communities							
Prioritize service provision for substance use, mental health treatment, housing support and other concrete family needs for pregnant women and families with young children							
Evidence-based guidelines for screening and standards of care for pre-diabetes and diabetes, and pre-hypertension and hypertension							

## 2. REFORM PAYMENT AND BENEFIT DESIGN TO INCENTIVIZE PREVENTION AND HEALTH IMPROVEMENT

Apply for a Medicaid Demonstration/Waiver (Section 1115) or Medicaid state plan amendment. Purpose of demonstrations: Expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, Provide services not typically covered by Medicaid and use innovative service delivery systems that improve care, increase efficiency, and reduce costs.	x			x	x	x	x
Create a Medicaid Benefit To Cover Case Management Services in Supportive Housing							
Provide funding for stable, affordable and safe housing for people with chronic mental health conditions close to mental health resources, with space available for people re-entering communities from hospitals or criminal justice settings (1115)	x	x	x				x
Develop a system to support shared savings							
Payment system which supports/align incentives to promote care coordination, referral to social services, etc.							
Mandate flexible payment systems for primary care practices of all sizes for a set percentage of each payers covered lives.							
Forge and incentivize collaborations between health care delivery system and community or public health							
Mirror CMS transitional care management (TCM) billing to both be consistent rather than different in process and to stimulate and reward PCPs to provide Transitional Care to Patients							
Incentivize adoption of breastfeeding policies							
Provide a stipend to support the time of small providers away from their practice to participate in these processes will expand the impact through these opportunities.							
Create incentives tied to reimbursement for health professionals and health care institutions to address nonmedical factors that affect health.							
Establish incentives and performance measures to spur collaborative approaches to building healthy communities							
Provide funding to Accountable Communities of Health to foster connections between healthcare professionals and resource providers such as WIC programs, mental health providers, and evidence based-community programs (such as speaker/networking events that bring a broad range of providers together around a cross-cutting topic, such as obesity							
Innovative funding models for community-based prevention that may prove effective in regions across WA State include: <ul style="list-style-type: none"> <li>Health impact bonds (HIBs) provide a market-based approach to pay for evidence-based interventions that reduce health care costs by improving social, environmental and economic conditions essential to health.</li> <li>A portion of ACO enabled cost-reduction savings for a designated population of patients, could be set aside to invest in community-prevention initiatives aimed at improving community environments.</li> <li>The 'community benefit' requirements imposed on nonprofit hospitals and health plans may represent a significant and sustainable source of funds for community-prevention initiatives.</li> </ul>							

Leverage foundation support for the ongoing realignment and allocation of state funds towards innovative collaborations and alliances. Legislators and private foundations alike may be persuaded by success stories that come from payment reform and restructured services towards early prevention and away from involuntary and ineffective care for those often 'high utilizers' suffering from mental illness.							
Negotiate a standard billing code for case management of Medicaid-eligible patients to be per-member-per-month instead of fee-for-service to defray costs of those requiring more intensive case management							
Standardizing the billing pattern process for providers and billers. Require all health plans to standardize key practices to reduce the administrative overhead to practices and support care for patients							
Evaluate provider reimbursement for EPDST/bright futures							
Implement payments for full Bright Futures periodicity of well child and developmental screening services,							
Require all insurance plans in Washington to cover proactive case management of people with chronic mental health conditions	x						x
Structure payment to allow for comprehensive treatment of people with co-occurring diagnoses of diabetes/pre diabetes, hypertension/pre-hypertension, and mental illness	x	x	x		x	x	x
Fund evidence based supportive housing services							
Require insurance companies to provide coverage for patients with a body mass index of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions. (USPSTF)	x			x	x	x	x
Require insurance companies to provide coverage for children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status. (USPSTF)	x			x	x	x	x
Require Insurance companies to provide coverage for evidence-based weight management programs, CDSMP, DPP, Weight Watchers, physical activity programs for populations at risk for weight-related chronic disease.	x			x	x	x	x
Require enhanced dental coverage for people with diabetes and periodontal disease and/or other oral health problems	x				x		
Increase reimbursement rates so that Medicaid enrollees have greater access to Diabetes Education	x				x		
Mandate or incentivize all health plans in the state to cover Diabetes Prevention Program.							
Mandate or incentivize coverage of asthma medications							
Establish sugar-sweetened beverage tax with revenue directed toward comprehensive obesity prevention	x			x	x	x	

**3. FOSTER AND ENGAGE PEOPLE, COMMUNITIES AND SYSTEMS IN HEALTH PROMOTION ACTIVITIES THAT ENABLE THEM TO EXERCISE CONTROL OVER THEIR HEALTH AND ENVIRONMENTS**

Governor to lead and support a Culture of Health initiative with key health promotion messages. Promote the new norm of health.	x		x	x	x	x	x
<p>CHW Network is non-governmental Network that becomes the backbone convener of the state’s many CHW efforts. It provides backbone services to loosely affiliated, grassroots, regional CHW networks and can coordinate mutually reinforcing CHW activities. The Network:</p> <ul style="list-style-type: none"> <li>• Develops CHW leadership across the state enabling the CHW collective voice to encourage community appropriate primary prevention and screening.</li> <li>• Identifies mutually reinforcing activities for community-based prevention and system changes that address primary prevention and screening.</li> <li>• Work with the Innovation Center to create the baseline information about the CHW field (e.g., ground-up information about what CHWs do, need, and want, populations served, etc.) and identify training and technical assistance needs across the state.</li> <li>• Represents CHW’s on the CHW TF and informs the TF of emerging policy priorities and strategies and develops the framework for defining the CWH scope of work, training standards, and potential financing models.</li> <li>• Support development of systems and plan for implementation of healthy competitive foods guidelines.</li> <li>• Promote and encourage collaboration of farmers markets across the region accepting SNAP.</li> </ul>							
SHAPE – Shape Health Action Plan for Empowerment. Mentors to increase physical activity for those with mental illness.							
Establish family and community programs that enable breastfeeding to continue if a mother returns to work.							
Community outreach to promote comprehensive and culturally tailored resources about the health benefits of breastfeeding							
Expand the use of mobile technologies that link people with community and health care delivery resources to improve preventive services and chronic disease management							
Establish Best Practices in Supportive Housing for High Needs Families and Develop Viable Funding Models							
Educate on the relationship between immunizations and health care reform, specifically how to implement universal coverage for all vaccines.							
Increase interventions for household smoking to reduce 2nd hand smoke exposure in-utero and early childhood							
Promote breastfeeding as an effective way to prevent obesity, SIDS and other health issues							
Establish a breastfeeding support ‘warm line’ and link to breastfeeding friendly hospitals. Warm line links moms with local lactation support by physician, nurses, lactation specialists, peer counselors and other providers.							
Establish a community fund for people to attend physical activity classes who could not otherwise afford it.							
Implement strategies that engage parent social networks to remind of social norms to vaccinate							

Expand capacity to promote parental skill development – parent coaching							
Encourage providers of behavioral services to encourage their clients to disclose the utilization of services to hospitals upon admissions.							
Increase early identification and family-oriented intervention for parental mental health and substance use issues during pregnancy and early childhood years (include mothers, fathers, and children)							
Emphasize healthy nutrition practices during prenatal and early childhood years with strong messaging and supportive practices for breastfeeding and healthy food choices. Consider stronger linkages between WIC programs and prenatal and pediatric practices.							
<ul style="list-style-type: none"> <li>• Help connect people to preventive health care and help them navigate their health system.</li> <li>• Develop a standard self-assessment tool and provide easy access to that tool for all citizens so that they can monitor their health in relation to a target and understand when appropriate screenings are due.</li> <li>• Improve understanding of preventive health care and what screenings are needed at what times of life.</li> </ul>							
Public awareness campaigns about the reasons primary care is better for health than specialty care.							
Encourage employers to help their employees be more physically active							
Conduct more community engagement to educate the public about ROI from investments in health							
<p>Promote and expand School-Based-Health Centers (SBHC) in Washington State; SBHCs are a cost-effective way to improve both individual health and academic outcomes. Students who miss school are at a higher risk of dropping out. By seeking clinical care in the school, students do not miss classes for health care appointments. An evaluation of 12 SBHCs in Seattle found that SBHCs helped reduce the rate of absenteeism and dropouts and contributed to improvement in students’ academic performance. In another study, students who used the SBHC for mental health services increased their GPAs over time compared to non-SBHC users. SBHC providers can identify health problems earlier, which can reduce the utilization of emergency departments and hospitalizations, and thereby decrease health care spending. SBHCs and the ACA are complementary; with the elimination of pre-existing condition clauses and provision of preventive services without cost-sharing, demand for services among youth will increase, and SBHCs can help address that demand. The ACA also supports the testing and evaluation of innovative care delivery models, including the patient-centered medical home (PCMH). The PCMH model is designed to provide care that is coordinated, continuous, accessible, comprehensive, culturally competent, and suited to each patient. Opportunities exist at state-level to:</p> <ul style="list-style-type: none"> <li>• Orchestrate a communications campaign to educate policymakers and communities about the benefits of SBHCs and raise awareness and support.</li> <li>• Support the appropriate state agencies and/or organizations in setting up liaisons to provide development and technical assistance to SBHCs and communities that want to start up SBHCs.</li> <li>• Encourage the appropriate state agency and/or organizations to assess the barriers to billing and reimbursement and develop sustainable reimbursement models.</li> <li>• Seek opportunities for SBHCs to be recognized and incorporated in health care reform implementation and Exchange formation in Washington State (e.g., network adequacy, essential community provider criteria under Qualified Health Plans). Create a standard bill procedure for Medicaid/CHIP-covered children seen in SBHCs.</li> </ul>							