

Accountable Community of Health Overview



Vision

Our vision of health is for every person to have a longer, more productive, higher quality lives by ensuring access to:

- Stable housing, nutritious food and transportation.
- Opportunity to attain post secondary education and training to allow for meaningful employment that pays the bills with some left over for savings.
- Community resources and opportunities for recreational and leisure-time activities.
- Social support networks that allow for emotional, social and psychological wellbeing.



Guiding Principles

- Truly effective health and community systems care for the whole-person and are utilized and accessible to all.
- The best solutions and implementation are local and originate from within the community.
- Prudent and efficient use of community resources and the health care system ensures lower costs and better health.
- To realize our audacious health goals we must approach this as a movement requiring each of us to lead, collaborate and orchestrate our work in creative and new ways.



Regional Health Priorities

- Dramatically improve whole-person care through the integration of behavioral, physical and oral health systems.
- Develop strong community systems that link housing, food security and income stability.
- Dramatically decrease obesity rates across all populations through prevention.
- Scaling community-based care coordination to improve health.

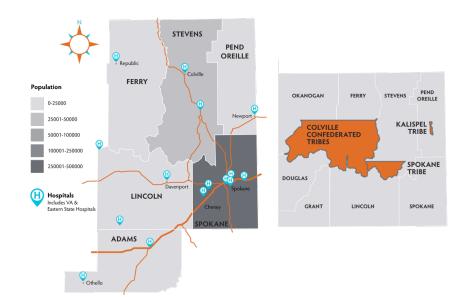
ACH in ACTION!

To demonstrate the value of multi-sector collaboration and integration in improving health and reducing costs, we are launching a pilot community referral hub model that will provide a single point for care coordination. The pilot is based on a national model currently being implemented in 20+ regions around the country, that includes best practices "pathways" for connecting individual to needed services, and provides a foundation for sustainable funding.

Ferry County Jail Transitions Pilot

Our first pilot will connect individuals transitioning out of the Ferry County jail, and their families, to the services needed to improve their health and reduce recidivism. Individuals and families will be connected to a Community Health Worker who will guide them along the "pathway" to receiving the care they need, and help in removing barriers along the way. This may include enrollment in health insurance and other eligible benefits, ensuring families have an established medical health home, and are connected to supportive services for housing, food, employment, education, among many other needs.

Within one year, we expect to demonstrate improved health status and savings to both the health care system and county budget. This program has been successfully running in Michigan where an analysis of 2,400 people who went through the program found that the recidivism rate for participants who had been on parole for two years fell from 46 percent in 2007 when the program began, to 21.8 percent in 2012.



Community Strategies

Population Health

Disrupt the intergenerational transfer of Adverse Childhood Experiences

Improve oral health

Control and prevent Type 2 Diabetes

Prevent environmentally induced asthma

Prevent unintended pregnancies

Prevent usage of Triangulum substances and increase cessation supports

Increase age appropriate immunization rates

Social Determinants of Health

Increase access and placement to stable and safe housing

Increase access to healthy and affordable food

Increase access to transportation through innovative partnerships

Increase opportunities to stabilize income

Improve education attainment

Increase access to socially supportive peer-groups

Integrated Care

Integrate behavioral health, oral health, and primary care

Accelerate the transition to value-based payments

Scale community based care

Increase patient engagement



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