**Feedback Session #1**

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|  | **Key Elements (Examples)** |  |
|  | *Use the examples provided only as a way to stimulate the thinking process and trigger exploratory discussion of what is right in the context of this community/county.* |  |
|  | Vision: The people of Okanogan Co. embrace and sustain a culture of health |  |
|  | Goal: The people of Okanogan Co. will have improved health at every stage of life |  |
|  | Principles: Alignment, Balance, Collective Action, Health,Health Equity, Participation, Quality |  |
|  | Meeting Attendee Notes:* Individual ownership of health
* Payer incentives for patients
* Focus on known problems
* Bottom’s up approach
* Increase Health literacy
* Personal accountability
* Cost effective
* Incentivize/disincentivize to patient, providers, communities for wellness care
* Measure improved health
* Access Cancer care alliance stats
* Engaged community-personal accountability/cost effectiveness
* Incentives/disincentives to/for healthcare
* Incentive-preventative care should be free/low cost
* Work on problems from bottoms up vs. top down. Start with customer/community members
* Health plans incentives
* Health plans-wellness incentives
* Start with the little problems first to help start fixing the larger problem
* Measurable collective action
* Prevention, self-care, cost effective, community based, personal responsibility and accountability, proactive, wellness, community and self-engagement, incentive/disincentive for patient and provider responsibility
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|  | **Overarching Priority (Example)** |  |
|  | Prevention and management of chronic disease and behavioral health issues, while addressing root causes |  |
|  | Meeting Attendee Notes:* Focus on high cost consumers
* Addressing underlying issues
* Diabetes education
* Duplication of resources
* Transparency of costs
* Identify abusers
* Identify subset of people who are most expensive and deal with them differently through payment reform, chronic disease management. Health education/literacy (through schools and business), focus on diabetes
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|  | **Initial Focus Areas (Examples)** |  |
|  | Cardiovascular disease and diabetes |  |
|  | Healthy eating, active living, tobacco free living and obesity prevention |  |
|  | Mental illness, substance abuse/use (opioids) |  |
|  | Trauma informed practices (e.g., Adverse Childhood Experiences or ACES) |  |
|  | Meeting Attendee Notes:* Wellness care vs. responsive care
* End of live care, oncology
* Transportation creates issues with access to care
* Re-thinking in-patient model in this county
* Be as focused as possible
* Identify costs
* Improve trust
* Payment reform
* Wellness care vs. responsive care
* Oncology/end of life care
* Transportation concerns
* Diabetes, healthy eating, active living, obesity prevention
* Assist with issues
* Co-occuring disorders
* Delineate costs
* Increase trust
* Increase transparency
* Change culture= decreased scare
* Make health a priority
* Transportation to providers
* Reorganize/rethink inpatient model
* End of life care and education
* Focus on known problems and make progress (such as frequent flyers)
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