



King County Safety Net System Study

Public Health - Seattle & King County

**Final Report
February 5, 2008**

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Executive Summary

The purpose of this study was to initiate a collective inquiry regarding safety net services in King County and explore how to increase effective and efficient access to care for the population utilizing the system. The component conducted by MCPP included interviewing key stakeholders currently engaged in the provision of safety net services.

Interviews and content analyses were conducted by MCPP, with strong participation and support from Public Health - Seattle & King County and key provider and non-provider stakeholders of the core health safety net in King County.

The interview process began by asking participants to state their perceptions about the **S**trengths, **W**eaknesses, **O**pportunities, and **T**hreats to the existing safety net (SN). Many of the key themes which follow were also identified throughout the interviews.

Strengths

- Staff & provider commitment and dedication to serving the SN population
- Focus on sub-population needs
- Existing clinics in accessible locations
- Scope of available services include enabling services and interpretation
- Mechanisms for system collaboration and communication exist- better here than in other places

Weaknesses

- Geographic disparities to access in the County
- Scope of services limited in areas of mental health, substance use disorders and dental care, access to specialty providers
- Inadequate infrastructure to ensure mechanisms throughout the system to collaborate with each other
- Inadequate mechanisms for sharing information and service coordination between providers/agencies
- Care that is frequently fragmented; organizational roles unclear
- Competition for patients with reimbursement and for inadequate public funding in a market-driven healthcare industry

Opportunities

- Increase capacity by opening clinics to improve geographic access
- Increase scope of services to include health/exercise classes, partnering with the community to build in early intervention with vulnerable and growing populations

- Make mechanisms/connections for system collaboration more visible and eliminate duplication of effort
- Patient-centered medical homes as a mechanism for service coordination along with implementation of EHRs and information sharing mechanisms
- Clarify PHSKC and other organizations' roles to eliminate fragmentation and duplication
- Reduce the problem of competition and service area conflicts by focusing on the whole system and making it more planned and rational

Threats

- Aging of the population will create demand for more providers to ensure access to services
- Needs for system collaboration overwhelm the existing mechanisms risking its ability to be effective
- Biggest risk is that the system works against itself, wasting effort to compete and lose focus
- How to finance SN care in a market-driven healthcare industry

Key Themes

Given the amount of data gathered, a relatively small number of key themes emerged that were repeated throughout the interviews. They include:

- **Commitment and Dedication to Serving the Safety Net Population**
- **Population and Geographic Access to Services**
- **Scope of Services That Are Available**
- **Patient-Centered Medical Homes**
- **Mechanisms for System Collaboration**
- **Bringing Stakeholders Together**
- **Mechanisms for Service Coordination**
- **Fragmentation/Unclear Roles of Organizations**
- **Addressing the Public's Health**
- **Competition/Financing in a Market-driven Healthcare Industry**

Moving Forward

Moving forward, many of those interviewed stated, was their greatest hope. Having acknowledged past history and the “politics of it all,” stakeholders expressed their willingness to:

- Agree to be bold in addressing the issues
- Agree on the leader/convener for this work
- Build trust by working together
- Create a transparent SN system built on what’s best for the population as a whole
- Meet the unique ethnic and cultural needs of those served by the SN as part of agreement
- Include both direct and non-direct provider stakeholders at the table

Conclusion

The interview dialogue was very illuminating and encouraging. It highlighted a number of existing strengths including the resilience and tenacity of the individuals and organizations currently providing a rich array of health services to those who are uninsured, under-insured, Medicaid or GAU funded. In addition, the interviewees candidly identified and discussed many weaknesses, warts, and wishes for the future as well as a number of models that might contribute to improving the existing system for the health of those most in need.

Great interest was expressed regarding “next steps” with a key message being stakeholders need to be around the table continuing with the difficult conversations and decisions that all see ahead. Ultimately, the success of this endeavor will be judged by the actions taken rather than by the words that result from the conversations.

Introduction

The purpose of this project was to initiate a collective inquiry regarding safety net services in King County and explore how to increase effective and efficient access to care for the population utilizing the system.

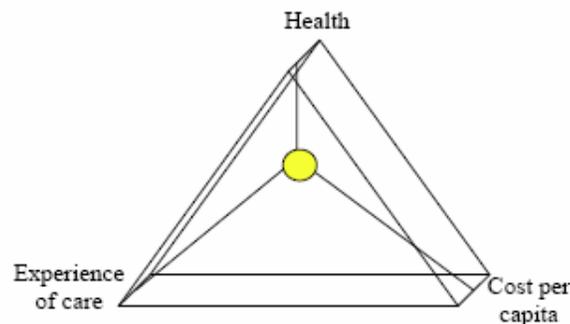
This project was initiated, organized and funded by Public Health Seattle-King County (PHSKC). PHSKC provides a wide variety of regional services that protect and promote the health of all 1.8 million King County residents, as well as hundreds of thousands of workers and tourists who enter the county each day. Over the last decade, the provision of public health services in King County has been continually challenged due to emerging health risks, the necessity for increased disease control, and federal, state and local mandates. Due to the increases in cost and the need for public health services, coupled with the funding challenges, King County engaged in a collaborative process to develop a Public Health Operational Master Plan. Based on the findings of Phase I of the master plan, Phase II will include addressing access for low income, uninsured, and underinsured residents in King County. As part of Phase II work, this study focused on gathering information from the key stakeholders of the King County safety net system.

Context

Important conversations are taking place nationally regarding the health of the population. The two concepts discussed in this section are promising approaches to implementing population-based solutions to providing effective and efficient quality health care.

The IHI Triple Aim Concept¹

“Transformation of health care delivery starts with a transformational aim. The Institute for Healthcare Improvement believes that one such transformational aim includes a balance or optimization of performance on three dimensions of care – which IHI calls the “Triple Aim”:



¹ Best Health Care Results for Populations: The “Triple Aim”

Achieving the optimal balance of good health, positive patient experience of care, and low per capita cost for a population INSTITUTE FOR HEALTHCARE IMPROVEMENT, TECHNICAL BRIEF JUNE 2007

1. The health of a defined population;
2. The experience of care by the people in this population; and
3. The cost per capita of providing care for this population.

These three dimensions of care pull on the health care system from different directions. Changing any one of the three has consequences for the other two, either in the same or opposite directions. For example, improving health can raise costs; reducing costs can create poor outcomes, poor experience of care, or both; and patients' experience of care can improve without improving health. With the goal of optimizing performance on all three dimensions of care, we recognize the dynamics of each dimension while seeking the intersection of best performance on all three.

To achieve the Triple Aim, an organization must act as *an integrator*. An integrator is an entity whose purpose is to achieve high levels of performance in all three components of the Triple Aim. It can assemble a system to improve and maintain health (in addition to treating illness). The system is usually made up of many different components that provide health promotion and health protection services as well as medical care. The parts are linked together as a virtual system with common purpose, policy, and values. The integrator "has an organization structure and management process which ensures care and services can be delivered."

Patient-Centered Medical Homes²

"The Physician Practice Connections-Patient-Centered Medical Home (PPC-PCMH) is a modification of the 2006 Physician Practice Connections (PCC). The PPC-PCMH version of the PCC reflects the input of primary care specialty societies and others on how to use the 2006 PCC to assess whether physician practices are functioning as medical homes.

The concepts embedded in the PCMH were further developed by a collaboration of the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP) and American Osteopathic Association (AOA). NCQA provided input related to their work on the PPC and a Commonwealth Fund grant to define "patient-centeredness." The joint principles, created and supported by ACP, AAFP, AAP, and AOA, define the following key characteristics of the PCMH.

Personal physician – Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

² NCQA (2008), *Overview Physician Practice Connections—Patient-Centered Medical Home (PPC-PCMH)*. Retrieved January 23, 2008, from <http://web.ncqa.org/tabid/631/Default.aspx>

Whole person orientation – The personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services and end of life care.

Care is coordinated or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home.

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients and the patient’s family.
- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision making and feedback is sought to ensure patients’ expectations are being met.
- Information technology (IT) is utilized appropriately to support optimal patient care, performance measurement, patient education and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician and practice staff...To achieve Recognition as a Patient-Centered Medical Home by meeting the NCQA PPC-PCMH standards, practices will attest to the 2007 Joint Principles of the Patient-Centered Medical Home...”

Further development of SN examples and models should, where ever possible, move these ideas forward.

Defining the Safety Net System of Care and the Population

The **Safety Net (SN) system of care** is defined as the planned collaboration and service coordination mechanisms that connect the SN population to appropriate and

timely services and providers among the core SN health service providers as well as specialty and hospital services.

The **SN population** is defined to include the Medicaid, GAU, uninsured, and underinsured populations. **SN core health services** may include primary healthcare services, mental health services, substance use disorder services, dental care services, maternity support services, family planning, the Women, Infant and Children program, and childhood immunizations. Access for the SN population to specialty and hospital care is another component of the SN system. The degree to which specialty access is available directly impacts primary healthcare service access, as well as the overall effectiveness and efficiency of the SN system.

Project Approach

The overall goal of this project was to initiate a collective inquiry regarding SN services in King County and explore how to increase effective and efficient access to care for residents utilizing the system. The component conducted by MCPP included interviewing key stakeholders currently engaged in the provision of safety net services.

A total of 19 stakeholders representing nine direct care organizations were interviewed by MCPP. Please see Attachment A for a detailed summary of these interviews.

- Community Health Centers of King County (CHCKC)
- Puget Sound Neighborhood Health Centers (PSNHC)
- International Community Health Services (ICHS)
- SeaMar Community Health Centers (SeaMar CHCs)
- Country Doctor Community Health Center (CDCHC)
- Seattle Indian Health Board (SIHB)
- Odessa Brown Pediatric Clinic
- Harborview Medical Center / Pioneer Square Clinic
- Pacific Medical Centers

Nine non-direct care stakeholders representing three organizations were interviewed by MCPP included the following organizations. Please see Attachment B for a detailed summary of these interviews.

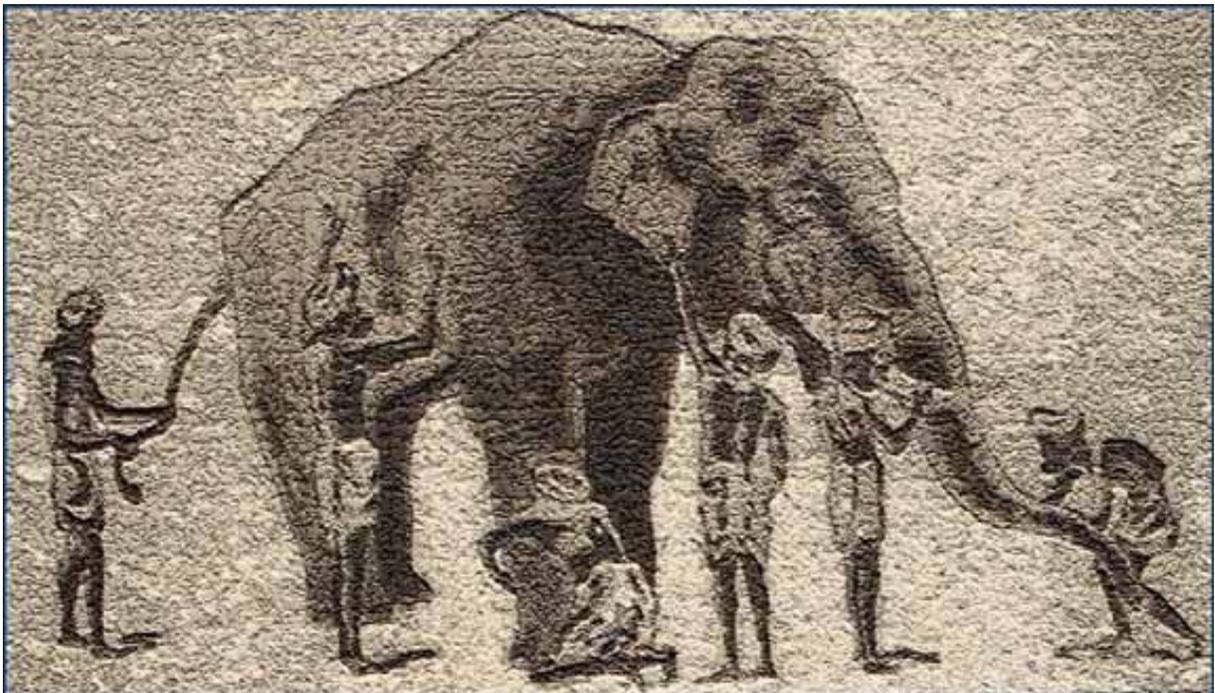
- Community Health Plan
- King County Project Access
- Molina Healthcare of Washington

In addition PHSKC staff interviewed 19 stakeholders representing 11 entities. Please see Attachment C for a detailed summary of these interviews.

- Group Health Cooperative
- Pacific Hospital Preservation & Development Authority
- Highline Medical Center and Foundation
- Children’s Hospital and Medical Center
- Valley Medical Center
- Tom Byers, Partner, Cedar River Group and past Deputy Mayor of Seattle
- Charles Heaney, Executive Director, King County Medical Society
- Professor Cindy Watts, Department of Health, University of Washington
- Patty Hayes, Executive Director, Within Reach and former Assistant Secretary of DOH
- Carrie Cihak, Staff to King County Council
- Jerry DeGriek, Public Health Advisor, City of Seattle Department of Human Services
- Dr. Bob Crittenden, University of Washington/Harborview Medical Center, Herndon Alliance Consultant and past health advisor to Gov. Booth Gardner
- Lance Heineccius, Health policy consultant, past staff director with Puget Sound Health Alliance and earlier with State Health Services Commission
- Evergreen Healthcare

Findings of MCPP Interviews

One of the overarching observations brought to mind the image below: many of the individuals interviewed provided detailed descriptions of the pieces of the SN system of care in which they were directly engaged and most familiar. However, **no one appeared to have a clear vision of the overall SN system. There is no coherent system of care for the SN – there are many separate processes.**



Everyone interviewed was clearly engaged and invested in improving care for the SN population. Some noted that the SN **history and the impact of early decisions on a variety of stakeholders have affected working relationships, trust and the willingness to collaboratively partner with each other.** It also appeared that there may be more than one set of issues to address in the existing SN system, as some of the geographic concerns vary.

What follows in the body of this report is a summary of the SWOT analysis and the key theme summary from all of interviews conducted: the direct and non-direct provider stakeholders interviewed by MCPP and the summary of the stakeholders interviewed by PHSKC staff. Significant differences and similarities between these three groups are noted. Please refer to Attachments A, B, and C for detailed summaries of each set of interviews.

The interview process began by asking participants to state their perceptions about the **S**trengths, **W**eaknesses, **O**pportunities, and **T**hreats to the existing SN. Many of the key themes which follow were also identified throughout the interviews.

Strengths

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Likert Scales (1= not at all, 5= absolutely)

Respondents were given three scaled questions within the interview (n=12). The first scaled question asked whether or not the SN population gets the **best possible access to care and service that it could based on the resources available** in the community. Thirty-three percent scored this between 2-2.9; Fifty percent scored this between 3-3.9; and seventeen percent scored this between 4-4.9. The second scaled question asked whether the SN population being served gets **the best possible effective, efficient quality care and service** that it could based on the resources available in the community. Thirty-three percent scored this between 2-2.9; forty-two percent scored this between 3-3.9; seventeen percent scored this between 4-4.9 and eight percent scored this as 5. The third scaled question asked how willing respondents and their organizations would be to **consider a future merger/consolidation of safety net delivery organizations** in order to create a more effective and efficient system. Thirty-six percent rated this 1; nine percent rated this between 2-2.9; thirty-six percent rated this between 3-3.9, 0 scored this as either 4-4.9 and eighteen percent scored this as 5.

Key Themes

Given the amount of data gathered, a relatively small number of key themes emerged that were repeated throughout the interviews. They include:

- **Commitment and Dedication to Serving the Safety Net Population:** Providers were consistent in their statements that it was the **motivation and talent of the people** working that continues to inspire many to stay. Though there were fewer comments for this theme, commitment seemed to be a large part of the overall underpinning of the success and endurance of the existing SN. Some providers commented that not all patients presenting for care are treated respectfully by

staff, which may be a reflection of perceptions held about people who utilize SN services. However, with all of its challenges, the SN has and continues to work well enough because of the staffs' commitment to problem-solving and their tenacity in ensuring that this population has access to health care and services.

Non-direct providers referred to the importance of staff knowledge and expertise in their comments noting that **front-line staff and people on the ground have made the system work in spite of inadequate infrastructure and funding.**

- **Population and Geographic Access to Services:** Providers stated that **uneven distribution of services continue to be a barrier to access.** Because of the increasing cost of living, people using SN services are moving to less expensive outlying areas of the county, thus creating additional transportation difficulties. Within the existing SN system additional obstacles identified included the **lack of available appointments for primary care, dental care, and specialty care as well as limited access to mental health and substance use disorder services.** Many respondents added that the existing uneven distribution of services across King County results in duplication in some instances (three pharmacies in downtown Seattle within blocks of each other) and no access at all in other areas (to dental services for adults). Restricting access to established primary care clinics and assigning patients to clinics by zip code may give the impression of access but does not result in access because people may seek care near their place of employment rather than their place of residence. In addition, the **traditional appointment structure and process are barriers** for those who are disorganized or unable to effectively plan in advance, resulting in lost capacity due to no shows.

Ongoing staff turnover (which impacts capacity) is due to low salaries and burnout from working in an environment in which demand exceeds capacity. Added to this are the **challenges of recruiting and retaining culturally competent, qualified staff** at all levels. The **diversity of the population** utilizing SN services also impacts access. Interpretation needs for the number of languages spoken, cultural differences, and understanding of the U.S “medical model” of care impacted individuals’ willingness to present for care and, if seen, to engage with recommended care plans. Non-provider interviewees described the CHCs as a lifeline, creating culturally sensitive choices for their communities.

Interviewees noted that access was better for primary care than for specialty care, though gaps were acknowledged in both. References were made about the lack of access to specialty care for SN patients, to returning soldiers not qualifying for the SN, **dental care, and services for children and adults with severe mental health and substance use disorders issues.**

One interviewee commented that the current SN provided “some net” to catch the growing number of people seeking care and services as an example of what was working well. Examples of existing resources and hopes for future resources

included the notion of designing an integrated innovative system of primary care for the next generation including “minute visits” and more consultation by phone and internet.

The **shortage of qualified primary care providers and specialists willing to work with the SN population** was also identified as an access barrier. Consistent with direct providers, non-direct providers believed that culture and language create additional barriers to access. One comment made was that access is enhanced by existing relationships within the SN system; it was also specifically noted that processes based on relationships are not sustainable because they are not systematic and structural.

- **Scope of Services That Are Available:** The most visible gaps were identified in the **lack of mental health service, substance use disorder services, and dental services**. Recognition was expressed that chronic diseases such as diabetes, obesity, and asthma will continue to widen the primary care gap as the population ages without the integration of health education and self-management supports into comprehensive health services. Creating a comprehensive model of outreach and service delivery which wraps housing, employment services, behavioral health and preventive and health maintenance services into alternative settings such as community centers or homeless shelters where people utilizing the SN are located should be explored.
- **Patient-Centered Medical Homes:** There were multiple mentions of the importance of implementing **patient-centered medical homes** throughout the direct provider interviews. Establishing medical homes was described as essential to creating the opportunity and the expectation that patients and families will be able to establish ongoing continuous relationships with their care teams who would in turn assure that their patients have access to an appropriate scope of services. Medical homes were described as the most promising method to increase access to a comprehensive array of health services, and to educate and engage SN patients in their ongoing health. Patients would be seen in the most appropriate settings with the intention of **increasing preventive care and self management, monitoring the health of those with chronic diseases, and decreasing inappropriate specialty and ED visits**. One specific suggestion was that school-based clinics could be used as a means of attracting families onto medical homes through their children.
- **Mechanisms for System Collaboration:** This theme focused on **system-level issues** including the political environment and leadership. Numerous comments were made about the **need for explicit leadership** to maximize the efficiency and effectiveness of SN services and the recognition that a comprehensive system of care does not currently exist. The long history of providing SN services in King County has included both collaboration and competition for resources, funding, and patients without the benefit of collaborative long range strategic planning efforts. Several interviewees mentioned the importance of rebuilding

PHSKC's Epidemiology Center's capacity to its former state to support community requests for population-based data. City, County, State, and Federal funders have numerous reporting requirements which have not been standardized to both streamline and create comparable performance data.

It was also noted that a **lack of infrastructure contributes to duplication of efforts, uncoordinated and redundant service provision, and misallocation of resources.**

Comments focused on the notion that building and implementing a comprehensive and collaborative system **requires that all key stakeholders be included at the table, including non-direct care providers.** Interviewees identified the CHC Council as a key stakeholder in the design of a coherent system. Non-direct providers described the existing SN system as "robust" with strong health plans as a strength. The non-direct care providers stated their belief that all providers should be required to see a mix of all members of the community. They also suggested that a broader range of training programs such as the UW/SU nursing schools and the UW Medical School be encouraged to actively participate as part of the SN system. Comments overlapped between the direct care and non-direct care providers in the following areas: that the existing SN currently has "no center," interest in sharing the burden of meeting the needs of SN patients, and the importance of creating an infrastructure to create a system of SN care.

Interviewees stated that the SN would benefit from **creating community consensus** about its role. There was acknowledgement about the need to **restructure the SN focusing on incentives that reward partnerships and collaboration** across public and private sectors, which was consistent across all three groups of interviewees. Many comments were made about the desire to build a network that extends beyond traditional health components of care to include **a broader scope of services delivered in a variety of settings** and to **assure coordination across primary care (dental, mental health/substance use disorder services), specialty care, and ED/hospital care.**

- **Mechanisms for Service Coordination:** This theme focused on **patient-level issues** including **information sharing mechanisms.** The lack of a interoperable Electronic Health Records (EHRs) makes communication or sharing of information across entities within the SN system difficult. HIPAA requirements, though often mentioned, are seen as workable. **Registries** were also mentioned as **another vehicle to manage care for a population with similar illnesses** such as diabetes or severe mental illness. Such efforts were viewed as mechanisms to support and monitor individuals' conditions (especially high risk and chronically ill individuals), clinical interventions/self-management efforts, and labs/medications. Creating dedicated care managers to orient and educate patients about the SN and how best to utilize care and services would help to engage them with their medical home and care team. It was also suggested that

RNs be placed alongside MDs or PAs to serve as care managers for patients with chronic illnesses.

The desire for a standardized EHR across the entire SN was noted both by direct care providers and non-direct care providers as a means to improve continuity of care, especially given the transient nature of the SN population. The benefit to the SN system of using a standard or interoperable platform would be to enable SN providers immediate access to information, when SN patients have granted permission, **improving continuity of care and reducing unnecessary waste and duplication of care or service**. One patient was described as having repeatedly presented to hospital EDs, receiving 25 CT scans. Implementing **Memorandums of Understanding** across the SN system would also facilitate communication and information sharing.

Comments by non-providers focused on the impression that the existing infrastructure works because of the “on the ground” expertise of the people working in the SN system.

- **Fragmentation/Unclear Roles of Organizations: Fragmentation was noted in the multiple examples of system “disconnects” between and across sites throughout the SN.** As previously stated, services – especially for people with serious mental illness, or substance use disorders and adults needing dental services – are often not easily available. In some cases, this may be an unintended outcome of provider competition for patients or funding. In other situations, patients with multiple and/or chronic conditions may need services that are not available or accessible in one location.

With each wait for an appointment or the need to travel to access care, the possibility increases that patients are not getting care or completing follow-up recommendations. An example of this occurs when patients are seen and given prescriptions for medications. If they do not have the funds to pay for the prescription, or the pharmacy is not easily accessible, it is likely that the prescription will not be filled.

Continuity of care is difficult due to a lack of coherent infrastructure, many choices for care, no shared information process and inconsistent communication. As noted by the direct-care providers, **patients with multiple diagnoses**, especially those that include both mental health and substance use disorders in addition to health issues, **often experience difficulties in moving across agency boundaries**. Again, concerns about duplication and wasted resources were mentioned. Interviewees noted that getting patients the appropriate level of care the first time would ultimately be cost effective and potentially would create capacity that is currently wasted in EDs and extra primary care visits when patients are not able to see specialists in a timely manner.

How **PHSKC** defines its role and **whether there is a conflict between its commitment to broadly looking at the health of the public and its role as a direct provider of primary care** came up frequently. A host of comments were made in response to the specific questions about the roles of PHSKC, some reflected confusion about how PHSKC defines its role. Many commented about **their hopes for leadership from PHSKC as a convener regarding issues related to the public's health and specifically in leading the SN "reconstruction" effort**, which was noted as one of the more traditional roles of PHSKC. Embedded in these comments, some discomfort was expressed about having a SN direct-care stakeholder serve in the role of convener as a potential conflict of interest. Interviewees stated they wanted the convener to be a neutral party.

Many interviewees stated their preference that PHSKC **discontinue their role as providers of primary care**. It was acknowledged, however, that **capacity would have to be created elsewhere to serve these patients**. Many of the comments included references to the CHCs, some noted competition for SN patients who have a payor source. Others wanted assurances that patients currently seen at the PHSKC clinics could and would be integrated into either existing clinics or new clinics in those geographic areas. There appeared to be an assumption that funds would flow to clinics absorbing PHSKC patients should those clinics close, creating the ability to create new capacity. The interviews conducted by PHSKC staff focused on a variety of suggestions and strategies which assumed that PHSKC would continue in its role as a primary care provider.

- **Addressing the Public's Health:** This theme focused on suggestions including how to engage in **education and outreach to the population**, exploring innovative approaches to engaging culturally diverse populations, and addressing life style issues like obesity, and workplace wellness and prevention. The Institute for Healthcare Improvement's '**triple aim**' model was mentioned **as a strategy to address the health outcomes of Seattle/King County's SN population** (achieving optimal balance of good health, patient experience met/exceeded, total per capita cost for the population).
- **Competition/Financing in a Market-driven Healthcare Industry:** Competition was identified as a barrier to collaboration, making it more unlikely that SN stakeholders will collaborate and actively cooperate with one another. Attracting **SN patients who have a payor source** is desirable for each of the SN sites, **creating competition** – for example, the SN population at one CHC is more than 50% uninsured. Because there are both inadequate funding and shifting funding streams, SN providers described themselves as either under continuous financial stress or the threat of financial duress. A number of comments were made about the **need to stabilize funding** for the SN, including a suggestion for some consolidation of provider organizations to take advantage of economies of scale. Generally, it appeared that those providing care were focused more on **dividing up the SN population to more equally share the burden of the unfunded**,

while those who focused on the whole of the SN, expressed more concern about how to do it all without as much concern about who does what.

Closing the PHSKC primary care clinics and co-locating and partnering in providing more comprehensive services were also mentioned. Another suggestion was to initiate “presumptive eligibility” health clinics with 90 days of pre-authorized Medicaid paid by the state; this would ensure that patients receive the care they need as an entitlement, while the longer-term insurance/payment issues are explored.

The non-direct providers identified competition among SN providers at the City and County levels for common grant funding. They also stated that **all community providers should see their “fair share” of the SN population, without the ability to opt out.** The non-direct care providers also noted there are unaddressed challenges regarding portability and pre-existing conditions which negatively impact access to care. Additional comments were that the increase in the uninsured is driving up healthcare costs for all and that the use of collaborative funding might be a vehicle for decreasing competition.

What is Needed to Move Forward

Moving forward, many of those interviewed stated, was their greatest hope. Having acknowledged past history and the “politics of it all,” stakeholders expressed their willingness to:

- Agree to be bold in addressing the issues
- Agree on the leader/convener for this work
- Build trust by working together
- Create a transparent SN system built on what’s best for the population as a whole
- Meet the unique ethnic and cultural needs of those served by the SN as part of agreement
- Include both direct and non-direct provider stakeholders at the table

Conclusion

The interview dialogue was very illuminating and encouraging. It highlighted a number of existing strengths including the resilience and tenacity of the individuals and organizations currently providing a rich array of health services to those who are uninsured, under-insured, Medicaid or GAU funded. In addition, the interviewees candidly identified and discussed many weaknesses, warts, and wishes for the future as well as a number of models that might contribute to improving the existing system for the health of those most in need.

Great interest was expressed regarding “next steps” with a key message being stakeholders need to be around the table continuing with the difficult conversations and decisions that all see ahead. Ultimately, the success of this endeavor will be

judged by the actions taken rather than by the words that result from the conversations.

Attachment A: Direct Providers: Detailed Interview Summary

SWOT Analysis

1. Strengths

Commitment and Dedication to Serving the Safety Net Population

- Cadre of engaged providers and organizations trying to be their best – mission-driven, visionary people out there
- Very strong dedication and commitment on part of staff; many work for less \$\$ than in private sector and stay for a long time
- Strong CHC network compared to any place else in the country and HMC provides an important foundation

Population/Geographic Access to Services

- Different venues for different folks to meet them “where they are” – expectations vary by individual
- Focus on sub-populations – ICHS, SIHB, SeaMar
- Some geographic distribution (but population is moving) to South King County
- Clinics are in accessible locations to help core populations in Seattle

Scope of Services that are Available

- CHCs are comprehensive: more consistent with concept of “medical home”
- Interpretation, enabling services (eligibility, outreach, care coordination)
- Pretty robust adoption of comprehensive dental and BH components

Mechanisms for System Collaboration

- Ability to connect with other parts of the community (School-based clinics, Faith-based organizations) via outreach, through housing and employment
- Create a common data base that specialty/other referrals are entered into so that it is possible to track follow up and % who connect with care provider
- CHC Council for planning
- CHP a huge advantage not many cities have own health plan
- History of community-based clinics and support from local and federal governments
- Great around crisis; people get taken care of
- KC/Seattle SN system better than many other metro-area systems
- Political climate a strength – actually dialogue between CHCs and the County Better than some urban areas.

- Strong interest in trying to solve problems – not always successful, but we're talking about it
- Work reasonably collaboratively

2. Weaknesses

Population/Geographic Access to Services

- There are geographic disparities in the County; there are choices, but not necessarily spread
- Access problems to specialty care, which will increase as age of population increases
- Lack of access to BH services
- When patients can't access specialty, they make more primary care visits, which decreases capacity
- Access difficult to MH, SA and dental specialty care
- We have very high language/translation needs that create barriers when unmet
- Lots of lip service to specialty access and hospital, but falling short of meeting SN needs; gives impression of access being there when it is not
- Hospital care for the uninsured
- We use traditional model for services (scheduled visits, scheduled far out in time) hard for disorganized to engage
- Not enough support to educate families about how to access care in a more planful way
- Poor transportation – difficult to get to care

Scope of Services that are Available

- Lack of funding for medication and inability to ensure medications get to uninsured patients who need them
- Link health & education together in a way that doesn't allow separation
- More dental care for kids & adults
- Very little of the care provided is actually evidence-based
- We do a better job for very vulnerable population rather than those marginally getting by
- We need to take health in its totality – housing, employment

Mechanisms for System Collaboration

- Because there's lots of choice, not enough communication between entities; not a coordinated approach. It is a barrier to patients to move across agency boundaries for BH & PC. A real disservice to patients
- System is disconnected, information doesn't flow; No established communication for different parts of the system to talk to each other
- There is not a good inventory of who does what throughout the SN system

- All City/County/State/Federal grants (that all CHCs apply and compete for) have a zillion reports with different requirements; how about one standardized report for all levels?
- Not enough infrastructure to meet the needs of patient population leading to misallocation of existing resources
- Don't collaborate enough; only CHCs meet regularly
- No long term vision or strategic plan for future of SN services; no mechanism for how care provided
- Lack of leadership on part of the community – focus on business of healthcare & bottom line
- We haven't made much progress in past 10 years on system of care, hospitals, specialty care access
- Subject to political whims between City & County; Board of Health role unclear

Mechanisms for Service Coordination

- IT capacity to share information as each EHR is different. Less able now to access information than before
- PHSKC not on EHR to share medical records
- BH access: inability to share information freely to provide continuity of care

Fragmentation / Roles of Organizations Unclear

- Role confusion with PHSKC. Pure PH model vs. PC provider
- Care frequently fragmented, not coordinated
- Inadequate, many holes, many redundancies
- MH and non MH/SA components of medical care in separate systems/silos
- PHSKC role is not clear: sometimes we partner & sometimes we compete

Competition/Financing in a Market-Driven Healthcare Industry

- Competition for patients with reimbursement gets in the way; especially within Seattle [Odessa, PHSKC, UW/peds]. This leaves CHCs with disproportionate share of the uninsured – not true outside of City
- Inadequacy of public funding support &/or misallocation of public resources
- Under continuous financial distress or threat of financial duress

3. Opportunities

Population/Geographic Access to Services

- Increase capacity by opening clinics (e.g., SeaMar on Eastside)

Scope of Services that are Available

- Aging population; opportunity for CHCs to provide free classes (yoga, pilates), health educators at clinics
- The obesity epidemic is providing the opportunity for really diverse people coming together from both community & healthcare
- Resilience factor when people are treated earlier works best with children 0-5 years
- Manage the cost of acute care for the aging population/seniors

Mechanisms for System Collaboration

- Some economies of scale to be had – the diversity of some clinics is expensive
There is a price to be paid for separateness
- Make connections more visible to maximize operational efficiencies. Currently relationship-based, which isn't sustainable over time
- Wring out duplication
- Gaps between primary care and BH; sales tax as opportunity to integrate BH & health, not just physical care
- Each weakness is an opportunity for improvement
- Huge opportunities to work together; coordinate between PC & specialty and hospital and CHCs and with Medicaid
- If everyone on the same page, really collaborate, we could really fix it!
- We need to be more bold in taking action
- We want PHSKC to be a leader in addressing health disparities – there are many unfunded good ideas, but funding is needed to make services available
- We're in a city that is large enough to measure, and still small enough to actually measure the entire population
- The health department not even a presence anymore – David Fleming has the ability to make significant changes in bringing us together to make improvements
- Break down artificial barriers between BH & medical care

Mechanisms for Service Coordination

- CHCs as medical homes; they need to gather and publish concrete data about their populations to increase accountability and look at results of care
- Medical homes are an opportunity for the evolution of primary care
- Develop an approach for dealing with transient population that moves from clinic to clinic
- Coordination of care – hard to define SN – Large registries and EHR for population based care and case coordination
- EHR – where we could get entire patient history at any time, anywhere
- Implement business MOUs so that clinics can talk to each other to coordinate patient care

- Start registering people who are in the streets as drug users, those who push drugs, people with serious mental illness so that there's a central place to document health efforts in a community-based manner that includes PHSKC, police, BH, housing, social services
- EHR – still in process of implementation – concerns remain about privacy, hepatitis, immigration status
- Community advocate role: CHCs need the support of outreach workers to get out into the community to engage those who don't present to clinics, but are in need of care/services
- Link health & education together in a way that doesn't allow separation

Fragmentation/Roles of Organizations Unclear

- Start with PHSKC defining its role, then others can align themselves. PHSKC controls policies, regulations, programs. Then create collaborating networks, strategic plan
- Get nuanced about the contributions of each partner – (e.g., HMC is sending provider to Kitsap PH, HIV clinic, to extend the specialty care into the community)
- In smaller communities, have seen value in links between ED/hospital/primary care/CHC/PHSKC/dental/BH – who has rights to what types of care?

Competition/Financing in a Market-Driven Healthcare Industry

- “Presumptive eligibility” health clinics – 90 days of pre-authorized Medicaid paid for by the state as in Hawaii and Michigan
- Solving the problem of the SN should not be seen as a threat to the CHCs or as job security
- Reduce service area conflicts & look at County-level needs instead of “turf” issues

4. Threats

Population/Geographic Access to Services

- Need more PC providers; how to bring them in & retain them?
- Difficult to recruit & retain qualified staff who are passionate, bilingual, committed
- Aging population – lots of seniors who will need CHCs – bimodal income re: wealth & poverty; reimbursement not as strong as for moms and kids
- Health disparities data shows race, gender, socio-economic status – factors paid limited attention to
- We need to focus on access to basic care availability
- Increasing burden of aging population
- Increasing burden of chronic diseases like asthma, obesity, obstructive sleep apnea, diabetes, etc.

- There's much more need than capacity – we're always looking at payer mix to fund unfunded needs. Without health education, we can't do preventive care
- Public perception of who's in the SN – immigrants, non-English speakers negatively impacts the under-insured

Mechanisms for System Collaboration

- There are a number of high level policy makers/officials who believe that insurance will fix this – though it's critical, it's not the only thing needed
- There are so many needs, bringing everyone to the table will lead to fragmentation & dis-economies of scale
- Impact of governor's race if Gregoire not reelected

Competition/Financing in a Market-Driven Healthcare Industry

- Healthcare as an industry vs. a community service that all are entitled to
- Biggest risk is that we compete, work against each other and lose focus on providing care
- Competition at County & City levels – between UW, PHSKC, CHCs. All vying for the same funds; it's costing more as all compete
- Instability of funding
- Multiple financing mechanisms – that aren't stable; state & federal funds always feel at risk
- Financing – SN is uninsured/underinsured – clear specialty vs. PC focus
- CHCs are dependent on the success of CPH & risk payments – a huge financial boon to us
- Concerns following election about changes in administration with CHC funding- Potential disruption to healthcare nationally
- Continued increase in the uninsured
- Funding – “PC is a money-loser.” King County has people coming from Centralia, Kitsap Counties because they can't find services in their own counties
- Provider refusal to take Medicaid and under-insured
- Undocumented patients – comes & goes as an issue
- Threats to Medicaid funding stream re: FQHC reimbursement
- Volume of uninsured/underinsured demand/capacity/financing. ED becomes default place that people go
- SN is not as strong as it used to be; less willingness of EDs to “do more”. The rules are more strictly enforced
- Unnecessary duplication of effort, fragmentation, competition for very scarce resources

5. What sub-populations do you feel are most important to address first to relative to existing gaps?

The Safety Net Population as a Whole

- Everyone is important
- It is difficult to separate out who is at highest risk

Sub-populations in Need of Attention

- People in all stages of chronic disease
- The homeless and formerly homeless who without support services, would likely become homeless again
- Pre-conceiving & pregnant women
- Children, especially those aged birth to five
- Single adults
- People who do not present for care, including African Americans and men, both groups being under-represented in the SN clinics
- Undocumented immigrants
- Adults in need of dental care
- People with serious mental illness who may not present for care
- Foster children who are not followed when they move
- Emergency Department over-utilizers
- Families
- The uninsured regardless of ethnicity, geographic location or specific health issues
- Those people not eligible for the SN who fall between the cracks

6. Access

Does the safety net population in need of service get the best possible access to care and service that it could based on the resources available in the community? (averaged by organization, from individual ratings)

1-1.9 (Not at all)	2-2.9	3-3.9	4-4.9	5 (Absolutely)
0	4 (33%)	6 (50%)	2 (17%)	0

Access Successes

- SN population does not get ideal care, but they do have good access based on available resources
- People who get through our doors get good quality care
- Access to primary care is better here than in many other cities

Access Opportunities for Improvement

- The demand is greater than capacity; we are not able to serve everyone
- Appointments not available for adult dental
- Appointments not available for specialty care (especially orthopedics)
- Care is rationed
- Transportation and support services lacking

Population/Geographic Access to Services

- Care is too segmented, making it difficult to know where to go for services
- Interpreter services are mandated but not funded
- Difficult to access Regional Support Network resources for people with uncontrolled mental illness and substance use disorders

Mechanisms for System Collaboration and Service Coordination

- We need infrastructure to support folks once they're in the door
- We need leadership to convene and bring together the SN community
- We could make more efficient use of the existing resources
- Medicaid is highly siloed, various levels of access between GAU, managed care pilot, and GA-X/SSI

7. What process and outcome measures do we need to monitor improvement in access to care?

Access Measures

- Re-define SN services first. Can't keep measuring using same parameters
- Identification of medical home/PCP
- Cultural appropriateness of care
- Access to care outside of clinic setting such as homeless shelters
- Patient satisfaction with ability to access care
- Number of days to appointment and to next available appointment

Clinical Measures of Health Status

- Diabetes management [HgbA1]
- SF 36, blood pressure, glucose, cholesterol control

Visit Counts

- Number of new users connected with resources at CHCs
- Number of people turned away for appointments/services

- Number of people seen vs. the number of people expected to need care
- Number of people waiting for routine vs. urgent care & for how long
- Number of SN population presenting to the ED for non-urgent care
- Number of patients leaving ED without being seen

Population Management

- Number of patients seen in ED who would have been less ill if they had presented for care sooner
- CHARS data & AHRQ – ambulatory diagnoses associated with avoidable hospitalizations
- Measures of preventable disease/morbidity from preventative disease
- Percent of children 0-5 years who have all of recommended immunizations
- Percent of people with chronic disease who are successfully managed as outpatients (e.g., asthma, obesity, hypertension, diabetes)
- Use existing measures for access: ability of people to find their way in the door, time to 3rd visit, access to specialty care, number of completed referrals

Other

- Standardization of referral tools/forms
- Continuity index from HS research using claims data
- Having a Leadership Forum that works efficiently

8. What three things, if changed, would improve access to:

A. Overall safety net system's care delivery?

Medical Home with a Range of Services

- Continuous healing relationship
- Efficient use of primary care visits
- Use of group visits, telephone visits, email
- Medical liaisons who advocate across systems as cultural mediators/patient navigators for patients
- Increase access to dental for uninsured adults
- Respectful healthcare environment
- Urgent care after-hours to keep folks out of ED
- Geography – more equal distribution of clinics & services
- Transportation to enable access to services

Full Participation of the Community

- Every employer expected to participate as a moral issue
- Providers should provide care to Medicaid patients
- More providers
- Need to have PC MDs stay in community

Financing

- Remove silos – create coherent funding stream for all; funding based on number of visits provided
- Collaborate vs. compete for funding – recognize niches for each clinic
- Money/funding stream
- Single payer system
- Increase funding (capital & operating)
- Better funding for adult services
- Better funding for ED case or strengthen ED system (mixed message)

Access to Specialty Care

- Deal with missing access to specialty care (e.g., orthopedics)
- Share the specialty burden like KCPA
- Guarantee access to specialty care

Mechanisms for System Collaboration and Service Coordination

- Create capacity designated for SN population in a planned way
- Common database county-wide that involves all players (PC & BH)
- Regionally share extended hours of PC clinics
- Put EHR in Primary Care coupled with population-based registries
- Information sharing – productivity of system
- Create accountability at network level (e.g., PC Networks in North Carolina with care management fee & accountability)
- Decrease duplication of effort
- Reliable system to identify those needing services & linking to available resources
- Address co-location of services like screening
- Fully integrate MH/SA services into core medical system – access to appropriate care at right time (wrap around, care management)
- Master information database online with who provides what services & where

Public Health - Seattle & King County Role

- PHSKC oversees everything & ensures that community is educated

- PHSKC looks at environmental and not just pathological effects

B. Your organization's care delivery?

Population/Geographic Management Access to Services

- Transportation/clinic locations as people move further away from city
- Additional exam rooms
- Extended hours with enough providers willing to work at our rates
- Built an additional 50 med/surg beds for SN population
- Availability of appropriate health professionals (the looming PCP shortage)
- Build capacity (new clinic in south County)

Medical Homes with a Range of Services

- Create patient-centered medical homes
- Continue to expand Homeless outreach program to become a medical home for the homeless
- Provide follow-up aftercare clinic for patients seen in ED for non ED level services (now being piloted)
- Address no show rates-case management, phone reminders
- Care delivery – ability to deliver outside of building: home-based, schools, community centers, group visits
- Outreach/patient navigator
- Recognition that for some patients, the traditional system (e.g., scheduled appointments weeks in advance) doesn't work

Scope of Services that are Available

- Substance use disorder/chemical dependency counselor on-site
- Psychiatry access on-site
- Work on dental: how & where we can provide it
- Expand specialty access for SN population

Mechanisms for System Collaboration and Service Coordination

- Build health literacy, awareness about health & importance of preventive care to avoid illness
- Build system-wide awareness of immigrant/refugee populations about western medicine
- Make sure providers are educated & using EHR
- Improve system efficiency & access, especially with EHR implementation
- Increases effectiveness of visit care
- PMC could provide primary care
- Open presumptive eligibility clinic

- Engage in pilots with PHSKC on research basis to see what works

Financing

- Increased capacity – facility, staff with resources & funding for both
- More resources including increased funding
- Better/more competitive salaries
- More funding to increase support staff salaries
- Have Medicaid fund MH/SA & medical illness at level that would provide incentive to care for these patients

Other

- Research
- Address the competing demands of research & education mission with care for vulnerable populations
- Invite David Fleming to practice in the CHCs as a provider

9. Effectiveness and efficiency

Does the safety net population being served get the best possible effective, efficient quality care and service that it could based on the resources available in the community? (averaged by organization, from individual ratings)

1-1.9 (Not at all)	2-2.9	3-3.9	4-4.9	5-5.9 (Absolutely)
0	4 (33%)	5 (42%)	2 (17%)	1 (8%)

Effectiveness/Efficiency Successes

- Reasonably effective at using what we have
- Current model very effective with ability to provide comprehensive care
- Good quality of care
- Great care & service for those who get in the clinic doors
- Rich in motivation & talent
- People providing care are inspiring – great
- Good distribution of services.

Efficiency/Effectiveness Opportunities for Improvement

- Pretty inefficient
- Only 3 CHCs are JCAHO accredited (CDCHC, SIHB, SeaMar)
- Inappropriate use of ED as indicator that people have not connected to clinic
- Not efficient: we have one patient who has had 25 CT scans at outside EDs – there is no way to track user utilization or easily share medical information

- What may be efficient in one environment may not be efficient in another
- Not efficient, inability to share information
- Good with high utilizers, not efficient in overall care
- Efficiency still a challenge
- Need to account for cultural overlay; visits may take longer than 15 minutes
- We have enough – not using resources well
- Believe there are adequate resources to take care of all needs if efficiency maximized
- Duplication within & across system
- People are careful about sharing information; so not shared

10. If you were to name three things that you would like to see changed that would improve effectiveness and efficiency of the overall safety net system's care delivery, what would they be?

Population/Geographic Access to Services

- Extended hours
- Do not assign patients based on zip code – not effective
- Modified open access for folks with some scheduled reminder calls. We know what no-show rate is and we can fill no shows with walk-ins for both medical & dental
- Patients get full range of care they need including specialty care
- Access to specialty care
- Access to hospital care
- Qualified workforce

Medical Home with a Range of Services

- Even with chronically ill who need more time & visits
- Utilize shelters/other potential sites for care delivery
- Acknowledgement that CHCs are the medical homes, have been for years

Mechanisms for System Collaboration and Service Coordination

- Change PHSKC role to drive it all → consistency, coherent whole
- PHSKC ought to be out of providing primary care. We could use those dollars & get more mileage for it
- Leadership for coordination
- Redundant, consistent information that is easily available at libraries, school, restaurants, social clubs to reinforce key messages about healthcare
- Decrease duplication
- Consolidate the number of players with PHSKC no longer providing primary care
- Expand capacity of PC system & connectivity of that system with others

- Research to better understand what really is effective & create consequences for those not providing care appropriately
- Provide incentives for 1-2 models of care
- Electronic information sharing
- Guiding principles & standards
- Strategic redistribution of healthcare resources to focus more on early intervention in childhood
- Providers have to be networked to share information; emerging trends, best practices to approach population management
- EHR that is easily shared; common data base that agree to use with appropriate HIPAA safeguards
- Eliminate silos – Include all communities
- Integrate MH/SA into medical care to promote better outcomes & avoid fragmentation
- Chronic care-marry-up competencies of PHSKC, CHCs & medical systems to address effectiveness
- Implement both EHR & registries to anticipate & manage chronic disease & avoid duplication of care & services
- Common database re: Rx issues for use with complicated care & drug seekers
- Communication – MOUs (e.g., To talk with housing folks to check on patients; they can tell case manager at shelter, who can tell shelter staff)
- Communication to all players

Financing

- Identify who is providing what & how much it's costing
- Need more capacity out in county as more people move there because of cost
- Changes with DSHS reimbursement for MH/SA service
- Funding for equipment
- Facilities issues – need to make capital investment more than City, entire county
- Increase funding

11. What things are working well in terms of coordination and collaboration within the safety net that result in effectiveness and efficiency that we should be sure to continue into the future?

Collaboration/Partnerships

- Healthcare for the Homeless network – RNs in the shelters works well
- School-based teen health centers
- SeaMar as example of being collaborative, responsive to their community
- Partnerships between CHCs for OB coverage, shared on-call
- CHC Council discussions at the County level regarding policies

- CHCs & CHC Council work pretty well together as a system of care that keeps patient care in the forefront
- KCPA is getting its legs
- PacMed is making progress
- GAU MH pilot
- Continue comprehensive services (SA/MH/WIC/Nutrition/Health Education)
- People willing to work together – effort to collaborate already underway
- PHSKC & MH coming together
- Disaster planning at larger scope with other players in system
- Learning collaboratives
- Mobile health initiatives WIC, Head Start, Child Profile
- Medical & MH collaborations; multi-disciplinary partnerships
- Multidisciplinary approaches like 1811 as creative response to difficult clinical & social problems
- Communication good among almost all the players; though too many players
Don't think we're all working toward the same goals
- Translation/interpretation services

Public Health - Seattle & King County Role

- PHSKC involvement/integrating between Healthcare for the Homeless network; to bring ideas & different people to the table
- David Fleming has met with the CHC Council 3 times in 2007 – that bodes well

Other

- Culture of patients identifying and loyal to specific providers (SeaMar, SIHB, ICHS). Don't turn it all into vanilla
- Community commitment among providers to SN population

12. What are the opportunities for and barriers to better coordination and collaboration within the safety net that would contribute to improving overall effectiveness and efficiency?

Population/Geographic Access to Services

- Lack of adequate access for adults to dental care
- Going out to where the homeless are is the best way to engage people who haven't accessed care before
- Time is a barrier
- SN shuttle van to move people & refill & non-urgent meds
- Make KCPA work to improve specialty access
- Creation of specialty capacity dedicated to SN population
- Unspokenness of health disparities; stakeholder should be the patient

Scope of Services that are Available

- We have people who are getting Rx without ability to pay for filling it
- Equity of care with individuality of care needed

Mechanisms for System Collaboration and Service Coordination

- Insufficient connections between PC & BH
- Within systems there is some collaboration/coordination, but not across systems
- Redundancies result in multiple task forces, collaborations on same/similar issues
- Standardize, collaborate, trust each other
- Nursing triage – all paying significant dollars to HMC for after hours RN
- Be flexible without duplication; e.g., multiple pharmacies downtown
- Integration of BH into Primary care (e.g., Highpoint: free-form – available in the moment while in the MD office & can then refer to MH)
- Impossible to access patient records across healthcare entities
- HIPAA – Not knowing what people are getting from other sources
- Need EHRs, registries
- Redundancy of information gathered because of reluctance to share it. Risk polarization of stakeholders

Competition/Financing in a Market-Driven Healthcare Industry

- Competitive nature between PHSKC and CHCs
- PHSKC & CHCs compete for funds
- We need to teach people to compete on best possible healthcare outcomes
- Unfunded initiatives
- As funding gets more tight, will decrease willingness. We need to create new opportunities for funding – create a bigger pie, not just shift elements around

Public Health - Seattle & King County Role

- I see PHSKC as the entity that imposes order, continuity & accountability
- See PHSKC as the key external stakeholder, not the CHCs because they don't focus on the entire community's population
- Medical community must step up to its part – PHSKC, UW leadership & providers. Must be part of their mission to “serve” not just “train”

13. What are three things that would improve effectiveness and efficiency of care delivery within your organization?

Commitment and Dedication to Serving the Safety Net Population

- Customer service with enhancing staff attitudes
- The ability to incentivize staff, to interest healthcare providers in working with the SN
- Efficiency of staffing – lots of turn-over with lower paid staff; want to attract the “right people”
- More stability in the work force. Even one provider vacancy impacts access
- How to make providers more efficient with use of extenders

Population/Geographic Access to Services

- Ability to extend provision of care beyond 4 walls of clinic
- Location – access to care & services. Could have more than one site
- As we look for new sites in the community, look for people where they congregate – we’ll have fewer no-shows
- Challenge – what best meets the needs of patients
- Balance research & training with delivery demands

Scope of Services that are Available

- Better access to outpatient care models such as respite where patients can continue to improve when they no longer meet inpatient medical necessity
- Frustrated with fragmentation; need staff to be able to provide end to end care to increase efficiency

Mechanisms for System Collaboration and Service Coordination

- Leverage use to EHR to coordinate, standardize & streamline processes
- Better medical records – EHR (registries as interim step)
- Clear standards that people are held accountable to
- Health literacy of patients and families about preventive care & current health episode
- Use Baldrige criteria/performance score card for system as a whole
- Rebuild infrastructure to deal with capacity
- Communication, coordination across disciplines with ability & willingness to “hold attention” over time
- Adoption of health information technology – common database/best practice model
- Complete full integration of electronic systems
- Fully using epidemiological capacity & expertise to understand our population

- Have NP/Women’s Specialist – similar model for Diabetic care for entire population
- Use case manager/liaison to get patients in to appointments
- Go “lean”

Financing

- Bill where you are able to, to get match funding; bill Medicaid/care

14. What process and outcome measures do we need to monitor improvements in effectiveness and efficiency in the safety net delivery of services?

Effectiveness of Safety Net Service Delivery (Outcome Measures)

- Patient satisfaction
- IHI ‘triple aim’ health outcomes of Seattle/King County population (achieving optimal balance of good health, patient experience met/exceeded, total per capita cost for the population)
- Inappropriate ED utilization
- ED utilization across the system
- Health outcomes for effectiveness

Efficiency of Safety Net Service Delivery (Outcome Measures)

- Access to care
- How much do we save in avoided hospital days, avoided work absences, unneeded specialty visits
- ED utilization with visits & charges. If they decrease and clinic charges increase and then drop over time as people engage with care, check-backs, and increase in compliance with care
- Number of people able to work & live independently

Efficiency of Safety Net Service Delivery (Process Measures)

- How many people get turned away/day because of lack of access
- Use of “triage cards” which are collected when patients are sent elsewhere
- Stability of staffing/providers (decrease turn-over)
- Qualitatively document collaboration

Review Existing Measures Before Creating More

- Look to Collaborative work to identify measures for diabetes
- Puget Sound Health Alliance doing some interesting things
- Have developed metrics:
 - Patients have medical home

- Protocols tracked to outcomes
- Readmissions
- Refer to Commonwealth Report: avoidable hospitalization, avoidable morbidity, academic achievement, elimination of social conditions (lack of food, housing), infant mortality, cost/impact of care delivery
- Review CDCHC dashboard sample
- Measure population health, vital statistics database
- Cost/resources consumed that are aligned with housing, case management

System Performance

15. What process and outcome measures do we need to monitor the quality of care delivered in the safety net?

Overall measurement

- Focus on common measures; narrow to those most important
- Association of Asian Pacific & 6 CHCs tracking 6 measures (Federal IT grant re: quality, paying for reporting, performance, ED utilization)
- Create consistent messages for all providers – intentional reinforcement based on patient need
- Biggest need to reduce the number of measures collected & reported to one common set used by all funders
- Don't add new measures that aren't easily gathered via EHR
- Don't think this is the time – premature till we know what kinds of partnership role we are talking about

Quality of Care (Process Measures)

- Doing own rounds at hospital
- Whatever measures are used must include population-specific indicators to acknowledge sub-populations like the homeless
- Diabetes and dental with all CHCs measuring same things
- Staff hand washing
- Completion of WIC vouchers
- “Triple aim” from IHI

Quality of Care (Outcome Measures)

- Measure the unique issues related to the SN population
 - Clinical/health status
 - Medical home
 - Housing needs managed
 - Benefits obtained
 - Healthcare outcomes

- IBHI project for EDs has new measures
- HEDIS – not going to be very good. Running quality programs out of billing data is a bad idea
- State measures for CHP, OPR – some measures compete with HEDIS. We don't need a new list, narrow the list to 2-3 measures for each
- CMS/state/United Way measures
- Measure by disease (e.g., Diabetes: hemoglobin, eye exams, flu shots)
- Use population disease rates – go back to Healthy People 2010

16. What penetration and utilization data do you think is most important to gather and report about the safety net's capacity and performance?

Overall Measurement

- Need registries
- Population base for outcome measures: hard to evaluate penetration & utilization without denominator. Where is PC delivered? Volume of visits?, geographic mix, health needs of the population; across system (Rx, housing, food)
- Don't collect data unless going to really use it to improve the system
- Want to be sure that data gathered is reliable in order to establish solid, consistent foundation with agreed upon measures
- How do we know how many, what needs are barriers and where resources are?
- The established baseline data measures are good. Need to stratify members or patients or population better
- We need some measures of strain on the system(e.g., capacity, saturation, turn over, sustainability measures on capital to measure how resilient we are going to be
- The null set (very difficult to get those who didn't get services)
- Sometimes we need to help patients through the system; sometimes need to walk them through

Utilization Data

- ED utilization
- Referrals to subspecialties and show rates
- How long it takes to get an appointment
- Homeless in jail who are psychiatrically ill
- Hospital bed-days (for insured only)
- ED utilization (for insured only)
- Use of generic medications (for insured only)
- No reliable way to get ED utilization, hospital bed-days, or use of generic Rx data for the uninsured or non-CHP patients
- Understanding high utilizers & how to meet their needs

- What % of uninsured are we actually seeing compared to overall population; where are they?
- Annual patients served
- Visits provided by income category
- How many are housed and stay housed? Did housing make a difference?

Performance Data

- Trends in STDs, AIDS, Teen pregnancy
- Utilization for jails and SOBER
- EPSDT & standard well-child
- Number of uninsured without personal provider
- Productivity data – encounters/MD/day (measures capacity)

Delivery Models

17. We'd like to learn more about your perspectives about Public Health's role

A. In improving the healthcare services available to people dependent on the safety net for their healthcare needs

Convener Role

- Improving services through being the convener, helping individual organizations enhance services, consultation, communication
- Integrating healthcare climate into larger social environment as Principal Investigator or funding community-based clinical research
- PHSKC role as a “connector of dots” infrastructure so that various parts of the system know what's being done
- PHSKC should be looking at whole county & convene leadership to provide needs. Lots of partners are competitive with each other
- PHSKC to monitor overall system performance (e.g., as convener of SN discussion re: system accountability role)
- Leadership & convener role

Planning Role

- Strategic planning – prioritization of PC services & accountability – reporting out to gain confidence in the system
- They are the awardees & subcontractors. They have grant-writing skills; they see how it fits with existing resources
- Rebuild Epidemiology center & ability to do long range planning
- Assessment capacity is needed. Does the SN meet the needs of the population?

Addressing the Public's Health

- Focus on healthcare for the homeless
- Broad roles: STDs, needle exchange, links to education, things that need broad infrastructure to support them
- Provide clinics re: immunizations, TB control
- Many services like prenatal care & well child exams could be done in coordination with CHCs
- Use PHSKC RNs to increase capacity of community-based care re: medication compliance & for those who don't come to clinics for care
- PHSKC RN role – could CHC do a better job than PHSKC? This needs to be coordinated, not with a separate PHSKC RN role

Working on Behalf of the Entire Community

- From surveillance & policy development perspective, PHSKC is logical entity to do this for the entire population
- Do great epidemiology, screening, and prevention
- Listen to the collective community to align PHSKC agenda with the entire community's agenda
- Effectively link mass marketing to the provision of care to help people step up to increasingly healthy behaviors

B. In providing primary care within King County

PHSKC as a Primary Care Provider

- PHSKC should not be a PC provider; competing with CHCs
- Before PHSKC became a primary care provider, the relationship was superb & mutually supportive
- PHSKC should do public health – not primary care. They haven't done it well
- PHSKC needs to be more explicit about who they're there to serve – those PHSKC clinics can't close without displacing that population
- PHSKC should not deliver primary care. It gets in the way of doing other things. Bureaucracy makes it less cost effective. It hurts those of us wanting to see more balanced populations with pediatrics going out
- If going to do it, do it right – on-call, going to hospitals. The CHCs have to fill the gaps – so unless PHSKC PC clinics become more comprehensive, don't provide primary care
- These funds could be better spent as part of the entire system of care than with PHSKC
- We have told PHSKC that we see their role as convener, advocate as multiple levels and that they need to be deliberate in determining which direct

care services are within their purview (mandatory partner notification, TB screening & detection/quarantine) for the safety of the population at large.

- There is some sense that it is time for them to stop. They have the capacity to provide very different services than PC. I don't want that to be a diversion
- It's not a good system. Doesn't address general adult population

Implications of Change in PHSKC Role

- If PHSKC closes its clinics, the SN will need to pick up its share of new patients
- Complex intertwining between PC and maternal and child health services. If maternal and child health services could be separated from PC, then get out of PC. Don't want the debate about PHSKC role to be distraction from other improvement to be made
- Tough one for PHSKC to answer. Their role when it's not going to be provided by anyone else. They're providing care to highly at-risk population. Are they the SN's safety net or are they a SN player?
- Don't fully understand PHSKC clinics – this started as gap filling – are there others who would step in? Not superfluous, need to cover the need – driven by delivery system's ability to pick it up
- Not sure what PHSKC nursing service does anymore
- On Eastside and Columbia City, they are the key player; don't really have a presence downtown. Dental care to provide access to adults, but not to primary care. They don't do any walk-in. Not sure what their funding base is
- PHSKC RNs separate from primary care clinics immunizations should be part of primary care not a separate program
- PHSKC services are unique/separate basket of services at each clinic
- Teen clinics in schools
- Continue with Jail care

Other

- Get people to the best/most appropriate place to decrease duplicated services
- Whoever is most efficient should be providing PC

C. In Providing Preventive (Wrap-Around) Services within King County

- A broader, deeper view is required: immunizations, school-based screening, social epidemiology like neglect/abuse, malnutrition, SA/crystal methamphetamine
- Preventive care, TB clinic, travel immunizations, STDs well suited to PHSKC
- TB clinic with access to chest x-rays; patients sent to CHCs now so that charges go through
- Expand shelter flu shots

- Greater role in prevention, drowning prevention, car seats. They have recognized knowledge/expertise. Maybe they are appropriate to partner with unlikely partners
- PHSKC role not as important to SN as in the past. CHCs doing some education. Big campaigns need to be coordinated state-wide & with CHCs to be successful
- Yes, re: health literacy – but not patient navigators by the county.
- If PHSKC does free immunizations, it is contrary to medical homes
- Depends upon the population strength in the maternal and child health. Have multiple case managers

18. What is your agency's primary “value-add” as it relates to serving this population?

- Core competency of CHCs is offering patient-centered healthcare home for people; offer comprehensive services, continuous healing relationship between patient and care team
- Specialty care – responsibility as part of the organizational culture to give back to the community
- RNs in the shelters
- The multicultural expertise and care provided to our specific and unique populations
- We add value in coordinating with PHSKC to ensure proper treatment by reaching out into the community (e.g., TB)
- Specialty care and care for highly complex populations
- Historical connection to our communities; relevance, commitment to advocacy
Currently see additional opportunities to partner more closely
- We see more uninsured folks than anyone else. We have AIDs expertise. We have JCAHO accreditation which says we provide care well
- We are the end of the pipeline; no wrong door. The place that can provide state of the art care to stave off long term effects of a failing health system

19. Tell us about any systems or collaborations (functional organizational models) that might serve as an inspiration to us as we embark on identifying the core elements of future systems we might aspire to create.

- CA counties: provide comprehensive healthcare to kids & extended families. Up to 30% up to 300% of FPL
- Cleveland
- Dallas
- Denver Health – one SN system
- Hawaii system
- Healthy People 2010

- Highline-PSNHC/Rainier Valley/Highpoint
- Medical-Legal partnership in Boston – legal services within a medical clinic through Davis, Wright, Tremaine. Appleseed & NW Justice partnering re: immigration, landlord issues
- Michigan – County system, and University of Michigan more structured than Whatcom County. Everyone has to play within the county to get funds (BH, SA at the table). Able to track utilization & outcomes
- Minneapolis
- Multnomah County (Portland), OR sole operator system
- NY Health + hospital corporation. Look @ quality/access
- Oakland/Alameda/SF – David Smith at UCSF
- Phoenix doing interesting collaborative projects
- Pierce County – they have already done this
- Salt Lake – Docs, mid-levels – MAs do everything
- San Diego: Core elements include having 2-3 people serving as champions, increasing sensitivity to disparate populations like the Navy/Hispanic communities as a practical way of dealing with health issues
- Washtenaw County, U of Michigan collaboration & data warehouse
- Wayne model – management of chronic care (more so than commercial population)

20. Consider a future merger/consolidation of safety net delivery organizations in order to create a more effective and efficient system. What issues and questions would be necessary to consider as you think through such a possibility for your organization?

A. How willing would you and your organization be to consider this? (averaged by organization, from individual ratings)

1-1.9 (Not at all)	2-2.9	3-3.9	4-4.9	5-5.9 (Absolutely)
4 (36.4%)	1 (9%)	4 (36.4%)	0	2 (18%)

Stakeholder Requirements for Merger/Consolidation

- There would need to be internal support from organizational leadership to implement a Michigan-type external plan
- Continue to provide unique services to meet needs of our populations
- Care needs to be community-based, ethnic in nature. Don't want one philosophy to override that; would worry about losing touch
- End competition for enrollment in Healthy Options & competition for staff
- Concern that some organizations may fall out. In the best of worlds, want some margin in order to continue operations
- How would we relate to a newly formed system – provide expertise in specialty/training (e.g.; work with DSHS + Psychiatry)?

- Will the whole county look at reconfiguration its functions? (MS/SA, PHSKC)
- Consolidation vs. coordination – what would be lost in one large organization?
- HIPAA privacy concerns. Info System that we use – would need to mollify turf battles re: common ground
- Depends on staff resources, system requirements such as IT issues & requirements for information
- The entity must be very collaborative so that parts of the system don't end up being "held hostage" or sub-optimized. Don't create a huge bureaucracy that can opt-out of SN or take it in the wrong direction
- No defined or active role between BOH and the HMC Board

Support Consolidation

- Too many groups trying to address same issue
- We are ready when PHSKC is. This would address SE county duplication, lack of cooperation
- No one has accountability to one place – more centralization is needed
Funding stream looking at same outcomes; same measurement (City, County, State)
- Yes – from management/medical staff perspective, but it's a Board question

Oppose Consolidation

- No way. Not an option
- Only if survival depended on it
- There's some animosity as some CHCs have grown
- I think it would be a big mistake. Can't imagine how it could be done

B. What would it take for you to fully support a merger-based system of care for the safety net population?

- PSNHC is ready, looking at capital campaign to add 2-3 sites in north county
- A merger would be hell – adding public sphere, from cultural standpoint. It would be a decrease in benefits for PHSKC folks – they'd be unhappy re: economics of it. Still think it needs to be done
- No way! Don't think a merger would be helpful. Make a 10 year investment to create a single culture. Better off creating an umbrella of values that each organization meets in its own way with common outcomes & mutual accountabilities which the existing system lacks. Expand the existing SN and bring in the rest of the community into the SN. We need to create an economic engine that meets the needs of the community – ask them directly what they need
- Concern about process/outcome measures and tracking that would take away from care provision. Only helpful if collaborative system that supported continued

uniqueness of each clinic. Common infrastructure without micro-management
Don't scare people away with "new structure"

- Can't imagine my Board going along with this
- Need to have model that is truly comprehensive
- Some level of consolidation to gain efficiency is desirable, but maybe not practical; Unwilling to give-up MH/SA for example
- Don't think some of mergers to date have been good. So much of this is around money
- Our community founded us 34 years ago. They would be angry with us if we no longer existed
- Concern about large system infrastructure & impact of that expense. Coordinated implementation with clear priorities, that are consistent across the entire system required
- CHC Council is as close as you're going to get. We've gone from 19 to 6 corporations. We serve different enough populations that our boards hold us accountable to. PHSKC doesn't have that. CHCs represent the foundation of healthcare reform. Run as a nonprofit, more coordinated system of care, based on the resources available
- Some level of continued identity & ability to grow services & programs. We are committed to our community heritage, which is essential to continue. Would want to retain relationships with CHMC & UW
- KC RSN eliminated all funding for HMC psych emergency services, which has led to severe fragmentation across all EDs
- It is a financially unsustainable system which makes it difficult to convene
- To be assured that better care would result; that focus on uninsured would remain as well as in special populations
- Our community boards are really important to maintain per patient representation
- It would be a waste of time & resources until specialty care issues resolved

21. If we are successful in improving the safety net delivery of care (access, quality, cost-effectiveness), what would that success look like in 1 year? 2 years? 4 years? at the system level? at the patient level? Imagine how you'd ideally want care to be provided on a typical day in your setting

System Level Year 1:

Implement Systematic Re-Organization

- Leadership in place, metrics, defined roles of entities, collaborators such as housing & health
- Get agreements in place for people to share information/use same models of care
- PHSKC gets out of direct care & ensures smooth transition

- Two tier system needs to be addressed-need others to contribute
- Prepare for people to be frustrated while change is in process, but not complete
- Perhaps decrease in ED utilization

Build Capacity and Access

- Efficient layout in north-end
- Process improvements
- Demonstration projects. Pilots that move forward
- Plans in place for dental clinics
- Full access to specialty care

Implement Common Database

- Providers not driven crazy by EHR
- Consistent IT infrastructure

System Level Year 2:

Infrastructure

- Leadership in place, metrics, defined roles of entities, collaborators such as housing and health. Info sharing
- Framework assures access to care
- PHSKC out of primary care business: DOH, City Council & KC Council all support transition from PHSKC clinics to CHC clinics
- Some organizations depart. Players clarified & committed
- Able to see change at 2 yrs: report characterizing who was in SN, health status

Improvement in Specific Measures

- 50% improvement in MH/SA access
- Undoing duplication within & across clinics. Perhaps decrease in system costs

System Level Year 4:

Infrastructure

- Integrated SN delivery – where ever patient enters care, gets appropriate care & assistance in getting where they need to be (Kroger example: QFC, Fred Meyer compete at one level, don't compete as a system, clearly sharing information)
- Multi-service centers have clinics, community services & libraries

- Lines of communication open & can see where patients have been getting care
- Coordination; infrastructure in place that is seamless to patients, Rx, lab, specialty care
- Patients we're concerned about have a liaison system in place to monitor & support them
- Better understanding of determinants of health not yet addressed
- Bring in other players such as hospitals into the fold – population focus
- Model system in place
- Information distribution, common database

Capacity and Access

- Enough people/providers to see patients
- Entire medical community/all providers doing their part in seeing patients (Whatcom County model)
- Full range of care accessible within all primary care sites
- At least one clinic open, robust integration of BH, dental & PC.
- More patients are seen in clinics

Financing

- Funding available for all services
- Distribution of resources

Improvement in Specific Measures

- 50% improvement in access to dental care
- Increase in quality of life measures
- Decrease in suffering
- Decrease in some MH problems
- Healthy teeth
- Better patient education
- MH/SA services accessed by those in need
- Solid, reliable, valid data
- Decrease in cost
- Increase in health, dental care
- Outcomes show little disparity in terms of access
- Outcomes improved to level of the commercially insured population
- Patients have medical homes & we understand what our patients need & provide it to them

Patient Level Year 1:

- Confusion for established patients about what's happening

- Patients get in to see providers they want to see or someone familiar with their care
- Patients get an appointment when they want to be seen
- Patients satisfied with care

Patient Level Year 2:

Access

- Streamline “hoops”; only one set
- Some understanding of how new system works
- Full range of services available
- Increased consistency re: Navigation, appointments, Rx filled
- Care for adults added to kid-only sites
- Improved access with neutral cost impact
- Right care at right time at reasonable cost

Patient Level Year 4:

Access

- Access to whatever service is needed – seamless!
- I'll get what I need when I need it without barriers
- Patient presents & receives same day care here or elsewhere in system
- Patients can be assessed & get their Rx same day
- Kiosks available so patients can have blood pressure taken at fire station & it can be downloaded into their EHR
- Seamless services; access to whatever care is needed
- Specialty care accessible so that patients don't return to Primary care as back-up plan
- Patient presents, gets what they need & it is paid for

Patient Experience

- Patients walk out the door feeling better than they did when they entered
- Feel heard, cared for. Rx filled before they leave
- Feel respected
- Community feels safe; I feel cared for by my community when I'm in need

Big Picture

22. If you were in charge, what solution(s) make the most sense to you?

Population/Geographic Access to Services

- Medical homes implemented
- Adequate providers – both primary care & specialty
- Hospitals turn over part of ED to CHCs as an urgent care clinic – to decrease lost costs to hospital & increase care continuity to CHC patients

Mechanisms for System Collaboration and Service Coordination

- Conversation needs to happen at big table, but not sure answers will arrive at the big table. David Fleming will have to be bold. It's very complicated, competitive. Big table discussions – not all can or should be done at the big table. Dental deserves its own table
- Need planning regions: North end, downtown & south end to design & create order in the SN. Right now there are 3 pharmacies within blocks of each other in downtown
- PHSKC leading, coordinating, collaborating and enforcing. Blow up the SN through community programs with assurance that there are enough resources for all
- Conduct public conversation & complete strategic planning. David Fleming leads it. Public engagement process & then a way for PHSKC to demonstrate convenor role/leadership
- Appropriate alignment of service delivery functions
- Would like to see the day when there is no need for SN – that the it is the foundation of healthcare delivery – all people are entitled & have access provided by private nonprofit practitioners on a salaried basis; agreed upon outcome measures based on prevention & health
- Best practices in care protocols. Need to do more to educate & assure their use & practice (Diabetes, obesity, asthma)
- Reliable, knowledge, information sharing capacity that would drive strategic planning
- PHSKC goes back to planning, convening role. Develop information needs to determine what's needed where

Competition/Financing in a Market-Driven Healthcare Industry

- Funding available to set up multi-disciplinary clinics in shelters with mobile mammograms, diabetic blood draws & open communication
- Single payer system or integrated delivery system with control over resource allocation

23. What else needs to be discussed that we have not asked about?

Population/Geographic Access to Services

- Translation of materials

Mechanisms for System Collaboration and Service Coordination

- What we need to do without getting bogged down; not get stuck in gathering more data. I think we have enough
- Consolidation will happen. It should be sooner than later
- Conduct public conversation and complete strategic planning. David Fleming lead it. Use public engagement process & then a way for PHSKC to demonstrate convener role/leadership
- Interesting that HMC not mentioned. They need to be more responsive to community. Right now they are a “non-player”
- We really don’t have a SN system of care. It’s a fragmented series of pieces
Make a deliberate decision about whether we want to build a system
- Linking to other systems like schools – school-based centers are isolated & not tied in (MH + sexual health)
- Screening – where do people go? Minute clinics + Walgreens
- Health disparities – need a complete picture & a plan to impact. Better integration of PHSKC & medical care systems
- What is the political perspective? What would political ramifications be?
- What would happen to those who drop out along the way?

Competition/Financing in a Market-Driven Healthcare Industry

- PHSKC – preparedness. Role has focused on education, but don’t see funding coming through to do prep, implementation. What about the “Do & Fund” parts??
Identify groups where is money to work it, resolve it, maintain it

Process Moving Forward

24. With respect to continuing this conversation and improving access to and quality of the services offered by the safety net, what is the most effective process for moving forward to get full and open participation?

- Not sure. Everyone will be looking out for own interests on behalf of the overall system
- PMC has invited Dorothy to come to a Board meeting to talk about this topic
- Bring all important players to the table. See what people think about communication. There needs to be a leadership organization identified that will keep players at the table. It will take funding – PHSKC & State

- We must get above/over/out of the “politics” of it all. There must not be hidden agenda, agree to disagree and agree to move this work forward
- Lots of history, sense of turf wars – who’s doing what, opening new clinics
- This is the closest we’ve come...because of funding coming up, partnerships springing up (HC for the Homeless Network, PHSKC, 2163 Vets levy with new MH funding)
- Build/create a system of care
- Get key players CHCS and David to the table – not all of the stakeholders – want to create a safe environment for discussion
- Old history, old hurts, many of same players have been around for a long time – have made strides – are they still real or can we move on? (CHCs among themselves; PHSKC & MH, City & County) David Fleming needs to understand some of this, but not be held back
- Model something that demonstrates success. Show people how it would work. Have to continue to produce care while improving the system
- Funding process pits organizations against each other, We operate in a “market” model in healthcare. Everyone has a business to operate. Need more transparency about how we all survive
- Bring everyone back together & start the conversation
- Lots of stakeholders (Molina, CHP, RSN). This is much bigger than the closing of the PHSKC clinics, which is potentially distracting
- Not sure health dept independent – may not be the best organization to lead the conversation
- BOH needs to deal with this. Hard for an individual stakeholder to lead this
- If there is a consensus on leadership, have a forum to come together. If not a theme, forcing it is not a good idea. Need to build consensus in pilots, building level of trust, maybe regional efforts

25. What do you need in order to be a full and open participant in this process?

- Nobody comes in with pure system focus, but will try to focus on it and respect the whole. IHI ‘triple aim’ would help
- I need to know there’s funding behind this – that somebody is taking funding to deal with SN, with the homeless, etc. It must be sustainable & funded for the future
- Seeing that all information gathered becomes tools for change, not just going through the motions
- Health disparities task force – no idea what happened, or that anything happened. David came, no outcome...
- When I see that reports generated are being used to generate action!
- My interest is dependent on whether I see something happen outside of talk, I’ll be at the table if I really sense that this is a serious effort. I want to fix this problem

- An effective group to lead and fund – maybe Swedish or PHSKC/David Fleming to convene with representation of all system partners
- So far David is doing a great job in coming to the CHC Council. At some point, he will have to do more public engagement with demonstrated support of all key elected officials
- Trust that there's enough transparency to see what's being done
- Roadmap
- A seat at the table
- Buy-in from my organization
- Need patient perspective to add to this!

Attachment B: Non-Direct Care Providers: Detailed Interview Summary

SWOT Analysis

1. Strengths

Population/Geographic Access to Services

- Patients have choice
- Care focused to special needs of populations – culturally sensitive
- CHCs seen as a lifeline; they can help; they are the “town square”
- Connect people with healthcare/respite for the homeless
- Network of CHCs with Harborview as an anchor

Mechanisms for System Collaboration

- Strong health plans
- System is robust
- CHC Council as an ongoing table where operations & medical leadership gather
- There is political will to address it; for most part it’s collaborative
- Focus/mission in King County to provide care from Ron Sims all the way down

Mechanisms for Service Coordination

- At the lowest levels, people know what’s going on & how to connect
- Infrastructure doesn’t look great, but it works because of on-the-ground expertise

2. Weaknesses

Population/Geographic Access to Services

- Access problems to specialty care, which will increase as age of population increases
- When patients can’t access specialty, they make more primary care visits, which decreases capacity
- Challenges with hospitalization – HMC takes the load
- There is unmet demand
- Lack of stable, dependable workforce; locums are not as productive as regular employees
- Problems with access to specialty care (orthopedics, joint replacement) and also to primary care

- Many core services in Seattle while more people pushed out to 4 corners of county because of cost

Mechanisms for System Collaboration

- CHC Council – PHSKC is not at that table
- Folks in King County politics are very process oriented, but want to see decisions/action

Mechanisms for Service Coordination

- PHSKC not on EHR to share medical records

Fragmentation/Roles of Organizations Unclear

- Because there's lots of choice, not enough communication between entities; not a coordinated approach. Its' a barrier to patients to move across agency boundaries for BH & PC
- Role confusion with PHSKC. Pure PH model vs. PC provider

Competition/Financing in a Market-Driven Healthcare Industry

- Multiple financing mechanisms – that aren't stable; state & federal funds always feel at risk
- PHSKC – primary care clinics reimbursement issues, overhead
- Need one coordinated approach for funding

3. Opportunities

Population/Geographic Access to Services

- Create incentive for PCPs (MDs & ARNPs) to become geriatric specialists or to develop expertise in geriatrics. They could travel around to clinics throughout all CHCs
- UW Dental clinic not out in communities

Scope of Services

- Aging population; opportunity for CHCs to provide free classes (yoga, pilates), health educators at clinics
- More wellness oriented

Mechanisms for System Collaboration

- Make connections more visible to maximize operational efficiencies. Currently relationship-based, which isn't sustainable over time
- Require all providers to see mix of all community members
- Come together collaboratively rather than territorial
- Could better leverage both Nursing programs (UW, SU) to connect them with communities
- Could better leverage residency experiences through Swedish to teach about care continuity
- Make the region attractive to providers; create a "magnet center" as a much broader way to deal with all residents of the community
- Opportunity to build collaborative structure
- We need to think regionally, metro-area. Patients don't know where County lines are – they look at" Puget Sound"
- Coalitions that have popped up – players not always the same. If there were consistent players or if PHSKC takes the lead, we could make some progress

Mechanisms for Service Coordination

- Develop an approach for dealing with transient population that moves from clinic to clinic
- Fund a dedicated care manager who does intake with new patients & educates/orients patients so they understand how to access care as means of establishing medical home

4. Threats

Population/Geographic Access to Services

- Immigration factors: if resident of County we'll see; know that PMC asks & won't see illegal immigrants
- Need more PC providers; how to bring them in & retain them?
- Shortage of specialists
- Shrinking ranks of Family Practice

Mechanisms for System Collaboration and Service Coordination

- Separation between tooth/mind/body – it's a core safety issue
- Duplication

Competition/Financing in a Market-Driven Healthcare Industry

- Fair compensation for providers – NW is one of lowest salaries with one of highest cost of living

- “Pecking order” – cascades from DOH to County...re: bioterrorism funds. What about creating a known/agreed upon order within PC arena & BH?
- Administrative burden – if new programs funded, start all over to build new infrastructure
- Competition at County & City levels – between UW, PHSKC, CHCs. All vying for the same funds; it’s costing more as all compete
- Continuing inability of employers to cover healthcare benefits or to cover less than before
- Pre-existing conditions: health insurance at odds with financing. We need to focus on access to care, portability, which don’t currently exist
- Instability of funding

5. What sub-populations do you feel are most important to address first to relative to existing gaps?

Sub-populations in Need of Attention

- Dual eligibles
- BH disabled
- Children with severe BH issues – especially teens with depression
- Foster children
- Homeless adults & children
- Pre-Medicare group
- Geriatric – not all aged are covered by Medicare (16% not eligible in County)
- Teens & Children
- Pregnant women
- Veterans
- Undocumented
- Non-users who don’t present for care
- Transient

6. Access

Does the safety net population in need of service get the best possible access to care and service that it could based on the resources available in the community? (averaged by organization, from individual ratings)

1-1.9 (Not at all)	2-2.9	3-3.9	4-4.9	5-5.9 (Absolutely)
0	1 (33%)	2 (66%)	0	0

Access Successes

- Good PCP access, not as good for specialty

- Potential is there

Access Opportunities for Improvement

- Need better access for adults
- We don't have good data about access; people don't know how to get help. Put workers out on the street to educate people about services
- Unmet demand & capacity issues

7. What process and outcome measures do we need to monitor improvement in access to care?

Process Measures

- Accurate diagnosis
- Prompt patient treatment in the right setting
- Process reporting about number of visits, monitoring systems
- HEDIS rates as good process measures
- Bring stats for healthcare up to that of sports teams

Clinical Measures of Health Status

- Blood glucose
- LDL < 120

8. What three things, if changed, would improve access to

A. Overall safety net system's care delivery?

Population/Geographic Access to Services

- Increase UW participation both clinics & medical students
- Need more primary care MDs in community
- Reduce ED care or strengthen ED system
- Clinic in every fire station for 24/7 access
- Increase provider reimbursement
- RNs in clinics as care providers to manage chronic care rather than MD or PA. regular visits scheduled, where RN reaches out to patients
- All community providers participate to decrease the crush on those who currently see SN patients
- Access/transportation
- Limited respite care

Medical Home with a Range of Services

- Opportunities for improvement re: service – wait times for visits
- Treat patients with respect

Mechanisms for System Collaboration

- Community education about what's available
- Get patients to the right place (remove recycling)
- Stable medical homes with stable providers/staff & populations

Competition/Financing in a Market-Driven Healthcare Industry

- Better funding for adult services for managed care

B. Your organization's care delivery

- Common infrastructure; IT/EHR that allows CHCs to share information for continuity of care and to manage referrals

9. Effectiveness and efficiency

Does the safety net population being served get the best possible effective, efficient quality care and service that it could based on the resources available in the community? (averaged by organization, from individual ratings)

1-1.9 (Not at all)	2-2.9	3-3.9	4-4.9	5-5.9 (Absolutely)
0	1 (33%)	1 (33%)	1 (33%)	0

Effectiveness/Efficiency Successes

- Great care through Molina & managed care. Not as much from some other types like FFS providers

Effectiveness Efficiency Opportunities for Improvement

- Staff concerns since stabbing downtown, concerns about facility safety
- Staff turnover
- Lack of respect
- Aging infrastructure & facility issues impact patient flow & efficiency

10. If you were to name three things that you would like to see changed that would improve effectiveness and efficiency of the overall safety net system's care delivery, what would they be?

Population/Geographic Access to Services

- After-hours access to PCP office or CHC
- Cultural & language barriers need to be reduced
- Ensure patient safety at sites

Medical Home with a Range of Services

- Reduce ED as a primary care provider
- Medical homes

Mechanisms for System Collaboration and Service Coordination

- Address fair share issue with all providers seeing SN patients
- Increase awareness of providers, community, potential patients about available resources
- Address provider biases that occur at the point of treatment based in insurance
- Ability to "fire" patients

11. What things are working well in terms of coordination and collaboration within the safety net that result in effectiveness and efficiency that we should be sure to continue into the future?

Collaboration/Partnerships

- Existing commitment that providers have to SN clients
- Ron Sim's leadership has been essential. Concerns about sustainability after he moves on
- Fact that we have coalitions trying to dialogue/deal with these issues & various forums to address/build awareness
- Want to see action/results – difficult to let/have someone take the lead
- EHR needs to be implemented across all sites
- Adult dental, especially as population ages
- South County – some way to collaborate in multi-service center – all of core services

Other

- Outreach efforts. Education on how to use their health care

12. What are the opportunities for and barriers to better coordination and collaboration within the safety net that would contribute to improving overall effectiveness and efficiency?

Mechanisms for System Collaboration and Service Coordination

- EHR & exchange of information re: individual patients. EDs talking to each other. Lots of waste. Collaborate to reduce cultural barriers
- Different masters – the CHC Council
- The County has been reluctant to take on role of convener
- Interdependence between the County & CHCs to build new access points

13. What are three things that would improve effectiveness and efficiency of care delivery within your organization?

Population/Geographic Access to Services

- UW participation
- Have more “commercial” MDs participate in both PCP & Specialty to provide good access. Right now all burden is on a small cadre
- Improve, share focus to adult care needs & services. Better balance between kids & adults
- Improve access & service
- More primary care access; with mandate to take all comers, it decreases capacity to see Medicaid & managed care populations
- Capital funding to build more capacity
- More PCPs
- Hospitals to back PCPs up
- Enhance employment recruitment & retention processes; this is the basis of our capacity

Financing

- Stabilize funding

14. What process and outcome measures do we need to monitor improvements in effectiveness and efficiency in the safety net delivery of services?

Overall Measurement

- Do existing measures need improvement?
- Need to overcome cultural barriers that bias the results or actions

- Some HEDIS are too narrow – need to measure behavior change & take action for treatment
- Are we sure that under-insured have worse health?
- Use measures that everyone is using (Puget Sound Health Alliance); increase their focus to include SN
- DOD had common data sets available

Effectiveness of Safety Net Service Delivery (Outcome Measures)

- Increase patient satisfaction

Efficiency of Safety Net Service Delivery (Process Measures)

- Decrease wait times
- % of patients who ask for same day appointment & actually get it
- Provider FTE ratios – vary across CHCs; each organization has productivity standards

System performance

15. What process and outcome measures do we need to monitor the quality of care delivered in the safety net?

- HEDIS measures

16. What penetration and utilization data do you think is most important to gather and report about the safety net’s capacity and performance?

Overall Measurement

- Need a common database to track frequent fliers, drug seekers & “train wrecks”
- CHC visit data for all sites & programs; then providers have productivity data that is RVU-based – then could extrapolate to the larger whole

Utilization Data

- ED visits
- Childhood immunizations
- Well child/well adult visits
- Use modeling to compare actual utilization with expected utilization

Performance Data

- Tracking patient engagement & hospital days/1000

- Any BRFSS data to compare King County to other comparable counties

Delivery Models

17. We'd like to learn more about your perspectives about Public Health's role

A. In improving the healthcare services available to people dependent on the safety net for their healthcare needs

- The public's health depends on everyone's health. Role that everyone knows where they can go to get care. Setting policy, as convener to ensure care quality
- Primary care – all core service – lots of it is hidden & undervalued
- It's all about infrastructure – it impacts everything; the public has not been educated

B. In providing primary care within King County

PHSKC as a Primary Care Provider

- Primary care is not a role for a government agency
- Not convinced that there's a direct role for PHSKC as provider. These funds could be better used to focus on public immunizations
- Pretty invisible – not aware of other sponsorship efforts
- Everyone is at capacity, they can't go away. How would it be financed? It would initially cost more

Convener Role

- How will PHSKC use this information as part of Master Plan?
- PHSKC can be a change agent in bringing people to the table, educate, collaborate

C. In providing preventive (wrap-around) services within King County

- Hard to answer. PHSKC should have a key role in primary care services (depending on their mission). Teen clinics in schools are way to reach population
- Policy, setting standards, education, community awareness
- See large role with preventive care, school programs, immunizations
- PHSKC has a role in facilitating not providing; broken to increase access to these services

18. What is your agency's primary “value-add” as it relates to serving this population?

- Great care is provided through our plan
- Some patients use clinics as urgent care. They don't expect to have to have to make an appointment
- Ability to drive system changes; great model for collaborative change
- Access to specialty care

19. Tell us about any systems or collaborations (functional organizational models) that might serve as an inspiration to us as we embark on identifying the core elements of future systems we might aspire to create.

- Project Access model from North Carolina
- Whatcom Alliance for Healthcare Access
- Wisconsin Collaborative
- Alaska Native model
- Mother Joseph model

20. Consider a future merger/consolidation of safety net delivery organizations in order to create a more effective and efficient system. What issues and questions would be necessary to consider as you think through such a possibility for your organization?

A. How willing would you and your organization be to consider this? (averaged by organization, from individual ratings)

1-1.9 (Not at all)	2-2.9	3-3.9	4-4.9	5-5.9 (Absolutely)
0	1 (33%)	1 (33%)	0	1 (33%)

- To be successful, the County would have to come out with a strong proposal. It can't look like it would benefit PHSKC. The model has to be laid out. There is the budget turf issue, which is not great. Can't win: hand off without funding vs. building PHSKC role
- This would be seen as a loss
- There's so much noise (Governor covering kids, adults no coverage). Instead of synergy, we have chaos, Difficult to find focus. We're tired of waiting for direction

B. What would it take for you to fully support a merger-based system of care for the safety net population?

- If the County is seen as the overseer & the CHCs contracted with the County and they would be held to same standards, expectations, accountabilities
- Get the County to increase access points rather than depending on the CHCs
- Not sure a merger is viable. Could see a consolidation of some services based on capacity & demand in part of non-users
- Ability to maintain separate entities to ensure cultural competence
- Ensure equity of care across all sites, common EHR with shared information

21. If we are successful in improving the safety net delivery of care (access, quality, cost-effectiveness), what would that success look like in 1 year? 2 years? 4 years? at the system level? at the patient level? Imagine how you'd ideally want care to be provided on a typical day in your setting

System Level

- Start data exchange at ED to primary care appointment. Get patient to the right service the first time. Referral management with IT collaboration & data exchange
- Access to specialty care
- More collaboration, less competition
- Increased stability of staffing
- Increased patient efficiencies

Patient Level

- Get patient to the right place the first time for both primary and specialty care
- Get patients correct information from health plan, a patient advocate for care planning & treatment
- Shared Care plans with all involved providers
- Patient knows where to get care & gets it when they want it
- Patient's don't feel put-off
- Patient navigators for selected populations
- Quality & access equal to commercial market place
- "Golden Rule" in full force all over
- Adequate infrastructure to support the system

Big Picture

22. If you were in charge, what solution(s) make the most sense to you?

- We have to address uninsured healthcare on a regional basis. Build a regional system

- This would allow health plans to maximize their strengths in areas/regions where their networks are good
- “Presumptive Eligibility” blanket with funding mechanism to ensure that providers will get paid by state or feds no matter what
- Agreement that we’ll be able to collaborate

23. What else needs to be discussed that we have not asked about?

- Need strong leadership; someone willing to take the lead with a blueprint that had tangible milestones, phases, stages with clear outcomes

Process Moving Forward

24. With respect to continuing this conversation and improving access to and quality of the services offered by the safety net, what is the most effective process for moving forward to get full and open participation?

25. What do you need in order to be a full and open participant in this process?

- Stay the course – stay engaged. Please keep us at the table, included in the dialogue. We are part of the solution. It’s great to be recognized as part of the SN
- Tell me what the expectations are, what direction is for the next 3-4 years so that I can anticipate
- Build trust across systems that what we’re doing will result in improved SN system: more efficient, better access, affordable
- Build trust across systems toward improving access to affordable efficient SN care
- Come together to carve up populations so everyone gets care
- All stakeholders need to be at the table

Attachment C: Key Themes Summary of PHSKC Interviews

Current Safety Net “System”: What is Working Well?

Population/Geographic Access to Services

- Primary Care Access at good capacity
- Family & pediatric medical residency programs add more access
- The Public Hospital web of clinics and urgent care programs
- There is some “net” to catch the growing number of folks
- Lots of CHCs in King County
- Don’t do anything to diminish capacity until some reform occurs at state/federal level
- Harborview & CHCs as “Legacy Providers” provide good primary care
- Harborview key for SN functions per ED admits
- Project Access important band-aid for SN
- Hopeful that new tax for MH will make palpable change
- PHSKC assessment role
- Orientation to primary care & CHC network
- Build a sense of accountability with suburban cities for this issue
- City & County need to work together, since where people live may be different from where they seek care
- Put the public funded hospitals together with CHCs
- Healthcare delivery system works well from acute to assisted living, hospice etc.
- Specialty referral via Project Access working at 1 yr anniversary
- EMS is fabulous and we should all be glad we have a Harborview in the Safety Net

Current Safety Net System: What is NOT Working Well?

Population/Geographic Access to Services

- May soon reach saturation of Primary Care capacity for Medicaid and Medicare patients
- Unclear about mental health capacity
- There is NO Specialty referral “system” for Medicaid, Medicare and no-pay clients
- Drug, alcohol & MH problems overwhelm what little capacity there is with a “non-system” left to deal with them
- “Cul de sac” for internal-only at UW primary care to specialty services
- Involuntary beds for mentally ill NOT available – worse than California; NO Care management

- Alcohol and mentally ill patients now not referred, but “boarded” at hospital because there are so few beds available
- Don’t know if enough specialists are available
- There’s no SN for returning soldiers

Mechanisms for System Collaboration and Service Coordination

- Large systems don’t talk to each other; no opportunities to share best practices
- All is decentralized, evolving from erosion, no center holding it
- Hospital charity care has increased
- SN needs “rebranding” to attract more users
- Explore how best to leverage government role (niche building) in future redesign of SN
- Insurance companies besides Molina and CHPW not players

Competition/Financing in a Market-Driven Healthcare Industry

- Rising uninsured drives up costs for all
- Collaborative funding works well (CHI, other coalitions)
- CHC Council acts as a PAC, are competitors

What Are the Top Things You Wish Were Different?

Population/Geographic Access to Services

- That there was a mental health “system” in place to treat clients with adequate beds, case management and services rather than the “boarding and shipping” system now acting as a default “system”
- Project Access had stable funding
- Provide avenues for drug maintenance in addition to abstinence
- We need to design primary care for the next generation of users, which may be a very different service model (minute clinics, consulting RN lines, more culturally customized care)
- Go upstream to stem the tide re: SA/SU with interventions birth to five year olds
- That there were specialists who would take Medicaid, Medicare and no pay client referrals

Mechanisms for System Collaboration and Service Coordination

- Need an honest, impartial broker to help foster best possible outcomes
- That community consensus existed about role of SN & how to diminish reliance on it
- Wish there was a “shared burden” view of the SN needs
- Incrementalism may not be best method of shoring up SN; pilots may be helpful to achieve sustained improvement

- Utilize a similar convening and planning approach as with Preparedness (planning for the unknown) to plan and rebuild the safety net system (what we know we need) with PHSKC leading the effort
- Restructure the county system with incentives that reward partnerships, collaboration, across public & private sectors
- Share infrastructure to create more of a “system” in operation & actuality
- Don’t over process or it can fall apart
- Wish that business community was engaged/willing to partner – they are key & needed for true transformation
- Gather information and data about what we do know vs. what we want to know
- Adopt a set of principles – perhaps from “Project Uplift” as a point of departure

Medical Home with a Range of Services

- Explore expansion of the school-based and school-linked clinics as systemic ways to bring whole families to a “medical home” by attracting the children first.

What Do You See as Public Health’s Current Role in the Safety Net? What Are Your Current Points of Contact with PHSKC?

- Currently working with PHSKC on primary care and immunizations, Child Profile, with the Kent Teen Clinic and on Preparedness
- Consider possibility that County SN model (form & function) may look different than City SN model
- Great connections with PHSKC via communicable disease & preparedness
- Explore if providing direct care detracts from PHSKC ability to be “nimble” and to do more systemic interventions. If PHSKC gets out of “clinic business” be careful to not injure the WIC program & its linkages to PHSKC clinics.
- Continue to track and report what is not working
- Continue to “stand on the Prow” & call out where the “dead heads” are – no one else on going to do that
- Infectious disease work with PH is just great
- PH in primary care business is not a problem; we need all of the capacity we can get
- See PH helping to guide improvements in the needed areas

What Might New and Emerging Roles be for PHSKC in the Future?

Convener Role

- PHSKC could take a leadership role in convening a Safety Net “reconstruction” effort similar to the successful Preparedness working group.
- Look for win/win opportunities with data sharing & practice management

- “Health Impact Zones” as a comprehensive way to approach health – from work to home & in between including land use planning to decrease risk of focus on “vulnerable populations”

Addressing the Public’s Health

- PHSKC could provide more education and outreach to the providers; linking providers to more information – information is not getting out.
- Explore innovative approaches with culturally diverse populations that embrace lower level interventions & more holistic approaches (hands-on patient education on how to cook healthy meals as means to decrease chronic disease like diabetes)
- Take on life style issues like obesity
- Develop best practices around family friendly environments and workplace wellness
- Would be interesting to promote employer interventions around wellness and prevention by sponsoring something modeled after the Sloan award and potentially partnering with the Chamber.
- Develop greater interactions with the workplace as area to focus on wellness & prevention – almost as “adult counterpart” of working with schools

PHSKC as a Primary Care Provider

- Move care delivery into the community via Consulting RNs, PAs, ARNPs, CHWs
- Make primary care more of a specialty in the future
- Provide a “business report” for PHSKC center like the CHCs
- PHSKC needs stable source of funding to sustain its core functions
- PHSKC contracts with private MDs as locums to increase capacity
- Pilot new arrangements at Columbia or North PHSKC clinics
- Extend hours of operation to evenings & Saturdays
- New pilot that moves providers to patients rather than requiring patients to move

New Partnerships

- Partner in news ways with Spokane or Yakima like San Francisco has done
- Look for unique opportunities for roles of PHSKC & government on behalf of SN (bonding, financing, bully pulpit, legal help, assessment & evaluation)