

Public Health
Seattle & King County



King County Safety Net Meeting
February 11, 2008
Convened by Public Health – Seattle & King County

Meeting Summary

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Introduction

On February 11, 2008, Public Health – Seattle & King County (“PHSKC”) convened a four-hour meeting of county safety net providers to begin discussing the future of the safety net and the population it serves. Approximately 50 people were in attendance, including several PHSKC staff who served as facilitators.

In preparation for this meeting, PHSKC conducted two assessments. Department staff conducted a quantitative assessment, summarized in a report entitled *Access to Health Care in King County for the Uninsured, Underinsured, and Medicaid Populations*. This assessment was based on the following questions:

- Who and where are the uninsured, underinsured, and Medicaid-covered populations in King County?
- What do we know about where they access health care services now?
- What do we know about who is not accessing care and why?
- What do we know about access for specific populations?

Concurrently, MCPP Healthcare Consulting conducted interviews of safety net providers regarding safety net services in King County. Interview topics included strengths, weaknesses, threats and opportunities of the current system configuration, ideas for increasing effective and efficient access to care for the population utilizing the system, and PHSKC’s role in assuring access to quality health care.

Meeting Goal

Building off the thoughts shared in the interviews, agree on how to begin the following three streams of work, linked by the common task of identifying goals, priorities and process:

- 1) *Where should we be heading?* What changes does the future hold and how does the safety net need to adapt to these changes?
- 2) *How should we start getting there?* What are the priority improvements and efficiencies that are under our control to begin to implement now?
- 3) *Who should be doing what?* What are the future roles of individual safety net partners, including Public Health Seattle and King County?

Meeting Agenda

The meeting opened with presentations of highlights from the assessment and interview findings. After the presentations, Dr. Fleming set the context for discussion of each of the three questions. Participants brainstormed ideas and discussed each question in groups with the aid of a facilitator, and then reported out their main points to the full group. The groups were constrained for time in each discussion and did not always have time to get through the entire exercise or come to consensus on their ideas. After each report out session, the large group identified themes. What follows is a high level summary of the discussion.

Discussion Summary***Question #1: Where should we be heading?***

Dr. Fleming shared his perspective on healthcare reform and reflected on the implications of the assessment data for the future of the safety net. Dr. Fleming stated that with the current national, state, and local focus on healthcare reform, we may see movement towards expanded health coverage in the next three to five years. He noted that this insurance coverage, however, will not be a local solution, given the cost of covering all residents of King County. If we assume that significantly more King County residents will have insurance coverage for basic healthcare services in the next 3-5 years, what can we do locally to improve access to the safety net independent of insurance financing? First, we must identify who the safety net will be serving in the future, and what they will need.

Dr. Fleming suggested that the assessment data shed light on that future population. While some may broadly define the safety net population being served as the uninsured in King County, the data suggest otherwise. The core safety net providers in King County are seeing approximately one-third of the uninsured population, and that sub-population tends to be the most vulnerable residents of King County. For example, uninsured people of color are three times as likely to be seen in the safety net, and well over half those living in poverty are seen in the safety net. The safety net, in essence, is an equity safety net, having developed expertise in providing primary medical and dental culturally diverse, poor populations. In a future where these populations have coverage, Dr. Fleming posited, they will still likely need the specialized services of the safety net. Our job is to better understand the barriers to access for these populations, and work together to improve the safety net for the future.

For purposes of this discussion, participants were asked to stipulate to some form of increased health care coverage in 3-5 years. In that context, they were asked to describe who the likely safety net population will be, what they will need, and implications for service delivery.

Participants described the demographics of the future safety net population as the poor and working poor; people who are less educated; immigrants and refugees, including people who are undocumented; people of color; people who are homeless, transient, and mobile; people with poor social support; and people who have difficulty navigating the health system. Added to this familiar list is an increase in seniors and the health risks and conditions associated with aging. The population will need a full spectrum of healthcare services, from primary care and prevention through specialty care and including mental health. They will need enabling services such as case management and system navigation, interpretation and translation, and transportation. (See Appendix A for a full list of needs). In terms of coverage, participants felt that the system would be serving more under-insured because the increased coverage will likely be at a basic level, as well as an increased number of Medicare covered residents due to the aging of the population.

Implications for future service delivery include increasing local access to health care services, provider recruitment and retention, more integrated service delivery models and systems for care coordination.

- **Local access:** Services need to be delivered locally, closer to home, work, and school, and include more flexible hours to accommodate working people. The delivery system needs to be geographically dispersed, farther from the core of Seattle, matching population needs.
- **Providers:** The system will need providers of color and providers who have cultural proficiency. More primary care providers will be needed, as well as more mid-level professionals. There will also be a need for more specialists who are willing to see safety net patients. Interpretation and translation services will continue to be needed.
- **Service delivery model:** The primary service delivery model should be based on a medical home, with integrated medical, behavioral health, and substance abuse services. It will require a multi-disciplinary team approach, and include different types of providers, prevention and chronic care model implementation, dental, and end-of-life and pain management services.
- **Systems for care coordination:** Participants identified the critical need to be able to share information across organizations and between providers serving the same patients. Also mentioned were the need for case management/social work, care coordination for complex medical conditions, and improved networking with, referrals to, and follow up from specialists..

Question #2: How should we start getting there?

Dr. Fleming referred to the meeting goal of identifying safety net improvement priorities that will position the system to better serve the safety net population of the future. In this discussion, participants were asked to review a list of 17 strategies for improving the efficiency and effectiveness of the safety net system. The list was populated with ideas that surfaced in the MCPP safety net interviews. Groups were asked to prioritize the ideas, as well as any new ideas, taking into consideration the likely return on investment in terms of improving the quality and efficiency of the safety net; the degree of interest and leadership commitment; and any other factors they saw operating in favor of or as a barrier to implementation. The following ten strategies were identified by at least three of seven groups (and in several cases more than three groups) as top priorities:

- Creating inter-operability of information systems to allow providers (including primary care, specialty care, mental health, and hospital based providers) at different sites access to information about shared patients.
- Creating and measuring against a standardized set of system level performance indicators for quality and efficiency.
- Expanding geographic access through coordinated system-wide facilities plan.
- Developing system-wide provider training, recruitment and retention efforts.
- Developing service delivery initiatives that increase access to specialty care.
- Developing service delivery initiatives that increase access to mental health and chemical dependency services.
- Developing service delivery initiatives that increase access to dental care.

- Developing shared and/or coordinated interpretation services.
- Developing a shared urgent care/after hours pilot focused on reducing inappropriate hospital emergency department use, and integrating mental health and chemical dependency treatment.
- Building out a medical home model for our most vulnerable populations.

Participants were also asked to identify whether each strategy a) could be implemented by the people gathered in the room with no to little new investment, b) requires a broader coalition of stakeholder to move forward, and/or c) requires a significant new investment to implement. These results are described in Appendix A.

Question #3: Who should be doing what?

Dr. Fleming introduced this session by stating that in an ideal world, all residents of King County would be covered by health insurance, and all would be connected to a medical home. In such a world, PHSKC may not need to be a provider of clinical services. Until such time, however, the department continues to be responsible for assuring services for all. Dr. Fleming stated that discussion about the department's future role in the providing direct care should be based on an understanding of what the department currently provides and how it funds those services.

Dr. Fleming shared the following information about the department's provision of clinical services. In 2006, PHSKC provided primary medical services to approximately 17,000 clients and primary dental services to approximately 16,000 clients (not including services provided in the King County jails). PHSKC provided other clinical services (WIC and maternity support services, immunizations, family planning, STD, and TB) to approximately 110,000 clients. FQHC revenues funded roughly one fifth of these other clinical services. Additional funding sources included grants and contracts, CX, Medicaid fee-for-service, State public health funds, MATCH, and patient- or other third party-pay. If the department loses its FQHC status, its ability to provide these other services will be severely curtailed.

Participants were asked to discuss the following questions:

- 1) How do you see Public Health's role in the provision of clinical services potentially and most effectively evolving over the next 3-5 years? For example,
 - Given the current population Public Health is serving as well as the manner in which the department funds clinical services, what opportunities do you see for developing a more complementary role for Public Health's provision of clinical services that, in collaboration with others, will result in the best access and health outcomes for the population being served?
 - Are there ways to begin to phase in some new roles and relationships through a focus on specific programs and populations?
- 2) Are there other relationship and/or role issues in the safety net that we should all be addressing? Is there a need for a more collaborative approach to serving the safety net population?

- What would a more collaborative model look like? Might it include a different system-wide planning model? Different governance model? What are some specific ideas?

Due to time constraints, the majority of participants did not get to question #2.

There was consensus on PHSKC's leadership role in convening, planning, and providing prevention, and population based care. Critical to this role is leadership in assessment and epidemiology. There was congruence regarding PHSKC's role in leading system-wide improvements and collective efforts for increased access to care, improved quality of care and greater efficiencies. PHSKC's focus should be on strengthening the entire health safety net. The department also has an important role in addressing health disparities through primary prevention and leading population based care, including education, outreach, advocacy, immunizations, Breast & Cervical Health program, colon cancer screening, tobacco cessation, and environmental health.

Participants were appreciative of the financial data shared by Dr. Fleming, which prompted additional questions. Some people expressed a desire to understand it better, commenting that there may be different ways to analyze the data. People also wanted more information on adult dental. There was confusion about PHSKC's FQHC status; some thought PHSKC has Look-Alike status. There was also some confusion about how the teen health services/school-based services are currently structured, and about whether PHSKC conducts patient satisfaction surveys. The comment was made that the safety net needs a common definition of "primary care." For some, primary care may include WIC, family planning, maternal support services, etc, and for others it may not.

With respect to PHSKC's evolving role in the provision of clinical services, several questions and issues were raised, echoing the themes that emerged from the safety net interviews. Some voiced concern that PHSKC's multiple roles as leader, grantor, monitor and provider compromise the department's ability to fulfill its leadership role. There was concern that the public health clinics do not have the community-based board structure and guidance of the community health centers, and that the department's higher salary structure makes it difficult for the community centers to recruit staff.

Most participants in this first safety net discussion on the topic supported phasing out the department's provision of primary care. Important considerations given this recommendation included:

- A safety net capacity analysis confirms that there is capacity for other safety net providers to absorb PHSKC's primary care clients;
- A safety net financial analysis determines that the community health centers can provide the same services as or more cost effectively;
- The safety net clinics collectively have the capacity to deliver linguistically appropriate and culturally competent care to a diverse patient population;
- A transition will not weaken the department's financial viability;

- The transition is made in conjunction with improvements in the safety net to reduce duplication and improve system efficiency; and
- The transition is planned and predictable, so that both patients and staff can be transitioned smoothly.

The following comments were made during the small group discussions. PHSKC has an important role to play in assuring access to care for hard-to-serve, vulnerable populations. PHSKC can provide support to safety net primary care providers by providing other clinical and preventive services. The question was raised as to whether the safety net providers can and should provide some of the categorical services in an effort to reduce the number of entry points into the system, which may create inefficiencies in patient care. It was acknowledged, however, that PHSKC services often incorporate a unique public health role, and that the department has a strong role in follow-up (e.g., partner notification), such that any transitions of these services would require partnerships with public health nurses working in conjunction with community health centers to continue that level and type of service. The concern was also raised that decreased funding for PHSKC's TB program is negatively affecting safety net providers, because they have historically referred clients to PHSKC for these services, but are now being forced to provide the care themselves - care they are not equipped to give (e.g., chest x-rays). Finally, the question was asked whether, given the crisis in adult dental, the department could have a role in increasing its direct provision of dental services.

Evaluation

Participants were very positive in their written meeting evaluations. Of the approximately 50 people in attendance, 23 turned in evaluations. All said that it was a valuable use of their time and that their expectations for the meeting were met, and in some cases, exceeded. All said that they were willing to participate in workgroups over the next several months to continue this work, and to reconvene as a larger group for a second half-day meeting. In terms of next steps, participants urged the department to keep the momentum going, and to stay in contact with those in attendance.

- Appendix A: Table Discussions Notes**
- Appendix B: Meeting Evaluation Comments**
- Appendix C: Meeting Attendee Roster**

Question #1: Where are we heading?

Who will the safety net population be?

Demographics

- Poor, less educated
- Immigrants and refugees, non-English speaking
- Undocumented
- Culturally diverse
- People of color
- Transient, homeless, mobile
- People with poor social support
- More adults than children, since almost all children will be covered
- Seniors
- Working poor
- Dependents
- Those who will have difficulty navigating a national program
- People who are confused because the health care delivery system is incomprehensible

Health Conditions

- Clients who need specialty care
- People with medical diagnoses and mental health or substance abuse diagnoses
- People with mental health and substance abuse issues
- People who need dental care (which can also lead to cardiac issues)
- Disabled
- People with chronic illness
- Children with learning disabilities/behavior issues
- HIV+ (women, people of color)
- Pregnant women
- Sicker patients discharged from hospitals

Insurance Status

- People with Medicaid
- More insured, but more under-insured
- People who were previously uninsured/underinsured but who have “aged” in to Medicare
- Adults without insurance

What are they likely to need?

Health care services

- Basic healthcare needs
- Higher levels of care for outpatient services
- Preventive services
- Dental services

- Mental health/substance abuse
- Specialty services
- Chronic disease care
- Geriatric services
- Pregnancy services
- Increased access to Rx

Enabling services

- Interpretation and translation
- Case management
- System navigators
- Transportation
- Health system navigation including education on preventive care and managing care , on how and when to access services, on technology to assist them in accessing services in a new healthcare technology age, and on how to use western medical system
- Tools (for social and cultural “issues” directly related to health, e.g., housing assistance, income, culture, social, etc), because they will have more access to health

Other

- Housing

What does this imply for service delivery?

Local access

- Need for more access locally (geographic planning of facilities)
- Services closer to home/work/school – easier access.
- Services to be delivered farther from the core of Seattle
- The delivery system needs to be geographically dispersed, matching population needs.
- More flexible hours to accommodate working people – near work, schools, home.
- More points of access
- We need to be more targeted in terms of where and to whom services are provided

Services

- Serious need for a robust chronic care model
- An effective prevention model
- Ramp up to provide end of life care and pain management
- Dental care
- Care for dependents
- Interpretation and translation

Providers

- Providers of color, cultural proficiency, links to educational systems

Primary care

- More primary care providers

- Need to fund training for family practice physicians;
- Increased need for mid-level professionals (e.g., PAs, nurse practitioners) and capacity at this level

Specialty care

- More specialists who will see SN patients
- Need better reimbursement rates so that more providers of these services are willing to see these clients.

Service delivery model

- A system based on the health care home, with corresponding funding and accountability is needed.
- Multi-system functionality in health care home; a regular source of care that provides medical, behavioral health, chemical
- “Planned intervention” – inserting education and tools at the time of service
- Care model redesign needs to include: different types of providers; chronic care models fully implemented; RN case management; group sessions; integrated MH/SA
- Will force safety net to look at whether we are providing healthcare as a team with health educators, case managers, etc.
- Need more multidisciplinary team approaches – implies need for more training, more culturally competent access
- Going to need to extend care for HIV, MH/CD into mainstream health systems
- Health workers who can help people access all of the care they need holistically.

Systems for coordination

- Registries
- Care coordination for complex medical conditions
- Better networking with specialists – follow up / feedback;
- A more efficient system for referrals to specialty care
- Linkage with hospitals and care management
- An “integrated” system across the SN that shares results, patients accessing the system, with oversight and facilitates integrated care.
- Funding for technology (EHR)
- Need for case management/social work

Other

- We need to “up-end” service delivery by rewarding the population you are taking care of (and a different payment system)
- Capacity/resource issues
- Non-profit managed care systems accountable for health improvements need to expand
- Public health could serve as an entry point for people, directing them to health care homes.
- Financial systems need to eliminate financial barriers to system redesign.
- Concern – Assuming health coverage expand, benefits package may erode; quality of care may decline.

Question #2: How should we start getting there?

High Priority Improvement Strategies (based upon number of tables reporting as a high priority):

- Build a shared IT platform to allow providers at different sites access to information about shared patients
- Develop shared and/or coordinated interpretation services
- Develop service delivery initiatives that increase access to specialty care
- Create and measure against a standardized set of system level performance indicators for quality and efficiency.
- Develop system-wide provider training, recruitment and retention efforts
- Expand geographic access through coordinated system-wide facilities plan
- Develop service delivery initiatives that increase access to mental health and chemical dependency services
- Develop service delivery initiatives that increase access to dental care
- Develop a shared urgent care/after hours pilot focused on reducing inappropriate hospital emergency department use, and integrating mental health and chemical dependency treatment.

Improvement strategies *sorted* by those within the control of the group and limited to little-to-no new investment; those requiring a broader coalition of stakeholders; and those requiring a significant new investment (check marks indicate number of tables selecting that cell).

Improvement strategy/Table sorts	Within control of this group and limited to little to no new investment	Requires a broader coalition of stakeholders	Requires a significant new investment
Create and measure against a standardized set of system level performance indicators for quality and efficiency.	✓✓✓✓		
Build a shared IT platform to allow providers at different sites access to information about shared patients.	✓✓✓	✓✓✓	✓✓✓
Develop system-wide provider training, recruitment and retention efforts	✓✓✓	✓✓	✓✓
Expand geographic access through coordinated system-wide facilities plan	✓✓	✓✓✓	✓✓✓

Improvement strategy/Table sorts continued	Within control of this group and limited to little to no new investment	Requires a broader coalition of stakeholders	Requires a significant new investment
Build shared registries for chronic care case management	✓✓✓		
Develop shared transportation services			✓
Develop shared and/or coordinated interpretation services	✓✓✓	✓	
Develop shared and/or coordinated pharmacy services	✓✓	✓	
Create shared urgent-care after hours system	✓✓✓✓	✓	✓
Develop shared OB and on-call services	✓✓		
Expand community-based early interventions, including education and outreach to culturally diverse populations on lifestyle issues and need for preventive services	✓✓✓	✓✓	
Extend community education/advocacy/outreach workers/navigators.	✓✓	✓	
Develop community based service delivery models (e.g., home-based, faith-based, community centers, shelters, fire stations, mobile services)	✓		
Develop service delivery initiatives that increase access to mental health and chemical dependency services	✓✓✓	✓✓✓✓	✓
Develop service delivery initiatives that increase access to dental care	✓✓	✓✓✓	✓
Develop service delivery initiatives that increase access to specialty care	✓✓✓	✓✓✓	
Build out a medical home model for our most vulnerable populations	✓✓✓✓	✓	✓
Advocate for reimbursement for phone and group visits	✓		

Question #3: Who should be doing what?

PHSKC leadership in planning, prevention, and population based care

- Public Health department should serve as a leader and a convener to work on designing a more rational system that looks at the services needed in what part of the county, and reduce the current waste in the system.
- PHSKC's role is to lead system-wide improvements and collective efforts for increased access to care, improved quality of care and greater efficiencies. PH's focus should be on strengthening the entire health safety net. PH must be the leader, convener, and driver.
- Lead, facilitate, convene and coordinate geographic review, assessment and planning to improve capacity regionally; lead coordinated systems planning – bring to light what are the needs for services and populations. “Be the Glue!” Involve providers in each area; don't do alone in a room, convene.
- Be **BOLD!** Create a new model with incentive and monitoring of standards. Start with adult dental a subset and area of increasing fragility.
- PH should do primary prevention – education, outreach, advocacy, immunizations.
- PH should be a leader/convener in addressing health disparities, such as the work PH does with the Breast & Cervical Health program and with Colon Health. PH leadership is important to move this and similar work forward.
- PH should focus on population based health – environmental health for example
- PH should strengthen its work and leadership related to epidemiology.
- PH has an important role in assessment. It should identify system improvements and address needs. It can help the entire safety net to leverage additional resources (such as from the CDC).

PHSKC evolving role in the provision of clinical services

Concerns and questions:

- Public Health serves in too many roles now: a grantor, monitor, player, primary care competitor. The role confusion makes it hard for partners to work with the department. Co-location with the public health department has inherent challenges, such as much lengthier lead times to make changes to facilities, and higher salary structure than community organizations.
- PH compromises its public health role of leading efforts to assure access to quality care by being a “competitor” with the community health centers.
- Problematic that PHSKC does not have to/elect to meet health center requirements such as having a community-based board with 51% patients on it. Important to have a community-driven health center program and PHSKC doesn't do this. (One table member noted that

PHSKC would gain some good will if it had a community-based board for its clinical services, similar to CHCs)

- Decreased funding for Public Health's TB program is negatively affecting safety net providers, because traditionally they (SN providers) would refer clients to Public Health but now they are forced to provide the care themselves - care they are not equipped to give (e.g., chest x-rays).
- Sharing PHSKC's financial information is an important first step, and people had a desire to understand it better, commenting that there may be different ways to analyze that data. People also wanted more info on adult dental specifically.
- There was confusion about PHSKC's FQHC status. Some thought PHSCK had Look-Alike status. There was confusion about how the teen health services/school-based services are currently structured. There was confusion about whether PHSKC conducts patient satisfaction surveys.
- We need a common definition of "primary care" so everyone is on the same page. For some, PC may include WIC, family planning, maternal support services, etc, and we need to consider whether SN providers should provide these services as to make the SN less fractured. Currently, there are too many "entry" points in the system, which creates "lost efficiency" in patient care, and spreads the system too thin. We - the SN - need to prioritize "owners" of patients.

PHSKC's evolving role

- PH should phase out/step away from its primary care services - carefully, to assure that there is capacity to provide the care, and not to jeopardize PH's FQHC status for its other personal health and categorical PH clinical services. There needs to be a more in depth assessment of the current clients served by PH to see if there is duplication and to plan for a transition to other providers.
- Recommendation to shift primary care to CHCs if analysis determines that they could do it more cost effectively. This is public money - need biggest bang for the buck. They could potentially do this without loss of capacity. (Concerns were raised about Union/labor issues.)
- Need to assess capacity for other safety net providers to take on PH primary care clients. Need planning and collaboration with safety net providers and with the community. Look at work that was done to assess capacity when PH pulled out of pediatrics at Northshore and in King County. (Pull out of primary care.)
- Any transition of the department away from providing direct services should be gradual and predictable, so patients and staff can be transitioned, too. It can't happen overnight. Question about whether MSS and WIC can continue without the department having FQHC status.
- PH has an important role to play in serving (or assuring access to care) for hard-to-serve, vulnerable populations (maternal-child health, schools, etc.) PH can provide support to other safety net primary care providers - wrap around/public health services, Child Profile, etc.

- Get the hard questions out and on the table e.g.: “If PH’s FQHC goes away would WIC die?”
- Examine both the financial and cultural aspects of any system changes.
- Given the large number of insured patients receiving dental services, can the department play a more important role in providing dental care for adults?
- Also envision role for CHCs in some of the categorical services, though need to look at each service separately to figure out approach. E.g, TB is something PH should likely continue to do – very specialized, requires a centralized approach. It was acknowledged that PH services often “go the extra step” and that PH has strong role in follow-up (e.g, partner notification), so the table envisioned having partnerships with public health nurses working in conjunction with CHCs to continue that level/type of service.

1. Overall, was this a valuable use of your time? Please comment: YES (23)

- Important to know who is viewed as having a role in important decisions about the safety net.
- Thank you for including us in this stakeholder conversation.
- I think it is very important work that needs to be done.
- Necessary discussion.
- Great to hear others' thoughts and ideas.
- Great job. Thanks for sharing HD budget info. Useful step.
- Interesting to ponder these issues in a broader, systemic fashion. Useful experience.
- Safety net services are important enough that we should spend additional time to prove and expand system.
- The pre-readings were excellent and helpful to understanding the big issues facing the safety net.
- That depends on the outcome.
- Very much. It's about time we started this conversation.
- It was good to have everyone in the room. In the beginning it did not seem like the discussion was going to be new. It ended being very new and very relevant.
- Somewhat – I met some very smart and committed people.
- Discussion groups were valuable but questions could have been more focused.
- Definitely. Great opportunity to get together and discuss with stakeholders.
- Opportunity to hear ideas from “like-minded” people on how to better serve vulnerable population.
- It was good to have the players in the room. Excellent info from David Fleming to frame the crisis of provision.

2. Were there expectations you had for today that were not met? Critical topics that were not addressed? Please comment:

- This exceeded my expectations. Very well organized.
- Performance measures.
- I believe that, in some sense, the request to “suspend disbelief” about future funding for the system short circuits the real elephant in the room.
- 1st meeting; big, diverse group – so I had pretty low expectations for outcome. I was impressed that most of the critical issues were out on the table.
- We touched briefly on ability to draw down federal dollars, through FQHC, that can be applied to others. We need more explicit understanding of whether KC is maximizing federal and state matching funds/draw downs.
- Yes – I understand that this is a first step/not solving “world hunger.” Successful examples of other community collaboration in the U.S.
- More discussion of hard questions and bottom line financial realities. Some stakeholders were gone before this conversation started and elements of the first exercises could have been done in individual interviews earlier.

- Where will overall leadership for efforts to “re-invent” the safety net come from?
 - Items were addressed – next steps will be important to keep momentum.
- 3. Was there any key person or institutional representative you would suggest including as a participant?**
- Rayburn Lewis, Swedish
 - Board of Health
 - The State, i.e., Marianne Lindeblad
 - If we’re talking dental, get WA Dental Service Foundation and U.W. Dental School in the room.
 - Medicaid program
 - Families impacted
 - Education system
 - Community based organizations (e.g., Centro de la Raza)
 - Someone from DSHS
 - WSHA
- 4. What are the most important next steps?**
- Follow-through on our comments.
 - That there be some next steps.
 - Internal evaluation and define role of Public Health.
 - Keeping the momentum moving forward. Honoring participants’ input by making steps to define Dept. role.
 - Adult dental, youth dental prevention.
 - Synthesis, then DO.
 - Reconvening – assessment.
 - There is a need for impartial technical analysis – need to hire consultant to do this work.
 - Focus on selected geographical areas to rationalize the system.
 - Move forward with pilots, better/more assessment of populations we serve
 - PH needs to be the leader, convener.
 - Keep discussing some of these complex issues and their evolution.
 - Define a rational system of care and figure out how to fund.
 - Service delivery planning and rational, efficient allocation of resources for underserved (e.g., adult dental).
 - Pick a goal and do something.
 - Digest what we’ve done today. Reconvene and talk more.
 - Keep the dialogue going. Continue as transparently as possible.
 - Get the communities involved.
 - Low hanging fruit is not necessarily the first step to improving the efficiency and effectiveness of the safety net. Focus on the first step.

- Report out.
 - Individual follow up contact (phone or coffee).
 - Distribution of potential plan well before any final decisions are made.
 - I would like to see convening around a pilot effort, such as (and especially) high utilizers of ED – soon. Good momentum today – don't let it dissipate.
 - Building on the trust expressed by the tables for Public Health to take the leadership role.
5. **Are you willing to continue this work by participating in a work group over the next two to three months?**
- Yes – 22
 - Depending on time constraints.
6. **Are you willing to reconvene for another half day to hear the results of the workgroup and provide further direction for this work?**
- Yes - 23
7. **Anything else you'd like to share?**
- Many of the report outs appeared to present impressions of the participants involved but many of us closer to the work know otherwise in certain cases. My assumption is that this will become apparent in the vetting of next steps.
 - Thanks for water and healthy snacks (as well as candy).
 - Good start. Moving toward transparent exchange.
 - I enjoyed the meeting.
 - After a long period of no visible action, good to finally be getting to honest, open conversation. Thanks for the leadership!
 - I truly appreciate David Fleming's candor and willingness to explore all options.
 - Well organized meeting.
 - Good information, process.
 - Thanks for your leadership!
 - We have resources that are not spent wisely and could be used for the safety net.
 - Specialty access will not improve without enhanced reimbursement.
 - Lots of talented, motivated folks in the room.
 - Well conceived and executed meeting!
 - Kudos to the group for getting the hard issues on the table.

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