Chair

King County

Kurt Triplett
King County Executive
401 Fifth Avenue, Suite 800
Seattle, WA 98104-1818
206-263-9600 Fax 206-296-0194
TTY Relay: 711
www.kingcounty.gov

The Honorable Dow Constantine
Chair, King County Council
Room 1200
COURTHOUSE

August 12, 2009

Dear Councilmember Constantine:

Enclosed is the Seattle-King County Department of Public Health's response to 2009 King County Budget Act, Ordinance 16312, Section 92, Proviso P-5, which reads:

> Of this appropriation, $100,000 shall only be expended or encumbered if, by January 31, 2009, the department of public health submits to the King County board of health and the King County council a 2009 health provision work plan. The health provision work plan shall include the scope and schedule for activities and deliverables in 2009 for accelerating the implementation of the adopted public health operational master plan strategies for health provision. Due to the ongoing public health structural financial crisis and the county's general fund challenge, the council finds that the current model for delivery of health provision services offered through the county's public health centers is not financially sustainable in the near term. Further, opportunities exist to achieve improved and more equitable health outcomes by coordinating with other community providers to produce a more effective system of health care. Therefore, the work plan shall include as a primary deliverable the transmittal to the council by July 15, 2009, of any financially viable options that would be proposed for implementation in 2010 for restructuring the delivery of health provision services through the public health centers, including family planning as referenced in Proviso P-4 of section 92 of this ordinance. The work plan shall also include specific recommendations for a process to engage the community in the development of these options, including a recommended schedule for a series of briefings to the council in the first half of 2009.

The enclosed report is responsive to this proviso, and describes three over-arching goals for the structuring of health services through the public health centers in 2010:

1) Support the implementation of the Public Health Operational Master Plan (PHOMP) health provision strategies concerning the design of the overall health safety net.

2) Develop an approach that provides for long term predictability, scalability, flexibility, and effective service delivery in county public health centers.
3) Identify additional guiding principles to guide the public health center 2010 budget decisions.

The proposed approach for restructuring health provision services through the public health centers is two-fold. First, a new public health center funding approach has been developed wherein infrastructure costs are separated from program costs and General Fund is used to cover only infrastructure costs. This creates predictability and transparency in the budget process, is scalable in response to available funds, ensures greater efficiency in the operation of the centers, and provides flexibility to respond to changing population needs and opportunities. Second, and because the new funding model does not solve the financial challenge in and of itself, guiding principles for budgetary decision making concerning the public health centers in 2010, including prioritizing population need, geographic access, additional efficiencies, and partnerships which will maintain and/or improve services to clients, are proposed.

At the time of transmittal of this proviso response, the county still faces uncertainty concerning available resources for 2010 with respect to the centers and the programs they house. The department expects to continue working closely with County Council staff and the Law, Justice, Health and Human Services Committee to refine and apply this model and the guiding principles to 2010 budget decisions. My 2010 recommended budget will reflect application of the funding model and these principles.

Sincerely,

Kurt Triplett
King County Executive

Enclosures

cc: King County Councilmembers
ATTN: Tom Bristow, Interim Chief of Staff
Saroja Reddy, Policy Staff Director
Anne Noris, Clerk of the Council
Frank Abe, Communications Director
Bob Cowan, Director, Office of Management and Budget (OMB)
Beth Goldberg, Deputy Director, OMB
David Fleming, Director, Seattle-King County Department of Public Health (DPH)
Kathie Huus, Chief of Staff, DPH
Dorothy Teeter, Chief of Health Operations, DPH
Benjamin Leifer, Chief Administrative Officer, DPH
Connie Griffith, Chief Financial Officer, DPH

2009 Public Health-Seattle & King County Proviso P5 Response

This proviso response is submitted in accordance with Section 92, Proviso P-5 of the 2009 King County Adopted Budget, Ordinance 16312, and provides the King County Council with a proposed approach for structuring the delivery of health provision services through the public health centers in 2010. The department's approach to structuring the delivery of services through the public health centers and in identifying our share of General Fund reduction options for the 2010 budget is three-fold: 1) support the implementation of the Public Health Operational Master Plan (PHOMP) health provision strategies concerning the design of the overall health safety net; 2) change and clarify the funding model for the public health centers and 3) develop additional principles to guide the public health center budget decisions needed to achieve this overall target reduction. These approaches are outlined in further detail in this proviso response.

An overarching principle of this work has and will continue to be close and open collaboration with the council and council staff in all aspects of this process. At the time of transmittal of this proviso response, the county still faces uncertainty concerning available resources for 2010 with respect to the centers and the programs they house. The department will continue working closely with County Council staff and the Law, Justice, Health and Human Services Committee (LJHHS) to refine and apply this model and the guiding principles to 2010 budget decisions. The 2010 recommended budget submittal for the public health centers will reflect the funding model and use of the additional guiding principles.

Background

Public Health is a mandated service for the residents of King County. Since elimination in 2001 of motor vehicle excise tax revenues that were dedicated for public health, the county has experienced a significant challenge in meeting the goal of public health to protect and improve the health and well-being of all people in King County and to reduce disparities in health that are experienced by different populations. This challenge is exacerbated by the increasing need for public health services due to resurgence of communicable diseases such as tuberculosis and new threats such as the H1N1 influenza, and the increasing number of people who completely lack or have inadequate health insurance and other demands. In the past few years, the county met this challenge through efficiencies and reductions in public health expenditures and by increasing the county's general fund contribution to public health, from about $15 million in 2001 to $32 million in 2008. To meet the ongoing public health financial shortfall in 2009, the adopted budget made $16.4 million in program reductions, many of which are efficiencies identified through the implementation of the PHOMP, a strategic plan adopted by the county council in 2007.

The financial outlook for the county General Fund in 2010 continues to be dire. The King County Board of Health, by Resolution 08-07, called on the State Legislature to provide adequate, stable, dedicated, long-term financing for public health and found that the risks to the health of the public as a result of the lack of financing are significant and unacceptable. The State Legislature's Joint Select Committee on Public Health Finance likewise concluded that the local public health system in the state is underfunded by more than $300 million annually and that the lack of a stable, dedicated source of funding for public health has eroded the ability to maintain a reliable statewide system that protects the public's health.

In light of the public health funding crisis and the growing pressures on the county General Fund, the 2009 adopted budget included a public health proviso concerning the public health centers. 2009 King County Budget Act, Ordinance 16312, Section 92, Proviso P-5 reads:

> Of this appropriation, $100,000 shall only be expended or encumbered if, by January 31, 2009, the department of public health submits to the King County board of health and the King County council a 2009 health provision work plan. The health provision work plan shall include the scope and schedule for activities and deliverables in 2009 for accelerating the implementation of the adopted public health operational master plan strategies for health provision. Due to the ongoing public health structural financial crisis and the county's general fund challenge, the council finds that the current model for delivery of health provision services offered through the county's public health centers is not financially sustainable in the near term. Further, opportunities exist to achieve improved and more equitable health outcomes by coordinating with other community providers to produce a more effective system of health care. Therefore, the work plan shall include as a primary deliverable the transmittal to the council by July 15, 2009, of any financially viable options that would be proposed for implementation in 2010 for restructuring the delivery of health provision services through the public health centers, including family planning as referenced in Proviso P-4 of section 92 of this ordinance. The work plan shall also include specific recommendations for a process to engage the community in the development of these options, including a recommended schedule for a series of briefings to the council in the first half of 2009.

The Law, Justice, Health & Human Services Committee of the King County Council has received monthly briefings related to this proviso since February of 2009. Key points from these briefings follow.

<u>There is insufficient capacity in the health safety net to meet the current and growing demand.</u> The population in need of health safety net services includes the uninsured, underinsured, and Medicaid insured population, and is estimated at 635,000 people or about one-third of King County's population. This population is increasing and over the next year the demand for health safety net services is likely to rise. The financial crisis has hit all parts of the health safety net, and all organizations are struggling just to maintain current levels of service.

The PHOMP defines public health's role in the provision of personal health services to include direct provision of services when there are important reasons to do so. The public health centers serve primarily low-income women and their young children, and vulnerable adults, including uninsured clients who are homeless and/or have complex, dual diagnoses and who do not have the skills to navigate the health care system. For some services, Public Health is the only provider. At a time when the entire health safety net is in crisis and the population in need is growing, the county's responsibility is to provide direct services while advocating for changes that will assure coverage and access for all.

Capacity in the health safety net is also tied to having sufficient numbers of primary care providers. An established and growing role of Public Health is to facilitate the pipeline of future providers through physician residency programs at the public health centers.

Public Health services are complementary to other health safety net providers.
The public health centers deliver services to roughly the same number of users as the Community Health Centers (CHC) and Harborview clinics combined (about 130,000 users each), but the services provided are complementary, not duplicative. All of the users at the CHCs and Harborview Clinics receive comprehensive primary care services. In contrast, 13 percent of users (17,000 users) at Public Health Clinics (PHC) receive comprehensive primary care while the large majority – 87 percent or 110,000 users – receives categorical services targeted at low-income women and their young children: Family & Maternal Support Services (MSS), Women, Infants and Children (WIC) nutrition programs, and Family Planning. An overarching goal of this proviso response is to ensure continued service to the public health center clients, many of whom would not have access to these services otherwise. (See Attachment A Pie Charts of clients served by the Seattle-King County Department of Public Health (DPH), CHCs, Planned Parenthood, and other in MSS, WIC, Family Planning, and Primary Care).

All parts of the health safety net are financially challenged. Because of the financial challenges and differences in service delivery, if budget reductions require the county to cut services at PHCs, the rest of the system will not be able to fill this gap.

The public health centers and their staff are critical components of Public Health Preparedness and Response. Staff in the public health centers are key to the county's mass vaccination and mass dispensing operations, medical needs sheltering capacity, alternative care facility staffing, and the county's surge capacity for disease surveillance and investigation. The public health centers play a key role in ensuring important medications, such as H1N1 anti-virals are available to vulnerable populations, and serve as critical providers of information nodes an emergency by responding to inquiries and providing communications in multiple languages.

[These topics were presented at the *February 24, 2009 LJHHS Committee meeting, briefing #2009-B004, March 24, 2009 LJHHS Committee meeting, briefing #2009-B0080, and the April 28, 2009 LJHHS Committee meeting, briefing #200—B0110]*

Context

Public Health Operational Master Plan

The text of the budget proviso affirms the goals and strategies of the Public Health Operational Master Plan, adopted in October of 2007, by the county and Board of Health ("Board").[1] The PHOMP establishes that

> King County's role in personal health care services is to help assure access to high quality health care for all populations and to fulfill

[1] http://www.metrokc.gov/exec/publichealthmasterplan/docs/FinalPublicHealthOMP20070906.pdf

> critical public health responsibilities such as preventing the spread of communicable diseases. Helping to assure access to quality health care includes convening and leading system-wide efforts to improve access and quality, advocating for access to quality health care for all, forming partnerships with services providers, and/or directly providing individual health services when there are important public health reasons to do so.

The PHOMP includes long-term and four-year goals for health provision:

> Long-term Goal: Increase the number of healthy years lived by people in King County and eliminate health disparities through access to affordable, appropriate, and quality health care services.
>
> 2008-2012 Goal: Increase access to affordable, quality health care through convening and leading the development and implementation of improved community strategies to provide services.

To achieve these goals, the PHOMP sets forth four-year health provision strategies in the areas of assessment (defining the problems), policy development (defining the solutions) and assurance (implementing the solutions). Strategies relevant to assuring access to care include:

- Convening of the local health care payor, provider, and consumer community to create a vision and identify local strategies for more cost-effective use of health care resources and improved health care access.
- Actively engaging with core safety net providers, including community health centers, to increase collaboration and identify methods to improve planning, efficiency and integration.
- Determining, in concert with the above strategies, the appropriate role of DPH in the direct provision of health care services.
- Improving the quality and cost-effectiveness of key health services delivered directly by DPH.

The department has been actively engaged with members of the core health safety net in the implementation of these strategies. In early 2008, the department convened a large group of health safety net providers to begin implementation of the PHOMP strategies. This meeting produced four areas of focus for health safety net planning and improvement: access to specialty care, mental health and substance abuse treatment integration with primary care, information technology inter-operability, and future complementary roles in the system. Workgroups were chartered in each of these areas, each co-chaired by a department leader and a community leader. With the exception of access to specialty care, which has evolved into a pilot project, the planning work of these groups continues. In addition, as the financial strain on the community and public health care sector grew to crisis proportions in late 2008 and early 2009, the focus of the future complementary roles worked broadened to include collaborating on advocacy for a long-term stable public health funding source and for health

reform, at both the state and federal levels. This work will continue in 2010 with the anticipated addition of a facilities master plan for the DPH.

Proviso Goals and Response

Three over-arching goals guide this proviso response for the structuring of health services through the public health centers in 2010:

1) Support the implementation of the PHOMP health provision strategies concerning the design of the overall health safety net.
2) Develop an approach that provides for long term predictability, scalability, flexibility, and effective service delivery in county public health centers.
3) Identify additional guiding principles to guide the public health center 2010 budget decisions.

1) Support the implementation of the PHOMP health provision strategies concerning the design of the health safety net.

In early 2008 the department convened a large group of health safety net providers to begin implementation of the PHOMP strategies. This meeting produced four areas of focus for health safety net planning and improvement: access to specialty care, mental health and substance abuse integration with primary care, information technology inter-operability, and future complementary roles in the system.

The work concerning future complementary roles in the health safety net is related to this proviso response and therefore provides an important context for this work. The department met several times with Executive Directors, Medical Directors, and Dental Directors of core health safety net providers to begin defining the future design of the safety net as well as how safety net partners will work together. Health safety net goals, attributes, and guiding principles were developed and approved to guide this work. (See Attachment B) As the financial strain on the community and public health care sector grew to crisis proportions in late 2008 and early 2009, the focus of this work broadened to include collaborating on advocacy for a long-term stable public health funding source and for health reform, at both the state and federal levels. The department and health safety net partners continue to discuss opportunities to create system efficiencies now as we begin to build elements of the system attributes described above. In addition, this work will continue to evolve in 2010, as the county undertakes a facilities master plan related to the health safety net.

2) Implement a change in the basic Center funding model that provides for predictability, scalability, flexibility, and effective service delivery.

As a primary guiding principle for county financing of public health centers, the department proposes a new financial model for the public health centers for 2010 that provides for predictability, scalability, flexibility, and effective service delivery. This budget approach assigns General Fund to core infrastructure of the public health centers, and assigns program revenues to program costs. The role of county funding in this model is to provide the

foundation upon which public health programs can be delivered. The department developed this model by assigning certain types of costs (e.g., facility based costs, departmental infrastructure such as IT and human resources) to an infrastructure category and program costs (e.g., employees, supplies) to a program category (see Attachment C for a complete break-down of the categories.) While the model in and of itself does not solve the financial challenges associated with the public health centers, it provides a financial planning approach that meets the county's needs for predictability, scalability, flexibility, and effective service delivery:

Predictability. ***A more strategic, transparent, and defined role for County financing is provided.***

The county's General Fund contribution has been used each year to plug financial gaps in service delivery which have grown significantly and unpredictably over time. The current structure of the budget combines direct program costs with infrastructure. This creates an unpredictable level of General Fund needed each year, creates challenges for budget planning and management accountability, and greatly complicates the development of options for the investment of General Fund resources.

The proposed funding approach provides the county with more predictable year-to-year of annual costs for budgeting purposes. The approach not only provides increased budget transparency, but is also helpful in clarifying options to address or mitigate financing challenges. The model will allow policy makers to make intentional policy decisions regarding financing of centers and programs and investment of General Fund resources that are difficult to examine with the current model.

Scalability. ***Because of uncertainty regarding the revenues that will be available in the next year to support public health centers, the 2010 budget for public health centers will be scalable to funds available.***

Uncertainty currently exists regarding the amount of revenue that will be available in the next year to support the public health centers. The approach provides scalability because the General Fund is not distributed to programs, but rather to centers. Once the amount of flexible funds to support public health centers in 2010 is known, the county can determine how many centers it is able to support.

Flexibility. ***An approach is provided that allows the county to balance the budget in the short-term while preserving flexibility and core capabilities over the long term.***

Uncertainty also exists regarding what our health system will look like over the longer term and what revenues will be available to support it. Further, our population's health needs will continue to evolve. This approach provides flexibility because General Fund dollars are invested in supporting the infrastructure for public health centers. Should needs change or opportunities arise to reconfigure services at a center to better respond to the community's needs, the department will be able to move forward in a timely manner.

Effective Service Delivery. ***County funds will be leveraged in a way that maximizes effective and efficient service delivery through the public health centers.***

The county lacks sufficient resources to meet the current, much less growing, demand for services in the health safety net. The current budget approach of cutting General Funds to public health programs in the centers without reducing the number of centers results in a dilution of services and less efficient centers. In the proposed approach for 2010, any cuts to General Fund are made to entire centers instead of across all centers, leaving the remaining centers whole in terms of efficiency and effectiveness of service delivery.

[This approach was presented at the March 24, 2009 LJHHS Committee meeting, briefing #2009-B0080, and the April 28, 2009 LJHHS Committee meeting, briefing #200—B0110]

3) Develop additional principles for public health center budget decisions in the 2010 Budget

The public health center funding model described above offers a solid platform for decision making concerning the public health centers and the 2010 budget. However, the model does not, by itself, solve the financial challenge. To further assist in decisions about budget reductions, the department consulted with core health safety net partners and City of Seattle and council staff to develop the following five additional principles for decision making concerning the public health centers in the 2010 budget:

1) Continue development and implementation of efficiencies to improve the cost-effectiveness of services,
2) Enhance partnerships with community-based providers and organizations,
3) Use clinical services revenue to backfill infrastructure gap,
4) Tailor services to population need, and
5) Assure continued geographic access.

Continue development and implementation of efficiencies to improve the cost-effectiveness of services.

The PHOMP four-year Health Provision Assurance strategy includes improving the quality and cost-effectiveness of key health services delivered directly by the department. In 2009, the department began implementation of several efficiencies, reducing the structural gap in the provision of these services by over $2 million. Examples of efficiency work in 2009 include technology investments such as communication equipment installed at each service point allowing for a reduction in the use of agency interpreters, business process streamlining such as standardization of paperwork and exam rooms and realigning capacity with service demand, and staffing model changes such as a move to use of community health workers to provide Family Support Services thus allowing nurses to spend more time on activities requiring their skills. (See Attachment D for additional examples of efficiencies implemented in 2009).

In 2010, the department expects will continue to implement and extend such efficiencies. In particular, we will limit center infrastructure costs by:

- Vacating space that is in poor condition or inefficiently configured.
- Maximizing use of remaining space for personnel and delivery of services.
- Continued redesign and standardization of clinical and business processes.

Enhance partnerships with community-based providers and organizations
Partnerships can be used to increase efficiency, improve service delivery, and create linkages in the health safety net, by:

- Strategically co-locating public health programs with community partners. Share space and costs among public health centers, community medical providers and other social service providers.
- Using centers as sites for training health care professionals or for the delivery of other public health and community interventions.
- Implementing mutually beneficial safety net system efficiencies (e.g., referral management, interpretation services).

The department has a long history of partnerships and collaboration within the county aimed at increasing access to services, improving health outcomes, and increasing efficiency of service delivery. Examples of current provision-related partnerships are provided in Attachment E.

Use clinical services revenue to backfill infrastructure gap:

In the new funding model, county funding covers infrastructure costs and program service delivery revenue covers program service costs. Currently available information regarding reimbursement for the public health clinical services we project providing in 2010 suggests these program revenues may be greater than program expenses. While over the long-term it would be ideal to invest any excess program revenue in additional uncompensated service delivery, in 2010 we will use excess revenue as a source of backfill for lack of county General Fund for center infrastructure, as we pursue additional partnerships and efficiencies to reduce infrastructure costs that can be implemented in 2011.

Tailor services to population need:

Prioritize access to services for target populations, particularly low income women and their young children, and vulnerable adults (including low-income and homeless clients who may have complex, dual diagnoses, limited English proficiency and lack the skills to navigate the health care system). In this context we will continue the process begun in 2009 of examining the value and cost of offering stand alone immunization services as a public health center function.

Assure continued geographic access:
Ensure sites are balanced geographically across the county where population need is documented. (See Attachment F for maps depicting target populations and PHC sites).

- The public health centers are fairly evenly distributed throughout the urban area of the county.
- All sites offer Family Support Services (FSS) and Women Infants and Children (WIC) services that serve low-income women and their young children. All but one site (Downtown) offers Family Planning. Primary Care and Oral Health are each offered at five centers, with access distributed throughout the County.
- The number of clients ranges from 9,000 to about 23,000. Most sites have around 15,000 to 17,000 clients.
- The number of visits ranges from 23,000 to 54,000. Most sites handle around 40,000 visits.

Conclusion

At the time of transmittal of this proviso response, the county still faces uncertainty concerning available resources for 2010 with respect to the centers and the programs they house. The department will to continue work closely with council staff and the LJHHS Committee to refine and apply this model and the guiding principles to 2010 budget decisions. Department staff are available to brief Councilmembers individually or collectively as more information about funding and the 2010 budget becomes available. The 2010 recommended budget submittal for the public health centers will reflect the funding model and the guiding principles.

Attachments:

A. Health Safety Net Services Pie Charts
B. 2008 Health Safety Net Goals, Attributes and Guiding Principles
C. Public Health Center Funding model categories
D. 2009 Operational Efficiency Examples
E. Public Health – Seattle & King County Partnership Examples
F. Public Health Center Target Population Maps

2009 Proviso P5 Response Attachment B: 2008 Health Safety Net Goals, Attributes, and Guiding Principles

Goals

- Health equity and reduced health disparities.
- System capacity to meet demands for care.
- Effective and efficient care.
- Strong leadership and organizational alignment.
- Financial health of the system and individual organizations.

Attributes

- Organizational roles based on areas of expertise.
- Delivery of care based on a health care home model.
- System efficiencies gained by collaborating in areas such as pharmacy, lab, interpretation services, and efforts to reduce inappropriate Emergency Department (ED) use.
- IT systems support the above.

Guiding Principles

- **Patients First** Commit to a common purpose of working in the patients' best interests; ensure that current patients will not be harmed by the process or outcomes.
- **Transparency** Share and use data to support claims and conclusions (capacity, costs, etc.), as well as measuring progress against goals. Put all financial cards on the table. Communicate openly about the process.
- **Good Faith** Engage in honest dialogue, and work to understand each others' perspectives. Keep organizations in the loop; avoid surprises and surface obstacles early.
- **Safety** Respect confidentiality of discussions except as otherwise agreed. No taboo subjects. Create ability to ask for, get, and give help. Offer a neutral conflict resolution mechanism.
- **Respect** Demonstrate respect and compassion towards patients, each other, and staff in all organizations. Communicate uniformly to staff.
- **Community Involvement** Include the voice of patients and staff in the process.

2009 Proviso P5 Response Attachment C: Public Health Center Funding Model Categories

Cost Category	Costs Included
Program Costs/Direct:	▪ Salaries and benefits ▪ Training ▪ Supplies ▪ Cars/transportation ▪ Quality, Practice and Programs and Program support ▪ Pharmacy
Program Costs/Shared Operational:	▪ Center staff required to support all services (staff are not dedicated to specific programs) ▪ Centralized operational staff required to manage, provide oversight, and support all public health (PH) center operations ▪ Float pool coordination and training ▪ Interpretation
Infrastructure/Facilities Costs: Building-related costs	▪ Telephones ▪ Rent, leases, facilities maintenance and management ▪ Equipment repair and maintenance ▪ Electronic Data Processing equipment ▪ Copy machines, furniture
Infrastructure/Distributed Costs: All overhead, minimum staffing required to operate any type of services in a PH center.	▪ King County Overhead ▪ Department Overhead ▪ Division Overhead (Division Manager, Deputy Manager, Finance Manager, other admin staff) ▪ Basic facility staffing (1 PHSS, 1 ASII receptionist, 1 ASIII records management)

2009 Proviso P5 Response Attachment D: 2009 PH Centers Operational Efficiencies Examples

	Strategy Type			Status	Outcomes
	Technology	Business Process Streamlining	Staffing Model Changes		
Interpretation Services	X	X	X	1) Centralized scheduling of backfill and Short Term Temporarys (STT) interpreter time. 2) New protocols and procedures for use of telephonic interpretation have been developed and implemented 3) Essential communication equipment and devices installed at every service point.	• Significant reduction in use of in-person agency interpreters and the use of (STT) interpreters. • Increased proportion of interpretation visits via the telephone. • Interpreters scheduled more efficiently, thus saving time and money at the public health centers (PHC). • Anticipate centralizing this portion of interpretation services by September 2009. • Expenditure reduction: $214,391
Dental Clinic Changes		X		1. Reconfigured and added one clinical day at the Renton Clinic to match demand. 2. Now including productivity goals in performance evaluations; 3. Increased appointment availability for high demand procedures; 4. Instituted flexibility within Dental Teams to cover each other when one team runs behind;and 5. Standardized clinical documentation	• Expenditure reduction: 131,689 • # patient visits up • Patient-generated revenue increased • Productivity increased
WIC		X		• Partnership with Swedish established; implementation of shared model underway. • Federal govt. increased caseload 4/1; currently expanding services to increase # clients served and increase revenues collected. .	Expenditure reduction: $135,659

2009 Proviso P5 Response Attachment D: 2009 PH Centers Operational Efficiencies Examples

	Strategy Type			Status	Outcomes
	Technology	Business Process Streamlining	Staffing Model Changes		
MSS/Infant Case Management			X	1. Created community health worker roles (job title of education specialist). 2. Hired in two waves; many of the new staff came from existing PH positions and have language skills and cultural experience that match our clients. 3. Centralized training; now in the process of meeting the initial competencies so their services can be billed to Medicaid. 4. Each site has developed an implementation plan for the new workers, with the ones who have already implemented sharing their lessons learned with those in the second wave.	• The Community Health Workers (CHW) have just begun to bill for services, so the fiscal impact of this change is not yet proven. Based on estimates, the average cost per visit will have declined from $140 to $120 when the model is fully implemented. • Revenue change expected: $1,502,462
North PHC Efficiencies		X		The following strategies are currently underway at the North PHC: 1. Enrollment process now includes increased use of Public Health Patient Cards; 2. Improving access to "Well Child Checks" through reminder letters and postcards; 3. Providing direct access to Client Services Specialists (CSS) for off-site dental patients; 4. Using Client Services Specialists Signature Codes for Insurance Status; 5. Increasing timely encounter form data entry; 6. Increasing number of patients assigned to a Primary Care Provider; and 7. Maximizing Dental Appointment scheduling.	• Comparison of Encounter Data entry for January – April 2008 and 2009 shows an increase of approximately 30% in Family Health and 35% in Family Planning. • Project is still in design phase; too early to determine budget savings.

2009 Proviso P5 Response Attachment D: 2009 PH Centers Operational Efficiencies Examples

	Strategy Type			Status	Outcomes
	Technology	Business Process Streamlining	Staffing Model Changes		
Eastgate PHC Efficiencies	X	X	X	The following strategies are currently underway at the Eastgate PHC: 1. Established teams of a defined provider, registered nurse (RN) and medical assistant assigned to provide care for a defined panel of patients; 2. Implemented daily team "huddles" to plan care; 3. Implemented an automatic interface with the lab for easy automated access to lab; and 4. Standardized exam rooms to decrease wasted time looking for equipment and supplies.	• Simplified and increased efficiency of scheduling newborn visits and interpreted visits. • Eliminated use of RN for adding on patients with urgent same day needs. • Increased number of patients seen throughout week by staggering provider schedules. • Decreased need for RN phone triage, allowing nurses to spend more time on patient education, assisting providers, and follow up care management. • Early estimates indicate a 10% increase in patient panel size as a consequence of a 5% increase in provider productivity. While these increases do not necessarily result directly in increases in patient generated revenue (over 60% of Eastgate's adult patient visits are uninsured), these efficiencies result in greater access and improved quality of care for the community.

2009 Proviso P5 Response Attachment D: 2009 PH Centers Operational Efficiencies Examples

	Strategy Type			Status	Outcomes
	Technology	Business Process Streamlining	Staffing Model Changes		
Family Planning		X	X	The following strategies have been implemented: 1. Expanded access to family planning services to adults during morning hours of operation at the Kent Teen Clinic; 2. Re-aligned capacity with demand at all family planning clinics through staffing changes; and 3. Increased the number of clients approved for Take Charge or Medicaid coverage.	• Salary savings achieved by assigning nurse practitioners to more than one clinic and holding nurse practitioner vacancies open. • Increased clinic efficiency and access through Implementation of standardized work hours across all five days per week. • An assessment of the Take Charge application process is currently underway, and we expect to identify and implement best practice system-wide by the end of June 2009. • Take Charge revenues appear to be on track to exceed budget based on year to date collections. • Any increase in client volume means that the system is working more efficiently, but it is too early to quantify any increase in revenue as a result of this change. However we estimate the following savings: - $90,000 Kent Teen Clinic serving adult clients (revenue) - $175,000 savings from vacancies and improving clinic operations (expense) - $31,000 increased Take Charge and Medicaid billing (revenue)
Practice Management System/Electronic Health Record	X	X		1. Currently seeking county approval of an IT project to replace the current practice management system. 2. Leveraging federal stimulus funds and loans to fund project.	Budgeted savings: No savings are budgeted for 2010. Typically, savings occur two years or more after the implementation of the systems, as is now occurring with the Jail Health System Electronic Health Records. Full implementation is anticipated in 2012.

The following are examples of the Seattle-King County Department of Public Health's (DPH) partnerships and collaboration within the county aimed at increasing access to services, improving health outcomes, and increasing efficiency of service delivery. A more detailed catalogue of these partnerships is available upon request.

1) Public Health Center-based partnerships, including:
   - Medical residency partnerships with Virginia Mason, Swedish, Children's, and the University of Washington. The Virginia Mason Residency at the Eastgate Public Health Center was mentioned as a "best practice" for public/private partnerships at the Eastside Human Services Forum (June 2009).
   - Clinical services partnerships such as those between the department and the University of Washington, where the UW provides obstetrics care to low-income women and public health provides public health nurse case management and home visiting services, Maternity Support Services and Women Infants and Children (WIC).
   - Human services partnerships in which public health centers partner with human services providers in each community served by the centers. One example is the White Center Early Learning Initiative, a 10 year initiative supported by Thrive by Five and the Gates Foundation, in which the department is one of three partners and oversees the Home Visiting components of the initiative. Another example is MOMs Plus, a collaboration between the department, the King County Jail, Washington State Department of Corrections, Drug/Mental Health Court, local hospitals, treatment centers, shelters and transitional housing. The department provides nursing evaluation and services to high risk women and their families who are pregnant and/or parenting with co-existing issues of incarceration, homelessness, drug and alcohol use/abuse, and mental illness. A third example is emergency food distribution to clients in need through the public health centers.

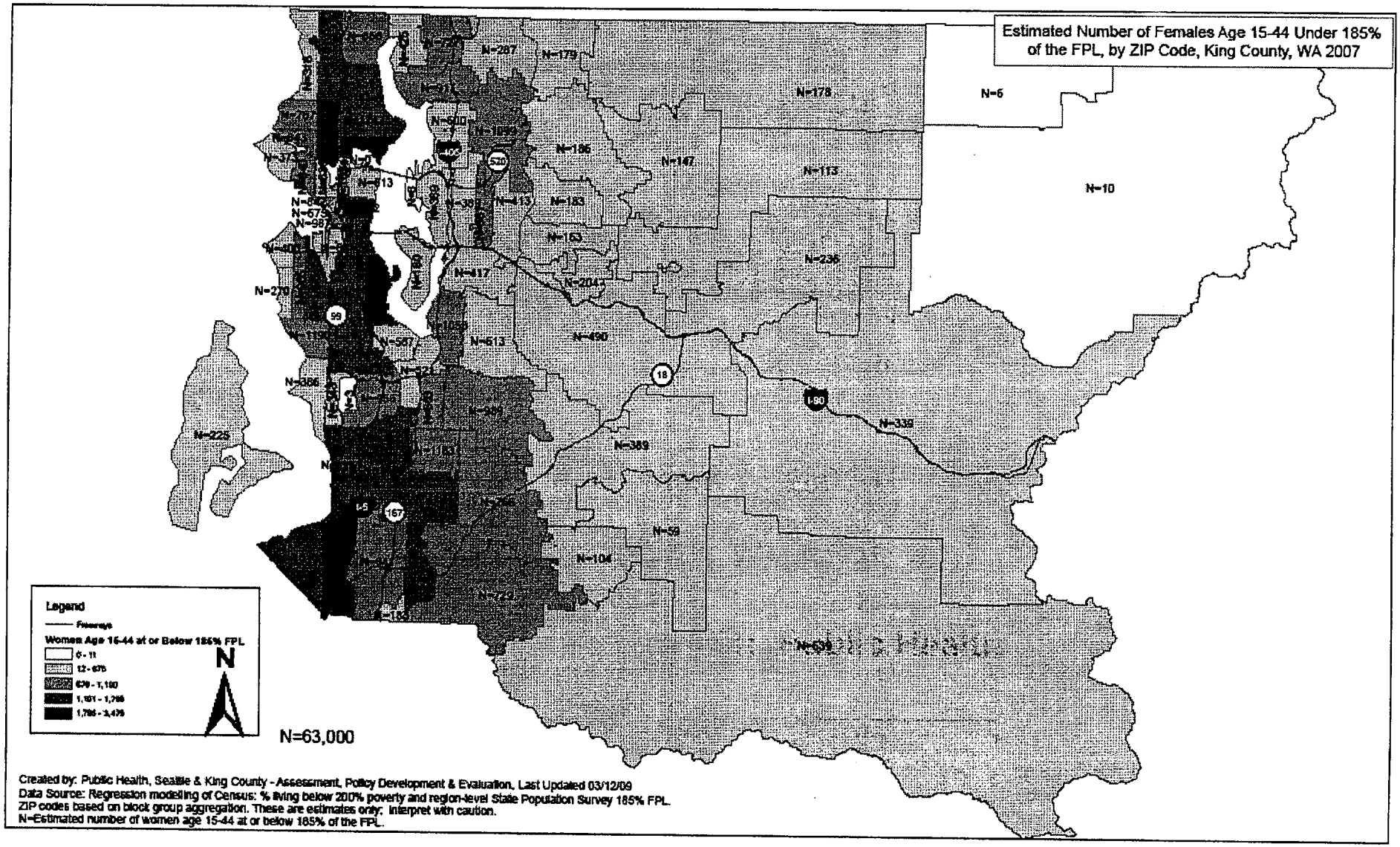
2) Population Health Focused partnerships, including:
   - Public Health Nurse/Community Service Office partnerships in which public health nurses are located in King County Community Service Offices and provide birth control education and risk reduction counseling, pregnancy tests with linkage and referrals, provision of condoms and emergency contraception, and referrals to family planning and other needed services.
   - Infant Mortality Prevention in which the department partners with the Center for Multicultural Health, Seattle Indian Health Board, El Centro de la Raza and YWCA to reach low income women of childbearing age in minority communities to promote linkage into health care before, during, and after pregnancy. The department helped form the Equal Start Coalition that is working on strategies to improve the health of childbearing aged women to reduce infant morality.
   - The department's Health Care for the Homeless Network collaborates with eleven community-based partner agencies to fund and send care providers to

work with homeless people in over 60 locations throughout King County, including selected shelters, day centers, transitional housing programs, faith-based programs, and clinics. Interdisciplinary, interagency teams provide a broad range of medical, mental health, substance abuse, case management, and health access services. Departmental staff assess needs across the homeless programs, work with community partners to determine where to site services, organize trainings on best practices, develop new programs in response to unmet needs, and facilitate safe and effective relationships between health care teams and the homeless agencies.

- Release Planning Partnership in which the Public Health Jail Health Services Release Planners and Criminal Justice Initiative (CJI)-funded Criminal Justice Liaisons partner to provide comprehensive release planning services for inmates of the King County Correctional Facility and the Maleng Regional Justice Center with serious mental illness and those with serious mental illness and co-occurring substance abuse and medical problems.

3) Health System Integration and Improvement Partnerships, including:
   - The Puget Sound Health Alliance, a regional partnership involving employers, physicians, hospitals, patients, health plans, and others working together to improve quality and efficiency while reducing the rate of health care costs increases.
   - The Mental Health/Substance Abuse/Primary Care Integration Committee, co-chaired by the department and King County Department of Community and Human Services –Mental Health, and Chemical Abuse and Dependency Services (DCHS-MHCADS) to promote the expansion of collaborative, integrated care models in the health safety net.
   - The Partnership for Health Improvement Through Shared Information (PHISI), convened by the department to improve real time care coordination and population health through the development of a King County safety net health information exchange.
   - The King County Healthcare Coalition, a network of healthcare organizations and providers that are committed to coordinating their emergency preparedness and response activities.
   - The King County Health Action Plan (KCHAP), a public-private partnership with DPH and approximately three dozen collaborating members. The mission of the KCHAP is to implement collaborative policy development and pilot projects that focus on system change and improvements of worsening health trends affecting vulnerable populations within King County.

2009 Proviso P5 Response Attachment F1: Public Health Target Populations



2009 Proviso P5 Response Attachment F2: Public Health Target Populations