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Introduced By: Larry Gossett

Proposed No.: **1999-0316**

1 MOTION NO. **10721**

2 A MOTION approving the plan for monitoring and evaluating
3 the department of public health's implementation of the
4 primary care, safety net partnership in south King County

5 WHEREAS, the department of public health has entered into partnerships to
6 address the need to deliver primary care services in south King County, and
7 WHEREAS, these partnerships involve the department in providing support
8 services and in assuring that primary care is appropriately delivered to residents, while
9 other partner institutions actually provide the primary care service delivery, and
10 WHEREAS, these relationships hold promise for refining and clarifying the role of
11 public health in service delivery to client populations and promoting cooperative efforts
12 among key actors in the health care field, and
13 WHEREAS, these relationships present a number of potential issues in assuring
14 that the character of care provided to client populations, including provision of
15 interpretation services, respectful fee collection, pharmaceutical service access including
16 access to vitamins, minerals, and other nutritional supplements, as indicated by a provider,
17 and community input via a formally established advisory committee, is at levels sufficient
18 to address client needs, and

1 WHEREAS, the council has directed, through proviso in the 1999 county budget,
2 that the department of public health submit a plan for monitoring and evaluating the
3 implementation of the primary care safety net partnerships in south King County; and
4 WHEREAS, the plan being submitted for approval is a monitoring evaluation of
5 limited scope, and a long term outcome evaluation will require resources and expertise
6 currently unavailable;
7 NOW, THEREFORE, BE IT MOVED by the Council of King County:
8 The plan submitted by the department of public health for monitoring and
9 evaluating the implementation of primary care, safety net partnerships is hereby approved,
10 and
11 BE IT FURTHER MOVED, that the department of public health is directed to seek
12 external funding for a formal, comprehensive evaluation of the primary care, safety net
13 partnership initiative, to provide the council, the community and the agency needed
14 information to assess the efficacy of such a partnership relationship, and

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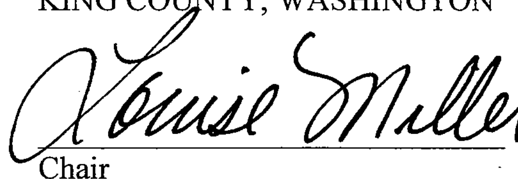
1 BE IT FURTHER MOVED, that the community advisory committee be established
2 as a systematic means of receiving community input on the primary care, safety net
3 partnership initiative with specific membership and defined meeting dates, and
4 BE IT FURTHER MOVED, that the King County council recommends that
5 vitamins, minerals, amino acids, enzymes and other nutritional supplements, as indicated
6 by the provider, be accessible for those who cannot afford them.
7 PASSED by a vote of ~~12~~ 11 to 0 this 6th day of July, 1999.

8 KING COUNTY COUNCIL
9 KING COUNTY, WASHINGTON



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11 Chair

12 ATTEST:

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14 Deputy Clerk of the Council

15 Attachments: Plan for Monitoring and Evaluating the Implementation of the New Primary
16 Care, Safety Net Partnerships in South King County

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Plan for Monitoring and Evaluation

Primary Care Safety-Net Partnerships in South King County

Introduction

The following plan focuses on monitoring and evaluating the implementation of the partnerships between Public Health and Highline Medical Enterprises and Public Health and Community Health Centers of King County. This is a process or implementation evaluation. It answers the questions:

- How is the partnership being implemented, what is in place, to what extent are Public Health and partner services being integrated?
- How are the partnerships addressing the interests and concerns of their communities and the King County Council?

Concurrently Public Health is in the process of defining the broader issue of primary care access and assurance in South King County, how we define it and evaluate its effectiveness.

The scope of this plan to monitor the implementation is necessarily limited by time and existing resources. We are seeking external resources to develop an outcome evaluation of the new public/private model of comprehensive primary care.

The following summarizes the partnership goals, objectives, performance measures and current status of implementation.

Partnership Goal

To develop partnerships with Highline Medical Enterprises, Public Health, Community Health Centers of King County in the South County communities they serve, assure comprehensive primary care for underserved populations in South King County.

Objective A: Implement the partnership through written memoranda.

Performance Measure: Signed MOB (Mutually Offsetting Benefit Agreement) in place.

Status: The MOB with Highline Medical Enterprises is in its final stages of revision. The agreement addresses the partnership between Highline Medical Enterprises and the Seattle-King County of Public Health and how the partnership will assure access to comprehensive primary care. The Council and the community

expressed particular concern about some specific issues which are addressed in the MOB Sections as follows:
Services: planned system of comprehensive care; availability of OB and pediatric specialty care; availability of interpretation services; one-stop shopping with public health services (WIC,MS/MSS, family planning, etc.) and primary care at the same place.
Access Support: insurance application support; sliding fee scale which slides to zero; no one denied services due to inability to pay; all services including specialty and pharmacy on sliding fee scale.
Feedback, Problem-solving: community input committee; systems /client advocate; joint operations team between public health and Highline Medical Enterprises.

The Health Department's existing contract with Community Health Centers of King County was not amended. It adequately addresses the assurance of access to medical and dental primary care for underserved populations.

Objective B: Monitor the progress of the partnership.

Performance Measure: Formal reports submitted to the Council on March 1, July 1 and October 1, 1999 (revised timelines).

Status: This plan for Monitoring and Evaluation of Primary Care Safety-Net Partnership in South King County was submitted March 1st and revised 3/16/99. Subsequent reports will be submitted to the Council on 7/1/99 and 10/1/99 (request for revised timelines). The reports will address the plan's objectives and following issues of concern to the Council and communities served:

- Level of integration of partner and Public Health services.
- Provision of safety-net for uninsured, not being turned away regardless of ability to pay.
- Access to medications regardless of ability to pay.
- Collection of fees for uninsured including donations.
- Comprehensive care provided, including specialty services and behavioral counseling/education.
- Access to interpretation services.
- Meaningful input from White Center community.

Performance Measure: Monthly written updates provided to all partners and community stakeholders.

Status: Updates are planned for the 2nd week of every month. The first update will be distributed March 19th.

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The monthly updates will include a summary of:

- Each partner site, its current operation and level of integration of Public Health services (wrap-around services: interpretation, maternity screening and support services, immunizations, family planning, insurance application assistance).
- Problems that have been identified and their resolution.
- Community input and communication activities.

The Community Input Committee will be consulted about the form of the updates, to assure that they are provided in a way which is most useful to the community.

Objective C: Assure that all primary care partners have goals for how soon clients can access health care.

Performance Measure: Written goals describing how soon clients can expect to access emergent, urgent and preventive care.

Status: Attached are the access goals for Community Health Centers of King County and Highline Medical Enterprises, Roxbury Family Health Care. Timely access will be captured in the problem tracking system. (See below Objective D.) In their regular meetings, the joint operations management team will discuss and resolve problems with timely access.

Objective D: Specify mechanisms to identify and resolve problems between the partners.

Performance Measures: Client/System Advocate (ombudsman) hired.

Status: Miriam Gray was hired as Client/System Advocate on 2/1/99. She has 10 years experience in Public Health, most recently in Managed Care and Access solving client and system problems relating to managed care and advocating with Medicaid and plans for system changes to ensure access.

Her duties are to: ensure community input, communicate the status of the partnership to stakeholders, track problems and their resolution, facilitate the integration of problem resolutions into the development of the partnership, write reports and updates, coordinate assurance activities in South Region, coordinate the

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development and implementation of the partnership and assurance program evaluations .

Performance Measure: Problem identification and tracking system in place.

Status: Problems are currently being identified, and a system for tracking problems has been developed. All stakeholders will have the phone number of the Client/System Advocate and access to the problem identification form. Stakeholders and staff can either complete the form independently or call the Client/System Advocate with issues. All problems will be put into an Access database which will include name of person reporting, date, client name if applicable, type of problem (including timely access), and resolution. Reports will be generated from the database and reviewed with interested community members and partners when discussing how to improve processes and prevent recurring problems.

Performance Measure: Documentation of problems and resolutions formally reviewed with the Director of Public Health on a monthly basis.

Status: Initial meeting to be held on March 5th, and scheduled on the first Friday of each month.

Objective E: Assure that the White Center community provides input into the partnership/program.

Performance Measure: Hold Community Input Committee meetings on a regular basis.

Status: The first meeting was held on February 4th. The agenda included an update, the role of Client/System Advocate, and a discussion on issues of concern and how best to get input from the community. Ongoing updates will include how issues of concern are being addressed. Issues of community concern will be included in all reports to the Council. The next meeting is scheduled on March 31st at 7:00 PM at Highline's new clinic, Roxbury Family Health Care. Agendas for subsequent meetings will be develop in consultation with the participants.

Performance Measure: Update and gather input from the White Center community at existing community meetings.

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Status: The Community Input Committee suggested that a monthly news brief be disseminated and updates and input be gathered at existing community groups such as: Head Start Parent Councils, Boys/Girls Club Cambodian breakfasts, and the Park Lake Homes newsletter. The monthly update will include action status on the key issues identified by the Community Input Committee.

Objective F: Public Health link individuals and families to a satisfactory medical home.

Performance Measure: The number of individuals or families in need; (1) former high-risk primary care clients (pre 1999) and (2) people who call Public Health in 1999 who are linked to primary care and are satisfied with their care. Reported by 7/1/99.

Status:
Former High-Risk Primary Care Clients: White Center Public Health is piloting a follow-up process by contacting former high-risk clients with special health care needs to determine if they have obtained medical care and if they are satisfied with it. Clients who have not obtained medical care, will be encouraged to seek care and linked to a primary care provider or medical home. After the follow-up process has been revised based on the pilot experience, other Public Health sites will call their former high-risk clients (or a sample of them) to assess their current primary care status .

We will also try to assess if former Public Health managed care clients got transferred into new managed care plans by checking electronic medical eligibility verification data, as available. However these data are difficult to get and may not be available.

1999 Calls to Public Health: Currently, when people call Public Health for information and assistance finding health care, we refer them to care and encourage them to call us back if they have problems. All calls are documented and a sample of these people will be contacted to find out if they did obtain medical care and if they were satisfied with the care they got.