



**City of Seattle**  
Human Services Department

**MEMORANDUM**

**To:** Councilmember Nick Licata, Chair,  
Seattle City Council Housing, Human Services, Health & Culture Committee  
Sally Bagshaw, Councilmember  
Bruce Harrell, Councilmember  
Tom Rasmussen, Councilmember

**CC:** Jeanette Blankenship, City Budget Office  
Patricia Lee, Council Central Staff

**From:** Catherine Lester, Interim Director, HSD  
Heidi Albritton, Public Health Strategic Advisor, HSD

**Date:** July 30, 2013

**Subject:** HSD Response to SLI 53-3-A-1 (Community Health Clinic Contract: Health Outcomes)

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**Summary:**

This memorandum transmits the Seattle Human Services Department's (HSD) response to the Seattle City Council's Statement of Legislative Intent 53-3-A-1. During the 2012 budget process, the City Council adopted Statement of Legislative Intent (SLI) 53-3-A-1, requesting that the Human Services Department (HSD) work with Public Health-Seattle & King County (PHSKC) to develop and implement health outcomes as part of the performance pay in the City's contracts for medical and dental services for uninsured clients.

Specifically, HSD was asked to:

1. Work with Public Health to require health outcomes as part of the performance pay in the 2013 contracts for medical and dental services for uninsured Seattle residents and,
2. Report back to the Council's Housing, Human Services, Health and Culture committee with the proposed changes.

The department was granted an extension in responding to the SLI, (in order to accommodate the recruitment and on-boarding of the new Public Health Strategic Advisor), with the understanding that new performance outcomes would be in place for the 2014 contract. This memorandum outlines the department's recommendations for improved performance commitments and health outcomes as requested by Council.

**Contract Background**

HSD currently contracts with Public Health's Community and School Based Partnerships Unit (CSBP) (contract DA13-1462), to provide oversight of the City's investments in Seattle's Federally Qualified Health Clinics and the community health center system. These investments support primary medical care, dental care, and health care access to the under-insured and uninsured residents of Seattle. The Program Manager at CSBP serves as the primary contact for the City to the clinics, their directors and staff.



**City of Seattle**  
Human Services Department

In 2011, the total amount contracted through the Community Health Center Partners (CHCP) program was \$6,284,074 with \$51,250 allocated to Project Access and the remaining \$6,232,824 allocated to all other primary medical, dental, and access services. Project Access provides assistance, including case management, to low-income and uninsured individuals in need of specialty care. In the 2012 budget cycle, City Council added \$250,000 in funding for uninsured medical and dental services, bringing the total budgeted 2013 contract amount to \$6,664,755.

The reimbursement method for this outcome-based contract is 75/25 with 75% of the total contracted amount reserved for base payment and 25% of the total contracted amount reserved for achievement of selected performance commitments.

**Need For Evidence-Based Performance Commitments to Achieve Healthy Communities**

HSD is actively engaged in evaluating all of its operations and contracting practices according to its *Healthy Families, Healthy Communities* strategic plan, which focuses on three complimentary challenges:

1. Creating a seamless service delivery system
2. Reorganizing and redesigning HSD's contracting infrastructure and process
3. Developing a data-driven environment

This desired alignment of health outcomes, system-wide improvements and performance management makes it essential that the city investment strengthen the partnership between Community Health Centers and Public Health to facilitate the development of a high performing community-based system of care. This City investment is critical to sustain the work of these high performing mission driven agencies who serve Seattle's most vulnerable residents. Every Community Health Center (CHC) aligns their everyday work to reduce health disparities and improve health outcomes in a cost effective manner that is responsive to the community members they serve and resilient to the dynamically changing health care environment. For examples of excellence in care that this investment supports see Exhibit A: [Creating an Integrated, Data Driven, Primary Care Medical Home Network to Improve the Health of the Most Vulnerable Residents in the City of Seattle.](#)

Public Health's Community and School Based Partnership Unit has played a critical role in convening and facilitating a CHC Health Outcomes Improvement Workgroup (hereafter referenced as Workgroup) comprised of safety net health center subcontractors, the Community and School Based Program's (CSBP) Program Manager and HSD's Public Health Strategic Advisor. The Workgroup's purpose is to build on strengths and foster network-wide collaborative efforts to improve the health of Seattle's most vulnerable residents, provide input and feedback on a metrics portfolio, and strengthen CHC capacity for reporting performance and improvement activities. This Workgroup's commitment to establishing goals shared by PHSKC, HSD, and the CHC partners will maximize and leverage this investment and foster learning through effective problem solving across organizational boundaries. Each stakeholder is engaged in each step of this formative and deliberate effort, with influential contributions from CSBP and HSD leads, and the CHC's Executive Directors, Medical and Dental Directors, and quality improvement leadership. The proposed portfolio of measures for 2014 was built on existing data sets uniformly used by the CHC's to improve the quality of care. The portfolio includes clinically significant health outcomes and is designed to retain CHCs' strong position as the mainstay medical home for their current patients and family members, support primary care medical home excellence, and allow them to be responsive to the dynamic influences of health insurance reform.



**City of Seattle**  
Human Services Department

**Serving the Uninsured and Under-insured**

Historically, the CHC's have been compensated for service delivery and achievement of performance commitments related to overall numbers of uninsured individuals served and enrollment in medical insurance. With the upcoming expansion of Medicaid benefits in 2014, there is the anticipation of a significant shift in coverage with savings at the local level. It is noteworthy that Seattle's CHC's disproportionately served our community's lowest income and most vulnerable community members. In 2012, 82% of CHC partner's medical service and 89% of their dental service users had incomes at 200% or below poverty level, with 62% and 71% of their users respectively, at 100% or below poverty level. Eleven percent (11%) of CHC patients are homeless, with one CHC's homeless client visits representing 54% of their total patient visits. Twenty one percent (21%) of the CHC's patients served were limited English-speaking, with one CHC's limited English-speaking client visits representing 69% of their total patient visits. These unique, richly diverse and vulnerable populations deserve to continue to be served by these culturally competent care teams, in medical homes in their neighborhood. The CHC's commitments to patient access is not insurance coverage alone – it includes care teams supporting their patients who seek and return for follow-up care in a setting that treats patients and their families with respect and dignity and builds partnership in each and every care encounter.

Furthermore, many of the CHC's clients (such as those in the immigrant and refugee community) will not benefit from the Medicaid expansion, necessitating continued funding relating to serving the uninsured. After the implementation of the Medicaid expansion on January 1, 2014 there will still be a significant number of Washingtonians that will be without insurance. They will include:

- The undocumented – in 2010, there were 217,000 undocumented people in WA, which is about 4% of the state's 5.9 million residents under the age of 65. These individuals are:
  - Not eligible for Medicaid
  - Barred from purchasing insurance in the exchange
  - Still eligible for emergency care
- Individuals who are eligible to purchase private insurance on the Exchange or are offered employer provided health insurance, but cannot afford premiums. This will be relevant for someone who makes more than 138% of Federal Poverty Level (FPL) (so not eligible for Medicaid), and despite premium tax credits cannot afford health insurance. Approximately 20% of the CHCP clients are around this threshold of 139-200% of the FPL (earning about \$22,000/yr as an individual, or \$47,000 for a family of 4).

**Despite hundreds of thousands of Washingtonians gaining coverage, about 367,000 people will remain uninsured, an estimated 40,500 in the City of Seattle.**

An additional gap in coverage that is not provided for under the Affordable Care Act is dental care. This gap is particularly problematic in terms of reducing health disparities and associated costs, as dental treatments continue to represent a high cost and frequent need among all residents.

(Source: Washington Association of Community & Migrant Health Centers communication with Shirley Prasad, JD, Director of Government Relations 5-28-13 and King County Public Health

<http://www.kingcounty.gov/healthservices/health/partnerships/HealthReform/AdultsNoInsurance.aspx> accessed 6-1-13)



**City of Seattle**  
Human Services Department

**Recommendations**

**Retain and redefine current performance measures to serving the uninsured**

*Seattle's CHCs are poised to play a key role in federal health care reform, including coverage expansions and the emphasis on primary care and medical homes.*

Mission driven to continue to demonstrate excellence in providing culturally competent care to Seattle's most vulnerable residents, these CHCs, with high likelihood, will continue to disproportionately carry the fiscal burden and service delivery challenges of caring for our city's most highly marginalized community members. Data from year six of Massachusetts' health care reform experience showed that in 2012, CHCs served 20% uninsured clients (<http://www.massleague.org/> accessed 7/3/13) while only 2% of the population remains uninsured ([http://www.cbsnews.com/8301-18563\\_162-57459563/massachusetts-health-care-plan-6-years-later/](http://www.cbsnews.com/8301-18563_162-57459563/massachusetts-health-care-plan-6-years-later/) accessed 7/3/13). It is likely that CHCs in Washington will, like Massachusetts, continue to disproportionately serve the uninsured.

There are many factors that contribute to the uncertainties and cautious estimates of improved access as defined by insurance coverage in this first year of expanded health care coverage. Uncertain factors on the 2014 expansion of Medicaid include:

- Uncertain timelines for locating and enrolling the thousands of uninsured
- Unknown toll of continuous open enrollment and its burden on clinic administrative operations and subsequent reimbursement success
- Changing service delivery to respond to newly insured
- Concerns of adverse selection impacts, with only the sickest people entering the insurance market and delivery system
- Unique to CHC client profiles, many existing clients will not benefit from the expanded coverage

Due to these uncertainties and the absence of predictive modeling to strengthen confidence in forecasting insurance coverage volumes for 2014, this recommendation of changing the long-standing performance commitment projections for serving uninsured in the 2014 contract proposal is modest. There is no standard definition or recognized valid or reliable contractual measure for "underinsured". The Workgroup considered several composite measures that attempted to address the socioeconomic attributes of clients served. The Workgroup's recommendation is to use a composite measure counting visit targets

- serving uninsured *plus*
- Low income insured clients served ( $\leq$ 200% poverty level).

Current experience with these low-income insured patients shows that they tend to seek medical or dental assistance to manage an episodic care need although they frequently have multiple co-morbidities needing more routine visits for effective management, and they are often underinsured (e.g. a low-income diabetic patient whose insurance does not cover eye exams and who cannot afford out-of-pocket payment.) Additionally, it is recommended that both the medical and dental performance commitment compensation for visits for uninsured and insured at 200% or lower poverty be reduced by 2% of the absolute contract, to accommodate new health outcome performance aims.



**City of Seattle**  
Human Services Department

This contract element of compensating for visits for uninsured and low-income care will undergo ongoing evaluation, with the Workgroup monitoring quarterly to reduce unnecessary risk, variation, learn together, and diminish any deleterious impacts, particularly as the full effects of the Affordable Care Act become known and understood.

**New Health Outcome Performance Commitments**

Every CHC in this investment has dedicated infrastructure that strategically works on quality and delivery system improvements. CHC commitment to health outcome improvements is demonstrated in an annually reported portfolio of leading medical and dental health indicators. This menu of health outcome measures includes nearly 20 medical (Uniform Data Set [UDS] per HRSA) and dental (National Network for Oral Health Access), health outcome indicators. Public Health's CSBP unit provides feedback on individual network performance and compares performance with available national and state federally qualified health clinic benchmark values. CHC's leverage change by engaging leadership for health outcome improvement, routine monitoring and quality improvement actions to promote staff ownership of clinic-specific quality scorecards, and universal pursuit of primary care medical home certification (PCMH).

Several years ago the transformation of this contract's quality performance commitments to strengthen quality of care to the City's most vulnerable residents was initiated. Through their contract for City funds, since at least 2010, CHC's have been required to report their key UDS health outcome indicators to Public Health's CSBP unit. Built on the use of reliable, valid measures and routine health outcome monitors, the recommendation for this performance management strategy is a blended portfolio for 2014 of

- reported individual CHC health outcome measures, based on the unique health needs of the specific populations served by each CHC
- shared health outcome performance aims on a few select measures which collectively showcases the value of this investment

See Exhibit B: Comparison of 2013 and 2014 CHCP Reporting and Performance Commitments for the full portfolio of measures and changes. In addition to these quality measures, the City recognizes that the CHC's must also emphasize different health measures aimed at treating the unique health needs of their local service population. The City plans to continue to recognize these unique measures striving to leverage the City investments in support of these distinctive population-based needs.

This 2014 proposal features two additional health outcome performance aims to assist in monitoring and rewarding system-wide improvement on select health outcomes of importance to the City's most vulnerable residents and public health.

**CHCP 2014 Performance Commitments (which represents 25% of total contract budget)**

**Retain existing 5% 'Enrollment' commitment**

- This provides for payment relating to the ongoing work at the CHC's in assisting Seattle residents to connect and enroll in publicly sponsored benefit programs

**Retain and expand definition of 'Uninsured Visits' Performance Commitment for Individual CHCs**

**1. Eight percent (8%) of the contract is contingent on the Medical Performance Commitment**



**City of Seattle**  
Human Services Department

- Number of uninsured (all income levels) + Insured users up to 200% poverty level for Seattle resident medical visits.

**2. Eight percent (8%) of the contract is contingent on the Dental Performance Commitment**

- Number of uninsured (all income levels) + “insured” users up to 200% poverty level for Seattle resident dental visits

**New Health Outcome Measures: Medical and Dental**

To build on the individual clinics’ unique priorities showcased in their reported quality scorecard, one medical and one dental measure was selected for investment-wide improvement. Each health outcome performance commitment is worth 2% of the total contract value, putting a total of 4% of the contract funds ‘at risk’ for performance-based pay. **While this may seem relatively minor in comparison with the City’s overall investment, these percentages represent an initial step towards implementing an outcome-based contractual relationship with the clinic system.** Given the ambiguity of the impacts of Health Care Reform, HSD recommends these modest changes for 2014, with the understanding that the contract will continue to be revisited and revised annually as more concrete information is available regarding these system-wide impacts. See Exhibit C: Clinical Quality Aims for Performance Commitments and Base Pay for a profile of proposed 2014 compensation proportions.

These health outcome measures and margins of change were selected for their clinical importance and for statistical confidence to ensure that the change measured demonstrated progress, is significant, and not just a change due to random variation. The diabetes measure’s margin of improvement is in fact are more demanding than the CDC expected 1-year change to achieve the Healthy People 2020 standards.

*Because the system capacity at the various clinics varies based on their client population and existing resources, some clinics already meet or exceed nationally accredited standards such as the Healthy People 2020 indicators. For these high performing clinics, we are recommending an alternative performance measure for both medical and dental which would reward them for continued high performance. Healthy People 2020 was developed under the leadership of the Federal Interagency Workgroup (FIW). The Healthy People 2020 framework is the product of an exhaustive collaborative process among the U.S. Department of Health and Human Services (HHS) and other federal agencies, public stakeholders, and the advisory committee and represents national best practice standards.*

**Medical Aim**

**3. Two percent (2%) of the contract is contingent on the Medical Performance Commitment**

- Each CHC will increase by 1.5% the absolute percentage of diabetic patients whose HbA1c levels are less than or equal to 9 percent. (Considered a leading health indicator by Healthy People 2020)
- **Medical Aim Alternative**  
High performing clinics will have a secondary contingency for satisfying this diabetes control measure by meeting or exceeding the following thresholds:
  - Based on its own 2010-2011 base line, each CHC must be at the amount it must improve by contract year 2014 to meet a Healthy People 2020 improvement standard of 10%



**City of Seattle**  
Human Services Department

- OR Achieve or exceed HP 2020 83.9% diabetic patients whose HbA1c levels less than or equal to 9 percent. Threshold Source: Healthy People 2020

**Dental Aim**

**4. Two percent (2%) of the contract is contingent on the Dental Performance Commitment**

- Dental Aim 1: Increase by 2% the absolute completion rates of adult phase 1 treatment plans.
- OR Dental Aim 2: Increase by 2% the absolute completion rates of child phase 1 treatment plans.
- **Dental Aim Alternative**

High performing clinics will have a secondary contingency for satisfying this treatment plan completion performance measure by meeting or exceeding either of the following thresholds:

- Adult: 55% or greater phase 1 treatment plan completion rate (Threshold Source: Safety Net Dental Clinic Report coauthored by Ohio Department of Health, Indian Health Service, and Association of State and Territorial Dental Directors. <http://www.dentalclinicmanual.com/> accessed May 17, 2013)
- Child: 80% or greater phase 1 treatment plan completion rate (Threshold Source: No national or regional threshold data available. CHP Dental Director's consult and consensus 5/13)

**Next Steps:**

- Once new performance measures for the 2014 contract are approved, HSD will submit new contract language reflecting those changes to Council by September 15, 2013.
- The new contract will be implemented on January 1, 2014.
- CSPB and the Workgroup will continue to collect, analyze and share Health Centers' UDS health outcome indicators.
- The Workgroup will continue to meet in support of the strategic use of performance standards, measures, progress reports and ongoing quality improvement efforts to ensure each agency achieves desired results.
- Future discussions and potential contract elements may include a move to 'aggregate' scoring, in an effort to emphasize the City's interest in Public Health and the Community Health Centers collectively addressing health issues as a system, and the health centers' collective ability to leverage programming, learning and City investments.
- As the impacts of Medicaid Expansion and the Affordable Care Act unfold, HSD will continue to monitor these impacts and make contract recommendations according to the changing funding and service environment.
- As the City's investment represents an annual contractual arrangement, HSD will revisit the contract annually to ensure that the contract structure and deliverables continue to meet City goals and objectives.