

## 2010 City of Seattle Investments in Public Health Services

### CONTRACT: PUBLIC HEALTH—SEATTLE & KING COUNTY (PHSKC)

Health Care for the Homeless Network (HCHN)				
Target Population	Service Description	Outcome Area	Outcomes/Performance Commitments	Allocation
Homeless people especially those who are medically fragile, or who have chronic health conditions	<p>Services improve access to health care for homeless people and address underlying health conditions. Community-monthly health programs provide services at shelters, day centers and other locations where homeless people congregate. Services include: medical respite, case management, access to medical and dental care, street outreach, management of chronic conditions, and technical assistance to health and housing agencies that serve homeless people.</p> <p>The Housing Health Outreach Team (HHOT) is integrated within HCHN and provides health care linkages and support to formerly homeless people in permanent supportive housing. HHOT provides onsite nursing services, chemical dependency, and mental health interventions. Outreach to homeless encampments assists people to access shelter and needed services.</p>	<u>Health Care Access for Homeless</u>	<ul style="list-style-type: none"> <li>• 5,000 unduplicated homeless people will have one or more face-to-face visits with a Health Care for the Homeless provider</li> </ul>	<p><b>General Fund: \$1,608,124</b></p> <p>Monthly Base Pay 75%: \$1,206,093</p> <p>Performance Commitments 25%: \$ 402,031</p> <p>Other Funds: \$5,237,126</p> <p>General Fund &amp; Other: \$6,845,250</p>
		<u>Prevent Spread of Communicable Diseases Among Homeless</u>	<ul style="list-style-type: none"> <li>• 20 communicable disease training workshops will be provided to high-risk shelters and day centers.</li> <li>• 250 shelter and day center staff will be trained in best practices for disease prevention and control.</li> <li>• 106 shelter and day center staff, who are trained in communicable disease prevention and complete an evaluation, will report increased knowledge and commit to behavior change as a result of the training.</li> <li>• 26 City-funded shelters and homeless service sites will meet the City's new standards for communicable disease prevention.</li> <li>• 13 City-funded homeless agencies will meet the City's new standards for compliance with TB guidelines.</li> <li>• 4 non-City-funded homeless agencies in the high-risk group will meet one or more of the recommended TB guidelines to help prevent and control TB in their agency.</li> </ul>	
		<u>Management of Chronic Health Conditions Among Homeless</u>	<ul style="list-style-type: none"> <li>• 1,500 unduplicated clients with chronic health conditions addressed during a HCH visit will receive education about self-management goal setting.</li> <li>• 675 unduplicated clients, educated about chronic disease self-management, will set at least one self-management goal.</li> </ul>	

<p><b><i>HCHN continued</i></b></p> <p>Homeless people who are at-risk of transmitting or contracting TB, or who have TB</p>	<p>TB prevention and control policies/activities are designed to help homeless shelters and day centers prevent and reduce the spread of TB. The enhanced TB services include a discharge planning function that helps homeless TB patients secure and retain stable housing and other services.</p>	<p><u><i>Stability for Homeless People with Chronic Substance Abuse Problems and Families with Health, Mental Health and/or Addiction Problems</i></u></p>	<ul style="list-style-type: none"> <li>• 120 outreach visits to encampments will be conducted and referrals to shelters and services made.</li> <li>• 200 unduplicated homeless REACH clients with chronic substance abuse problems will move from homelessness into housing.</li> <li>• 40 unduplicated REACH clients will receive case management services to improve or maintain housing</li> <li>• 130 unduplicated REACH clients will improve or maintain housing.</li> <li>• 95 unduplicated homeless clients will move from encampments into housing.</li> </ul>	
		<p><u><i>Link formerly Homeless Residents of Permanent Supportive Housing to Health Services and a Primary Care Medical Home</i></u></p>	<ul style="list-style-type: none"> <li>• 700 unduplicated clients will engage one-on-one with HHOT medical team.</li> <li>• 420 engaged clients will be linked to and participate in at least one of the following: mental health care, substance abuse services, dental care, nutrition education, and/or tobacco cessation program.</li> <li>• 280 engaged clients will be successfully link to primary care.</li> </ul>	
		<p><u><i>Housing Stability for Homeless TB Patients</i></u></p> <ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• 15 unduplicated homeless people with active TB will receive case management services.</li> <li>• 6 TB patients will move to transitional or permanent housing upon completion of their TB treatment.</li> <li>• 5 TB patients will remain in stable housing at least 6 months after treatment to help prevent and control TB in their agency</li> </ul>	

**Community Health Partnerships (CHP)--Health Safety Net Primary Medical Care, Dental Care, and Access Services**

Target Population	Service Description	Outcome Area	Outcomes/Performance Commitments	Allocation
<p>Low-income, uninsured and underinsured people, and people from groups experiencing disparities in health outcomes</p>	<p>Primary care medical and dental services are delivered to target population through a cohesive system of community health centers to improve access to quality care Outreach and assistance is made to enroll uninsured families and individuals into publicly-sponsored health insurance programs.</p>	<p><u>Primary Medical Care for Low-Income, Uninsured Residents</u></p>	<ul style="list-style-type: none"> <li>• 255,260 primary care medical visits will be provided to <u>low-income</u> Seattle residents</li> <li>• 31,258 primary care medical visits will be provided to <u>uninsured</u> Seattle residents.</li> <li>• 5 subcontractors will achieve their aim in key clinical outcomes for patients with chronic conditions in target populations</li> </ul>	<p><b>General Fund: \$6,284,074</b>                      Monthly Base Pay 75%:                      \$4,713,056                      Performance Commitments 25%:                      \$ 1,571,018                       Other Funds: \$851,000                       General Fund &amp; Other:                      \$7,135,074</p>
	<p>Project Access provides assistance, including case management to low-income and uninsured individuals to access needed specialty care. A network of specialty care providers donates the services.</p>	<p><u>Dental Care for Low-Income Uninsured Residents</u></p> <ul style="list-style-type: none"> <li>• .</li> </ul>	<ul style="list-style-type: none"> <li>• 131,588 dental visits will be provided to <u>low-income</u> Seattle residents.</li> <li>• 23,083 dental visits will be provided to <u>uninsured</u> Seattle residents.</li> <li>• 4 subcontractors will improve rates of treatment plan completion for target population patients.</li> <li>•</li> </ul>	
		<p><u>Specialty Care for Under-Insured and Uninsured Residents</u></p> <ul style="list-style-type: none"> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• 535 Seattle patients access medical specialty care service through Project Access</li> <li>• 70 Seattle based specialty care providers will participate in Project Access enhancing specialty care for uninsured patients in multi-specialty groups or hospital systems</li> </ul>	



<p><u>PeoplePoint: Bridge to Benefits</u></p> <p>Low- and moderate income people in need of public benefits</p>	<ul style="list-style-type: none"> <li><u>PeoplePoint:</u> Provides client advocacy to help poor and vulnerable residents gain access to human services; training to enhance the effectiveness of service delivery to specific client groups; and comprehensive access to and enrollment in multiple public benefits through Peoplepoint, including low-cost health insurance, child care subsidies, basic food programs, utility rate assistance and the Earned Income Tax Credit.</li> </ul>	<p><u>Access to public benefits via PeoplePoint Bridge to Benefits Program.</u></p>	<ul style="list-style-type: none"> <li>750 low income clients will obtain health insurance coverage</li> <li>400 low income clients will receive other public benefits</li> </ul>	
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<b>Best Beginnings</b>				
<b>Target Population</b>	<b>Service Description</b>	<b>Outcome Area</b>	<b>Outcomes/Performance Commitments</b>	<b>Allocation</b>
<p>Pregnant/parenting adolescents will receive services.</p>	<p>Regular public health nurse home visits provide support and coaching, while educating adolescents on pregnancy, child health, and development.</p> <p>The program links clients to services, e.g., health insurance, prenatal care, child care, public assistance, school, work, training and other basic needs.</p>	<ul style="list-style-type: none"> <li><u>Access to case management for first time pregnant, low-income, and high-risk adolescents and their children</u></li> </ul>	<ul style="list-style-type: none"> <li>2,100 Public Health nurse visits to enrolled high-risk, first-time pregnant or parenting teens will be made.</li> <li>169 pregnant/parenting adolescents will receive services.</li> <li>80 pregnant adolescents receiving services will access prenatal care.</li> <li>118 participating adolescent mothers will progress in school (improved attendance, advance in grade level, complete GED, graduate) and/or in employment or training.</li> <li>68 participating adolescent mothers will have positive birth outcomes (birth weight, decreased prematurity [37+ weeks])</li> <li>143 participating adolescent mothers will delay a second pregnancy at least until their first baby is two years old.</li> </ul>	<p><b>General Fund: \$539,816</b></p> <p>Monthly Base Pay 75%: \$404,862</p> <p>Performance Commitments 25%: \$134,954</p> <p>Other Funds: \$928,710</p> <p>General Fund &amp; Other: \$1,468,526</p>

**HIV Prevention Enhancements**

Target Population	Service Description	Outcome Area	Outcomes/Performance Commitments	Allocation
<p>People living with HIV and people at highest risk of acquiring HIV/AIDS</p>	<p>The project will allow Country Doctor and Carolyn Downs Clinics to expand routine HIV testing using “rapid testing technology</p> <p>The project will expand NAAT (nucleic acid amplified test--more sensitive than conventional antibody test) to high prevalence private medical practices that serve large populations of men who have sex with men (MSM).</p> <p>Program assures access to HIV testing at Gay City.</p> <p>This project continues a peer driven referral project that provides HIV counseling and testing to African American MSM.</p>	<p><u>Expanded Screening &amp; Testing for HIV</u></p> <p>”</p>	<ul style="list-style-type: none"> <li>• 1,500 routine HIV tests will be administered.</li> <li>• 3 new HIV cases will be identified using routine HIV testing.</li> <li>• 500 HIV nucleic acid amplification tests (NAAT) will be provided to high-risk clients receiving services in private medical practices.</li> <li>• 1,988 men having sex with men (MSM) will be tested by the Gay City Wellness Center.</li> <li>• 1,600 men having sex with men (MSM) will be tested with</li> <li>• <u>NAAT</u> by Gay City Wellness Center.</li> <li>• 30 men having sex with men will test positive for HIV.</li> <li>• 1 new “window period case” will be identified (those cases found with NAAT testing that would not be found with routine testing by those tested in private practices and Gay City).</li> <li>• 513 African American men having sex with men will be screened.</li> <li>• 360 African American men having sex with men will be tested for HIV. (NAO -Baseline)</li> </ul> <p>3 African-American men will test positive for HIV.</p>	<p><b>General Fund: 153,750</b></p> <p>Monthly Base Pay 75%: \$115,314</p> <p>Performance Commitments 25%: \$38,436</p> <p>Other Funds: \$150,000</p> <p>General Fund &amp; Other: \$303,750</p>

**HIV/AIDS Case Management**

Target Population	Service Description	Outcome Area	Outcomes/Performance Commitments	Allocation
People living with HIV/AIDS	<p><u>Case Management:</u>                      People living with HIV/AIDS receive case management services including ongoing assessment of needs, development of a comprehensive, individualized service plan, and linkages to primary care, prescription drugs, mental health, substance use treatment, dental care, health insurance, and housing.</p>	<u>HIV Case Management</u>	<ul style="list-style-type: none"> <li>• 4,700 referrals will result client receiving actual services.</li> <li>• 3,000 unduplicated clients with HIV/AIDS or at high risk of acquiring HIV will receive case management services.</li> <li>• 7,000 referrals will be made to prescription drug programs, mental health therapy, substance abuse treatment, dental care, case management, insurance benefits, and/or housing assistance.</li> </ul>	<p><b>General Fund: \$227,851</b>                      Monthly Base Pay 75%: \$170,888                      Performance Commitments 25%: \$56,963                      Other Funds: \$3,226,839                      General Fund &amp; Other: \$3,454,690</p>

**Perinatal HIV Consortium**

Target Population	Service Description	Outcome Area	Outcomes/Performance Commitments	Allocation
HIV positive women, children and adolescents	<p><u>Perinatal HIV Consortium:</u>                      Services provided to HIV positive women, children and adolescents includes, case management, psychosocial peer support, medical care, obstetrical care and perinatal transmission care.</p>	Expanded Screening & Testing for HIV	<ul style="list-style-type: none"> <li>• 139 referrals will result in service linkages (primary care, mental health therapy, substance abuse treatment, etc.)</li> <li>• 5 unduplicated clients will receive obstetrical services</li> <li>• 5 positive birth outcomes will occur with no HIV transmission from mother to child.</li> </ul>	<p><b>General Fund: \$33,388</b>                      Monthly Base Pay 75%: \$25,041                      Performance Commitments 25%: \$ 8,347                      Other Funds: \$926,994                      General Fund &amp; Other: \$960,382</p>

**Robert Clewis Center**

Target Population	Service Description	Outcome Area	Outcomes/Performance Commitments	Allocation
Injection drug users who are at-risk of acquiring or transmitting HIV or other blood-borne illnesses	New sterile syringes in one-for-one exchange for used contaminated syringes. Used injection equipment is disposed of safely and clean injection equipment is distributed. Needle exchange customers receive a range of clinical and educational harm-reduction services.	<u>Needle Exchange services to lower the prevalence of HIV infection among injection drug users</u>	<ul style="list-style-type: none"> <li>40,000 needle exchange encounters will occur.</li> <li>2.5 million used syringes will be safely disposed of and exchanged for clean syringes.</li> <li>4% of Seattle residents who inject drugs will have HIV.</li> </ul>	<p><b>General Fund: \$417,648</b></p> <p>Monthly Base Pay 75%: \$313,248</p> <p>Performance Commitments 25%: \$104,400</p> <p>Other Funds: \$620,944</p> <p>General Fund &amp; Other: \$1,038,592</p>

**Methadone Vouchers**

Target Population	Service Description	Outcome Area	Outcomes/Performance Commitments	Allocation
Opiate-dependent Seattle residents, including people referred from the Seattle Needle Exchange, Municipal Mental Health Court, and current Methadone users	Vouchers for methadone treatment are redeemable for opiate replacement treatment to assist clients to manage their opiate dependency.	<u>Methadone Vouchers for Treatment</u>	<ul style="list-style-type: none"> <li>200 unduplicated opiate dependent clients stabilize their Methadone treatment.</li> <li>1,175 months of Methadone treatment will be provided to opiate dependent clients.</li> <li>130 opiate dependent clients will be in treatment 12 months or longer</li> </ul>	<p><b>General Fund: \$526,073</b></p> <p>Monthly Base Pay 75%: \$394,557</p> <p>Performance Commitments 25%: \$131,516</p> <p>Other Funds: \$0</p> <p>General Fund &amp; Other: \$526,073</p>



**CONTRACT: KING COUNTY DEPARTMENT OF COMMUNITY AND HUMAN SERVICES (KCDCHS)**

<b>Chemical Dependency Interventions for High Utilizers at Harborview Psychiatric Emergency Services Department (CDI)</b>				
<b>Target Population</b>	<b>Service Description</b>	<b>Outcome Area</b>	<b>Outcomes/Performance Commitments</b>	<b>Allocation</b>
Chemically dependent homeless people in crisis	Program provides stabilization services to chemically dependent homeless people in crisis. Chemical dependency professionals are located onsite at Harborview Medical Center and provide access to chemical dependency and mental health services.	<u>Services for Chemically-Dependent Homeless People in Crisis</u>	<ul style="list-style-type: none"> <li>• 300 consultations for chemical dependency (CD) will be provided.</li> <li>• 40 unduplicated persons who are high users will receive CD case management services.</li> <li>• 40 unduplicated persons will receive next-day appointment services.</li> <li>• 90 unduplicated persons will be admitted to detox services.</li> </ul>	<b>General Fund: \$119,020</b> Monthly Base Pay 75%: \$89,265 Performance Commitments 25%: \$29,755  Other Funds: ,,,,,, \$21,077 General Fund & Other: \$140,097
<b>Emergency Service Patrol (ESP)</b>				
<b>Target Population</b>	<b>Service Description</b>	<b>Outcome Area</b>	<b>Outcomes/Performance Commitments</b>	<b>Allocation</b>
Chronic public inebriants and intoxicated or incapacitated individuals	ESP responds to 911 dispatch calls freeing-up City Police and Fire personnel to respond to other calls by providing assessment, direct assistance and transportation to chronic public inebriants.	<u>Emergency Services Patrol (ESP) Transporting Public Inebriates</u>	<ul style="list-style-type: none"> <li>• 1,600 in-person responses will be provided in situations where police or fire department personnel are standing by</li> </ul>	<b>General Fund: \$542,116</b> Monthly Base Pay 75%: \$406,596 Performance Commitments 25%: \$135,520  Other Funds: \$849,330 General Fund & Other: \$1,391,446



**TOTAL PUBLIC HEALTH INVESTMENTS**  
**King County Department of Community and Human Services (KCDCHS)**

Total General Fund: **\$925,099**  
 Monthly Base Pay Gen Fund 75%: \$693,833  
 Performance Commitments Gen Fund 25%: \$231,266

Total Other Funds: \$1,099,157  
 Total General Fund & Other: **\$2,024,256**

**CONTRACT: AMERICAN LUNG ASSOCIATION of the Mountain Pacific**

<b>Master Home Environmentalist Program</b>				
<b>Target Population</b>	<b>Service Description</b>	<b>Outcome Area</b>	<b>Outcomes/Performance Commitments</b>	<b>Allocation</b>
People at-risk of lung disease and families with asthmatic children, with focus on specific Seattle Health Planning Areas where health disparities exist	Provides community outreach and residential in-home assessments and education that identify toxins and asthma triggers and creates plans to improve indoor air quality. The program provides outreach to landlord and tenants to identify and remedy structural changes to improve indoor air quality	<u>Indoor Air Pollutants Education</u>	<ul style="list-style-type: none"> <li>25 Master Home Environmental community forums or special outreach events will be provided to residents with education/ information about pollutants in indoor air.</li> <li>18 community forums aor special outreach events will be conducted in the City's high-risk Health Planning Areas (those with a significantly higher-than-county-average rate of asthma hospitalization for children and adults).</li> <li></li> </ul>	<b>General Fund: \$128,697</b> Monthly Base Pay 75%: \$96,523 Performance Commitments 25%: \$32,174 Other Funds: \$38,433 General Fund & Other: \$167,130
		<u>Home Pollutant Exposure Reduction</u>	<ul style="list-style-type: none"> <li>150 Seattle households with members vulnerable to lung disease or children with asthma will receive a Home Environment Assessment List (HEAL) risk assessment and will create a Home Action Plan.</li> <li>67 households receiving a HEAL assessment will be located in a high-risk Planning Area.</li> <li>25 households receiving a HEAL assessment will have a child living with parentally-reported asthma.</li> <li>105 households, receiving a HEAL assessment and creating a Home Action Plan will make at least one change to improve air quality.</li> <li></li> </ul>	



**CONTRACT: PUBLIC HEALTH—SEATTLE & KING COUNTY (Families and Education Levy)**

<b>School Based Health Services (SBHS)--School Nurses and School Based Health Centers</b>				
<b>Target Population</b>	<b>Service Description</b>	<b>Outcome Area</b>	<b>Outcomes/Performance Commitments</b>	<b>Allocation</b>
Students in ten Seattle high schools and four middle schools, especially students who have chronic conditions and have health-related barriers to success in school	Provides school-based health services for students at middle and high schools in Seattle. Includes medical and mental health services, and health related support, focused on supporting students' academic success. Services are provided by health centers and school nurses.	<u>School Based Health Services</u>	<ul style="list-style-type: none"> <li>12,000 students will be informed about and encouraged to use School Based Health Centers (SBHC).</li> <li>5,000 students will have their primary health care needs met at SBHCs.</li> <li>5,000 students will be fully immunized in compliance with state requirements.</li> <li>1,800 students will manage their chronic conditions (e.g., asthma, diabetes, depression).</li> </ul>	General Fund: \$0 Families & Education Levy: <b>\$4,002,362</b>  Monthly Base Pay 75%: \$3,101,831 Performance Commitments 25%: \$900,531  Other Funds: \$59,960  General Fund & Other: \$4,062,322
		<u>Support to Improve Academic Achievement for Academically at-Risk Students</u>	<ul style="list-style-type: none"> <li>3,000 students will be screened for academic risk factors.</li> <li>13,500 academically high-risk students will receive SBHC interventions to improve academic achievement.</li> <li>1,000 students helped by SBHC and nurses will graduate as 12<sup>th</sup> graders and/or meet the WASL standard in reading, writing and math for their grade level.</li> </ul>	

<b>GRAND TOTAL 2010 PUBLIC HEALTH INVESTMENTS</b>	<b>PHSKC, King County DCHS, American Lung Association of the Mountain Pacific, The Northwest Network and Catholic Community Services Northwest</b>			
	<b>SUBTOTAL</b>	<b>General Fund:</b>	<b>\$11,678,472</b>	
	<b>PHSKC School Based Health Centers</b>			
	<b>SUBTOTAL</b>	<b>Families &amp; Education Levy:</b>	<b>\$4,002,362</b>	
	<b>TOTAL</b>	<b>City Investments:</b>	<b>\$15,680,834</b>	
<b>TOTAL</b>	<b>Non-City Funds:</b>	<b>\$15,766,163</b>		
<b>GRAND TOTAL City Investments &amp; Non-City Funds</b>				<b>:</b>
				<b>\$31,446,997</b>

