Regional Health Care Initiative

July 2007

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STAFF

Laura McCrary
Director, Regional Health Care Initiative

Dean Katerndahl
Director, Government Innovations Forum

MARC
Mid-America Regional Council

Regional Health Care Initiative
Mid-America Regional Council
600 Broadway, Suite 200
Kansas City, MO 64105
Phone 816/474-4240
Fax 816/421-7758

INITIAL PRIORITIES

Introduction

The Mid-America Regional Council (MARC) created the Regional Health Care Initiative to work with health care stakeholders in the Kansas City metropolitan area — Cass, Clay, Jackson, Platte and Ray counties in Missouri and Johnson, Leavenworth and Wyandotte counties in Kansas — to facilitate system change in the provision of quality, affordable, accessible health care for the uninsured and underserved.

In 2006, MARC contracted with Health Management Associates (HMA) to conduct an assessment of accessibility of health care services for the uninsured and underserved in Kansas City. The HMA study (available online at www.marc.org/healthinitiative) assessed the problem, cataloged local and national initiatives that address the issue, and recommended a set of initiatives for the Kansas City metropolitan area. The study was based on an extensive set of interviews of health care stakeholders, as well as research and the experience of the consultants.

The HMA report recommended a set of specific initiatives to:

1) improve the efficiency and effectiveness of the safety net system,
2) increase the amount of federal funds coming to the region, and
3) increase the number of citizens who have health care coverage.

Regional Health Care Initiative staff conducted an additional 70 interviews with health care stakeholders from April to June 2007. During these sessions, staff explained the Regional Health Care Initiative, solicited input from local stakeholders regarding the services that they provide, and sought their opinions regarding barriers and opportunities for improving health care for the uninsured.

Using the HMA study and stakeholder input, the Regional Health Care Initiative staff developed this report to summarize current conditions of the safety net system, identify opportunities for change, define what a system might look like, outline the conditions necessary for success, and identify priorities for the initiative's next steps.

Conditions of the Safety Net System

Nearly 200,000 people in the Greater Kansas City region — almost 11 percent of the population — are without health insurance or any other coverage such as Medicaid. People lacking other resources often rely on a "safety net" of providers made up of clinics, health departments and hospitals for health care and other health-related services.

During discussions with stakeholders, a number of widespread "themes" or common conditions emerged. These conditions, outlined below, paint a picture of the current safety net system and provide a springboard to future discussions.

■ Diversity

The region's safety net system is characterized by complex relationships and individual goals. Each safety net provider is unique in its organizational structure, funding mechanisms, clientele served, eligibility requirements, sophistication of business functions and geographic location. This diversity is important, and it allows the safety net system to address an extensive set of needs in the Greater Kansas City community. However, it also contributes greatly to the complexity associated with accessing health care in the region. One of the major challenges of the Regional Health Care Initiative is to develop a safety net system that serves patients and clinics by improving accessibility, capacity and quality while honoring the distinctive nature of the safety net clinics and other providers.

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■ Capacity

Many, but not all, safety net providers indicate that they are at or near capacity. Several clinics report that they are full and do not accept new patients. Some have extensive waiting lists. Some report that clinic appointments are difficult to obtain, with patients calling hourly for an available spot or waiting lengthy periods of time to be seen. However, other safety net providers report that they can accept new patients and still others have state-of-the-art facilities that are not fully utilized due to a lack of health care providers. A safety net system must utilize all available resources and facilitate an increase in capacity to address needs that are currently not being met.

■ Collaboration

Safety net clinics not only have unique business and operational characteristics, but the demands placed on each clinic make it difficult for them to devote a lot of time to collaboration. Most of the clinics have informal contact and relationships with other clinics, but there are few area-wide systems aimed at improving clinic operation, improving the quality of care or enhancing capacity.

Two exceptions are KC CareLink and the Project Access programs: WyJo CARE, MetroCARE and Northland CARE. These programs attempt to deal with important safety net issues — referrals and specialty care, respectively— from a systems approach. These initiatives are still fairly new, and while they have been conceptually embraced, they have yet to prove their sustainability and generate the level of commitment from individual stakeholders that will be necessary for success. New system initiatives can learn much from these two initiatives.

■ Information

Reliable information on the need for services is not available system wide. Data is lacking in many areas including: the capacity of safety net providers; the extent of care being provided to the uninsured by non-safety net clinics; the potential additional capacity that could be made available and what it will take to make it available; the need for specialty care and the capacity to meet that need; the value

of safety net services; and measures of quality care. Clinics and other providers have a wide range of capacity to collect, analyze and use such data, but for the most part it is not collected on a system-wide basis. When system data is available, such as through KC CareLink, it is frequently not used.

System data is crucial for the following reasons:

- In order to bring additional resources into the system, it will be necessary to identify unmet needs and areas where additional capacity is required.
- Reliable data is essential to identify the system enhancements that will have the greatest impact and to evaluate the efficacy of those enhancements.
- Reliable data can help assure that care is being provided in the most efficient manner possible, thus helping to extend existing capacity.
- Reliable data can help assure that each patient is receiving the highest quality of care, especially when it comes to chronic disease management.

Opportunities to Impact Change

Throughout the stakeholder interviews, numerous ideas, opinions and perspectives were shared regarding integration of the safety net system. Many of these ideas are components of the Medical Home model that was presented to safety net providers by representatives of the Commonwealth Fund and TransforMed.

■ Health Information Systems

Some stakeholders suggested the need for a community-wide system to share basic patient information. Clinic directors reported having established clientele, but they also acknowledged a percentage of patients that were moving regularly throughout the safety net system. In most cases this is due to patients changing residency or employment, which may change eligibility for services. KC CareLink data corroborates this, with over one-third of the patients in the database receiving medical care from two or more providers in the region.

KC CareLink has already developed a beneficial system for transferring referral information. Stakeholders suggested that KC CareLink could be expanded beyond a referral system to serve as an information backbone for uninsured health services in Greater Kansas City. For this to occur, KC CareLink needs to work with clinics and other providers to identify their information needs and then develop a strategic approach to providing a sustainable technology foundation to meet those needs.

■ Access to Care

All of the stakeholders acknowledged substantial concerns regarding overall access to health care for the uninsured. Many major issues were cited, including lack of transportation, overcrowded clinics, clinic hours that coincide with working hours, cultural barriers, language barriers and poor clinic image. These barriers have resulted in the uninsured using emergency rooms as their primary care providers or simply not receiving care. The Kansas City Metropolitan Healthcare Council reported that in 2006 approximately 34 percent of emergency room visits could have been diverted to an urgent care or primary care provider.

● 24/7 Care

A number of stakeholders pointed to the fact that few safety net clinics are open after traditional work hours. Many of the uninsured are working and cannot leave work during the day. Consequently, stakeholders point out that their only option for care may be to use the emergency room. A number of approaches may be required to address this issue, such as staggered hours and nurse call lines. This issue was a major element of the medical home discussion. However after-hours care is addressed, it will have to be addressed by the safety net system, not a single clinic.

● Urgent (Acute) Care

Many of the uninsured do not have financial resources to pay the out-of-pocket expenses associated with for-profit urgent care clinics. Swope Health Services, in partnership with St.

Luke's Hospital, established a clinic adjacent to the hospital's emergency department at 44th and Wornall. After evaluation by St. Luke's medical staff, emergency room patients who do not need emergency care are given the option of being seen more promptly at the clinic. This model can help both the uninsured and insured reduce inappropriate use of emergency room care. In the long run, it may produce significant savings for the entire health care system, including the consumer. Other options to link the safety net system to urgent care facilities should be explored.

● Location

The geographical distribution of clinics and transportation issues were cited as a problem by some clinic directors. These clinics noted that some of their patients travel considerable distances for care. Areas with especially significant needs for clinics include Johnson County, south Kansas City, eastern Jackson County, and areas north of the Missouri River. Increasing the number and distribution of clinics would be facilitated by partnerships among clinics and other providers.

■ Management Support

● Business Functions

The safety net clinics demonstrated a wide range of expertise in the management of their business functions, including payroll, medical billing, auditing, human resources and development functions. Safety net providers currently fulfill these functions through a variety of innovative arrangements. Some of the clinics have established agreements with hospitals, university systems or "parent" non-profits, while others attempt to fulfill these functions themselves. Stakeholders reported a variety of solutions, including contracting out the functions, opting out of some functions such as medical billing or eligibility assistance, or simply doing it themselves on evenings and weekends. Many indicated that a centralized system for addressing business functions would benefit a number of the safety net clinics.

● Pharmaceuticals

Access to pharmaceuticals for the uninsured is managed in many different ways throughout the safety net system. Some clinics demonstrated state-of-the-art pharmaceutical dispensation and management with comprehensive formularies; others had cumbersome, sample-based programs that relied primarily on donations. Several safety net clinics do not maintain medications on-site and refer patients to other programs to obtain medications. Most clinic directors reported a high utilization of the $4 generic prescriptions available at some retail stores.

Most clinic directors acknowledged the importance of pharmaceutical management for their patients, but noted that it was time consuming and drained valuable clinic resources.

Several stakeholders suggested the exploration of a community-wide model that could manage the acquisition and allocation of pharmaceuticals for the safety net clinics and/or their patients. Wyandotte County is currently using a model in which the Wyandotte County Health Department administers a pharmaceutical and lab voucher program. Exploring community-wide medication assistance programs for Greater Kansas City offers promise.

● Cooperative Purchasing

Each safety net provider has established its own system for purchasing medical supplies and office supplies. These range from sophisticated contracts with a hospital purchasing firm to simply purchasing items as needed from local stores and vendors. Centralizing the purchasing for the safety net providers could potentially reduce costs and save time. Some stakeholders indicated interest in a cooperative purchasing system.

■ Case Management and System Navigation

Due to the complexity of the health care system in Kansas City and the highly individualistic characteristics of the safety net clinics, many patients may have to visit several clinics several times to get care. Some clinics have staff that perform the case management function; however it is a costly and time consuming service. These individuals connect the uninsured to medical homes and specialty services and determine if they are eligible for enrollment in Medicaid or SCHIP. This function might be provided through a new system approach or by making the existing system easier to navigate.

System Change

Advocates for improved health care access emphasize the importance of "system change." While we often heard about protecting the uniqueness of each of the safety net clinics we also heard from many stakeholders that improvements will require "changes to the system" and that we need to "be bold." Some stakeholders were skeptical, however, that even those who advocate system change would be willing to make such changes.

Because system change is such an important part of the Regional Health Care Initiative's agenda, it is important that we define what is meant by system change and the benefits that might be realized by committing to such change. A *system* involves a set of interrelated and coordinated parts that together serve an overall mission that cannot be achieved by any part of the system on its own. For our purposes, the "parts" of the system include safety net clinics, hospitals, labs, doctors, nurses, volunteers, pharmaceutical companies and other stakeholders. Currently, it is somewhat of a misnomer to refer to the provision of health care for the uninsured in Kansas City as a safety net "system." The clinics and other parts of the current system are, by and large, not interrelated and coordinated. However, some new efforts are underway to systematize some parts of safety net care, including referrals and access to specialty care.

The mission of the safety net system is to provide the best possible health care to every uninsured and underserved patient. It is a fundamental premise of the Regional Health Care Initiative that this can best be done if individual safety net clinics and other providers work together to act as a system. Some of the benefits include:

- **Increased Access to Health Care**
  There are a number of services that are difficult for individual clinics to provide that could be better managed within a system of individual clinics and providers collaborating and coordinating their efforts. This could include providing 24/7 care and special services that not all clinics can offer individually.
- **Improved System Navigation**
  When a number of clinics and providers are not coordinated, it can make finding the right care more difficult for the patient. We heard a number of anecdotal stories about patients being referred from place to place until they eventually found the right service or just gave up. A safety net system would help alleviate this situation by establishing protocols for directing people to the right places and the right services.
- **Increased Efficiency and Reduction in Costs**
  A systems approach can often help clinics and providers reduce costs or make more efficient use of existing resources, thus increasing the capacity of the system to serve more patients. This might range from cooperative purchasing to sharing staff to improving data systems.

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It will be incumbent on the Regional Health Care Initiative to work with all of the safety net stakeholders to develop systems that provide significant improvements to health care for the uninsured and underserved while respecting the individual characteristics, needs and assets of each clinic and stakeholder. A fundamental premise is that the system is there to serve the patients, clinics and other stakeholders, not the other way around.

Conditions Necessary for Success

To achieve the goal of an effective and efficient system of care for the uninsured, all Greater Kansas City safety net providers will need to join together in the creation of a dynamic partnership with a principal focus on the quality of care for the patient. Following are a few key conditions that will be necessary if we are going to be successful in making significant improvements to health care for the uninsured:

1) **Shared Responsibility**
   It is critical that the leadership of ALL of the safety net providers be active participants in transforming health care for the uninsured in the region.

2) **Shared Vision**
   Safety net providers will need to create a common vision and set of principles for improving the safety net system. This shared vision, among other things, must be patient centered.

3) **Shared Commitment**
   The leadership of the safety net providers must be committed to the shared vision and to making the system enhancements a success.

Next Steps

The first major undertaking is to assemble a Safety Net Working Group. The safety net working group includes the executive leadership of the safety net clinics, the Project Access programs and KC CareLink. Additional members with expertise in health care reform will also be a part of the working group. The group will be co-chaired by doctors working in both Kansas and Missouri.

The Safety Net Working Group has two principal charges:

- Develop a vision and set of principles for what a successful safety net system should look like. This target will guide the efforts of the working group.
- Implement specific initiatives that will assist in achieving the vision. The medical home model is recommended to guide the initial strategies and activities of the working group.

The Safety Net Working Group is expected to address a number of different initiatives. Subgroups, which may include people with expertise outside of the working group, will be formed to address specific issues. Depending on the issues, the working group may invite individuals representing different interests to join them in the discussion of specific initiatives.

The Regional Health Care Initiative will also work parallel to, and in coordination with, the Safety Net Working Group to address new ways to better leverage existing resources in order to expand funds coming into the metropolitan area. In addition, the initiative will work with stakeholders to develop new approaches to increasing coverage available to the uninsured. Finally, the initiative will work with both states to be informed and engaged in discussions of health reform and to make sure the region is well positioned to take advantage of these reforms.

Final Impressions

Clearly, the greatest strength of the Greater Kansas City safety net system is the commitment of the leadership of the safety net providers and senior level staff to meeting the needs of the uninsured. Most view their role holistically and strive to provide not only health care, but also other critical services that will help improve the lives of the people they serve. The quality of the clinics and hospital facilities is remarkable — clearly equal, and in some cases superior, to those for the fully insured.

The Regional Health Care Initiative staff appreciated the opportunity to meet with many different members of the health care community. These individuals openly shared their ideas, challenges, visions and dreams for health care in Greater Kansas City. We wish to thank all the members of the health care community who generously gave of their time and resources.

We often heard that it was important to build consensus around significant changes in system issues. However, we heard equally that it was critical to BE BOLD, and that real lasting change in the system would not occur just through consensus building. This is a difficult balance to achieve as we move forward with this process. All stakeholders must be willing to commit to the conditions for success listed above, to work together collaboratively and be willing to take risks if we hope to achieve true and lasting change in our health care system.

The commitment of MARC's Regional Health Care Initiative is to work with all of the safety net providers and stakeholders to build on the very solid base that has already been put in place. Our role will be to listen, suggest ideas, bring information and expertise to the table, and work with the providers and stakeholders to implement and evaluate the programs and systems that are identified as having the best chance of improving health care for those who are uninsured or underserved. Success will be measured by serving more people in need, providing better care, and doing it in a way that strengthens the safety net clinics and stakeholders.

Appendix A: Related Issues

A multitude of issues arose during the stakeholder meetings that, while not directly related to the integration of the safety net system, are important enough to include in this report.

■ Health Insurance Coverage

Some opportunities exist to explore three-share health insurance plans where the employee, employer and the state share the cost of a health insurance product. Both Kansas and Missouri enacted legislation to form pilot programs to test the feasibility of using Medicaid to fund the state's portion of the three-share product. Both states will be seeking Medicaid funds for their projects. Kansas City may be a possible pilot site.

Stakeholders reported a variety of ideas about coverage that bear further exploration. One stakeholder reported that she was interested in approaching small businesses that were not providing coverage and asking them to contribute monetarily to the safety net clinic. In return, primary care would be provided through the clinic and specialty care through the Project Access program. Insurance cards and insurance handbooks could be produced for the patients.

■ Mental Health

In the initial round of interviews, MARC Regional Health Care Initiative staff did not speak to mental health providers. However, health care stakeholders often indicated that physical health care services need to be provided in conjunction with mental health services for many of their patients to have successful health outcomes. Some stakeholders indicated that as many as one out of every four patients had such significant mental health needs that they require one-to-one assistance in the clinic or hospital. Some clinics provide limited mental health services and others have partnerships with local mental health providers, but all indicated a significant need to increase access to mental health services for the uninsured.

The accessibility of mental health services is further complicated as the landscape regarding the provision of mental health services continues to evolve. New Medicaid Home and Community-Based Service (HCBS) waivers in Kansas will change the procedures for mental health hospitalization and the establishment of new Medicaid providers in Kansas may increase availability of services. Additional mental health funds are available in Kansas City, Mo., through a tax levy. However, concern regarding access to mental health services was expressed equally on both sides of the state line. The HMA report also documented considerable expression of concern regarding mental health services. HMA noted that access to mental health services was frequently cited by stakeholders as a significant weakness in the current safety net, on both sides of the state line.

■ Language Barriers

Stakeholders clearly reported that identification and acknowledgement of cultural issues is of paramount importance when developing a health care system for the uninsured. Many clinics reported difficulty in sharing health care information with patients who had limited English proficiency. One clinic requires staff members to be bilingual. Others are utilizing technological innovations to access offsite interpreters. Still others have become adept at communicating through community advocates, family members, and, in extreme cases, by drawing pictures. A system-wide solution that provides a reliable technology solution for patients who have limited English proficiency would significantly improve the communication process.

■ Telemedicine

Interest was expressed in the utilization of telemedicine/telehealth to expand health care services to rural portions of the Kansas City area and to expand existing telehealth programs. New technology has made this method of health care more efficient and cost effective for patients who have limited access to transportation. It can be used to provide both physical health care and behavioral health care services.

Further exploration of the use of telemedicine is particularly important as the new MOHealthNet bill has authorized the Missouri Department of Social Services to work with the Missouri departments of

Mental Health and Health and Senior Services to establish rules to govern the practice of telehealth in Missouri. Additionally, the legislation stipulates that telehealth may be used to provide Medicaid services and that they are reimbursable. Similar legislation in Kansas allows telehealth to be used and reimbursed through Medicaid for both health and behavioral health services.

■ School Health Services

School health services have generally not been considered to be part of the health care continuum for the uninsured. However, some stakeholders pointed out that school nurses often have regular daily contact with children and their families and have well-established relationships in the community. School nurses can be the bridge to more traditional safety net services.

There appears to be renewed interest in the opportunities to use and collaborate with existing health care resources in the public/private schools. Swope Health Services has fielded a mobile medical clinic that is currently in use at Ft. Osage School District with assistance from LINC. The Kansas City, Missouri, and Center school districts are exploring alternatives for school-based clinics, and the Kansas City, Kan., schools are interested in looking at new ways to use their telemedicine clinics. The programs listed above represent only a portion of the school health initiatives that are in place in our community.

■ Education and Training

Stakeholders reported wide variability in the knowledge and use of technology systems and medical billing procedures. All clinic directors were proficient in their technology skills but lower-level staff members who have responsibility for day-to-day utilization and management of data were reported to have technology skill deficits. Also stakeholders reflected that the amount of time required for education and training to ensure effective utilization of technology systems and medical billing systems was daunting. Some stakeholders reported high staff turnover and the need for some type of training program that would help staff members quickly gain the necessary skills to gather and record data. An education and training program targeted to safety net providers may be beneficial to some safety net clinics.

■ Funding for the Safety Net Clinics

Stakeholders all reported funding to be a critical issue of concern. Some have fairly well established funding mechanisms in place, while others characterize their funding as tenuous at best. Most stakeholders reported that much of their time and energy was devoted to pursuing funding through grants, medical billing, special events, individual donations, etc. Stakeholders indicated that this ongoing pursuit of funding often puts them in direct competition with each other. This in turn fosters a lack of trust and an unwillingness to share promising practices or innovative ideas. Some stakeholders indicated that if Kansas City grantmakers could align their grant application processes and their outcomes it would produce a significant savings in time and resources.

■ Collaboration Examples

Collaboration was mentioned in the body of this report as essential and necessary. Some collaborative efforts are already underway.

One constructive example of a safety net partnership is KC CareLink. This is an electronic health care referral system that significantly reduces the amount of time necessary to refer patients between providers. In order to be successful, KC CareLink requires close cooperation and trust between the safety net providers. For the majority of safety net providers, the referral system has worked well. However, if one safety net provider does not follow through, the entire system can be jeopardized. Therefore, it is critical that all safety net providers agree to follow specified conditions for the maximum benefit of all.

A second example of safety net collaboration is the development of the new Project Access programs. While MetroCARE and Northland CARE are just beginning, WyJo CARE has been in operation for almost a year. These programs coordinate specialty care appointments for the uninsured. Safety net clinics refer patients who require specialty care to the access programs. The access programs determine necessary tests and lab work and coordinate the patient's visits.

■ Data and Quality of Care

Currently, data that documents the quantity of health care provided to the uninsured in Kansas City is collected piecemeal. Hospitals, safety net providers

and funders gather selected data elements. However, little continuity exists in the process and a lack of trust exists when compilations are reported. The following are examples of the lack of reliable data.

- Figures reporting the percentage of uninsured in Greater Kansas City are out of date. The Lewin Uninsured Study 2000 is seven years old and does not reflect the impact of the Missouri Medicaid cuts in 2005.
- Safety net providers all gather data regarding the number of patient visits and the numbers of patients seen each year. However, it is gathered in a variety of formats based upon individual specifications and technological sophistication. Thus, it is time consuming and of questionable reliability to combine this data.
- Costs associated with the provision of charity care are gathered using a variety of definitions. Thus, stakeholders report little confidence in comparisons between providers and compilations are difficult and often unreliable.
- Clinic management data varies by clinic. Some clinics have robust management systems while others gather only encounter data or no data at all. Due to this variability, it is difficult to use management data to impact system improvements.

Gathering quality-of-care data for the uninsured in Kansas City is challenging. Currently, performance measures are gathered and maintained by some of the safety net providers. However, the specific performance measures that are gathered and analyzed are based upon the unique interests of each clinic and the clinic's grantmakers. Since positive health outcomes for patients is the primary goal of the safety net system it makes some sense to collaborate on a set of common health outcome measures and how they are used.

■ Health Information

Safety net providers manage their patient medical records using an assortment of strategies. Most clinics reported primary utilization of a paper-based system. However, at least two clinics use technology to track portions of the patient medical record. Several clinics indicted that they plan to move to an electronic medical record at some point in the next two years. Alternately, another indicated that electronic records worked well in theory but would be difficult to implement in practice. Overall, most stakeholders indicated that they are interested in exploring the use of HIPPA-compliant systems that would allow clinics to maintain medical records electronically.

■ Program Enrollment

Clinic directors reflected mixed views regarding their responsibility to help patients enroll in social service programs. Some clinic directors feel that their staff simply does not have time or resources necessary to assist in determining eligibility for social services. Others indicated that there is deterioration in patient trust when financial or residency documentation is requested. However, some stakeholders take the opposite approach and garner resources to work very closely with their patients to ensure that all resources available to the patient are accessed.

Helping the clinics enroll patients who are eligible for Medicaid or SCHIP programs is promising. A recent study completed in Wyandotte County documented that one in four children who are eligible for Medicaid or SCHIP services were not enrolled.

Appendix B: Meetings with Stakeholder Groups

Stakeholder Interviews			
Meeting Date	Meeting Time	Organization	Attending
4/25/2007	8:30 a.m.	Duchesne Clinic	Amy Falk
4/25/2007	2:30 p.m.	Metropolitan Healthcare Council	Mike Dunaway
4/26/2007	10:00 a.m.	Mid-America Coalition on Health Care	Bill Bruning
4/27/2007	8:00 a.m.	Johnson County Health Department	Leon Vinci
4/27/2007	9:30 a.m.	WyJo CARE, MetroCARE and Northland CARE	Jacque Amspaker, Ruth Smerchek, Jill Watson and Karen Dolt
4/27/2007	1:30 p.m.	KC CareLink	Linda Davis
4/30/2007	10:30 a.m.	Lafayette County	Jill Thompson and Robin Jones
4/30/2007	2:00 p.m.	Samuel Rodgers Health Clinic	Hilda Fuentes
5/1/2007	9:30 a.m.	Kansas City, Mo., Health Department	Pat Morgestar
5/1/2007	2:30 p.m.	Community Health Council of Wyandotte County	Michael Mayberry
5/2/2007	11:00 a.m.	Swope Health Care	Barrett Hatches
5/3/2007	2:00 p.m.	Children's Mercy Hospital	Alice Kitchen and Scott Lakin
5/4/2007	2:00 p.m.	Midwest Center for Practical Bioethics	Myra Christopher, Linda Ward and Terry Rosell
5/14/2007	9:00 a.m.	Wyandotte County Health Department	Joe Connor
5/14/2007	3:00 p.m.	United Community Services of Johnson County	Debbie Doud and Karen Wulfkuhle
5/15/2007	6:00 p.m.	Officers of Wyandotte and Johnson County Medical Societies	Jacque Amspacker, Gary Baker and others
5/16/2007	10:00 a.m.	Chamber Health Council and Blue Cross/ Blue Shield	Tom Bowser, David Oliver, Teresa Gerard, Pete Levi and Kristi Wyatt
5/17/2007	9:00 a.m.	United Auto Workers — Ford Community Health Initiative	Cathy Davis
5/17/2007	3:30 p.m.	Kansas City, Mo., Health Department	Rex Archer
5/18/2007	11:00 a.m.	Turner House Children's Clinic	Joseph So
5/21/2007	3:00 p.m.	Truman Medical Center	Gerard Grimaldi
5/22/2007	9:00 a.m.	University of Missouri — Kansas City	Betty Drees
5/22/2007	2:00 p.m.	Cabot Westside Health Center	Liz Levin
5/23/2007	9:00 a.m.	Health Partnership of Johnson County	Amanda Lowe
5/23/2007	Noon	University of Kansas Hospital — External Affairs and Telemedicine	Dave Cook and Ryan Spaulding
5/23/2007	2:00 p.m.	Silver City Health Clinic	Mary Virden and Mike Bleich
5/23/2007	6:00 p.m.	Metro Med Medical Society Officers	Jill Watson, Officers
5/24/2007	9:00 a.m.	Southwest Boulevard Health Clinic	Sharon Lee
5/24/2007	11:00 a.m.	Black Health Care Coalition	Stacy Daniels-Young
5/29/2007	9:30 a.m.	Local Investment Commission School-Based Clinics	Robin Girer
5/31/2007	10:00 a.m.	H&R Block, Blue Cross/Blue Shield, Nets to Ladders	Theresa Gerard, Marc Ferguson, Andrew Olso and Bernard Wilson
6/2/2007	9:30 a.m.	Health Summit	Health Stakeholders

Stakeholder Interviews, continued			
Meeting Date	**Meeting Time**	**Organization**	**Attending**
6/4/2007	11:30 a.m.	Blue Cross/Blue Shield	Theresa Gerard and Community Blue Team
6/5/2007	9:00 a.m.	Operation Breakthrough	Sister Berta Sailor, Claudia York
6/5/2007	2:00 p.m.	Kansas Action for Children State Children's Health Insurance Program meeting	Gary Brunk, Billie Hall, Rebecca Kilburn and Andy Allison
6/6/2007	10:00 a.m.	Catholic Charities	Mike Jurkovich and Irene Caudillo
6/6/2007	3:00 p.m.	KC Free Clinic	Sheri Wood
6/7/2007	9:00 a.m.	Project Eagle	Martha Staker
6/7/2007	2:00 p.m.	KC CareLink	Linda Davis
6/11/2007	9:00 a.m.	Seton Center	Sister Loretto Colwell
6/11/2007	1:30 p.m.	Chamber Health Council	Members
6/12/2007	9:00 a.m.	Jackson County Free Clinic	Bridget McCandless
5/24/2007	2:00 p.m.	Sojourner Clinic	Brook Nelson and Joanne Marties
6/13/2007	1:00 p.m.	St. Luke's Health System	Rich Hastings
6/14/2007	5:30 p.m.	Northland Health Care Access Board of Directors	Karen Dolt, Directors
6/20/2007	9:00 a.m.	Mercy and Truth	Cathy Gordon
6/22/2007	12:30 a.m.	University of Kansas Hospital	Bob Page and Scott Glasrud
6/27/2007	1:30 p.m.	Riverview Health Services	Rose Tsizka
6/27/2007	3:00 p.m.	JayDocs	Nick Stucky
7/2/2007	10:00 a.m.	Turner Children's Clinic	Jim Coleman