
HMA

HEALTH MANAGEMENT ASSOCIATES

*Evaluation of the Kansas City Regional Health
Care Initiative*

PRESENTED TO
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Background

Health Management Associates (HMA) was engaged by the principal funders of the Mid-America Regional Council's (MARC) Regional Health Care Initiative (RHCI), the Health Care Foundation of Greater Kansas City, and REACH Healthcare Foundation (Funders), to evaluate how well the RHCI has met the following goals:

- Improve collaboration and partnership among safety net organizations in the region.
- Increase access to care in the region.
- Improve coordination and efficiency within and among safety net organizations in the region.

In determining whether the RHCI has met these goals, HMA was asked to consider what changes have occurred in the safety net since the implementation of the RHCI, what barriers inhibited change, and what lessons might be gleaned to inform future activities.

Impetus for the Regional Health Care Initiative

In 2006, MARC engaged HMA to investigate the feasibility of establishing and sustaining both a broad health care policy planning and coordination forum and a regional program(s) related to financing and access to indigent health care. HMA, in close consultation with MARC, the MARC Technical Advisory Committee, and the newly formed Chamber Health Council, was asked to provide expertise and guidance, research national and local health care access initiatives, and engage the health care community in a discussion of possible solutions. HMA submitted a report which included three recommendations based on its assessment:

- 1) Formalize coordination among the safety net and maximize the value of specialty care.
- 2) Maximize federal funding.
- 3) Pursue targeted coverage expansions.

HMA's report recommended the formation of a Health Care Safety Net Board to oversee the implementation of the initiatives, as well as to monitor changes in the health care industry and delivery system to enable Greater Kansas City to keep pace in meeting future demands. The RHCI was the outgrowth of this recommendation.

The RHCI is a regional initiative promoting innovative, collaborative approaches to providing health care to the uninsured and medically underserved in metropolitan Kansas City. The principal focus of the RHCI is to facilitate greater coordination and efficiency in the safety net system that will lead to greater access to high-quality, affordable health care for individuals living in poverty and those who are medically uninsured. While the RHCI has undergone several structural changes since its creation, its work has been largely organized around the following:

- Safety Net Collaborative
- Kansas City Bi-State Health Information Exchange
- Metropolitan Mental Health Stakeholders
- Community Health Worker
- Oral Health Access Committee

Evaluation Methodology

HMA's approach to the evaluation relied on information obtained from an extensive document review and stakeholder interviews.

Document Review

HMA reviewed and analyzed all documents provided by the RHCI and Funders, 85 in total, to gather background information and understand the history, philosophy, and operation of the RHCI. A data collection tool was created and utilized to compile and summarize the information gleaned. Examples of types documents reviewed include: grant proposals and reports; data reports; newsletters; committee/subcommittee mission statements and charters, meeting minutes, and directories; survey templates; and external assessments and evaluations. A listing of all documents reviewed can be found in Appendix A of this report.

Stakeholder Interviews

Based on information gained through the document review and the evaluation goals, HMA developed structured interview guides designed to assess the interviewee's

- understanding of the overall structure and priorities of the RHCI and its committees;
- expectations for activities and achievements of the individual committee(s)/subcommittee(s);
- perspective as to the barriers encountered in committee work, as well as missed opportunities; and
- opinion as to whether the RHCI had achieved the three goals articulated by the Funders.

A master interview guide was utilized for all interviews along with one or more of five committee-specific guides (i.e., Community Health Worker, Health Information Exchange, Metropolitan Mental Health Stakeholders, Safety Net Collaborative, and Oral Health Access), depending on the area(s) in which the interviewee had participated.

HMA interviewed 31 RHCI participants and six current and former MARC staff. Interviews were completed both in-person and over the telephone with individuals and groups. (A listing of all interviews completed can be found in Appendix B.) In order to ensure interviews were representative of all stakeholders, HMA reached out to engage a variety of stakeholders, including:

- current and former participants from each of the committees and subcommittees of the RHCI;
- representatives of each of the major stakeholder groups, including providers (e.g., safety net clinics, community mental health centers, and hospitals), consumer and advocate groups, and others such as local universities and community colleges;
- individuals who have held or currently hold leadership positions (i.e., committee chair or co-chair) and those who have not; and
- a committee representative from Missouri and Kansas, in order to capture a bi-state perspective.

It is important to note that, while HMA used a variety of follow-up questions to probe participants' recollection and understanding, many of the activities undertaken by the RHCI occurred as many as six years ago, and some level of clarity can be lost in that length of time. As a result, our evaluation gives more weight to issues and themes that were identified by multiple interviewees and/or that were also substantiated in the document review.

Report Organization

The next section of this report, titled Regional Health Care Initiative Committees, includes a detailed background and analysis for each of the core committees (presented in chronological order):

- Safety Net Collaborative
- Kansas City Bi-State Health Information Exchange
- Metropolitan Mental Health Stakeholders
- Community Health Worker
- Oral Health Access Committee

Within each Committee section, the report provides the following detail based on information and insights gained from the document review and stakeholder interviews:

- Background
- Committee and Subcommittee Structure
- Priorities, Activities, and Accomplishments
- Barriers and Missed Opportunities

The final section of the report lays out the Findings and Recommendations, identifying opportunities to learn from both the successes and shortcomings of the Initiative and to implement change in order to better advance the mission of the initiative.

REGIONAL HEALTH CARE INITIATIVE COMMITTEES

Safety Net Collaborative

Background

The Safety Net Collaborative (SNC) was the first work group to come out of the Regional Health Care Initiative (RHCI). While its structure and membership have changed over the years, the core of the group has consisted primarily of representatives from the safety net clinics in the region. The SNC originally began its work focusing on the proposed activities outlined in the 2007 HMA report. However, the group was unable to reach consensus around these activities and moved early on to develop its own structure and agenda.

SNC members and RHCI staff reported that, more so than the other RHCI work groups, the SNC struggled early on to overcome issues of competitiveness and develop a level of trust and communication between safety net providers. Most of the individuals interviewed for this evaluation noted that many of the organizations that participated in the SNC had never sat around the same table previously. Some of the organizations were familiar to each other but had a relationship that was more competitive than collaborative.

SNC Committee and Subcommittee Structure

Since its inception, the SNC has undergone several structural changes in an effort to align the work of the group with identified priorities and areas where the membership thought it could have the greatest impact through working collaboratively. During the first two years, the SNC developed subcommittees for access to care, safety net capacity, advocacy, and health information technology (HIT). The HIT subcommittee later became its own work group focused on regional health information exchange (see Kansas City Bi-State Health Information Exchange). This structure remained largely in place through 2010.

In 2011, the SNC completed a strategic planning process to determine its priorities and goals for the coming years. The planning resulted in the creation of three work groups—specialty care, infrastructure support, and care coordination—which were the platform for the SNC’s work through the end of 2012.

At the end of 2012 the SNC assessed the “need for and effectiveness of the SNC and the partnership with the RHCI.” It was determined that the SNC would continue to meet as a group, but only three times per year, primarily for networking, information sharing, and education purposes. At the same time, the RHCI proposed to establish a “Patient Centered Care Collaborative,” which would bring together smaller groups of providers and other stakeholders to collaborate. A consultant was identified to assist with this effort, but the consultant later left, leaving the project with an uncertain future.

Some of the individuals interviewed for this evaluation believed the SNC had made the right decision in deciding to reduce its scope and number of meetings. They cited “meeting fatigue” and expressed that they did not see substantial additional opportunities for collaboration on a regional level. However, others felt strongly that, by reducing its scope, the SNC was scaling back just at the time it should be taking

on a more significant role. Scaling back at the time when health reform implementation is accelerating would put the SNC at risk for losing the relationships and momentum that had built up over the previous years.

Most of the individuals interviewed for this evaluation believed that the membership of the SNC is representative of the region geographically and that most of the safety net clinics were represented. Most also believed that all members had an equal voice on the SNC’s agenda and activities, though a minority believed that the SNC agenda was dominated by a handful of organizations. In the SNC’s early years, the committee limited participation by establishing membership criteria. Some interviewees noted that this practice contributed to mistrust and may have inhibited the group’s progress early on. In contrast, other RHCI subcommittees have applied an open membership structure.

Priority Areas, Activities and Achievements

The table below summarizes the priority areas, activities, and achievements of the SNC from its inception in 2007 through 2012 to the extent that we were able to document activities and outcomes based on document review and interviews with RHCI stakeholders and staff. While not exhaustive, the table provides an overview of the SNC’s work and organizational structure over the years.

Year(s)	Goals	Activities	Outcomes/Achievements
2007-2009	<i>Organization.</i> Assemble Health Care Safety Net Coordinating Council, hire staff, develop working relationships with wide range of stakeholders	Developed Safety Net Working group, hired executive director and assistant and began developing working relationships with stakeholders.	Development of close working relationships was instrumental to the creation of behavioral health and HIE initiatives early on.
	<i>Implementation Planning and Preparation.</i> Put Steering Committee in place; put strategy in place with committed stakeholders for each steering committee.	Developed subcommittees of the Safety Net Working Group for access to care, safety net capacity, HIT and advocacy. Identified key issues facing the safety net community including: <ul style="list-style-type: none"> • System and clinic capacity • Patient navigation of the system • Training and recruitment of staff • Electronic medical records and exchange of information • Providing multilingual services • Coordinated advocacy 	
	<i>Initiative Implementation.</i> Implement and evaluate one or more initiatives.	<ul style="list-style-type: none"> • Created RHCI web site • Created RHCI monthly e-newsletter • Developed web-based KC Health Resource Guide 	<ul style="list-style-type: none"> • Educated state and local officials and other stakeholders on role of/issues facing safety net • Safety net providers and

		<ul style="list-style-type: none"> Completed “The Safety Net Story” Launched evening and weekend hours program and put program evaluation structure in place. Produced report on capacity and demand for safety net services. Developed a collaborative patient navigation proposal and grant application to HRSA (grant was highly rated, but not funded) 	<p>other organizations had a single resource for the patients (KC Health Resource Guide) and a source of data on access/need to support planning and development efforts.</p>
2010	<p><i>HIT.</i> Support the Health Information Technology Committee in expanding the capacity of safety net providers to access, use and support electronic medical records and other health information technology and actively participate in and benefit from a regional health information exchange.</p>		
	<p><i>Advocacy.</i> Support the Advocacy Committee in continuing to develop information and advocate for the safety net community with key audiences.</p>		
	<p><i>Access to Care.</i> Support the Access to Care Committee by providing fiscal, administrative and coordination support for the weekend and evening hours initiative; assist in the expansion of evening and weekend services pending evaluation; develop appropriate information to assess the capacity needs of the safety net and develop strategies to meet those needs; investigate ways to strengthen care coordination and continuity of care; and investigate ways to further extend safety net services to the underserved.</p>	<p>SNC members worked with RHCI to develop data collection system to provide statistics on safety net services and document the complexity of services needed by safety net patients. RHCI helped coordinate data collection by NORC to track utilization, diagnoses, type of services & demographic information.</p>	<p>After-hours participating clinics continue to learn from each other re staffing model and best practices; evaluation shows modest gains in access; initiative resources re-allocated based on evaluation of project to date.</p>
2011	<p><i>General.</i> Undertake activities in one or more specific areas and produce specific products benefiting the medically underserved and safety net operations.</p>	<p>Strategic Planning process completed that resulted in 3 priority areas with corresponding work groups (specialty care, infrastructure support,</p>	

		care coordination)	
	<i>Specialty Care.</i> Assess need for and availability of specialty care for underserved patients and develop strategies to meet the identified gaps in service.	<ul style="list-style-type: none"> Specialty care survey sent to SNC members in summer 2011 Work group identified strategies to improving specialty care access, including addressing state line barriers, training and education of PCPs, improved collaboration, recruitment of physicians, and e-consult. 	Survey identified highest need specialties, including dental, GI, general surgery, sleep medicine, cardiology and dermatology.
	<i>Infrastructure Support.</i> Articulate the need for funding for basic safety net clinic infrastructure. Work with foundations and other funders to develop strategies to meet this need. Position SNC providers for delivery system and payment reform.	Work group developed 4 framework documents: workforce capacity framework; affordable care act, information and data systems, and organizational capacity. Each framework included recommendations.	
	<i>Care Coordination.</i> Support the provision of enhanced patient care while extending limited resources through care coordination.	Launched care coordination pilot as part of after-hours initiative. Work group later rolled into Capacity Expansion subcommittee.	
	<i>Other.</i> Identify public health issues affecting vulnerable populations and strategies for addressing these issues. Develop an effective regional response to health reform that maximizes the benefits for the medically vulnerable.	<ul style="list-style-type: none"> RHCI participates in the bi-monthly meetings of the Metropolitan Officials Health Agencies of the Kansas City Area (MOHAKCA). RHCI staff accumulates and reports information on health reform at monthly SNC meetings and also provides ongoing health reform educational opportunities through training, outside speakers and its monthly newsletter. 	MARC was awarded a CDC Transformation Grant. RHCI staff, the SNC and grant partners are developing training for safety net clinics on high impact clinical preventive services.
2012	<i>Capacity Expansion/Care Coordination.</i> Expand capacity of safety net system and provide quality care to the medically vulnerable.	Continued support for and monitoring of after-hours project and care coordination pilot.	<p>Increased encounters by 3%, increased number of uninsured patients seen by 3%, maintained 73 total weekly hours of after-hours care.</p> <p>Care coordination initiative resulted in reduced unnecessary ED visits and improved medication access for individuals in the pilot.</p>

	<i>Specialty Care.</i> Assess need for and availability of specialty care for underserved patients and develop strategies to meet the identified gaps in service.	Focus of Specialty Care Task Team was on virtual appointments, sharing of specialists and patient/family engagement. Subcommittee disbanded at the end of 2012.	
	<i>Infrastructure Support.</i> Articulate the need for funding for basic safety net clinic infrastructure. Work with foundations and other funders to develop strategies to meet this need. Position SNC providers for delivery system and payment reform.	Presented framework documents to HCF and REACH and facilitated discussion around infrastructure challenges. Subcommittee disbanded at the end of 2012.	
	<i>Other.</i> Continue effective collaboration on safety net issues affecting the medically underserved.	Multiple speakers and presentations	

Most Significant Achievements

After-hours initiative. This project, which supported evening and weekend capacity at six safety net clinics, was almost universally cited as the most significant achievement of the SNC. The project was subject to an annual outside evaluation by the National Opinion Research Center (NORC), which demonstrated a measurable increase in access and also documented some of the initial barriers that were confronted by participating clinics, including provider recruitment and retention and the challenges of a largely uninsured population with multiple unmanaged chronic conditions. The evaluation did not, however, quantify the “return on investment” from the initiative, nor did it address the long-term sustainability of the initiative. The initiative is now being funded directly by the funders to the clinics.

Care Coordination Initiative. This initiative was created as a component of the After-Hours initiative and has grown and dovetailed with some of the activities undertaken by the CHW Work Group. A small evaluation of the initiative indicated significant gains in access to medications and reductions in unnecessary ED visits for participants.

Infrastructure papers. Many of the individuals interviewed for this evaluation cited the SNC infrastructure white papers as a significant achievement. They noted that the papers were helpful in articulating to funders and other stakeholders the ongoing infrastructure needs in the safety net. They were unable, however, to cite a specific impact that resulted from the papers beyond their educational/informative value.

KC Health Resource Guide. The *KC Health Resource Guide* was launched in 2009 and was widely cited by individuals interviewed for this evaluation as a valuable resource for their clients.

Collaboration. Many of the individuals interviewed for this evaluation cited the collaborative structure established by the SNC was, in and of itself, a significant achievement. Some cited specific examples of how “sitting around the same table” had directly contributed to positive changes within their organizations that they don’t believe would have occurred in the absence of the SNC. For example, one SNC member noted that his clinic began collaborating with another clinic, which they had previously viewed only as a competitor, on quality improvement metrics.

Barriers and Missed Opportunities

Lack of clear goals and measurable objectives. While the funders reported having met with participating organizations both collectively and individually on multiple occasions to assure them otherwise, numerous individuals interviewed for this evaluation stated that they believed safety net clinics participated only because they thought their funding was at stake if they didn’t participate, rather than participating with a goal of identifying areas for collaboration. They also expressed that there was a lack of clarity from the funders and the RHCI staff about the goals of the initiative. For example, organizations were unclear to what extent RHCI participation was a “pre requisite” for any support from the funders beyond the ongoing operational support they had received. When asked about the mission of the SNC or RHCI, responses varied widely, but were largely focused on the process of “meeting around the same table” rather than a clear sense of working toward measurable outcomes in the areas of access, collaboration, coordination/efficiency, and preparing the safety net for health care reform. Adding to the lack of clear direction, the RHCI website still lists the original priorities for the RHCI that were identified in the HMA report but were long-since replaced.

This lack of clarity around expectations was also evident in the absence of measurable goals in many of the SNC’s activities. With the exception of the after-hours initiative and a small evaluation of the care coordination initiative, there is little qualitative or quantitative data on which to evaluate the impact of SNC activities.

Integration with Metropolitan Mental Health Stakeholders (MMHS) activities lacking. Both the document review and interviews indicated a lack of coordination and integration between the SNC and the MMHS. While there is some cross-representation of membership, and RHCI staff attend and reported updates at both meetings, there appeared to be little coordination of strategies and activities. Each committee has independently worked on related projects, MMHS Integration and SNC Care Coordination, without consideration of how the two groups could internally coordinate and work together to achieve a more integrated healthcare delivery system.

Affordable Care Act funding and delivery system reform opportunities. The last several years since the passage of the Affordable Care Act in 2010 have seen rapid and unprecedented change in our nation’s health care system. As the most visible components of the legislation approach implementation, the pace of change will continue to accelerate. While the RHCI did apply for some federal funding opportunities, there were significant missed opportunities as well. These missed opportunities are noteworthy both because they offer an additional funding source to extend and leverage the work of the RHCI and because they provide an opportunity to test and refine new strategies prior to the full implementation of the Affordable Care Act. For example:

- *FQHC New Access Point and capital funding.* The Affordable Care Act included a trust fund to support the creation of hundreds of new Federally Qualified Health Center (FQHC) sites – known as “New Access Points.” Increasingly, funding for new health center sites is being targeted at: 1) regions that can demonstrate significant levels of unmet need or insufficient primary care access; and 2) organizations that demonstrate strong collaborative partnerships with other safety net providers. The platform created by the RHCI, supported by MARC’s data and analytic capabilities, could be leveraged to maximize federal funding for primary care in the region through the FQHC program. To date, it appears that the region was the recipient of one New Access Point award (Health Partnership Clinic) and two capital awards (Swope).
- *CMMI Innovation Grants.* The Center for Medicare and Medicaid Innovation (CMMI) has issued two rounds of funding opportunities for organizations (or groups of organizations) seeking to implement and test payment and delivery system reform innovations.
- *Navigator Funding.* MARC applied for, but did not receive, a federal navigator grant.

Data and Analytics. MARC has a wealth of data capabilities that have not been fully utilized by the SNC or other components of the RHCI. These data and analytic capabilities could be an invaluable resource for the RHCI and could also be a significant “value added” for individual RHCI members. For example:

- *Community Needs Assessments.* Safety net providers and funders are increasingly reliant on community needs assessments to target limited resources to those services and geographies where they can have the greatest impact.
- *Return on Investment (ROI).* Funders are also increasingly asking grantees to demonstrate a return on investment from the funded activity or intervention. In many instances, capturing the return on investment requires complex cross-programmatic analysis. For example, savings realized from an investment from a primary care jail “in-reach” program will likely accrue to the criminal justice system – in the form of reduced recidivism – rather than within the health care system.
- *Measurement and evaluation.* As noted above, many of the SNC’s activities lacked measurable process and outcome goals and measures, making it difficult to assess impact and prioritize future activities.

Specialty Care. Several individuals cited this as a missed opportunity and attributed the missed opportunity, at least in part, to the two regional specialty access programs (WyJoCare and MetroCare), which perceived these efforts as duplicative. It was also apparent from the document review that there was much initial excitement within the SNC for addressing specialty care access, as it is an issue that was shared by virtually all safety net clinics. Options discussed included addressing state line barriers, training and education of PCPs, improved collaboration, recruitment of physicians, and e-consult. An additional strategy that was not cited in the document review is incorporating limited specialty services within FQHCs. Despite much work and investment, however, the SNC failed to produce concrete recommendations or take definitive action on this important issue. While multiple factors may have contributed to this, strong leadership at the staff and/or co-chair level was needed to overcome the barriers.

Delivery and Payment System Reform. RHCI has facilitated and hosted numerous educational forums on delivery system and payment reform and also keeps members abreast of changes in this area through its monthly e-newsletter. Beyond these educational activities, however, there was little activity focused on helping prepare the region's safety net for the rapidly changing delivery system and payment landscape.

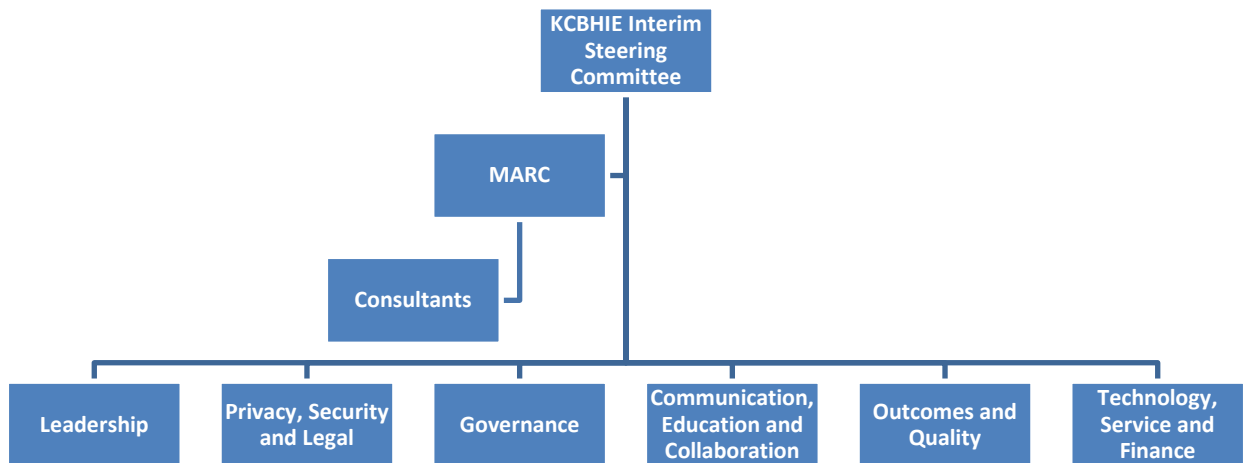
Kansas City Bi-State Health Information Exchange

Background

In September 2008, KC CareLink, the former CareEntrust; the Kansas City Quality Improvement Consortium (KCQIC); Mid America Assistance Coalition (MAAC) Link; and the Mid-America Regional Council’s (MARC) Regional Health Care Initiative (RHCI) joined together to explore the creation of one robust health exchange for Greater Kansas City. At the time, there were multiple health information exchange (HIE) products being utilized in the region, and none of them spoke to one another. Adoption of an electronic health record (EHR) by primary care providers in the Kansas City market was estimated between 5%-15%; only 3 of 16 safety net clinics had functioning EHRs. The group envisioned developing a bi-state HIE with a focus on the medically underserved population. The development of a regional health information exchange was a logical fit under the RHCI, as it was an emerging issue at the federal level and complimented the work being done by the Safety Net Collaborative.

KCBHIE Committee and Subcommittee Structure

The following structure and workgroups were formed to begin planning and developing the regional HIE.



The planning process was open to all interested health care stakeholders to promote inclusiveness and recognize the incremental and developmental approach required by such a voluntary collaborative effort. Participating stakeholders included the existing HIEs, hospital systems, safety net clinics, and the local medical societies representing physician groups. The workgroups met at MARC on a weekly basis for two-years.

After KCBHIE was incorporated as eHealthAlign (eHA), the new entity was managed by a chief executive officer (CEO) and community based Board of Directors (BOD).

Priority Areas, Activities and Achievements

During 2008 the group formed the Kansas City Bi-State Health Information Exchange (KCBHIE) which developed and worked on the following issues: 1) a mission and vision for the exchange; 2) preliminary work on a roadmap for the exchange; and 3) a review of HIEs and regional health information organizations (RHIOs) in other states. The group established the following mission for the KCBHIE:

To enhance access, quality, safety and the efficiency of health care through the implementation of a secure, integrated, interoperability health information exchange that supports the data needs of authorized users across organizational boundaries including; health care providers, health systems/hospitals, patients, employers, health plans and other regional stakeholders for over 2 million people in the greater Kansas City region.

In late 2008, MARC conducted a survey of software applications in Kansas City safety net clinics. Analysis of the survey results indicated that the clinics had limited-to-no capacity to qualify for the American Reinvestment and Recovery Act's (ARRA) meaningful use criteria. The workgroup identified that without a regional HIE much of the safety net would not qualify for ARRA funds and ultimately be unable to successfully develop and implement an electronic health record. They therefore set the goal of building a core technology infrastructure that would connect safety net health and other care providers together and enable the real time, electronic exchange of health information across organizations throughout the Kansas City region. As one interviewee pointed out, this goal and the work that would be done in subsequent years to form a regional HIE was ahead of its time.

Building the Foundation for a HIE

Between March 2009 and March 2010, MARC convened and conducted intensive community-wide planning to develop the exchange, with a large group of key stakeholders participating and lending expertise. During this time MARC and the RHCI provided extensive support to the planning and development process and grant management, and served as the fiscal agent to incubate the organization until such time that it achieved the financial and social capital to exist independently of MARC. Specific activities conducted by MARC and the KCBHIE include the following:

- Through a grant awarded to MARC, HIE consultants were hired to provide support and technical assistance to the volunteer chairs of each committee. Together with the consultants, each workgroup developed a charter and deliverables that were used to inform the technical requirements for the core technology solution.
- A second consultant group was brought on to develop the Request for Proposal (RFP) for the core technology solution.
- A vendor selection committee, comprised of representatives from many Kansas City health care organizations, was formed in late 2009 to choose a technology vendor. The national RFP was issued in November 2009.
- In the spring of 2010, MARC:

- contracted with local consultants to conduct a technology readiness assessment of the 10 area safety net providers. The assessment provided baseline data necessary for the implementation of the HIE.
- engaged a marketing company to brand and market the HIE and develop a communications plan, and
- hired a law firm to support legal tasks associated with the establishment of the entities corporate structure
- The Kansas City Bi-State Health Information Exchange was incorporated as eHealthAlign (eHA) in Missouri on June 4, 2010, and was registered in Kansas.
- In September 2010, eHA began to operate independently of MARC and contracted with:
 - Support KC to act as its fiscal agent and provide accounting and payroll services
 - Informatics Corporation of America (ICA) as the selected technology vendor

New Partnerships and Collaborations Changed the HIE Landscape

In October 2010, eHA joined the Kansas Collaborative to work with the Wichita HIE (WHIE), the Kansas Hospital Association (KHA), the Kansas Medical Society (KMS), and the state to develop a consortium approach to the development of HIEs in Kansas that would build upon the work already begun in KC and Wichita. In December 2010, the Kansas Health Information Network (KHIN) was incorporated as a technology services organization that would provide core technology services to its partner organizations (eHA, WHIE, KMS, and KHA) and rural portions of Kansas not served by eHA or WHIE.

When it became apparent that the hospitals wanted to be a part of a statewide effort, KHIN negotiated a contract with ICA to cover the remainder of the state not covered by the eHA ICA contract. Based on the belief that KHIN was a more durable platform and had a sustainable business model, the eHA BOD voted to merge the two ICA technology contracts into one under the management of KHIN. The final report of eHealthAlign discussed the positive impact the merger would have on the HIE landscape by ensuring greater collaboration, allowing better development of core HIE services across Kansas, and reducing duplication and costs associated with multiple HIE organizations. In light of the significant changes in the service environment, the eHA BOD reassessed its purpose, structure and business model and in September 2011 approved a resolution to dissolve eHA.

Current HIE Project in Kansas

Despite the dissolution of the eHA, the MARC continues to work with safety net providers to help them connect to existing health information technology. MARC has been working with a select group of safety net partners in Kansas to achieve full connectivity and deployment of an HIE since April 2013. The initial pilot consists of 10 regional safety net health care provider clinics, three hospitals, and three health information organizations (HIOs) serving Wyandotte and Johnson Counties. This effort has been funded solely by the REACH Foundation independent of the RHCI.

Participating organizations were assessed and evaluated in the early stages to identify the barriers and challenges to securely sharing patient information in the HIE. With the help of a project consultant, BluePrint Healthcare IT, the cohorts identified “use cases” with similar characteristics that could be used for a pilot project. These use cases can eventually be shared with other providers in an expanded net-

work. The pilot will identify other issues shared among the participating providers that need to be resolved in the HIE. The overall purpose of the HIE project is to improve the quality of safety net patient care through the use of enhanced technology and the secured sharing of patient information. MARC is planning to seek additional funding to develop a second pilot in 2014.

Barriers and Missed Opportunities

Hospital Participation

A common barrier to implementation of a robust HIE is lack of hospital participation. While many if not most hospitals provide admitting physicians remote access to electronic health records, there is minimal data sharing among unaffiliated organizations. Competition and adversarial relationships among hospitals and between providers and health plans have long been major barriers to communitywide clinical data sharing. Hospital competition was identified by one interviewee as a barrier encountered by the KCBHIE. In part because of this competition and unwillingness to work together, the KCBHIE was not successful in its initial effort to develop, implement, and maintain a successful bi-state HIE. While there are hospitals participating in the current HIE initiative, this Kansas-only effort does not meet the workgroup's primary objective of achieving a bi-state HIE.

Lack of Community Engagement and Leadership

Multiple interviewees identified that the individual hired as CEO by eHA was not the right fit, as he was unable to engage and lead a diverse group as needed. As a result, some funding for eHA ultimately had to be returned to investors when eHA was unable to deliver. Without a champion in the community, there was no one to advocate on behalf of maintaining the local HIE, eHealthAlign, which had been established. In addition, in order to facilitate the work necessary to build a HIE from the ground up, the RHCI had to engage expertise from a number of external consultants. One interviewee acknowledged that such external expertise was necessary given the highly specialized focus of the workgroup; however, they believe that the reliance on consultants resulted in a lack of ownership within the Kansas City community.

Metropolitan Mental Health Stakeholders

Background

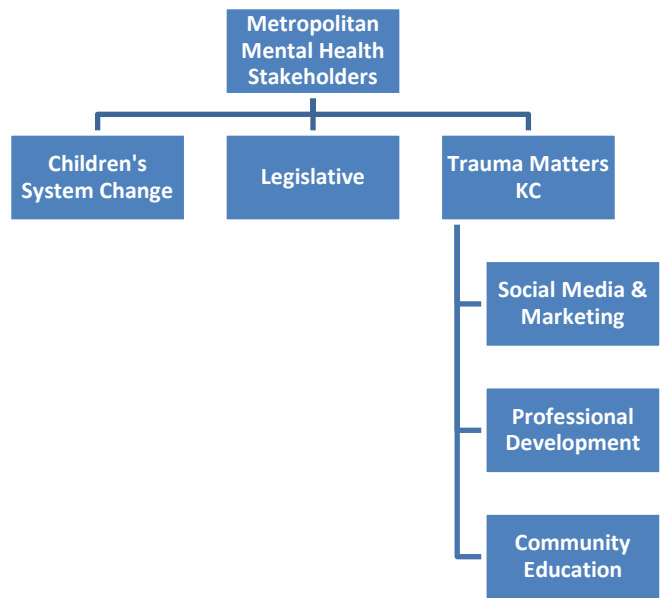
Community mental health centers (CMHCs) are the primary direct service provider of mental health services in the Kansas City region. As a result of the structure of the behavioral health system, each CMHC has a dedicated catchment area for which they are responsible; thus the CMHCs do not compete with one another and have a history of working collaboratively to meet the needs of the community. CMHCs on both sides of the state line in Kansas City have been meeting in some fashion over the years.

Over 10 years ago, a group of mental health stakeholders (Stakeholders) was organized in Missouri at the direction of the State of Missouri’s Mental Health Director. The grass roots group was pulled together by the Kansas City Chapter of the National Alliance on Mental Illness (NAMI) and the local department of mental health. Early on the work of the Stakeholders group focused primarily on issues related to corrections and consumer advocacy.

In 2008, the RHCI Director approached the Stakeholders and proposed becoming a regionally based group by broadening their membership to include representatives from Kansas, with the support from the RHCI. Through this partnership, the Metropolitan Mental Health Stakeholders (MMHS) was formed.

MMHS Committee and Subcommittee Structure

Since the involvement of the RHCI, the MMHS has expanded from a single committee to include three subcommittees. The current structure of the MMHS is as follows:



The MMHS does not follow a formal process to guide the creation and/or governance of its subcommittees. Rather, the process is described as organic, with subcommittees emerging from ongoing projects or because of the strong leadership and passion of one of the stakeholder members.

Committee Membership

The MMHS is an open membership group, welcoming participants from all backgrounds and positions. With the exception of the Legislative subcommittee and Trauma Matters KC, which have only a single chair, each committee/subcommittee is led by two co-chairs elected by the membership, one from each state to ensure equal representation. While the group initially gathered around consumer-related issues and advocacy, the focus and membership has broadened. Today MMHS and its subcommittees include representatives from organizations with varying levels of touch in the behavioral health system. MMHS' open membership structure appears to have served the group well and contributed to a relatively high level of trust among participants. As stated in the MMHS 2012 Mission-Vision Statement:

The Metropolitan Mental Health Stakeholders of Greater Kansas City (MMHS) consists of consumer advocates, mental health professionals and organizations, public administrators, correctional related institutions and the legal community.

Most interviewees indicated that while all parties are not always in attendance, the overall organizational make-up of the workgroup is sufficient, the noted exception being the lack of hospital participation in discussions/projects related to integration of primary care and behavioral health. While there is representation from hospital system behavioral health staff, there is a lack of stakeholders from primary care. In addition, interviewees indicated that all CMHCs are at the table; however, there is an inherent imbalance in representation geographically due to the fact that there are five CMHCs on the Missouri side and only two on the Kansas side. It was reported that at times participation of the Kansas CMHCs has been lacking.

Much like the organic nature of the committee structure, the membership and levels of participation often fluctuate in correlation with the priorities. As the committee engages in discussions and activities around new topic areas, consideration is given to the appropriateness of the membership and whether any organizational gaps exist. When gaps are identified, MMHS members make recommendations, and the RHCI staff recruits new organizations or individuals to the committee. For example, at the time of this report, the group identified that they would need to seek additional membership from housing organizations to provide expertise and input with respect to MMHS' new focus on this issue.

Priority Areas, Activities and Achievements

In 2009, the MMHS organized its work primarily around the service needs of consumers and created two subcommittees: the Continuum of Care Subcommittee and the Privatization Subcommittee, which focused on the closing of the children's unit at Western Missouri Mental Health Center. The closing of the children's unit and the state's need to redirect the appropriated funds to a new program provided the MMHS a clear agenda upon which to act and ultimately led to the creation of the Children's Enhancement Project and the Children's System Change Subcommittee discussed in detail below.

In 2009, MARC hired HMA to perform a behavioral health needs assessment of the region. Based on HMA's review of existing needs assessments, identification of services and gaps and through a series of interviews, focus groups, and surveys of the community; eight (8) areas of need were identified. The final report included recommendations for community initiatives that would address the identified needs;

based on the recommendations MMHS chose to prioritize its work around integration and housing in 2010.. And in 2011, with the assistance of the RHCI, the MMHS Committee engaged a consultant to facilitate a formal strategic planning session to choose its priorities. As a result of this effort the MMHS adopted the following mission statement.

Metropolitan Mental Health Stakeholders of Greater Kansas City fosters universal access to high quality prevention and treatment services for all persons with mental health, substance abuse and developmental disability issues.

As part of the strategic planning effort, the following priority areas were identified for 2012 and based on the committee's assessment of progress; there was a decision to carry these priorities through 2013.

- Meeting the housing needs of consumers with chronic mental illness.
- Using MMHS expertise and resources to build trauma informed communities.
- Integration of primary and behavioral health care.

As the primary direct service provider of mental health services in the Region, the CMHCs play a significant role in driving the priorities of the MMHS. One interviewee indicated that the priorities have shifted away from the initial emphasis of the original stakeholders group, consumer needs, to a provider- and professional-focused agenda. This was not identified as a shortcoming of the RHCI, but rather acknowledged as the reason the MMHS may continue to see less participation from consumer-focused organizations.

Members of the MMHS refer to the Committee as a loosely organized group. While the MMHS and some of its subcommittees have undergone strategic planning efforts to set priorities, to date there have been no measurable goals identified by which to track the completion and success or failure of a project. Interviewees likened the process of identifying and implementing new priorities and activities to raising a child: each project goes through a unique life cycle, requiring more attention and work from Committee members in its infancy with the goal of eventually "graduating" from the purview of the MMHS out into the community as a self-sustaining program. However, because there are no measurable goals or benchmarks identified at the outset of the project, there is no formal process by which the Committee determines when a project is complete. Rather the Committee, under the leadership of the co-chairs, regularly discusses and gauges the readiness of the project to "graduate."

Multiple interviewees stated that the goal of the MMHS is as much the process itself as it is the outcomes. Several noted that bringing people together creates an opportunity to learn from one another. Still others acknowledge that expectations of the Committee are high, and other communities have found it can take 5 to 10 years to achieve system change. Therefore, in the short term the group has tried to identify and address the low hanging fruit, and now what is left to tackle are large-scale systematic issues. Committee members acknowledged that these large-scale system change issues will be difficult and complex but will also keep the membership actively engaged.

Housing—Housing has been a longstanding priority of the MMHS; however, for a variety of reasons the work has not yet begun. In 2010 the MMHS set the goal of developing a 3-5 year regional housing

roadmap for individuals with behavioral health needs. A survey was conducted of housing providers to build a housing database and identify capacity issues; however, according to the document review, this work was not completed because at the recommendation of the RHCI Director, the Committee agreed to put housing-related work on hiatus to support the current efforts of the Kansas City Homeless Task Force and not duplicate meetings and tasks. More recent plans and projects related to housing have been delayed by the Committee to ensure ongoing priorities in other areas—specifically, integration and trauma informed care—have enough resources and focus to be successful. At the time interviews were being conducted for this evaluation, the Committee was anticipating the housing work would begin in the fall of 2013.

Integration of Primary Care and Behavioral Health— In 2010, the MMHS initiated efforts to bring external consultants to provide technical assistance (TA) to the Region’s CMHCs with the goal of developing a model of integration for Kansas City. However, when the State of Missouri launched its Medicaid health home initiative, the focus of this TA effort shifted to a Kansas-only project so as not to duplicate efforts underway in Missouri. Some interviewees reported that the TA was not beneficial to their organization: the consultant’s proposed model of integration lacked the necessary flexibility to incorporate the local needs of the CMHC.

In 2012 the MMHS redirected its overall approach to integration and, rather than pursuing implementation of an integration model, a survey was developed to assess readiness for integration across all providers within the behavioral health system. This approach would allow the Committee to identify gaps, connect providers with technical assistance, identify pilot projects, and develop sustainable funding and data sharing across providers. The results of the survey were utilized to develop topics for an Integration Forum Series. The Series was developed by the Committee to lay a foundation and educate behavioral health and safety net providers on emerging issues and best practices related to integration of primary care and behavioral health. Interviewees identified that the healthcare system has historically been reactive, treating whoever comes to their door rather than taking a more global approach to understanding population health and how to manage a population. While the MMHS has yet to begin pursuing this new approach to care, they see the Forums as an opportunity to start moving in this direction, assuming strong leadership from the RHCI. However, it was noted that, in order to achieve integration, behavioral health and primary care would not be meeting separately; they would be meeting together around population health.

Individuals indicated that the desired outcome of integration efforts are long term and too early to measure. They believe the first step would be assessing the degree to which best practices are being put in place. Another interviewee stated that the real value is the “ah ha” moments that come out of the forums; that is what drives the change, but it is difficult to measure. Multiple interviewees acknowledged that they and their staff have found the Series to be informative; however, to date no formal assessment of the impact of the Series has been undertaken. As of August 2013, the Committee had hosted three of the four planned forums. After every forum the Committee assesses action items and next steps.

Children’s Enhancement Project— Upon closure of the children’s unit at Western Missouri Mental Health Center in 2009, the state consulted with the MMHS to develop a program that would reallocate the Center’s \$1.2 million budget back to the community. The MMHS developed a proposal creating the Children’s Enhancement Project (CEP) to serve children with serious emotional disturbance (SED) in the community by providing resources and supports to families that were not previously available. Despite a significant decrease in the budgetary allocation, the CEP, as proposed by the MMHS, was approved by the state and began serving children in 2010.

An evaluation conducted by the University of Kansas and finalized in March 2013 found that the CEP made significant developmental strides. The establishment of healthy collaborative relationships, strong leaderships, and significant support for CEP direct service staff were identified as particular CEP strengths. In addition, stakeholders expressed a general consensus that the CEP is achieving positive outcomes for the children and families served by CEP. Overall, the CEP has increased access by expanding the continuum of community-based services available to children. Some of the interviewees identified the CEP as one of the significant achievements of the MMHS in that it began with a concept that was developed into a program that is now self-sustaining and has increased access by expanding the continuum of community-based services available to children.

Children’s System Change Subcommittee

The Children’s System Change (CSC) subcommittee was developed alongside the Children’s Enhancement Project to spearhead system-level change and develop a broad continuum of care inclusive of the intensive services available under the CEP. The CSC Charter describes the subcommittee as “a formal planning and advisory body that is charged with the development of recommendations and on-going assessment of transformational initiatives to enhance behavioral health care for children in the region.”

In July 2011, the CSC subcommittee commissioned a Children’s Behavioral Health Needs Assessment for Greater Kansas City to evaluate gaps and barriers to care and develop recommendations to improve access to quality behavioral health care for children in the region. Primary research included a consumer survey of 602 children and caregivers, a survey of 30 behavioral health care providers, and nine intensive interviews. Secondary research included county demographic profiles, a literature review, policy scans in both Kansas and Missouri, and a resource inventory. The needs assessment led to key recommendations, which were further refined at a community forum held on January 19, 2012, and attended by more than 130 mental health stakeholders. Multiple interviewees identified the completion of the Children’s Behavioral health Needs Assessment as one of the significant achievements of the MMHS. In 2012, the CSC utilized results of the Children’s Behavioral Health Needs Assessment and feedback from the community forum to determine its priority areas. They choose to pursue the following three objectives:

- Inform resources to expedite entry to care.
- Work to make child behavioral health affordable and accessible.
- Incorporate assessment of history of abuse/trauma, family history of BH/SA and high-risk pregnancy into health screenings by all providers.

Interviewees reported that there was significant activity around these objectives; however, because of the broad scope and lack of specific and measurable goals, little was completed. Recently, a strategic planning effort (August 2013) was conducted to identify tangible, measurable, and targeted primary objectives for 2013.

1. Design and launch a pilot program in the Kansas City, Missouri, school district in which both student mental and physical health needs are addressed through appropriate partnerships with local resources and attention by staff professionals, such as nurse practitioners and mental health counselors. Work will also be done to identify current local programs to learn which ones have been effective and which ones have not.
2. As an integral part of the pilot program, address family issues that emerge through onsite and remote consultations with parents and others involved in the student's well-being.
3. Identify and resolve emerging technology issues in the pilot program to enhance care and reduce redundancy.

The committee intends to document a work plan with implementation steps for each objective at its next scheduled meeting.

Legislative Advocacy Subcommittee

Since 2010, the MMHS has developed an annual legislative agenda that is used by RHCI staff and MMHS members to educate legislators and other stakeholders regarding issues related to behavioral health services and funding. The subcommittee identified four priority issues for 2013:

- Support of Medicaid expansion under the Affordable Care Act up to 138 percent of the federal poverty level.
- Support for open access to mental health medications.
- Increased funding to community mental health centers.
- Support of housing policies that benefit persons with mental illness.

Throughout the years, the subcommittee has engaged in a number of advocacy efforts such as holding a series of informative lunches with individual elected officials, writing newspaper editorials, and sending Christmas cards highlighting the MMHS' impact on behavioral health. In addition to meeting with legislators, the RHCI Director has developed relationships and partnered with a variety of organizations to move the MMHS legislative agenda forward. This year the subcommittee is hosting a number of open houses at the RHCI offices to bring legislators and MMHS members together to discuss important issues related to mental health.

One MMHS participant stated that the uniform front that RHCI represents for policy issues is powerful. Others indicate that they do not expect the RHCI and the work of the Legislative subcommittee alone to facilitate policy change; there are many other organizations with strong lobbying arms that are front and center in the advocacy arena. This is not the primary purpose of the MMHS; rather, interviewees believe it is the role of the MMHS to validate other organizations (e.g., National Alliance on Mental Illness and

Mental Health America) by joining the voices of the MMHS to all others out there. They believe this defines the value of the subcommittee.

Trauma Matters KC Subcommittee

The Trauma Informed Care Subcommittee initially developed as an outgrowth of the findings from the Children’s Behavioral Health Needs Assessment conducted by the CSC. A separate committee has since been formed and is referred to as Trauma Matters KC. The goal of the committee is to establish common practices on trauma informed care among agencies in the Kansas City community. To achieve this goal, the Subcommittee has created three subgroups which represent the chosen areas of focus:

- social media and marketing
- professional development
- community education

In January of 2013 the RHCI and MMHS co-sponsored—with the Health Care Foundation of Greater Kansas City, REACH Healthcare Foundation in cooperation with the National Association of State Mental Health Program Directors, and SAMHSA—a two-day training on understanding and developing a “Trauma Informed Community.” Several interviewees identified the work done by the Trauma Matters KC, primarily the trainings, as the most significant achievement of the MMHS to date. They point to the strong leadership and passion of the Subcommittee’s chairperson as the impetus for the successes to date. As a result of the work done, there is a greater awareness of the concept of trauma informed care and a readiness among some organizations to adopt models. This assessment of progress is based on anecdotal feedback and not a survey or other quantitative evaluations of the community’s awareness and understanding of trauma informed care.

The Professional Development subcommittee conducted a survey of area health and mental health organizations to help identify training needs and other areas where help is needed in the Greater Kansas City community.

The Community Education and Social Media and Marketing subcommittees are organizing activities to help implement the key recommendations for messaging and communication related to trauma informed care that were identified in the Children’s Behavioral Health Needs Assessment.

Barriers and Missed Opportunities

Disparate State Laws

The majority of requirements related to mental health services and funding are regulated at the state level. This has a significant impact on providers and consumers in the Kansas City region, as Missouri and Kansas have differing mental health provider regulation and programs, services, and funding streams. Members of the MMHS indicate that there is little common ground between the two states, which creates barriers for the Committee when identifying and pursuing projects that are beneficial across the region. For example, the next priority that will be addressed by the MMHS is housing for individuals with a chronic mental illness. Missouri has funding mechanisms available for providers to develop new housing opportunities and programs; Kansas does not offer providers the same funding opportunities. As such,

the Missouri MMHS members are ready to begin researching and designing housing models, while the Kansas members focus would have to be patching together money with existing housing entities. As a result of this barrier, some Kansas stakeholders anticipate they will not be active participants in any housing projects.

While the MMHS has a legislative advocacy committee, interviewees indicate that making changes to state regulation and policy is extremely challenging when working across two states. State legislators do not want to hear about other states and how their regulation and policies do not align. Therefore this makes addressing regulatory issues unique to the metropolitan area very difficult. Interviewees do not feel that aggressively pursuing legislative change is a valuable use of MMHS and RHCI resources; rather they believe that the Committee must find ways to work within the constraints of state law, primarily by finding commonality across the two states and pursuing initiatives in those areas.

Relationship with RHCI Unclear

Members of the MMHS, some of whom have held leadership roles in the Committee, indicate they are unclear about the relationship between the MMHS and RHCI. It was the sense of the members that while the Safety Net Collaborative was a core committee, the MMHS were “squatters or adopted.” From their perspective this has left members and Committee chairs uncertain as to the role of the RHCI staff and their ability to access RHCI staff and financial resources, which results in missed opportunities and efficiencies.

Integration of the RHCI

The MMHS conducted a survey to assess readiness for integration within the behavioral health provider community. While this survey was informative, there was a missed opportunity to also survey the primary care provider community to learn how the two groups can begin to address the issues together. In addition, as previously noted, the MMHS’ efforts to educate and move the system towards a more integrated model have lacked meaningful representation and input from the primary care community. While RHCI staff share updates across all of its committees, there is a lack of integration at the committee level that could be achieved by bringing all the committees together to prioritize goals for the overall Initiative and to identify cross-purpose goals and projects that the committees can all contribute to.

Community Health Worker Committee

Background

The Community Health Worker (CHW) Committee was created outside of the Regional Health Care Initiative by the KC Care Clinic and other stakeholders with the goal of improving health outcomes for at-risk, medically vulnerable patients by assessing the need for and better understanding the role of Community Health Workers. In 2012, the group requested to be merged into the RHCI both to provide infrastructure and support for the group and to more closely align its work with other components of the RHCI.

CHW Committee and Subcommittee Structure

After joining the RHCI, the Committee transitioned from an advisory group within the RHCI to a formal committee to address the training, promotion, and sustainability of CHWs. The Committee recently completed a strategic planning process, which resulted in the formation of two work groups. The first group will work on community education and membership, including recruitment and outreach. It will also determine community needs to adjust and refine training curriculum and identify CHW best practices going forward. The second group will focus on sustainability, including researching state certification options, and explore potential payment legislation based on similar activity in other states. It will also look at what barriers and challenges affect the acceptance and use of CHWs.

Priority Areas, Activities, and Achievements

Since its creation, the CHW Committee has focused on the following priority areas:

- Reviewing models and lessons learned from other geographies with respect to CHW certification, buy-in, and curriculum and payment models and using this information to develop a regional CHW model.
- Developing and piloting a CHW curriculum in conjunction with MCC and the KC Cares Clinic.
- Developing a survey to assess employer buy-in and identify potential CHW employers.
- Beginning to work on measuring financial impact and pursuing payment legislation.

Committee members and other stakeholders identified several key Committee achievements:

Curriculum development. Over the past year, members worked in an advisory capacity in support of the Metropolitan Community College system, as part of a Missouri workforce development grant. The grant supported the establishment of a pilot program and development of training materials, curriculum, and marketing plans for the training of CHWs. Pilot graduates are now working at the KC Care clinic and Truman, and MCC is preparing to begin a second pilot cohort.

Regional definition and acceptance of CHWs. Individuals interviewed for this evaluation felt fortunate to be an active part in the decision-making process that led to the development of the region's CHW model, including the CHW definition and training. They also reported significant progress in educating providers and other stakeholders about the role of CHWs

Barriers and Missed Opportunities

Business case/ reimbursement

While the CHW Work Group has made significant strides in a relatively short timeframe, stakeholders acknowledged that perhaps the biggest challenge to the acceptance and diffusion of CHWs is the financial model. The recently created CHW sustainability work group is charged with exploring payment legislation. It is unclear if this work group will also focus on documenting the business case for CHWs both to support fee-for-service payment legislation and to demonstrate CHW value under risk-based payment models.

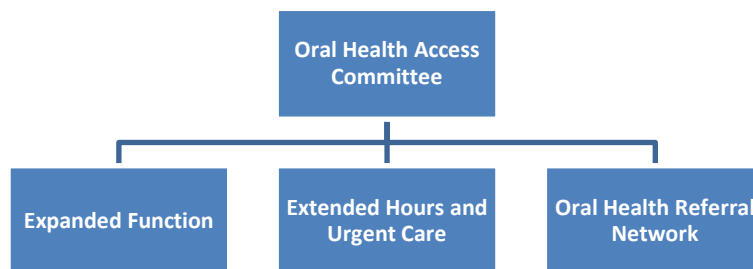
Oral Health Access Committee

Background

In 2010, the University of Missouri-Kansas City (UMKC) School of Dentistry received a Robert Wood Johnson Foundation grant to fund the placement of students and faculty in safety net clinics to provide oral health services to indigent children. The Use of Students project sought to expand the capacity of dental health clinics in five community health centers with the goal of improving access to dental safety net providers. As the grant period ended and the clinics began to seek funding independently, the Foundations (REACH and Health Care Foundation of Greater Kansas City) provided a bridge grant. The RHCI was approached by project leads to assist in finding a sustainable funding stream for the project and to provide policy support with the broader goal of expanding oral health access throughout the region. Through this partnership the Oral Health Access Committee was formed in 2012.

Oral Health Access Committee and Subcommittee Structure

The Oral Health Access Committee has three working groups that tie directly to the three identified priority areas of the Committee. The Committee meets on a monthly basis and the Workgroups meet at least monthly reporting up to the larger Committee.



Similar to the other RHCI committees, two individuals co-chair the Oral Health Access Committee. However the current co-chairs, the original creators of the Committee, both represent Missouri organizations. There is a process underway to nominate new chairs following the RHCI bi-state model. The co-chairs meet with the RHCI Director monthly to set meeting agendas and strategize around long-term priorities. The interviewees indicated that the RHCI staff assist with the administrative needs of the Committee and, to some degree, help shape the group's work.

Interviewees report that the committee membership is representative of the region's oral health community with participants from all safety net clinics offering dental services, the medical referral organizations, community colleges with dental programs, and UMKC. In the event that a gap in expertise is iden-

tified, the RHCI staff reaches out to engage an organization or individual with that expertise and ask them to join the committee.

Priority Areas, Activities and Achievements

Following the inception of the Committee, the RHCI staff created and sent out a survey to Committee members to identify the top three oral health priorities. From this initial survey, the Committee determined its priority areas, which included Expanded Function, Use of Students, and Specialty Care Access. The Committee reports that an additional survey is planned to assess what oral health services are currently offered by Safety Net Clinics in the region and better understand each clinic's clientele, business model, volunteers, services, operating protocols, medical and technology capacity, and relationships with other clinics and safety net partners. Though a more comprehensive and thorough assessment is anticipated, the survey will help the Oral Health Access Committee begin to:

- Understand the current capacity of the safety net system and identify capacity shortfalls and appropriate strategies to address them.
- Better understand business and volunteer recruitment and utilization practices and identify potential areas where clinics might more effectively work together.
- Catalog information on oral clinic operating protocols and inter-clinic relationships to facilitate coordination and cooperation among oral health clinics.

In addition to gathering feedback through survey responses, the co-chairs actively engage with the community and stakeholders to ensure that the Committee's priorities are representative of the needs of the community being served.

In 2013, with some experience under its belt, the Oral Health Access Committee redefined its three priority areas (listed below) to have greater focus on projects that were not only relevant, but where they believed they could be successful. While the priority areas are based on needs identified through a membership survey, to date measures have not been set to track the status of projects or whether or not the work has been successful. Thus, the following activities and achievements are anecdotal.

Extended Hours and Urgent Care

This new subcommittee is working towards developing a more systemic approach to after-hours and urgent oral health care for safety net patients.

Expanded Function Training

Interviewees report the Expanded Function Training as the Committee's greatest achievement to date. The Committee has created a training series to provide dental assistants working in the Missouri safety net clinics with the skills necessary to perform expanded functions; this will allow dentists to focus their time on more skilled procedures, thereby increasing productivity and ultimately access. Committee members reached out to schools and instructors to donate space, time, and other resources, which allow the cost of the training to remain low. The Missouri Primary Care Association has also supported the program by purchasing equipment; the Association intends to expand the program statewide.

To date 13 to 14 dental assistants have completed Level 1 training, a precursor to Level 2 training, which is the portion of the training that will result in practice level change and ultimately impact access. The Committee continues to develop the curriculum for Level 2 and work with the state of Missouri to obtain approval. In addition, the subcommittee is looking for other areas to improve or expand.

Oral Health Referral Network

Studies have shown that a significant portion of dental issues flooding the emergency rooms could be avoided with better access to oral surgery and endodontics. The Specialty Care Access subcommittee sought to address this issue by increasing access to specialty care in the region. However, because of the lack of specialists willing to donate their time or accept Medicaid patients, the Committee was not successful in its initial efforts. Having identified this barrier, the Committee shifted the focus of its priority and is researching other models of care, including an Oral Health Referral Network, to remedy this long-standing access issue.

Other Committee Achievements

Collaborative Thinking

The Committee has brought the dental community together through its regular meetings and activities. Interviewees state that they have all become more aware of what each other are doing, and this has led to sharing of ideas and best practices. Such “collaborative thinking” has resulted in changes at individual clinics. For example, the clinics participating in the Use of Students project were able to discuss experiences and share lessons learned about how to use the students in a manner that is more time- and resource-effective and efficient. This has benefited the students, the clinics, and ultimately the community. Anecdotally, the interviewees report that there has been an increase in access resulting from the efficiencies that have been gained.

Free Dental Clinic

Dr. Oz hosted an event at Bartle Hall in the Kansas City Convention Center at which the Oral Health Access Committee opened a free dental clinic. During the two-day event, the clinic treated approximately 2,000 patients. Some interviewees stated that they would not have been able to coordinate across all the participating clinics and providers had they not already been at the table with the Committee working together, but one interview questioned the ultimate impact of the event, noting that there was little effort to connect patients to dental home to meet ongoing dental needs.

Oral Health Resource Directory

The MARC staff compiled and updates a list of oral health programs and resources available within the region. It is not clear whether this is an internal resource for the Committee or is shared more broadly with the community, like the Kansas City Health Resource Guide.

Barriers and Missed Opportunities

The respondents identified barriers and missed opportunities outlined below are those that have impeded the activities of the Committee to date. Some of these the Committee has elected to accept and work around while others were identified as potential areas for improvement.

Scope of Practice Limitations

The rules and regulations for medical and dental practitioners differ across state lines, requiring different approaches within each state to address access issues. Several interviewees noted that, because of the more limited nature of Kansas' scope of practice for dental assistants, the Expanded Function training was not a viable solution. To date, the Oral Health Access Committee has not taken on these regulatory/policy issues; rather they have acquiesced to working within the confines of existing state laws. However, one interviewee noted that there were significant scope of practice changes occurring in Kansas at the time and that the Oral Health Access Committee would have been more effective if it leveraged these efforts rather than solely focusing on a Missouri approach.

Data Gathering and Measurement

Respondents acknowledge that the Committee has not set goals with measurable outcomes, and therefore data has not been collected to set a baseline against which to measure success, regardless of whether it is increased access to oral health services or the effectiveness of a new process. They identified this as a missed opportunity. Without baseline data and ongoing evaluations, the Committee is only able to quantify the impact of their work anecdotally, making expansion and/or replication of projects or requests for funding a challenge. The respondents believe that there are factors that should be measured and that the RHCI should play a role in assisting the Committee with identifying appropriate measures and obtaining data. In particular, the respondents discussed that the RHCI should be working closely with the local public health departments to access data.

RHCI Structure and Priorities Unclear

The interviewees believed that the addition of the Oral Health Access Committee seemed a natural complement to the RHCI's other committees: SNC and MMHS. However, they also indicated that they did not believe that the Oral Health Access Committee was one of the "official" RHCI initiatives. They did not have a clear understanding of the committee structure or priorities of the RHCI and therefore could not speak to whether it has been effective in assisting and supporting the Committee's activities.

Key Findings and Recommendations

HMA was engaged by the principal funders of MARC's RHCI to evaluate how well the RHCI has met the following goals:

- Improve collaboration and partnership among safety net organizations in the region.
- Increase access to care in the region.
- Improve coordination and efficiency within and among safety net organizations in the region.

In determining whether the RHCI has met these goals, HMA was asked to consider what changes have occurred in the safety net since the implementation of the RHCI, what barriers inhibited change, and what lessons might be gleaned to inform future activities.

What changes have occurred in the safety net since the implementation of the RHCI?

Since its creation in 2007, the RHCI can be credited with some significant achievements that have changed the Kansas City safety net. Notable among these are:

- The after-hours initiative, which increased access to primary care during critical evening and weekend hours.
- The care coordination initiative, which has shown a positive impact on improving access and reducing unnecessary emergency room visits.
- The creation and implementation of a CHW curriculum, as well as the development of a regional CHW definition that is helping to change the dialogue and increase the receptiveness of the local safety net to CHWs.
- The diffusion of trauma-informed care throughout the region, which is educating both health care and non-health care system partners about this important issue.
- The completion of a children's behavioral health needs assessment, which has identified gaps and barriers to care and developed recommendations to improve access to quality behavioral health care for children.

These activities were widely cited by stakeholders as successful. The most often-cited achievement of the RHCI, however, is that it succeeded in bringing organizations to the table that historically did not work with each other. It is difficult to place a value on this, but almost all the individuals interviewed for this evaluation believed their organization benefitted from sitting around the table with other organizations from across the region. In some cases, interviewees were able to cite specific collaborations that resulted from sitting around the RHCI table, and in their opinion, would not have occurred without the RHCI. While others could not cite a specific impact on their organization, they still believed there was an inherent benefit in RHCI participation that was significant enough to continue bringing them to the table.

With few exceptions, the stakeholders interviewed for this study acknowledged the need to move beyond "sitting around the same table" toward more concrete, outcome-based goals, but they also ex-

pressed a strong belief that this next phase of the RHCI's work could not occur without the foundation that has been established. Many noted that they have come to rely on the RHCI as a resource for data and information, as well as a vehicle for learning from and collaborating with other organizations. Many also expressed that the early years of the initiative – while fraught with “territorial-ness” and competitiveness – were necessary in order to build the level of trust that exists today and that trust was a necessary precursor for any successful collaboration.

What barriers inhibited change?

Throughout the document review and stakeholder interview process, several barriers to change were identified. In many cases, these barriers cut across many or all of the core components of the RHCI. Below we summarize the most significant.

The mission and goals of the RHCI have not been consistently articulated, supported, or measured by the RHCI or the Funders. Though the Funders note there were significant efforts to clearly articulate the mission and goals of the RHCI at the outset.

During each interview, participants were asked to articulate the mission of the RHCI. Answers varied widely, but very few individuals articulated that improving access, creating efficiencies, or improving coordination were part of the mission. Many expressed that the mission of the organization was simply to “bring people together around the same table.” In addition, the RHCI web site contains an outdated mission statement that was reflective of the original goals of the initiative based on the HMA report but is not reflective of the revised structure and goals.

The RHCI was created based on the belief that safety net organizations could learn from and leverage each other to find areas where, working together, they could achieve a whole greater than the sum of its parts. It was also clearly built on the principle that the safety net organizations themselves were the experts and, therefore, should take the lead in identifying these opportunities, with guidance, support, and facilitation from the RHCI staff. While we understand that the stakeholders completed a “visioning” process early on, the individuals interviewed for this evaluation articulated widely varying versions of the vision. This is indicative of – in our experience – several factors:

- *Inadequate communication and messaging.* The mission and goals of the RHCI should be clearly articulated in all RHCI materials, including external reports, the RHCI web site, and internal reports and communications.
- *Inadequate or uneven supports and technical assistance.* Some of the RHCI committees and subcommittees likely could have benefitted from additional strategic planning support and technical assistance to identify high-value priority areas and develop work plans.
- *Lack of focus on or measurement of outcomes.* In many cases, RHCI committees and subcommittees did not establish and were not held to measurable goals that could be tied back to the vision (see discussion below).

Despite early efforts around strategic planning, the RHCI as a whole lacks a unifying strategic plan. The level of strategic planning across the core committees varied, but committees with a clear plan appeared to be most successful in engaging members.

While most of the RHCI committees have undergone some level of strategic planning, ranging from informal to formal, the RHCI as a whole has not completed a strategic planning process to define its mission and vision and then establish a structure, goals, and implementation plan that are consistent with the mission and vision. The strategic planning process should:

- Identify where the RHCI can have the greatest impact working collaboratively and across state lines.
- Establish clear, measurable, time-limited goals for the initiative that align with the mission and vision.
- Provide a multi-year road map for the initiative to guide committee structure, staffing, and resource allocation with flexibility to allow the RHCI to take advantage of unexpected opportunities that align with its mission and vision.
- Identify areas where other organizations/initiatives are already active and effective and where the RHCI can play a supportive role.

The bi-state focus of the RHCI sets it apart from other organizations doing working in health care policy and programming. However, the disparate approach of the states to policy and funding creates a significant barrier that has often inhibited RHCI projects from being pursued across the state line.

There was a unanimous response from interviewees that the RHCI is the only organization doing work across the state line in the greater Kansas City region, and many indicated that because of this unique approach, participation in the Initiative is valuable to their organization. Many individuals identified issues of disparate state law and funding as a barrier to projects being pursued by the RHCI and its committees. However, rather than address the issues, in many cases projects are being pursued and implemented on one side of the state line (i.e., MMHS-MO Housing, Oral Health-MO Expanded Function). If the RHCI determines through a strategic planning effort that representing the region as a whole is core to its mission and goals, then there should be a greater effort to address the issues that create division, choose projects that can be successful on both sides of the state line and identify initiatives where a single state approach aligns with the RHCI mission, goals and objectives.

It is not clear that the organizational structure, leadership, and membership are appropriate or sufficient for the organization's mission.

Multiple interviewees expressed confusion about the overall structure of the RHCI and how their committee or subcommittee fit into the structure. For example, some MMHS and Oral Health Committee members did not feel that they were on equal footing with the SNC and did not know how their committee's resource needs were prioritized relative to the needs of other committees within the RHCI. Committee chairs do not have annual budget allotments, making it difficult to plan activities and secure outside resources (e.g., speakers and consultants) where needed.

Without exception, RHCI members spoke very highly of RHCI's administrative ability and resources. Meeting logistics, including planning, materials, minutes, coordination with outside presenters, etc., are handled entirely by RHCI staff. Busy committee chairs and members cited RHCI administrative staff support as invaluable, as it allowed them to focus on substance rather than logistics. Some of the individuals interviewed for this evaluation believed that the RHCI staff needed to be larger and/or have a deeper level of subject matter expertise. Others believed the scale of the RHCI was so broad that the staff's role should be that of facilitation and issue identification, with subject-matter expertise provided by the membership and outside consultants.

The membership of the RHCI committees was quite representative on a geographic basis, and the open membership structure provides substantial flexibility to invite additional organizations to the table as appropriate. For example, as the MMHS group begins to focus on housing issues, it is planning to reach out to various housing organizations that have not been at the table to date. Notably absent from the RHCI, however, were several critical pieces of the safety net that, depending on specific goals and activities, could be very important. These include:

- Medicaid health plans and the state Medicaid agencies
- long-term services and supports (LTSS) providers, and
- hospital providers (note: there was some hospital representation on various RHCI committees, but it was unclear if they were positioned to inform system-level decision-making and change).

The complexity of the work undertaken by the RHCI – especially the dynamics of working across multiple organizations and a state line – highlight the importance of effective leadership at both the RHCI and committee co-chair levels. Multiple examples from the document review and interviews indicate the importance of effective leadership in moving a complex agenda forward (e.g., trauma-informed care) and, conversely, the missed opportunities that might have benefitted from strong leadership (e.g., specialty care).

RHCI impact and outcomes have not been sufficiently measured or documented.

Closely related to the findings above, many of the projects and activities undertaken by the RHCI lacked clear goals and measures against which to evaluate progress. There were notable exceptions to this, including the after-hours initiative, which had a formal external evaluation, and the care coordination initiative. While not every activity requires a formal evaluation, we found it difficult in many cases to glean even process-oriented measures from the documents reviewed. The lack of evaluation and measurement also made it extremely difficult to measure the relative success of any given project within the RHCI. Our review of the annual RHCI reports to each of the funders also indicated that the funders did not emphasize measurement and evaluation as part of the funding process.

RHCI tools and materials have had varying levels of impact, with some being utilized extensively and others rarely.

Stakeholders reported that they and their clients or patients frequently utilize the KC Health Resource Guide and have come to rely on it as the comprehensive source of information on safety net services. Many of the individuals interviewed also reported using the *Safety Net Story*, the regional access study,

and the infrastructure white papers for grant-writing and external relations purposes. Having access to these resources saved them time and money that they would have otherwise had to expend to gather this information individually.

In contrast, most of the individuals interviewed did not use the monthly e-newsletter or the RHCI website as a regular source of information. Data provided by the RHCI indicate that visits to its website have increased significantly over the last few years. However, most people spend less than two minutes on the site, and interviews revealed that RHCI members rarely use the web site, as the content is limited and not frequently updated.

	2009	2010	2011	2012	2013 (6 mos, annualized)
Visits	7,744	7,487	7,347	9,201	10,910
Page Views	3,933	3,949	4,144	5,034	6,536

What lessons might be gleaned to inform future activities?

If the RHCI is to move forward it must build off of the existing foundation and establish a new culture based on a shared vision, clear expectations, and measurable goals. Specifically, HMA identified the following lessons that might inform future RHCI activities:

A comprehensive strategic planning process is needed to identify high-value activities and prioritize activities and resources based on anticipated impact.

The strategic planning process should begin with articulating the mission, vision, and values of the Initiative. The strategic priorities should be routinely communicated to RHCI members and other stakeholders and should form the basis for decision-making, resource allocation, and measurement/reporting.

While the strategic plan should be created by the regional safety net stakeholders, several potential priority areas were identified during this evaluation including the following:

- **Provider Workflow Integration**— As safety net providers struggle to integrate data from the HIE into their clinical workflows, the RHCI can work with providers to develop processes, work flows, and use cases. Ultimately, this will provide safety net clinics across the region with a more cost effective means of accessing and utilizing the data available to improve care planning, care management, and population management. It is important to note that MARC is already doing this work outside of the RHCI umbrella, but this would appear to be a logical function of the RHCI and closely aligned with the goals of improving coordination, collaboration and efficiency.
- **Specialty care**— Access to specialty care was an issue identified in the HMA report and recommended as a focus area for the RHCI because of the potential for addressing the issue on a regional rather than a provider-specific basis. The SNC dedicated more than a year to this issue and identified multiple promising strategies that have been successful elsewhere, including e-consults, expanded specialty training for PCPs, and joint recruiting. However, the subcommittee

ultimately disbanded without taking any action. This is an area that calls out for regional solution, and the RHCI provides a vehicle for developing that solution.

- **Data/analytics**— MARC has a wealth of data capabilities that have not been fully utilized by the RHCI. These data and analytic capabilities could be an invaluable resource for the RHCI and could also be a significant “value added” for individual RHCI members. Fully utilizing these resources, however, will likely require MARC to supplement its current staff with health informatics expertise.
- **Delivery system and payment reform**— As we move rapidly toward full implementation of the Affordable Care Act, payers are increasingly looking to providers that can offer enhanced levels of clinical integration and that are willing to take on increasing levels of financial responsibility for patients over time. This is an area that appeared to get little attention from the RHCI but one that could also be successfully supported on a regional level if the right parties are at the table. This would require engaging the Medicaid program, Medicaid health plans, and providers across the full continuum of care (including LTSS) in order to establish pilots. It could also encompass some of the model of care work being done by the RHCI, including the development of the CHW model and the behavioral health integration work.

The strategic plan should drive the committee structure and membership and staffing for the next several years. It should also drive decision-making with respect to prioritization of activities and resource allocation. One funder noted that they believed time should be invested in developing a logic model or theory of change for the RHCI. This is an effective tool for articulating why a strategic approach was chosen and how the activities will create the expected results. It can also be an effective tool for keeping participants moving in the same direction by providing a common language or reference point.

Major programs and activities should have clear, measurable goals that link back to the strategic plan and vision.

As noted throughout this evaluation, many of the RHCI’s activities lacked measurable process and outcome goals and measures, making it difficult to assess impact and prioritize future activities. Not every activity requires a formal evaluation, but each activity should be aligned with the overall mission and should have measurable, time-limited goals against which to assess progress or lack thereof. Measurement will also be critical for demonstrating the value of any given activity, which will drive sustainability (see below).

RHCI structure requires strong “facilitating leadership” at the Executive Director and committee co-chair levels.

The RHCI was created on the premise that the participants themselves are the experts and that they would be responsible for identifying areas where, working collaboratively, they could leverage each other. This type of organization requires a special kind of leadership, known as “facilitating leadership,” both at the Executive Director and committee co-chair levels. Facilitating leaders do not impose or manage to a pre-set agenda or process; rather, they harness the resources of an organization to achieve the organization’s mission. Facilitating leaders must have excellent communication, motivational, and con-

flict resolution skills. They must also provide their organization with the information and tools to be successful.

In many instances, the RHCI's successes and missed opportunities can be traced back, at least in part, to the strength of the leadership in place at the time. For example, strong subcommittee leadership was widely cited as critical to the success of the Trauma Matters KC initiative. Conversely, the SNC was unable to capitalize on a significant amount of momentum on the specialty care issue, in part, because the leadership could not overcome barriers and conflicts within the group.

Major programs and activities should demonstrate value and achieve sustainability over time.

While the RHCI has applied for and received funding from local and national sources, the bulk of its funding continues to come from the two funders of this evaluation. To the maximum extent possible, the RHCI should seek to leverage this funding with support from other sources, including other foundations; local, state and federal grants; and organizations that benefit from RHCI activities. Measurement and evaluation activities should, where applicable, seek to quantify the value created by the activity and to whom that value accrues. For example, if the after-hours initiative was successful in avoiding unnecessary ED visits and, ultimately, inpatient admissions, demonstrating this value to hospitals and health plans could help leverage foundation funding to support the continuation of the initiative. Similarly, it will be important to demonstrate the value of the community health worker model to support a payment model.

Appendices

Appendix A- Document Review

The following is a comprehensive list of the documents provided by the Funders and MARC staff to HMA for review and analysis. The document names are captured here as provided.

Committee/ Project	Document
After-Hours	2009-2012 minutes
After-Hours	Final Template Year III Overall Outcomes Reporting
After-Hours	Grant Reports
After-Hours	NORC Evaluation of the KC Safety Net Expansion Project
After-Hours	NORC Assessment of the KC Safety Net Expansion Project, Year 2
Children's System Change	2011 System Change meeting minutes
Children's System Change	2012 System Change meeting minutes
Children's System Change	CHARTER System Change Committee
Children's System Change	Discussion from the April 2013 Children
Children's System Change	Recommendations Timeline
Children's System Change	CEP Stakeholder Interview and CSWI report 03.29.13 FINAL
Children's System Change	Children's needs assessment_MARC2012
CHW	05 Deployment Approach
CHW	2013
CHW	COMMUNITY HEALTH WORKER
CHW	Draft Dec 2012 CHW min v2
CHW	KC Care Coordination report
KC BHIE	05 Deployment Approach
KC BHIE	DRAFT KCBHIE Grant Proposal
KC BHIE	eHealthAlign power point template update
KC BHIE	eHealthAlignPacket
KC BHIE	FINAL eha report 11 4 11
KC BHIE	Formational Board of Directors
KC BHIE	Governance Principles 1.12.10
KC BHIE	ISC Participant Directory
KC BHIE	Kansas Safety Net Technology Assessment
KC BHIE	KC BHIE Advisory Notes
KC BHIE	KC BHIE Reports 06.26.09
KC BHIE	KCBHIE Presentation Updated 5.13.10
KC BHIE	KCHBIE Proposed Interim Decision Making
KC BHIE	Missouri Safety Net Technology Assessment
KC BHIE	org chart 1 2
KC BHIE	SNC EMR - EHR survey
MMHS	2009 Minutes
MMHS	2010 Minutes
MMHS	2011 MMHS Minutes
MMHS	2012 Minutes
MMHS	2013 Minutes

Committee/ Project	Document
MMHS	MMHS 2012 Mission-Vision statement
MMHS	MMHS draft definition on integration
MMHS	mmhs-legislative-priorities-Final Document
MMHS	October MMHS Directory
Oral Health	Oral Health Access Survey Template
Oral Health	Oral Health Directory
Oral Health	Oral Health meeting minutes 2012
Oral Health	Oral Health meeting minutes 2013
RHCI	HCFR Final.RHCIReport 2010yr
RHCI	hcf-Grantee-Final-2011yr
RHCI	REACH 2010 Final narrative
RHCI	REACH.inal.2011
RHCI	REACH.final.2012
RHCI	REGIONAL HEALTH CARE INITIATIVE
RHCI	RHCI2009 Final Report
RHCI	rhci 2012 hcf
RHCI	HCF - RHCI Interim Report 6 28 13 - 2.doc
RHCI	Regional Health Care Initiative 09 Strategy.doc
RHCI	Web HRG Eng only '12 final
RHCI	Web HRG Spn only ' final
RHCI	Monthly Newsletters
RHCI	MARC - RHCI 2011 Proposal FINAL
RHCI	MARC Special Initiative Proposal 2854
RHCI	Mid America Regional Council Final Abstract 2173
RHCI	Mid America Regional Council Final Grant Report 2173
RHCI	Mid America Regional Council Final Grant Report 1686
RHCI	Mid America Regional Council Proposal 1686
RHCI	RHCI 2012 - Narrative Proposal
RHCI	RHCI 2012 - Proposal for Certified Diabetes Educator
RHCI	RHCI 2013 - Proposal Narrative
SNC	SNC 2009 Minutes
SNC	2010 SNC Minutes
SNC	2011 SNC Minutes
SNC	2012 SNC Minutes
SNC	KC Safety Net Status and Health Reform
SNC	safety net story brochure
SNC	Safety Net Story
SNC	SNC Task Team Recs: Committees and Charges
SNC	SNC Task Team Charges
SNC	Final RHCI Capacity Report 2-10
SNC	SNC Brief
Trauma Matters KC	2012 Notes
Trauma Matters KC	2013 Notes

Committee/ Project	Document
Trauma Matters KC	Trauma Matters KC Committees
MISC	Contracts
MISC	Other Trainings
MISC	KC Health Resource Web Stats

Appendix B—Stakeholder Interview List

Name	Title	Organization
Amy Falk	Executive Director	Caritas Clinics
Barbara Wiman	Industry Coordinator	Metropolitan Community College Institute for Workforce Innovation
Brenda Lasater	Director of Dental Services	Seton Center and Family Health
Cielo Fernandez	Project Manager, Health Promotoras Program	El Control
David Warm	Executive Director	MARC
Dean Katerndahl	Director, Government Innovations Forum	MARC
Dennis Boody	Executive Director	Riverview Health Services
Dennis Dunmyer	Vice President of Behavioral Health & Community Programs	KC Care Clinic
Dennis Meier	Associate Executive Director of Clinical Services	Synergy Services
Gerard Grimaldi	Vice President, Government Relations & Public Policy	Truman Medical Center
Guyla Stidmon	Executive Director	NAMI-KC
Hilda Fuentes	Chief Executive Officer	Samuel U. Rodgers Community Health Center
Jason Wesco	Executive Director	Health Partnership
Jill Watson	Chief Executive Officer	KC Metro Physicians
Jimmy Brown	President/Chief Executive Officer	HealthNet, Inc.
Jody Denson	Project Manager	KHIN
Julie Quirin	Chief Executive Officer	St. Luke's Hospital
Kathy Harms	Senior Director of Therapy Services	Crittenton Children's Center, St. Luke's
Kathy Knotts	Government Relations Director	Truman Medical Center
Laura McCrary	Executive Director	KHIN
Liz Cessor	Chief Executive Officer	Cabot Health Center, St. Luke's Mission & Community
Mark Wiebe	Director of Public Affairs	Wyandotte Inc.
Marlene Nagel	Community Development Director	MARC
Marsha Morgan	Chief Operations Officer for Behavioral Health	Truman Behavioral Health

Michelle Haley, MD	General Pediatrician, Associate Medical Director at CM Pediatric	Children's Mercy Hospital
Mike Jurkovich	Dental Director	Samuel U. Rodgers Community Health Center
Mike McCunniff	Chair of Dental Public Health & Behavioral Science Department	University of Missouri at Kansas City School of Dentistry
Peter Zevenbergen	President/Chief Executive Officer	Wyandotte Inc.
Robin Harrold	Senior Vice President	Shawnee Mission Medical Center
Sharon McGloin	Owner	Experiential Alternatives
Scott Lakin	Executive Director	Regional Health Care Initiative
Sherrie Wood	Chief Executive Officer	Kansas City CARE Clinic
Susan Crain	President/Chief Executive Officer	Mental Health Association of the Heartland
Terry Cunningham	Coordinator	Children's Enhancement Project
Tom Cranshaw	Chief Executive Officer	Tri County Mental Health Services