Health Care Foundation
OF GREATER KANSAS CITY

Safety Net RFP Glossary of Terms

This document is a companion to the Safety Net RFP and the Safety Net Theory of Change. These concepts and definitions are designed as a resource for prospective applicants. This document is not a fully exhaustive list of relevant safety net concepts. Please contact an HCF Program Officer if you have questions.

Access

One of HCF's safety net strategies: Timely use of personal health care services to achieve the best health outcomes.
Source: Institute of Medicine, 1993.

Quality

One of HCF's safety net strategies: Health care that is patient-centered, integrated across conditions, providers and settings and delivered in a way that is safe, timely, effective, efficient, and equitable.
Source: Institute of Medicine, Six Domains of Quality Care, 2001.

Cost

One of HCF's safety net strategies: Quality health care reduces overall health care costs through improvements.
Source: Institute for Healthcare Improvement, Triple Aim.

Advocacy for policies

Advocacy is defined as any action that speaks in favor of, recommends, argues for a cause, supports or defends, or pleads on behalf of others. Activities that comprise policy advocacy include, but are not limited to, lobbying, organizing, grassroots mobilization, legislator education, and public education. Advocacy is also often focused on institutional policies, practices, and commitments. It can include capacity building, relationship building, network development, and leadership development. HCF grantees play a vital role in the development and implementation of public policy to promote an informed, healthy, and strong community.
Source: Nonprofit Oregon.

Care coordination

Care coordination is "the deliberate integration of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of health care services." It involves activities and interventions that attempt to reduce fragmentation and improve the quality of referrals, transitions and response to social service needs. Care is coordinated and/or integrated – across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
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(Care coordination – Continued from the previous page.)

Effective care coordination programs, regardless of patient population, share four common elements:

- Assuming accountability
- Providing patient support
- Developing relationships and agreements with other providers within the continuum of care
- Establishing connectivity that assures appropriate information transfer

Sources: Ed Wagner, MD, MPH, MACP (2011) The Patient-centered Medical Home: Care Coordination, 2011. MacColl Center for Healthcare Innovation, Group Health Cooperative, 2010. Commonwealth Fund, 2011. Institute for Health Improvement, 2011.

Core operating support

The working capital nonprofits need to sustain their day-to-day operations. Core operating support grants may be used to cover day-to-day activities or ongoing expenses, such as: salaries, utilities, office supplies, technology/facility maintenance, etc.; technology purchases, and professional development.

Note: This is not intended to be unrestricted funding.

Evidence informed strategies

Evidence informed strategies include evidence-based, practice-based, and promising practices. These strategies and practices represent approaches that have been identified as worthy of replication through evaluation. Evidence informed strategies can be found in numerous publications including peer reviewed journals, governmental agency guidance (e.g. Centers for Disease Control), and other health focused publications.

Formalized and meaningful partnerships

Formalized and meaningful partnerships represent collaboration between one or more entities guided by defined roles and agreements. These agreements can take the form of letters of commitment, contracts, or memorandum of understanding. Partnerships that are meaningful also generally provide benefits to patient care and patient experience.

Health care delivery system and continuum of care

The overall health care delivery system and Continuum of Care is a combination of institutions, clinics, physician groups, and public health organizations. It includes, but is not limited to:

- Public and teaching hospitals
- Emergency departments
- Community health centers (CHCs), also known as federally qualified health centers (FQHCs)
- Local public health departments and public nursing services
- Community-funded clinics (Free, low cost or sliding-fee primary care services)
- Federally designated rural health clinics (RHCs)
- Community mental health centers
- Community-based, low-income dental clinics
- Private physicians' offices
- "Non-traditional" providers such as nonprofit, social services and faith-based organizations

Integration and integrated systems of care

Integration facilitates the coordination of patient care across conditions, providers, settings, and time in order to achieve care that is safe, timely, effective, efficient, equitable, and patient-focused. To achieve integration, we need to promote changes in provider culture, redesign payment methods and incentives, and modernize federal laws. Advancing along the continuum of integration requires moving beyond care delivered in traditional hospital or physician practice settings to incorporate a wider array of provider networks, care settings, and processes of care. This broader approach aligns with an emerging paradigm that is at the heart of increasingly popular care models, such as patient-centered medical homes (PCMH), health homes, and Accountable Care Organizations (ACOs). 2

Leadership and workforce development

Leadership and workforce development activities improve the operations of an organization through increased staff knowledge and skills. This includes improving the work life of health care providers, including clinicians and staff.

Source: Influenced by the Institute for Healthcare Improvement's Quadruple Aim.

Navigation

Navigation is similar to care coordination and involves promoting access by eliminating barriers to care that result in improved health outcomes and increased clinical and organizational efficiencies. Successful patient navigation supports patients by eliminating barriers to timely screening, treatment, and supportive care of chronic diseases. Patient navigation saves lives and improves resolution rates of patients. When implemented at the organizational level within a community, it results in increased efficiencies and improved outcomes.

Sources: National Cancer institute; Harold P Freeman Patient Navigation Institute.

Patient-centered approaches and strategies

Patient-centered approaches and strategies involve many of the same approaches used to define Patient Centered Medical Homes (PCMH):

- Ongoing relationship with a primary care provider
- Care team who collectively take responsibility for ongoing care
- Whole person orientation provides all health care or makes referrals
- Care is coordinated and/or integrated
- Quality and safety are hallmarks
- Enhanced access to care is available
- Payment appropriately recognizes the added value

Sources: Adapted from the Joint Principles of the Patient-Centered Medical Home (2007), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA).