Strategies, Outcomes & Indicators Workbook
 for Safety Net Grantees

These strategies, outcomes, and indicators allow the Health Care Foundation of Greater Kansas City (HCF) to collect data on progress toward outcomes across grantees and allow your organization and HCF to measure and describe your impacts systematically. For each outcome that you identified as part of your project, please review its indicators and report on those for which you have or can obtain data. You do not need to report on every indicator. Some indicators may be listed under multiple outcomes. For grantees who regular report and submit UDS data, we request that you submit this same data to us. The UDS indicators are all under the Improved Health Outcomes indicator.

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| **SAFETY NET STRATEGIES** **Increase Access** * Fund service delivery and core operating support
* Facilitate greater care coordination and navigation
* Increase health care coverage that supports quality care
* Advocate for policies that increase access in underserved communities
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| 1. Outcome on Access: Increased number of patients receive adequate care and services
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| **Indicator** | **Definition**  | **Notes** |
| **1a) Number of unduplicated clients**  | Report two numbers: 1) the number of unduplicated clients receiving care from the funded project in the grant year, 2) if possible, the number of clients in the prior 12 months, to show changes in number of patients seen. |  |
| **1b) Number of services/visits by clients** | Report two numbers: 1) the number of services or visits by clients receiving care from the funded project in the grant year, 2) if possible, the number of services or visits by clients in the prior 12 months, to show change in number of services or visits by clients.  |  |
| **1c) Number of new patients seen** | Report one number for total number of patients seen this year who had not received care from your organization in the last 2 years. |  |
| **1d) Changes in the average length of time to 3rd next available appointment (also called TNAA)** | Report two numbers, if possible: 1) TNAA in the beginning or prior to funding, 2) TNAA toward the end of the funding period. Report on any evidence that time to the 3rd next available appointment is reduced. Tracking tool and resources can be found here: <http://www.safetynetmedicalhome.org/sites/default/files/Third-Next-Appointment.pdf> |  |
| **1e) Increases in the overall number of people receiving care in the broader health care system** | Qualitative summary of contributions to increasing the overall number of people receiving care in the broader health care system (e.g., decreased number of visits to the ER due to preventive care). |  |
| **1f) Change in the no-show rate** | Report two numbers, if possible: 1) no-show rate in the beginning or prior to the funding, 2) no-show rate toward the end of the funding period.  |  |

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| 1. Outcome on Access: More individuals have insurance coverage
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| **Indicator** | **Definition**  | **Notes** |
| **Number of insured clients**  | Report one set of numbers: 1) the number of clients receiving care from the funded project in the grant year who have become newly enrolled in Medicaid, Medicare, and private insurance in the last 12 months. |  |

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| 1. Outcome on Access: Patients successfully navigate through the health care system
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| **Indicator** | **Definition**  | **Notes** |
| **3a) Number of patients who have completed a referral provided by your organization** | Provide numbers that you use to track patient referrals. If possible, show number of patients who have completed a referral provided by your organization. |  |
| **3b) Number of patients who have utilized your services because they were referred by another organization** | Report numbers that you use to track where your clients come from and how clients are referred to your organization. Include pertinent information and the names of the organizations referring to your site, if possible.  |  |
| **3c) Number and type of organizations in your referral network** | Report total number and types/names of organizations in your referral network. If this network has increased or changed over the course of the funding year, please explain. |  |

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| **SAFETY NET STRATEGIES****Improve Quality** * Implement evidence-based, practice-based and promising practices in service delivery
* Improve patient care experience, engagement & satisfaction
* Promote system transformation through implementation of innovative care models, practices, and workforce
* Advance the use of health data and health information technology (HIT)
* Promote integrated systems of care across SN clinics, hospitals, providers and key community-based services
* Develop strategic partnerships through formal agreements that lead to system transformation
* Advance leadership and workforce development opportunities
* Advocate for and support policies that improve health
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| 1. Outcome on Quality: Increased capacity to deliver high quality care
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| **Indicator** | **Definition**  | **Notes** |
| **4a) Serving clients with additional operating hours**  | Provide a description of your ability to serve patients with additional clinic hours. |  |
| **4b) Changes in the average length of time to 3rd next available appointment (also called TNAA)** | Report two numbers, if possible: 1) TNAA in the beginning or prior to funding, 2) TNAA toward the end of the funding period. Report on any evidence that time to the 3rd next available appointment is reduced. Tracking tool and resources can be found here: <http://www.safetynetmedicalhome.org/sites/default/files/Third-Next-Appointment.pdf> |  |
| **4c) Clinic Optimal Capacity**  | Report two numbers, if possible, 1) the % of clinic sessions booked in the beginning or prior to the funding, 2) the % of clinic sessions booked toward the end of the funding period. Describe any evidence of changed capacity.  |  |
| **4d) Implementation of a Quality Improvement Process**  | Describe any improvements that have increased quality of care, including improvements in systems, processes, or workflow (e.g., patient safety, new technologies). |  |
| **4e) Increased staff capacity or leadership development** | Describe any improvements in staffing or advancements in leadership development.  |  |

| 1. **Outcome on Quality: Improved health outcomes**
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| **Indicator** | **Definition**  | **Notes** |
| **5a) Diabetes (Hemoglobin A1c Poor Control): Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c greater than 9.0% during the measurement period (UDS).** | **Numerator Description**: Patients whose most recent HbA1c level (performed during the measurement period) is greater than 9.0%**Denominator Description:** Patients 18-75 years of age with diabetes with a visit during the measurement period. |  |
| **5b) Hypertension (Controlling High Blood Pressure): Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90mmHg) during the measurement period (UDS).** | **Numerator Description:** Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.**Denominator Description:** Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period, excluding patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period. |  |
| **5c) Dental Sealants: Percentage of children, age 6 through 9 years, at moderate to high risk for caries who received a sealant on a permanent first molar during the measurement period (UDS).** | **Numerator Description**: Patients who received a sealant on a permanent first molar tooth in the measurement year.**Denominator Description**: Dental patients aged 6- 9 who had an oral assessment or comprehensive or periodic oral evaluation visit during the measurement year and documented as having moderate to high risk for caries, excepting children for whom all first permanent molars are non-sealable. |  |
| **5d) Asthma Use of Appropriate Medications: Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period (UDS).** | **Numerator Description**: Patients who were dispensed at least one prescription for a preferred therapy during the measurement period.**Denominator Description**: Patients 5-64 years of age with persistent asthma and a visit during the measurement period, excluding patients with emphysema, COPD, cystic fibrosis, or acute respiratory failure during or prior to the measurement period. |  |
| **5e) Other Clinically meaningful improvements in patient population defined by a chronic condition** | Other Chronic Conditions: % of patients that made significant reduction in other chronic conditions based on judgment of provider over at least 6 months. |  |
| **5f) Reduction of disparities in patient chronic conditions** | Report numbers and a description of any reductions in racial/ethnic disparities for any chronic conditions. |  |
| **5g) Tobacco Use and Screening & Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user (UDS).** | **Numerator Description:** Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.**Denominator Description**: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period, excluding patients whose medical record reflects documentation of medical reason(s) for not screening for tobacco use. |  |
| **5h) Colorectal Cancer Screening: Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer (UDS).** | **Numerator Description**: Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria: fecal occult blood test (FOBT) during the measurement period; flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period; or colonoscopy during the measurement period or the nine years prior to the measurement period.**Denominator Description**: Patients 50-75 years of age with a visit during the measurement period, excluding patients with a diagnosis or past history of total colectomy or colorectal cancer. |  |
| **5i) Depression Screening & Follow-up: Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen (UDS).** | **Numerator Description**: Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.**Denominator Description**: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period, excluding patients with an active diagnosis for depression or a diagnosis of bipolar disorder, or patient refuses to participate, or medical reason(s), such as patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status or situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. |  |
| **5j) Increased use of other patient screenings**  | Report on the numbers and (%) of patients receiving oral health screenings or any other screenings  |  |
| **5k) Patient’s perception of their own health (patient self-assessment of wellness)** | Report the number and percent of patients who have assessed their own health through self-report (from surveys, tracking, or interviews) and describe any improvements or changes in clients’ perceptions of health. |  |

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| 1. Outcome on Quality: Improved patient care experience, engagement and satisfaction
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| **Indicator** | **Definition**  | **Notes** |
| **6a) Number of patients accessing services who 6b) return for additional services within the project year** | Report the number (%) of patients who return for services or are compliant with follow-up during the project year. Provide any descriptive data on what kinds of return visits are included.  |  |
| **6b) Patient satisfaction with their visit/experience/provider** | Report the number (%) of patients reporting satisfaction with their visit/experience/provider through surveys, interviews or data tracking.  |  |
| **6c) Increased patient engagement with their health care experience**  | Describe practices and methods used to increase patient engagement with their health care experience (e.g., access to health records, patient education). |  |
| **6d) Summary of patient experience improvements**  | Describe any improvements in patient experience including reduction in waiting times, ability to provide culturally-relevant care (e.g., translation services). |  |

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| 1. Outcome on Quality : Increased use of evidence-based, practice-based, promising practices, and patient-centered strategies in service delivery
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| **Indicator** | **Definition** | **Notes** |
| **Advances in using evidence-based, practice-based, promising practices, and patient-centered strategies in service delivery** | Describe any use of evidence-based, practice-based, promising practices, and patient-centered strategies in service delivery. |  |

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| 1. Outcome on Quality: Increased formalized and meaningful partnerships between health care delivery providers and social services
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| **Indicator** | **Definition**  | **Notes** |
| **8a) Type of new partnerships with other health care delivery providers and social services** | Name the partner organizations and describe the new partnerships and that have been secured over the grant year. |  |
| **8b) Changes to existing partnerships with other health care delivery providers and social services** | Name the partner organizations and describe how you have strengthened existing partnerships over the grant year. |  |

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| 1. Outcome on Quality: Greater integration of care
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| **Indicator** | **Definition**  | **Notes** |
| **9a) Data sharing arrangements with other health care delivery providers and social services** | Describe how you have integrated data systems or increased data integration over the grant year.  |  |
| **9b) Other arrangements with other health care delivery providers and social services not covered elsewhere** | Describe any other ways that you have integrated service delivery with other providers. |  |

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| 1. Outcome on Quality: Multisector groups work together to produce systems level change
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| **Indicator** | **Definition**  | **Notes** |
| **Multisector groups work together to produce systems level change** | Describe which groups have come together, how you have been working together, what changes the group has been implementing and where you are in the change process.  |  |

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| 1. Outcome on Quality: Policies are established that improve health
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| **Indicator** | **Definition**  | **Notes** |
| **11a) Organizational or institution policy changes** | Describe new internal policies that you have implemented to improve the health of the population. |  |
| **11b) Local, state or national policy changes** | Describe any other of your efforts to impact local, state or national policies to improve the health of the population. |  |

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| **SAFETY NET STRATEGIES** **Reduce Costs*** Support approaches and policies that reduce costs, promote sustainability or contain costs
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| 1. Outcome on Cost: Lowered or maintained health care costs for SN organizations
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| **Indicator** | **Definition**  | **Notes** |
| **Lowered or maintained per-patient health care costs** | Summary of per-patient health care costs that have decreased or have been maintained for the organization. If possible, report on which specific costs have been maintained or lowered.  |  |

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| 1. Outcome on Cost: More affordable health care for individuals
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| **Indicator** | **Definition**  | **Notes** |
| **Lowered or maintained health care costs for patients** | Summary of health care costs that have been decreased or maintained for patients. If possible, report on which specific costs have been maintained or lowered. |  |

***Additional Questions that will be included on the Final Report:***

**LESSONS LEARNED**

a.) What have been the important discoveries or lessons you have learned this year as you have implemented the project?

b.) How have you incorporated this new knowledge into project operations or how will you incorporate it into future planning?

**CHALLENGES & BARRIERS**

Please describe the main needs, challenges or barriers that you experienced while advancing this project (including any challenges around measuring intended outcomes).

**SUPPORTS**

Please describe the strengths, supports or external conditions that helped facilitate the project's accomplishments and the greatest opportunities for future growth.

**SUSTAINABILITY**

Describe how the project will be sustained beyond this grant award. If you have been able to leverage additional funding because of your HCF grant, please let us know.

**CASE STUDY/VIGNETTE (*OPTIONAL)***

Please provide a brief case study or vignette that highlights how HCF funds made a significant difference in the lives of individuals, families or in your community. Keep the story brief and no more than a half page, stick to the facts, include direct quotes if they strengthen the story, avoid jargon, and keep messages simple and concise.