Health Care Foundation
OF GREATER KANSAS CITY

SAFETY NET PORTFOLIO REPORT

AN EVALUATION OF SAFETY NET GRANTS AWARDED 2015

PROCESS

This portfolio report was developed from the final grant reports that summarize the work of 25 HCF Safety Net grantees. HCF awarded these Safety Net Grants in December 2015.

These 12-month grants were implemented throughout 2016 and early 2017, with final grant reports submitted to HCF beginning in January 2017.

HCF began development of the Safety Net Portfolio Report in fall 2017 when the final grant reports had been received and approved. HCF worked with Informing Change to develop the report format and to synthesize data across the 25 final grant reports.

QUALITY CONTROL

The data in this report is all self-reported by the grantees. Inconsistent or questionable data was flagged and then confirmed by grantees.

CONTEXT

When the 2015 Safety Net funding round was initially announced, HCF was still developing its theory of change and updating the evaluation process. Thus the following should be considered when reading this document:

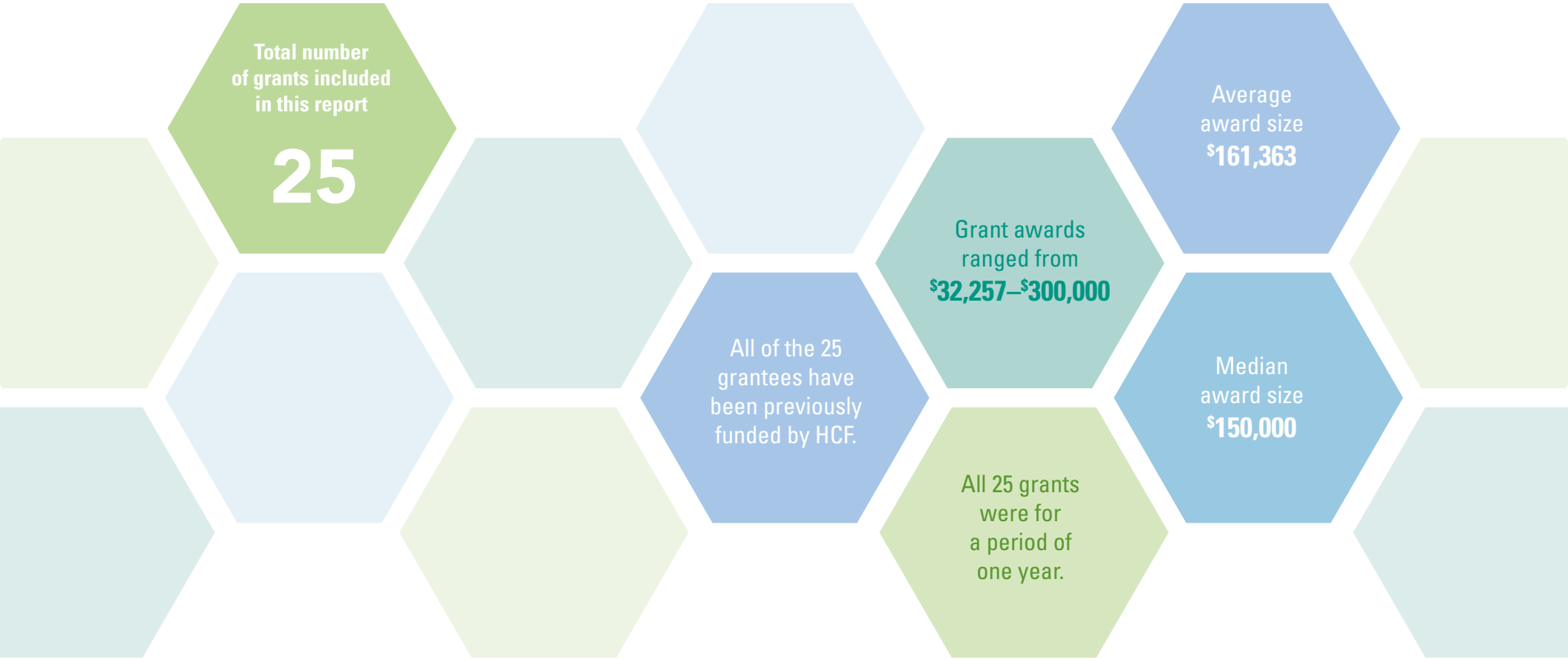
- These grantees did not have the Safety Net theory of change at the time of application.
- Grantees were not required to choose from each area of access, quality, and cost.
- Grantees chose which outcomes and indicators best reflected their project. HCF did not make the connection between strategies, outcomes, and indicators for them.

PORTFOLIO OVERVIEW

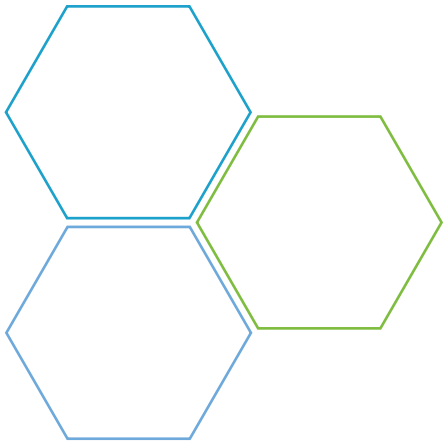
In 2015, HCF issued awards totaling $4.25 million to 27 grantees through the Safety Net RFP.

This report includes an analysis of data from final grant reports from 25 Safety Net grantees who were awarded 12-month grant terms in 2015. The remaining two grantees were awarded multi-year grants and have not yet submitted their final report data.

This analysis is intended to be an examination of data across organizations and programs to reflect the cumulative work of the grantees within the HCF service area.



DEMOGRAPHICS AND IMPACT



DEMOGRAPHICS

Final grant reports provide data on the population served by HCF-funded organizations. Grantees report data on the overall population they serve. They also report data on the specific populations served through their program funded by HCF.

While these numbers are estimates (given that we do not track unduplicated clients across safety net agencies), they illustrate the great need for these vital health care services and the agencies that provide them.

HCF funding reached approximately

74,432

individuals during this grant cycle

These individuals received services through HCF-funded programs resulting in

173,226

encounters during this grant cycle

In total, the organizations receiving HCF funding serve approximately

650,745

individuals each year

In total, these organizations provide services to individuals through

1,089,871

encounters annually*

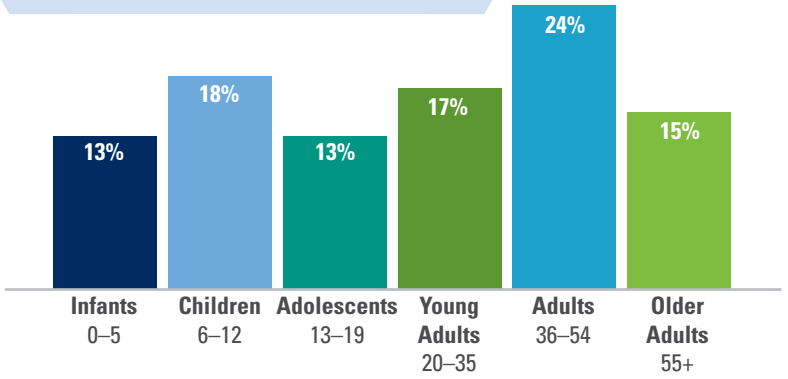
We recognize that HCF is part of a larger support system for these organizations. We are one of many partners who provide critical funding and support to organizations.

*Some of these encounters may be duplicates because some individuals access services from multiple organizations.

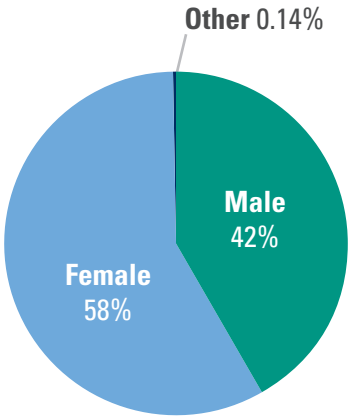
DEMOGRAPHICS

- HCF-funded programs served more female patients than male.
- Funding served people in all stages of life: patients' ages range widely, though slightly more adults ages 36–55 are being served.
- Almost half of all patients served with HCF Safety Net funding are from Jackson County and/or KCMO[1], and a quarter of all patients are from Wyandotte County.

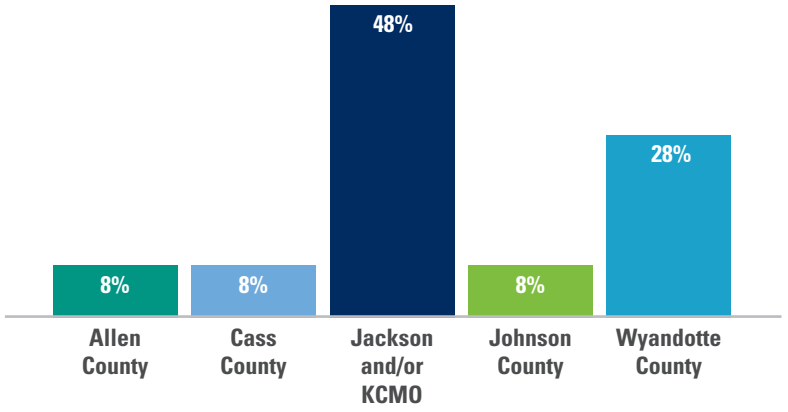
AGE



GENDER



GEOGRAPHY



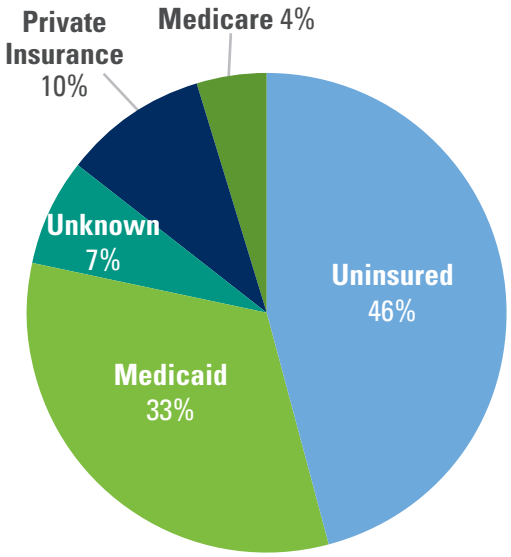
[1] May include all of Jackson County and/or Kansas City, Missouri (KCMO) portions of Clay and Platte counties.

Note: This demographic data is collected and reported by our partner agencies.

DEMOGRAPHICS

INSURANCE

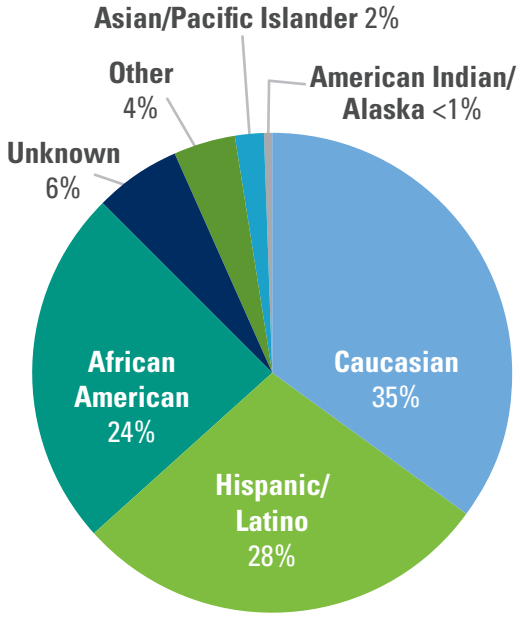
Eleven grants served client populations in which more than 50 percent are uninsured, and four reported that 90 percent or more of their clients are uninsured.



RACE

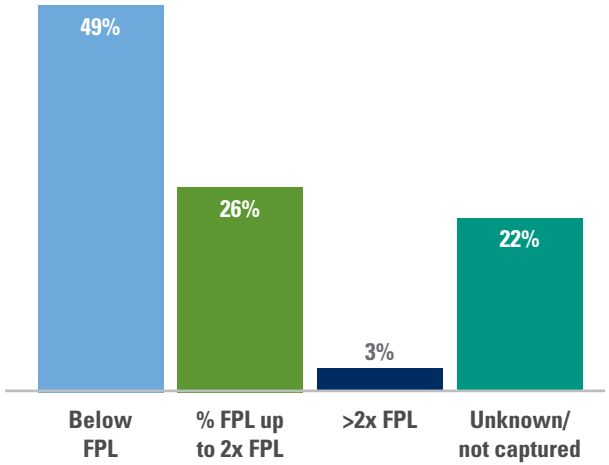
Nineteen of the 25 grantees reported a majority of non-white clients, and most grantees served a racially diverse client population.

Two grantee organizations served nearly half of the 19,000 Hispanic/Latino clients.



POVERTY LEVEL

Sixteen grantees reported that more than 50 percent of their clients live below the federal poverty level (FPL).



* In 2017, the federal poverty level was $24,600 for a family of four.

SAFETY NET STRATEGIES

13 Grantees
Fund direct services or core operating support

12 Grantees
Facilitate greater care coordination and navigation

7 Grantees
Improve patient care experience, engagement, and satisfaction

3 Grantees
Advance the use of health data and health information technology

3 Grantees
Develop strategic partnerships through formal agreements that lead to system transformation

0 Grantees
Advance leadership and workforce development opportunities

7 Grantees
Increase health care coverage that supports quality care

8 Grantees
Implement evidence-based, practice-based, and promising practices in service delivery

0 Grantees
Promote system transformation through implementation of innovative care models, practices, and workforce

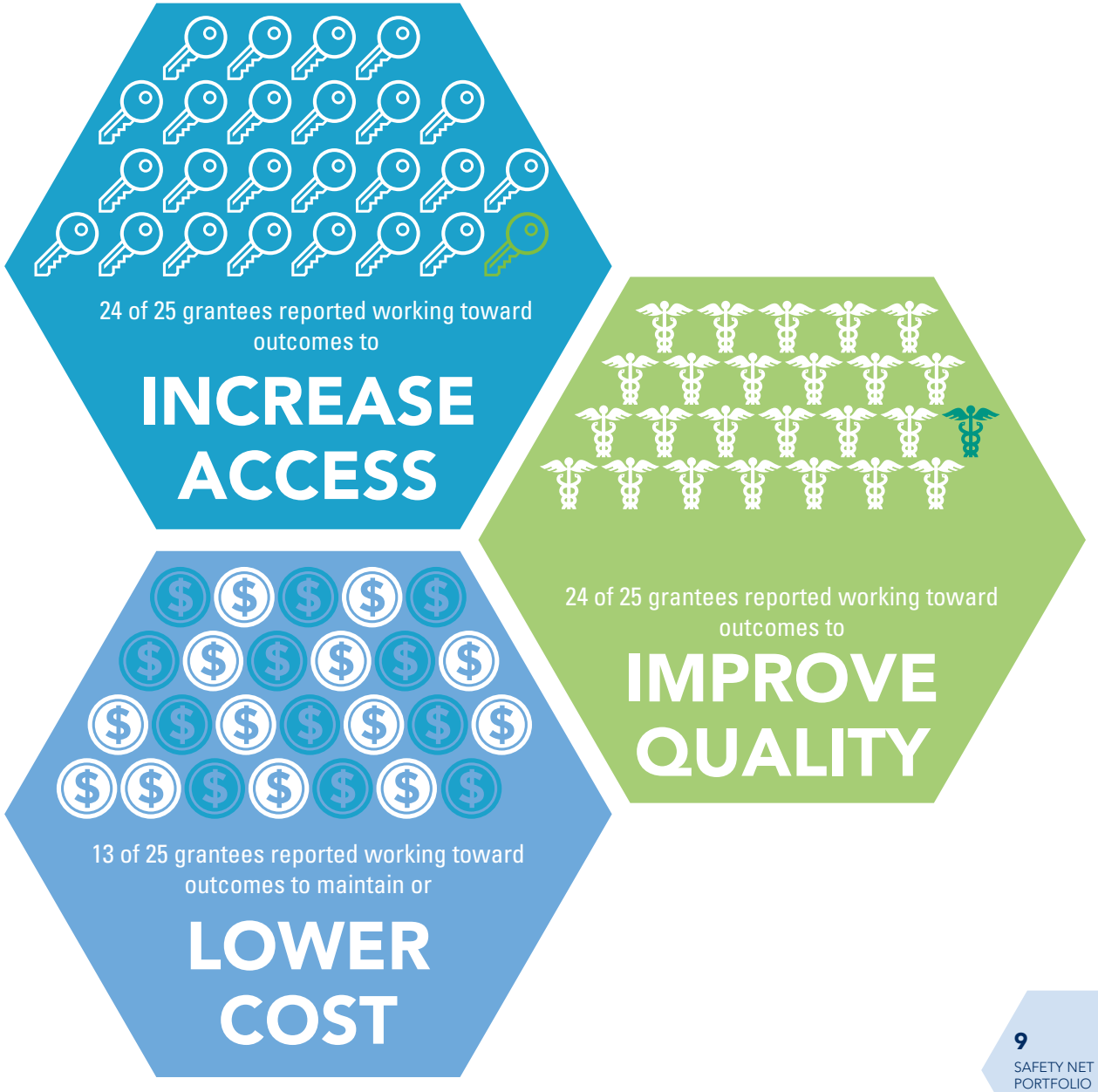
4 Grantees
Promote integrated systems of care across safety net clinics, hospitals, providers, and key, community-based services

7 Grantees
Support approaches that reduce costs, promote sustainability, or contain costs

GRANTEE OUTCOMES

Grantees were asked to select the outcomes that aligned with their funded project and to report on related indicators for which they had data. Since this was the first year that grantees reported data under the Safety Net theory of change, some of these indicators were new and had not yet been tracked over time by the organization.

We expect that in coming years, organizations funded by HCF will be able to show progress over time. However, we also know that outcomes and success are not always measured in numbers.



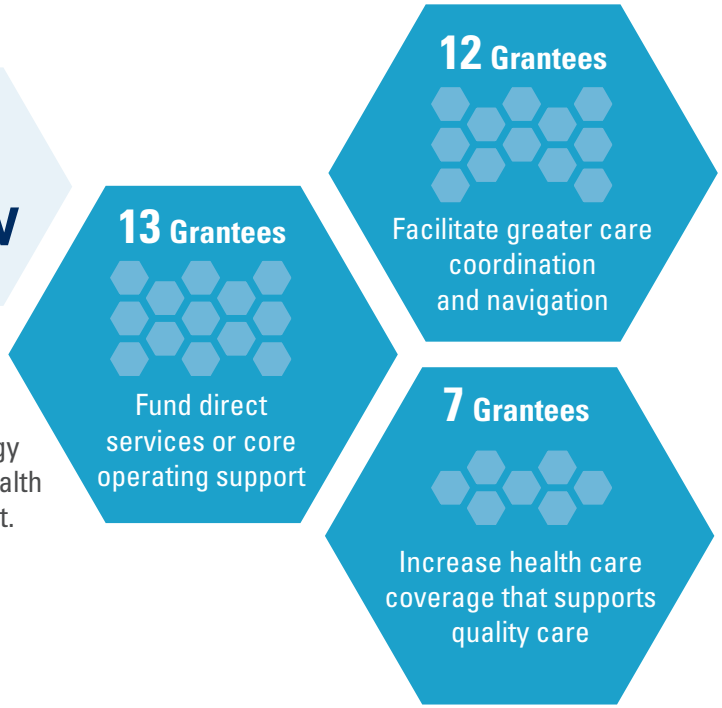
INCREASING ACCESS STRATEGIES & OUTCOMES

ACCESS SUMMARY

- Most grantees chose a strategy and outcome around access.
- Access is central to the work of safety net organizations, and most are already collecting this data.
- Grantees are well-positioned to address access yet outstripped by the overwhelming need.
- Core operating support is critical to the needs of the organizations and the safety net system.
- There is no one-size-fits-all approach to access, and organizations were responsive to client needs.
- Staff turnover internally and at partner organizations impacted ability to deliver quality care.
- Multiple grantees reported encountering challenges in recruitment and retention of qualified staff and volunteers (i.e. finding necessary staff or volunteers to meet demand also included struggles to maintain the level of quality and access during periods of staff transition).

ACCESS OVERVIEW

All 25 grantees reported using at least one strategy to increase access to health care within the safety net.



ACCESS STRATEGIES

Twelve grantees reported that their HCF-funded project was facilitating greater care coordination and navigation as a strategy to increase access.

Specific practices employed were:

Three grantees **increased or sustained support services** to help patients navigate the application and renewal process for insurance coverage through the ACA marketplace, Medicare, Medicaid, disability benefits, or private insurance. This strategy included providing access to certified application counselors and conducting outreach activities to encourage patients to enroll.

Five grantees **hired or increased the hours of a patient care navigator** to provide individualized attention and help patients assess their needs, schedule appointments, apply for financial assistance, and access other related services.

Five grantees **engaged volunteers or designated staff to conduct outreach** to patients in their homes, provide multidisciplinary disease management strategies, and help patients navigate safety net resources.

Seven grantees **increased health care coverage** that supports quality care as a strategy to increase health care access.

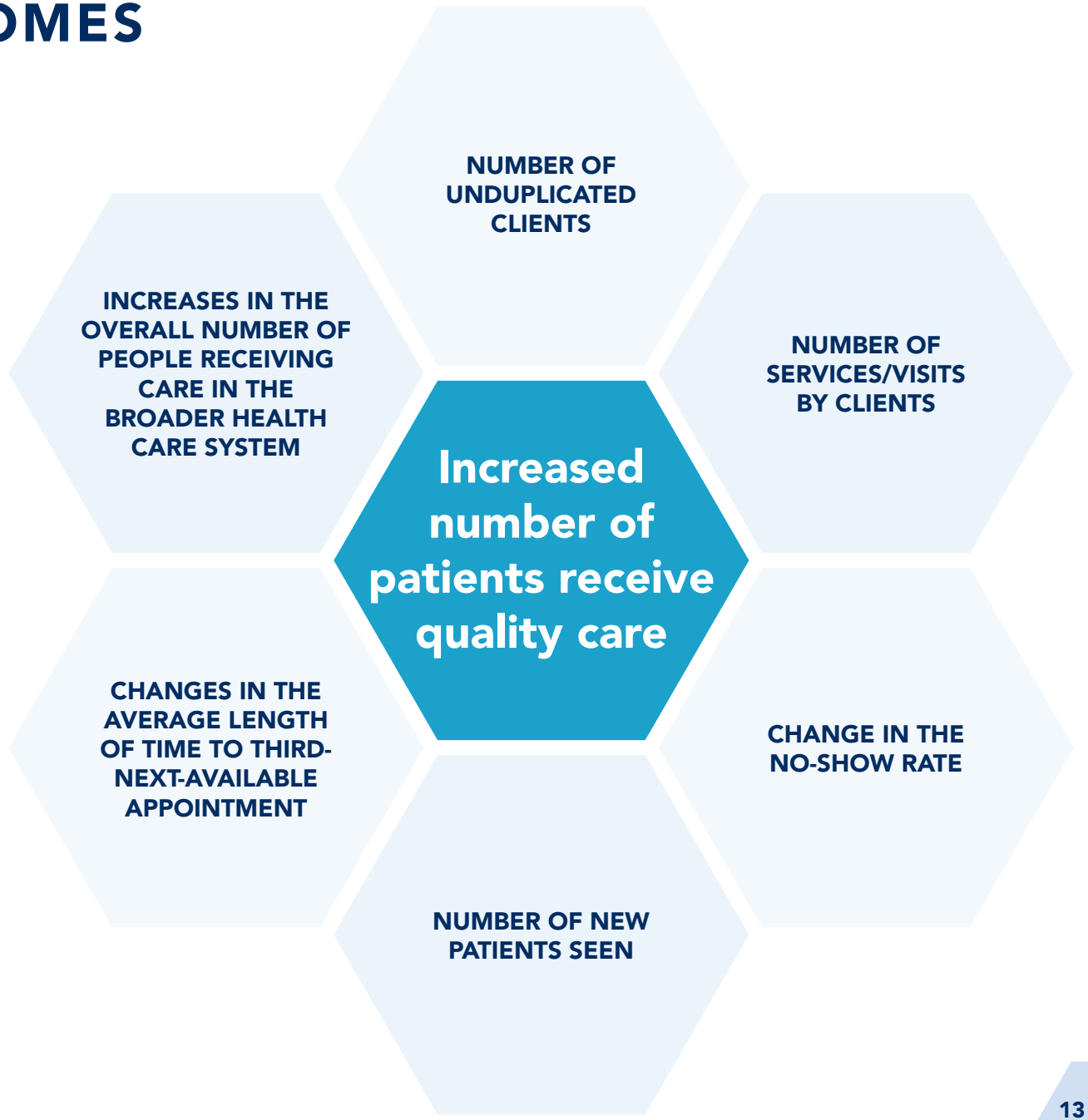
Other grantees **integrated or streamlined administrative processes** and medical record keeping and sharing in order to identify gaps in the safety net system.

ACCESS OUTCOMES

Six grantees reported increases in the number of clients served from last year or from projected estimates; increases ranged from 4 percent to 55 percent with an average of 20 percent.

Three grantees reported on their no-show rates, with two declining and one increasing slightly during the grant year.

Two grantees reported on changes to their wait time for appointments: one decreased wait time from 2.5 weeks to 1.5 weeks, while the other remained constant at one week.



LESSONS LEARNED

The **IMPORTANCE OF SAFETY NET SERVICES GRANT SUPPORT** to our operating efforts truly cannot be stressed enough, as these dollars fluctuate regionally. Providing support across many budget categories such as **SALARIES AND BENEFITS** for the clinic team and **INDIRECT OPERATING EXPENSES** and supplies. Core operating dollars allow the clinic to be **PROACTIVE IN PROGRAMMATIC PLANNING**, yet dynamic and flexible in order to **MEET THE NEEDS** of the medically underserved in our community.

- 2015 Grantee

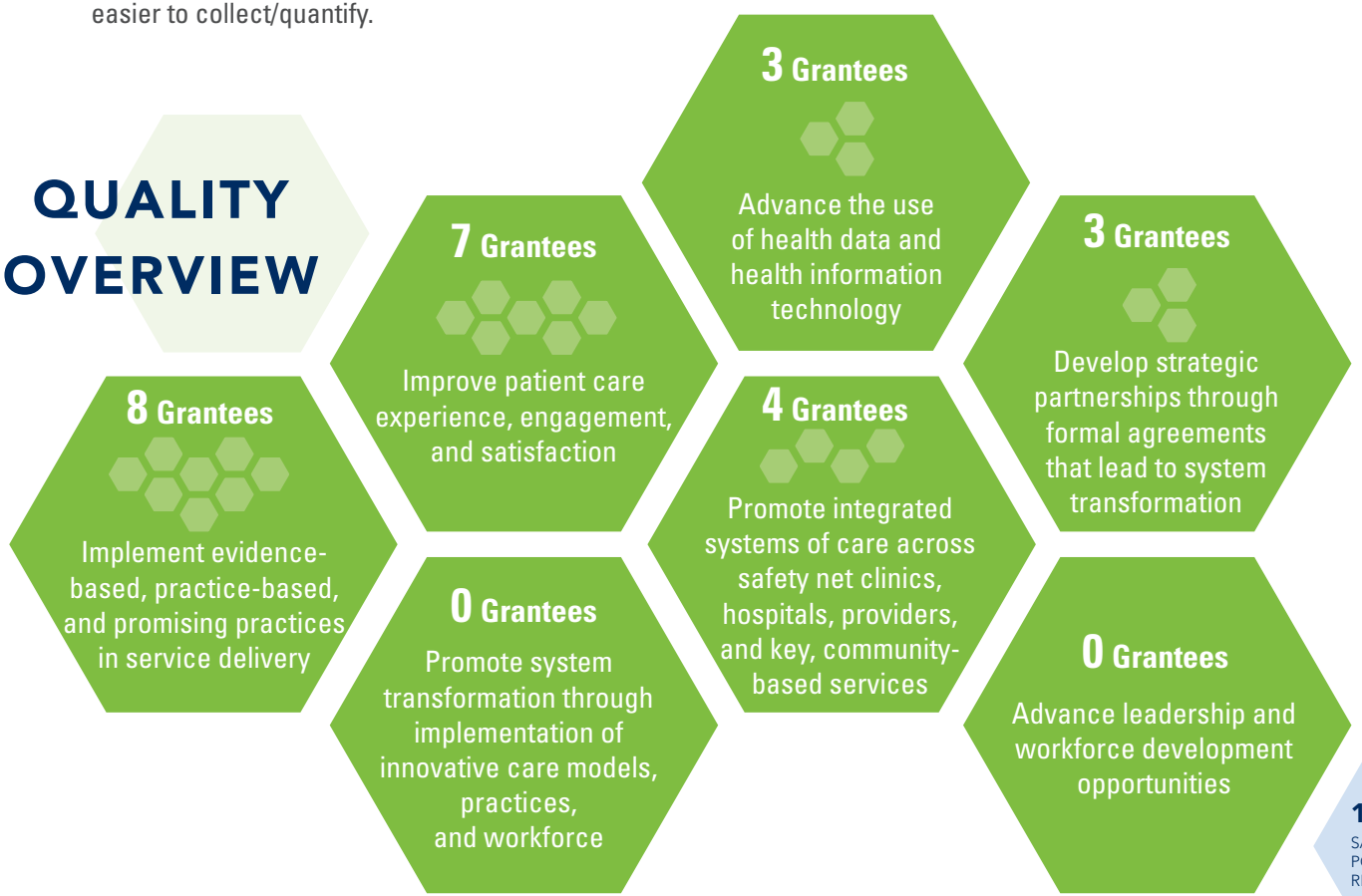
QUALITY STRATEGIES

QUALITY SUMMARY

Quality health care is defined as patient-centered; integrated across conditions, providers, and settings; and delivered in a way that is safe, timely, effective, efficient, and equitable.

- Implementation of evidence-based models and improving patient care experience were the top two quality strategies chosen by grantees.
- Organizations are incorporating patient surveys and increasing responsiveness to patients.
- Grantees explained how challenging integration is across departments and separate agencies, and that it requires multi-year funding.
- Grantees noted the challenges of coordinating care.
- Lack of workforce/innovation strategies could indicate the lack of organizational capacity among safety net grantees. It may also be a reflection of HCF limiting the number of strategies grantees could select, and grantees prioritizing other strategies, particularly those that are easier to collect/quantify.
- Staff turnover internally and at partner organizations impacted their ability to deliver quality care.

QUALITY OVERVIEW



QUALITY STRATEGIES

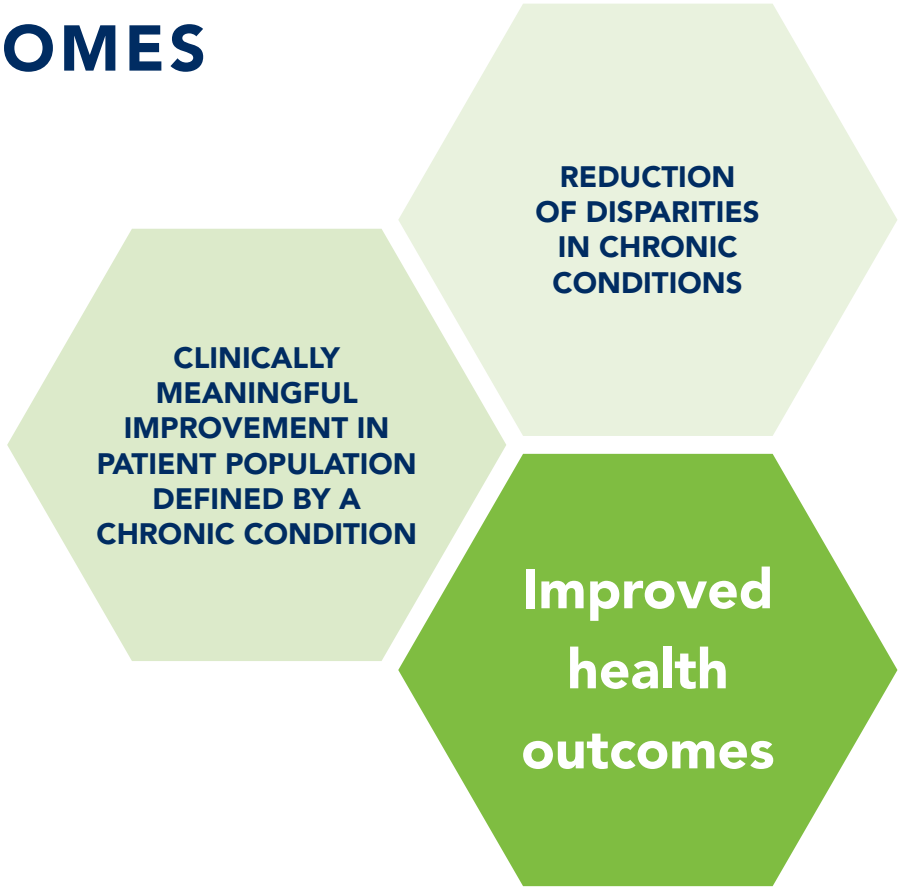
Eight grantees selected, "**implement evidence-based, practice-based, and promising practices,**" as a strategy to improve quality.

Five grantees **delivered a new medication or medical service.**

Three grantees **integrated care coordination into their medical service delivery** and achieved patient-centered medical home status, as recognized by the National Committee for Quality Assurance.

QUALITY OUTCOMES

- **Eleven grantees reported indicator data for the clinically meaningful improvement in patient population defined by a chronic condition**, particularly on measures related to A1C readings, blood pressure and hypertension, implementation of service plans and goals, stress, mental illness symptoms, and BMI, among others.



PROJECT OUTCOMES

84% of clients with a diabetes diagnosis who participated in the education program, either maintained or decreased their A1C readings over the course of the year.

71% of patients with a diagnosis of high blood pressure achieved control of their high blood pressure.

80% of the youth with chronic disease had a measurable improvement in their conditions (i.e. weight loss, blood pressure).

93% of patients achieved one service plan goal.

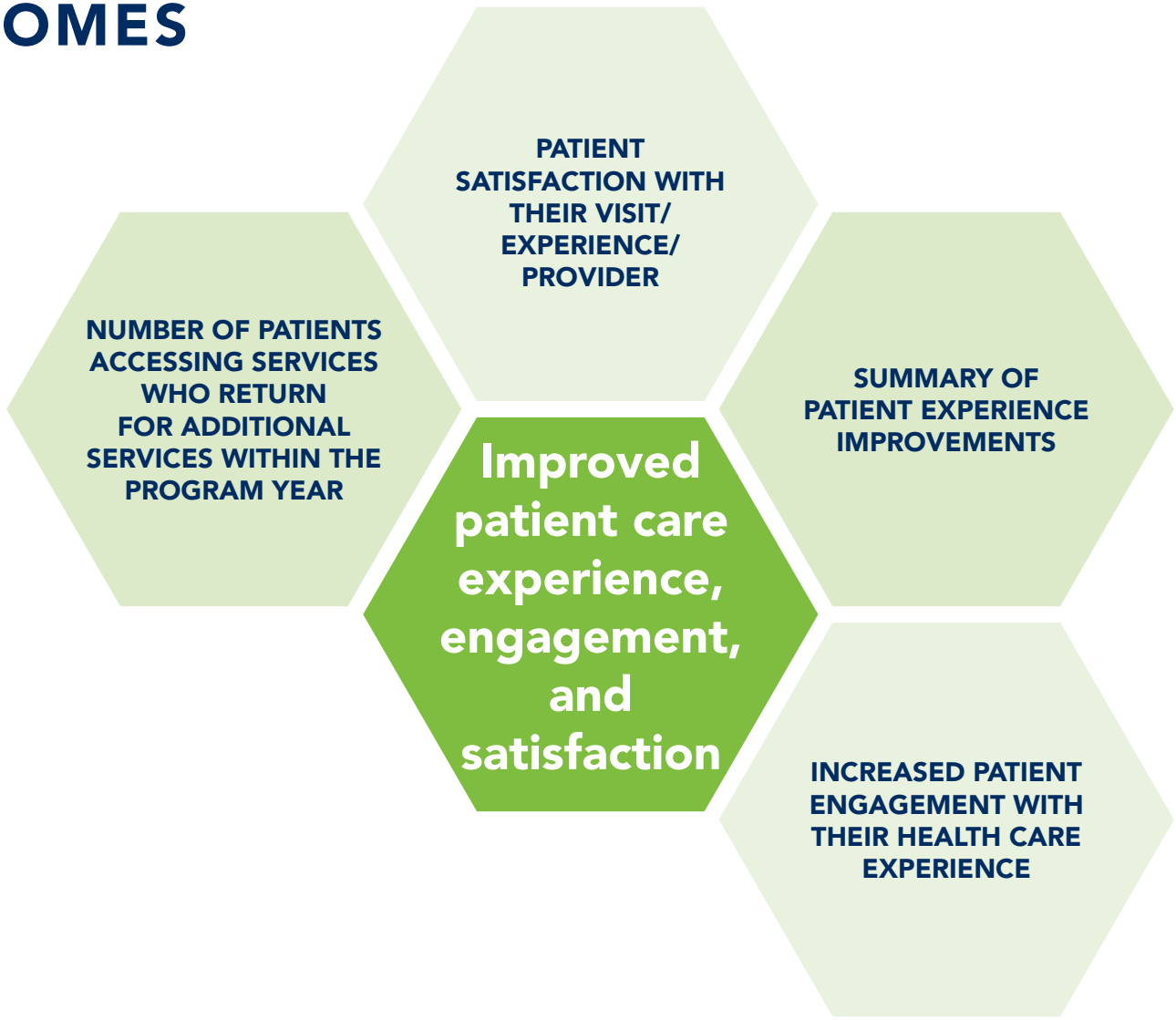
QUALITY OUTCOMES

- **Two grantees reported a continuing trend in patients returning for additional services**, with one clinic averaging about 3.4 visits and the other increasing repeat visits from 5.5 to 7.7 annually — a reflection of the long-term and participative relationships that the provider team has established with their patients.

- **Four grantees reported that they had maintained high rates** (or improved rates) **of satisfaction** based on patient satisfaction surveys administered in 2016.

  All four reported satisfaction rates (e.g., "very satisfied," "completely satisfied," "satisfied," "good," "excellent") ranging from 93–98 percent for a variety of areas: the services provided, the quality of their patient care coordinators, access to care, and clinic cleanliness.

- **Three grantees summarized improvements to patient care experience** in a descriptive way, reporting the use of new technology (e.g., 3D Cone Beam Imaging) to minimize patient discomfort and better diagnose dental issues; integration of educational and clinical work to streamline patients' user experience; and the addition of volunteers to engage patients in waiting areas.



QUALITY OUTCOMES

- **Five grantees reported they had witnessed improvements in patient engagement**, which were measured in a variety of ways:

Surveying clients directly to see how participative they were in their health care and treatment plan, and how well staff actively engaged clients.

83% felt included in their treatment.

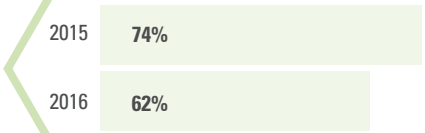
88% felt clinic staff listened to them and knew what they wanted.

70% had a lot to say about what happens in their treatment.

Improved patient care engagement

Using patients' improved or sustained health outcomes as evidence of continuing engagement (or lack thereof), finding that 62 percent of oral health recall patients in 2016 were decay-free — a decline from 74 percent of patients in 2015.

Recall Patients Who Are Decay-Free



Reporting on care plan completion rates as a proxy for patient engagement, citing that 2/3 of patients seen during the grant year completed their treatment. This was significant for their client population, which experiences barriers to accessing treatment (e.g., transportation, cost, child care) and reflects patient commitment to their health and treatment plan.

Care Completion Plan Rates

66% Completed

LESSONS LEARNED

INTEGRATION IS EXPENSIVE, time-consuming, and challenging. It is easy for efforts at integration to be sidelined due to capacity issues from either partner, staffing changes, or even outside challenges. However, **INTEGRATION DOES LEAD TO BETTER OUTCOMES** for the people we serve through improved quality of care and reduced barriers to service. The lessons learned regarding service integration will be used to **DEVELOP FUTURE COLLABORATIONS** and **PARTNERSHIPS** with clinics, hospitals, and other service providers. Understanding the hard and soft costs, capacity, and timing issues will help to **BETTER PLAN FUTURE PROGRAMS**.

We see the need to **FURTHER ALIGN SERVICES**. Enhanced **COLLABORATION** between departments supports consistent implementation of processes and practices to **IMPROVE CARE AND INTEGRATION**.

- 2015 Grantee

REDUCING COST

COST SUMMARY

Quality care reduces overall health care costs through improvements.

- The cost category is relatively new and the most elusive for grantees to track. Because of this, only seven of 25 grantees selected a cost strategy for their grant. To address this, HCF made the following changes to future funding rounds:
  - Reporting on cost data is now mandatory.
  - The cost category includes the new strategy, more affordable health care for individuals.
- Interpreting cost data can be difficult because agencies collect and self-report it.
- Collecting this information helps HCF and our partners tell the story of cost across the system.

COST OVERVIEW

7 Grantees

Support approaches that reduce costs, promote sustainability, or contain costs

Only seven organizations addressed this strategy because grantees were not required to report on all three strategy areas.

COST STRATEGY

Seven grantees selected the one cost strategy available: support approaches and policies that reduce costs, promote sustainability, or contain costs.

Grantees **cited strategies** that could generate revenue:

- Expanding areas of services to tap into new funding
- Using services to generate revenue

Grantees **worked to decrease costs** by reducing unnecessary emergency room usage by:

- Offering affordable office visits to disincentivize ER visits
- Investing in care navigator software to increase data collection and analyses for increasing efficiency and measuring ROI

Grantees **contained costs** by:

- Completing multiple procedures in the same appointment to reduce return visits
- Purchasing medical supplies at a discount and deploying a contract staffing structure to reduce overhead costs and staff expenses

LESSONS LEARNED

With the support from the **HEALTH CARE FOUNDATION**, **WE ARE ABLE TO ASSIST** those clients who do not qualify for [our voucher] program with similar direct services. Additionally we assist clients with deposits for surgeries, appointment costs for specialty care, and exams **NOT AVAILABLE THROUGH** the clients' **SAFETY NET** clinics. The program helps lower costs for patients through assisting with **APPLICATIONS FOR FINANCIAL ASSISTANCE** at various hospitals and health providers, or by making payment arrangements that are **MORE AFFORDABLE** for the client.

- 2015 Grantee

STRENGTHS AND CHALLENGES

STRENGTHS

There were common themes in what grantees reported as the biggest supports in executing their work and accomplishing their goals over the past year:

Partnerships with referral organizations, service partners, community coalitions, and other collaborative relationships.

The dedication and excellence of their staff as a strength, with several grantees citing specific staff by name for their contributions to the work.

The commitment and support from their leadership and board, in particular, for generating and allocating the resources needed to make their work possible and providing thoughtful guidance and support for the project, both internally and externally.

Additional strengths that a few grantees identified as supporting their work were staff's engagement in advocacy activities, community trust in navigator staff, expansion of clinic service offerings, support from funding partners, and the restoration of dental benefits for Missouri Medicaid beneficiaries.

CHALLENGES

The most common challenges grantees cited dealing with this past year was the **collection, management, and analysis of data** for reporting or evaluation, maximizing efficiency in internal processes, and improving patient outcomes. This was due to the inherent challenges involved in collecting consistent and accurate health information; staff's lack of expertise or capacity to do the time-consuming work involved in inputting and extracting data; and the lack of technological infrastructure to store and analyze data.

A few grantees also reported on a variety of additional challenges, including

- **working with insurance providers**
- **ensuring patients had the means to access health care services** (e.g., transportation, childcare)
- **patients' lack of insurance**
- **high wait times and backlog** due to high demand
- **low referral rates**
- **lack of community awareness** about the organization's services
- **low usage rates** of certain pilot services

MOVING FORWARD

MOVING FORWARD

Theory of Change and Program Design

- All 2017 grantees selected strategies, outcomes, and indicators, in their proposals, from each area of the Triple Aim (access, quality, cost), using a common template.
- Additional indicators were added for 2017, including clinical reporting indicators. HCF will continue to review the list of indicators for 2018 and make adjustments accordingly.

Technology and Technical Assistance

- The final report portal — to be used in 2016 and 2017 — has been redesigned with a series of filters. In the new design, each grantee's selected strategies, outcomes, and indicators will be connected in the system. This new portal will reduce the time it takes to complete the final report as well as reduce reporting errors and data "cleaning."
- HCF hosted a grantee meeting in the fall of 2017 to provide technical assistance around the outcomes and indicators that grantees will provide in their final reports. HCF will host additional convenings for technical assistance, feedback, and ongoing dialogue in 2018.

Systems Cost

- HCF will continue to discuss the concept of reduced health care system costs in 2018 and how each organization within the safety net defines, and contributes to, cost savings within the overall health care system.

Core Support and Organizational Capacity

- HCF will continue to explore organizational capacity and organizational core support as an area of interest, including how best to address core support and organizational capacity needs of safety net providers.

Workforce and Quadruple Aim

- HCF will further explore workforce issues and organizational issues related to the Quadruple Aim, which addresses the fourth aim of workforce health and stability in addition to access, quality, and cost.

APPENDIX

SAFETY NET THEORY OF CHANGE

PURPOSE

To support greater access to a safety net of services that provide safe, timely, effective, efficient, equitable, integrated, affordable and quality health care and oral heath care.

PRINCIPLES

- Patient engagement in health care will result in better patient experience and health outcomes
- The continuum of health care includes prevention, treatment, and maintenance
- Health equity is a core value of a high-quality health care delivery system
- People are best served when systems of care are patient-centered, integrated, and coordinated
- Using the Triple Aim framework: Better Health, Better Care and Lower Costs will improve the health care delivery system and health outcomes

PARTNERS

- The uninsured, under-insured, and underserved in our service area
- Safety net clinics, community health centers, and safety net hospitals
- Community-based organizations that support health care services

BARRIERS

- The health care delivery system is fragmented and difficult to navigate
- Health care services are not always patient-centered, integrated, and coordinated
- Individuals lacking adequate health insurance have difficulty accessing services
- The cost burden of health care is very high

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

Improve Quality

- Implement evidence-based, practice-based and promising practices in service delivery
- Improve patient care experience, engagement, and satisfaction
- Promote system transformation through implementation of innovative care models, practices, and workforce
- Advance the use of health data and health information technology
- Promote integrated systems of care across safety net 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

Reduce Costs

- Support approaches and policies that reduce costs, promote sustainability, or contain costs

OUTCOMES

SHORT-TERM

Access

- Increased number of individuals receive quality care and services
- More individuals have insurance coverage
- Patients successfully navigate through the health care system

Quality

- Increased capacity to deliver high quality care
- Improved health outcomes
- Improved patient care experience, engagement, and satisfaction
- Increased use of evidence-based, practice-based, promising practices, and patient-centered strategies in service delivery
- Increased formalized and meaningful partnerships between health care delivery providers and social services
- Greater integration of care
- Multisector groups work together to produce systems level change
- Policies are established that improve health

Reduce Costs

- Lowered or maintained health care costs for safety net organizations
- More affordable health care for individuals

LONG-TERM

ULTIMATE IMPACT

People are able to live healthier lives because they have access to a health care delivery system that includes preventive care and provides regular, affordable, and high-quality health and oral health care.

GRANTEE SNAPSHOTS

BAPTIST-TRINITY LUTHERAN LEGACY FOUNDATION

PROJECT	Kansas City's Medicine Cabinet
PROJECT SERVING	Jackson County and/or KCMO (may include all of Jackson County and/or KCMO portions of Clay and Platte counties)

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$150,000	$1–3M	Multiple years	12 months

Total number of unduplicated clients served by this project

3,968

Total number of visitors/ encounters for this project

4,595

STRATEGIES

- Fund direct services or core operating support
- Promote integrated systems of care across safety net clinics, hospitals, providers, and key, community-based services

Final Report Abstract

Kansas City's Medicine Cabinet, a program of Baptist-Trinity Lutheran Legacy Foundation, facilitates access to crisis-related medical services (dental emergencies, diabetic supplies, durable medical equipment such as hearing aids, prescriptions, and vision care) for low-income individuals in the Kansas City metro area.

The program partners with 14 social service agencies and over 100 medical service providers. The partnering social service agencies determine client eligibility and need, and provide service vouchers to those individuals. Clients then take the vouchers to participating service providers. These providers fill the client's needs, and then fax the service voucher directly to Medicine Cabinet program staff for payment. The program has grown since its inception in 2005, having provided 32,213 services worth $6.4 million to tens of thousands of low-income, underserved people in the Kansas City area. In 2016, the program provided 4,595 services to 3,968 unduplicated individuals. These services had a collective value of $1.1 million.

The Medicine Cabinet recently began providing services to homeless individuals with no temporary address (potential clients previously had to provide some proof of residency, such as a letter from the person with whom they were staying). Clients can now sign a statement affirming their identity and that they have no address. The program also began allowing individuals to exceed the $500 limit for service vouchers issued on a particular date of service. This change was largely due to rising prescription medication costs. The changes have helped more people get the services they so desperately need.

GRANTEE SNAPSHOTS

CANCER ACTION

PROJECT	Patient Services Program
PROJECT SERVING	Jackson County and/or KCMO (may include all of Jackson County and/or KCMO portions of Clay and Platte counties)

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$87,000	Under $1M	Multiple years	12 months

Total number of unduplicated clients served by this project

1,281

Total number of visitors/ encounters for this project

5,613

STRATEGIES

- Fund direct services or core operating support
- Implement evidence-based, practice-based, and promising practices in service delivery

Final Report Abstract

The mission of Cancer Action is to decrease distress and improve the quality of life for those living with cancer in the Kansas City area. Cancer Action has provided some of the agency's most critical safety net services — prescription assistance, transportation assistance, and nutritional supplements — to those facing the challenges of a cancer diagnosis living in underserved areas of the Kansas City metro. These services are a part of the Patient Services Program that offers a comprehensive array of services to address the physical, social, emotional, and financial needs of persons affected by cancer. The agency provides services through three offices located strategically throughout the city.

Through this grant, Cancer Action provided more than 754 rides to life-saving treatment appointments, increasing a person's chances for recovery and improving quality of life for those battling this difficult disease; purchased over 1,600 prescriptions for those unable to afford their medications; and provided more than 10,000 servings of nutritional supplements to help maintain patients' weight and energy as they go through the rigors of cancer treatment. Cancer Action provided case management services to patients and families, offering emotional support and guidance to help over 1,200 families navigate this difficult journey.

The success of the program is demonstrated through evaluations that indicated 96 percent of clients reported an increase in quality of life and/or decrease in the level of distress as a result of Cancer Action's support.

GRANTEE SNAPSHOTS

CASS COMMUNITY HEALTH FOUNDATION

PROJECT	Cass County Dental Clinic
PROJECT SERVING	Cass County

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$150,000	$1–3M	Multiple years	12 months

Total number of unduplicated clients served by this project

3,150

Total number of visitors/ encounters for this project

6,817

STRATEGIES

- Fund service delivery and core operating support
- Implement evidence-based, practice-based, and promising practices in service delivery
- Improve patient care experience, engagement, and satisfaction

Final Report Abstract

Cass County Dental Clinic (CCDC) is the first and only safety net dental clinic in Cass County, Missouri, serving Medicaid and low-income, uninsured children and adolescents. CCDC strives to eliminate oral disease through preventive education, early intervention, and comprehensive dental services. The clinic provides services to children and adolescents from birth through age 20 who are insured by Missouri Medicaid (98 percent of patient population) or who are uninsured and at or below 200 percent of the FPL (2 percent). A patient care coordinator assists patients who are referred to a specialist by scheduling appointments and arranging for language or transportation services, as needed. In 2016, CCDC served 3,150 children and adolescents through 6,817 dental encounters/visits.

Services provided were:

- 40.36 percent preventive
- 39.01 percent diagnostic
- 18.51 percent restorative
- 2.12 percent extractions

CCDC exceeded its goal for number of children served by serving 3,150 (goal 2,639 children), for treatment plan completion by attaining 80.1 percent (goal 75 percent), for sealant placement by attaining 95.17 percent (goal of 80 percent), for patient satisfaction by attaining 96.50 percent (goal 90 percent) and for encounters with 6,817 (goal 6,772).

While recruiting dentists, they learned that their applicant pool is extremely limited since most candidates interested in public health want to secure student loan repayment in addition to salary. The clinic has been unsuccessful to become a site designation with the state of Missouri for reimbursement opportunities with either the state or national programs. Instead, they have worked to develop a bonus program to help their dentists with student loans.

GRANTEE SNAPSHOTS

COMMUNITY HEALTH CENTER

OF SOUTHEAST KANSAS

PROJECT	Allen County Safety Net Clinic Capacity
PROJECT SERVING	Allen County

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$200,000	$10M+	Multiple years	12 months

Total number of unduplicated clients served by this project

7,245

Total number of visitors/ encounters for this project

24,561

STRATEGIES

- Facilitate greater care coordination and navigation
- Fund service delivery and core operating support
- Implement evidence-based, practice-based, and promising practices in service delivery

Final Report Abstract

Increasing the capacity of Allen County's safety net clinic initiative provides operational funding for the Community Health Center of Southeast Kansas' clinic in all-rural Allen County. With this support, CHC/SEK exceeded original growth projections and provided medical, dental, and mental health services — regardless of ability to pay — to 7,245 individuals through 24,561 patient visits in what is the least healthy and poorest region of Kansas. One in three Allen County residents received care from a CHC/SEK provider in-clinic, as an inpatient at Allen County Hospital, as a resident of a local nursing home, or through their expansive oral health outreach program in schools, child care, and mental health centers.

In-clinic mental health services were significantly expanded with the recruitment of a full-time board-certified psychiatrist — one of the few practicing in rural Kansas — to the community, and the addition of a second site within the community mental health center in Humboldt. Ground was broken for the construction of a new 15,000 sq. ft. facility that will provide fully-integrated, one-stop care plus an in-house pharmacy, and radiology and telespecialty services.

Completion in 2018 will eliminate the challenges faced with the co-location of two philosophically different medical practices in an over-crowded and inefficient environment. It will also allow for further expansion of enabling services and eligibility assistance. Physical limitations, however, have not prevented quality improvement within the clinic, nationally recognized as a NCQA Patient-Centered Medical Home.

GRANTEE SNAPSHOTS

DUCHESNE CLINIC

PROJECT	Better Health for the Uninsured
PROJECT SERVING	Wyandotte County

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$150,000	$1–3M	Multiple years	12 months

Total number of unduplicated clients served by this project

1,434

Total number of visitors/ encounters for this project

5,032

STRATEGIES

- Fund service delivery and core operating support
- Advance the use of health data and health information technology

Final Report Abstract

Duchesne Clinic prioritizes care for the whole person. When a patient has an accident or their diabetes is out of control, Duchesne Clinic helps them get back on their feet by providing care with the goal of increasing their agency over life choices that impact their health.

In 2016, 1,434 uninsured residents of Wyandotte County who were living below 150 percent of federal poverty guidelines received primary medical care, chronic disease management, and care coordination for off-site specialty care. With a total of 5,032 uniform data system visits, the clinic sees patients an average of 3.5 times per year.

Duchesne medical providers cared for 5 percent more patients than the previous year. 30 percent of diabetic patients were enrolled in their bilingual diabetes education program, and over the course of the grant period, 84 percent who participated either maintained or decreased their A1C readings. Of Duchesne Clinic's 406 patients managing high blood pressure, 71 percent improved control of their blood pressure based on the standard NQF0018 hypertension report. The clinic's pharmacy assistance program administered $1.4 million in medications to help patients better manage their health.

The clinic learned that even with their advances in usage of the electronic health records (EHR), they still have to optimize provider usage of the EHR related to diagnosis coding. The clinic also learned that their projected numbers for participation in the bilingual diabetes education program were optimistic, and relearned it's essential to remember the patients at Duchesne Clinic confront multiple barriers to achieve better management of their health.

GRANTEE SNAPSHOTS

EL CENTRO

PROJECT	Health Navigation
PROJECT SERVING	Wyandotte County

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$145,265	$1–3M	Multiple years	12 months

Total number of unduplicated clients served by this project

1,196

Total number of visitors/ encounters for this project

1,543

STRATEGIES

- Facilitate greater care coordination and navigation
- Increase health care coverage that supports quality care
- Promote integrated systems of care across safety net clinics, hospitals, providers, and key, community-based services

Final Report Abstract

El Centro's health navigation program primarily works with Latinx, new immigrants (the majority of whom are undocumented), Spanish-speaking people, low-income individuals, and mixed-status families who are uninsured/underserved in Wyandotte and Johnson counties. The program is vital to this community as it provides access to quality and affordable health care services by educating and navigating clients through barriers to their care in a linguistically and culturally sensitive way.

Clients are assisted with services, including:

- Prescription assistance
- Obtaining specialty care appointments and surgeries
- Ordering medical supplies
- Optical care, enrolling in health insurance
- Dental care
- Medical interpretation and care coordination for WyJo Care
- Financial health literacy and application assistance
- Receiving referrals
- Advocacy assistance

The health navigation program served 1,196 unduplicated clients with 1,543 units of service during the 2016–17 grant cycle. The health navigation team exceeded all proposed outcomes during the grant cycle, with 100 percent of clients served having at least one positive access to health care services and 25 clients receiving assistance with specialty care or surgeries. Moving forward, the program will now conduct satisfaction surveys on a quarterly basis, rather than annually, in order to reach more clients for results and data. Additionally, staff will be following new follow-up procedures with clients to improve the overall assistance they receive from the program. These changes will help the program successfully run and grow to its full potential.

GRANTEE SNAPSHOTS

HEALTH PARTNERSHIP OF JOHNSON COUNTY

PROJECT	Improved Pharmaceutical Access
PROJECT SERVING	Johnson County

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$175,347	$3–10M	Multiple years	12 months

Total number of unduplicated clients served by this project

15,225

Total number of visitors/ encounters for this project

38,366

STRATEGIES

- Increase health care coverage that supports quality care
- Implement evidence-based, practice-based, and promising practices in service delivery
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

Health Partnership Clinic's (HPC) pharmacy program serves low-income, uninsured, and under-insured individuals and families living in the Johnson County area. HPC's pharmacy, which opened on October 18, 2016, provides an average of 55 prescription fills per day. Annually, the pharmacy is anticipated to fill 12,000 or more prescriptions for HPC patients.

HPC hired pharmacy staff, renovated space for pharmacy services, applied for pharmacy licensure, applied for credentialing with third party payers, ordered pharmaceutical supplies, set up point-of-sale resources/services, and initiated 340B pharmacy services.

HPC has not previously offered onsite 340B pharmacy services. On average, HPC's pharmacy is filling 55 prescriptions daily. Pharmacy staff are an integral part of the team, providing a valuable medication adherence program to complement the work of medical, dental, and behavioral health staff.

The most important discovery is the extreme financial barriers faced by HPC patients, and the need for access to affordable medications. Numerous patients have shared their gratitude with staff, and have spoken about how this program has helped overcome barriers, allowing them to improve their overall health and quality of life.

GRANTEE SNAPSHOTS

JEWISH FAMILY SERVICES

PROJECT	Older Adult Access and Care Management
PROJECT SERVING	Johnson County

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$90,000	$3–10M	Multiple years	12 months

Total number of unduplicated clients served by this project

774

Total number of visitors/ encounters for this project

1,894

STRATEGIES

- Facilitate greater care coordination and navigation
- Fund service delivery and core operating support
- Develop strategic partnerships through formal agreements that lead to system transformation

Final Report Abstract

The target population for Older Adult Access Network (OAAN) is older adult-serving organizations in Jackson County, Missouri, and Johnson County, Kansas. The target population of care management is underserved, low-income older adults who live in independent settings but are at high risk of hospitalization or significant health status changes.

Key program strategies included:

- Development and implementation of the Greater Kansas City OAAN to strengthen integration and coordination of health care and social services for older adults.
- Increased access and improved quality of care through client-centered, evidence-based practices that deliver integrated and coordinated care management services to older adults, thereby enabling them to continue to live at home in better health and at lower cost.

Measures of success for care management are encouraging. During their active care management participation last year, there were 49 reports of falls over the program's 2,534 visits with 249 clients — significantly lower than the national average of one in three older adults falling per year. None of the program's 249 clients were admitted to a nursing facility during the course of their care management service and 24 ER visits and 34 hospitalizations. At discharge, 97 percent of clients reported feeling positive about their ability to manage their health care and social service needs and 96 percent reported being more optimistic about their ability to remain living in their home.

In order to increase enhanced information and referral rates, access to community service referrals, and reduce call center duplication, the call center is being moved to MARC.

GRANTEE SNAPSHOTS

KANSAS CITY CARE CLINIC

PROJECT	General Medicine and Oral Health Care
PROJECT SERVING	Jackson County and/or KCMO (may include all of Jackson County and/or KCMO portions of Clay and Platte counties)

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$350,000	$10M+	Multiple years	12 months

Total number of unduplicated clients served by this project

3,819

Total number of visitors/ encounters for this project

11,026

STRATEGIES

- Fund service delivery and core operating support
- Implement evidence-based, practice-based, and promising practices in service delivery
- Promote integrated systems of care across safety net clinics, hospitals, providers, and key, community-based services

Final Report Abstract

The general medicine and oral health programs of the Kansas City CARE Clinic provide vital safety net services to the community. In the program year, the general medicine program served 3,863 patients through 9,962 visits, and the dental program served 648 patients through 1,064 visits. The clinic's target population is diverse: 60 percent are racial minorities, 70 percent live below the poverty level, 74 percent are uninsured, and the majority of patients (75 percent) reside in KCMO/Jackson County.

Key program strategies include increasing access through delivering quality services, improving quality by implementing evidence-based practices, and promoting the integration of programs to further improve the quality of care. Specific activities include providing patient-centered, low-cost medical services for uninsured and underinsured patients; improving patient self-management of chronic conditions, as verified by medically recognized standards; providing comprehensive oral health care which is integrated with KC CARE's primary care and behavioral health; facilitating screening to further integrate care and increase access to needed services; and tracking patient satisfaction and working to attend to patient experience.

The clinic is meeting or approaching goals for health indicators related to chronic care management and completing dental treatment plans. The clinic is exceeding all goals that relate to patient satisfaction. Lessons learned include the need for ongoing staff training to reinforce key processes, increased attention to patient experience and satisfaction, and enhanced communication between staff and across various programs to support integration.

GRANTEE SNAPSHOTS

KANSAS UNIVERSITY ENDOWMENT ASSN.

PROJECT	JayDoc Free Clinic
PROJECT SERVING	Wyandotte County

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$40,000	$10M+	Multiple years	12 months

Total number of unduplicated clients served by this project

DID NOT REPORT

Total number of visitors/ encounters for this project

1,276

STRATEGIES

- Facilitate greater care coordination and navigation
- Increase health care coverage that supports quality care
- Improve patient care experience, engagement, and satisfaction

Final Report Abstract

In 2016, JayDoc served a diverse group of Kansas Citians experiencing significant barriers to obtaining health care including language, lack of insurance, lack of education, lack of health literacy, and poverty.

JayDoc made quantitative improvements in their management of diabetics and chronic diseases through an interdisciplinary team approach involving volunteers and professionals in social work, pharmacy, dietetics, laboratory, and medicine. Patients needing gynecological or obstetrical services are also receiving greater continuity of care or referrals when indicated. Additional improvements were made at the organizational level, facilitating a smoother transition of the executive board and an expansion of both specialty and social services offered.

More of JayDoc's diabetics are now demonstrating blood glucose measurements consistently within target range, and even more show positive lifestyle modifications through resultant reduction in BMI, blood pressure, and glycemic indicators. Additionally, all pregnancies were screened and referred appropriately, with greater compliance for postpartum follow-up. Finally, the JayDoc executive board now participates in a file-sharing program, which facilitates quality handoffs between daily clinic sessions and across years as the organization grows.

JayDoc's emphasis on providing interdisciplinary care included educational sessions on use of social and community health workers. This has positively impacted JayDoc's patients and also helped address the continuing challenge of patient compliance with treatment plans by addressing obstacles specific to each individual. Because of increased efficiency, JayDoc has been able to reach more patients in 2016 and set new, larger goals for the future.

GRANTEE SNAPSHOTS

KU HEALTH PARTNERS

PROJECT	Silver City Health Center Primary Care Safety Net Services
PROJECT SERVING	Wyandotte County

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$50,000	$1–3M	Multiple years	12 months

Total number of unduplicated clients served by this project

1,029

Total number of visitors/ encounters for this project

3,721

STRATEGIES

- Fund service delivery and core operating support
- Advance the use of health data and health information technology
- Improve patient care experience, engagement, and satisfaction

Final Report Abstract

Safety net operations support has empowered SCHC to provide a patient-centered medical home in Wyandotte County, an area of well-documented need. In 2016, the number of patients served was 1,029 in 3,721 visits; 14 percent were new patients, 35 percent were uninsured, and 43 percent were enrolled in KanCare. 95 percent of uninsured patients qualified for discounted services under the sliding fee scale, a key component of access. In addition to primary care, the team provides nutrition and dietetics services as well as a robust pharmacy assistance program; they recently added prenatal and geriatric care.

Their improvement program targets patient access and quality of care, and demonstrates a commitment to improved health outcomes that incorporate Triple Aim and patient-centered medical home philosophies. Program outcomes included improved time to next third appointment, patient access to multiple visits, and improvements in patient screenings. Assessment of the patients, families, and students engaged in care at the SCHC, and the Argentine neighborhood, revealed areas of positive impact and opportunities for improvement that were forefront during the development of an impactful new mission, vision statements, and annual goals.

Along with partners Turner House Children's Clinic and the University of Kansas Health System, the SCHC is in the midst of reorganizing efforts and planning after recently learning the Wyandotte Community Health Center's collaborative application for federal health center new access point funding was unsuccessful. In an effort to improve sustainability, partner operations are being organized into a "look-alike" health center in the near term and the designation will be reapplied for when the opportunity arises.

GRANTEE SNAPSHOTS

LEGAL AID OF WESTERN MISSOURI

PROJECT	Affordable Care Act (ACA) Project
PROJECT SERVING	Jackson County and/or KCMO (may include all of Jackson County and/or KCMO portions of Clay and Platte counties)

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$100,000	$3–10M	Multiple years	12 months

Total number of unduplicated clients served by this project

85

Total number of visitors/ encounters for this project

85

STRATEGIES

- Increase health care coverage that supports quality care

Final Report Abstract

The project provided legal representation and counsel to individuals facing legal obstacles to adequate health care. This included wrongful denials and terminations of health coverage, as well as other issues, such as the need for guardianship over a disabled, adult child. On a broader scale, high-impact casework was conducted, which involved appealing to high-level agencies to change flawed systems and policies. Additionally, the community was educated about their rights and responsibilities under the Affordable Care Act through 125 outreach activities.

During the grant period, brief advice and counsel was provided to 64 individuals facing a legal barrier to health care, and legal representation was provided for another 21 individuals. Additionally, there are cases open on 13 additional individuals which have yet to be resolved. An important discovery has involved the effects on health care access when a disabled child reaches the age of majority. Once a child turns 18, the parents are no longer able to consent to medical treatment for their child. Thanks to HCF, we expanded the project, and helped several families obtain judicial guardianship orders over a disabled adult child in need of health care.

The racial demographics of the population served through this project are as follows:

- 32 percent African American
- 40 percent Caucasian
- 19 percent Hispanic
- 2 percent Asian
- 7 percent Other

The majority (76 percent) of clients resided in Jackson County, with the remaining living in Cass (2 percent), Clay (12 percent), Platte (8 percent) and Ray (2 percent) counties. Additionally 59 percent of clients were female, and 41 percent were male.

GRANTEE SNAPSHOTS

MILES OF SMILES

PROJECT	Safety Net Portable Dental Care
PROJECT SERVING	Jackson County and/or KCMO (may include all of Jackson County and/or KCMO portions of Clay and Platte counties)

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$80,960	$1–3M	Multiple years	12 months

Total number of unduplicated clients served by this project

2,258

Total number of visitors/ encounters for this project

5,893

STRATEGIES

- Fund service delivery and core operating support

Final Report Abstract

Miles of Smiles provides free, portable dental care to low-income children of Clay and Platte counties who have a Kansas City address. Miles of Smiles defines low-income children as those who live below 200 percent of the federal poverty level. The number of Kansas City children treated by Miles of Smiles during the grant period was 2,258. The primary strategy of Miles of Smiles is to make dental care as accessible as possible by providing comprehensive dental care in the school setting, at community agencies, and at public access locations.

The following outcomes were achieved:

- 81 percent of patients demonstrated reduced cavities at subsequent visits
- 79 percent of patients completed his/her treatment plan
- 10 percent more patients were on Medicaid than the previous year.

The main lesson learned is that the strength of the relationship with the school districts is imperative to Miles of Smiles' success, as well as the recruiting and hiring of dentists to work full time.

GRANTEE SNAPSHOTS

PLANNED PARENTHOOD OF GREAT PLAINS

PROJECT	Health Care and Education in Kansas City's Urban Core
PROJECT SERVING	Jackson County and/or KCMO (may include all of Jackson County and/or KCMO portions of Clay and Platte counties)

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$73,679	$3–10M	Multiple years	12 months

Total number of unduplicated clients served by this project

5,844

Total number of visitors/ encounters for this project

6,352

STRATEGIES

- Increase health care coverage that supports quality care
- Develop strategic partnerships through formal agreements that lead to system transformation
- Improve patient care experience, engagement, and satisfaction

Final Report Abstract

Planned Parenthood of Great Plains (PPGP) focused on improving the health care and education provided at their Patty Brous health center in the urban core of Kansas City. Many of the patients served at Brous are underinsured or uninsured. During the grant period, PPGP aimed to increase access to care, offer education in the health center, increase partnerships with other safety net providers, incorporate volunteers into the heath center, and introduce new services to our patients.

PPGP was able to increase the care we provide, increase the number of partner organizations, improve the patient experience through volunteer engagement, and expand services. They were not as successful in maintaining expanded hours and introducing education sessions at the health center. They learned that the expansion of health services best meets the needs of our patients and greatly improves the care we provide.

We discovered the importance of maintaining relationships with partner organizations and how impactful the engagement of volunteers can be with our patients. It was a wonderful opportunity for PPGP to learn what is important for the delivery of care to patients and how they can best meet their ongoing needs. PPGP plans to continue to use the lessons learned from this grant to expand access to all their health centers across Kansas, Missouri, Oklahoma, and Arkansas.

GRANTEE SNAPSHOTS

RIVERVIEW HEALTH SERVICES

PROJECT	Riverview Health Services
PROJECT SERVING	Wyandotte County

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$185,000	Under $1M	Multiple years	12 months

Total number of unduplicated clients served by this project

1,745

Total number of visitors/ encounters for this project

5,990

STRATEGIES

- Fund service delivery and core operating support
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

Riverview Health Services provides bilingual services to vulnerable workers and those who are uninsured and underinsured of all ages. While 85 percent of those served live in four impoverished neighborhoods in eastern Kansas City, Kansas, Riverview served people in 69 zip codes last year, including clients from Sedalia, Kearney, and Emporia. Riverview collaborates with clinics, hospitals, doctor offices, and social service agencies to connect at-risk people with the medical services they need.

In 2016, Riverview accessed 4,367 medications and medical supplies valued at more than $600,000 for 1,307 people and provided 1,623 health education services to 438 people. During this grant period, Riverview prioritized building more and stronger partnerships in order to reduce barriers to service and help more people, and have learned more about the complexity and expense of service integration. These lessons will be used to ensure that Riverview continues to be a good partner as well as a compassionate and meaningful resource for their clients.

GRANTEE SNAPSHOTS

ST. LUKE'S HOSPITAL FOUNDATION

PROJECT	Care Coordination
PROJECT SERVING	Jackson County and/or KCMO (may include all of Jackson County and/or KCMO portions of Clay and Platte counties)

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$260,000	$1–3M	Multiple years	12 months

Total number of unduplicated clients served by this project

5,374

Total number of visitors/ encounters for this project

5,374

STRATEGIES

- Facilitate greater care coordination and navigation
- Promote integrated systems of care across safety net clinics, hospitals, providers, and key, community-based services
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

The care coordination program targets clients with significant barriers to care. In the 2016 grant year, the program served 5,374 patients in the Greater Kansas City metropolitan area, including Jackson County, Missouri, and Wyandotte and Johnson counties in Kansas. These populations were primarily uninsured (88 percent), low-income (53 percent below federal poverty level), and racial and ethnic minority groups (67 percent). The program features coordinated services — facilitated through community health workers — with safety net clinics, community agencies, and related partners. Additionally, patients received care in 2016 through Saint Luke's Health System, University of Kansas Hospital, Research Hospital, and North Kansas City Hospital.

As a primary strategy to facilitate greater care coordination and to promote integrated systems of care, the program currently embeds community health workers with 24 safety net clinics, numerous specialty providers, and the emergency departments at St. Luke's, KU, and North Kansas City Hospital. These efforts to increase impact and minimize duplicative efforts, in turn, facilitate the program's primary goals to reduce costs and unnecessary emergency department visits.

Program outcomes include achievements in patient access to medication; patient linkage to a medical home; patient achievement of service plan goals; patients maintaining or improving their health status and levels of motivation and confidence; and decreased use of emergency departments. The key lesson learned is the continued need to stabilize technology challenges, primarily to create and maintain a uniform documentation system. This will provide an improved foundation for the program to use a more uniform process, reflecting greater analysis, efficiency, and return on investment.

GRANTEE SNAPSHOTS

SAMUEL U. RODGERS HEALTH CENTER

PROJECT	Community-Centered Care Initiative
PROJECT SERVING	Jackson County and/or KCMO (may include all of Jackson County and/or KCMO portions of Clay and Platte counties)

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$225,000	$10M+	Multiple years	12 months

Total number of unduplicated clients served by this project

308

Total number of visitors/ encounters for this project

375

STRATEGIES

- Facilitate greater care coordination and navigation
- Increase health care coverage that supports quality care

Final Report Abstract

This program worked with residents of Chouteau Courts and Riverview Gardens housing communities to improve access to health care by embedding health care and social service staff in the communities themselves. The number of patients who had access to health care increased, as did the number of visits those individuals made and kept.

The primary lesson learned is that it's imperative to make the residents equal partners in the process, rather than assuming that outsiders know what's best. It takes time to develop relationships, but when that time is invested, it pays off in better access and better health care for those living in the community.

GRANTEE SNAPSHOTS

SETON CENTER FAMILY & HEALTH SERVICES

PROJECT	Expanding Oral Health Care
PROJECT SERVING	Jackson County and/or KCMO (may include all of Jackson County and/or KCMO portions of Clay and Platte counties)

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$229,506	$1–3M	Multiple years	12 months

Total number of unduplicated clients served by this project

884

Total number of visitors/ encounters for this project

2,212

STRATEGIES

- Facilitate greater care coordination and navigation
- Improve patient care experience, engagement, and satisfaction
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

Seton Center provided dental care to the needy living in a 10-county area in metro Kansas City. The poor, mentally ill, homeless, incarcerated, and those recently released from prison comprised the population served. As part of this opportunity, dental services were provided to children in five area schools and instruction on how to brush their teeth properly to better maintain their oral health. Many of the children received dental care for the first time. Dental Services was able to serve 1,836 patients through 9,180 patient visits providing oral health services for improved oral health with an 85 percent satisfaction rate.

GRANTEE SNAPSHOTS

SOUTHWEST BLVD. FAMILY HEALTH CARE SERVICES

OF GREATER KANSAS CITY

PROJECT	Safety Net Services
PROJECT SERVING	Wyandotte County

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$300,000	$3–10M	Multiple years	12 months

Total number of unduplicated clients served by this project

4,127

Total number of visitors/ encounters for this project

14,204

STRATEGIES

- Fund service delivery and core operating support
- Increase health care coverage that supports quality care
- Implement evidence-based, practice-based, and promising practices in service delivery
- Improve patient care experience, engagement, and satisfaction
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

Southwest Blvd. Family Health Care Services (FHC) is located in Wyandotte County and most of the 4,127 patients receiving health care are from the poorest areas in the Kansas City metropolitan area. FHC promotes the highest quality of clinical, medical, and oral health care through evidence-based practice guidelines, and through a team-based approach to the patient. Integral to FHC's work and stipulated in their mission statement, continuity of care involves developing and maintaining true personal connections based on mutual trust with patients and their families over many years.

FHC endeavors to sustain their work through cost-effective (cost-conscious) choices, comprehensive on-site care to reduce costly referrals, and reduced redundancy through coordinated care. Cost-effective supports are measured through tracking the utilization of the patient assistance programs. Over 200 patients received assistance with an average of 2.5 prescriptions each. FHC provided assistance to help patients with Medicaid applications and applications for ACA Coverage that allowed patients to access additional health services.

Lessons learned are that FHC can keep up with the challenges of an ever-changing health care system, and meet the needs of their patients through close attention to both the larger environment (community, state and nation) as well as continual emphasis on quality improvement for operations and clinical services. An important on-going lesson is that integration of services with primary health care needs are critically important to the disadvantaged individuals served.

GRANTEE SNAPSHOTS

SWOPE HEALTH SERVICES

PROJECT	Dental Services for Low-income, Uninsured and Underinsured Residents of the Kansas City Metropolitan Area
PROJECT SERVING	Jackson County and/or KCMO (may include all of Jackson County and/or KCMO portions of Clay and Platte counties)

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$235,060	$10M+	Multiple years	12 months

Total number of unduplicated clients served by this project

1,617

Total number of visitors/ encounters for this project

2,743

STRATEGIES

- Facilitate greater care coordination and navigation
- Fund service delivery and core operating support
- Implement evidence-based, practice-based, and promising practices in service delivery

Final Report Abstract

Swope Health Services' dental department provides affordable, quality oral health care to low-income, uninsured/underinsured residents of all ages in the Kansas City metropolitan area. Through this project, 1,617 patients — 64 percent of whom were of minority race and 78 percent of whom had incomes below 200 percent federal poverty level — received services. The project was based at the SHS-Central clinic.

The project dentist provided exams, some cleanings and periodontal scaling, fillings, crowns and dentures, extractions and oral health education. The dentist was assisted by two full-time dental assistants. The dental care coordinator worked with prioritized patients — pregnant women and patients with chronic diseases — to access timely dental care and other recommended medical and ancillary services.

The project dentist served 1,316 dental patients through 2,442 clinic visits. Sixty-two percent of patients completed treatment. The dental care coordinator assisted 301 patients with accessing timely dental services and other medical, vision, educational, and supportive services needed to sustain their health. The coordinator was able to link 154 patients with chronic conditions with needed services, a substantial increase over the prior grant period.

The restoration of dental benefits for certain types of Missouri Medicaid beneficiaries helped increase the percentage of patients that completed treatment and the number of patients with chronic conditions that engaged in both dental and medical care. Swope's enhanced capacity to coordinate patient care across service areas reinforced the dental department's efforts to ensure continuity of care for patients.

GRANTEE SNAPSHOTS

SYNERGY SERVICES

PROJECT	Homeless Youth Campus Integrated Health Clinic
PROJECT SERVING	Jackson County and/or KCMO (may include all of Jackson County and/or KCMO portions of Clay and Platte counties)

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$125,000	$3–10M	Multiple years	12 months

Total number of unduplicated clients served by this project

2,727

Total number of visitors/ encounters for this project

8,229

STRATEGIES

- Facilitate greater care coordination and navigation
- Develop strategic partnerships through formal agreements that lead to system transformation

Final Report Abstract

The on-site medical, dental, and mental health clinic is a centerpiece of the Resiliency Center and an important expansion of safety net services. The youth served often do not have access to mental health services, regular health or dental care, and many times cannot recall when they last had a physical or dental exam. These young people suffer from the physical and mental health consequences of a life of poverty, abuse, and neglect.

As homeless youth are still developing mentally and physically, the impact of this lifestyle is often severely damaging and can affect the health of these teens throughout their lives. Designed to overcome the barriers that have prevented homeless and runaway youth from receiving quality health care, the clinic is focused on providing better access and improved quality to consistent care using an integrated and affordable model of service provision. In most cases, even when homeless youth are able to access health care, they are often confronted with a fragmented system that does not offer cultural competence, coordination, or a youth-focused environment.

Synergy's clinic increases access and improves quality of care by truly integrating medical, dental, and mental health services in a wrap-around, whole person approach. The clinic also emphasizes consistent relationship-based care through the same providers and encourages youth to use the clinic as their primary health care home. The goals of Synergy's on-site integrated clinic are designed to increase the access and quality of health services, while reducing the overall cost of care.

GRANTEE SNAPSHOTS

THE CHILDREN'S MERCY HOSPITAL

PROJECT	Children's Mercy Dental Clinic: Program for Indigent Children with Medically Complex Conditions
PROJECT SERVING	Jackson County and/or KCMO (may include all of Jackson County and/or KCMO portions of Clay and Platte counties)

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$200,000	$10M+	Multiple years	12 months

Total number of unduplicated clients served by this project

2,206

Total number of visitors/ encounters for this project

3,309

STRATEGIES

- Facilitate greater care coordination and navigation
- Improve patient care experience, engagement, and satisfaction
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

Children's Mercy dentistry practice represents a vital safety net for the region's uninsured and underinsured children, as well as for children with medical complexity. Specializing in providing comprehensive, preventive, and therapeutic oral health care, dentists at the Children's Mercy Dental Clinic are the go-to team for complicated and high-risk dental problems for all children. Approximately 35 percent of the dental clinic's patient population have severe medical conditions. These medically complex children often receive care from a number of the specialty services at Children's Mercy in collaboration with the dental clinic. Approximately 5 percent of the dental clinic's patient population require general anesthesia for their procedures.

The primary strategies for increased access, improved patient experience and health outcomes, and reduced health care costs involved: empanelment of 25 percent more medically complex pediatric dental patients in the dental home; increasing the number of dental operatories from five to eight; and acquisition of a 3D Cone Beam Imaging System. Early detection of problems helps reduce need for repeated visits, more expensive procedures as problems magnify over time, and number of general anesthesia episodes for patients who cannot be treated without general anesthesia.

Increasing the number of treatment rooms required added attention to communication and teamwork. To address these needs, Children's Mercy Dental Clinic worked with the hospital's leadership to implement the LEAN system, geared to improving staff communication, increasing efficiency and the quality of care and safety for the patients. Clinic staff consider the hospital's leadership staff to be among their greatest supporters.

GRANTEE SNAPSHOTS

THRIVE ALLEN COUNTY

PROJECT	Health Care Organizing and Mobilization for Equity 2016 (HOME 2016)
PROJECT SERVING	Allen County

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$32,257	Under $1M	Multiple years	12 months

Total number of unduplicated clients served by this project

259

Total number of visitors/ encounters for this project

465

STRATEGIES

- Facilitate greater care coordination and navigation

Final Report Abstract

The HOME 2016 grant was used to serve the population of Allen County, especially those at 100–250 percent of federal poverty level. This county is rural and socially economically depressed. Many of the consumers need help using technology and come for assistance in enrolling in insurance because they lack the technical skills needed (or technology in general needed) to apply for insurance on their own. They also lack the information needed to understand the plans available to them via the health insurance marketplace, which navigators are trained to easily and understandably explain to them.

The program's main component was enrolling Allen County residents on the federal marketplace exchange. This was done by in-person appointments that were made after consumers heard of the opportunity through word of mouth, radio ads, newspaper articles, or via social media posts. The navigators saw 465 consumers over the past year who needed assistance enrolling and/or understanding their insurance.

Disseminating correct information regarding the ACA and enrollment was a big lesson this year. There were many rumors flying during this open enrollment and being prepared to answer questions in a non-biased, knowledgeable manner was important. The importance of having multiple navigators on hand during open enrollment periods also became apparent. So many people walk into Thrive for assistance that it is more than one person can handle on their own. Having multiple trained and experienced navigators on staff, especially during open enrollment periods is a necessity for the continued success of the navigator program.

GRANTEE SNAPSHOTS

TURNER HOUSE CLINIC

PROJECT	Patient-Centered Medical Home and Delivery of Integrated Services
PROJECT SERVING	Wyandotte County

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$300,000	$3–10M	Multiple years	12 months

Total number of unduplicated clients served by this project

5,214

Total number of visitors/ encounters for this project

12,117

STRATEGIES

- Facilitate greater care coordination and navigation
- Advance the use of health data and health information technology
- Implement evidence-based, practice-based, and promising practices in service delivery

Final Report Abstract

During the grant term, Turner House Children's Clinic served 5,214 unique uninsured and underserved pediatric patients up to age 18, in 12,117 visits for primary medical, behavioral health and dental care. Approximately 96 percent of patients resided in Wyandotte County and 4 percent of patients resided in Johnson County, Kansas. The project focused on increasing access and improving quality through implementation of greater care coordination and case management practices; launching an on-site dental clinic based on an evidence-based practice model of integrating dental and primary medical care; promoting system transformation; and training staff to support their optimal use of the electronic health record and practice management system, advancing the use of health data and health information technology.

In the second quarter, the executive director resigned and Turner House's board determined with stakeholder input that designation as a Federally Qualified Health Center (FQHC) or FQHC Look Alike was the best path forward for sustainability. Turner House took action to achieve those changes via a transition plan and recruitment strategy for a new CEO, and by establishing a collaborative partner arrangement with the University of Kansas Health System and KU Health Partners. A key lesson learned during the grant term is that challenges can be leveraged to become opportunities. Turner House successfully implemented the project strategies established in their grant proposal, managed day-to-day operations, achieved health outcome improvements and weathered a 4 percent cut in KanCare (Medicaid) rates of reimbursement while concurrently pursuing and managing changes in leadership, business models, and new business partners.

GRANTEE SNAPSHOTS

WEST CENTRAL MO COMMUNITY ACTION AGENCY

PROJECT	Health Services Clinic
PROJECT SERVING	Cass County

GRANT AMOUNT	OPERATING BUDGET	FUNDED BY HCF	GRANT TERM
$100,000	$10M+	Multiple years	12 months

Total number of unduplicated clients served by this project

689

Total number of visitors/ encounters for this project

1,434

Final Report Abstract

West Central Missouri Community Action Agency (West Central) served low-income and uninsured men, women, and children at the Cass County clinic at 119 Congress St., Belton, Missouri. Clients were from Cass, Henry, Bates, and Jackson counties. Activities included providing reproductive health with free or reduced cost for visits and contraceptives, and also acute and chronic disease care at a low cost.

West Central staff were successful in changing clinical protocols, scheduling, equipping client rooms, advertising, and signing a new medical director. The clinic increased client visits but not at a sustainable rate to combat the decreasing program funding levels for the coming year. West Central has suspended direct client services and is restructuring their health services programs to continue to make an impact on communities and people served.

STRATEGIES

- Fund service delivery and core operating support
- Support approaches that reduce costs, promote sustainability, or contain costs

REPORT TIMING & DATA SOURCES

This portfolio report was developed from 25 final grant reports that summarized the work of HCF safety net grantees who were awarded grants in December 2015. These grants were implemented throughout 2016 and early 2017 and final grant reports were submitted to HCF beginning in January 2017. Final reports are due 30 days after the completion of the grant. This portfolio report was developed beginning in the fall of 2017 once all reports had been received and approved. HCF worked with Informing Change to develop the report format and to synthesize data across the 25 final grant reports.

FUTURE VERSIONS OF THIS REPORT

HCF has already responded to grantee feedback and lessons learned from the development this report by implementing several changes that will improve the quality of future reports and the ease of reporting for grantees:

1. All 2017 grantees were asked to select outcomes and indicators in their grant applications, using a common template.
2. The final report portal, which will be used by 2016 and subsequent grantees, has been redesigned to streamline reporting on outcomes. This new portal will reduce the time it takes to complete the final report as well as reduce reporting errors and data "cleaning."
3. HCF hosted a grantee meeting in the fall of 2017 to provide technical assistance around the outcomes and indicators that grantees will provide in their final reports.

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