Health Forward
FOUNDATION

SAFETY NET PORTFOLIO REPORT

AN EVALUATION OF SAFETY NET GRANTS AWARDED IN 2016 (REPORT RELEASED IN 2019)

INTRODUCTION

Health Forward Foundation is pleased to release the Safety Net Portfolio Report highlighting our 2016 Safety Net grantees. This report marks the second year of data collection and analysis around a set of common strategies, outcomes, and indicators. We are pleased with the progress our grantees have made and are humbled by their dedication to the clients that they serve.

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PROCESS

This Safety Net Portfolio Report was developed from final grant reports that summarize the work of 26 Health Forward Safety Net grants. A final grant report is submitted by each grantee to help Health Forward evaluate the program for which the grantee received funding. The final report is one way Health Forward learns about grant progress. Interactions with grantees, including site visits, are also a rich source of information that is not reflected here.

Health Forward awarded Safety Net grants in December 2016. These grants were implemented throughout 2017 and early 2018, with final grant reports submitted to Health Forward beginning in late January and continuing through May 2018. Health Forward began development of the portfolio report in fall 2018. Informing Change, a strategic learning firm based in California, helped develop the report format and synthesize data across the 26 final grant reports.*

Data in this report are all self-reported by each grantee. To the extent possible, inconsistent or questionable data were flagged and subsequently confirmed or amended by grantees.

Health Forward grants support specific programs that align with our theory of change. Our grantees select the most relevant strategies, outcomes, and indicatorsto report only on their grant-funded program. This represents only a portionof the work they do, and this is the data included in the portfolio report. Partner agencies address a wide variety of community health needs through work that is not represented in this report.

DATA LIMITATIONS

Comparing one year to the next has limitations. Each funding round represents a slightly different mix of grantees based on the pool of applicants, relative strengths of proposed program, and geographic and population diversity.

** While Health Forward awarded 28 Safety Net grants in 2016, this report examines the work of 26 of those grantees who finished projects and submitted complete final reports.*

THEORY OF CHANGE BACKGROUND

Health Forward developed the Safety Net theory of change in 2015-2016, in collaboration with Informing Change and in alignment with our mission to eliminate barriers and promote quality health for those most in need — the uninsured and underserved in our service area. The theory of change shows our priorities for the Safety Net funding round and outlines specific strategies the short- and long-term outcomes that we hope to achieve in partnership with our grantees. Structured around the Institute for Healthcare Improvement's Triple Aim, our Safety Net theory of change focuses on increasing access, improving quality, and reducing cost.

The theory of change provides a visual representation of how and why we expect to see change in our community, as well as a mechanism to assess progress toward outcomes across grantees. It also clarifies the desired outcomes and the strategies we believe will be necessary to achieve them. For the 2016 funding round, Health Forward asked grantees to address all three strategies of access, quality, and cost.

Portfolio reporting represents a shift and evolution in the way Health Forward understands and uses data. Prior to developing this evaluation framework, we didn't have a way to examine grants as a whole, so we reported about grantees singularly and considered outcomes of their programs individually. After adoption of common metrics, we are able to report on grantees as a portfolio.

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 Cost

- 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 Cost

- 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.

PORTFOLIO OVERVIEW

In 2016, Health Forward Foundation issued Safety Net grant awards totaling $4.2 million dollars to 28 grantees.*

All 28 grantees had previously received grant funding from Health Forward, though not necessarily in consecutive years or for the same program. This report includes an analysis of data from end-of-year grant reports from 26 grantees who were awarded 12-month grants in 2016 and examines data across organizations and programs to reflect these grantees' cumulative work. It is aligned with the Safety Net theory of change and analyzes the work of grantees across the safety net field within the Health Forward service area.

This report provides information on Health Forward's funding round and not on the broader safety net system. We recognize that any single grant round represents a portion of the organizations — and the work they do — that contribute to the overall system. In the future, we hope to put this portfolio data in the context of the larger community and overall safety net system. This will require analyzing data from multiple sources to achieve a more sophisticated and contextualized analysis.

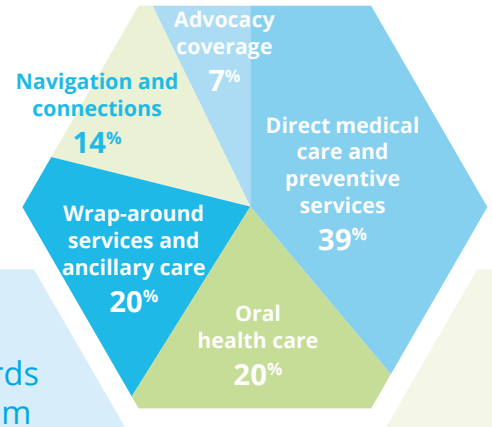
Total number of grants included in this report

26

Grant awards ranged from **$34,166–$365,000**

Median award size **$135,533**

GRANTEE ACTIVITIES



* *While Health Forward awarded 28 Safety Net grants in 2016, this report examines the work of 26 of those grantees who finished projects and submitted complete final reports.*

DEMOGRAPHICS

Grantees provide data on the population served by Health Forward-funded grants. Grantees also report data on the overall population they serve. However, it is not always easy for grantees to parse which clients were funded by this specific grant, especially if the funds are devoted to core operating support.

Grantees use a variety of approaches and systems to count clients and track data. We know that it is impossible to get an unduplicated count of individuals served across multiple agencies, since a single patient can access services from multiple organizations in a given year. Still, these numbers illustrate the great need for these vital health care services and the agencies that provide them.

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

OVERALL IMPACT DURING THE FUNDING YEAR

Health Forward funding reached

70,892

individuals during this grant cycle

These individuals received services through Health Forward-funded programs resulting in

227,372

encounters during this grant cycle

In total, the organizations funded by Health Forward served

187,608

individuals

In total, the organizations funded by Health Forward provided services to individuals through

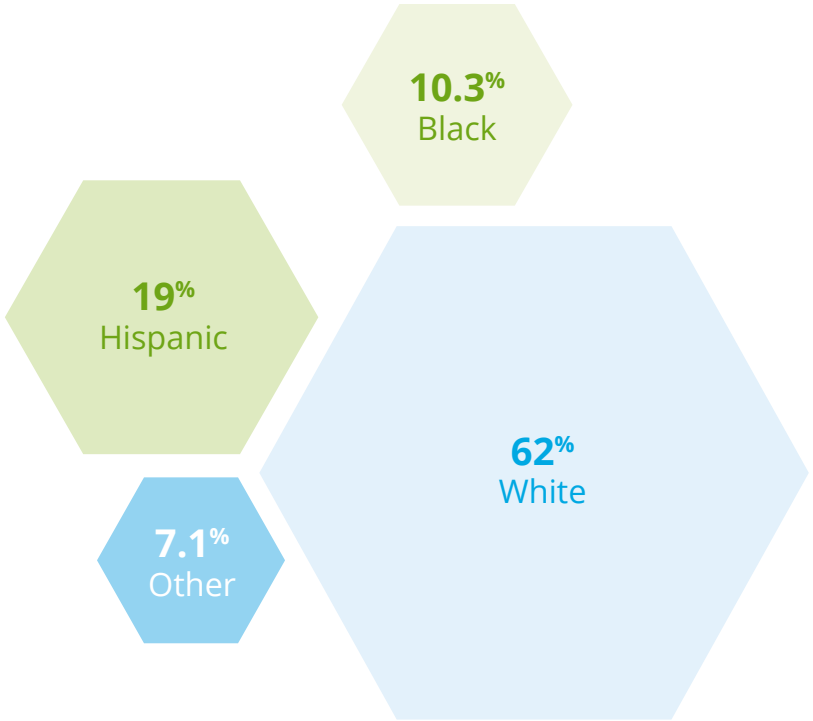
617,761

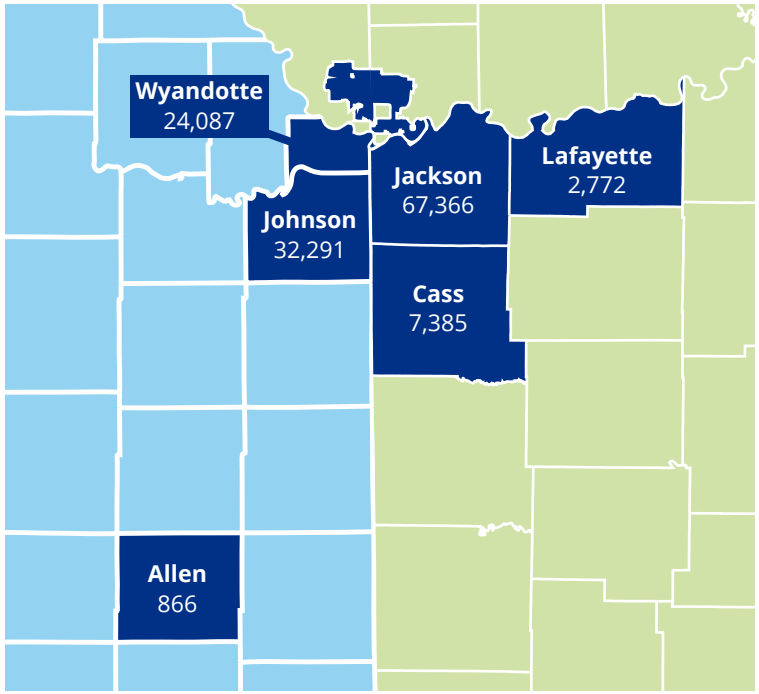
encounters

DEMOGRAPHICS

WHO ARE THE UNINSURED IN OUR SERVICE AREA?

Of uninsured people between the ages of 19-64:**





WHERE DO THE UNINSURED LIVE?

There are an estimated 134,767 uninsured people under age 65† in Health Forward's service area.

** *Kansas and Missouri Consumer Health Access Survey*

† *Small Area Health Insurance Estimates (Census Bureau), Single year (2016) estimates of health insurance status for all counties in U.S.*

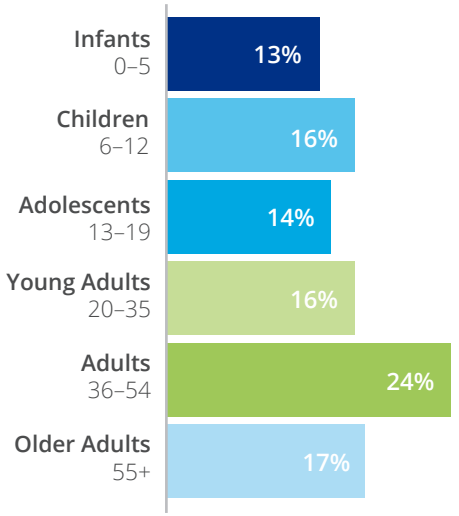
DEMOGRAPHICS

Demographic data indicate Health Forward is reaching its target population in terms of geography and need. Grantees reported serving high levels of uninsured clients, those with Medicaid coverage, and those living on a lower income. Demographics among those served by 2016 grantees are comparable to those served by 2015 grantees.

AGE

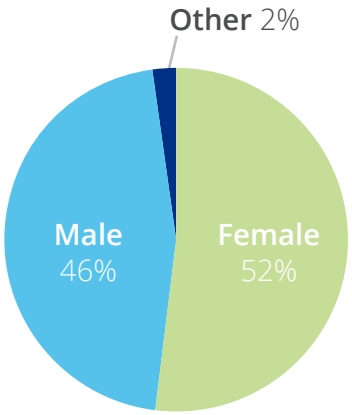
Funding serves people in all stages of life: clients' ages range widely, though slightly more adults ages 36-55 are being served.

This is not surprising since this age range commonly falls in the insurance gap. Other age ranges are more likely to have coverage, since low-income children qualify for Medicaid and older adults (65+) qualify for Medicare. This is also the age when many individuals are diagnosed with chronic conditions that require ongoing care and management.



GENDER

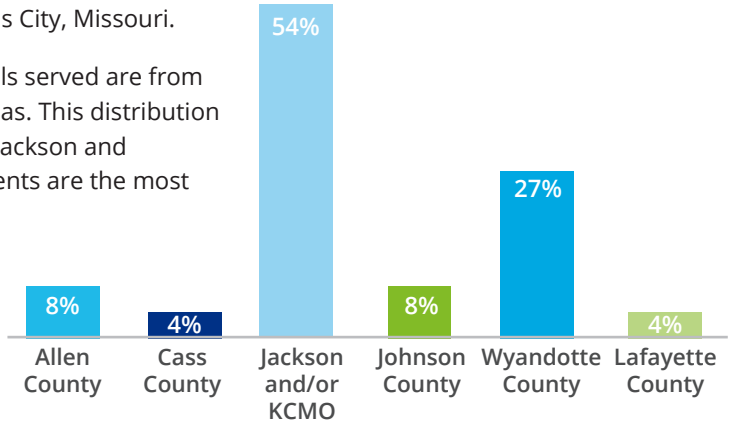
Health Forward-funded programs continue to serve slightly more female clients than male clients.



GEOGRAPHY

More than half of all individuals served through Health Forward funding reside in Jackson County or Kansas City, Missouri.

A quarter of all individuals served are from Wyandotte County, Kansas. This distribution makes sense given that Jackson and Wyandotte county residents are the most likely to be uninsured.

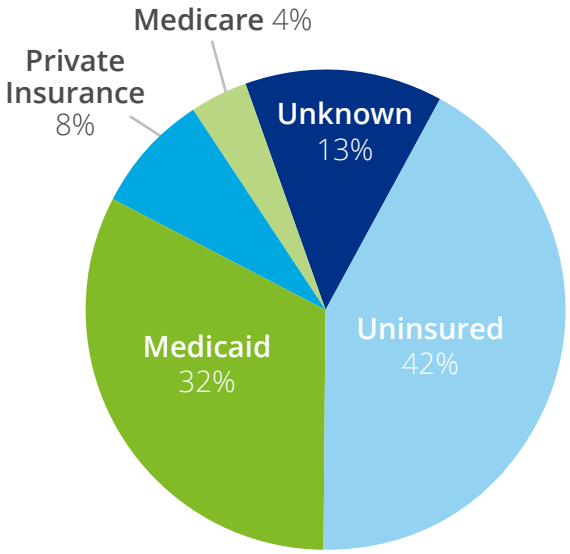


DEMOGRAPHICS

INSURANCE

Forty-two percent of clients served were uninsured, and an additional 32 percent were covered by Medicaid.

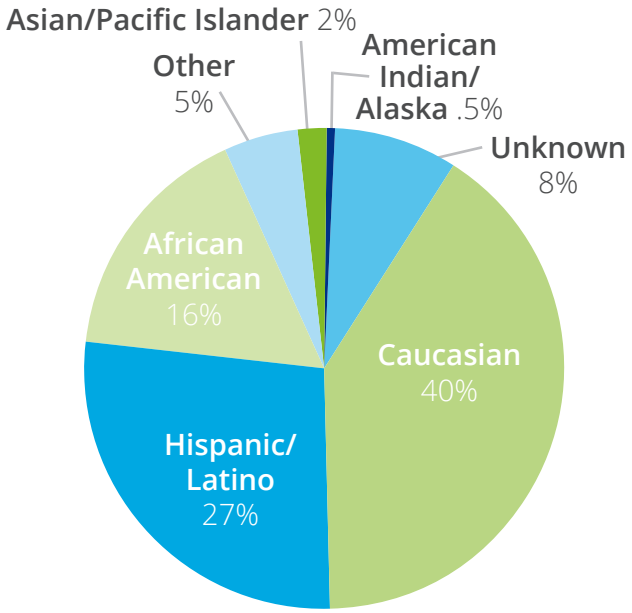
Data on insurance status was not available for 13 percent of clients.



RACE

Most grantees served a racially diverse client population.

More than half of clients served identified as either Hispanic/Latino, African-American, Asian/ Pacific Islander, American Indian/Alaskan Native, or another race (non-Caucasian).



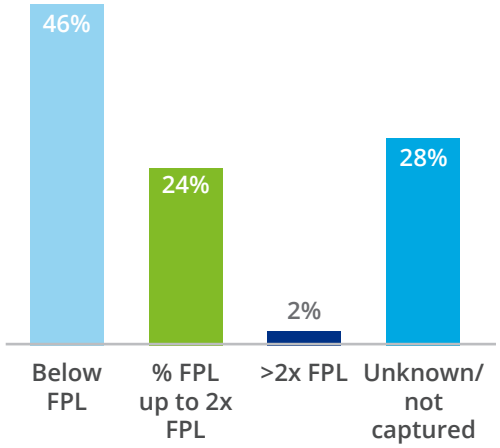
POVERTY LEVEL

Health Forward continues to ask grantees to report on client income as a percentage of the federal poverty level (FPL). In 2017, the FPL for a family of four was $24,600.

Only 2 percent of clients served reported incomes above 200 percent of the FPL.

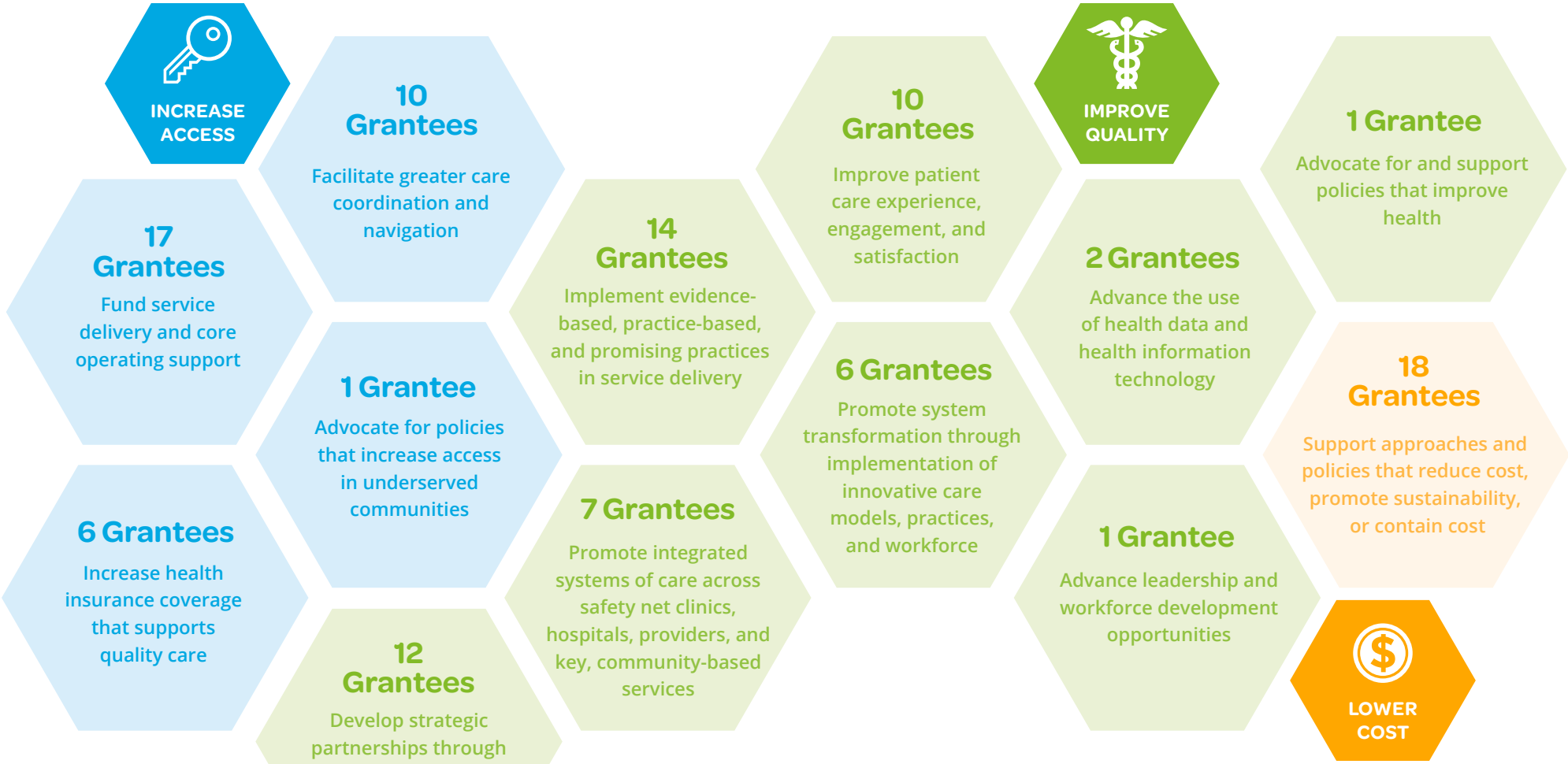
The percentage of unknown income represents more than a quarter of clients.

Not all grantees track income information, and many identify economic need through proxy measures such as SNAP (food stamps), free and reduced lunch, and Medicaid enrollment.



SAFETY NET STRATEGIES

In 2016, grantees were required to select at least one strategy under all three areas of access, quality, and cost. They could also select more than one in each category if desired.



GRANTEE OUTCOMES

Grantees selected the outcomes that aligned with their funded program and reported on related indicators for which they had data. They provided both quantitative and qualitative data. Health Forward requested all grantees report on at least one indicator related to each of the three strategies: access, quality, and cost.

However, not all grantees were able to track and report specific indicators related to all three areas. We expect that in coming years, organizations funded by Health Forward will be able to show progress and improve on reporting these measures.

24 GRANTEES WORKED TO INCREASE ACCESS

23 GRANTEES WORKED TO IMPROVE QUALITY

16 GRANTEES WORKED TO DECREASE COST

INCREASE ACCESS

INCREASING ACCESS

Why Access?

Access is defined as the timely use of personal health care services to achieve the best health outcomes. Access to comprehensive, high-quality health care is important for promoting and maintaining health, preventing and managing diseases, reducing unnecessary disability and premature death, and achieving health equity (Healthy People 2020).

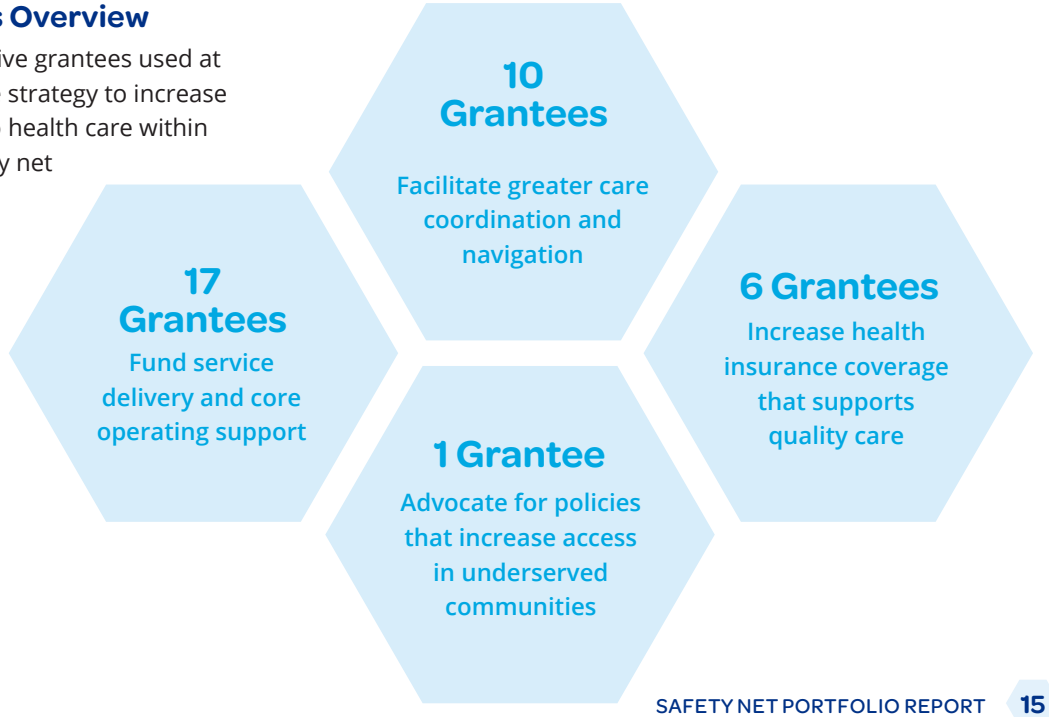
Among Health Forward's grantees, access strategies are robust and have been developed over a number of years since access is essential to their mission and core work. Often, access strategies have been tailored to specific target populations in order to address unique needs and overcome distinct barriers.

Access Summary

- Grantees are clustered around the service delivery and core operating strategy and the care coordination and navigation strategy.
- Core operating support continues to be critical for grantees, allowing flexibility and responsiveness that benefits the safety net system.
- Grantees employ a variety of approaches to increase access to address the unique needs of multiple sub-populations and targeted geographies.
- This is the first year an advocacy-focused strategy was available for grantees to select. Only one grantee selected it, although we know many partner organizations participate in advocacy activities funded through other sources.

Access Overview

Twenty-five grantees used at least one strategy to increase access to health care within the safety net system.



ACCESS STRATEGY

Fund service delivery and core operating support

More than half of the grantees selected funding service delivery and core operating support as one of their access strategies. These critical funds were used to support daily operations, services, and staffing. Health Forward funds are largely used to cover multiple salaries and benefits for staff leading and delivering services, along with other essential direct program expenses.

Nine grantees worked to increase the number of clients accessing their services.

> **Example:** Southwest Boulevard Family Health Care earned designation as a Federally Qualified Health Center Look-Alike and expanded the number of available appointments.

Eight grantees increased access for one or more vulnerable populations, including pediatric and geriatric populations, homeless individuals, and underinsured or low-income groups.

> **Example:** In recognition of the fact that oral health contributes to overall health, Swope Health's dental clinic targets pregnant women and those with chronic conditions who could be more negatively impacted by poor oral health.

Four grantees offered new services to clients, including additional medical screenings, opening additional sites of service, or offering dental care in addition to medical services.

Four grantees used Health Forward grant funds to improve operational infrastructure, including hiring additional staff, purchasing equipment, and improving electronic health record systems.

> **Example:** Turner House Clinic (now part of Vibrant Health) hired a new pediatrician, and Health Partnership Clinic used funding to support key staff salaries.

Three grantees offered additional health education services, including eligibility assistance, medical insurance counseling, and education on specific chronic medical conditions such as diabetes.

ACCESS STRATEGY

Facilitate greater care coordination and navigation

Ten grantees reported that their Health Forward-funded program facilitated greater care coordination and navigation as a strategy to increase access.

Eight grantees used Health Forward funds to improve inter-clinic coordination and communication, including improving the referral system, coordinating tests run on individuals between multiple clinics, and facilitating communication between clinics serving the same populations.

> **Example:** For Thrive Allen County, the first step was to create formalized systems with local health care providers for referrals. Outreach to the Federally Qualified Health Center, Critical Access Hospital, Rural Health Clinic, pharmacy, and private practice primary care provider in Allen County created stronger connections between those systems.

Three grantees focused on improving clients' knowledge and navigation of the health care system. This included assisting clients in applying for additional benefits, assisting clients with making appointments, and employing interns to help address clients' questions.

> **Example:** Jewish Vocational Service connected immigrants to case management services to identify and address health issues in a supportive manner while enrolling them for health coverage, connecting them with a medical home, educating them about local health resources, and teaching them how to use public transportation to access services.

One grantee focused on making the organizational workflow of patient care more efficient, allowing providers to see more clients in the same amount of time.

> **Example:** Turner House Clinic (now part of Vibrant Health) worked to improve patient workflows and increase appropriate patient referral rates.

ACCESS OUTCOMES

Twenty-four grantees used at least one outcome to increase access to health care within the safety net. Compared to 2015, a greater proportion of grantees are investing in the strategy to increase the number of clients receiving quality care. Supporting delivery of core services is clearly a priority among Safety Net grantees.

18 Grantees

Increase number of clients receive quality care

9 Grantees

Help clients successfully navigate through the health system

3 Grantees

Increase number of individuals with insurance coverage

ACCESS OUTCOMES

Increased number of clients receive quality care

Eighteen grantees reported on indicators related to an increased number of clients. Most were direct care organizations.

Number of unduplicated clients: 14 grantees

- Six grantees reported increases.
- Average overall change was an increase of 20 percent.
- Most other grantees reported numbers consistent with the year prior or minor decreases.
- The number of unduplicated clients helps show an organization's penetration within the community.
- An increase in numbers served may indicate growth, but it must be considered along with encounter data in order to understand capacity and depth of service delivery.

Number of services/visits provided: 16 grantees

- Ten grantees reported increases compared with the prior year.
- Average overall change was an increase of 12 percent.
- **Example:** Southwest Boulevard Family Health Care increased the number of visits provided by 15 percent, and they anticipate additional growth in the future.

Number of new clients: 2 grantees

- Cass County Dental Clinic saw 1,294 new clients, representing 37 percent of their clients served.
- Turner House Clinic (now part of Vibrant Health) saw 928 new clients.

Increases in the overall number of people receiving care in the broader health system: 3 grantees

- Increased numbers of people receiving dental care and increasing access for individuals with developmental disabilities.
- **Example:** Individuals with an intellectual and/or developmental disability (I/DD) have inadequate access to oral health promotion and quality oral health care. Eitas worked to ameliorate this issue by providing an opportunity for oral health professionals to learn how to improve their skills when treating this underserved population.

Change in the no-show rate: 2 grantees

- Both demonstrated a decrease in the no-show rate.
- One grantee decreased the no-show rate from 20 percent to 6 percent.
- **Example:** Quote from Cass Community Health Foundation: With the 3 percent decline in patient activity, eligible patient encounters were down about 6 percent from the previous year but are expected to increase with the addition of another full-time dentist, plus a psychologist/addiction counselor once space and funds are available to accommodate this new position. The number of encounters per patient continues to increase, which is an indicator of development of our clinic as a "health home."

ACCESS OUTCOMES

More individuals have health insurance coverage

Number of insured clients indicator: 3 grantees

- All three reported increases.
- Their work during the grant period represents a combined 414 clients who gained coverage.
- **Example:** Legal Aid of Western Missouri's program attorney provided brief legal advice and counsel, as well as extensive legal representation for clients who faced wrongful denials or terminations of health care coverage through Medicaid, Medicare, the Missouri marketplace, and other forms of health insurance. The attorney was able to assist clients in appealing these wrongful denials or terminations, so that they could gain access to health care coverage, and receive adequate and necessary health care.

Fewer grantees selected this outcome in this funding round and reported on this indicator than in the previous year. There are many possible reasons for this and Health Forward has identified this as an area to monitor.

ACCESS OUTCOMES

Clients successfully navigate the health care system

Nine grantees reported on indicators related to patient navigation.

Number of clients who have completed a referral provided by your organization: 7 grantees

- Grantees reported this in different ways
    - Four reported the rate of completed referrals, which ranged from 13 percent to 85 percent
    - Three reported the number of completed referrals, totaling 883

Number of clients who have used your services because they were referred by another organization: 3 grantees

- These three grantees cite a total of 408 clients who used the organization's services through a referral from another organization.
- **Example:** Jewish Family Services (JFS) saw 328 clients during 2017, an increase in capacity of 79 clients over the prior year. Partner agency MARC provided enhanced information and referral to 1,073 individuals last year, 209 of whom were linked with care management services at JFS and other partner organizations.

Number and type of organizations in your referral network: 3 grantees

- The number and type varied between grantees, but referral networks were critical to the work accomplished.
- **Example:** Lazarus Ministries partnered with the UMKC Dental School to operate the SMILE Clinic to bring critical dental assessment and care to homeless individuals. A new pop-up clinic through a partnership at Iglesia del Camino de Verdad in the northeast neighborhood of Kansas City, Missouri, allowed the program to expand services to more Latino residents and connect them to dental care.

KC CARE HEALTH CENTER

“

Health Forward funds supported service delivery and core operating costs that allow KC CARE to decrease health disparities by providing medical and dental services to some of the community’s most vulnerable citizens. With the increase in demand, KC CARE has worked to increase access and adapt to meet community needs by providing an expanding range of quality services. We have leveraged new opportunities by growing capacity and our range of patient-centered services… KC CARE offers expanded-hours clinics, same-day appointments, and access to specialty services — all of which are critical to patient-centered practice.

”

IMPROVE QUALITY

IMPROVING QUALITY

Why Quality?

Although increasing access to care often receives more attention in public discourse surrounding health care, the importance of quality cannot be overstated. All people deserve high-quality care, and this is a critical component of reducing health disparities and increasing health equity.

To move toward our vision of healthy people in healthy communities, Health Forward must support the improvement of health care quality for the underserved in our service area.

The U.S. Institute of Medicine defines quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality care addresses six key domains:

- Safety
- Patient-centeredness
- Effectiveness
- Timeliness
- Efficiency
- Equity

Quality Overview

Twenty-three grantees used at least one strategy to improve quality within the safety net system. The following pages highlight some of these strategies and the outcomes and indicators associated with them.

Quality Summary

- In comparison with the year prior, 2016 grantees focused more on quality strategies.
- The top two quality strategies selected by grantees were implementing evidence-based models and developing strategic partnerships.
- Health Forward also saw growth in the number of organizations promoting integrated systems of care and promoting system transformation.
- Only one grantee implemented strategies related to advancing leadership and workforce development. The same was also true of strategies related to advocating for policies that improve health.
- Quality can be more difficult to measure directly. In many cases multiple indicators can correlate with a single strategy, and no one outcome provides a full picture of quality.

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

10 Grantees
Improve patient care experience, engagement, and satisfaction

1 Grantee
Advocate for and support policies that improve health

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

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

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

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

1 Grantee
Advance leadership and workforce development opportunities

QUALITY STRATEGY

Implement evidence-based, practice-based, and promising practices

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

Five grantees focused their efforts on providing holistic health services, including helping clients find housing, being sensitive to clients' abilities to pay for care, and seeking patient-centered medical home certification.

Example: To address chronic homelessness, Artists Helping the Homeless, in partnership with ReDiscover, proposed an evidenced-based approach known as Housing First. The features of Housing First have included the direct, or nearly direct, placement of targeted homeless people into permanent housing; no requirement to participate in health or behavioral health services as a condition of housing; the use of assertive outreach to reach people who are reluctant to engage or remain engaged; and the continued effort to provide case management and housing services and supports.

Five grantees aimed to better serve diverse populations, such as disabled persons, persons with pre-diabetes, and persons from different cultural backgrounds through educating caregivers and rearranging protocols for care.

Example: Duchesne Clinic provided chronic disease management and care coordination including culturally competent diabetes health education. The diabetes educator uses the American Association of Diabetes Educators AAED 7 Self-Care Behaviors curriculum, an evidence-based approach.

QUALITY STRATEGY

Implement evidence-based, practice-based, and promising practices

Four grantees addressed indirect causes of poor physical health (e.g. financial background, mental health) and provided greater support for clients at risk for preventable diseases such as diabetes.

Example: Thrive Allen County's care coordination program used evidence-based strategies to prevent and reduce the incidence of obesity, diabetes, hypertension, and stroke. The Diabetes Prevention Program, a CDC evidence-based program, has helped a full class of 15 people in 2017. In 2018, Thrive is offering "4 Life," a hypertension management class based on "Check, change, control," a program of the American Heart Association.

One grantee reallocated resources to better serve more people, based on evidence suggesting that doing so would not reduce quality of care.

Example: The Visiting Nurse Association's in-home pharmacist program uses pharmacy student interns to implement a model that has been shown to be effective elsewhere with a full-time paid pharmacist. Thanks to the support of their partners at the UMKC–School of Pharmacy, the student-staffed program is producing positive results for aging clients while providing valuable experience for students.

QUALITY STRATEGY

Develop strategic partnerships

Twelve grantees selected develop strategic partnerships through formal agreements that lead to system transformation as a strategy to improve quality.

Formal partnerships ranged from strong relationships with just one other organization to broad cross-organization systems of up to 13 service providers. During the grant term, grantees reported developing a total of 39 new partnership agreements.

Four grantees used their formal agreements with other organizations to support each other's work by relying on each other's services, sharing specialists to provide cross-organizational trainings, or interns to supplement staff during regular operations. These partnerships also extended to school districts for one grantee.

Example: Saint Luke's care coordination program has formal partnerships with numerous medical systems and safety net clinics by placing their community health workers on-site in those partner locations. Community health workers are located within three emergency departments of Saint Luke's Health System, the University of Kansas Hospital, Research Medical Center, and four outpatient clinics within Children's Mercy Hospital as well as nine safety net clinics. Community health workers identify clients in need of assistance with medical care.

Two grantees used formal agreements to improve their referral networks, thereby expanding the range of care options that individual grantees could help clients navigate.

Example: In the past year, the Community Health Center of Southeast Kansas (CHC/SEK) has forged partnerships with United Healthcare, one of the Medicaid managed care organizations, that is supporting a full-time population health manager at CHC/SEK and has transferred more than 1,000 of their members to CHC/SEK. As one of the lowest cost, highest quality Medicaid providers in the state, United designated CHC/SEK as its preferred provider and is working with them to make sure United Healthcare's participants are engaged. Toward that end, both United and CHC/SEK staff members work through lists of individuals who have not had preventive care in more than a year or who have medical conditions that would benefit from additional resources and case management. Once in contact with these individuals, the two organizations connect them to appropriate care.

QUALITY STRATEGY

Develop strategic partnerships

Two grantees leveraged a formal partnership with each other to merge into a federally-qualified health center look-alike organization.

Example: As part of a shared vision to improve community health by reducing health disparities and increasing access to care, Turner House Clinic and KU Health Partners/Silver City Health Center joined a third Wyandotte County safety net clinic to form Vibrant Health under the federally qualified health center model.

QUALITY STRATEGY

Improve patient care experience

Ten grantees selected improve patient care experience as a strategy to improve quality.

Three grantees aimed to improve the patient care experience by investing in public outreach including providing complimentary services to the public and first approaching prospective clients publicly, rather than in a clinical environment.

> **Example:** The program attorney at Legal Aid of Western Missouri conducted outreach events at various local agencies throughout the program period.

One grantee focused specifically on improving the quality of its care by renewing recognition as a patient-centered medical home.

One grantee described its efforts to make care less demanding on clients' time and travel by coordinating all care to take place in as few visits as possible.

> **Example:** KU Endowment (JayDoc Free Clinic) provides almost all basic laboratory testing in-house on the night the patient is seen. This has allowed the clinic to successfully see and treat clients within one night as well as provide them definitive results on a variety of conditions.

One grantee sought to better engage its clients by improving culturally and linguistically competent practices in its care, through staff trainings and hiring translators.

QUALITY OUTCOMES

24 grantees reported using at least one outcome to improve the quality of health care within the safety net. Compared to 2015, more grantees are investing in the improved patient care experience, engagement, and satisfaction strategy. Quality outcomes were generally clustered around patient health and patient experience.

16 Grantees
Improved patient care experience, engagement, and satisfaction

13 Grantees
Improved health outcomes

5 Grantees
Improved capacity to deliver high quality care

5 Grantees
Increased use of evidence-based, promising practices, and patient-centered strategies in service delivery

5 Grantees
Increased formalized and meaningful partnerships between health care providers and social services

5 Grantees
Greater integration of care

5 Grantees
Multi-sector groups work together to produce systems level change*

2 Grantees
Policies are established that improve health*

** These outcomes were new in 2016.*

QUALITY OUTCOMES

Improved patient care experience, engagement, and satisfaction

Sixteen grantees reported on indicators related to patient experience, engagement, and satisfaction.

Patient satisfaction with their visit/experience/ provider: 13 grantees

- Organizations are collecting this information differently (e.g. paper surveys distributed to a sample of clients or electronic surveys sent to all clients) and using different tools — there is no single approach.
- Patient satisfaction is generally straightforward to measure, and many grantees are already collecting this data.
- This is an important element of value-based care and a useful indicator for how well a clinic is serving clients.

Increased patient engagement with their health care experience: 6 grantees

- This indicator was often reported in a qualitative manner, but it is clear that grantees are working at both patient and system levels.
- **Example:** Jewish Vocational Service provides culturally competent services that respect the culture of refugee and immigrant clients. The use of interpreters in health screenings and navigation is vital for refugees to experience quality care and understand their diagnosis and treatment. Without interpretation, treatment is ineffective and not patient-centered.

QUALITY OUTCOMES

Improved health outcomes

Thirteen grantees reported on indicators related to patient health. Some relevant comparisons to national performance on these measures are provided for additional context. The National Center for Quality Assurance (NCQA) collects Health Effectiveness Data and Information Set (HEDIS) information from health plans and other health organizations. The HEDIS numbers provided below are for the nation-wide Medicaid population in 2016.

GRANTEES
37%

HEDIS
43.3%

Diabetes — HbA1c measure of 9 percent or higher, indicating poor glucose control: 5 grantees

- Percentage of clients with poorly controlled diabetes range from 24–49 percent with an average of 37 percent.
- The HEDIS comparison for poor control in Medicaid clients for this measure was 43.3 percent, so our grantees are on average achieving better results for clients.
- **Example:** KC CARE noted that they are striving to progress beyond the "old" model of the patient simply seeing a doctor and receiving medication to an updated model of incorporating the patient more actively into self-management of their care. This is a challenge due to limited funding for needed support services.

GRANTEES
60%

HEDIS
56.5%

Hypertension — Blood pressure reading less than 140/90, indicating adequate control: 4 grantees

- Percentage of clients with well controlled hypertension ranged from 46–69 percent with an average of 60 percent.
- The HEDIS comparison for this measure was 56.5 percent, so our grantees are on average achieving better results for clients.

GRANTEES
67%

MISSOURI COMPARISON
49%

Dental sealants — Pediatric clients receive a sealant on their first molar: 3 grantees

- Percentage of clients who received a sealant were 54 percent, 63 percent, and 84 percent respectively.
- In 2016, all federally qualified health centers in Missouri averaged 49 percent on this indicator, meaning our grantees are on average achieving better results for clients.

QUALITY OUTCOMES

Improved health outcomes

GRANTEE
97.3%

HEDIS
29.6%/
51.7%

Asthma — Use of appropriate medications: 1 grantee

- 97.3 percent of clients were prescribed the appropriate therapy.
- The HEDIS measure for this indicator was 29.6 percent for children and 51.7 percent for adults, so our grantee is on average achieving better results for clients.

GRANTEE
92%

HEDIS
76.2%

Tobacco use screening and cessation intervention: 1 grantee

- The HEDIS measure for this period was 76.2 percent, so our grantee achieved better results for clients.

Patient's perception of their own health: 3 grantees

- This indicator is recognized as a reliable proxy for assessing patient health status.
- One grantee had 82 percent of clients report improved health. Another grantee experienced 82 percent of clients reporting their health was good or excellent. The third grantee reported that 87 percent of clients felt positive about managing their health care needs.

QUALITY OUTCOMES

Increased formalized partnerships

A total of five grantees reported on indicators related to improving quality through increasing partnerships.

Type of new partnerships with other health care delivery providers and social services: 4 grantees

- **Example:** Community Health Center of Southeast Kansas is partnering with a district drug court in providing medical evaluation and medication-assisted treatment (an evidence-based model of care to overcome opioid abuse) to participants. This is a model program for the nation as an alternative to imprisonment for those with drug-related offenses.

Changes to existing partnerships with other health care delivery providers and social services: 3 grantees

- **Example:** KU Endowment (JayDoc Free Clinic) strengthened existing partnerships with the Community Health Council of Wyandotte County and its Community Health Worker program. Through monthly phone meetings and in-person meetings between the social service directors, they continue to enhance their relationship and work toward establishing more efficient, effective visits for clients.

QUALITY OUTCOMES

Greater integration of care

A total of five grantees reported on indicators related to improving quality through greater care integration.

Data sharing arrangements with other health care delivery providers and social services: 4 grantees

- Swope Health set up data-sharing agreements with a homeless shelter and a dental clinic to better facilitate patient contact and holistic care. Synergy Services better facilitated data sharing between practitioners of different specializations within their organization.
- **Example:** The Visiting Nurse Association improved its program by allowing access to patient electronic health records with pharmacy students who provide in-home medication reconciliation.

SYNERGY SERVICES

Resiliency Center's clinic is based upon the medical home model. This model fulfills the underlying goals of Synergy's Resiliency Center as it not only ensures quality health care, but it emphasizes consistent ongoing relationships between the health care providers and the patient.

Through the years of working with (homeless youth), Synergy has found that youth who succeed, no matter how traumatic their experiences, are those who have found positive primary connections with others. Based on the year-end report for 2017, the rate at which teens return to the clinic fluctuates from month to month, but over 50 percent of these youth who previously had little-to-zero access to health care throughout their lives are returning for additional and or follow up care and nearly 25 percent of the youth returned to the clinic more than three times. This level of engagement demonstrates that the youth are making permanent connections with clinic staff, experiencing little wait time for appointments, and finding staff to be helpful in meeting their needs.

Prior to the clinic, less than 10 percent of youth Synergy served were able to have return visits to medical services, and they often saw different providers, had to use different clinics based on availability, and treatment was generally provided on a one-time basis rather than ongoing care for prevention or chronic conditions.

All patients are encouraged to be active partners in their health, their treatment plans, and to any education and prevention information necessary for optimal health and success.

REDUCING COST

REDUCING COST

Why Cost?

When compared to health care around the globe, health care in the United States costs more and results in poorer overall population health. The current rate of increasing health care cost is unsustainable, so reducing cost must be central to our philosophy and approach.

Given the reality of limited resources and significant community need, the health care system requires strong partnerships. Members of the safety net system must work collaboratively to leverage resources and meet needs. This is also central to a value-based care model, which prioritizes quality and patient outcomes.

Health Forward recognizes our grantees address cost reduction in a variety of ways. Cost indicators are especially difficult to measure given the complex factors that influence cost. Even so, we saw an increase in the number of grantees who are engaging in this area. They are working to reduce costs in ways that align with Health Forward's strategies.

Cost Summary

Quality health care reduces overall health care costs.

- Eighteen grantees reported reducing costs as part of their Safety Net strategies — an increase from the seven grantees who reported on this strategy as part of the previous cohort.
- This increase is not surprising, since in 2016, Health Forward requested that all programs address cost in some way.
- Cost continues to be difficult for grantees to report. Only 18 grantees selected this as a strategy, and only 16 of those grantees were able to report specific outcomes.

Cost Overview

There are three distinct ways to frame health care costs: system-wide costs, organization-level costs, and patient out-of-pocket costs. All three of these measures contribute to the overall goal of reducing per capita health care costs.

Grantee organizations approach costs from multiple angles, and most grantees can speak to the ways their program reduces costs. However, given the complexity of cost indicators, not all grantees can measure it at this point. Those who are measuring costs are doing so in a variety of ways, based on the design of the program and available data, so it is difficult to make comparisons across the portfolio or programs.

COST STRATEGY

Reduce Cost

Health Forward's theory of change includes just one strategy related to cost reduction: Support approaches and policies that reduce costs, promote sustainability, or contain costs. Safety Net grantees approached this from a number of different angles.

Seven grantees either directly subsidized patient costs or offered free or reduced rates to specific populations, including school-age children, the underinsured, the unemployed, and individuals suffering from homelessness or living in poverty.

> **Example:** Seton Center keeps cost at a minimum by offering one of the lowest sliding fee scales in the area.

Seven grantees aimed to reduce health care costs by preventing emergency hospitalizations through increased access to preventive care. Specific strategies included providing transportation to clinics, offering translators, and reaching out to under-treated populations such as victims of domestic violence, refugees, and elderly individuals.

> **Example:** Rose Brooks Center partners with KC CARE Health Center to provide on-site medical services. Survivors of domestic violence often arrive at the shelter with multiple significant, mostly untreated health care needs. Before this program was implemented, it was not uncommon for residents to be transported to the ED in an ambulance, resulting in significant system costs.

Six grantees focused their efforts on providing increased care to populations with chronic conditions, such as asthma, obesity, hypertension, HIV, and mental health diagnoses. These efforts overlapped with those described under the previous bullet.

Four grantees reduced costs by negotiating with their suppliers for discounts in basic medical or dental supplies as well as pharmaceuticals.

COST STRATEGY

Reduce Cost

Two grantees conducted internal organizational shifts in an effort to reduce overhead costs.

Two grantees addressed indirect compounders of medical costs, such as patient housing and employment.

One grantee helped clients win insurance claim cases.

One grantee referred its clients to third party resources to help clients save costs.

> **Example:** El Centro offers clients billing navigation in which clients receive assistance applying for financial assistance at hospitals/providers' offices, receive education about the billing system, and help making payment arrangements to avoid medical debt. El Centro also helps clients apply for patient assistance programs that allow them to receive costly medications they need at a free or reduced cost.

COST OUTCOMES

Sixteen grantees reported using at least one outcome to reduce costs within the safety net. The distribution of grantees reporting on the two cost outcomes in 2016 was similar to 2015.

11 Grantees
More affordable health care for individuals

7 Grantees
Lowered or maintained health care costs

COST OUTCOMES

Lowered or maintained per-patient health care costs

Seven grantees reported on indicators related to the outcome of lower per-patient costs.

- Three grantees reported reductions in per-patient costs, which were 5 percent, 5 percent, and 9 percent reductions.
- Saint Luke's Health Center saw a 52 percent reduction in ED visits among its clients served by the grant.
- Jewish Family Services noted zero ED visits and only 42 hospitalizations among its 328 clients aged 65+.
- Jewish Vocational Service helped refugee clients establish a medical home, and 82 percent of clients kept follow-up appointments at those clinics, reducing reliance on emergency visits and urgent care.
- The Visiting Nurse Association estimates that their in-home pharmacists have saved the health care system $200,000. The pharmacist interventions have prevented 311 unnecessary visits to a higher level of care.

COST OUTCOMES

Lowered or maintained health care costs for clients

Eleven grantees reported on outcomes related to cost savings for clients.

- Miles of Smiles, Artists Helping the Homeless, and KU Endowment (JayDoc Free Clinic) offered completely free medical services.
- The Visiting Nurse Association and Riverview Health Services provided reduced cost or free medications or medical supplies, saving clients $75,000 and $1.5 million, respectively.
- Saint Luke's Health System was also able to assist with medication access for 87 percent of its clients.
- Synergy Services and Seton Center worked to reduce general medical expenses for its clients. Seton Center reported reducing patient costs by 50–100 percent.
- Baptist-Trinity Lutheran Legacy provided hearing aids at a reduced cost of $700, or 33–50 percent of market price.
- Legal Aid of Western Missouri provided free legal assistance to clients involved in insurance claim cases.
- El Centro cited helping clients navigate the insurance system.

BAPTIST-TRINITY LUTHERAN LEGACY FOUNDATION

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The Medicine Cabinet program reduces costs in two ways. The first way is that the program has negotiated lower rates for items like prescriptions, expensive durable medical equipment like hearing aids, and prosthodontic dental procedures. The other way the program reduces costs is by encouraging medication adherence. While Baptist-Trinity Lutheran Legacy Foundation does not monitor medication adherence, it facilitates access to prescription medication and other critical medical services. This access helps to improve medication adherence, which has the potential to decrease hospitalization rates, which decreases health care costs over time.

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INSIGHTS + LESSONS LEARNED

INSIGHTS + LESSONS LEARNED

Health Forward encourages grantees to reflect on their work and share lessons learned in the spirit of collaboration and continuous quality improvement. Their insights and learning are valuable to Health Forward and the safety net system as a whole.

Grantee Insights

"By retroactively fitting our project into the revised Health Forward outcomes and indicators, we have been able to identify new ways in which data collection can be used to examine the effectiveness and impact of our projects. In particular, we have noted the importance of data tracking to strengthen our referral networks that promote integrated systems of care and holistically serve the needs of our target population … We believe that tracking this data more thoroughly may lead to a better understanding of the role our referral network plays in serving our clients, as well as ways in which we can improve or [expand] upon on partnerships with referring agencies."
– Legal Aid of Western Missouri

"The current political climate is affecting the Hispanic population, which is approximately 40 percent of HPC's patients. They have expressed fear of government-based programs due to the current administration's position on immigrants. Many of the Hispanic patients know, or possibly are, immigrants and fear participating in government programs will lead to deportation of friends and loved ones. For this reason, Hispanic patients are delaying care and not engaging in preventive services."
– Health Partnership Clinic

"Low-to-moderate income families are struggling with many things to keep their family afloat, and dental care falls down the priority list. Our school partners tell us that families will not sign up for the dental program because they feel it isn't important, or they simply haven't read the information coming home in the backpack about the dental program."
– Miles of Smiles

"Even with our lean resources and no traditional case management/social worker position, we can still develop a workflow that provides deeper care coordination for our most vulnerable diabetic patients."
– Duchesne Clinic

"As the program has grown, we have learned that providing more in-depth, meaningful services provides better results than episodic engagement."
– Saint Luke's Health System

STRENGTHS

Grantees were asked to describe strengths, supports, or external conditions that helped facilitate success and opportunities for growth. Analysis of their responses revealed three key themes related to grantee strengths and the strengths of the overall safety net system in the region. These were consistent with the strengths cited by grantees in previous years and include collaboration and partnerships, dedication of staff, and responsive and adaptable organizations.

Collaboration and Partnerships

Grantees noted that they rely on many other organizations to provide their clients with the services and supports that they need to address their health. Given the complexity of needs within the most vulnerable populations in the Health Forward service area, it is not surprising that providers collaborate and partner together to leverage resources, expand access, and improve care.

- **Mutual promotion** — Miles of Smiles applauded its partner schools for their support and communications to parents about the visiting dental clinics.
- **Sharing of resources** — The Rose Brooks Center has received training from KC CARE Health Center staff and takes advantage of the KC CARE Health Center electronic health record system.
- **Active partnership** — Jewish Vocational Service is partnering with the Missouri Immigrant Refugee Advocates to provide complementary services to recently-immigrated refugees.

STRENGTHS

Dedication of Staff

Although staffing is always a challenge within the health care sector, grantees noted the extraordinary dedication of their key staff, volunteers, and board members. They are charged with identifying creative solutions to significant challenges.

- **Staff commitment** — Cass Community Health Foundation had two particular employees who took on more clients in order to decrease the organization's referral rate.
- **Board leadership** — Riverview Health Services board members volunteered even more time to support employees during a particularly difficult period for the organization.
- **Organizational innovation** — Baptist-Trinity Lutheran Legacy Foundation praised its Emergency Medical Assistance committee, which analyzes and recommends program innovations.

Responsive and Adaptable Organizations

As safety net providers are challenged to do more with scarce resources, their resiliency is evident in their ability to respond and adapt to new challenges. Six grantees commented on the importance and utility of general funding, which allowed them the flexibility to meet demand, that is not present in more restrictive funding streams. Several organizations also noted that they relied on other, non-financial support from Health Forward and other organizations to enhance the quality and mix of their services and supports to their clients.

- **General funding** — Health Partnership Clinic noted that core operating dollars allow them to provide care for a high percentage of uninsured clients, including homeless individuals and families.
- **Innovation** — Legal Aid of Western Missouri identified the importance of collaboration and support in identifying innovative strategies for improving access.

CHALLENGES

High demand for care and limited resources

Six grantees noted that they did not have adequate resources to fully meet the demand that they experience in the region. KC CARE Health Center noted that the needs of their large uninsured and low-income population — 70 percent of clients — exceeds the capacity of their funding, especially given the high rates of diagnosis of chronic diseases like diabetes. Synergy Services and Miles of Smiles find clients often present with severe dental needs that are outside of the scope they can provide in-house.

Similarly, six grantees noted the general challenges facing the safety net health care system, such as insecurity related to the viability of the Affordable Care Act and the lack of Medicaid expansion in Kansas and Missouri. Many of these grantees also noted challenges that affect the entire system, such as a lack of affordable housing options and addressing significant health disparities among vulnerable populations.

Leadership and Workforce Continuity

Several organizations had leadership transitions that began during the period covered in this report. Similarly, retaining sufficient staff was a challenge noted by five grantees. This challenge is compounded by a competitive job market in the region, overall workforce shortages in several areas, and high demand for volunteer medical workers. Cass Community Health Foundation reported ongoing challenges hiring dentists to staff its rural clinic, and KU Endowment (JayDoc Free Clinic) faces challenges recruiting and retaining enough volunteers to staff its clinics.

Data Collection and Technology

The challenges related to data collection and technology continue to be noted by grantees (eight grantees for 2016). Although most Safety Net grantees have had electronic health record systems in place for years, generating actionable data, integrating data into practice improvement, and reporting to multiple organizations (e.g. federal, state, and local funders) remains complex, time consuming, and challenging for organizations with limited resources. Swope Health notes that, while clinical services are documented in their electronic records, other supportive services are documented in activity logs that must be audited by hand.

MOVING FORWARD

MOVING FORWARD

We are grateful to our grantee partners for their thoughtful reflections on their data and experiences and for adapting to Health Forward's theory of change reporting structure. We will continue to work with our partners to advance access to quality health care and preventive care. There will be continued pressure to contain cost and to limit the impact of high cost on low-income clients. We want to support our partners as they explore creative ways to think about and measure the impact on cost across the spectrum.

For 2019, Health Forward has identified three areas of focus:

1. Strengthening the safety net workforce and the stability of safety net organizations.
2. Facilitating ongoing partnerships, collaboration, and learning among grantees and the broader safety net system.
3. Supporting safety net organizations through funding for advocacy and system change.

Health Forward plans to address these three areas of focus through:

1. **Core operating support and technical assistance**
   More flexible funding and targeted technical assistance for areas related to workforce, leadership, and quality.
2. **Convening**
   More opportunities for learning, collaboration, and partnership around specific topics and areas of need.
3. **Policy and Advocacy Support**
   General and targeted support for policy change that improves overall safety net system capacity and quality of care.

GRANTEE SNAPSHOTS

ARTISTS HELPING THE HOMELESS

PROJECT	Finnegan Place (Artists Helping the Homeless)
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	YEARS FUNDED	GRANT TERM
$158,000	<$1M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

115

Total number of **visits/ encounters** for this project

296

STRATEGIES

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

Final Report Abstract

The Finnegan Place program targeted individuals 18 years and older at risk of homelessness with physical, oral, and behavioral health disorders. Targeted geographic areas included Jackson, Johnson, Lafayette, and Wyandotte counties. The program served 141 individuals. The dental and medical clinics served 115 individuals.

Several partners supported this highly collaborative program. Artists Helping the Homeless (AHH) delivered program oversight, fiscal management, service delivery, and data collection. ReDiscover provided service delivery, referrals, and evaluation. Saint Luke's Hospital contributed operating and clinical support, as well as client referrals. World Outreach Foundation provided medical professional support, exam rooms, and medical equipment ($50,000+ donated). University of Missouri Kansas City–School of Nursing supplied nursing students.

Early in the grant term, AHH and partners assembled a grant committee that developed and implemented policies and protocols to guide the program. In the first quarter of the grant and beyond, the program enrolled participants and delivered services. Staff continued to track program fidelity and assess outcomes.

The program aims to reduce homelessness, increase housing tenure, improve health outcomes, and reduce costs. This has translated into the following outcomes: reduced number of days spent homeless, increased number of days housed, improved access to care, improved dental health, improved behavioral health symptoms, and improved employment status. The team employed lessons learned from previous grant cycles, such as the value of daily conversations between AHH and community partners, the necessity of buy-in from leadership, and the importance of a welcoming, patient-centered care philosophy. Engaging frontline clinical staff proved essential to the success of the program.

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PROJECT 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	YEARS FUNDED	GRANT TERM
$130,000	$3M–10M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

3,874

Total number of **visits/ encounters** for this project

4,443

STRATEGIES

- Fund service delivery and core operating support
- Promote integrated systems of care across SN clinics, hospitals, providers and key community-based services
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

Kansas City's Medicine Cabinet, a program of Baptist-Trinity Lutheran Legacy Foundation, facilitates access to crisis-related medical services such as dental emergencies, diabetic supplies, and durable medical equipment like hearing aids, prescriptions, and vision care. The program serves low-income individuals who live below twice the federal poverty level, and more than 95 percent of clients are from counties in Health Forward's Kansas City metro service area.

The Medicine Cabinet partners with 13 social service agencies, six domestic violence shelters, and more than 100 medical service providers. Partner agencies establish client eligibility, identify the need, and provide clients with service vouchers. Clients then take the vouchers to participating service providers who meet the client's needs and request payment directly from Medicine Cabinet. The program has grown immensely since its inception in 2005, having provided over 35,000 services worth over $7.4 million to more than 32,000 low-income, underserved people in the Kansas City area. In 2017, the program provided 4,443 services to 3,874 unduplicated individuals. These services had a collective value of $1,324,590.

The program's greatest strengths include the Emergency Medical Assistance Committee of BTLLF's board of directors and the active partnership of so many key community agencies. Some of the main program challenges are increasing service expenses, ensuring staff at all partner agencies are familiar with the program, and client transportation needs. To mitigate the rising costs of certain types of medical services and prescriptions, the Medicine Cabinet is considering allowing agencies to issue vouchers for 90-day prescription supplies to lower the per-dose cost. The board is also considering other cost control measures to help ensure the continued availability of funds across each year.

CASS COMMUNITY HEALTH FOUNDATION

PROJECT	Cass County Dental Clinic
PROJECT SERVING	Cass County

GRANT AMOUNT	OPERATING BUDGET	YEARS FUNDED	GRANT TERM
$177,000	$1M–3M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

3,516

Total number of **visits/ encounters** for this project

6,897

STRATEGIES

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

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 (97 percent of patients) or who are uninsured and at or below 200 percent of the federal poverty level (3 percent of patients). A patient care coordinator assists patients by scheduling appointments and arranging for language or transportation services, as needed.

In 2017, CCDC served 3,516 children and adolescents through 6,897 dental visits. Services provided were 43 percent preventive, 40 percent diagnostic, 16 percent restorative, and 1 percent extractions. CCDC exceeded several goals for the grant term:

- Served 3,516 children, surpassing the goal of 3,386 children
- Provided 6,897 encounters, surpassing the goal of 6,772 encounters
- Completed 83 percent of treatment plans, surpassing the goal of 75 percent completion
- Achieved 92 percent sealant placement, surpassing the goal of 80 percent
- Reached 97 percent patient satisfaction with services, surpassing the goal of 90 percent

CCDC continues to encounter challenges recruiting dentists. The applicant pool is limited, and most candidates want to secure student loan repayment in addition to their salary. The clinic has been unsuccessful in becoming a designated site for such reimbursement opportunities with either state or national programs. Instead, they have worked to develop a bonus program to help dentists with their student loans.

COMMUNITY HEALTH CENTER OF SOUTHEAST KANSAS

PROJECT Access to care for all in Allen County

PROJECT SERVING Allen County

GRANT AMOUNT	ORGANIZATION SIZE	YEARS FUNDED	GRANT TERM
$200,000	$10M–50M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

7,034

Total number of **visits/ encounters** for this project

23,135

STRATEGIES

- Fund service delivery and core operating support
- Promote system transformation through implementation of innovative care models, practices, and workforce
- Develop strategic partnerships through formal agreements that lead to system transformation

Final Report Abstract

Community Health Center of Southeast Kansas (CHC/SEK) provided quality, affordable, and accessible medical, dental, and behavioral health services to 7,034 patients through 23,135 visits at its clinic in Iola, Kansas. All services were provided regardless of the patient's ability to pay. In addition, outreach services including oral health screenings were provided to 1,394 children. Allen County, which is entirely rural, is one of the least healthy counties in Kansas and has a declining population. CHC/SEK continues to focus on increasing access and quality of care for the 79 percent of patients who are uninsured or served by government programs. The county is working to overcome the disparities faced by the almost 90 percent of patients living at or below 200 percent of the federal poverty level.

During the reporting period, CHC/SEK continued to work on a significant clinic expansion. To increase capacity, improve efficiency, and fully integrate services, CHC/SEK completed construction of a 14,000 square foot, $2.3 million facility in Iola in July 2018. With the capacity for an additional four providers, the expanded staff now includes a second, full-time dentist and two new pharmacists. An in-clinic pharmacy ensures all patients have access to their medicine regardless of income.

Quality remains a high priority. The clinic is a designated patient-centered medical home and recognized as a National Quality Leader by the Health Resources and Service Administration. Additionally, CHC/SEK transitioned to focus on population health and practice transformation, facilitated in part by partnerships with third-party payers and Aledade, a Medicare ACO that is also contracting with Blue Cross and Blue Shield of Kansas for value-based care. The organization partners with the 31st Judicial District's drug court as one of the first in the nation to introduce medication-assisted treatment for participants.

DUCHESNE CLINIC

PROJECT	Health care for the uninsured
PROJECT SERVING	Wyandotte County

GRANT AMOUNT	OPERATING BUDGET	YEARS FUNDED	GRANT TERM
$130,000	$1M–3M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

1,465

Total number of **visits/ encounters** for this project

5,524

STRATEGIES

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

Final Report Abstract

Duchesne Clinic prioritizes providing care for uninsured residents of Wyandotte County who live at or below 150 percent of the federal poverty level, currently $36,450 for a family of four. During the grant period, the clinic served 1,465 people who otherwise would not have been able to access primary health care. At least 80 percent of the population (1,200 patients) accessing this care identified as Latino. Compared to the year prior, Duchesne Clinic increased number of patients served by four percent and also increased Uniform Data System (UDS) visits by 9 percent.

Using the evidence-based American Diabetes Association's bilingual diet and exercise curriculum, which is provided in group settings in conjunction with chronic disease management, Duchesne helped patients make concrete but achievable changes in diet and exercise. This approach is clinically proven to help improve control of chronic disease. The program is in its fourth year of partnership with Riverview Health Services, and patients are experiencing excellent results. Seventy percent of patients who participate in more than one education session see a decrease in long-term blood sugar levels measured through HbA1C tests. Patients who participated in our bilingual diabetes management education programs were expected to improve their health outcomes by maintaining healthy blood sugar. As a result of this program, 76 percent of diabetic patients had HbA1C results of 9 percent or less.

Through this program, the clinic learned that even with lean resources and no traditional case management or social worker positions, they could still develop a workflow that provides deeper care coordination for their most vulnerable diabetic patients. One of their quality improvement programs this past year was training staff on best practices for using the electronic health record system to code and complete referrals. Workflow has been streamlined and adjusted to increase the efficiency and capacity of electronic records.

EITAS

PROJECT Improving oral health for people with intellectual and developmental disabilities

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

GRANT AMOUNT	ORGANIZATION SIZE	YEARS FUNDED	GRANT TERM
$73,152	$10M–50M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

66

Total number of **visits/ encounters** for this project

66

STRATEGIES

- Increase health care coverage that supports quality care
- Implement evidence-based, practice-based, and promising practices in service delivery
- Promote system transformation through implementation of innovative care models, practices, and workforce

Final Report Abstract

Eitas supports individuals with developmental disabilities and their families with services that respect their choices, increase their opportunities, encourage their independence, and assist their inclusion in all aspects of the community. This program used several tactics to improve oral health for people with intellectual and developmental disabilities (I/DD).

First, Eitas provided a training video to people with I/DD and their families. The video focuses on increasing comfort with receiving oral health services and improving overall oral health routines to increase oral health prevention through daily actions. Eight individuals watched the video and then completed a survey, with results demonstrating an improvement in knowledge.

Additionally, a two-day training seminar was launched to increase the awareness of oral health professionals regarding the needs of individuals with I/DD. Thirty providers attended the lecture on day one and practicum on day two, where they were able to apply their skills. People with I/DD shared what they need from providers to be comfortable receiving oral health services. Results from the pre/post-test demonstrated improved knowledge among those oral health providers.

Finally, the Oral Health Coalition was created to bring together oral health providers associated with Missouri oral health centers, Eitas representatives, dental hygienist students at University of Missouri–Kansas City, and representatives from UMKC–Institute for Human Development. Together, participants share knowledge, solve problems, and develop strategies to improve oral health practices at home and in a clinical setting. Twenty-eight individuals attended coalition meetings. The coalition continues, and is completing a program to provide oral health gift bags to support providers in Missouri to pass on to individuals with I/DD.

EL CENTRO

PROJECT	Health navigation program
PROJECT SERVING	Wyandotte County

GRANT AMOUNT	OPERATING BUDGET	YEARS FUNDED	GRANT TERM
$141,065	$1M–3M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

1,500

Total number of **visits/ encounters** for this project

2,037

STRATEGIES

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

Final Report Abstract

El Centro's health navigation program increases access to quality, affordable health care services and coverage in a culturally and linguistically appropriate way for the population served. The majority of clients were Latino, multi-generational immigrants (many of whom were undocumented), Spanish-speaking, low-income, and uninsured or underserved in Wyandotte and Johnson counties in Kansas.

The program aligns with Health Forward's strategies of increasing access, improving quality, and reducing costs. El Centro achieved the outcome of increasing the number of patients that receive adequate care. Compared to the prior year, the program increased the number of clients by 25 percent, serving 1,500 unduplicated clients. The program also increased the number of encounters by 32 percent, providing a total of 2,037 units of service. El Centro improved patient experience, engagement, and satisfaction, with 99 percent of clients surveyed reporting satisfaction with the services they received. Greater integration of care was also achieved, with 60 unduplicated clients receiving specialty care services. Finally, individuals received more affordable health care, as 655 households were assisted with health insurance navigation.

During this grant period, El Centro learned the importance of program evaluation. Changes to their post-service satisfaction surveys made it easier to reach a greater number of clients and receive more informative data. The organization's biggest challenge remains the lack of access to specialty care services for their patients, particularly when it comes to cancer treatment. Local hospital systems continue to turn away cancer patients who are uninsurable, while El Centro continues to advocate for this much-needed policy change.

HEALTH PARTNERSHIP CLINIC

PROJECT Health home for Johnson County's underserved

PROJECT SERVING Johnson County

GRANT AMOUNT	OPERATING BUDGET	YEARS FUNDED	GRANT TERM
$175,000	$3M–10M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

15,404

Total number of **visits/ encounters** for this project

39,216

STRATEGIES

- Fund service delivery and core operating support
- 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 (HPC) provides safety net health care services to low-income, uninsured, and underinsured individuals and families living in the Johnson County area. In 2017, HPC provided access to affordable health care services for 15,404 area residents through 39,216 patient visits. To accomplish this, HPC used grant funding to cover staff salaries. HPC provides care to a high percentage of uninsured patients, especially in Olathe, where more than 60 percent of their patients are uninsured. Such significant levels of uncompensated care make it difficult for HPC to provide services without additional support for staff salaries.

During the grant term, HPC improved patient outcomes in the following areas:

- Improved the tobacco screening measure to 92 percent compliance
- Increased the hypertension measure to 59 percent compliance
- Decreased the percentage of diabetics whose A1C (blood sugar) was outside of the recommended range

Additionally, patient satisfaction surveys indicate that HPC's patients are satisfied with the services they receive and consider HPC their ongoing source of patient care. The most important lesson learned during this grant term was the importance of building and maintaining rapport with minority populations, specifically the Latino population, which accounts for approximately 40 percent of HPC's patient population.

JEWISH FAMILY SERVICES

PROJECT Older adult care management

PROJECT SERVING Wyandotte County

GRANT AMOUNT	OPERATING BUDGET	YEARS FUNDED	GRANT TERM
$128,000	$3M–10M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

328

Total number of **visits/ encounters** for this project

1,954

STRATEGIES

- Facilitate greater care coordination and navigation
- Implement evidence-based, practice-based, and promising practices in service delivery
- Develop strategic partnerships through formal agreements that lead to system transformation
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

In order to live at home, many older adults need support to navigate and access health care and other social services. The older adult care management program at Jewish Family Services (JFS) provided services to 328 at-risk older adults residing in Jackson County, Missouri and Johnson County, Kansas. The program improved care by providing client-centered care coordination, addressing challenges and barriers, and facilitating better communication, interaction, and integration among health care and social service providers, as well as between the individual and caregivers. The Older Adult Access Network, a coalition of community-based organizations, also developed a streamlined system to connect older adults and their caregivers to community supports. The program's goal is to decrease the number of falls and higher acuity admissions by bolstering clients' access to resources through care management.

Measures of success are encouraging. During active care management, 29 reports of falls over the program's 1,954 visits were significantly lower than the national average of one in three older adults (65+) falling each year. None of the 328 JFS clients were admitted to a nursing facility during their care management. Additionally, during the year there were no ER visits and only 42 hospitalizations. At discharge, 87 percent of clients reported positive feelings about their ability to manage their health care and social service needs. Seventy-three percent of clients indicated that care management meetings helped them feel optimistic about their ability to continue living at home, and 76 percent reported that care management helped decrease their sense of isolation.

MARC, a program partner, provided enhanced information and referrals to 1,073 individuals last year, 209 of whom were linked with care management services. A new collaboration with MARC to form a managed service network will create the potential for additional sustainable revenue to community-based organizations serving older adults in the metro area.

JEWISH VOCATIONAL SERVICE

PROJECT	Refugee-immigrant health access
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	YEARS FUNDED	GRANT TERM
$90,000	$3M–10M	Multiple years	24 months

NUMBERS

Total number of **unduplicated clients** served by this project

855

Total number of **visits/ encounters** for this project

N/A (DATA MISSING)

STRATEGIES

- Facilitate greater care coordination and navigation
- Increase health care coverage that supports quality care
- Develop strategic partnerships through formal agreements that lead to system transformation
- Improve patient care experience
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

Jewish Vocational Service (JVS) served 855 refugees, primarily from Africa, Asia, the Middle East, and Russia. JVS assists refugees through a range of services, including:

- Accessing medical navigation services on arrival
- Helping patients establish a medical home with Samuel U. Rodgers, Children's Mercy, or Truman Medical Center
- Performing vaccinations and health checks
- Coordinating referrals
- Providing language interpretation
- Training refugees on using the local transportation and health care systems

Program outcomes demonstrate increased access to care. Ninety-nine percent of refugees served in the program received Medicaid or Refugee Medical Assistance and were enrolled in a medical home. Ninety-eight percent received health screenings for critical illnesses (e.g., Hepatitis B, diabetes), a medical case review, vaccinations, and attention to acute or emergent health issues. Ninety-nine percent of new refugees received the services of an interpreter as needed for health screenings, emergent care, and routine appointments, thus improving their understanding of the U.S. health care system, as well as their own diagnosis and treatment.

Federal changes in refugee resettlement have compelled JVS to be ready to adjust and adapt. Although JVS has admitted fewer refugees than expected due to recent executive orders, the organization is prepared to work with refugees with chronic illnesses and disabilities. JVS has found that community events, such as health fairs and health classes, are effective for engaging the refugee community to learn more about health care systems and increase their health literacy. JVS continues to establish strong partnerships with hospitals and clinics to ensure clients can efficiently access culturally competent care.

KC CARE HEALTH CENTER

PROJECT	General medicine & dental services
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	YEARS FUNDED	GRANT TERM
$365,000	$10M–50M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

8,542

Total number of **visits/ encounters** for this project

19,003

STRATEGIES

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

Final Report Abstract

KC CARE Health Center provided general medicine and dental services to 7,625 unduplicated medical patients and 1,438 unduplicated dental patients through more than 19,000 encounters during the reporting period. KC CARE's target population is diverse:

- 54 percent are racial minorities
- 73 percent live below the federal poverty level
- 70 percent are uninsured
- 13 percent are underinsured

More than 60 percent are diagnosed with one or more chronic condition.

KC CARE implemented the following strategies to provide safety net health services to the underserved of Kansas City: funding of direct services/core operating support, implementation of evidence-based practices, improvement of patient care quality and satisfaction, and cost reduction. Activities included preventive medical care and screenings, care for acute and chronic medical conditions, specialty medical care, prescription assistance, care coordination, dental prophylaxis, and urgent or emergency dental services.

KC CARE achieved the goal of providing a quality health care experience through the availability of services and an overall positive experience of care. Although KC CARE made progress toward improving the medical and dental health of patients with chronic conditions, the program did not achieve the degree of success of patients to self-manage conditions, adhere to a treatment plan, attend scheduled medical visits, and improve their overall health. Barriers included a lack of knowledge and equipment to self-monitor chronic symptoms, and socioeconomic factors that reduced the ability to focus on and/or access resources for self-management. As a result, KC CARE learned that integrating patient cooperation and a patient's ability to participate in care plans is crucial to improving overall health.

KU ENDOWMENT (JAYDOC FREE CLINIC)

PROJECT	JayDoc Free Clinic
PROJECT SERVING	Wyandotte County

GRANT AMOUNT	OPERATING BUDGET	YEARS FUNDED	GRANT TERM
$40,000	>$50M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

1,161

Total number of **visits/ encounters** for this project

947

STRATEGIES

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

Final Report Abstract

JayDoc Free Clinic provides multidisciplinary health care and social services, at no cost, to patients in the greater Kansas City metropolitan area. A nonprofit clinic located in Wyandotte County, Kansas, JayDoc serves the uninsured, underinsured, and undocumented community. In the past year, JayDoc completed 1,161 patient encounters.

Care is provided by volunteer community physicians who mentor medical student volunteers in patient care and medical ethics. Clinic services include language interpretation, laboratory services, dietary counseling, medication counseling, social services, and basic procedures. The JayDoc social services office provides patients with referrals to medical homes and specialty care clinics including mental health services and JayDoc's specialty clinics, as well as educational opportunities to improve quality of life and prevent chronic diseases.

Because JayDoc patients have a wide variety of health care concerns, JayDoc has evolved to include multiple specialty clinics that run on a rotating basis every Tuesday night. These specialty clinics include diabetes, women's health, radiology, ophthalmology, dermatology, and musculoskeletal night. Musculoskeletal night was added just this past year, and these specialty nights have allowed the clinic to provide much more comprehensive treatment than was possible in the past. JayDoc believes the expansion of services along with the addition of specialty nights reduces return patient visits. Providing patients with more comprehensive health information and services equips them to take a more active role in their health.

KU HEALTH PARTNERS

PROJECT Vibrant Health-Argentine

PROJECT SERVING Wyandotte County

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

NUMBERS

Total number of **unduplicated clients** served by this project

1,322

Total number of **visits/ encounters** for this project

4,317

STRATEGIES

- Fund service delivery and core operating support
- Implement evidence-based, practice-based, and promising practices in service delivery
- Advance the use of health data and health information technology (HIT)
- Develop strategic partnerships through formal agreements that lead to system transformation
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

With safety net funding, Vibrant Health-Argentine provided care for 1,958 unique patients through 4,620 visits during the grant term. Funding provided essential support for the care team during an exciting time of transition. The clinic is now part of a multi-site federally qualified health center look-alike, which will ensure the neighborhood continues to receive affordable, quality health care.

In 2018, 78 percent of patients were adults, 53 percent were female, 73 percent identified as Hispanic/Latino, and 60 percent identified as white. Patients spoke eight primary languages, although Spanish (56 percent) and English (43 percent) accounted for the majority. Ninety-four percent of patients were treated by their chosen primary care provider. All pediatric patients had a recorded weight assessment, and the 12345 Fit-Tastic! assessment is being implemented with hopes to expand the pediatric obesity management program. Sixty-three percent of adults with diabetes had an HbA1c (blood sugar) test at or below 9.0 percent, an area for planned improvement, and 69 percent of patients with hypertension had controlled blood pressure (less than 140/90), nearly at goal.

Vibrant Health care teams are dedicated to helping patients achieve health outcome goals. Current findings indicate success for several proposed outcomes. Patients frequently have multiple chronic conditions and are impacted by social determinants of health, which together can slow one's ability to adequately manage health factors and achieve better outcomes. Thus, incremental changes and short-term health improvements must be acknowledged, providing fuel for continued efforts toward sustainable improvements.

LEGAL AID OF WESTERN MISSOURI

PROJECT Advocates for family health-Affordable Care Act extension

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	YEARS FUNDED	GRANT TERM
$55,000	$3M–10M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

43

Total number of **visits/ encounters** for this project

N/A (DATA MISSING)

STRATEGIES

- Facilitate greater care coordination and navigation
- Increase health care coverage that supports quality care
- 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
- Improve patient care experience
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

Legal Aid of Western Missouri provided legal assistance to 43 clients, with a total of 69 individuals (children and other household members) benefiting from these services. All were low-income residents of Jackson, Cass, or Lafayette counties seeking help with matters hindering their access to health care. Clients were 49 percent Caucasian, 41 percent African-American, 5 percent Hispanic, and 5 percent another race/ethnicity.

Legal Aid provided brief legal advice, referrals, and extensive legal representation as needed to assist clients with gaining access to health care. Attorneys assisted clients with coverage terminations and denials by means of legal representation or brief advice while also working to address root causes. They provided legal assistance in other matters that acted as barriers to health care. Such cases included paternity, guardianships, and evictions. The attorneys provided brief advice and counsel to 34 clients, conducted 46 outreach events, completed one, high-impact activity, and provided extensive representation to nine clients.

This report is based on cases that closed during the grant period; however, an additional 22 cases remained open after the program period ended. The closed case outcomes fall short of goals to complete 15 extensive representation cases and two, high-impact activities. However, the organization did surpass their goal of providing 30 clients with brief advice and counsel, as well as the goal of conducting 35 outreach events. This program allowed Legal Aid to identify marketplace trends and their effects on clients' needs. They also identified new legal issues impacting their clients' access to health care.

MILES OF SMILES

PROJECT Safety net portable dental 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	YEARS FUNDED	GRANT TERM
$105,000	$1M–3M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

2,485

Total number of **visits/ encounters** for this project

4,955

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
- Develop strategic partnerships through formal agreements that lead to system transformation
- Improve patient care experience
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

Miles of Smiles provides free, portable dental care to children under the age of 18 residing in Kansas City, Missouri, as well as Clay and Platte counties, whose families earn less than 200 percent of the federal poverty level. During the grant year, the Safety Net Portable Dental program provided free dental care to 2,485 Kansas City residents. Nearly 70 percent of the families served live below 100 percent of the poverty level.

Outcomes achieved during the grant year demonstrate the success of the program:

- 83 percent of patients demonstrated reduced cavities at subsequent appointments
- Completed 5 percent of school-based treatment plans
- Compared to the year prior, 12 percent more patients had Medicaid coverage
- 100 percent of returned surveys indicated patients were "satisfied" or "very satisfied" with services

Miles of Smiles believes these achievements represent success in the areas of improving access to care, improving quality of care, and reducing health care costs for families.

RIVERVIEW HEALTH SERVICES

PROJECT	Riverview Health Services
PROJECT SERVING	Wyandotte County

GRANT AMOUNT	OPERATING BUDGET	YEARS FUNDED	GRANT TERM
$150,000	<$1M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

1,742

Total number of **visits/ encounters** for this project

7,337

STRATEGIES

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

Final Report Abstract

Riverview Health Services increases access and decreases costs for patients by providing help and case management for complicated pharmaceutical assistance programs, vouchers for immediate-need medications, and access to a wide range of health supplies and health education programming. Through this grant, Riverview Health Services served 29 percent more unduplicated people (1,742) with 48 percent more services (7,337) and leveraged more than $1.5 million in medication and medical supply assistance.

While most of the people served reside in eastern Kansas City, Kansas, last year Riverview saw people from 69 zip codes throughout the greater metropolitan area and beyond. During this grant period, Riverview implemented significant shifts in its staffing model, workflows, and data collection, and the organization emerged with a new emphasis on quality services delivered by highly trained staff, following evidence-based programs and best practices. While collaborations and partnerships have always been important, Riverview is developing a new model to further diversify funding while supporting better care. The strategic partnerships to be developed over the next 12 months may lead to a new way of delivering core services.

ROSE BROOKS CENTER

PROJECT SafeCARE domestic violence health integration

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	YEARS FUNDED	GRANT TERM
$107,800	$3M–10M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

197

Total number of **visits/ encounters** for this project

596

STRATEGIES

- Fund service delivery and core operating support
- Facilitate greater care coordination and navigation
- Improve patient care experience
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

Funding from Health Forward Foundation supported Rose Brooks Center's SafeCARE domestic violence health integration programming. The program offers health services to low-income victims of domestic violence and their children residing at the Rose Brooks Center's high-security emergency shelter. These clients would otherwise access health services through the emergency department. This program was successful in ameliorating the profound barriers victims of domestic violence face in accessing health care. Services included:

- On-site health assessments
- Health promotion and advocacy
- Psychiatric services
- Medical services provided at the on-site clinic
- Ongoing medical services and navigation provided by a community health worker and navigator

The outcomes achieved through this program align with the Safety Net theory of change. During the grant period, 197 clients were served through 596 visits, in comparison to 146 clients served with 478 visits in the prior 12-month period, demonstrating an increase in access. Regarding quality of services, 94 percent of shelter residents surveyed during this reporting period stated that Rose Brooks Center staff helped them with their medical needs. Clients received free on-site treatment at Rose Brooks Center, reducing the use of costly emergency services. Additionally, patients are enrolled through KC CARE Health Center, which connects them to long-term care.

Valuable lessons learned during the grant period include identifying how to best use the on-site time of community health workers to prevent duplication of services. Rose Brooks Center and KC CARE Health Center continue to work together to protect the safety and confidentiality of victims served at the on-site clinic.

SAINT LUKE'S HEALTH SYSTEM

PROJECT Care coordination 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	YEARS FUNDED	GRANT TERM
$270,000	$1M–3M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

4,865

Total number of **visits/ encounters** for this project

19,903

STRATEGIES

- Facilitate greater care coordination and navigation
- Promote system transformation through implementation of innovative care models, practices, and workforce
- 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
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

The care coordination program targets clients with significant barriers to accessing and participating in care, as well as those at high risk of falling out of care. It helps minimize duplicative health care efforts, with the primary goals of reducing costs, unnecessary emergency department (ED) use, and inpatient visits. In the 2017 grant year, the program served 4,865 unduplicated clients in the greater Kansas City metropolitan area, including Jackson County in Missouri and Wyandotte and Johnson counties in Kansas. Clients are primarily uninsured, low-income members of racial and ethnic minority groups.

The program partners with numerous medical systems and safety net clinics, using KC CARE Health Center (KC CARE) community health workers to coordinate services. These health workers are embedded within the EDs of Saint Luke's Health System, University of Kansas Hospital, Research Medical Center, and Children's Mercy Hospital outpatient clinics. Community health workers are also on-site at nine safety net clinics, domestic violence agencies, Legal Aid of Western Missouri, churches, and other social service agencies to identify patients in need.

Program outcomes include improved medication access; improved health outcomes and patients' perception of their own health; improved patient care experience, engagement, and satisfaction; and lowered or maintained health care costs for both patients and health care organizations through decreased inpatient and ED visits. Key lessons include recognizing that more meaningful, in-depth service with community health workers equals improved results; the critical need for up-to-date database training; and the importance of adjusting processes to align with new partnerships.

SETON CENTER

PROJECT Expanding oral health for uninsured and vulnerable

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	YEARS FUNDED	GRANT TERM
$150,000	$1M–3M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

1,627

Total number of **visits/ encounters** for this project

4,881

STRATEGIES

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

Final Report Abstract

Seton Center focused on increasing access to dental services for underserved populations while providing quality services at a reduced cost. Clients served by this program reside in Health Forward's six-county service area. Sixty-five percent of clients are female, and 35 percent are male. The majority of clients are Caucasian (57 percent), with smaller proportions of Hispanic (32 percent) and African-American (9 percent). Ages range from infants to older adults. The target population includes individuals who are low-income, mentally ill, homeless, incarcerated, or recently released from prison. As part of this opportunity, dental services were also provided to children in area schools, along with instruction on how to brush their teeth properly to maintain better oral health.

Studies show that improved oral health benefits individuals' overall health outcomes. Seton Center increased access to oral health care. By having one of the lowest sliding fee scales in the area, along with funding for charitable care, Seton Center was able to care for individuals who otherwise would have a lengthy wait for services and would have to pay out of pocket from limited budgets. A dental hygienist completed education screenings at 392 child visits, increasing awareness of oral hygiene and regular professional oral health care. Seton Center also improved the oral health of patients: 358 adults and children benefited from special needs funding for assessment, cleaning, filling cavities, varnish, sealants, and other necessary services.

Seton Center learned key lessons by addressing challenges. The start of some services was delayed due to turnover in nursing staff at a partner school. The newly hired nurse had to be trained in Seton's Adopt-A-School program process. Seton Center incorporated additional training and assistance with paperwork to ensure that enrollment packets were distributed on time for the 2018–19 school year.

SOUTHWEST BOULEVARD FAMILY HEALTH CARE

PROJECT Family health care safety net services

PROJECT SERVING Wyandotte County

GRANT AMOUNT	OPERATING BUDGET	YEARS FUNDED	GRANT TERM
$200,000	$3M–10M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

4,077

Total number of **visits/ encounters** for this project

16,323

STRATEGIES

- Fund service delivery and core operating support
- Develop strategic partnerships through formal agreements that lead to system transformation

Final Report Abstract

Most Southwest Boulevard Family Health Care (FHC) patients are from Wyandotte County, the poorest part of the Kansas City metropolitan area. In 2017, FHC served 4,077 unique individuals through 16,323 visits, signaling improved access to health services.

FHC safety net services align with all three Safety Net theory of change strategies of access, quality, and cost. Access is improved by offering same- or next-day access for urgent needs (e.g., rashes, fever, GI or URI symptoms) and is thought to reduce the use of emergency departments. FHC promotes the highest quality of clinical, medical, and oral health care through evidence-based practice guidelines and a team-based approach. FHC's staff are trained to provide care such as fluoride varnishes, shots, lab testing, patient education, and other services, and receptionists and billing staff have been trained in Mental Health First Aid. Cost-effective supports are measured by tracking use of the patient assistance programs. More than 200 patients received assistance with an average of 2.5 prescriptions each. FHC assisted patients with applications for Medicaid and Affordable Care Act coverage that allowed more than 150 patients to access additional health services.

FHC also prioritizes evaluation and quality improvement, emphasizing evidence-based, accountable care that includes audited performance, outputs, and outcomes. FHC's goal of individual patient health improvements, such as improving blood pressure, can result in population changes. FHC continuously learns from and modifies its approaches to patients and their health care. The organization has also implemented new recommendations for checking for colon cancer, for the prevention and early diagnosis of HIV, and for diabetes patient education.

SWOPE HEALTH

PROJECT Dental services for low-income, uninsured and underinsured families

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

GRANT AMOUNT	ORGANIZATION SIZE	YEARS FUNDED	GRANT TERM
$164,121	>$50M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

1,766

Total number of **visits/ encounters** for this project

42,124

STRATEGIES

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

Final Report Abstract

In 2017, Swope Health provided dental treatment to 1,171 Kansas City area residents and dental care coordination services to 595 patients. Dental patients were 62 percent black/African-American, 28 percent white, 7 percent Hispanic ethnicity, and 4 percent all other minorities, with 6 percent not reporting a race. Seventy-seven percent of dental patients had incomes below 100 percent of the federal poverty level, 47 percent were uninsured, and 48 percent had Medicaid dental benefits. Most patients served by the dentist and dental care coordinator were women or aged 36 or older.

Swope's dentist provided treatment as recommended by the American Dental Association. Quality indicators included first molar dental sealants for children ages 6 to 9 and adult tobacco screening and cessation intervention. Among 90 patients ages 6 to 9, 40 had eligible molars and 25 received sealants. Among patients ages 18 and older, 216 screened positive for tobacco use and received cessation counseling and referrals.

The dental care coordinator provided education and assistance in accessing dental care and other primary care to prenatal patients and patients with chronic conditions. Quality indicators for the coordinator included diabetic patients' follow-through with recommended services: 33 percent completed a vision exam, 26 percent had a foot exam, 56 percent reviewed a blood sugar test with their provider, 38 percent had lipid levels measured, 46 percent had a test to detect kidney damage, and 13 percent had at least one education session with a nurse educator or nutritionist. Eight diabetic patients maintained blood pressure and glucose control throughout the year.

In terms of lessons learned, Swope saw the impact of the restoration of adult dental benefits for certain Missouri Medicaid beneficiaries. This expanded coverage brought in patients who had previously gone without care for some time. Many also had multiple chronic health conditions, thereby increasing the complexity of dental treatment.

SYNERGY SERVICES

PROJECT Homeless youth campus integrated 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	YEARS FUNDED	GRANT TERM
$125,000	$3M–10M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

2,268

Total number of **visits/ encounters** for this project

6,663

STRATEGIES

- Implement evidence-based, practice-based, and promising practices in service delivery
- Promote integrated systems of care across SN clinics, hospitals, providers and key community-based services
- Improve patient care experience
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

The homeless youth campus integrated clinic is a centerpiece of the Resiliency Center and an important expansion of safety net services provided collaboratively by Synergy Services, Children's Mercy Hospital, Miles of Smiles Dental Program, and Insight Eye Care. Synergy's on-site clinic is designed to improve access to quality, affordable health care for homeless, runaway, and at-risk youth who are often left out of the traditional health care system. The youth served often do not have access to mental health services, regular health care or oral health 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.

Since all youth are still developing mentally and physically, the impact of homelessness is often severely damaging and can affect the health of these teens throughout their lives. In many cases, even when homeless youth are able to access health care, they are confronted with a fragmented system that does not offer cultural competence, coordination, or a youth-focused environment.

The homeless youth campus integrated health clinic is designed to overcome the barriers that have prevented homeless and runaway youth from receiving quality health care. Synergy's clinic increases access and improves quality of care by truly integrating medical, oral health, and mental health care 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. Through the bi-directional integration of comprehensive health services, the clinic aims to improve access to health care for homeless and at-risk youth, improve the quality of health care for this population, and reduce health care costs by providing low-cost care in an integrated and timely manner.

THRIVE ALLEN COUNTY

PROJECT Navigator and care coordination

PROJECT SERVING Allen County

GRANT AMOUNT	OPERATING BUDGET	YEARS FUNDED	GRANT TERM
$38,328	$1M–3M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

320

Total number of **visits/ encounters** for this project

573

STRATEGIES

- Facilitate greater care coordination and navigation
- Increase health care coverage that supports quality care
- Advocate for policies that increase access in underserved communities
- Implement evidence-based, practice-based, and promising practices in service delivery
- Promote system transformation through implementation of innovative care models, practices, and workforce
- Develop strategic partnerships through formal agreements that lead to system transformation
- Advocate for and support policies that improve health

Final Report Abstract

This program served Allen County with health insurance navigator and care coordination services, including both clinical bi-directional referrals and referrals for poverty assistance services based at Thrive Allen County.

Allen County, Kansas, is a small, rural county with 12,951 total residents, located almost exactly 200 miles from Wichita, Tulsa, Joplin, and Kansas City. The county median household income of $40,914 accurately conveys the working-class character of a region marked by a dual history of industrial extraction (and its decline) and agriculture.

Thrive's care coordinator created clinical, systemic referral systems during the year, brought clinical providers into closer collaboration, and provided services to 56 individuals during the year. Thrive's health insurance navigator program assisted 413 consumers, both in special enrollment periods and open enrollment for federal marketplace coverage. Allen County's uninsured rate has steadily fallen since 2013, and Thrive believes that a successful open enrollment period in 2017 helped to continue that trend.

This program addressed community needs by both bringing care coordination services to bear on patients with high needs and meeting patients' needs for navigating the social safety net more broadly. The need for systemic integration is served by creating policies, models, practices, and connections for other systems to use in creating similar programs. Additionally, helping consumers navigate a fragmented, unpredictable safety net are vital, as Iola no longer hosts an office of the Department of Children and Families, formerly the key resource for many low-income individuals and families.

TURNER HOUSE CLINIC

PROJECT Patient-centered medical home & delivery of integrated primary pediatric care services

PROJECT SERVING Wyandotte County

GRANT AMOUNT	ORGANIZATION SIZE	YEARS FUNDED	GRANT TERM
$280,000	$3M–10M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

5,619

Total number of **visits/ encounters** for this project

15,731

STRATEGIES

- Fund service delivery and core operating support
- Facilitate greater care coordination and navigation
- Promote system transformation through implementation of innovative care models, practices, and workforce
- 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
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

Health Forward funding helped Turner House Children's Clinic provide care to 5,619 unique patients through 15,731 visits. Ninety-six percent of patients were children — birth to age 19 — who received primary medical, dental, and behavioral health services; 4 percent of patients were adults who received preventive and restorative dental care services. Eighty-four percent of patients lived at or below 200 percent of the federal poverty level; 41 percent of patients were uninsured, and 56 percent were insured through Medicaid (KanCare). More than 73 percent of patients identified as Hispanic/Latino.

Increasing access to care and improving quality were two key program strategies. In regards to access, the number of unique patients served grew by almost 20 percent, and visit numbers increased almost 30 percent between 2016 and 2017. A significant contributor to this growth was the addition of a pediatrician in January 2017 and conducting more effective outreach to promote the clinic and decrease patient no-shows. Quality outcomes included successful transition to the federally qualified health center business model, achievement of Federally Qualified Health Center Look-Alike designation, and the integration of two safety net clinics into the operations of Vibrant Health.

A key lesson learned relates to the patient portal, which offers self-serve, real-time access to frequently requested patient information, such as the immunization record and school physical summary, as well as new patient forms. Vibrant Health staff made improvements in marketing and portal functionality, and approximately 8 percent of patients registered for portal access. Eighty-four percent of those who registered logged onto the portal at least once. However, less than 1 percent of those who logged on used portal services. This is not an issue unique to Vibrant Health. More action is necessary to increase portal adoption, in order to leverage a patient's potential to manage their care along with their primary care physician and care team.

VISITING NURSE ASSOCIATION

PROJECT In-home pharmacist

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	YEARS FUNDED	GRANT TERM
$50,000	$10M–50M	Multiple years	12 months

NUMBERS

Total number of **unduplicated clients** served by this project

201

Total number of **visits/ encounters** for this project

201

STRATEGIES

- Implement evidence-based, practice-based, and promising practices in service delivery
- Develop strategic partnerships through formal agreements that lead to system transformation
- Improve patient care experience
- Support approaches that reduce costs, promote sustainability, or contain costs

Final Report Abstract

The Visiting Nurse Association's (VNA) in-home pharmacist program provided medication reconciliation and education to 201 patients and discovered 786 medication discrepancies. Services consist of a medication review by two, senior-level UMKC School of Pharmacy interns based on the patient's chart and referral information, followed by a meeting in which the interns educate the patient and review their actual medications in the home.

A typical patient is 72 years old, taking an average of 14.5 medications, which include prescriptions, over-the-counter medication and herbal supplements, and has, on average, 10 medical diagnoses such as congestive heart failure, chronic obstructive pulmonary disease, and diabetes. Since its inception in 2014, the program is estimated to have saved more than $1.5 million dollars in health care costs. The program prevented approximately 221 unnecessary hospital visits since 2014, and during the reporting period the program helped 24 patients avoid unnecessary hospital admissions, trips to the emergency department, and urgent care clinic visits.

Decreasing the rotation for students from eight weeks to four weeks was a challenge this year, as students and the supervising pharmacist are spending more time training and less time on patient visits. This challenge must be overcome with adjustments to program goals and expectations. VNA nurses and therapists are learning new methods and information about medications and their impact on patient outcomes. The VNA in-home pharmacist program shows tremendous potential to not only decrease the number of patients hospitalized from medication error, but also to teach a new generation of pharmacists a better way to approach patient care.

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