YEAR 10 RETROSPECTIVE: FINAL REPORT

Evaluation of the Kansas City Safety Net Capacity Expansion Project

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Executive Summary

The Kansas City Safety Net Capacity Expansion Project (Expansion Project) through the Health Forward Foundation (Health Forward) has provided safety net clinics with financial resources to extend office hours into nights and weekends since 2009. The clinics that have received funding under this grant primarily serve uninsured and Medicaid patients in the Kansas City metropolitan area, who may have challenges attending appointments during traditional business hours. There were three clinics that received ongoing funding through Year 10: Health Partnership Clinic of Johnson County, Kansas City CARE Clinic, and Swope Health Services. Another longtime participant, Family Health Care, received funding through Year 9.

NORC at the University of Chicago (NORC) has conducted an ongoing, mixed-methods evaluation of the Expansion Project for Health Forward. Since 2010, NORC has collected quarterly administrative data from participating clinics, tracking the number of visits and patients, patient characteristics, common diagnoses, and types of visits that occur during expanded hours. NORC has also collected qualitative data from clinic directors, providers, patients, and other stakeholders through interviews and focus groups conducted during site visits, as well as through a content analysis of grantees' reports to Health Forward.

The Year 10 report summarizes comprehensive, longitudinal data and analysis of service expansion under the grant and assesses the participating clinics' experiences providing care through the Expansion Project. Findings focus on the following topics:

1) Trends in after-hours utilization over the course of the Expansion Project, including numbers of visits and patients and patient characteristics
2) Clinical needs of patients served during expanded hours and the types of care received
3) Clinics' performance on a set of shared measures related to preventive care and health care utilization
4) Clinics' implementation of expanded hours, including the number of hours, staffing, and spending patterns
5) Lessons learned related to successes and challenges in operations, funding, and a changing health care landscape to inform Health Forward's future safety-net programming

Key Findings

After-Hours Utilization

The Expansion Project increased access to after-hours care for vulnerable residents in Greater Kansas City, reaching 62,842 patients with 73,542 visits over 10 years. While these clinics transitioned from being free clinics to federally qualified health centers (FQHCs) during the grant, they continued to serve diverse, low-income, uninsured, underinsured, and publicly insured populations. More than a quarter of patients seen during extended hours were new patients.

- Patients who sought after-hour services were more likely to be female, but use by males increased over the course of the project. By Year 10, the composition of the patient population by gender was 53 percent female and 45 percent male.
- Thirty-eight percent of after-hours patients were black; 35 percent were white, non-Hispanic; and 19 percent were Hispanic.
- Adult patients age 36 to 55 composed the largest proportion of after-hours patients, at 40 to 46 percent each year of the program.
- The proportion of patients with incomes below the Federal Poverty Level (FPL) fluctuated over the course of the evaluation, with a high of three-quarters (Year 3) and a low of less than half (Year 7).

Care Needs of After-Hours Patients and Care Delivery

At the start of the Safety Net Capacity Expansion Project, 44 percent of patients seen during expanded hours did not have a regular source of care. Over the course of the project, all clinics reported a high prevalence of chronic illness. The most common chronic condition diagnoses included hypertension (14 percent), diabetes mellitus (8 percent), disorders of lipoid metabolism (4 percent), and asymptomatic HIV infection (3 percent). Two behavioral health diagnoses—nondependent drug abuse (4 percent) and episodic mood disorders (3 percent)—were also among the top 10 diagnoses.

Most visits were for established clinic patients, although many new patients came to the clinics each year. The high proportion of Level 3 visits (15 minutes) and Level 4 visits (25 minutes and moderately complex) among these clinics supports the finding that the after-hours visits were not minimal visits for acute problems. Not surprisingly, clinic directors and clinicians remarked that they often spent more time with patients during after-hours visits and often provided services that other staff would provide during regular office hours, such as case management. There are notable accomplishments for these clinics with regard to their achievement of preventive care measures, highlighting that they saw after-hours clinics as an important chance to address their patients' needs comprehensively.

Clinics' Implementation of Expanded Hours

Over 10 years, the Safety Net Capacity Expansion Project supported an additional 27,634 early morning, evening, and weekend clinic hours in greater Kansas City. By the conclusion of the program, after-hours care was fully integrated into clinic operations and, in some cases, expanded to additional locations.

Lessons Learned in Safety Net Capacity Expansion

Participating clinics experienced successes and challenges related to operations, funding and sustainability, and the changing health care landscape. From the outset, operational challenges often focused on staffing expanded hours. Clinics described success over the years at meeting their staffing needs by building on the free-clinic model of volunteer and student providers and the introduction of mid-level providers. Becoming FQHCs and increasing billable encounters may have helped with staffing in the later years.

Clinics discovered early in the project that patients were presenting during extended hours for chronic issues as opposed to acute needs. Clinics described the limits of grant funding when patients faced chronic conditions. Clinics reported success in applying patient-centered medical home (PCMH) principles to care delivery for their after-hours patients, but providing their patients with diagnostics, pharmacy, social services, and specialists were challenges.

The Expansion Project provided base funding for after-hours care but did not cover the full cost of operations or further service development. In some years, the clinics were able to raise additional funds or use in-kind services to maintain the after-hours project but still reported that they could have been more effective with general operating support rather than a targeted grant.

Participating clinics encountered opportunities and challenges in light of state and federal policy shifts and local market responses. The passage and implementation of the ACA resulted in new funding sources for community health centers. Most of the Expansion Project clinics became FQHCs or expanded in response to those opportunities. By the end of the project, clinic directors reported challenges serving the area's growing immigrant populations, reporting that immigrants had stopped seeking care, and there is a potential role for free clinics to fill this need.

Conclusions

The Expansion Project has played a vital role in the evolution of Kansas City's safety net over the last decade. A highly successful, long-term grant program, it increased access for vulnerable Kansas City residents to convenient health care. When drawing conclusions from this experience, it is important to consider that most program-specific grants do not last a decade. By continuing this line of funding annually for 10 years, Health Forward's Expansion Project functioned in some ways as basic operating support and in others like pilot funding by enabling participating clinics to experiment and evolve their programs. By the conclusion of the grant, these programs became fully integrated in the clinics' operations.

We observed a cultural shift as the clinics became FQHCs, although they remained committed to their missions to serve the uninsured. Clinic directors viewed these billable visits as an important way to subsidize care for the remaining uninsured. However, they noted that gaps remain—in particular, related to access and coverage for diagnostics, pharmacy, social services, and specialty care. Clinic directors emphasized that flexible, long-term funding enables them to construct creative solutions to address their patient populations' needs in the context of evolving health and social policies and shifting demographics.

Introduction

Health Forward Foundation's (Health Forward) Safety Net Capacity Expansion Project (Expansion Project) operated from 2009 to 2019, providing safety-net clinics in greater Kansas City with financial resources to extend office hours into nights and weekends. Health Forward, formerly the Health Care Foundation of Greater Kansas City, contracted NORC at the University of Chicago (NORC) to conduct an ongoing, mixed-methods evaluation of the Expansion Project. The Year 10 report is a summative evaluation of the project.

From its start in 2009, the long-term goals of the Expansion Project were to increase the number of patients, health care visits, and new patients receiving care by providing grants for clinics to remain open during nontraditional hours. The project was initiated prior to the passage of the Patient Protection and Affordable Care Act (ACA) in 2010 and its landmark expansion of insurance coverage through Medicaid and subsidies for low-income Americans to purchase coverage in the marketplace. The ACA also increased funding for community health centers, the primary providers of care to underserved populations. However, neither Kansas nor Missouri elected to expand their Medicaid programs under the ACA. In 2016, two years after the ACA was fully implemented, estimates showed that 8.4 percent of the Kansas City metro population was uninsured and approximately 14.5 percent was covered by Medicaid.[1,2] The Expansion Project has played a vital role in meeting the health care needs of Kansas City's vulnerable populations as the ACA has prompted a range of delivery system reform efforts.

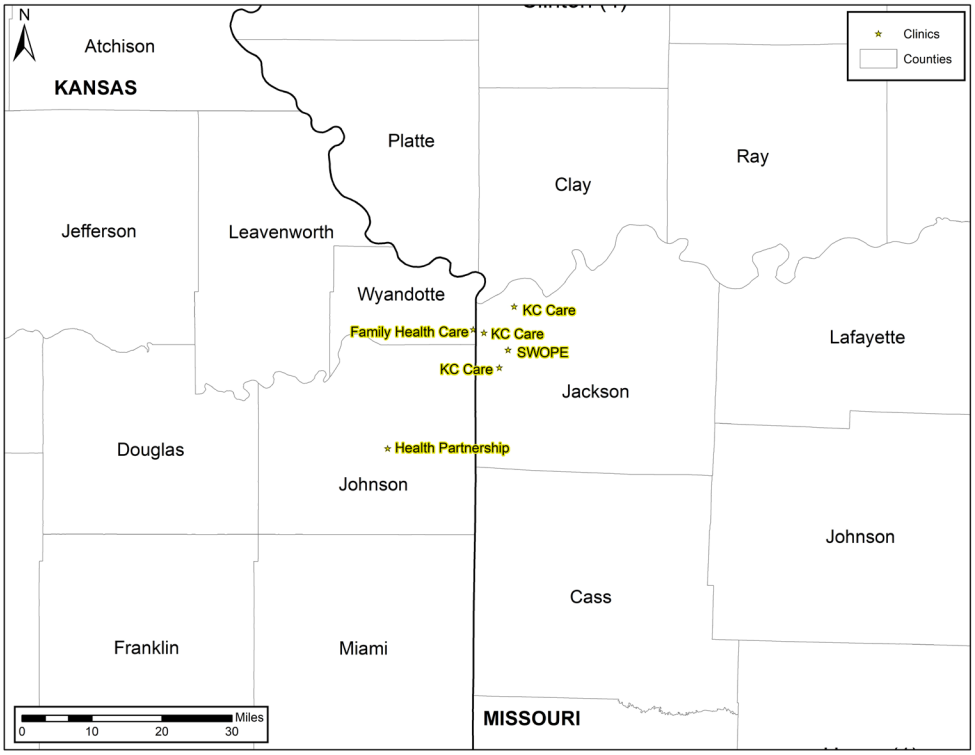
Participating Clinics

The Safety Net Capacity Expansion Project launched in 2009 with five clinics located throughout the metropolitan Kansas City area. Three clinics participated in the tenth and final year of the Expansion Project: Health Partnership Clinic of Johnson County (Health Partnership); KC Free Health Clinic, which is now called Kansas City CARE Health Clinic (KC CARE); and Swope Health Services (Swope Health). Southwest Boulevard-Quindaro Family Health Care (now known as Family Health Care) participated through Year 9. Samuel U. Rodgers Northland (Rodgers) participated in the first three years. Exhibit 1 summarizes the year of opening and target populations served by each clinic. Exhibit 2 maps the locations of the four clinics that participated for the majority of the project.

Exhibit 1. Safety Net Capacity Expansion Project: Participating Clinics in Years 1–10

Clinic	Years of Participation
Family Health Care (formerly Southwest Boulevard-Quindaro Family Health Care)	2009–2018
Health Partnership Clinic of Johnson County	2009–2019
Kansas City CARE Health Clinic (formerly known as KC Free)	2009–2019
Samuel U. Rodgers Northland	2009–2012
Swope Health Services	2009–2019

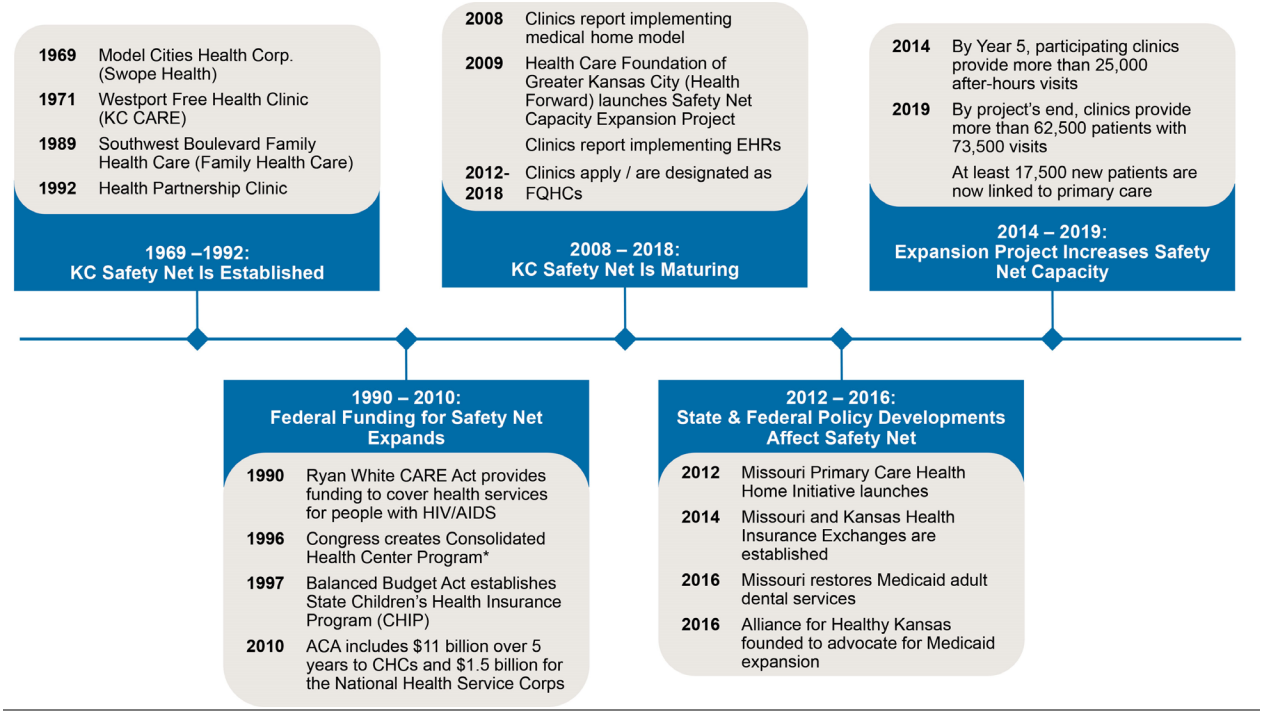
Exhibit 2. Safety Net Capacity Expansion Project: After-Hours Locations, Year 9



Policy Context

The Expansion Project was administered during a time of significant change in the policy environment. While the 2010 passage of the ACA is a dominant milestone, Exhibit 3 depicts ongoing, simultaneous local- and clinic-level reforms.

Exhibit 3. Kansas City Safety Net Health Care and Policy: 10-Year Retrospective, 2019



*Includes Health Care for the Homeless Program, Community Health Centers, Migrant Health Centers, and Primary Care in Public Housing. Notes: EHR - electronic health record; FQHC – federally qualified health center; ACA - Patient Protection and Affordable Care Act.

All of the participating clinics operated as free clinics for more than a decade before Health Forward created the grant, but most did not benefit from major national funding initiatives for safety-net care because they were not federally qualified health centers (FQHCs). KC CARE was the exception, operating as a Ryan White clinic for persons with HIV and AIDS.

Prior to the passage of the ACA, Health Partnership and KC CARE developed the capacity to serve as patient-centered medical homes (PCMHs), and both became FQHCs before full ACA implementation. Federal funds subsequently became available because of these designations.

Eventually, the state of Missouri added dental care into Medicaid. At the same time, the Expansion Project had already reached 5,000 Kansas and Missouri residents, of which almost 1,500 were new to the clinics. The absence of Medicaid expansion continued to be a barrier to additional funding and, as the clinic directors would describe, placed pressure on the grantees. However, by 2019, as FQHCs, all the clinics received Medicaid dollars for a portion of their patient populations and would benefit if and when state advocacy coalitions succeed in passing expansion legislation.

Overview of Report

This retrospective provides comprehensive, longitudinal data on service expansion under the grant and assesses the participating clinics' experiences providing care through the Expansion Project. In this report, we summarize data and methods and key findings observed over the course of the evaluation. Findings focus on the following topics:

1) Trends in after-hours utilization over the course of the Expansion Project, including numbers of visits and patients and patient characteristics
2) Clinical needs of patients served during expanded hours and the types of care received
3) Clinics' performance on a set of shared measures related to preventive care and health care utilization
4) Clinics' implementation of expanded hours, including the number of hours, staffing, and spending patterns
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Data and Methods

The evaluation of the Safety Net Capacity Expansion Project employs qualitative and quantitative data collection and analysis to measure the impact of the grant on access to after-hours care and describe service use, outcomes, and demographic characteristics associated with patients receiving after-hours care. The evaluation examined data annually and cumulatively over the 10-year grant period. The quantitative data illustrates how the project increased access, as well as the reach of the project. The qualitative data was collected to understand the impact of the project on clinic operations and the policy environment on the clinics, as well as successes and challenges during the 10 years of implementation. This final analysis fully integrates the results of our quantitative and qualitative approaches to provide a comprehensive assessment of trends and outcomes at the conclusion of the grant. Specifically, this 10-year retrospective utilizes the following sources of data:

- Two site visits to first develop and then gather feedback on the administrative data template (Year 1)
- Aggregated quarterly administrative data reported by clinics on numbers of visits and patients, staff hours, patient demographics, and care received (Years 2–10)
- Systematic content review of grantees' interim and final annual reports to Health Forward (Years 1–10)
- Interviews and focus groups with clinic administrators, providers, and patients (conducted during site visits in Year 7)
- Focus group with clinic leadership overseeing the after-hours program (Year 10)
- Interviews with state and regional primary care association policy experts (Year 10)

Exhibit 4. Safety Net Capacity Expansion Project: Data Collection Timeline

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Administrative Data	x*	x	x	x	x	x	x	x	x	x
Grantee Reports	x	x	x	x	x	x	x	x	x	x
Interviews	x						x			x
Focus Groups							x			x

Note: *Due to data inconsistency, we excluded Year 1 administrative data from our analysis.

The Expansion Project began in 2009, and there was one combined report for all participating clinics for the first three years. The final combined project report only included data through the third quarter of 2012. Individual clinic reporting began in Year 4, at which time the reporting period became the last quarter of the prior year and the first three quarters of the reporting year, e.g. Quarter 4 2012–Quarter 3 2013. Exhibit 5 illustrates the dates covered by annual Expansion Project clinic reporting.

Exhibit 5. Safety Net Capacity Expansion Project: Project Year Dates, Years 1–10

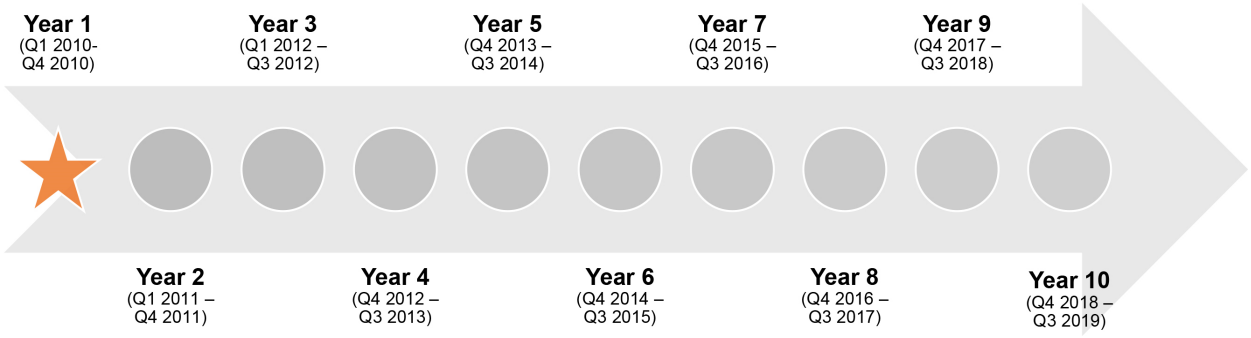


Exhibit 6 crosswalks the research questions examined in this evaluation to the data sources and analytic approaches employed to address them. The sections that follow provide detail on data collection and analysis associated with each analytic activity.

Exhibit 6. Safety Net Capacity Expansion Project: Key Research Questions, Data Sources, and Analytic Approaches

Research Question	Analytic Approach	Data Source
1. Who are the Kansas City residents the after-hours grant served? What were their health care needs and what services were provided to them?	▪ Descriptive analysis of annual and trend data	Administrative data on patient demographics and utilization
	▪ Qualitative thematic analysis ▪ Descriptive analysis of annual and trend data	Outcome and financial data in grantees' annual reports (interim and final)
2. How did Kansas City Safety Net Clinics deliver after-hours care, and how did it change over the 10-year grant period?	▪ Descriptive analysis of annual and cumulative data ▪ Trend analysis	Administrative data on clinic operations
3. How did access to after-hours care change in Kansas City?	▪ Descriptive analysis of annual and cumulative data ▪ Trend analysis	Administrative data on clinic operations
	▪ Qualitative thematic analysis ▪ Descriptive analysis of annual and trend data	Outcome and financial data in grantees' annual reports (interim and final)
	▪ Qualitative thematic analysis	Interviews and focus groups
4. During the 10-year grant period, what opportunities and challenges did the participating clinics encounter?	▪ Qualitative thematic analysis ▪ Descriptive analysis of annual and trend data	Outcome and financial data in grantees' annual reports (interim and final)
	▪ Qualitative thematic analysis	Interviews and focus groups
5. What impact did the Safety Net Capacity Expansion Grant have on after-hours access and the participating clinics?	▪ Descriptive analysis of annual and cumulative data ▪ Trend analysis	Administrative data on clinic operations
	▪ Qualitative thematic analysis ▪ Descriptive analysis of annual and trend data	Outcome and financial data in grantees' annual reports (interim and final)
	▪ Qualitative thematic analysis	Interviews and focus groups

Administrative Data

Over the course of the Expansion Project, NORC collected and analyzed administrative data on patient volume; patient demographics, including gender, age, race/ethnicity, insurance coverage, patient income; and the type of care provided during the after-hours visits. NORC analyzed data collected quarterly each year of the evaluation, as well as across Years 2 through 10 to identify changes and trends over time.

Data Collection Instrument. In collaboration with Health Forward and with input from the Mid-America Regional Council and the clinics on the indicators that would be reported, NORC developed a template to facilitate routine administrative data collection from participating clinics. NORC revised both the data collection strategy and the design of the template for Year 2 when quarterly data collection began. The final administrative data template included four sections: demographic information, geographic information, top 10 diagnoses, and top 10 procedures (see Appendices A and B for the data collection template and instructions provided to the clinics). Exhibit 7 highlights the data elements collected from clinics each quarter.

Where possible, NORC used standardized measures, such as primary diagnoses from the International Classification of Diseases, Ninth (and then Tenth) Revision (ICD-9/10).[3] For procedures, we used Current Procedural Terminology, Fourth Edition (CPT-4) codes.[4] As part of the Year 3 revisions, ICD-9 three-digit diagnosis codes were combined into broader disease categories to identify common illnesses. Similarly, CPT-4 procedural codes were limited to office visit codes, including outpatient and preventive care visit codes, to track common types of clinical visits.

Exhibit 7. Safety Net Capacity Expansion Project: Data Elements Captured in Administrative Data Collection Template

Elements	Variables
Hours covered by the grant	■ Number of clinic hours ■ Number of physician hours ■ Number of mid-level staff hours
Number of patients that received medical care, new patients and patient visits	■ Number of patients ■ Number of new patients ■ Number of patient visits
Demographic information on patients receiving after-hours care	■ Health care insurance coverage ■ Gender ■ Age ■ Race/ethnicity ■ Income according to the Federal Poverty Level (FPL)
Geographic information on patients receiving after-hours care	■ The number of patients by zip code ■ The number of patients by county
Top 10 primary diagnoses clinics reported during extended hours	■ Three-digit ICD-9-CM codes and name of the diagnosis
Top 10 procedures clinics reported during extended-hours visits	■ CPT-4 office visit codes and name of the procedure

Limitations. Over the course of the Expansion Project, clinic reporting varied considerably due to changes in program participation and differences in electronic health records (EHR) and their implementation. Rodgers only participated in Years 1–3, and Family Health Care exited after Year 9. These clinics are not included in the evaluation after their exit from the program.

Administrative data collection began on a quarterly basis in Year 2 after NORC revised and finalized the data collection strategy with guidance from Health Forward and the participating clinics. Therefore, Year 1 administrative data are excluded from administrative trends. In addition, it is important to note that demographic information was not reported consistently across all participating clinics, as some clinics changed their reporting processes on demographics over time. For example, Swope Health did not report race/ethnicity until Quarter 4 of Year 7. Family Health Care did not report on Race/Ethnicity at all. In order to maximize available information, data are reported when at least three of the four clinics reported in a given year. These variations in data availability are noted under each individual exhibit where appropriate. As such, some data cannot be compared from year to year.

Systematic Review of Grantee Reports

NORC reviewed interim and final reports that grantees submitted annually to Health Forward. Participating clinics reported on a set of mutually selected and agreed-upon outcomes related to visits, population health, preventive screenings, patient perception of health, and cost of care, which was operationalized with measures of health system utilization.[i] These reports provided data on each clinic's goals, outcome measures, activities, organizational changes, lessons learned, and sustainability planning over the 10 years of the Expansion Project.

NORC reviewed a total of 58 interim and final reports from the four clinics, with Years 1–3 consisting of a combined report from the Mid-America Regional Council. Two research analysts conducted coding using NVivo 12 (QSR International Pty Ltd) and revised the preliminary codebook based on discussions of discordant themes and category overlap. The two analysts then independently applied the finalized codebook, meeting regularly to discuss coding discrepancies until consensus was reached. Two senior researchers provided input and conducted a random spot-check of the final codebook for conceptual agreement. The final codebook contained 50 nodes organized across eight parent nodes that were developed through inductive coding: clinical issues, context, lessons learned, organization, outcomes, challenges, success, and timeline. Using the NVivo's crosstab query function, we validated the spread of codes and summarized results related to "challenges" and "successes." Finally, we revisited reports as needed to capture additional context around a theme of interest to inform findings at a higher level.

Limitations. Clinic reporting on specific measures varied over the course of the Expansion Project. Due to improvements in information technology—specifically EHR capacity—more consistent data became available in the later years of the project, although some clinics were unable to use their EHRs to facilitate reporting on the grant. In order to maximize available information, data are reported when at least three of the four clinics reported in a given year. For example, clinics started reporting the number of patients who were hypertensive and those with comorbidities of diabetes or hyperlipidemia in Year 7; therefore, only Years 7–10 data on chronic conditions are available and included in our final analysis.

Primary Data Collection

NORC engaged in a range of primary data collection activities over the course of the 10-year evaluation. In the initial year, NORC conducted two site visits to first develop and then gather feedback on the administrative data template. In Year 7, NORC conducted site visits, which included interviews with providers and clinic staff and focus groups with patients, to provide context to the quantitative findings. In Year 10, NORC conducted a focus group with clinic leadership to discuss the project holistically. In addition, we also conducted two interviews with state and regional primary care association policy experts. The objective of these activities was

[i] Grantees also reported on patient experience of care; however, these data are not comparable due to clinics' use of different instruments and measures. As such, patient satisfaction is not included in this summative report.

to enhance the analysis of the administrative data and grantee reports, further explaining the impact and changes experienced at the four participating clinics.

During interviews and focus groups, an NORC staff member took detailed notes, and with the permission of the participants, all discussions were audio-recorded to help confirm details in the notes. NORC completed a thematic analysis of all primary data collected. The Year 10 focus group protocol is included as Appendix E.

Human Subjects Protection. NORC submitted the project description and protocol for review to the NORC Institutional Review Board (IRB).[ii] The IRB determined that the project did not constitute human subjects research.

[ii] IRB #: 16.06.04

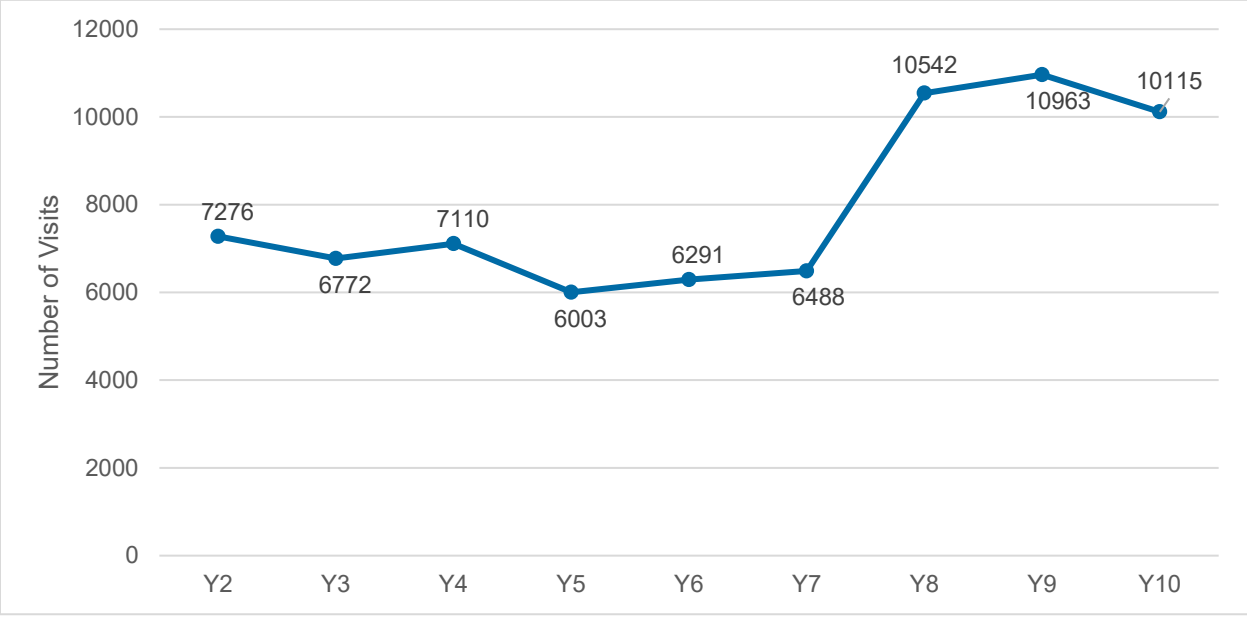
Findings: After-Hours Utilization

The Expansion Project increased access to primary care and other services for vulnerable residents in Greater Kansas City, reaching 62,842 patients with 73,542 visits. While these clinics transitioned from being free clinics to FQHCs, they continued to serve diverse, low-income, uninsured, underinsured, and publicly insured populations. In this section, we describe trends in after-hours utilization over the project period. We report the number of visits provided and patients served and their demographic characteristics.

Trends in Number of Visits and Patients

In Years 2 through 10, participating clinics provided 71,560 after-hours visits through their Expansion grants.[iii] Exhibit 8 shows the number of patient visits each year of the project, beginning in Year 2. In Years 2–6, the number of annual visits fluctuated in the 6,000–7,200 range, but Year 7 saw a sharp, 65 percent increase to 10,542. The number of visits stayed around that level for the remaining years of the project.

Exhibit 8. Safety Net Capacity Expansion Project: Number of After-Hours Patient Visits, Years 2–10



Source: Administrative data reported by participating clinics to NORC at the University of Chicago (January 2011—September 2019). Note: Years 2–3 included Samuel U. Rodgers Northland Health Center. Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health.

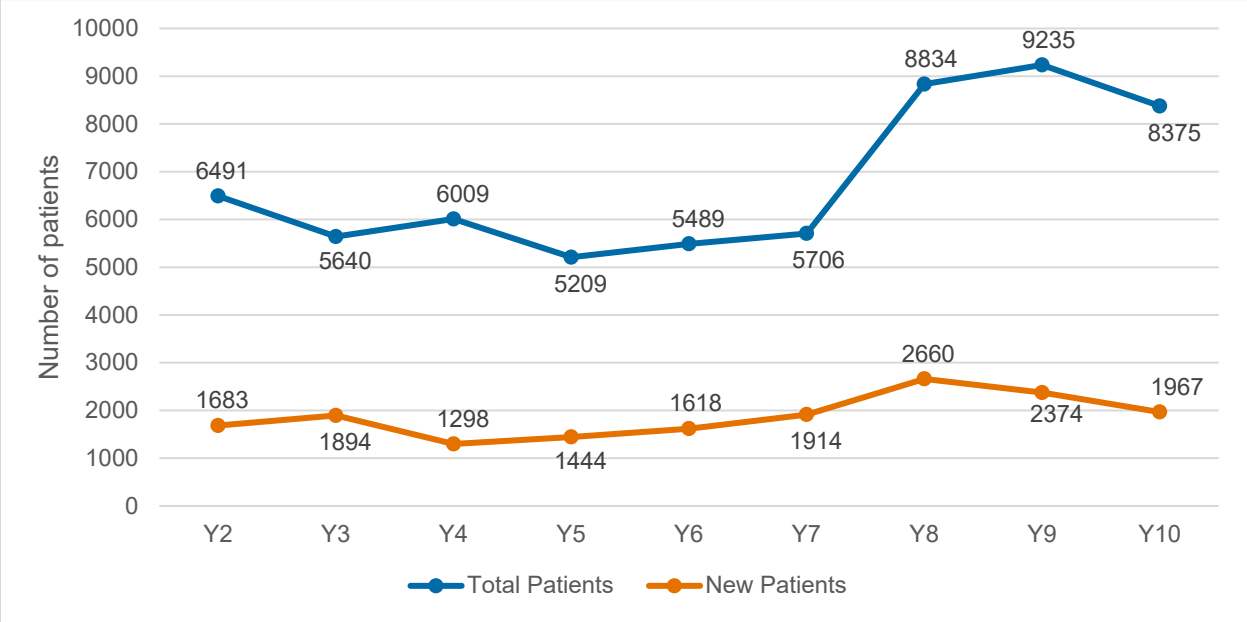
[iii] This total is likely higher, as it accounts only for Years 2 through 10, after standardized administrative data collection was implemented.

The increase in the number of visits between Years 7 and 8, was due to a quadrupling of KC CARE's visits from 1,333 to 5,747. The clinic reported that, as a newly designated FQHC, it faced new standards and guidelines regarding after-hours access and was focused on developing its pediatric practice with access to additional funding. As a result, it expanded capacity by hiring nurse practitioners who were expected to work after-hours shifts and by designing a new scheduling process to more efficiently schedule patient visits. During these years, the other clinic visits grew at a steady rate, and growth continued in Year 9. However, the growth trajectory stopped in Year 10 with the exit of Family Health Care. Without this change in participation and with constant growth rates that continued at the same rate as the prior year, the projected number of after-hours visits in Year 10 would have been 11,400.

The Safety Net Expansion Capacity Project served a total of 60,988 patients in Years 2–10. The growth trend in number of patients parallels that of visits. As indicated in Exhibit 9, the number of patients served annually ranged from a low of 5,209 (Year 4) to a high of 9,235 (Year 9). Following some fluctuation in the early years, the number of patients served increased steadily between Years 4 and 7, with a jump between Years 7 and 8 (5,706 to 8,834). Year 9 saw the largest number of patients, but the number fell in Year 10, at least in part due to the exit of one of the clinics from the program. The Expansion Project would have reached 9,650 patients in Year 10 had all four clinics participated and growth had continued at the same rate as the prior year.

More than one-quarter of patients seen during expanded hours were new patients (16,852, cumulatively) in Years 2–10. The proportion of new patients was highest in Years 7 and 8 (33 and 30 percent, respectively).

Exhibit 9. Safety Net Capacity Expansion Project: Total Number of Patients and New Patients, Years 2–10



Source: Administrative data reported by participating clinics to NORC at the University of Chicago (January 2011—September 2019). Note: Years 2–3 included Samuel U. Rodgers Northland Health Center. Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health.

Location of patients. Participating clinics provided after-hours services in six different locations to residents throughout the metropolitan Kansas City region, spanning 160 zip codes in 43 counties in Kansas and Missouri. The largest concentration of after-hours patients came from Jackson County, followed by Johnson and Wyandotte counties. Approximately 90 percent of patients came from these three counties each year. The remaining 10 percent came from 40 different counties in the metropolitan area.

As shown in Exhibit 10, users of the Expansion Project's after hours drew from 160 zip codes. The maps show the increase in the number of patients between Years 3 and 9 in the zip codes most proximate to the participating clinics. By Year 9, 20 zip codes[iv] each drew about 200–600 after-hours patients to these well-established programs, whereas in the early years, only six zip codes[v] drew several hundred patients; most drew fewer than 100 patients.

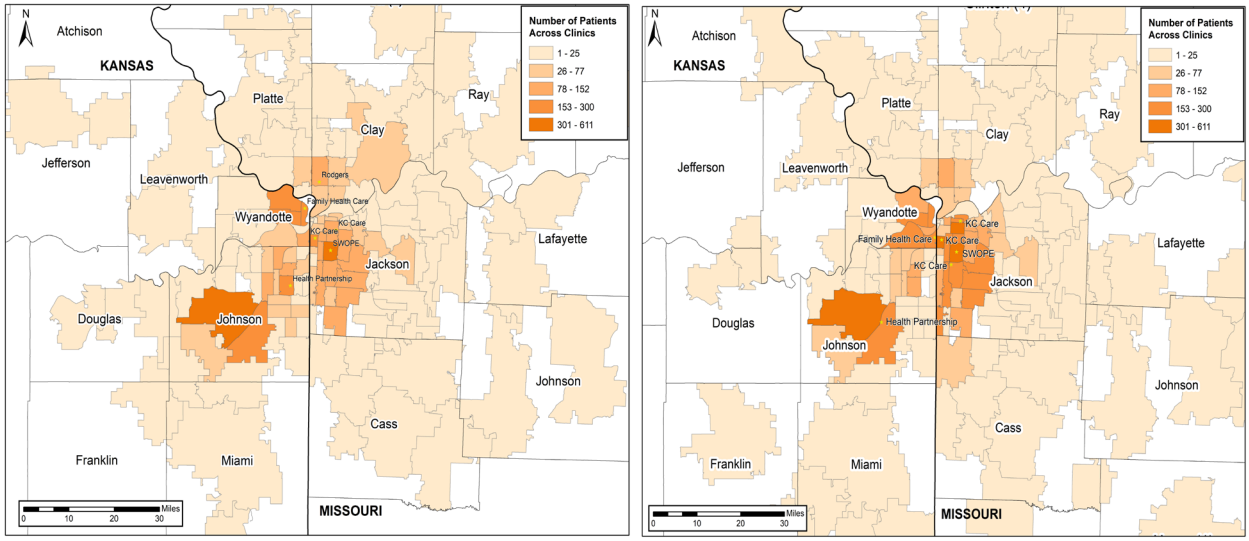
As noted earlier, the changes due to the ACA and the transition to FQHCs encouraged both clinic outreach and patient awareness of available clinic hours. In addition, the broad dispersion of Expansion Project patients across the region suggests that these services fill an important gap in the availability of safety net care. In the concluding focus group, one clinic director noted that

[iv] 66061, 64130, 64127, 64111, 64132, 66062, 64128, 64110, 64131, 64109, 66103, 64134, 66102, 64124, 64138, 64133, 66106, 66101, 64123, 64145

[v] 66061, 64130, 66212, 66062, 66104, 64111

due to gentrification in the clinic's immediate vicinity, a group of patients no longer resided near the clinic.

Exhibit 10. Safety Net Capacity Expansion Project: After-Hours Patients by Zip Code, Year 3 and Year 9

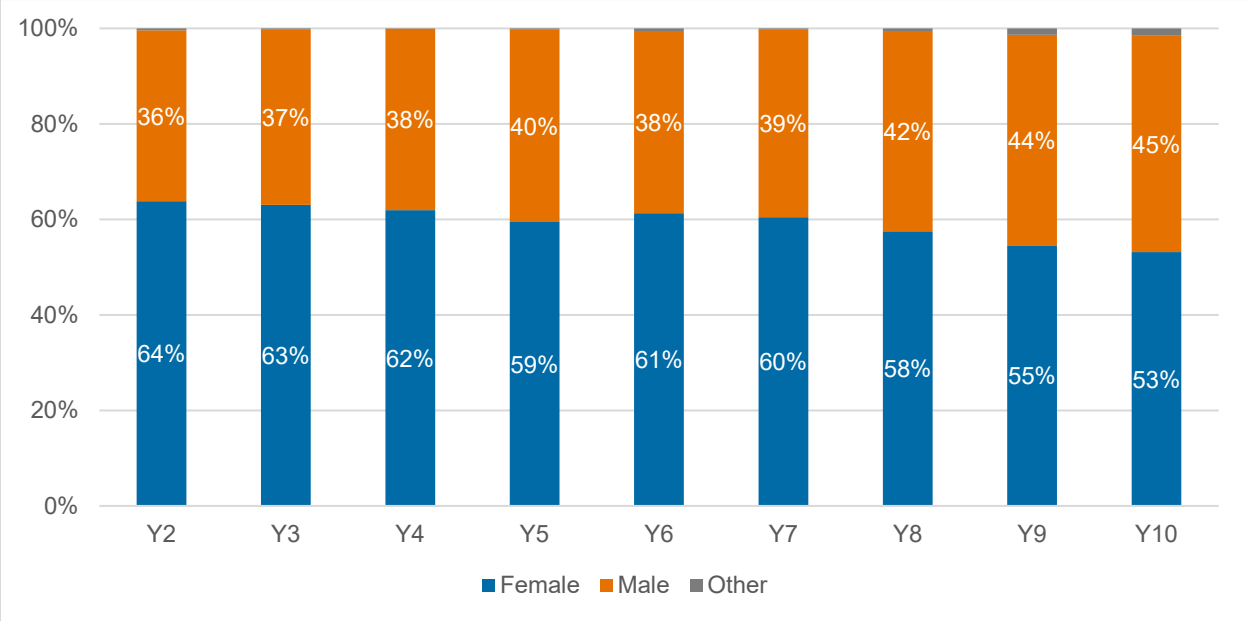


Source: Administrative data reported by participating clinics to NORC (January 2012–September 2018).

Patient Demographics

Patients who sought after-hour services were more likely to be female, but use by males increased over the course of the project. In the Expansion Project's early years, nearly two-thirds of after-hours patients were female. However, as shown in Exhibit 11, the proportion of after-hours patients who were male gradually increased over time. By Year 10, the composition of the patient population by gender was 53 percent female and 45 percent male. Only a few patients in any project year did not report using the existing categories or had an unknown gender.

Exhibit 11. Safety Net Capacity Expansion Project: After-Hours Patients by Gender, Years 2–10

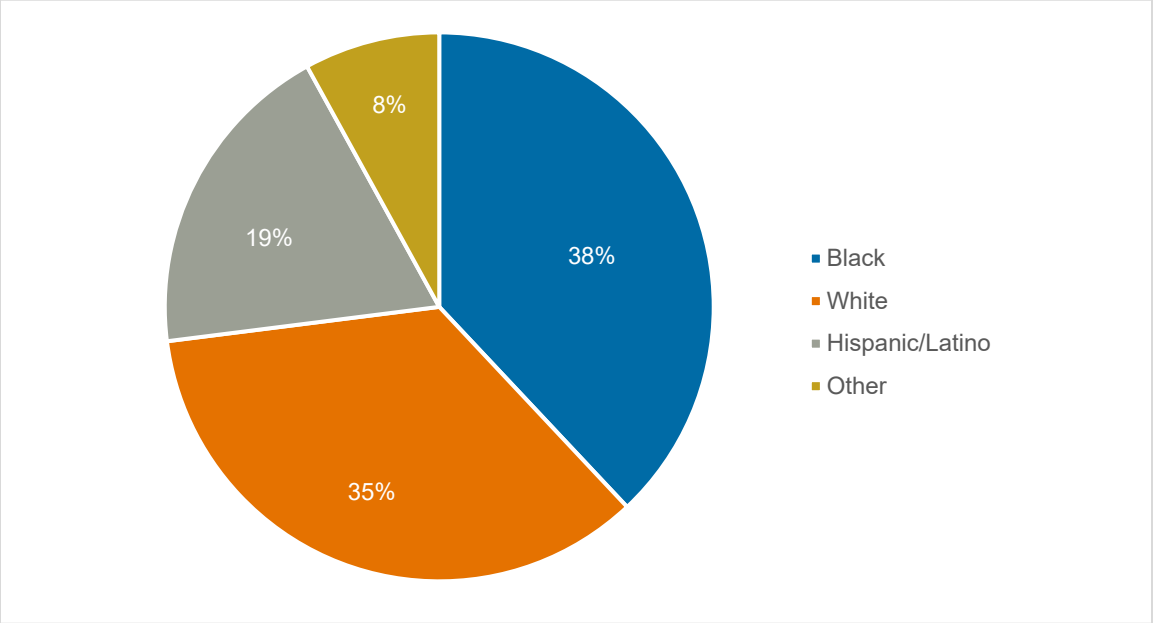


Source: Administrative data reported by participating clinics to NORC (January 2011–September 2019). Note: Years 2–3 included Samuel U. Rodgers Northland Health Center. Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health.

Half of after-hours patients represented racial and ethnic minority groups. The racial and ethnic composition of the after-hours patient population remained fairly constant over the course of the project, and disproportionately included racial and ethnic minority groups when compared to Kansas City's general population. Thirty-eight percent of after-hours patients were black; 35 percent were white, non-Hispanic; and 19 percent were Hispanic. By comparison, the racial and ethnic composition of the population of the three counties the clinics primarily serve – Jackson (Missouri), Johnson and Wyandotte (both in Kansas) – is 17 percent black, 78 percent white, and 11 percent Hispanic.[5] Clinics saw small numbers of Asian Pacific Islanders, American Indians, or Alaska Natives. As described in the Methods section, race and ethnicity data were not reported consistently across clinics, and over time, individual clinics changed their

processes for collecting and reporting these data. Any interpretations made from these data should be done with these limitations in mind.

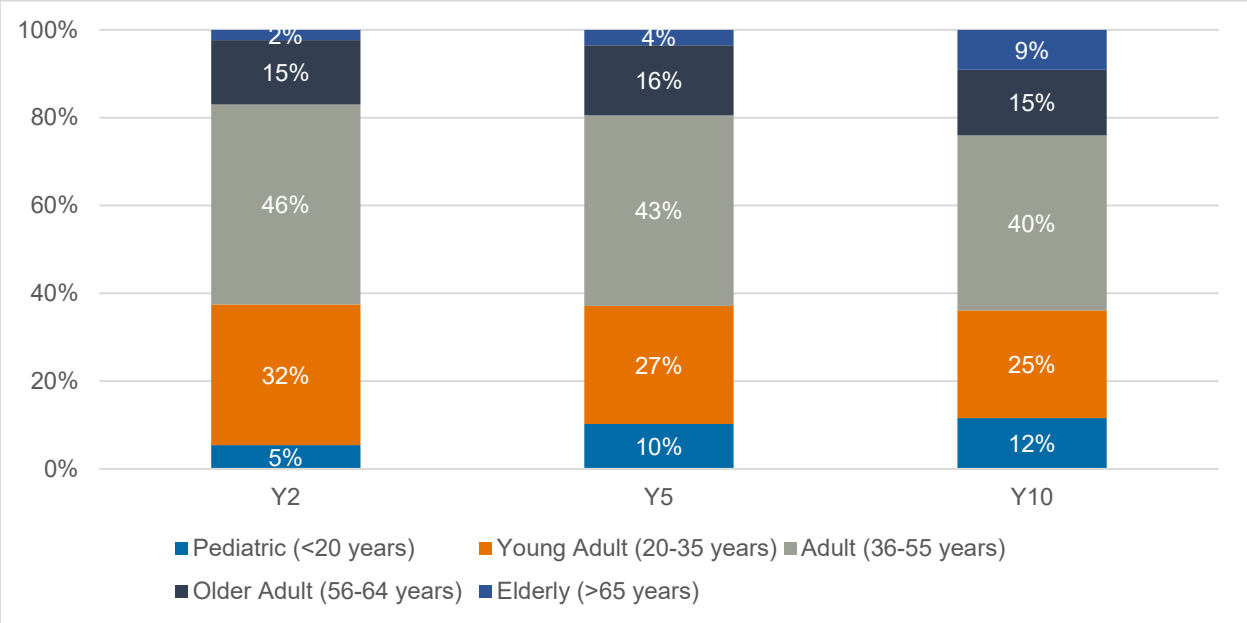
Exhibit 12. Safety Net Capacity Expansion Project: After-Hours Patients by Race and Ethnicity, Years 2–10



Source: Administrative data reported by participating clinics to NORC (January 2011–September 2019). Note: Years 2–3 included Rodgers. Swope Health did not report Hispanic/Latino patients until Year 8. Family Health Care did not report race/ethnicity at all.

Adult patients age 36 to 55 composed the largest proportion of after-hours patients, at 40 to 46 percent each year of the program. As shown in Exhibit 13, the proportion of patients who were adult (36 to 55 years old) or older adult (56 to 64 years old) remained consistent over the course of the project. Young adults (20 to 35 years old) declined from 32 percent of the patient population at the beginning of the project to 25 percent in the last year.

Exhibit 13. Safety Net Capacity Expansion Project: Patients by Age, Years 2, 5, and 10



Source: Administrative data reported by participating clinics to NORC (January 2011–September 2019). Note: Year 2 included Rodgers. Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health.

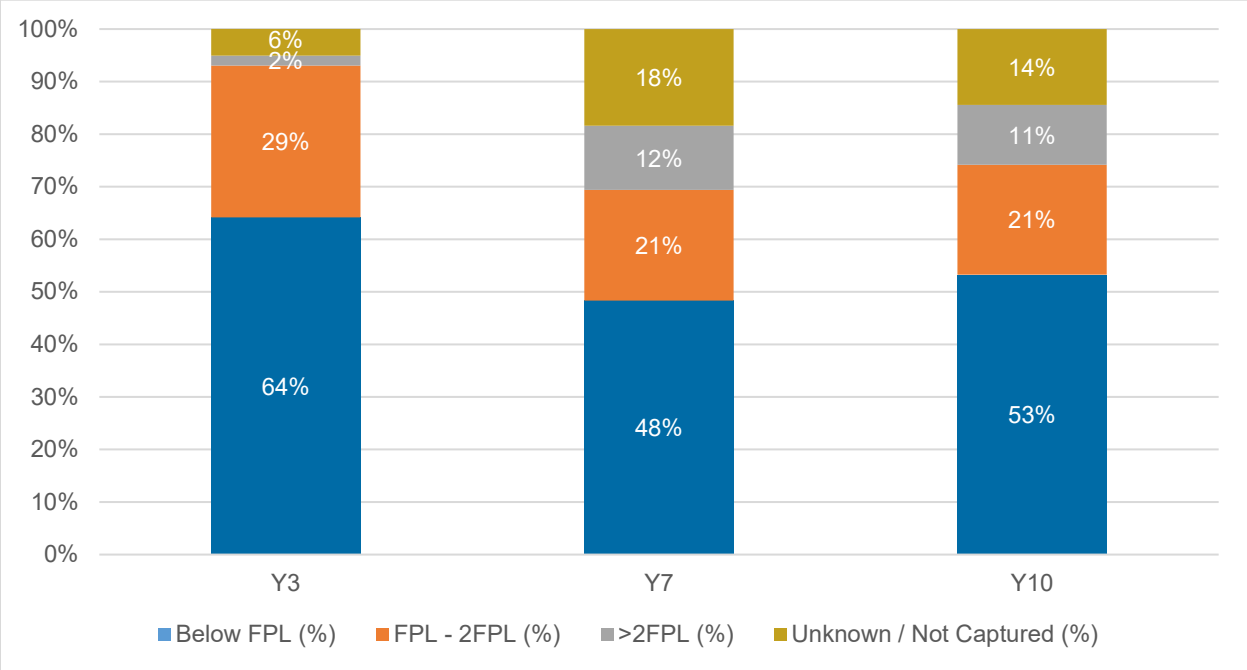
Elderly adults and pediatric patients had similar trajectories. At the beginning of the program, elderly adults composed just 2 percent of after-hours users and increased to 9 percent by the end of the program. Similarly, pediatric patients were 5 percent of the patient population in Year 2 and grew to 12 percent by the end of the project. The gradual growth in elderly patients may be due to aging of existing patients at the clinic. It may also be that expanded hours made it possible for working family members, on whom elderly patients may rely for transportation, to take them to the clinic.

The growth in pediatric patients may be associated with the expansion of regular pediatric programs to the after-hours program in three of the four safety net clinics. When the clinics became FQHCs, pediatric patients were more likely to have coverage through Medicaid or CHIP and elderly patients through Medicare or both Medicare and Medicaid, resulting in more billable encounters for these clinics.

The proportion of patients with incomes below the FPL fluctuated over the course of the evaluation, with a high of three-quarters (Year 3) and a low of less than half (Year 7). While the Expansion Project targeted patients below 200 percent of the FPL, the proportion of after-hours patients whose incomes were at least two times the FPL (>2FPL) increased significantly over the life of the project, from 2 percent in Year 2 to 11 percent in Year 10 as shown in Exhibit 14. The overall distribution of patients who use the after-hours clinics is similar to the national distribution of patients who use FQHCs.[6] After Year 5, clinics reported a higher percentage of after-hours patients whose incomes were two times the FPL; this was

partially caused by lack of Medicaid expansion in both Kansas and Missouri, which created a challenging environment for patients and providers.[7]

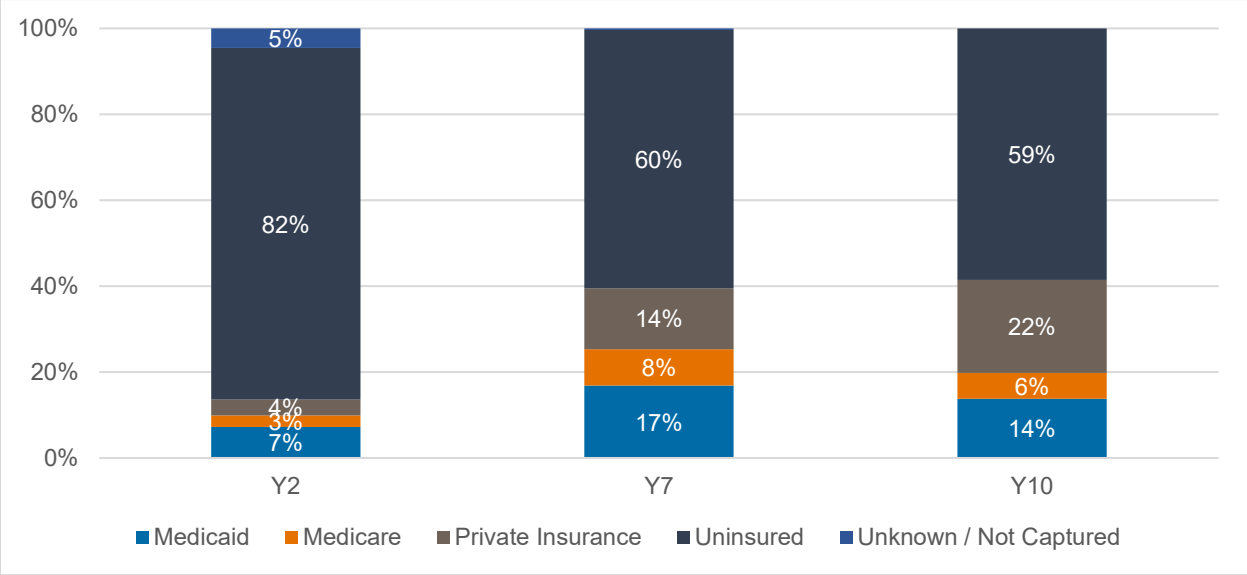
Exhibit 14. Safety Net Capacity Expansion Project: Patient by Income Status, Years 3, 7, and 10



Source: Administrative data reported by participating clinics to NORC (January 2011–September 2019). Note: Year 3 included Rodgers. Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health.
FPL: Federal Poverty Level; 2FPL: two times the Federal Poverty Level

The proportion of uninsured after-hours patients decreased from 82 percent in Year 2 to 59 percent in Year 10. Exhibit 15 shows the shift in the insurance status of after-hours clinic patients from Year 2 to Year 10. Paralleling changes in income status (see Exhibit 14), the proportion of patients with coverage (public or private) increased over the course of the project, and the proportion of uninsured patients decreased significantly and has been stable since Year 7.

Exhibit 15. Safety Net Capacity Expansion Project: Patients by Insurance Status, Years 2, 7, and 10



Source: Administrative data reported by participating clinics to NORC (January 2011–September 2019). Note: Year 2 included Rodgers. Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health.

When the Expansion Project began in 2009, the ACA was still being debated in Congress, and none of the participating clinics were designated FQHCs. They operated mostly as free clinics for the uninsured. Therefore, it is not surprising that the insurance status of the patient population changed during the course of the project. As with income, there was a shift in the insurance status of the patient population from Year 4 to Year 5. The percent of patients with private insurance increased from 2 percent in Year 4 to 13 percent in Year 5. By Year 9, three of the four participating clinics had become FQHCs that provide care on a sliding fee scale but are prohibited from denying care if patients are unable to pay. Clinic directors noted in the focus group at the conclusion of the project that the legacy of being a free clinic is strong, as some patients still expect the care to be free of charge.

Findings: Care Needs of After-Hours Patients and Care Delivery

At the start of the Safety Net Capacity Expansion Project, 44 percent of patients seen during expanded hours did not have a regular source of care. Over the course of the project, all clinics reported a high prevalence of chronic illness, noting that the needs of the after-hours population reflected those of their general clinic populations.

Patient-Centered Medical Home (PCMH)

The National Committee for Quality Assurance (NCQA) recognizes practices that achieve the values of the Joint Principles of the PCMH:

1. Personal physician
2. Physician-directed medical practice
3. Whole person orientation
4. Care is coordinated and/or integrated
5. Quality and safety
6. Enhanced access to care
7. Payment

The complexity of patients' clinical and social needs called for significant time from providers to assess and address health concerns during visits. To this end, clinics employed the principles of patient-centered medical homes (PCMH).[8] A few participating clinics became certified around the time that the grant started and others later on. These initiatives were supported by the state primary care associations. Clinics described the impact of PCMH in their annual reports to Health Forward. For example, one clinic reported at the end of Year 5 that "working on PCMH has helped transform the [clinic] culture to help staff see the value of evening and weekend clinics." In multiple years, clinics reported not simply improved access, but quality improvements and new services.

In this section, we present results from our analysis of quarterly administrative data that clinics reported to evaluators, focus groups with clinic directors, as well as data that clinics reported to Health Forward in their interim and annual reports. We describe the clinical needs of patients served during expanded hours, the types of care patients received, and clinics' performance relative to benchmarks on project-specific outcomes.

Clinical Needs and Care Delivery

Patients presented during expanded clinic hours with diverse clinical needs. In this section, we highlight common diagnoses and chronic disease burden reported by clinics. Understanding the clinical needs of expanded-hours patients provides important context for interpreting the types of office visits performed at clinics.

Common Diagnoses. The top 10 diagnoses reported by clinics accounted for just more than half (57 percent) of the 10,115 visits provided in Year 10 and are consistent with those reported throughout the project (see Appendices F and G). Clinical needs included chronic conditions as well as various routine consultations and examinations.

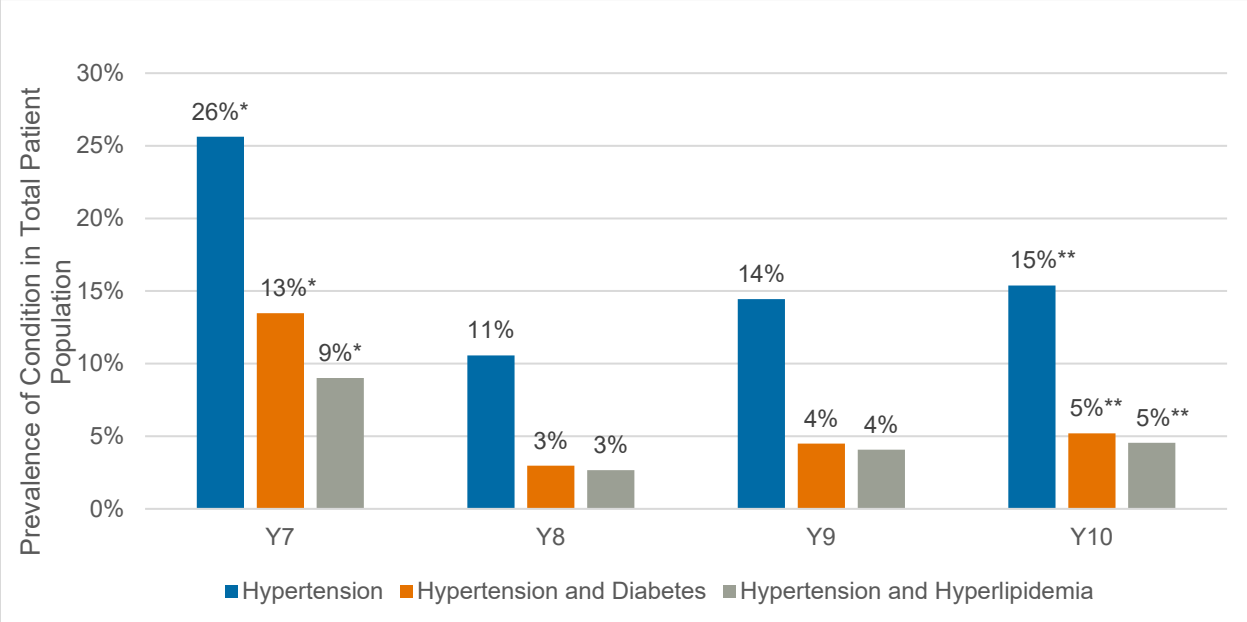
- The most **common chronic condition diagnoses** included hypertension (14 percent), diabetes mellitus (8 percent), disorders of lipoid metabolism (4 percent), and asymptomatic HIV infection (3 percent).
- **Common medical examinations** included a variety of vision, hearing, dental, gynecological, pregnancy, skin, radiological, laboratory, and other tests (special investigations and examinations—9 percent); general medical exams (4 percent); consultations (4 percent); and vaccinations (4 percent).
- Two **behavioral health diagnoses**—nondependent drug abuse[vi] (4 percent) and episodic mood disorders (3 percent)—were also among the top 10 diagnoses.

These trends correlate with national data regarding the most common diagnoses seen during outpatient visits.[9]

Chronic Disease Burden. Hypertension and hypertension with comorbidities of diabetes or hyperlipidemia were prevalent conditions among after-hours patients. Exhibit 16 shows clinic-reported data on these complex chronic conditions. Over time, these patients with these conditions composed a smaller proportion of the clinics' patient populations; however, as the total number of patients seen during expanded hours increased so too did the number of patients with these chronic conditions (not shown). This suggests that clinics experienced continued growth in complex patients who may have greater needs over time.

[vi] The general category "nondependent drug abuse" includes alcohol, tobacco, cannabis, hallucinogens, sedatives, hypnotics, anxiolytics, opioids, cocaine, amphetamine, antidepressant, and other mixed or unspecified drug abuse.

Exhibit 16. Safety Net Capacity Expansion Project: Prevalence of Hypertension, Hypertension with Diabetes, and Hypertension with Hyperlipidemia, Years 7–10



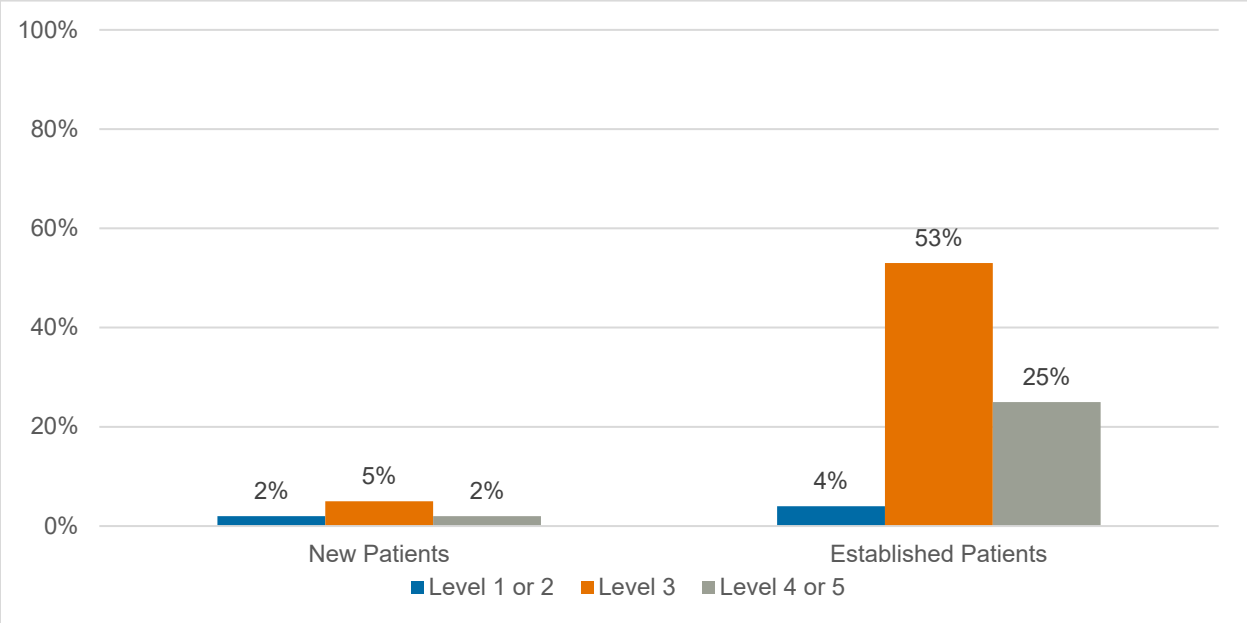
Source: NORC analysis of Safety Net Capacity Expansion Project grantees' annual reports to Health Forward Foundation, 2019.

Notes: Clinics started collecting data on chronic conditions starting in Year 7. *Year 7 only included three participating clinics: KC CARE, Swope Health, and Family Health Care. Health Partnership did not report data. **Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health. Family Health Care did not report data.

Office Visits during Expanded Hours. Throughout the 10 years of the Expansion Project, most visits were with established clinic patients. Visits tended not to be minimal visits of 5 to 10 minutes for an acute problem. Rather, they were either Level 3, a visit of 15 minutes and low complexity, or Level 4, a 25-minute, moderate-to-high-complexity visit, addressing one or two chronic conditions. The administrative data indicate that in Year 10 (see Exhibit 17), over three-quarters of expanded hours visits were Level 3 or 4/5 with established patients (53 and 25 percent, respectively).

In focus groups, clinic directors reflected that during expanded hours, patients' complex, chronic needs are treated, not simply urgent care issues.

Exhibit 17. Safety Net Capacity Expansion Project: Common Types of Office Visits, Year 10



Source: Administrative data reported by participating clinics to NORC (October 2018–September 2019). Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health. Note: Levels 1 and 2 are visits of minimal length for 5 to 10 minutes face-to-face; Level 3 are low-level visits of 15 face-to-face minutes to address a few minor problems or one stable chronic condition, and Level 4 or 5 visits are moderate to high complexity with 25 minutes or more face-to-face.

The high proportion of Level 3 and Level 4 visits among these clinics supports the finding that the after-hours visits were not for acute problems. Not surprisingly, clinic directors and clinicians remarked that they often spent more time with patients during after-hours visits and often provided services that other staff would provide during regular office hours. They noted that after-hours providers filled the roles of case manager, social worker, and mental health counselor and performed tasks that included both medical (medication, referrals, and access to specialty care) and social service supports (helping patients access food, housing, utility assistance).

Clinical Outcomes

Midway through the project, clinics began reporting on a set of preventive care measures, with agreed-upon goals for care delivery. In addition, clinics collected and reported data on health care use that are commonly regarded as drivers of health care costs. In this section, we present results from our synthesis of these measures that clinics reported to Health Forward and highlight trends and variation in outcomes.

Preventive Care

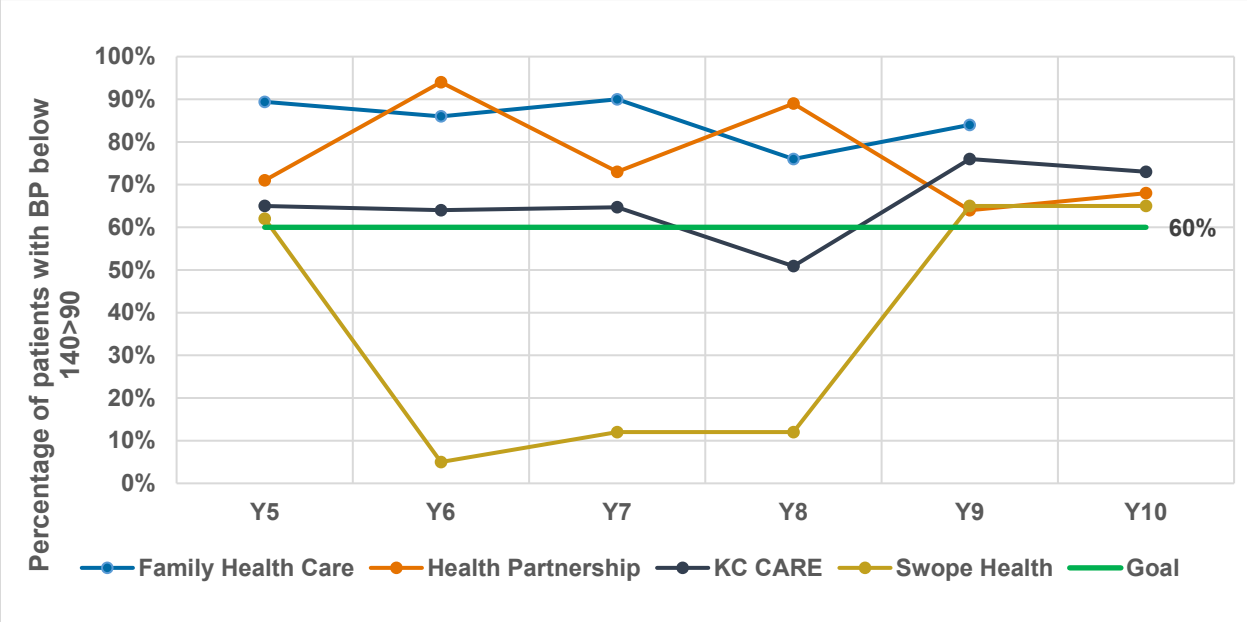
Over the years the indicators were tracked, most clinics exceeded established preventive care goals for blood pressure, mental health screening, and tobacco screening and counseling.

Blood Pressure. Clinics tracked the proportion of patients with hypertension whose blood pressure was less than 140/90, the Healthcare Effectiveness Data and Information Set (HEDIS) measure for controlled blood pressure [10], shown in Exhibit 18.

- Three of the four participating clinics exceeded the 60 percent goal in almost all years.
- Two clinics (Health Partnership and Family Health Care) achieved rates of 90 percent three years in a row.
- During the same period, Swope Health reported very low rates, but by Year 9 had also exceeded the goal. The clinic's director noted that diabetes and hypertension were among the most common diagnoses for their after-hours patients and that these patients may have utilized the clinic visit to receive medication refills.

Nonetheless, it is clear that it is not easy for clinics to help their patients maintain blood pressure control. These data suggest that the shifting health care environment may have affected access to blood pressure medication among established patients while new patients may have been in poorer health, challenging clinics to meet their prevention goals.

Exhibit 18. Safety Net Capacity Expansion Project: Proportion of Patients with Controlled Blood Pressure, Years 5–10

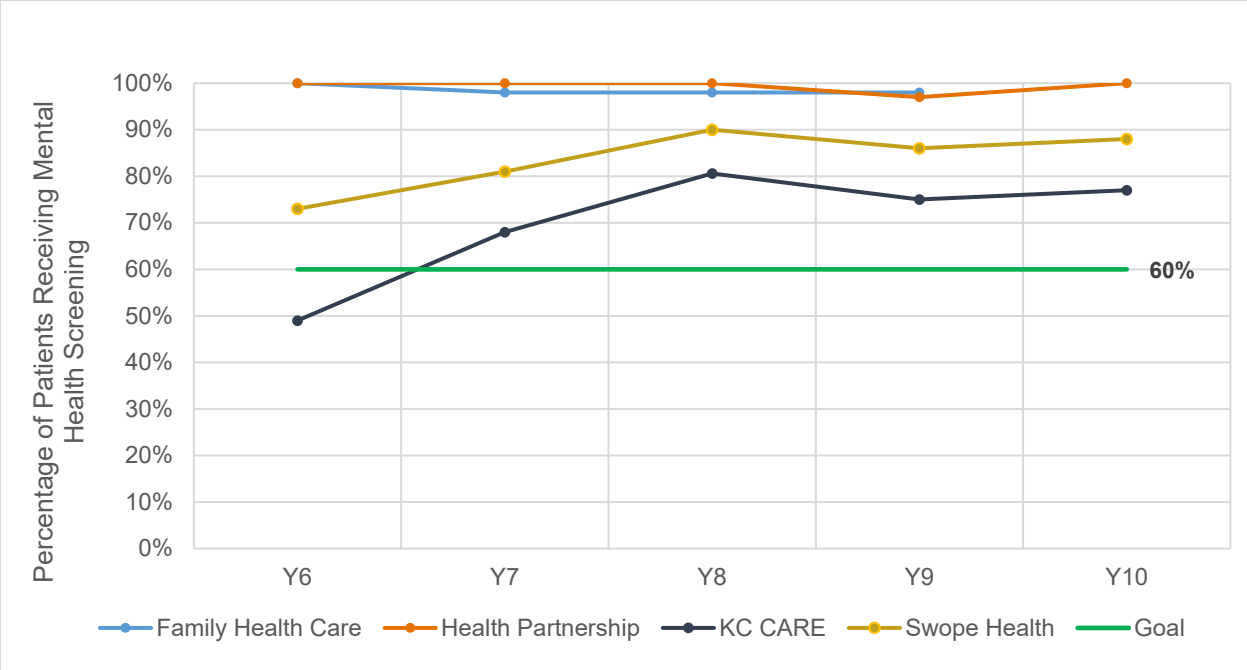


Source: NORC analysis of Safety Net Capacity Expansion Project grantees' annual reports to Health Forward Foundation, 2019.
Note: Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health.

Mental Health Screening. Patients receiving care through the Expansion Project were screened for mental health concerns. Exhibit 19 shows how all clinics achieved high screening rates in Years 7–10, far exceeding the goal of 60 percent. Clinics' mental health screening rates ranged from 77 to 100 percent in the last years of the project. Clinics also described providing follow-up screenings using a range of instruments for depression once patients were identified.

This was a notable accomplishment for these clinics, highlighting that they saw after-hours as an important chance to address their patients' needs comprehensively. One director noted "recognizing you are moving patients away from the one off-visit, so you really need to invest and think it as the outreach opportunity."

Exhibit 19. Safety Net Capacity Expansion Project: Proportion of Patients Receiving Mental Health Screening, Years 6–10



Source: NORC analysis of Safety Net Capacity Expansion Project grantees' annual reports to Health Forward Foundation, 2019.
Note: Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health.

Tobacco Use Screening and Smoking Cessation Counseling. Tobacco screening and counseling rates varied across clinics. At the conclusion of the project, the clinics screened most patients and provided counseling to many tobacco users. Exhibit 20 highlights these clinics' respective success achieving high rates of screening or counseling or both.

- Two clinics (Family Health Care and Health Partnership) achieved consistently high levels of screening, with values greater than 90 percent.
- Two clinics (KC CARE and Swope Health) began with lower rates (57 and 28 percent respectively) but improved steadily, achieving screening rates of 84 and 80 percent, respectively, by Year 10.
- The proportion of positively screened patients who were counseled varied considerably. Family Health Care reported the highest rates of follow-up, followed by Health Partnership, KC CARE, and Swope Health. One clinic attributed its reported low rates to problems with how the EHR documented follow-up and referral needs.

Exhibit 20. Safety Net Capacity Expansion Project: Proportion of Patients Receiving Tobacco Screening and Tobacco Cessation Counseling, Years 7–10

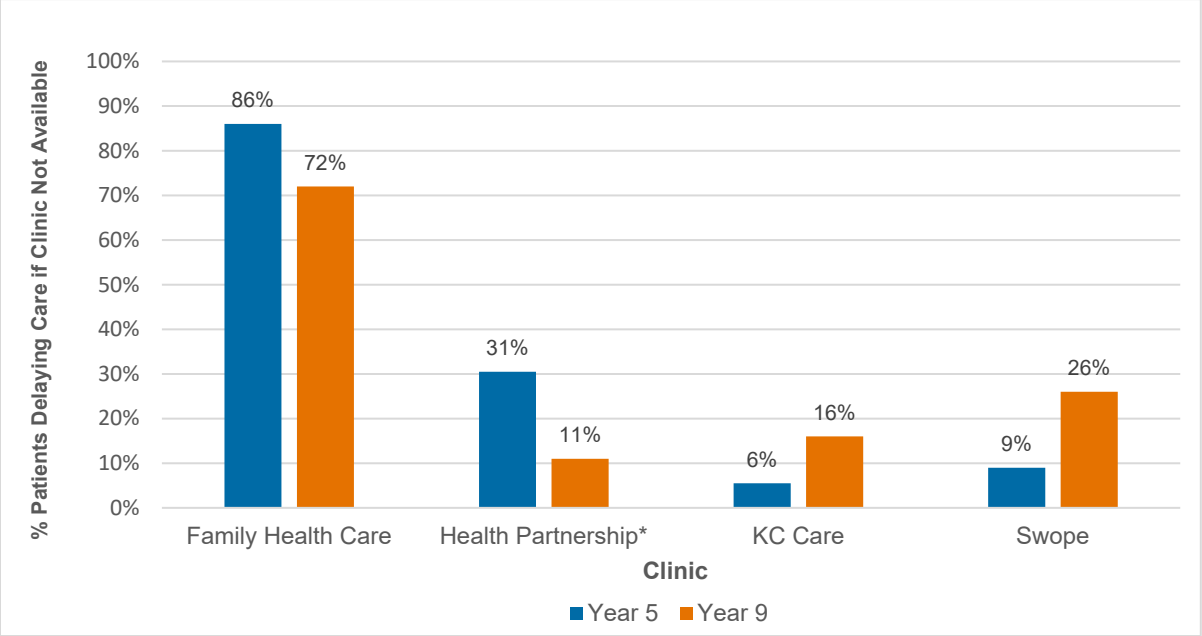
	Year 7		Year 8		Year 9		Year 10	
	% of Patients							
	Screened	Once screened, counseled	Screened	Once screened, counseled	Screened	Once screened, counseled	Screened	Once screened, counseled
Family Health Care	96%	84%	96%	84%	96%	84%	N/A	N/A
Health Partnership	N/A	N/A	100%	53%	91%	100%	100%	100%
KC CARE	57%	45%	75%	38%	86%	60%	84%	86%
Swope Health	28%	7%	49%	19%	60%	28%	80%	39%

Source: NORC analysis of Safety Net Capacity Expansion Project grantees' annual reports to Health Forward Foundation, 2019.
Note: Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health.

Emergency Room Use and Delayed Care

In response to illness, individuals who are uninsured, underinsured, or who lack a regular source of care may choose to delay care or use the emergency department instead of seeking care at a primary care clinic or office. In fact, data on the inappropriate use of emergency departments as well as the costs associated with preventable hospitalizations have long formed the basis for arguments that expanded insurance coverage reduces health care costs.[11] In order to assess the role of the Expansion Project in preventing more costly care, participating clinics tracked patient-reported measures of where they would seek care if expanded-hours clinics were not available: delay care (Exhibit 21) or go the emergency room (Exhibit 22).

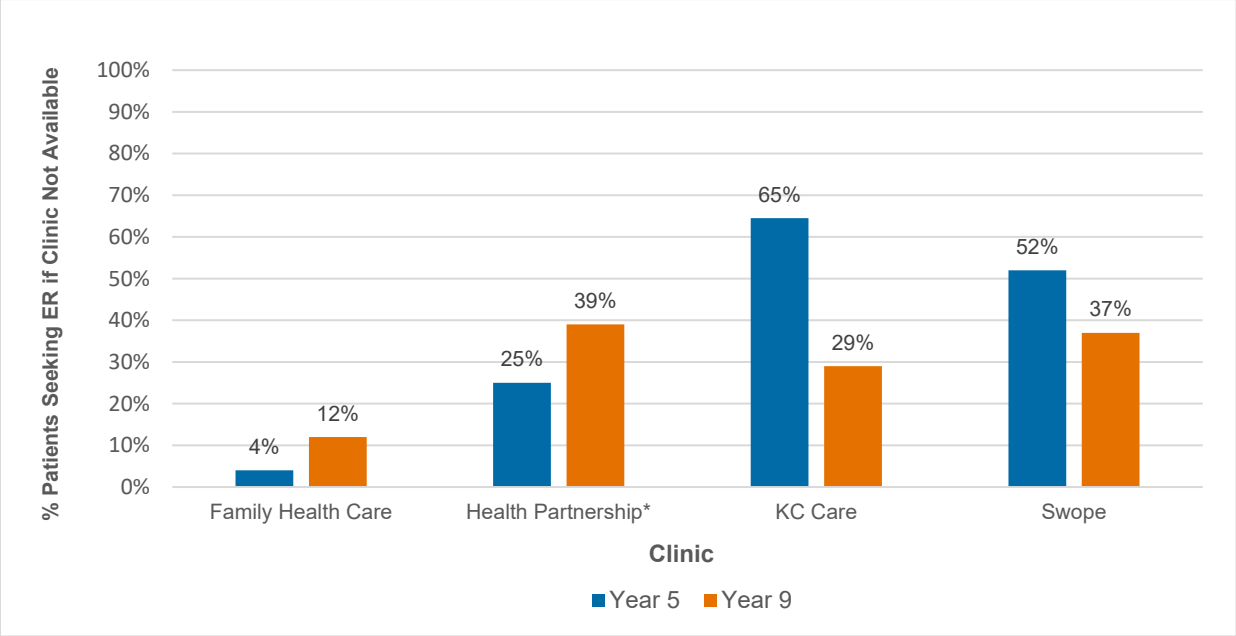
Exhibit 21. Safety Net Capacity Expansion Project: Percent of Patients Who Would Delay Care if Expanded Hours Clinics Were Not Available, Year 5 and Year 9



Source: NORC analysis of Safety Net Capacity Expansion Project grantees' annual reports to Health Forward Foundation, 2019.
Note: *Year 6 data was used for Health Partnership, as Year 5 data was not available.

The percent of patients who reported they would have **delayed care** ranged from 6 percent to 86 percent in Year 5 and from 11 percent to 72 percent in Year 9. The percent reporting they would have delayed care decreased in two of the clinics and increased in the other two. Family Health Care was an outlier, with a very high percentage of patients reporting they would have delayed care.

Exhibit 22. Safety Net Capacity Expansion Project: Percent of Patients Who Would Visit Emergency Room if Expanded Hours Were Not Available, Year 5 and Year 9



Source: NORC analysis of Safety Net Capacity Expansion Project grantees' annual reports to Health Forward Foundation, 2019.
Note: *Year 6 data was used for Health Partnership, as Year 5 data was not available.

The percent of patients who would have **gone to the emergency room** ranged from 4 percent to 65 percent in Year 5 and from 12 percent to 39 percent in Year 9. The percent reporting they would have gone to the emergency room decreased in two of the clinics and increased in the other two. Again, Family Health Care was an outlier, with a very low percentage of patients reporting they would have visited the emergency room.

Given that many individual and market factors influence access to care and emergency room utilization, these data may not fully reflect the impact of the project, but they provide some insight. Taken together, they show that in the second-to-last year of the project, after-hours care was an important alternative to the emergency room and reduced potentially costly delays in care, although some patients may still rely on the emergency room for primary care.

Findings: Clinics' Implementation of Expanded Hours

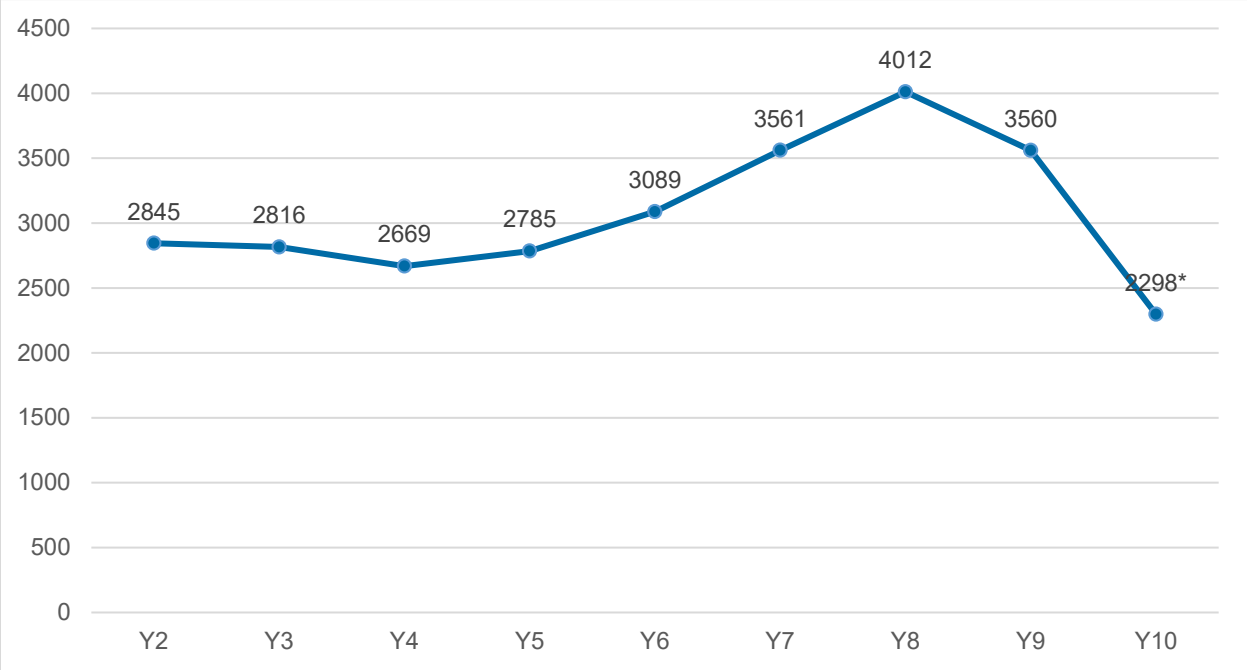
Over 10 years, the Safety Net Capacity Expansion Project supported an additional 27,600 early morning, evening, and weekend clinic hours in greater Kansas City. By the conclusion of the program, after-hours care was fully integrated into clinic operations and, in some cases, expanded to additional locations.

In this section, we describe trends in both the number of hours and different days and times at which expanded hours were provided throughout the project. We also report on the mix of providers clinics employed to staff expanded hours. We conclude with a financial analysis of grantees' annual spending reports.

Hours

The Expansion Project has provided a total of 27,634 hours of expanded-access clinic hours over 10 years. As indicated in Exhibit 23, the number of hours increased steadily from Year 2 to Year 8, from 2,845 to 4,012 hours, respectively. The number of hours decreased in Year 9, falling to the level reported in Year 7. Hours continued to decrease in Year 10 at least in part due to the exit of one of the clinics from the program. As one medical director commented during the focus group, the integration of the after-hours program into clinic operations results in availability that reflects overall clinic capacity rather than demand or even possibly optimal access for patients.

Exhibit 23. Safety Net Capacity Expansion Project: Expansion Project Clinic Hours, Years 2–10



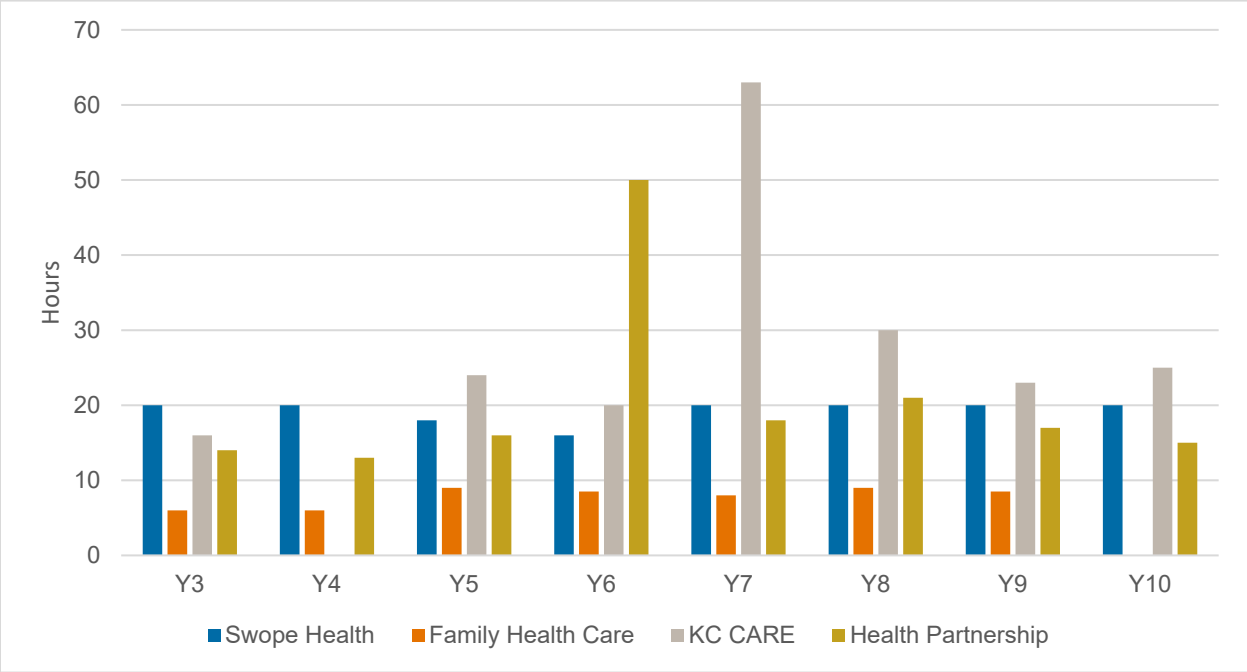
Source: Administrative data reported by participating clinics to NORC (January 2011–September 2019).

Note: Years 2–3 included Rodgers. *The hours in Year 10 are based only on three participating clinics: Health Partnership, KC CARE, and Swope Health, as Family Health Care had exited the program.

The Expansion Project provided, on average, 20 hours per week of expanded access. While clinics and locations differed, many of the hours were after work, with clinics remaining open until around 7:00 pm or opening before 9:00 am on weekdays. With the exception of Swope Health, clinics also provided Saturday hours at least twice a month.

Throughout the project years, the number of expanded hours offered by each clinic varied. For example, Exhibit 24 shows that the number of weekly hours offered by Swope Health and Family Health Care was relatively consistent and grew modestly while KC CARE and Health Partnership expanded mid-project and then stabilized in the last few years. In focus groups, clinic directors described how they experimented with when and where to offer after-hours care. Some clinics shifted from early morning to evening visits whereas others targeted pediatric walk-in patients in the morning, and this bears out in the data.

Exhibit 24. Safety Net Capacity Expansion Project: Number of Weekly Hours, Years 3-10



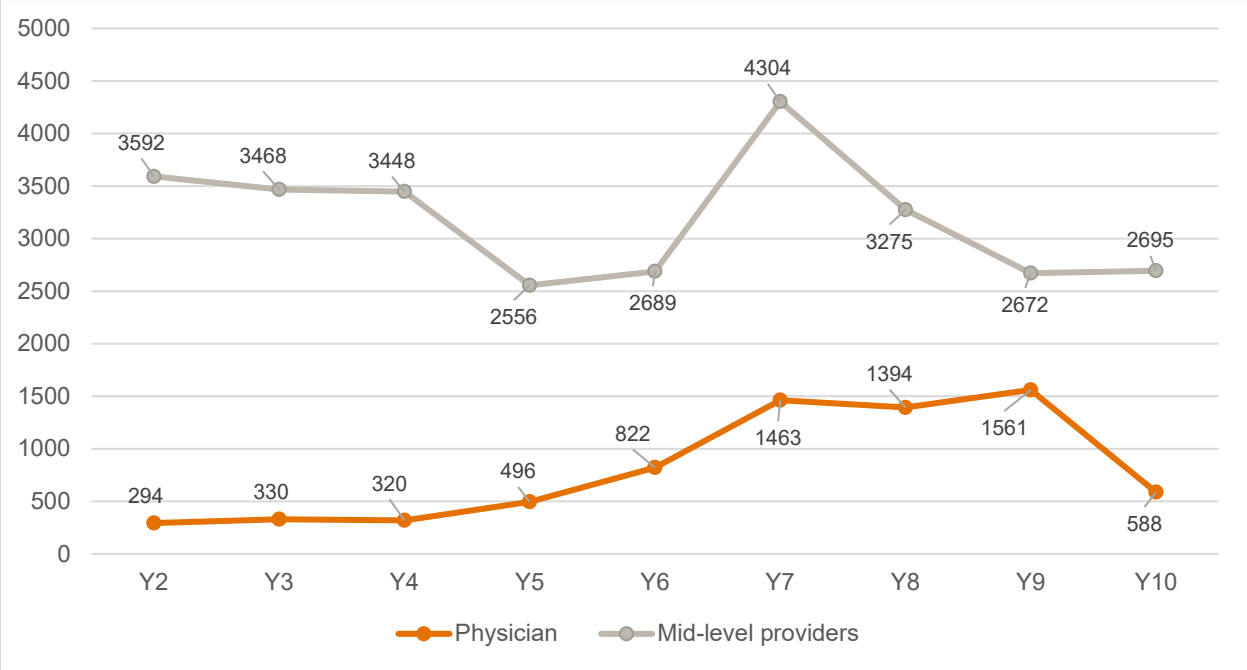
Source: Administrative data reported by participating clinics to NORC (October 2013–September 2018).

Notes: Year 4 only included three participating clinics: Health Partnership, Swope Health, and Family Health Care. Year 5 did not have full year hours information for Swope Health and KC CARE. Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health.

Staffing

Between Years 2 and 10, the Expansion Project supported 35,967 provider hours. Overall, 28,699 hours (80 percent of all provider hours) were provided by mid-level clinicians (e.g., practical nurses, advanced practice registered nurses, physician assistants) and 7,268 (20 percent of all provider hours) by physicians. This distribution shifted over the duration of the project. The share of mid-level hours started at 92 percent in Year 2 and gradually dropped to 63 percent in Year 8. The share of hours provided by physicians started at 8 percent in Year 2 and peaked at 37 percent in Year 9. In the final year of the project, the number of physician hours significantly dropped. This was due in part to the exit of one clinic that primarily used physicians to staff after-hours clinics. These staffing dynamics reflect both clinic experimentation and the ongoing integration of after-hours capacity.

Exhibit 25. Safety Net Capacity Expansion Project: Number of Hours Staffed by Physicians and Mid-Level Providers, Years 2–10



Source: Administrative data reported by participating clinics to NORC (January 2011–September 2019). Note: Years 2–3 included Rodgers. Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health.

As shown in Exhibit 25, the total number of provider hours peaked in Year 7 and then dipped in Years 8 and later, despite an increase in number of visits during the same period (see Exhibit 8). Interviews with administrative staff, providers, and patients at that time suggested that mid-level providers spent a substantial amount of time with their patients, and these data on number of hours may reflect that practice. Clinicians noted that they intentionally spent 20–30 minutes with each patient in an effort to review other health concerns, identify potential comorbidities, and convey important health information. Since patients may not visit the clinic until they are already acutely ill, each visit presented an opportunity to also provide preventive care to patients. This is supported by findings that the most common types of office visits that clinics bill during afterhours are Level 3 and 4 (see Exhibit 17). In addition, clinic administrators indicated that staffing changes occurred at multiple locations during that period and the addition of new staff may have contributed to this shift.

Staffing Issues. Clinic administrators noted that meeting their after-hours staffing needs was often a challenge. Since the passage of the ACA, there has been increased competition for all levels of clinic staff, especially as hospital systems increased their provision of primary care to patients covered by Medicaid. Over the course of the evaluation, clinics relied on a mix of employed staff and volunteers. Diversified staff roles and new hires have helped to

In annual reports, grantees indicated clinic staff reflected the diversity of their patient populations in terms of racial or ethnic group or language. One clinic notes that diversity across the organization's staff and board was "a resource to diverse patient populations."

maintain more consistent hours or, for some clinics, expand service hours for evening care.

The utilization of **mid-level providers** allowed the clinics to increase their hours of patient care at reduced expense compared to physician costs. As noted in Family Health Care's Year 8 Final Report, in particular, the clinic leaned heavily on the work of support staff, noting that in Year 8, salary costs included nine practitioner hours and 32 support staff hours. There were some instances, early in the project, in which clinics shared staff that no one alone could hire on a full-time basis.

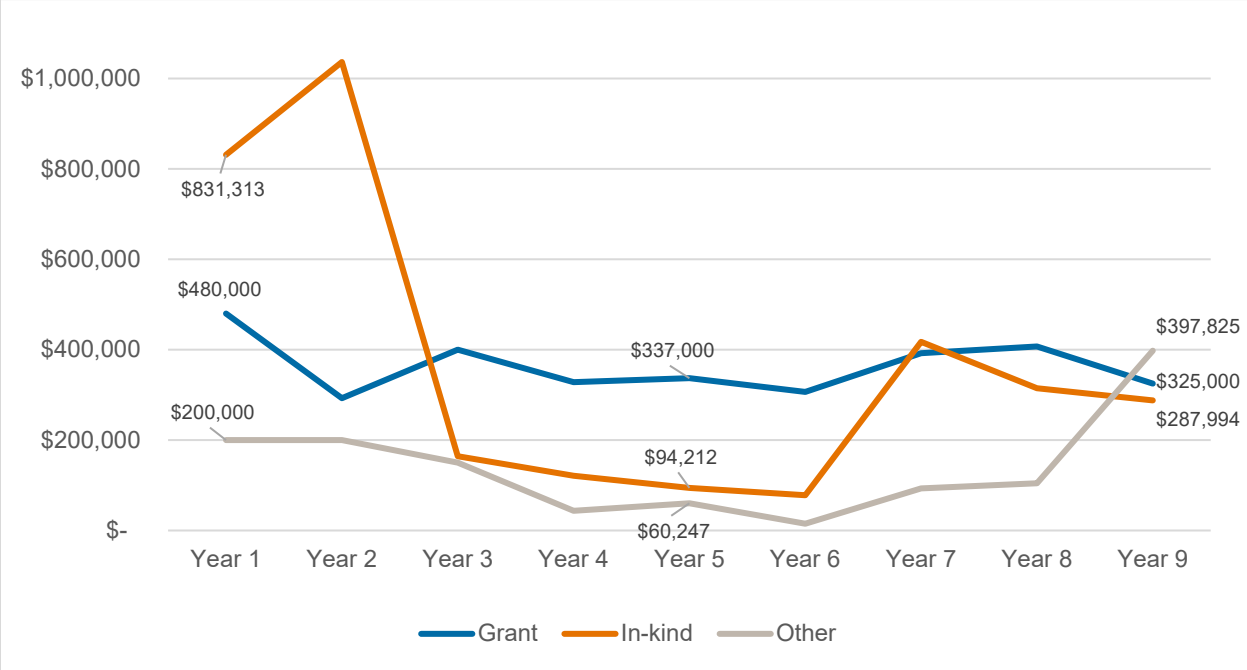
Early in the project, **volunteer providers** and medical students played an important role in the delivery of after-hours care. In-kind staff increased available capacity beyond the grant-funded amount and provided access to a range of specialty care (e.g., cardiology, chiropractic), as well as specialized services (e.g., diabetic support group through a volunteer pharmacist, walk-in clinic with a volunteer registered nurse for patients with sexually transmitted infections). As clinics transitioned from free clinics to FQHCs, the role of volunteer providers lessened.

Financial Analysis

With each interim and annual report, clinics provided a budget and narrative to describe their income and expenses over the course of the Expansion Project. The grant provided base funding to the clinics to staff the additional clinic hours, and from the beginning, the clinics supplemented the grant with in-kind donations and other sources.

Exhibit 26 presents total revenue by type for all clinics across Years 1–9. Grant funding remained relatively stable across the years, with a slight dip in Year 2 after the initial start-up. Interestingly, this corresponded with a peak in in-kind revenue that may reflect a different method for calculating clinic contributions when the project operated regionally and all clinic reporting was in the aggregate. As a result, we observe a sharp decrease in the in-kind revenue category from Year 2 ($1,036,518) to Year 3 ($164,328). Over the course of the project, the level of in-kind support needed to maintain the after-hours program was equal to a low of 28 percent of the grant amount to just over 100 percent. (It was not until the last year that the three participating clinics report other funding that exceeded the grant amount.) In the later years, however, as the ACA was implemented and most of the clinics became FQHCs, we observe increases in both in-kind and other revenue. From the perspective of the clinic directors, there was an increase in overall clinic financial stability in recent years, although there was also concern about a shift in some funders' priorities away from direct service provision.

Exhibit 26. Safety Net Capacity Expansion Project: Total Revenue by Type, All Clinics, Years 2–9

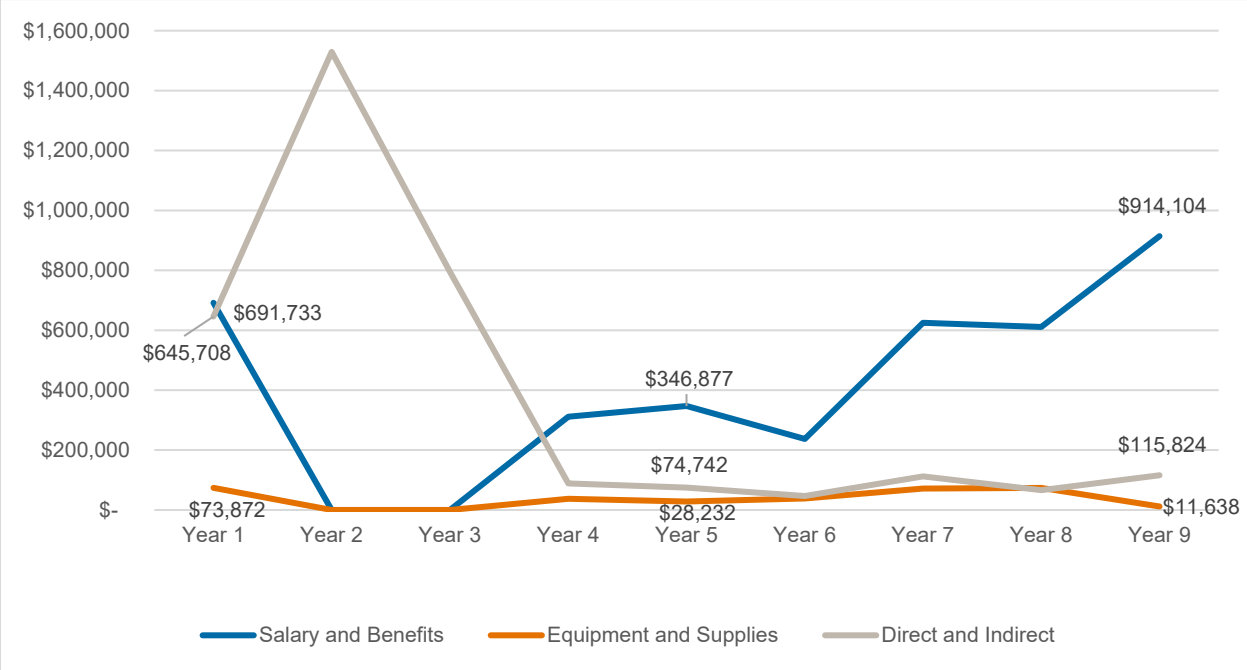


Source: NORC analysis of Safety Net Capacity Expansion Project grantees' annual reports to Health Forward Foundation, 2019.

Notes: Years 1–3 include data from a fifth clinic, Rodgers. Year 6 grant revenue includes interim report data from KC CARE. No data on in-kind or other revenue was reported by KC CARE in Year 6. No revenue data was reported by Family Health Care in Year 9.

Exhibit 27 presents total expenses by type for all clinics across Years 1–9 of the Expansion Project. In the aggregate regional report, no salary and benefits expenses were reported in Years 2 and 3, but the second trend line shows that expenses in this category increased over the remainder of the grant period, accounting for the majority of expenses. In Year 9, they accounted for 79 percent of total expenses. As noted above, we observe a possible variation in expense reporting for direct and indirect costs, based on the larger amounts of in-kind donations reported in Years 2 and 3. For the remainder of the grant, direct and indirect expenses remained low as clinic capacity increases are more likely observed in the increases in expenses for salary and benefits over the same period. Equipment and supplies remained stable over the course of the grant period, accounting for only 4 percent of total expenses across the total grant period. It is important to note that in the Year 10 focus group, clinic and medical directors articulated a set of additional service lines, including direct expenses beyond salary that would improve their after-hours operations going forward. These included diagnostic equipment, such as an EKG machine, and behavioral health and support services, such as social workers. After 10 years and with evidence of successful integration into their clinics, the Expansion Project would benefit from a new stream of investment to support these programs.

Exhibit 27. Safety Net Capacity Expansion Project: Total Expenses by Type, All Clinics, Years 2–9



Source: NORC analysis of Safety Net Capacity Expansion Project grantees' annual reports to Health Forward Foundation, 2019
Notes: Years 1–3 include data from a fifth clinic, Rodgers. No expense data was reported by KC CARE in Year 6. No expense data was reported by Family Health Care in Year 9.

Findings: Lessons Learned in Safety Net Capacity Expansion

Over the course of the Safety Net Capacity Expansion Project, participating clinics experienced successes and challenges related to operations, funding and sustainability, and the changing health care landscape. In this section, we present findings from interviews, focus groups, and grantees' reports over the years that describe lessons learned related to the expansion of safety-net capacity as well as the delivery of safety-net care in greater Kansas City. These lessons may inform Health Forward's opportunities and future directions in safety-net capacity programming.

Operational

Lessons learned in safety-net provider operations address staffing, the provision of comprehensive services, and basic clinic infrastructure. In this section, we take each of these in turn.

Staffing. From the outset, operational challenges often focused on staffing expanded hours. Staffing has long been a challenge for safety-net providers, a challenge that has been aggravated by the competition to capture Medicaid and other newly insured patients since the ACA went into effect. Clinic directors noted that not all clinicians and staff work well within the safety-net context, given the complexity of the patient population and resource constraints. When participating clinics introduced after-hours programs and expectations regarding working the after-hours shifts, they reported challenges retaining providers due not only to required after-hours schedules but to overall provider availability and consistency.

It was not easy for the clinics to maintain regular after-hours, which was evident in fluctuations in quarterly data reports. As hiring and retaining providers continued to be an issue, it directly affected the clinics' encounter rates during the expanded hours. In particular, clinics described in their reports to Health Forward that services were interrupted due to unexpected or long-term staff leaves, delays in hiring qualified staff when providers left the clinics, and the inability to hire bilingual staff. As clinics expanded, they also reported an increased demand for all types of staff, including front desk and community health workers.

At the same time, it should be underscored that during the project, clinics described success over the years at meeting their staffing needs creatively and pragmatically, building on the free-clinic model of volunteer and student providers. This included the incorporation of specialists and the introduction of mid-level providers as well as sharing of staff across clinics. In addition, by becoming FQHCs and increasing billable encounters, these clinics have expanded and increased funding stability, which may have helped with staffing in the later years. The impact of these efforts was evident in the concluding focus group as clinic and medical directors considered after-hours as one of their regular lines of business.

Delivery of Comprehensive Services. The Expansion Project funded clinic visits in the early morning, evening, and on weekends, but it was not designed to support all of the needs of after-hours patients. It became clear within a few years of the grant that patients were presenting for chronic issues as opposed to acute needs. In early reports and later in interviews and focus groups, clinics described the limits of such targeted funding when patients faced chronic conditions.

> *When I first started, I was wondering how come we are open late but not providing the full services to our patients. We did not have behavioral health consultants, no pharmacy available, no labs. How do you even do primary care without pharmacy and labs? That's why we have to expand everything, not just certain services.*
>
> - Clinic Director

Clinics reported success in applying PCMH principles to care delivery for their after-hours patients and developed solutions, such as integrating behavioral health services in one location to reduce attrition and patient costs as well as improve timeliness. Two clinics were able to open and fund dental clinics once Missouri reintroduced the benefit into Medicaid.

However, clinics noted that providing their patients with diagnostics, pharmacy, social services, and specialists were challenges. Medical directors felt that it was important for safety-net providers to have specialty capacity onsite. These concerns became more pronounced in the later years when clinics were responsible for achieving FQHC quality standards, yet funding and availability for services such as mammograms and colonoscopies were lacking. They additionally noted that the lack of Medicaid expansion and decrease in hospital charity care in the region since the implementation of the ACA made it difficult to refer patients to the next level of treatment or service.

> *One of the best ways to provide great care but at a lower cost is not only to bring in specialists, but also to bring in technology to the primary clinics (e.g., point-of-care ultrasound, EKG [electrocardiogram] on handheld devices, stress test). There are a lot of things that we could bring to the primary care offices to help eliminating the costs by sending our patients to see cardiologists.*
>
> - Clinic Director

Clinic Infrastructure. The development of a clinic infrastructure around implementing EHRs and becoming FQHCs challenged the clinics. All clinics reported advantages related to the adoption and use of EHR systems, including integrated care for patients across services, the potential to increase efficiency and tracking, and better documentation of all medical services. EHR implementation also contributed to the clinics' compliance in fulfilling FQHC requirements, which supported the overall sustainability of the clinics. However, the conversion to an EHR system required an extensive amount of training time and caused disruptions in the workflow for providers and staff members, which negatively affected provider productivity, patient scheduling, and delayed reporting to Health Forward.

Funding and Sustainability

The Expansion Project provided base funding for after-hours care but did not cover the full cost of operations or further service development. In some years, the clinics were able to raise additional funds or use in-kind services to maintain the after-hours project but still reported that

they could have been more effective with general operating support rather than a targeted grant. Overall, clinic executives felt that the Expansion Project was experimental, and when relying on grants and volunteers, it was difficult to fully realize a modern and full clinic infrastructure that delivers comprehensive services. The reality, as described by the directors, was that additional flexibility was needed to meet the needs of these complex patients.

PCMH and FQHC Status. Clinics pursued PCMH or FQHC status as a way to enhance patient care and ensure sustainability of their programs. These designations made clinics eligible for additional funding through the federal Health Resources & Services Administration (HRSA), other grants, and enhanced Medicaid reimbursement. For example, one clinic converted its dispensary into a pharmacy through the federal 340B program, with the intent of increasing patients' access to discounted medications and generating additional revenue for the clinic.

Clinic directors underscored that as FQHCs, they were now accountable for preventive screenings, mammographies, and colonoscopies, but they could not control access to these services. They described increased uncertainty regarding the funding for direct services beyond reimbursement for covered patients, citing a general reduction in local funding of direct services. Clinic directors stressed the importance, as FQHCs, of insured patients to their clinics' bottom lines, yet they continued to embrace their missions to meet the needs of the uninsured.

Need for Flexible Funding. During the final focus group, clinic and medical directors first expressed that a new mechanism for funding comprehensive and specialty services was needed. Second, they emphasized that flexible funding is critical to long-term grants in order to respond to changes in patient demand that impact program effectiveness. One director aptly concluded that they might be constrained in finding creative solutions. "Although we have some other strong sources of funds as we transitioned to FQHCs, there are still no funds for trying things out, and new experiments. It's causing us to be more conservative." In short, there remains a need for general operating support that can be used by clinics to plan and address the changing needs of vulnerable patients with or without insurance coverage.

Health Care Landscape

Participating clinics encountered opportunities and challenges in light of state and federal policy shifts and local market responses. The passage and implementation of the ACA resulted in new funding sources for community health centers. Most of the Expansion Project clinics became FQHCs or expanded in response to those opportunities. For example, until 2016, there was funding for outreach that enabled clinics to actively engage patients who were eligible for Medicaid but not enrolled.

After-hours utilization and service numbers reflect fundamental shifts in the demand for safety-net services from adults and children on Medicaid and those who are underinsured. Interviews with clinic directors described the reality of increased demand from Medicaid patients due to the awareness raised by the ACA and limited availability of Medicaid providers in Kansas City. Specifically, the reduction in Medicaid reimbursement rates diminished the number of providers who were willing to take on patients with Medicaid. As a result, safety-net clinics experienced an increase in Medicaid patient volume. The lack of Medicaid expansion additionally cost the clinics significant federal matching dollars.

> *We did our own analysis [on the impact of lack of Medicaid expansion] within the organization. It was estimated that the top-line revenue would go up to over a million dollars with the Medicaid expansion, which can make our salaries to be more competitive and attract people to come to our team.… That's the direct impact of the Medicaid expansion, which can help improving the capacity and the quality of your team.*
>
> - Clinic Director

Serving Kansas City's Immigrant Population. The Expansion Project clinics embraced a core mission of serving greater Kansas City's vulnerable patients, which necessarily meant serving the area's growing immigrant populations, most of whom were ineligible for Medicaid coverage. By the conclusion of the Expansion Project, the situation had become precarious, especially for undocumented immigrants, due to implementation of the ACA and the introduction of several laws and regulations challenging immigrant rights. Clinic directors described how immigrants had stopped seeking care: "We have [a] poster out there stating that we won't ask for status, but most of them just don't come." This contrasts with the challenges described just three years earlier when clinics faced shortages of bilingual staff and were competing with other Medicaid providers to hire them. As FQHCs, there is a question as to whether these clinics can provide care for immigrants, and therefore, there is a potential role for small free clinics to fill this need.

Conclusions

The Expansion Project has played a vital role in the evolution of Kansas City's safety net over the last decade. The findings in this report describe a highly successful, long-term grant program that was able to achieve its primary objective of increasing access for vulnerable Kansas City residents to convenient health care. Key accomplishments include the following:

- Participating clinics provided over 25,000 expanded hours and over 73,000 visits.
- About 18,000 new patients were linked to clinics that operated as PCMHs, where they received essential primary and preventive care, including treatment for chronic diseases like diabetes, counseling on tobacco use, and mental health screening.
- Some patients were also able to access additional or complementary services—specialty consults, dental care, and medications—that were funded by in-kind donations or other donations and grants.
- By Year 10, 78 percent of patients were established clinic users—a significant accomplishment, considering that in the first year of the project, close to half of after-hours patients did not have a regular source of care.

Through the Expansion Project, the participating clinics were able to experiment and evolve their programs. When drawing conclusions from this experience, it is important to consider that most program-specific grants do not last a decade. By continuing this line of funding annually for 10 years, Health Forward's Expansion Project functioned in some ways as basic operating support and in others like pilot funding. In reports, interviews, and focus groups, directors stressed that after experimenting with different times, staffing, and services, these programs had become fully integrated at the conclusion of the grant.

The ongoing operational support also had a largely positive impact on clinic operations as the environment changed with the ACA's passage. Each of the participating clinics was influenced by the move to expand coverage through the marketplace and increased funding opportunities for FQHCs. We observed a cultural shift as the clinics became FQHCs, although they remained committed to their missions to serve the uninsured. The administrative data highlight the increase in Medicaid and insured patients after 2014. Clinic directors viewed these billable visits as an important way to subsidize care for the remaining uninsured. However, they noted that gaps remain, in particular related to access and coverage for diagnostics, pharmacy, social services, and specialty care. Clinic directors emphasized that flexible, long-term funding enables them to construct creative solutions to address their patient populations' needs in the context of evolving health and social policies and shifting demographics.

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Appendix A: Administrative Data Collection Instructions (Quarter 3 2019)

Extended Hours Administrative Data Email Template

Good afternoon,

It is time for NORC's quarterly administrative data collection. Attached, please find the template for data collection for **data from Q3 2019 (July-September 2019); detailed instructions are included as the first tab in the document**. Note that data reported should ONLY be for patients seen during After Hours, not during your regular clinic hours.

This data collection will include 2 components:

1. Quarter 3 2019 full data collection, reported at the aggregate quarterly level for July 2019 through September 2019.
2. After-hours schedule by month. Please include only your After-Hours schedule (not your regular hours) for all months in the same time period (July 2019 through September 2019).

Please remember to **roll all ICD-10 Diagnosis coding up to the 3rd digit.** Also, please remember that CPT codes should be limited to **office visit codes**. If you have any questions about how to do this or need a list of office visit CPT codes, please contact me.

Please email Quarter 3 2019 administrative data to Figueroa-Alexandria@norc.org by **Friday, October 11, 2019.**

Please do not hesitate to contact myself at Figueroa-Alexandria@norc.org or 301-634-9275 if you have any questions, or if the point of contact at your site has changed.

Thank you,
Alexandria

Extended Hours Administrative Data Instructions, Quarter 3 2019

The following instructions are for the extended hours administrative data to be collected and returned to NORC. Please submit the following data:

1. **Your aggregate administrative data for each of the quarters from Quarter 3 2019 (July, August, September) Q3 2019_Dems, Q3 2019_Geo, Q3 2019_Diag, and Q3 2019_Proc** tabs. To clarify, each data point to the number of hours/visits/diagnoses etc that occurred in that quarter as specified in the variable instructions are listed below.
2. Your after-hours schedule (do NOT include regular hours) by month on the Extended Clinic Hours tab

All data should be submitted by October 11th, 2019.

Please list the total number of unduplicated patient encounters for the aggregate quarter (summing data across all 3 months) in each category listed below:

Part A: Clinic and Demographic Information

- Hours
  - Clinic (#) – The number of clinic hours paid for by the grant.
  - Physicians (#) – The number of direct patient contact physician hours paid for by the grant.
  - Mid-level Staff (#) – The number of direct patient contact mid-level staff hours paid for by the grant.
  - Patients
  - Patients (#) – The number of patients that received medical care.
  - Visits (#) – The number of patient visits.
  - New Patients (#) –The number of new patients. A new patient is any patient that has not received any professional or face-to-face service, i.e. internal medicine or primary care services, from the provider in the past 3 years.
- Coverage
  - Medicaid (#) – The number of patients covered by Medicaid.
  - Medicare (#) – The number of patients covered by Medicare.
  - Private Insurance (#) – The number of patients covered by private insurance.
  - Uninsured (#) – The number of uninsured patients.
  - Unknown / Not Captured (#) – The number of patients whose health coverage information is unknown or was not captured.

- Gender
  - Females (#) – The number of female patients.
  - Males (#) – The number of male patients.
  - Other (#) – The number of patients whose gender is categorized as other.
  - Unknown / Not Captured (#) – The number of patients whose gender is unknown or was not captured.
- Age
  - Pediatric (<12 years) (#) – The number of patients under 12 years.
  - Teenage (13-19 years) (#) – The number of patients between 13 and 19 years.
  - Young Adult (20-35) (#) – The number of patients between 20 and 35 years.
  - Adult (36 – 55 years) (#) – The number of patients between 36 and 55 years.
  - Older Adult (56 – 64) (#) – The number of patients between 56 and 64 years.
  - Elderly (>65) (#) – The number of patients 65 and older.
  - Unknown / Not Captured (#) – The number of patients whose age is unknown or was not captured.
- Race / Ethnicity
  - Caucasian (#) – The number of Caucasian patients.
  - African American (#) – The number of African American patients.
  - Hispanic / Latino (#) – The number of Hispanic/Latino patients.
  - Asian/Pacific Islander (#) – The number of Asian/Pacific Islander patients.
  - American Indian/Alaska Native (#) – The number of American Indian/Alaska Native patients.
  - Other (#) – The number of patients whose r/e is not categorized as any of the above options.
  - Unknown/Not Captured (#) – The number of patients whose r/e is unknown or was not captured.
- Income
  - Below FPL (%) – The percent of patients living below the federal poverty level.
  - FPL – 2FPL (%) – The percent of patients living between the federal poverty level and two times the federal poverty level.
  - >2FPL (%) – The percent of patients living two times above the federal poverty level.
  - Unknown / Not Captured (%) – The percent of total patients who income level is unknown or was not captured.

Part B: Geographic Information

- Zip Code – The number of patients by zip code. List the zip code in the zip code column and corresponding number of unduplicated patients in the # column. Add rows as needed.
- County – The number of patients by county. List the county in the county column and the corresponding number of unduplicated patients in the # column.

Part C: Top Ten Diagnoses

Top 10 Diagnoses (% by ICD-10 code if possible) – The primary diagnosis and corresponding percent of total visits by ICD-10 code if possible. To calculate the top ten primary diagnoses by percent: (1) determine the top ten primary diagnoses that occurred in that month during extended hours; (2) insert the applicable ICD-10 code and name of the diagnosis into the ICD-10 and Diagnosis columns, respectively; (3) insert the corresponding percent of total visits into the % column.

Part D: Top Ten Procedures

Top 10 Procedures (% by CPT-4 office visit code) – The procedure and corresponding percent of total visits by CPT-4 office visit code. Provide the top ten CPT-4 office visit codes, using the total number of CPT-4 office visit codes as the denominator. To calculate the top ten procedures by percent: (1) determine the top ten procedures that occurred in that month during extended hours; (2) insert the applicable CPT-4 code and name of the procedure into the CPT-4 and Procedure columns, respectively; (3) insert the corresponding percent of total visits into the % column.

Part E: Clinic Hours

Please list the hours of extended operation (paid for by the grant) for Q3 2019.

Appendix B: Administrative Data Template

Part A. Clinic and Demographic Information

Extended Hours		Q3 2019
Number of:		
Hours	Clinic (# hours)	
	Physicians (# hours)	
	Mid-level Staff (# hours)	
Patients	Patients (#)	
	Visits (#)	
	New Patients (#)	
Coverage	Medicaid (#)	
	Medicare (#)	
	Private Insurance (#)	
	Uninsured (#)	
	Unknown / Not Captured (#)	
Gender	Females (#)	
	Males (#)	
	Other (#)	
	Unknown / Not Captured (#)	
Age	Pediatric (<12 years)(#)	
	Teenager (13-19 years) (#)	
	Young Adult (20-35 years) (#)	
	Adult (36-55 years) (#)	
	Older Adult (56-64 years) (#)	
	Elderly (>65 years) (#)	
	Unknown / Not Captured (#)	
Race / Ethnicity	Caucasian (#)	
	African Americans(#)	
	Hispanics / Latinos(#)	
	Asians / Pacific Islander (#)	
	American Indian / Alaska Native (#)	
	Other (#)	
	Unknown / Not Captured (#)	
Income	Below FPL (%)	
	FPL - 2FPL (%)	
	>2FPL (%)	
	Unknown / Not Captured (%)	

Part B. Geographic Information

Q3 2019					
Zip Code	Zip Code	#	County	County	#

Part C. Top Ten Diagnoses

	Extended Hours		Q3 2019
	ICD-10	%	Diagnosis
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

*NOTE PLEASE ROLL ICD-10 CODES UP TO THE 3rd DIGIT.

Part D. Top Ten Procedures

	Extended Hours		Q3 2019
	CPT-4 office visit code	%	Procedure
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Part E. Clinic Hours

Please provide the hours of operation for after-hours care for each day of the week and then the average number of hours per week dedicated to after-hours care.

Time Period*	Mon	Tues	Weds	Thurs	Fri	Sat	Sun	Hours per week
April								
May								
June								

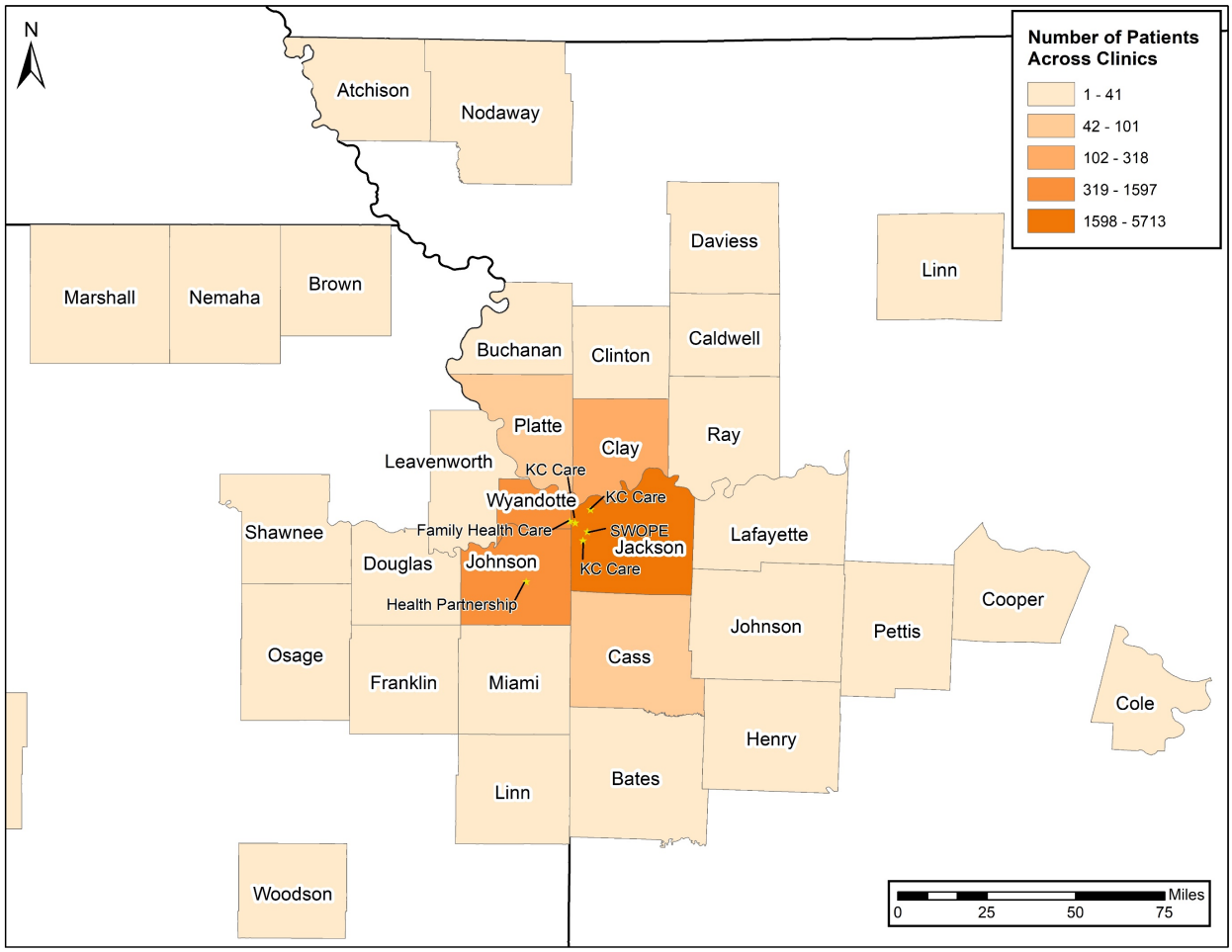
*If your clinic has had the same hours of operation across all time periods, you only need to fill in the first row.

Appendix C: Grantee Reports Codebook

Name	Files	References
Challenge	46	162
Clinic issues	0	0
Collaboration	41	130
Clinic structure	7	10
Partners	10	14
Shared staff	3	3
Volunteer providers	10	28
Communication	39	59
EHR or EMR	33	67
Finance	38	94
Patient-related	13	17
Access to care	33	55
Complexity of care	14	32
Policy	27	57
Productivity	5	15
Reduce no shows	9	13
Resources	7	10
Staffing	55	271
Coverage	15	25
Other staffing limitation	4	5
Recruitment & Retention	13	28
Staff Roles	2	4
Context	31	54
Abstract	24	26
Services	5	6
Acute or speciality care	29	127
Primary care	34	83
Target population	38	85
Location	31	70
Lesson Learned	40	48
Organization	0	0
Health Partnership	23	40
KC CARE	25	52
SW Boulevard	21	45
SWOPE	23	50
Outcomes	5	17
After-hours Patients	54	104
ED Diversion and Utilization	46	57
Health indicators	50	72

Name	Files	References
Patient Engagement_coordination	46	90
Patient Satisfaction	39	47
Population Health	33	36
Prevention	47	73
Program Goals	58	223
Program hours	51	108
Success	56	292
Timeframe	0	0
Years 1-3	4	6
Years 4-6	25	32
Years 7-10	30	33

Appendix D: Safety Net Capacity Expansion Project: After-hours Patients by County, Year 9



Source: Data reported by participating clinics to NORC at the University of Chicago (October 2017—September 2018).

Appendix E: Focus Group Protocol

Focus Group Protocol for Clinic Leadership

Introduction

Hello, my name is Gretchen Torres, and I am with Susan Cahn. Thank you very much for taking the time to participate today. We work with NORC at the University of Chicago, an independent research institution that provides data and analysis to inform program decisions. As you know, NORC has been contracted by the Health Forward Foundation (HFF) to conduct an ongoing assessment of Kansas City Safety Net Expansion Project and its impact since 2010.

Purpose

The purpose of this focus group is to hear your experiences at the clinics, as well as to learn the impact and changes that your clinic has experienced during the course of the grant. The information learned from this focus group will be used to produce a final report about the Extended Clinic Hours program. Please note that there are no right or wrong answers to those focus group questions. We are interested in your opinions, and would like for everyone to contribute his/her thoughts.

Consent Statement

We are going to review a brief consent statement regarding your participation.

This focus group will be audio-recorded, and we will be taking notes to ensure the discussions are captured accurately. Only NORC researchers assigned to this study will be listening to the recording as they will help us develop a report based on the key findings from our discussion. Your responses will remain confidential, and no names or any identifiable information will be included in the report.

Finally, your participation in this focus group today is voluntary, and you may stop at any time during the course of the discussion. Of course, we ask that you keep what you hear from your colleagues today confidential. Also, you may refrain from answering questions and choose to end your participation in this discussion at any time.

Contact

If you have any question about this project during or after the discussion, you may contact the project director, Gretchen Torres at 312-759-4049.

Do you have any questions before we begin? Do you agree to participate in this focus group and be recorded? [Note for the recording that all verbally consented]

Discussion Questions

Overview and Introduction

1. Please share with us your name, job title, and how long you've been with your clinic.
2. Over the last 10 years, what are the one or two environmental changes that you have observed that have had the greatest effect on safety net providers in the Greater Kansas City area?
3. When you consider the original goals of the program and needs that the program was designed to address, how are your organization's goals different today with regards to expanding access and capacity?
4. How did the expanded clinic hours respond to your population and their problems with access to care, and how has it changed over the past 10 years of funding?
   a. *What, if any, other approaches could improve the access?*

Impact of the Program

5. Over the 10 years of funding, how did the grant meet the needs you described earlier? What needs were not met?
6. What has been the greatest impact of the after-hours program at your clinics?
   a. *Beyond access to needed healthcare, what has been the broader impact on your patients?*

Role of the Foundation

7. What has been the role of the foundation in supporting the development and success of the after-hours program at participating clinics?
   a. *What has been most helpful?*
8. In your opinion, what changes were observed over time with respect to the foundation's engagement and support? How did that affect the programs?
9. This grant opportunity lasted for 10 years. What role did the ongoing availability of grant funding play in the development of your after-hours program?
10. In your opinion, what elements are critical in a direct grant program to support safety-net clinics in meeting their organizational goals?
11. What is the optimal duration for a similar grant?
12. How can the Health Forward Foundation best support the needs of your clinics in the future?
13. What health policies could Health Forward Foundation align with to maximize their grant monies in the future?

Lessons learned

14. What are the lessons learned from the after-hours program?
    a. *What were the greatest challenges the after-hours program encountered? How did you overcome these challenges?*
15. Is there anything else you'd like to share with us about your organization or the program?

Appendix F: Safety Net Capacity Expansion Project: Top 10 Primary Diagnoses, Year 10

ICD-9	Diagnosis	Counts	%
401	Essential hypertension	1429	14%
V72	Special investigations and examinations	886	9%
250	Diabetes mellitus	822	8%
V65	Other persons seeking consultation	436	4%
V70	General medical examination	434	4%
V03	Need for prophylactic vaccination and inoculation against bacterial diseases	371	4%
272	Disorders of lipoid metabolism	369	4%
305	Nondependent abuse of drugs	364	4%
V08	Asymptomatic HIV infection status	348	3%
296	Episodic mood disorders	298	3%
	All other	4358	43%

Source: Data reported by participating clinics to NORC at the University of Chicago (January 2018—September 2019).

Note: Years 2-3 included Samuel U. Rodgers Health Center (Rodgers). Year 10 only included 3 participating clinics (Health Partnership Clinic of Johnson County (Health Partnership), Kansas City CARE Clinic (KC CARE), and Swope Health Services (Swope).

Appendix G: Safety Net Capacity Expansion Project: Common Diagnoses

ICD-9	Diagnosis	Y2	Y3	Y4	Y5	Y6	Y7	Y8	Y9	Y10
401	Hypertension	25%	13%	11%	18%	12%	22%	18%	17%	14%
250	Diabetes mellitus	12%	7%	8%	15%	8%	14%	10%	9%	8%
272	Disorders of lipoid metabolism	4%	3%	2%	<1%	<1%	5%	5%	3%	4%
042	Asymptomatic HIV infection	-	<1%	1%	4%	3%	<1%	<1%	<1%	-
V72	Special investigations and examinations	3%	2%	3%	<1%	9%	8%	7%	7%	9%
V70	General medical exams	5%	<1%	<1%	2%	<1%	2%	<1%	3%	4%
V03/V04	Vaccinations	<1%	-	-	<1%	<1%	<1%	<1%	<1%	4%
305	Nondependent abuse of drugs	4%	2%	-	-	-	<1%	<1%	<1%	4%
300/311/296	Episodic mood disorders	<1%	5%	<1%	<1%	5%	<1%	4%	4%	3%

Source: Data reported by participating clinics to NORC at the University of Chicago (January 2018—September 2019).

Note: Years 2-3 included Rodgers. Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health.

Safety Net Capacity Expansion Project: Top 10 Clinical Procedures, Year 10

CPT-4	Procedure	Counts	%
99213	Established Patient, Level 3	5328	53%
99214	Established Patient, Level 4	2424	24%
99203	New Patient, Level 3	552	5%
99212	Established Patient, Level 2	246	2%
99202	New Patient, Level 2	231	2%
99204	New Patient, Level 4	185	2%
99211	Established Patient, Level 1	124	1%
99215	Established Patient, Level 5	74	1%
99394	Established Patient, 12-17 yrs.	41	<1%
99396	Established Patient, 40-64 yrs.	36	<1%
Other		874	9%

Source: Data reported by participating clinics to NORC at the University of Chicago (January 2018—September 2019).

Note: Years 2-3 included Rodgers. Year 10 only included three participating clinics: Health Partnership, KC CARE, and Swope Health.

Appendix H: Financial Data by Participating Clinic, Years 4-9

Clinic	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9
Revenue – Grant						
HP	$ 75,000	$ 75,000	$ 100,000	$ 95,000	$ 95,000	$ 90,000
KC CARE	$ 113,000	$ 110,000	$ 72,500	$ 140,000	$ 145,000	$ 145,000
SWOPE	$ 110,000	$ 110,000	$ 97,084	$ 87,300	$ 91,260	$ 90,000
FHC	$ 30,376	$ 42,000	$ 37,000	$ 70,000	$ 75,760	--
Total	$ 328,376	$ 337,000	$ 306,584	$ 392,300	$ 407,020	$ 325,000
Revenue – Other						
HP	$ 15,700	$ -	$ -	$ -	$ -	$ 230,615
KC CARE	$ -	$ 24,482	--	$ 59,669	$ 79,417	$ 167,210
SWOPE	$ -	$ -	$ -	$ -	$ -	$ -
FHC	$ 27,880	$ 35,765	$ 15,000	$ 33,370	$ 25,180	--
Total	$ 43,580	$ 60,247	$ 15,000	$ 93,039	$ 104,597	$ 397,825
Revenue – In-kind						
HP	$ -	$ -	$ -	$ 139,064	$ 204,396	$ -
KC CARE	$ 70,361	$ 21,567	--	$ 165,078	$ -	$ 180,000
SWOPE	$ 31,750	$ 31,750	$ 31,750	$ 66,908	$ 64,041	$ 107,994
FHC	$ 19,100	$ 40,895	$ 46,282	$ 46,282	$ 46,282	--
Total	$ 121,211	$ 94,212	$ 78,032	$ 417,332	$ 314,719	$ 287,994
Expenses – Salary and Benefits						
HP	$ 82,538	$ 66,156	$ 91,332	$ 212,691	$ 286,982	$ 276,535
KC CARE	$ 141,673	$ 137,840	--	$ 285,219	$ 163,583	$ 578,634
SWOPE	$ 45,876	$ 43,911	$ 44,661	$ 20,355	$ 53,545	$ 58,935
FHC	$ 41,220	$ 98,970	$ 100,950	$ 106,812	$ 106,812	--
Total	$ 311,307	$ 346,877	$ 236,943	$ 625,077	$ 610,922	$ 914,104
Expenses – Equipment and Supplies						
HP	$ 3,341	$ 2,765	$ 3,000	$ 13,101	$ 6,000	$ 8,400
KC CARE	$ 7,370	$ 3,467	--	$ 25,842	$ 36,849	$ -
SWOPE	$ -	$ -	$ 6,660	$ 5,808	$ 3,940	$ 3,238
FHC	$ 26,476	$ 22,000	$ 28,610	$ 26,600	$ 26,600	--
Total	$ 37,187	$ 28,232	$ 38,270	$ 71,351	$ 73,389	$ 11,638
Expenses – Direct and Indirect						
HP	$ 9,821	$ 11,079	$ 5,668	$ 14,371	$ 11,414	$ 45,680
KC CARE	$ 35,534	$ 24,742	--	$ 30,377	$ 19,801	$ 40,511
SWOPE	$ 28,169	$ 22,051	$ 18,826	$ 45,309	$ 12,828	$ 29,633
FHC	$ 15,110	$ 16,870	$ 22,100	$ 22,000	$ 22,000	--
Total	$ 88,634	$ 74,742	$ 46,594	$ 112,057	$ 66,043	$ 115,824

Note: Year 6 grant revenue includes interim report data from KC Care.