



A DECADE
of DIFFERENCE

PHYSICAL
HEALTH



In 2005, the Health Care Foundation of Greater Kansas began making grants to Kansas City area organizations committed to eliminating the barriers to quality health for the uninsured and underserved. The foundation was created two years earlier through the sale of Health Midwest hospitals to Hospital Corporation of America. Since 2005, HCF has awarded over \$200 million to hundreds of entities.

The past decade has been a difficult period for many individuals and organizations served by the foundation. Yet it has also been a time of unmatched opportunity. Most notably, the passage of the Patient Protection and Affordable Care Act in 2010 represented a landmark event in the evolution of health care reform.

As the foundation completes its first decade, we have looked back across the health care landscape to better understand the obstacles and accomplishments surrounding care to the uninsured and underserved in the Kansas City region. Our objective is to learn from, and reflect upon, past experience in order to better inform and assist the community's collective efforts going forward.

HCF contracted with researchers to conduct a series of interviews and focus groups with health care stakeholders in the safety net arena. The results of those conversations represent the heart of this report. More than 50 individuals participated in the process, and their reflections and insights about the past, present and future of safety net care in the region were enormously beneficial.

But even though stakeholder perceptions form the bulk of this document, the final product inevitably has been filtered through the foundation's lens. The contents therefore ultimately are the responsibility of the foundation.

This document is not meant to be an evaluation of HCF or the safety net care grants we've funded over the past 10 years. Nor is this an assessment of population level health needs or secondary data trends. Rather, the goal was to take advantage of our unique perspective in the health care community to examine system level challenges, changes and opportunities.

This assessment has allowed us to more clearly see the enormous strides that have been made in our region since 2005. Too often, those knee-deep in the day-to-day work of bringing about change are unable to pause to appreciate the role they have played in advancing the field. A spirit of cooperation, collaboration and commitment is reflected in these pages and in these efforts, and the HCF is proud to be a part of the progress our community has experienced.



PROVIDERS STRENGTHEN SAFETY NET AMID DIFFICULT, CHANGING TIMES



The transformation under way across the U.S. health system has produced dramatic change throughout the Kansas City area over the past decade. Local free clinics, community health centers, safety net hospitals and community organizations all have scrambled to adapt in a fast-changing environment marked by new methods of care delivery, coordination and reimbursement.

The journey has not been easy. The challenges of providing quality care to the uninsured and underserved remain numerous and formidable. Beyond the profound structural changes brought on by reform, safety net providers have contended with the effects of the Great Recession, an increasingly complex and diverse client population and deep budget cuts at the state level. Yet through it all, they've managed not only to sustain safety net care, but strengthen it.

Improved business practices, increased provider capacity, more effective care coordination, expanding use of technology and stronger advocacy efforts all are emerging hallmarks of the area's safety net system. Importantly, many of these improvements have stemmed from better cooperation and collaboration between organizations.

"The difficulties of recent years have brought people together and helped us develop creative and sustainable solutions," said Graciela Couchonnal, program officer at the Health Care Foundation of Greater Kansas City (HCF). "We're increasingly tackling our collective challenges in smarter, more cooperative ways."

SINCE 2005,
HCF has awarded

\$54 MILLION

in grants **TO SUPPORT**

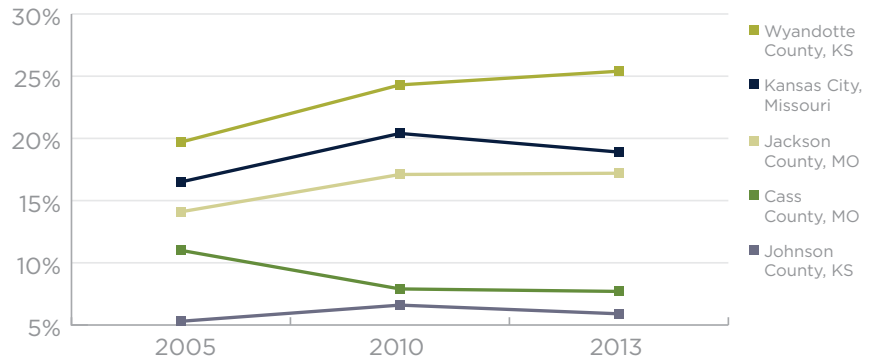
improving access to quality health care services.



IMPACT OF THE GREAT RECESSION

The Kansas City region’s safety net landscape is a far different place today than in 2005. In those days, most providers had simple organizational structures and were limited to offering basic primary and chronic care services to a smaller number of uninsured and underserved clients. Agencies worked in relative isolation and many were chronically understaffed and underfunded.

The economic free fall that began in 2008 turned up the financial pressure on providers and unleashed forces that continue to shape safety net care today. The number of working poor and uninsured jumped. Many middle-class breadwinners that traditionally had received health insurance through their employers suddenly found themselves out of work. As these individuals and families lost coverage, a growing number began presenting for care at safety net facilities.



PERCENT OF POPULATION BELOW POVERTY LEVEL by City and County, 2005-2013

SOURCE: U.S. Census Bureau, 2005, 2010 and 2013 American Community Survey 1-year estimates

CHANGING DEMOGRAPHICS

Dramatic growth in the ethnic diversity of residents living in the Kansas City area further accelerated demand for safety net services. According to the 2010 U.S. Census, nearly 10 percent of residents in Kansas City, Missouri, and 15.6 percent of residents in Wyandotte County speak a language other than English, with Spanish being most prevalent.

While many providers have expressed a willingness to support immigrant care, delivering services has been difficult due to state and federal policies that don’t include mechanisms for reimbursing non-citizen care. The language and cultural barriers immigrants face in attempting to access health care — coupled with a shortage of bilingual safety net staff — likewise have widened the gulf between those in need and those able to provide care.

“There’s a growing recognition of the necessity not only to find better ways to provide services for this population, but also for improved language and cultural access,” said Cathy Anderson, manager of language and cultural services at Jewish Vocational Services. “That’s very different than was the case 10 years ago.”

HCF has dedicated over

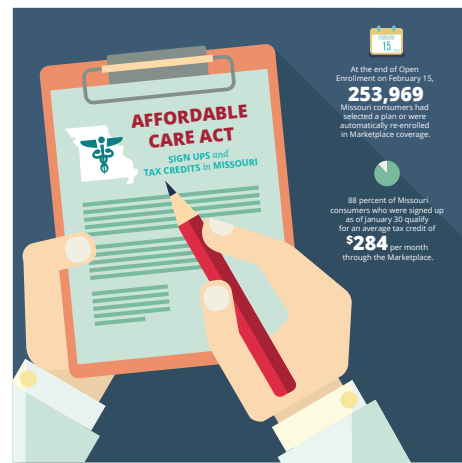
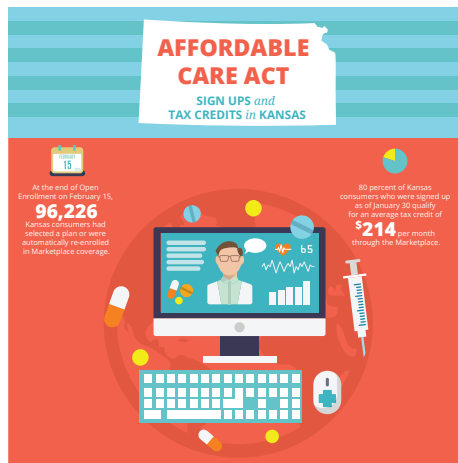
\$1 MILLION

to support the spectrum needed to get from awareness to access in the health insurance marketplace.

A REGULATORY REVOLUTION

The economic upheaval and shifting demographics seen in recent years have unfolded against a backdrop of major policy changes at the federal and state levels. Many of these new rules, programs and approaches have strengthened area safety net care. But others, most notably decisions in Missouri and Kansas to forego Medicaid expansion, have seriously undermined it.

There's no question that the Patient Protection and Affordable Care Act (ACA) has emerged as a primary driver of change across entire health care system since its passage in 2010. The sweeping legislation included provisions that make coverage more stable and affordable for those who already have it while extending insurance protection to those who don't. The law also aims to strengthen the health system through better care coordination, payment reform, promotion of health information technology, preventive health measures and other efforts.



AFFORDABLE CARE ACT

2010

MARCH 2010
President Obama signed the law

2010
Placed new rules on premium increases and rights to appeal insurance company decisions

2011

2011

- Required insurance companies to spend 80–85 percent of premiums on medical care
- Provided free preventive care and reduced prescription drugs for seniors
- Provided grants for wellness programs

2012

JANUARY
Incentivized physicians to create Accountable Care Organizations

Get

COVERED

Health Care  Foundation
OF GREATER KANSAS CITY

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Improving access to care through federal and state insurance exchanges remains the centerpiece of the ACA. So far, the exchanges have played an important role in reducing the ranks of the uninsured, which have fallen from 14.4 percent nationwide in 2009 to 11.9 percent in 2015. In Kansas, 96,000 have gained coverage since the exchanges began in 2013; another 253,000 have been covered in Missouri.

During the first marketplace enrollment in 2013, HCF undertook outreach efforts to inform underserved, uninsured households about the new options available through the health insurance marketplace. The CoverKC Marketplace Coverage Initiative efforts included in-person enrollment assistance through certified application counselors, door-to-door canvassing, mail and Internet advertising. The effort was continued in subsequent enrollments periods through grants to organizations such as United Way's 211 and the Mid-America Regional Council.

2013

OCTOBER

Electronic recordkeeping is standardized and secured for exchanging health information

JANUARY

- Expansion for funding preventive services
- Increased Medicaid payments to providers
- Flat fee bundling

2014

OCTOBER

- States received two more years to fund children not eligible for Medicaid providers

JANUARY

- Health Insurance Exchanges coverage begins
- Individual mandate for coverage applies
- Federal funds available for Medicaid expansion in states that have chosen to expand eligibility
- Insurance companies prohibited from exclusion due to pre-existing condition

2015

JANUARY

Physician payments tied to the quality of care they provide



UNINTENDED EFFECTS

The exchanges and the subsidies they provide have helped ease the burden on safety net providers by finally putting health coverage within reach for millions. Yet some of the newly insured continue to fall through the cracks, and the reforms triggered by the ACA have not been without negative consequences.

Many individuals and families who've enrolled in the exchanges' lowest-cost "bronze" plans, for example, have faced significant challenges. Bronze plans offer low monthly premium payments but include high deductibles and high out-of-pocket costs. Because the plans typically are chosen solely on the basis of their lower up-front cost, the large deductibles have left some enrollees functionally uninsured. Others are afraid to seek medical care because of the uncertainty about the costs.

Another complication emerging from the ACA has been the loss of benefit programs for some newly insured, low-income patients. When individuals obtain coverage through the federal marketplace, they are no longer eligible for pharmaceutical assistance programs that provide access to medications and supplies. Nor can they access a range of other programs at free clinics that serve only the uninsured.

SOME OF THE NEWLY INSURED CONTINUE TO FALL THROUGH THE CRACKS, AND REFORMS TRIGGERED ARE HAVING OTHER NEGATIVE CONSEQUENCES.

Finally, those who do not qualify for marketplace subsidies continue to face barriers to insurance coverage and health care. Many, in fact, have discovered that their incomes are too high to qualify for Medicaid but too low to be eligible for private plan subsidies. Their only remaining option is to pay full price for insurance, something that is cost-prohibitive for most low-income individuals and families.

“I think the ACA has been great for a large group of patients, but the insurance exchanges do not benefit many of the patients our safety net clinics and charitable care programs serve,” said Sheila McGreevy, M.D., of the University of Kansas Medical Center. “That group of patients is still there, needing help.”

THOSE WHO DO NOT QUALIFY FOR MARKETPLACE SUBSIDIES CONTINUE TO FACE BARRIERS TO INSURANCE COVERAGE AND HEALTH CARE.



NEW MUSCLE FOR FEDERALLY QUALIFIED HEALTH CENTERS

Much of the ACA's focus to date has been on expanding insurance coverage, but new resources have been directed toward extending care to the underserved. One of the most important tools for accomplishing this has been the law's favorable treatment and increased funding for Federally Qualified Health Centers (FQHCs).

FQHCs are designated community-based health centers that provide comprehensive primary health care and behavioral and mental health services to all patients, regardless of their ability to pay or their health insurance status. Located in medically underserved areas, FQHCs are a critical piece of the health care safety net and play an essential role in expanding care through the ACA. FQHCs serve patient populations that are predominantly low-income, minority and uninsured or that rely heavily on public insurance.

FQHCs are entitled to a range of benefits in exchange for meeting rigorous federal requirements, including favorable cost-based reimbursement from Medicare and Medicaid, federal grants to offset the costs of caring for the uninsured, federal malpractice protection for providers and other benefits.

As is the case with other ACA initiatives, an emphasis has been placed on expanding preventive services and developing quality outcomes within the FQHC model. Particular attention has been paid to the needs of the low-income elderly and low-income special needs patients, since both populations tend to have higher medical costs and more complex care needs.



FQHCs ARE A CRITICAL PIECE OF THE HEALTH CARE SAFETY NET AND PLAY AN ESSENTIAL ROLE IN EXPANDING CARE THROUGH THE ACA.





“The new money for FQHCs was geared toward both supporting the existing facilities and getting new sites out there,” said Sheldon Weisgrau, director of the Health Reform Resource Project. “So we have a lot more safety net clinics than we otherwise would have had without this level of federal support.”

The Health Partnership Clinic of Johnson County functioned as a free clinic for many years before converting to an FQHC. The process of applying for and receiving FQHC designation is complex and resource-intensive, but the Health Partnership Clinic prevailed. The clinic now accepts a variety of insurance products and provides approximately five times more care visits annually for adults and children than it did in 2011.

In addition to the support for FQHCs, other federal-level policies have had an important positive impact on the safety net population. The Children’s Health Insurance Program (CHIP), while not part of the ACA per se, remains a primary source of public health insurance for children. The program allows families to purchase coverage for children at reduced rates and has proven highly effective in cutting the number of children who are uninsured while increasing appropriate screening and preventive services.

Currently, 93,000 children in Missouri and 76,000 in Kansas participate in CHIP. Congress recently passed legislation to extend the program through 2017, although uncertainty exists about long-term funding as the health insurance exchanges and the ACA mature.



MEDICAID WOES

Perhaps the most challenging aspect of ACA-related reform locally has been the decisions by both Kansas and Missouri not to participate in expanded Medicaid coverage. The ACA provided funding to increase Medicaid coverage. But the Supreme Court ruled in 2012 that it was up to the states to decide whether to implement expanded Medicaid eligibility and coverage.

Unfortunately, the rejection of expansion by Kansas and Missouri legislators has left thousands who would otherwise have health coverage without access to Medicaid. Not only does this undermine care for vulnerable populations, including the working poor, but it also has increased the already heavy burden facing safety net providers.

“Our patient population is largely not eligible for the ACA because they fall within that income eligibility gap, so our only saving grace could conceivably be Medicaid expansion,” said Hilda Fuentes, chief executive officer of Samuel U. Rodgers Health Center.

KANCARE WORRIES

In Kansas, the decision not to expand Medicaid left an estimated 60,000 residents uninsured who would have otherwise qualified for Medicaid and accelerated a trend of continually reduced funding for safety net providers. Many stakeholders believe the problems surrounding Medicaid have been compounded by the 2013 conversion of the state's entire Medicaid population to managed care plans.

Critics say the decision to shift Medicaid to commercial managed care under the KanCare initiative has significantly undermined the Medicaid system. Problems include difficulty in credentialing providers, low provider payment rates, slow payments to providers, limited options for enrollees seeking redress or adjudication, and major concerns surrounding a reduction of services to special-needs populations.

**IN KANSAS, THE DECISION
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WHO WOULD HAVE
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MISSOURI CUTS

As in Kansas, Missouri's rejection of Medicaid expansion has reduced access to care for many in need. An estimated additional 300,000 individuals would have been covered under the expanded program. Advocates say the decision compounds the extensive damage done to the Medicaid program by a series of deep cuts initiated in 2005. The funding reductions and changes in eligibility for some low-income families, disabled and elderly that year resulted in 147,000 individuals losing coverage.

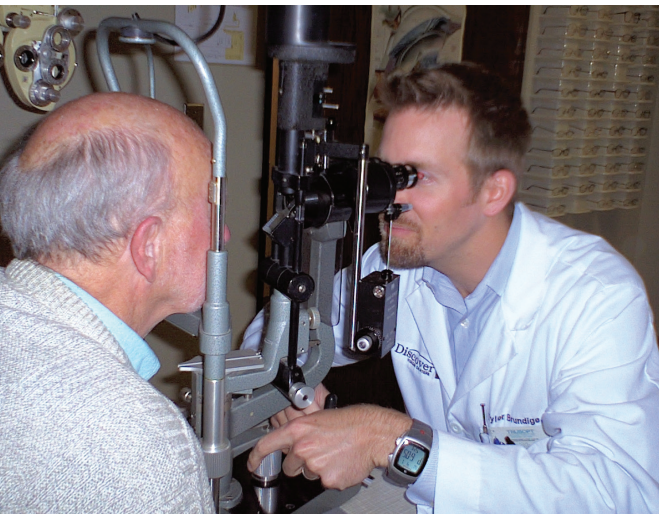
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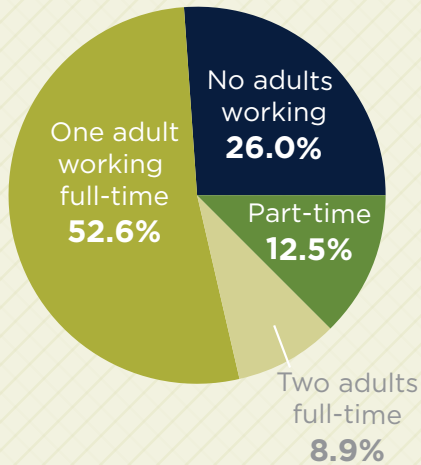
Other changes have contributed to weakened safety net care in the state. In 2013, the Missouri's Family Support Division underwent a significant reorganization. The consolidation of processing from local offices to regional centers led to difficulty in tracking applications, longer processing wait times and a lack of one-on-one access to informed case workers.

In 2014, Missouri initiated significant, phased-in tax cuts that will ultimately reduce the state budget by hundreds of millions of dollars per year. The full impact of these cuts will be felt in the upcoming budgets and will affect all levels of state safety net investment, including direct health services, support to economically vulnerable populations, public health and health care workforce training.

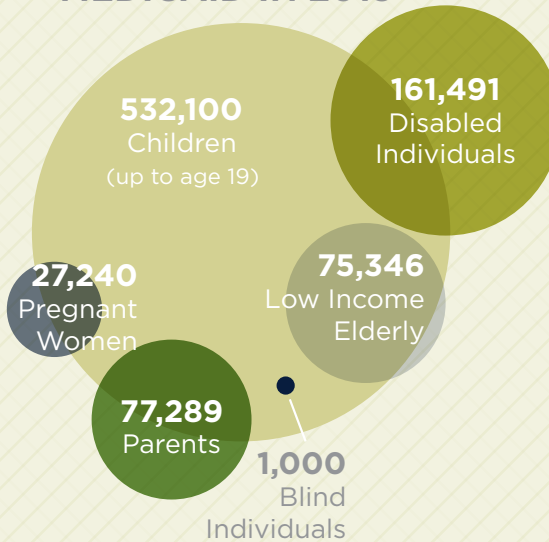
Budget pressures on both sides of the state line have already taken a toll on public health agencies. Although experiences varied across municipalities, most health department stakeholders reported that the reduction in prevention and public health funding has impeded their ability to meet the needs of the safety net population. Several area health departments have had problems maintaining services like lead screening, prenatal care and other important activities.



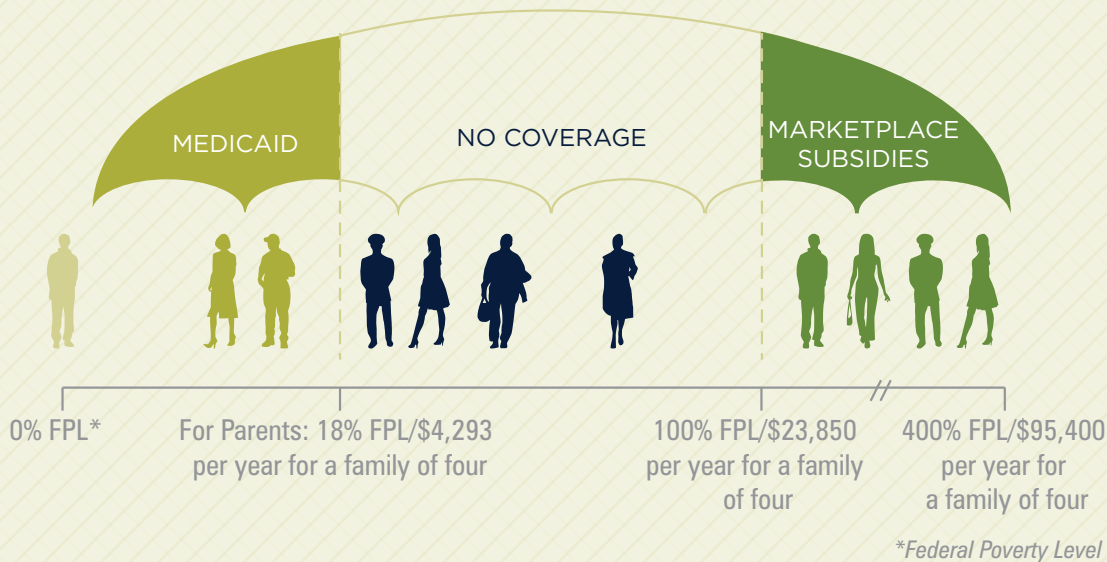
EMPLOYMENT STATUS OF THE UNINSURED



ENROLLED IN MEDICAID IN 2013



MISSOURI ADULT HEALTH INSURANCE COVERAGE GAP



STRENGTH THROUGH ADVERSITY

Despite the increasingly grim political climate in Kansas and Missouri, stakeholders say collective advocacy helped produce several notable safety net successes over the past decade. In 2009, Missouri introduced “express-lane” eligibility for children’s health insurance enrollment. This simplified approach expedited children’s insurance eligibility determination and renewal and has helped prevent lapses in coverage.

Another bright spot was the recent reinstatement of Medicaid budget appropriations for the coverage of adult dental services in the state. The full impact of this funding will not be seen for more than a year, but it will help meet a major need for Medicaid recipients.

Locally, ongoing support for the Kansas City, Missouri, Health Levy continues to provide a vital lifeline for safety net providers. In 2005, Kansas City voters passed a 22-cent increase to the city’s health levy during a time when state Medicaid funds were being cut. Thanks in large part to the collective advocacy efforts of providers, advocates and local foundations, the levy was again approved in 2013. This extended funding for the local safety net system for an additional nine years.

The levy produces approximately \$50 million annually from property taxes and service charges and helps support Truman Medical Center, five safety net clinics, the Kansas City Health Department and ambulance services.

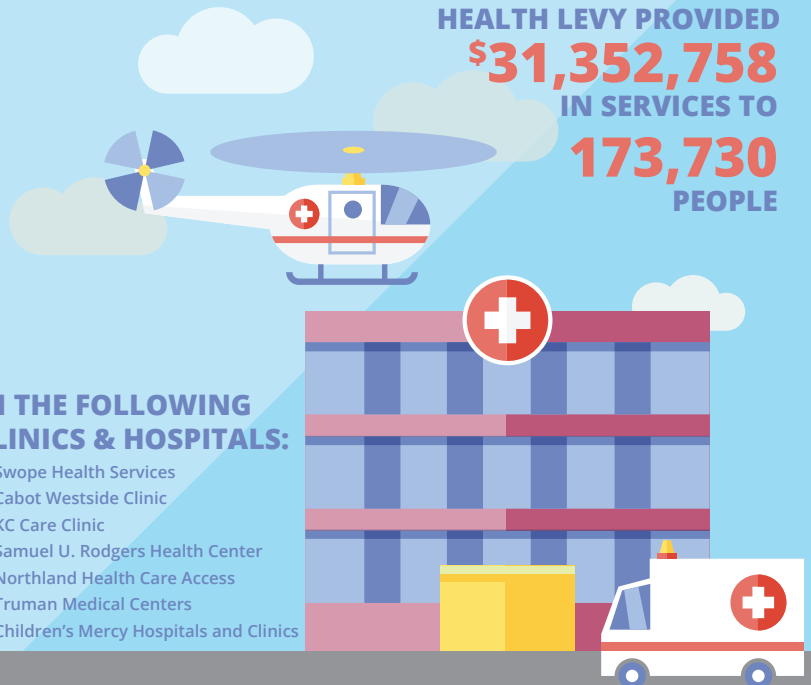
**KANSAS CITY,
MISSOURI, VOTERS
APPROVED A 22-CENT
INCREASE TO THE
CITY’S HEALTH LEVY
FOR THE SECOND TIME,
CONTINUING A VITAL
LIFELINE FOR LOCAL
SAFETY NET PROVIDERS.**

KANSAS CITY, MO HEALTH LEVY

IN 2012, THE
HEALTH LEVY PROVIDED
\$31,352,758
IN SERVICES TO
173,730
PEOPLE

IN THE FOLLOWING CLINICS & HOSPITALS:

- Swope Health Services
- Cabot Westside Clinic
- KC Care Clinic
- Samuel U. Rodgers Health Center
- Northland Health Care Access
- Truman Medical Centers
- Children’s Mercy Hospitals and Clinics



SAFETY NET CAPACITY EXPANSION

Since 2009, several clinics have worked together to provide more non-urgent care hours on both evenings and weekends. By partnering they have efficiently used resources, and added additional hours in a well-distributed way. The program has greatly increased access and also led to improvements in quality of care.

From 2009 – 2014, HCF has provided this program a total of \$2,584,525 in funding.

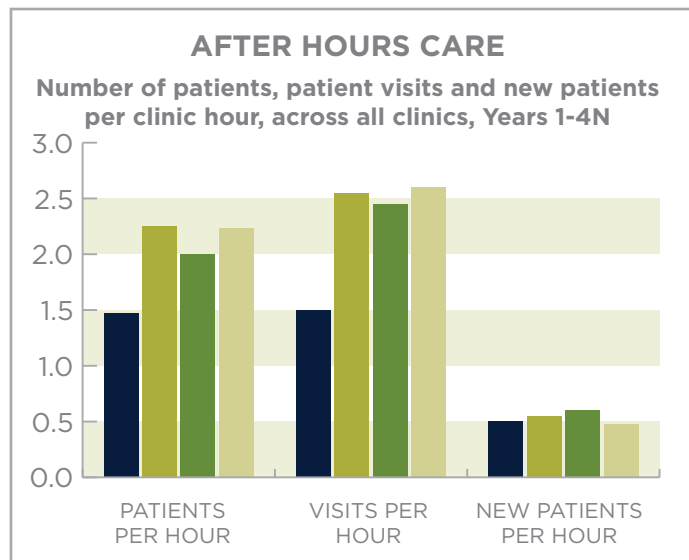
EXPANDING CAPACITY

Many organizations have increased capacity in the face of growing demand as part of their efforts to capture more revenue. Swope Health Service applied for and was awarded a grant from the Health Resources and Services Administration (HRSA) to open a new access point in Kansas City, Kansas, and Children’s Mercy Hospital has created a new pediatric care satellite location in Kansas City, Kansas.

Several safety net clinics, including Kansas City CARE Clinic, Swope Health Center, Southwest Family Health Center and Health Partnership of Johnson County, all have collaborated to increase their clinic hours during evenings and weekends. The goal is to provide an alternative to the expensive emergency department care for those with routine primary care problems.

Provider consolidation — a major factor in the larger, ongoing transformation taking place across health care — is not always an option for stand-alone safety net organizations. As a result, the economies of scale and new efficiencies that mergers and acquisitions can produce in the for-profit/non-profit care arena frequently are out of reach to safety net providers.

Nonetheless, consolidation has occurred and will likely continue in those situations where cultures and missions closely align. Cabot Westside Clinic, for example, was subsumed by the Samuel U. Rodgers network of health centers in 2013. The move was viewed as a positive for patients of Cabot Westside, since they gained access to the more comprehensive range of services available through Samuel U. Rodgers, a FQHC.



“THE EXPANDED ACCESS PROJECT

has enabled safety net providers to expand the hours of clinical services to meet the needs of our patients that are employed but cannot take time off during the work day to see a medical provider,” said Sheridan Wood, chief executive officer at the Kansas City CARE Clinic.



“It’s NOT about SICK CARE anymore. It’s ABOUT HEALTH CARE.”



Although we MAY NOT be there yet, that's WHERE we're HEADED."

CATHY HARDING
WYANDOTTE HEALTH FOUNDATION

EVOLVING SYSTEMS OF CARE

The hurdles facing safety net organizations on both sides of the state line, as significant as they've been, have compelled most agencies to adapt and evolve. The convergence of forces affecting the system, in fact, has triggered a number of positive developments, including new operational philosophies and more advanced approaches to care.



Increasingly, safety net organizations are adopting sophisticated business techniques to better align with changing reimbursement patterns and funding opportunities. For many, this process has meant transitioning to new models of care that allow for improved patient outcomes, greater efficiency and more sustainable operations.

“Safety net clinics are working to transition into this new world, and usually on a shoestring budget,” said Cathy Harding, president and chief executive officer of Wyandotte Health Foundation and previously executive director of the Kansas Association for Medically Underserved.

“It’s not about sick care anymore. It’s about health care. Although we may not be there yet, that’s definitely where we’re headed. So providers of safety net clinics and private practices alike who learned to practice medicine a certain way now must re-learn how to approach it.”

Altering long-standing funding strategies has been a key part of this shift. Even though local foundations, including HCF, continue to provide critical support to fill gaps created by reduced public contributions, organizations increasingly understand the need for financial self-sufficiency.

For many, the traditional dependence on philanthropic funding and fees from low-income patients has proven problematic in today’s environment. Donor funding can be an unpredictable, patchwork solution that too often is overly reliant on relationships with donors. If and when a funder’s priorities change, a clinic can lose access to those dollars.

William Pankey, M.D., medical director for Turner House Children’s Clinic, noted that restrictions on grant funding also create problems for safety net agencies.

“We spend a lot of time chasing grants to cover the core services that we provide, but so many of those grants are project-specific,” he said. “As a result, our biggest struggle is securing operating funds and capital improvement dollars. Fewer people are interested in funding those areas.”

Added one focus group participant of the changing operational environment: “If you have an organization that’s going to provide services, you’ve got to figure out pretty quickly how to keep the doors open and the lights on. In response to changes in the market, we’ve had to rearrange the financing and develop new ways to generate revenue, primarily through public and private insurance reimbursement.”

Fortunately, the ACA and the ongoing marketplace transformation have created opportunities for organizations seeking to transition from charity care to public and private reimbursement. Although Medicaid expansion currently remains on hold in both Missouri and Kansas, some entities that traditionally had offered services free of charge completed requirements for billing Medicaid in anticipation of an expanded client population. As a result, these providers are now generating Medicaid reimbursements and are looking for additional payer opportunities.

The Kansas City CARE Clinic (previously the Kansas City Free Clinic) shifted from providing free care to accepting patients with both public and private insurance coverage. Other safety net agencies have taken advantage of new federal grants available through ACA, including FQHC funds, to both enhance the capacity of existing centers and provide support for new access points. The result has been increased revenue streams and improved long-term stability.

Physical Health Care Provided in 2014

	Outpatient visits	Unduplicated patients
Samuel U. Rodgers Health Clinic	81,143	25,512
Health Partnership	36,138	14,333
JayDoc	1,197	1,197
Turner House	12,240	4,696
Southwest Boulevard	12,694	3,554
Duchesne	4,259	1,354
HCC	8,231	2,747
Truman Medical Center	322,387	112,814
KC Care Clinic	11,287	8,841
Swope Health Services	213,981	39,653



Making the transition from a charity-self-pay model to third-party payments and/or becoming an FQHC are not simple tasks. But the process ultimately has helped create more financially sound organizations. Turner House Children’s Clinic, though not an FQHC, has adopted a more rigorous business approach and in so doing, increased its financial viability as well as the number of patients the organizations can serve.

NEW CARE MODELS

Underpinning the financial and structural changes taking place in the safety net community are new delivery models designed to improve care quality, continuity and efficiency. Among the most prominent of these are the patient-centered medical home (PCMH) and the accountable care organization (ACO). Both approaches are designed to better coordinate and integrate care and are supported by a range of provisions within the ACA.

As these models have gained traction across the larger health care system, area providers and organizations have worked to adapt them to the safety net arena. Stakeholders overwhelmingly agree that this shift has been beneficial in meeting the needs of the underserved.

The PCMH model — developed and promoted by the Agency for Healthcare Research and Quality — is focused on transforming the way primary care is organized and delivered. PCMHs typically incorporate several key characteristics:

- Care is delivered in a patient-centered and coordinated fashion between different providers.
- The full spectrum of services is provided, including preventive services, acute care, chronic care and end-of-life care.
- Services are made as accessible as possible, with a heightened focus on patient communication, quality and safety.



Area safety net clinics were already moving toward the PCMH model before the ACA provided a framework and incentives for accelerating the transition. In the past few years, a number of regional safety net providers — including Turner House Children's Clinic, Health Partnership Clinic, Silver City Health Center and Children's Mercy Hospital — have become recognized by the National Committee on Quality Assurance as patient-centered medical homes.



“OVER THE YEARS the complexity of the patients we treat has grown with many being seen for chronic illnesses that require frequent appointments for multiple issues,” said Sheridan Wood, chief executive officer at the Kansas City CARE Clinic. “Being accredited by NCQA as a Patient-Centered Medical Home reflects our commitment to comprehensive care for these patients with a team that focuses on the individual’s unique needs.”

“To achieve this level of recognition, you have to truly transform how you provide care,” one advocate said. Another stakeholder emphasized that Kansas City safety net providers are fully committed to changing the way care is provided. “Whereas in other states it’s about checking the box, the clinics in this area said, ‘If we’re doing it, we’re doing it fully. We’re going all in.’”

A major component in the push toward more coordinated and integrated care has been recognition of the complexities that surround many safety net patients’ lives. “People want to be treated more where they live and regularly gather,” one provider said. “That’s part of the medical home concept. It’s why coordinated care matters so much.”

To date, much of the effort to improve integration locally has focused on linking primary health care with both behavioral and oral health.

“Our health centers have tried to build capacity to offer more services under one roof so that patients can get all medical services in one place,” said Joe Pierle, chief executive officer of the Missouri Primary Care Association. “You can no longer simply provide care in isolation. You need to take a coordinated approach. Yet you still have the same limited resources and portion of the population that is not reimbursed. So it’s definitely a challenge.”

Financial support for integration efforts has been crucial. Early funding was provided by the REACH Foundation, which in turn recruited Qualus, a national organization that has helped several local clinics achieve PCMH recognition. HCF, for its part, partnered with the Missouri Foundation for Health and a consortium of funders to support the Missouri Health Home Learning Collaborative. The collaborative is a statewide group of physical and mental health providers working collaboratively toward PCMH recognition.

“Today, parents can bring a child into Health Partnership Clinic for a medical visit, a dental visit and a behavioral health visit all on the same day and all delivered in an integrated manner,” said Jason Wesco, president and CEO of the Health Partnership Clinic.

“That’s going to save the entire system a lot of money. I’m not sure I can quantify those savings, but think about the improved nature of care that child will receive and how much easier accessing care has become for the family.”



“YOU CAN NO LONGER SIMPLY PROVIDE CARE IN ISOLATION. YOU NEED TO TAKE A COORDINATED APPROACH... SO IT’S DEFINITELY A CHALLENGE.”

JOE PIERLE, MISSOURI PRIMARY CARE ASSOCIATION

QUALITY CONTROL

Improved care quality is a primary goal of today's health care transformation and thus has been an integral element, directly or indirectly, in nearly all of the reform work done across the safety net community. A growing number of organizations are adopting evidence-based care, or systematic protocols that ensure clinical best practices. Improved patient safety — including medication safety — likewise has become prominent in area care programs. Not only do these programs support clinical improvements, but they can also boost reimbursements.



IN 2007, Children's Mercy Hospital received a PIN Grant from the Robert Wood Johnson Foundation, with matching funds from HCF, to develop the Clinical Scene Investigator program. This program provided nurses with the knowledge and support necessary to implement nurse-led quality improvement projects, which have been shown to improve patient and staff outcomes as well as boost economic efficiencies.

“What we're seeing with all the insurance companies is that we can get much better rates if we deliver on quality rather than just pure numbers,” said one stakeholder. Providers conceded that measuring quality outcomes for commercial payers can be challenging, in part because the federal government remains primarily focused on the volume of patients served.

And even with the benefits the PCMH model can create, not all organizations have the resources or capabilities to make the transition. Challenges that include safety net continuity, workforce shortages and information technology requirements have made it difficult for some providers to accommodate the PCMH model.

An accountable care organization (ACO) provides similar integration benefits for both providers and patients. A central goal of the ACO is to ensure that patients — particularly those with chronic health conditions — get the right care at the right time, while avoiding unnecessary duplication of services and medical errors. However, because ACO incentives at this point are primarily oriented toward the Medicare population, and because most safety net providers serve Medicaid patients, the approach has so far seen little uptake in the Kansas City area safety net community.



CONNECTING CARE

Information technology is essential to virtually all advanced models of health care. Better information exchange holds the promise of increasing care quality, efficiency and integration, while reducing costs for payers, providers and patients.

Not all organizations have had access to the resources required to adopt new applications and maintain pace with the systemic changes driven by information technologies. However, those that have managed to secure funds to acquire and implement electronic health records (EHRs) and health information exchanges (HIEs) have seen significant benefits.

“The quality of care in the safety net system has improved dramatically with the advent of electronic medical records and health information exchanges,” said Dave Barber, president and chief executive officer of Swope Health Services. “Being able to review information such as lab reports, test results and medication history from other clinics provides a solid foundation for the care needed at that moment. It can also lessen the chances of someone receiving duplicate tests or excess medications.”

The push to help fund EHRs capable of facilitating quality reporting has grown as public funders and large foundations increasingly ask safety net organizations to report health outcomes data.

In Kansas, major support for EHRs has come from the Kansas Association for the Medically Underserved (KAMU). The organization was instrumental in helping Kansas City, Kansas, safety net providers move forward with selecting and implementing EHRs. KAMU is the federally designated Primary Care Association (PCA) in Kansas, and among other tasks, is required to provide training and technical assistance for FQHCs.

In 2009, another organization, the Kansas Foundation for Medical Care, received a regional extension center grant to help clinical practices implement electronic health records and achieve functional use of the systems.

Federal incentive programs — most notably 2009’s HITECH Act — have been developed to support the adoption of EHRs by physicians and hospitals and to provide decision support at the point of care. Unfortunately, few safety net providers beyond FQHCs have been eligible for the meaningful use funding to help offset the cost of EHR implementation. Nonetheless, Turner House Children’s Clinic and the Health Partnership Clinic have successfully received HITECH Act meaningful use funding. One of the most important aspects of this funding is decision support for providers at the time of visit.

**“BEING ABLE TO
REVIEW INFORMATION...
FROM OTHER CLINICS PROVIDES A
SOLID FOUNDATION FOR
THE CARE NEEDED
AT THE MOMENT.”**

DAVE BARBER, SWOPE HEALTH SERVICES



IMPLEMENTATION CHALLENGES

Covering the costs of building and sustaining a robust health information technology (HIT) infrastructure continues to represent a critical gap in the transformation of the safety net system. But even when funding is available, the road to successful EHR implementation can be a bumpy one.

Several safety net providers noted that most EHR systems have not been developed with safety net care in mind, nor do they adequately address the needs of new integrated care models. As a result, implementations frequently require extensive redesigns or workarounds, as well as the adoption of new work flows.

Modifying internal processes to accommodate the EHRs, in turn, can require a steep

learning curve and increase the time providers spend on technology-related activities. This diminishes opportunities for patient care and can lead to decreased provider productivity.

“I think many administrators were under the impression that the EHR would allow the entity to see more patients, but that hasn’t panned out,” one stakeholder said. “The documentation elements of EHR require that you spend the same amount of time as before.”

Overall, safety net providers agree that EHRs have enabled better coordination of care and improved patient outcomes. But implementation can be daunting, and many organizations are concerned that accommodating new technology will continue to divert energy and resources from their primary mission of caring for patients.

**OVERALL, SAFETY
NET PROVIDERS AGREE
THAT EHRs HAVE
ENABLED BETTER
COORDINATION OF
CARE AND IMPROVED
PATIENT OUTCOMES.**

REGIONAL INFRASTRUCTURE

Electronic health information exchanges (HIEs) provide a community-wide electronic infrastructure that allows EHRs and providers to communicate with each other. With access to an HIE, doctors, nurses, pharmacists, other health care providers and patients can securely share and access vital medical information. This capability contributes to improvements in the continuity, quality, safety and speed of care, while helping reduce costs.

Though still in the early phases of implementation, HIEs are emerging in the Kansas City region and are altering the way safety net providers operate. Safety net organizations in the greater Kansas City area are served by three HIEs: The Missouri Health Connection (MHC), the Lewis and Clark Information Exchange (LACIE) and the Kansas Health Information Network (KHIN).

Over the past decade, funding provided by HCF has played an important role in helping bring the HIE concept to life. One early effort that received HCF funding was the Kansas City Bi-State Health Information Exchange (KCBHIE). The initiative — which was incorporated in 2010 and later became known as eHealthAlign — was one of several initial collaborative efforts that brought together stakeholders interested in the sharing of health information.

Eventually eHealthAlign dissolved due to increased competition throughout the region, but it was nonetheless successful in helping develop a collective vision for a regional HIE system.

Most recently, HCF funding provided a group of Community Mental Health Centers and safety net primary care clinics with funds to build HIT capacity for improving care coordination and reducing both emergency department use and hospital readmissions.

OVER THE PAST DECADE, FUNDS PROVIDED BY HCF HAVE PLAYED AN IMPORTANT ROLE IN HELPING **BRING THE HIE CONCEPT TO LIFE.**



AN EXPANDING WORKFORCE

As important as technology is, it will ultimately be the clinicians, administrators and support staff on-site who will determine how effective today's health care transformation can be across the Kansas City area. Fortunately, the area's safety net workforce has continued to evolve to keep pace with changes in the design, delivery and reimbursement of care.

More formalized training and the creation of new roles have helped organizations adapt to new tasks and responsibilities. In fact, the Kansas City area has emerged as a leader in the development and training of a new professional designation focused on helping meet the needs of the underserved.

Stakeholders say one of the most far-reaching workforce changes that has occurred throughout the safety net community in recent years has been an evolution away from volunteer staffs to paid providers and administrators. This transition has helped create greater stability across organizations and ensured that the necessary skills are available to function effectively in an increasingly complex environment.

IN FACT, THE KANSAS CITY AREA **HAS EMERGED** AS A LEADER IN THE **DEVELOPMENT** AND **TRAINING** OF A NEW **PROFESSIONAL DESIGNATION** SPECIFICALLY FOCUSED ON **HELPING MEET** THE **NEEDS** OF THE **UNDERSERVED**.

A paid staff is especially important for those organizations that have applied to become FQHCs or have already achieved that designation, as well as entities that have shifted to the patient-centered medical home model. The importance of quality reporting and EHR use in the new delivery models necessitates greater HIT skills at both the clinical and administrative levels. Coordination of care and patient navigation also are vital in new delivery systems, as is the integration of care with non-clinical social service agencies.

The employed staffing model has played a major part in accomplishing these goals. And, a new professional role is emerging to help accomplish these objectives while boosting both the scope and quality of care in the region, stakeholders say.

Known as community health workers (CHWs), this public health professional credential is focused on preparing non-clinicians to take into account the experiences, language and culture of the populations they serve in order to improve outreach and education. CHWs also work to connect community members with health services and advocate for individual as well as community health needs.

The ACA included provisions that are helping enhance the role of CHWs in the U.S. health care system. These include an increase in federal and state funds to support efforts aimed at formalizing the CHW designation through standardization of definitions, scope of work practice, training and certification.

Area institutions are leading the way in codifying CHW educational requirements and role definitions. The Missouri Department of Health and Senior Services, for example, helped the Metropolitan Community College in Kansas City develop a CHW curriculum that included a six-week program for those interested in obtaining a CHW certificate. Scholarships made available with funds from the U.S. Department of Health & Human Services, Health Resources & Services Administration, Bureau of Health Professions and others have helped boost the program.

In addition, the Regional Health Care Initiative (RHCI) several years ago established a program to develop uniform CHW curriculum and training and to educate employers on how CHWs can strengthen the workforce and reduce costs. Other local resources include Care Connection, a collaborative CHW program between St. Luke's Hospital and Kansas City CARE Clinic that employs six CHWs.

Several programs supported by HCF are using CHWs to promote linkages between health systems and community resources with the objective of discouraging high utilization of emergency departments. Finally, the Kansas City CARE Clinic is working with Swope Health Services, Health Partnership of Johnson County and Family Health Center to provide CHWs to better connect patients with available community resources.

Because needs differ between organizations and no fixed blueprint for care coordination and patient navigation yet exists, the CHW position will continue to evolve to meet patient and provider needs, stakeholders say.

Funding to support professional staffing continues to be a major issue for all safety net organizations, despite the availability of federal grants and assistance from area foundations, including HCF. To help control salary requirements, some organizations are using physician extenders, such as nurse practitioners, in lieu of physicians. Efforts also are under way to expand the roles of other care professionals, including emergency medical technicians, pharmacists and physical therapists.



PULLING TOGETHER

One of the most encouraging developments that has occurred in the safety net community over the past decade has been a dramatic increase in collaborative efforts between and among organizations. Greater cooperation and communication continues to be instrumental in developing a range of solutions to systemic problems.

“In 2004, we had very few advocacy organizations or advocates in the capitol,” said Amy Blouin, executive director of the Missouri Budget Project. “With the infusion of resources in the policy-based organizations, we really developed a network of health advocates that could fight for the safety net. People have been working together much more strongly. In particular, there is currently a very broad, diverse group working on Medicaid expansion.”

The organizational isolation that had long characterized much of the area’s safety net community began to fade in 2007, when the Mid-America Regional Council’s Regional Health Care Initiative established a safety net collaborative. This effort brought providers together to improve trust and to develop a vision for collective action.

Funded by area foundations, including HCF, REACH Healthcare Foundation, the H&R Block Foundation, the Hall Family Foundation and others, the collaborative has continued to engage in strategic planning and also has developed topical sub-groups.

Numerous forums, meetings and facilitated conversations among grantees working on similar issues have deepened relationships among individual institutions and fostered new solutions.

“I think that philanthropy, including HCF, has played a critical role in building the infrastructure and in sustaining the limited advocacy that we have around those investments at the state level,” said Shannon Cotsonradis, president and chief executive officer of Kansas Action for Children.

“Without the strength of our philanthropic community, not only would we have not seen gains in the infrastructure and the ability to provide services, but we wouldn’t have had the advocacy that we have at the state level to benefit those vulnerable children and families.”

Along with collective advocacy efforts, the safety net system has engaged in numerous collaborative projects and programs over the past 10 years. In many cases, stakeholders said, the efforts were set in motion by joint funding opportunities. The result has been new partnerships and innovative initiatives across the system. One example: Truman Medical Center received an innovation grant from the Centers for Medicare and Medicaid Services (CMS) in 2012 and partnered with Communities Creating Opportunity to incorporate a community organizing component in their care coordination program.

HCF has
awarded the
Regional Health
Care Initiative

\$1.4

MILLION
DOLLARS

over the past

8 YEARS.



Another prominent collaborative success has been system-wide efforts to improve networking and referrals across organizations. Because not all institutions can provide a full range of services or have expertise in multiple fields, it becomes advantageous for providers to partner to help fill the gaps in care.

MetroCare and Wy/Jo Care are community partnerships with private physicians designed to improve access to specialty health care for low-income, uninsured residents throughout the metro. Accessing specialty care can be very difficult for the uninsured or underinsured. Without the ability to pay the high cost of care, patients often go without. These referral programs combine care provided in primary care clinics with donated specialty care offered in private practice offices. All told, the partnerships have leveraged approximately \$56 million in donated specialty services.

“Our thinking today is that we can’t do everything,” said Dave Barber, president and chief executive officer of Swope Health Services. “And, rather than attempt to, we’ve formed a robust referral network that allows each of us to play to our strengths and deliver the care people need.”

Stakeholders concede that the collaborative process is not without challenges. They note that working with other organizations can be time-consuming and can crowd out other priorities. In addition, aligning can be difficult when groups are at different points on the spectrum in terms of their own transformation efforts.

Some observers also described difficulties in getting partners to share similar data to more accurately evaluate initiatives, an issue that is particularly prevalent in programs involving both safety net and non-safety net institutions. Frequently, these problems stem from different approaches to measuring as well as reporting clinical information.

HCF HAS AWARDED
 the MetroCare/WyJo Care Specialty Care Project

13 GRANTS, totaling
\$3,284,700
 to engage medical professionals
 to provide voluntary health care services.

This funding **HAS LEVERAGED**
 more than **\$56 MILLION** in care.





LESSONS LEARNED

Even in a climate characterized by profound political and financial uncertainty, most observers believe the area safety net system today is stronger today than ever before.

An emphasis on rapid adaptation, coupled with greater collaboration and more diversified funding, has allowed the system to prevail in a period marked by frequent and dramatic change.

Greater system capacity, improved models of care and increased financial self-reliance all have emerged during the trial by fire that most providers have endured. At the same time, the broader commitment to reforming the health care system — as evidenced in the many changes brought about by the ACA — has created an increasingly solid framework for sustaining the hard-won gains of the past 10 years.

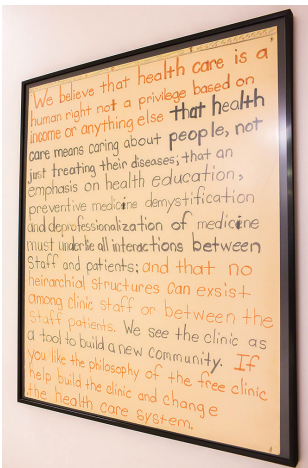
“We have traveled a great distance,” one provider said. “But the journey does not end.”

LOOKING AHEAD

The past decade has been a tumultuous time for the safety net community — one marked by major shifts in policy, technology, care delivery and reimbursement. Although the grinding uncertainty of recent years will likely continue, stakeholders are largely in agreement about priorities for improving safety net care in the years ahead.

Key objectives include:

- Continuing to enhance the quality of integrated care through patient-centered medical homes and community health worker programs.
- Developing a greater focus on upstream social determinants of health.
- Increasing collaboration through collective advocacy and other avenues.
- Expanding funding for both core operations and innovative initiatives.
- Providing leadership to create a common vision and agenda for the future.



SOLIDIFYING NEW APPROACHES

The emergence of the PCMH, coupled with the role of community health workers (CHWs), has created opportunities to increase knowledge surrounding current trends and best practices. Because the process of becoming a certified PCMH can be time-consuming and complicated, efforts to share the lessons of those who've already progressed to certification should be formalized and expanded. As for provider integration efforts generally, stakeholders expressed a desire to learn more about the health and economic outcomes resulting from existing initiatives, both to inform future efforts and to help secure additional funding.

Community health worker programs, meanwhile, have the potential to significantly strengthen the safety net system and bring care directly to where patients live.

Observers agree that the Kansas City area should capitalize on its leadership role in the emerging CHW field to better define training and workplace roles, and to explore opportunities for public and commercial reimbursement.

MOVING UPSTREAM

As part of the PCMH's overall emphasis on treating the whole person, stakeholders emphasized that providers, funders and government need to focus more preventive social determinants of health. These include issues like poverty, educational opportunities, employment, housing and income. Working to address problems at an earlier stage can help mitigate health concerns later on.

Community-based organizations have emphasized the need to build healthy physical and social environments to support the lives of their clients.

“Safety net providers, in my opinion, can take a much wider role than just providing direct care,” said Joe Pierle, chief executive officer of the Missouri Primary Care Association. “I think they have to be rooted in the community and working to solve societal issues in a broader context.”

Examples of this kind of proactive approach could include working to rid a home of asthma-causing mold instead of merely treating the condition. Community-based organizations have emphasized the need to build healthy physical and social environments to support the lives of their clients outside of the clinical or social service setting.

One option for providing care where patients live is to enlist care coordinators to support patients in meeting basic needs for themselves and their families. “It could be as simple as having coordinators on-site with the medical providers to make sure that the individual is working with other social support entities in the community, whether it’s job training, housing or whatever else,” one stakeholder said.





EXPANDED COLLABORATION

Stakeholders believe more should be done to bring clinicians, community-based organizations, consumers and advocates together, despite the progress that's been made in recent years.

“There is a continued role for the safety net collaborative, but it needs to be inclusive,” said one stakeholder. “If we are going to change the culture of the safety net system, it can't be just the providers sitting at the table. There has to be meaningful and equal participation of other voices and entities to be able to shift how health care delivery happens here.”

Said another participant: “I wish there was a place where the safety net folks could meet and have real problem-solving sessions, and real discussions about what's going on or what's going to happen when x, y, and z occur.”

Clinics and other providers could also benefit from closer cooperation with hospitals outside of the traditional safety net system. Because all non-profit hospitals are required to conduct a regular collaborative community health needs assessment, this process could present an ideal vehicle for fostering greater system-wide collaboration.

Collective advocacy, which has played a role in bringing about important policy changes over the past decade, should continue to be a priority for area organizations.

Expanding these efforts to include more than a handful of organizations would improve the probability of sustaining a strong safety net system. One means of helping engage more providers is targeted education surrounding government policies. Many providers are not experienced with advocacy and are unaware of the opportunities that exist to influence policy.

Collective advocacy will continue to be essential around issues that affect the entire system, as evidenced by the work done around Medicaid expansion, CHIP reauthorization and the Kansas City Health Levy.

“When you look at what's going on in both states, all of us are affected by some of these policies, so we need to speak with one voice,” one stakeholder said.

RELIABLE FUNDING

Even with changing models of care that emphasize financial self-sufficiency, most safety net providers remain dependent on multiple sources of grant funding for core operations. It is therefore critical that a variety of funding sources continue to support both day-to-day operations as well as new programs for responding to the changing health care environment.

“I think anybody in health care now has a real sense of insecurity,” said Jason Wesco, president and chief executive officer of the Health Partnership Clinic. “We just don’t really know what the future is going to look like. We just know it’s coming really fast.”

Chronically underfunded operating budgets reflect, in part, the ongoing erosion of government contributions. In addition, philanthropic funders may lack a full appreciation of the resources required to operate a safety net institution.

“Many of the safety nets are small hand-to-mouth kinds of organizations,” said one stakeholder. “They scrap for every dollar, and they have been heroic in many cases just to be keep the doors open. It’s really hard to wake up each day and think about how you’re going to make payroll.”



“THERE IS TREMENDOUS PRESSURE ON THE CLINICS NOW THAT WAS NOT PRESENT FIVE OR TEN YEARS AGO.”

JASON WESCO, HEALTH PARTNERSHIP CLINIC

One stakeholder pointed out that core funding can have a multiplier effect: “Increased access to core operating support leads to greater sustainability, expansion of services, increased encounters and greater professionalization of staff.”

Beyond core funding, organizations will require technical assistance and consultation, as well as a real-time feedback from funders to support implementations in new areas. Specific areas targeted for innovative solutions include behavioral health integration, telemedicine, modified medical home models and social entrepreneurship.



WORKFORCE CHALLENGES

Workforce issues present significant problems for many safety net providers. This has become particularly true as organizations shift from a volunteer approach to salaried staff. Competition for bilingual practitioners and primary care providers, as well as salary pressures from competing non-safety net organizations and the high debt loads carried by many new clinicians, all have made it difficult for safety net organizations to recruit and retain personnel.

“We do tend to bleed talent. We can’t pay what the others pay,” said one working group participant. “They can offer all kinds of incentives like 12-hour shifts, weekend differential, night-shift pay, and a lot of other incentives. We can’t really do that.”

In Wyandotte County, Kansas,

15.6
PERCENT

of residents speak a language other than English, with Spanish being most prevalent.

Because safety net providers learn to function in resource-limited settings and are trained to focus on population health, they are increasingly in demand by for-profit institutions outside the safety net system. And while the safety net workforce is largely mission-driven, the realities of higher salaries and better benefits continue to draw clinicians away.

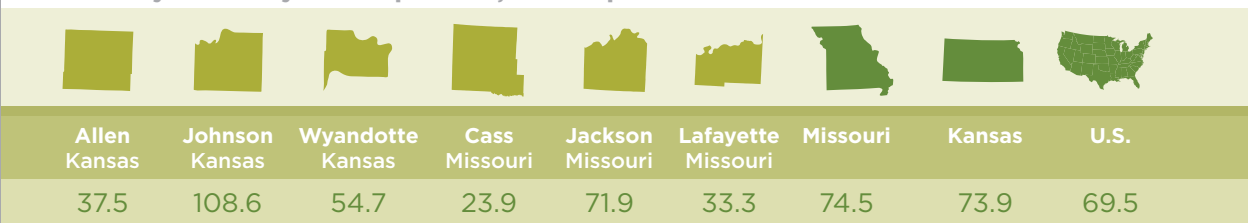
Most believe that the medical education system, with its increasing tuition and subsequent debt burden, hampers efforts to enlist new physicians. Additionally, many younger physicians are less available to volunteer to provide care free of charge.

Finally, provider diversity remains a serious and chronic difficulty in the safety net system. Recruitment of bilingual staff has been a particular challenge. “When you start getting into the mid- and high-level professions, it becomes very difficult to find someone who speaks Spanish,” one focus group participant said. “We looked for nine months before we finally gave up.”

Eva Creydt Schulte, president and chief executive officer of Communities Creating Opportunity, said a greater emphasis should be placed on training diverse and bilingual providers across all skill levels.

“We need to be smart about Kansas City’s changing demographic and how we are preparing the labor force,” she said.

Primary Care Physicians per 100,000 Population





“WITHOUT THE STRENGTH of our
PHILANTHROPIC COMMUNITY... we wouldn't have had
THE ADVOCACY that we have AT THE STATE LEVEL
TO BENEFIT those VULNERABLE CHILDREN and FAMILIES.”

SHANNON COTSORADIS
KANSAS ACTION FOR CHILDREN



HCFDecadeofDifference.org