STRONG SAFETY NET

Strengthen the capacity of the safety net and community to provide high quality, integrated care for consumers with no or inadequate health insurance coverage.

REACH healthcare foundation

STRATEGY 1

Advocacy and policy strategies and training programs to expand the oral healthcare workforce.

This strategy is designed to expand access to oral health care services provided in the safety net system through legislative action to create a new category of trained oral health provider called the dental therapist. The strategy calls for securing legislative approval for this new category of oral health provider, along with development and implementation of training programs.

STRATEGIC FOCUS

1. Invest in advocacy and policy work at the national and state level to gain legislative approval to make the dental therapist part of the oral health team with appropriate training, supervision and reimbursement for services.
2. Invest in programs to develop and implement curricula and training for dental therapists in keeping with national accreditation standards as adopted by the Commission on Dental Accreditation (CODA)[1].

[1] Dental Therapist CODA standards: http://www.ada.org/~/media/CODA/Files/dt.ashx

TARGET POPULATION

This strategy is designed to impact the most disconnected and marginalized populations in our service area (e.g., rural and urban uninsured, undocumented, immigrants, migrants) by deploying more trained professionals in areas of the community that are largely unserved or underserved or that lack connectivity between these populations and the oral health safety net system.

BARRIERS THE STRATEGY ADDRESSES

1. Uneven distribution of oral health care providers across the REACH service area with portions of the area lacking health care services, particularly in areas of high poverty.
2. Lack of providers serving the uninsured and underinsured population, including those with Medicaid.
3. Medical and dental health professional shortage areas (HPSAs) in rural and frontier portions of the region that could be served with a dental therapist model.
4. Workforce challenges for community health centers and other public health settings due to market competition and limited resources.
5. Lack of primary care, mental health and oral health providers, specialists and supportive service providers limits access to care for uninsured and underinsured. These consumers have fewer options for care and delay seeking medical care, which results in health issues that are more advanced, costlier to treat and compounded by other morbidities.

RATIONALE/SUPPORTING EVIDENCE FOR STRATEGY

The literature on workforce expansion in the health care industry indicates that different strategies must be found to close the access gap for persons living in poverty and in HPSAs. For example, research has found that workforce shortages for physicians and nurses will not be significantly reduced, especially if Medicaid expansion occurs. Consequently, creating advanced practitioner positions such as dental therapists and supportive service health professions will be essential to closing the workforce gap.

- Nash, et al (2014) in an extensive review of the global literature on dental therapists found that the quality of technical care provided by dental therapists (within their scope of competency) was comparable to that of a dentist and in some studies was judged superior. The authors also indicate that they did not find any evidence that care provided by dental therapists is associated with safety issues or harm. The article highlights evidence that mid-level provider models have increased access to care and provided cost savings to countries which use these providers in school dental programs.[1]
- Phillips and Schaefer (2013) conducted a review of the research literature on the technical competence of mid-level dental providers. They found that 21 of the 23 identified publications concluded that mid-level dental providers were technically competent in the assessed procedures. All of the studies that directly compared the performance of mid-level providers and dental students or dentists found that mid-level providers performed equally well.[2]
- In January 2017, HRSA indicated that 100 of 105 counties in Kansas have been designated as dental HPSAs; Missouri had 113 of 114 counties designated as dental HPSAs.[3]

[1] David A. Nash et al., Dental Therapists: A Global Perspective, International Dental Journal, 58 (2008): 61-70.

[2] Phillips E., Shaefer HL. Dental therapists: evidence of technical competence. Journal of Dental Research. Jul; 92(7 Suppl) (2013): 11S-5S. doi: 10.1177/0022034513484333. Epub 2013 May 20.

[3] See http://datawarehouse.hrsa.gov/Tools/MapToolQuick.aspx?mapName=HPSADC).

DEFINITIONS

DENTAL THERAPIST: licensed primary oral health care professionals who are trained to perform basic clinical dental treatment and preventive services within a variety of practice settings.

ADVOCACY: Advocacy is defined as any action that speaks in favor of, recommends, argues for a cause, supports or defends, or pleads on behalf of others.

UNDERINSURED: Underinsured people have some form of health insurance, but lack the financial protections needed to cover out-of-pocket medical care expenses. A more formal definition of underinsured individuals includes people who are insured all year but have at least one of the following qualifiers: a) Medical expenses greater than 10 percent of annual income; b) An annual income less than 200 percent of FPL and medical expenses greater than 5 percent of annual income, and c) Health plan deductibles equal to or greater than 5 percent of annual income.

TRAINING PROGRAMS: Programs offered by higher education to prepare professionals to serve as dental therapists.

COMMISSION ON DENTAL ACCREDITATION (CODA): CODA serves the oral health care needs of the public through the development and administration of standards that foster continuous quality improvement of dental and dental-related educational programs. Graduation from an accredited program is almost always stipulated by state law and is an eligibility requirement for licensure and/or certification examinations.

INDICATORS OF EFFECTIVE IMPLEMENTATION

1. Increase the number of champions in the Missouri and Kansas Legislatures.
2. Establishment and growth of effective advocacy coalitions tasked with advancing dental therapy legislation.
3. Bills establishing dental therapists introduced in Missouri and Kansas.
4. Committee hearings with opportunities for testimony provided by dental therapist advocates and experts.
5. Legislative progress toward passage of a bill that authorizes dental therapists to operate under general supervision in the safety net system and in HPSAs across Kansas.

TARGET GOAL

Increase the number of consumers served by the health care safety net in the foundation's service area from 185,000 in 2014 to 220,000 by 2020.

STRONG SAFETY NET

Strengthen the capacity of the safety net and community to provide high quality, integrated care for consumers with no or inadequate health insurance coverage.

REACH healthcare foundation

STRATEGY 2

Implementation of strategies to transform care such as trauma-informed care, patient-centered medical home and care integration.

This strategy is designed to support organizations that are or wish to be engaged in clinical transformation to become more trauma-informed and patient-centered and to provide integrated care for uninsured and medically underserved persons.

STRATEGIC FOCUS

The primary strategic focus is the support of organizations that are or plan to transform their clinical practice. The foundation will focus its investments in nonprofit health care organizations that are in the planning or beginning stages of implementing trauma-informed care, patient-centered medical home, and/or service integration. Examples of eligible organizations include those with co-located services, partially integrated services or that demonstrate interest but lack resources or knowledge to adopt these evidence-based practices

TARGET POPULATION

This strategy is designed to impact all uninsured and underserved individuals receiving health care services in the safety net system by investing in organizations that are committed to continuous improvement and patient-centered care. In particular, homes, undocumented immigrant, migrant and transition-age youth would benefit from trauma-informed and patient-centered medical home models of care.

BARRIERS THE STRATEGY ADDRESSES

1. **Fragmented system of care:** The key safety net systems for the delivery of primary care and behavioral health—community health centers and community mental health centers (CMHCs)—have developed largely in isolation from each other with different mandates and funding structures. While the two systems may be serving the same population, the result can be fragmented systems operating in parallel and non-integrated settings. PCMH and integrated care are designed to create a more supportive experience of care, increased patient engagement in care decisions, and higher quality of care for highly vulnerable and underserved in our community.
2. **Providing services to the uninsured:** While community health centers have a federal mandate backed with substantial funding to provide care regardless of a patient's ability to pay, CMHCs are not funded to provide the same level of coverage. Due to limited public funding, CMHCs must prioritize care for those with severe and persistent mental health illnesses first, unless others with less severe conditions have insurance coverage. As a result, the uninsured with mild to moderate mental illness are often referred to the local community health center. Consequently, depending on the diagnosis and health care coverage, there are different doors to services that create a significant barrier to integrated care.
3. **Fragmented payment system:** Integrated care often involves a level of care coordination and provider collaboration that takes time and is not always billable through conventional fee-for-service systems.
4. **Vulnerable populations** are often vulnerable because of significant trauma experiences and life histories. Addressing the effects of trauma in a patient-centered, integrated care setting provides continuity of care, stable and consistent patient-provider relationships, and a marked reduction in the likelihood that health care needs are addressed before becoming life-threatening.

5. **Information sharing:** The smooth exchange of pertinent health information to and from a variety of sources is a key integration challenge.
6. **Workforce issues:** The acute shortage of behavioral health and primary care providers in many areas makes care integration difficult. This problem is compounded by the reality that primary care and behavioral health providers often are not trained or educated about how to work in an integrated setting.
7. **Lack of continuity of care** for vulnerable, low-income patients who tend to have more complex, chronic and co-occurring health conditions.
8. **Managing care transitions** historically has fallen on the patient, requiring them to navigate on their own complex systems of primary and specialty care, payers and ancillary services.
9. **Safety net clinics continue to struggle with finding the appropriate payer mix** to serve a very diverse set of patients (e.g., uninsured, undocumented, children, Medicare, self-pay, Medicaid managed care) as well as rapid changes due to health care reform. This strategy keeps safety net organizations well positioned to take advantage of anticipated changes in payment reform and the growing trend of Accountable Care Organizations (ACO).

RATIONALE/SUPPORTING EVIDENCE FOR STRATEGY

Implementing the patient-centered medical home framework has proven to be effective in delivering high quality care as well as in lowering costs and improving health outcomes. Examples include:

- In 2014, Horizon Blue Cross Blue Shield of New Jersey examined claims data for members receiving care from a patient-centered practice and compared them to members receiving care from traditional primary care settings. PCMH patients had higher rates of improvement for diabetes control, cholesterol management, and screenings such as colorectal and breast cancer screenings. Findings also showed more coordinated care was provided at lower cost as PCMH patients had lower hospital admissions rates, emergency room visits and total cost of care.[1]
- DeVries et al (2012) found patients treated within NCQA-recognized PCMH practices had equal or better care management, fewer inappropriate prescriptions as well as avoidable emergency department visits and hospitalizations.[2]
- Heyworth, et al's (2014) findings indicate patients receiving care from a patient-centered medical home reported improved satisfaction with their care, including better communication with their providers.[3]
- The Institutes of Medicine[4], the World Health Organization[5] and other leading health care institutions[6] recommend that behavioral and physical health care be provided in an integrated, collaborative fashion. These recommendations are recognition of mounting research into the interrelated nature of mental, addictive and physical illness and treatment. Research indicates that people with a variety of common and costly health conditions, such as diabetes and heart disease, are prone to behavioral health disorders that can worsen the course of the underlying disease. Recent studies also have highlighted disparate health outcomes for people with mental illness, many of whom are dying 25 years earlier than average due to non-mental illness related health problems.

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[1] http://www.horizonblue.com/about-us/news-overview/company-news/horizon-blue-cross-blue-shield-new-jersey-expands-patient-center.

[2] Andrea DeVries, Chia-Hsuan Winnie Li, Gayathri Sridhar, Jill Rubin Hummel, Scott Breidbart and John J. Barron. Impact of Medical Homes on Quality, Healthcare Utilization and Costs. Am J Manag Care (2012), 18(9):534-544.

[3] Heyworth L, Bitton A, Lipsitz SR, Schilling T, Schiff GD, Bates DW, Simon SR. Patient-centered medical home transformation with payment reform: patient experience outcomes. The American Journal of Managed Care (2014), 20(1):26-33.

[4] Institute of Medicine, Improving the Quality of Health Care for Mental and Substance-Use Conditions (Washington, D.C.: National Academy Press, 2005).

[5] World Health Organization and World Organization of Family Doctors (Wonca). Integrating Mental Health into Primary Care (Geneva, Switzerland: World Health Organization, 2008). Retrieved 19 April 2010. http://www.who.int/mental_health/policy/Integratingmhintoprimarycare2008_lastversion.pdf.

[6] U.S. Department of Health and Human Services, New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. (Rockville, MD: DHHS, 2003). Retrieved 19 April 2010. http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html.

DEFINITIONS

TRAUMA-INFORMED CARE: An organizational structure and treatment framework that involves understanding, managing and responding to the effects of all types of trauma.

PATIENT-CENTERED MEDICAL HOME (PCMH): A patient-centered philosophy that drives primary care excellence. The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA): A private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda. For seven years, REACH has supported safety net clinics in making application for NCQA patient-centered medical home recognition.

COMMUNITY MENTAL HEALTH CENTER (CMHC): A health care facility or network of agencies that is part of a system originally authorized by the U.S. government to provide a coordinated program of continuing mental health care to a specific population. It is a widely-used term with no standard definition in federal law. Medicare defines CMHCs as outpatient organizations that provide partial hospitalization services to Medicare beneficiaries. In Kansas and Missouri, CMHCs are generally nonprofit agencies with a board that is representative of the community, designated by the state mental health authority with a defined geographical service area, providing behavioral health screening/evaluation/referral, crisis, outpatient, medication services, case management, children's services, and follow-up post hospitalization services.

THE JOINT COMMISSION: An independent, not-for-profit organization that accredits and certifies more than 20,500 health care organizations and programs in the U.S. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality and commitment to meeting certain performance standards.

COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES (CARF): An independent, nonprofit organization focused on advancing the quality of services to meet consumers' needs for the best possible outcomes. CARF provides accreditation services worldwide at the request of health and human service providers.

INTEGRATED CARE: A systematic coordination of general/primary, mental and oral health care that produces the best outcomes and proves the most effective approach to caring for people with multiple health care needs. Features of fully integrated care include but are not limited to: Collaboration between providers is driven by a shared concept of team care; formal and informal meetings occur to support an integrated care model; communication is consistent at system, team and individual levels; roles and cultures are blurred or blended; information integration and sharing through EHR and other technologies; scheduling integration; care coordination; and treatment teams composed of appropriate health disciplines based on patient needs.

EVIDENCE-BASED DENTISTRY: According to the American Dental Association, "an approach to oral health care that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences."[1]

[1] http://ebd.ada.org/en/about

INDICATORS OF EFFECTIVE IMPLEMENTATION

1. Increase in the number of individuals accessing care at quality, accredited or formally recognized medical homes.
2. Increase in the number of individuals accessing care at mental health agencies that have achieved quality recognition/accreditation.
3. Improvement in patient satisfaction as reported by consumers that services are accessible, coordinated and meeting their needs.
4. Increase in the number of individuals with multiple health conditions receiving integrated care services in quality-recognized clinics and mental health agencies.
5. Increase in the number of health organizations implementing trauma-informed models of care.

TARGET GOAL

Increase the number of consumers served by the health care safety net in the foundation's service area from 185,000 in 2014 to 220,000 by 2020.

STRONG SAFETY NET

Strengthen the capacity of the safety net and community to provide high quality, integrated care for consumers with no or inadequate health insurance coverage.

REACH healthcare foundation

STRATEGY 3

Connect health care consumers, providers and services to reduce the gap between consumer need and health care.

This strategy is designed to close the gap between health care consumers and health care services in order to create greater patient access and engagement and coordinated care. Several approaches will be tested in this strategy: 1) Expand access to health care services provided in the safety net system by utilizing care connectors; 2) Deploy technology to create communication connections among providers and between providers and consumers; and 3) Deliver health services where consumers are located (place-based), especially in rural, remote or high-poverty neighborhoods not easily connected to traditional care settings.

STRATEGIC FOCUS

1. Invest in safety net organizations to expand the number of community health workers, engagement specialists, care coordinators, care navigators and connectors supporting uninsured and underinsured consumers.
2. Invest in training programs to prepare more individuals to serve in connector roles in the safety net system.
3. Invest in technology innovations (e.g., telehealth, technology-facilitated personal care management, connectivity between health care providers and organizations through HIE) and safety net organizations to utilize these innovations to improve connectivity between their patients and providers and patient engagement in care.

TARGET POPULATION

This strategy is designed to impact disconnected and marginalized populations in our service area (e.g., homeless, rural and urban uninsured, remote, high poverty, refugee, migrant, and undocumented immigrant) by deploying more trained professionals in areas of the community that lack systems to connect these populations with accessible, affordable, quality health care services. In particular, the "hotspot" neighborhoods in Wyandotte and Jackson counties and rural migrant worker programs and immigrant communities represent populations that may benefit from this strategy.

BARRIERS THE STRATEGY ADDRESSES

1. Uneven geographic distribution of health care providers across the REACH service area with portions of the area lacking a physical presence of health care services, largely in areas of high poverty in urban and rural communities.
2. Lack of primary care, mental health and oral health providers, specialists and supportive service providers makes it more difficult for the uninsured and underinsured to access health care services.
3. Consumers who are uninsured or underinsured have fewer options for care, wait longer to seek medical care and when they do seek care their diseases or conditions are more advanced, harder and costlier to treat, and are compounded by other morbidities.
4. Uninsured and underinsured individuals have less experience navigating a complex health care

system, often lack health literacy and health insurance literacy, are often distrustful of a system they don't understand, and avoid accessing services in systems that are not culturally familiar.

5. Perhaps the most important organizational barrier to the adoption of new technology is cost and trained staff. For new technology, both start-up costs and maintenance costs can be high and staffing needs tend to outpace qualified candidates.
6. According to the authors of "Reducing Barriers to Health Care: Practical Strategies for Local Organizations" report, published by the Center for Health Strategies, Inc., vulnerable populations face these barriers to accessing health care services:
    - Problems with getting drug prescriptions filled.
    - Families making inappropriate use of emergency department services because they were not equipped to use better alternatives.
    - Language and literacy barriers due to a shortage, and poor organization, of medical interpreter services and bilingual providers.
    - Problems with medical transportation due to cultural insensitivity, unnecessary restrictions, and misuse of the transportation system by providers.
    - Families needing greater health literacy on common illnesses and preventive care.
    - Lack of understanding among consumers concerning Medicaid benefits and system navigation.
    - Lack of understanding among health care providers and pharmacists concerning allowable benefits and access barriers faced by families.
    - Individuals and families being disconnected from the health care system.

RATIONALE/SUPPORTING EVIDENCE FOR STRATEGY

With growth in enrollment through the marketplace, more consumers are seeking health care and navigating health care systems with which they are unfamiliar. Many individuals will continue to be unable to obtain health insurance. These individuals face health risks as they continue to lack a pathway to coverage and access to care.

Despite efforts to increase equity in the U.S. health care system, not all Americans have equal access to health care—or similar health outcomes. With the goal of lowering costs and increasing accessibility to health care, the ACA includes certain provisions that expand health insurance coverage to uninsured and underinsured populations, promote medical homes and support coordination of care. These provisions may help narrow existing health care disparities. Many of the most vulnerable patients, however, will continue to have difficulty accessing and navigating complex health care delivery systems. Patient navigators not only can facilitate improved health care access and quality for underserved populations through advocacy and care coordination, but also can address patient distrust in providers and the health care system that leads to avoidance of health problems and non-compliance with treatment recommendations.

By addressing many of the disparities associated with language and cultural differences and barriers, patient navigators can foster trust and empowerment within the communities they serve.[1]

Health information technology (HIT) involves the exchange of health information in an electronic environment. Widespread use of HIT within the health care industry will improve the quality of health care, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork and expand access to affordable health care.[2]

People living in socially disadvantaged locations (which are usually characterized by socio-economic disadvantage, social exclusion, higher crime rates and poorer physical environments) have consistently poorer health and well-being outcomes. Urban renewal and place-based interventions have been implemented as a means of addressing the problems of concentrated social disadvantage. Place-based interventions offer options for tackling concentrated social disadvantage including addressing behavioral, psychological and material pathways and by impacting the social determinants of health in a neighborhood setting.[3]

Place-based care can be very effective in rural communities as a result of the small number of people and

the ability to build relationships among the local stakeholders. Integration of place-based care is a way to efficiently utilize resources and get the community involved in taking care of one another.[4]

[1] Natale-Pereira, A., Enard, K. R., Nevarez, L., & Jones, L. A. (2011). The Role of Patient Navigators in Eliminating Health Disparities. Cancer, 117(15 0), 3543–3552. http://doi.org/10.1002/cncr.26264.

[2] The Office of the National Coordinator for Health Information Technology (ONC) Office of the Secretary, United States Department of Health and Human Services. Federal Health IT Strategic Plan: 2015-2020. http://www.healthit.gov/sites/default/files/federal-healthIT-strategic-plan-2014.pdf

[3] Larsen, K. (2007). The health impacts of place-based interventions in areas of concentrated disadvantaged: A review of the literature. Sydney, AU: Sydney South West Area Health Service

[4] Simmer-Beck, M., and Branson, B. (2014). Place-based dental care. Available: http://www.dentalcare.com/media/en-US/education/ce452/ce452.pdf

DEFINITIONS

EXPANSION: Expanding the staffing of connectors and technology in the safety net system.

UNDERINSURED: Underinsured people have some form of health insurance, but lack the financial protection needed to cover out-of-pocket medical care expenses. A more formal definition of underinsured individuals includes people who are insured all year but have at least one of the following qualifiers: a) Medical expenses greater than 10 percent of annual income; b) An annual income of less than 200 percent of FPL and medical expenses greater than 5 percent of annual income, and c) Health plan deductibles equal to or greater than 5 percent of annual income.

TRAINING PROGRAMS: Programs offered by community organizations or higher education to prepare community health workers, mental health engagement specialists, care coordinators/navigators and connectors.

CARE CONNECTORS: Including engagement specialists, community health workers, Promotoras, care coordinators, and health navigators.

PROMOTORES DE SALUD (PROMOTORA): Promotores de salud, also known as "promotoras", is the Spanish term for "community health workers". The Hispanic community recognizes promotores de salud as lay health workers who work in Spanish-speaking communities. Promotoras may receive specialized training to provide basic health education in the community without being a professional health care worker. While most of their work entails educating target audiences about health issues affecting their community they also provide guidance in accessing community resources associated with health care.

COMMUNITY HEALTH WORKER: A community health worker is a frontline public health worker who is a trusted member of the community being served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

ENGAGEMENT SPECIALIST: An engagement specialist provides outreach to and case management for clients of outpatient services who are identified as needing assistance to stay engaged with their services. The engagement specialist works closely with program therapists, case managers, nurses, and prescribers to re-engage clients in services. The term "engagement specialist" is not as important as having a position on staff that performs the functions of an engagement specialist.

CARE COORDINATORS: A care coordinator deliberately organizes patient care activities to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

HEALTH NAVIGATOR: Health navigators are people who take individual patients through the continuum of healthcare needs, ensuring that any and all barriers are resolved and that each stage of care is as quick and seamless as possible.

PLACE-BASED CARE: Providing access to health care directly where people live, work, go to school, worship or receive social services.

INFORMATION TECHNOLOGY (IT)/TECHNOLOGY: The use of computers, hand-held devices such as phones, storage, networking and other physical devices, infrastructure and processes to create, process, store, secure and exchange electronic data.

INDICATORS OF EFFECTIVE IMPLEMENTATION

1. Development and implementation of training programs for health care connectors and navigators to work with underserved populations.
2. Increased availability of care connectors and navigators in safety net health care organizations.
3. Adoption of technology solutions by safety net organizations that improve connectivity among providers and between consumers and providers.
4. Placement of health care connectors and navigators in rural and urban high-need communities.
5. Increased use of place-based care and telehealth solutions to provide services in remote and high poverty community settings.

TARGET GOAL

Increase the number of consumers served by the health care safety net in the foundation's service area from 185,000 in 2014 to 220,000 by 2020.