

Harbor Village

Rural Health Outreach Grant



ANNUAL PERFORMANCE REPORT

2009-2010

Authored by: Community Asset Builders, LLC

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INTRODUCTION

The evaluation plan includes quantitative and qualitative data and includes outcome, performance and process measures. Data elements include goals, objectives, strategies, programs/activities, demographics, health indicators, partners/resources, and survey/interview responses (including patient satisfaction).

Evaluation cannot be conducted in isolation. Therefore, stakeholders are part of the evaluation process to ensure that their perspectives are understood. Three principle groups of stakeholders include the individuals involved in project design and operations (staff, leadership team, network partners); individuals served through the programs offered (patients/clients); and primary intended users of the evaluation. Stakeholders are kept informed about progress of the evaluation through periodic meetings and other means of communication, in addition to this annual report.

The evaluation contains a project description that explains what the project is trying to accomplish. The description also illustrates the project's core components and elements, ability to make changes, stage of development, and how the project fits into the broader community environment. The description sets the frame of reference for future decision-making and allows for comparison to other rural health outreach efforts.

The method of evaluation is observational, supported with credible evidence (primary and secondary data). Because all types of data have limitations, the evaluators use multiple procedures for gathering, analyzing, and interpreting data. Key indicators are used to determine progress toward Harbor Village's capacity to deliver integrated services; achieving participation targets; patient/consumer satisfaction; and longer-term changes (e.g., changes in health behaviors).

Further, a standard quality improvement process, Plan, Do, Check, Act (right) is followed using an innovation cycle that emphasizes continuous learning. The information gathered is discussed for future improvements. The leadership team uses local and national evaluation to make decisions about project refinement, measuring progress toward meeting goals and objectives, holding project staff accountable for implementing activities on schedule, and informing community stakeholders, and the general public about progress. Trended data will also be analyzed beginning in Year 2 and published in the annual report to illustrate trends over time. All data will be used to solicit continued support for Harbor Village and the integrated care model.



PROJECT DESCRIPTION

The Harbor Village Consortium was organized in response to results of detailed community assessments and planning that demonstrated an evident need for integration of primary and behavioral health services. Because Benton County has the second highest aging population age 65 and older in Missouri (30 percent) and the median age for residents is 45.6 compared to 37.4 for Missouri, the primary target population is adults, with an emphasis on older adults (60+).

Elderly persons with mental health problems are more likely to seek help in primary care facilities than in mental health settings. They are also more likely to have physical co-morbidities, compared with younger patients. The primary care physician plays a pivotal role as the first health care contact for an aged population and needs to work closely with a mental health provider to achieve positive health outcomes. As a result, the proposed goal and objectives of the Harbor Village Consortium are focused primarily on integrating primary care and mental health services through a coordinated and integrated network of care. Each of the project's objectives and corresponding strategies will help the Harbor Village Consortium achieve its goal of a coordinated and integrated network of care that is person/family-centered and addresses the bio-psychosocial needs of individuals across the lifespan, with a particular focus on the aging.

The priorities identified in the needs assessment relates to chronic disease, mental health and suicide prevention. Therefore, the programs focus on health and wellness and collaboration between primary care and behavioral health providers and senior services to impact chronic disease and depression. Services to be provided include primary care, preventive health and wellness services, and mental health services through multiple entry points, but with coordinated service delivery and co-location of providers.

In summary, the purpose of the project is to provide a coordinated and integrated network of care that is person/family centered and to address the bio-psychosocial needs of individuals across the lifespan, with a particular focus on aging, through an integrated referral system. The emphasis is health and wellness collaboration between primary care, behavioral health and senior services partners to impact chronic disease and depression. The goal is to provide access to these integrated services through Harbor Village. Although multiple entry points exist for accessing services, service delivery will be coordinated through Harbor Village. **The primary measures of success will be the increase in the number of people accessing services through Harbor Village and that patients report having a health care home.**

PROCESS EVALUATION

As part of the process evaluation, there are a few questions that are key to determining how successful Harbor Village has been with implementation of its initiative. The questions are outlined below with objective responses from the evaluator. The evaluator obtained information by observing and participating in meetings of the leadership team, participating in teleconferences with the leadership team and staff, interviews with staff, and participation in teleconferences with the technical assistance advisor for the project.

How closely did implementation match the plan?

The original plan submitted with the grant was revised by the leadership team after several discussions with the technical assistance advisor, both on-site and by teleconference. It was determined after review of the plan that, although comprehensive in nature, the plan was too aggressive to be achieved in the existing three-year grant period. After significant consultation and several thorough discussions, the original plan was streamlined, maintaining the intent and integrity of the original application, yet narrowing the focus to two primary objectives, and reorganizing and prioritizing the strategies to fully address these two objectives. Data collection for the original objectives is still in the longer term plan; however, for purposes of this three-year grant, the more focused work plan was approved and will be the basis for the evaluation.

What changes were made to the originally proposed plan?

The goal of “a coordinated and integrated network of care that is person/family-centered and addresses the

bio-psychosocial needs of individuals across the lifespan, with a particular focus on the aging” remained the same. The anticipated outcomes are a system-wide planning process and an evaluation process to measure progress.

The original plan consisted of four objectives, as outlined below:

- 1) By 2011, provide person-centered access to information and evidence-based disease prevention and health promotion activities.
- 2) By 2011, establish a healthcare home model for individuals served that fully integrates primary and behavioral health care in Benton County.
- 3) By 2011, create a collaborative structure that transcends existing systems to guide appropriate and effective mental health services and supports.
- 4) By 2011, develop a system-wide individual planning process that is the same across all service venues and that fully incorporates the values of recovery, resiliency, and self-determination.

The revised, and subsequently approved, objectives are as follows:

- 1) By 2012, create a collaborative structure that guides and supports health and wellness in a health care home model.
- 2) By 2012, be in a position to establish a sustainable healthcare home model for individuals served that integrates primary care, behavioral health, and wellness.

The original objectives were not lost, but rather were integrated into the new objectives through specific strategies, as follows:

- Cooperative management between partners;
- Electronic data support and retrieval;
- Quality standards;
- Evidence-based disease management, prevention and health promotion;
- Care coordination and continuity;
- Aging and Disability Resource Center; and
- Cultural competence.

What led to the changes in the original plan?

Changes to the original plan resulted from discussions with the technical assistance advisor and the recognition by the leadership team that some fundamental cultural shifts needed to occur within each organization to fully realize integrated services on any level. Even though all the partners have worked together for many years and collaborated extensively on the grant application, the realization that what was identified conceptually, in reality is much more difficult to implement without these cultural shifts. Therefore, the leadership team took a step back to review the plan, prioritize activities and streamline implementation. Following is a summary of progress for each of the current plan measures:

Objective 1: By 2012, create a collaborative structure that guides and supports health and wellness in a health care home model.

Strategies	Activities	Measure	Timeframe
1. Cooperative management between partners	1a) Identify a process for managing referrals.	Process identified and implemented for managing behavioral health and primary care referrals; task force progress.	6-12 months; ongoing
	1b) Assess organization, provider and staff education needs.		

	1c) Establish task forces to concentrate on specific issues identified.		
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Progress: The leadership team has identified three task forces under the umbrella of Disease Prevention and Health Promotion-Enhanced Wellness to address specific issues related to processes and implementation. The three active task forces are ADRC, Care Plan, and Depression/McArthur Initiative. Although each task force has a specific agenda, it has been noted that many of the issues that surface in each task force overlap with one or more other task forces. This overlapping has been deemed a benefit by the leadership team because the task forces are making connections between their efforts and those of the other task forces and also how they relate to the overall objectives of the grant. Detail on the activities and achievements of each of the task forces is contained in the “progress” section under Objective 2. Each task force meets regularly, with more than 15 task force meetings convened during the grant period.

The individual task forces have been charged with assessing organization, provider and staff education needs related to the task force issue (ADRC, Care Plan, and Depression/McArthur Initiative). Upon initial discussion, it was determined by the task force chairs that cross education among the Network partners is necessary prior to educating providers and staff. As a result, “lunch and learns” are being held periodically to allow each partner an opportunity to educate the other partners about the services they provide, who they serve, how individuals qualify for services (eligibility requirements), referral sources, and other information as identified during the session.

In addition to the work of the task forces, it is important to recognize other achievements since the grant was implemented, particularly the implementation of the Transportation Voucher Program that began January 1, 2010. This program increases access to services by the target population by offering transportation vouchers through a contracted vendor. Within the first year grant period, 71 vouchers were issued to 46 individuals through the Transportation Voucher Program.

To measure the effectiveness of cooperative management between partners, a series of interview questions were used, asking individual members of the Network’s leadership team to self assess the team’s progress toward collaboration, leadership and strategic vision for meeting the goal of a coordinated and integrated network of care that is person/family-centered and addresses the bio-psychosocial needs of individuals across the lifespan, with a particular focus on the aging. The results of the survey indicate that the leadership team is in full agreement that the current work plan is action-oriented and is moving the team toward meeting identified goals. The team was also in agreement, although to a lesser degree, that they were able to operate within ground rules that provide the basis for mutual trust, respect and accountability; among them, there is an effective group problem-solving process; and that as a team, they are able to communicate strong differences of opinion in ways that are compatible with resolving differences with others in a productive manner. There was less consensus about the team’s ability in providing ideas and information in ways that allow them to move from problem stating to problem solving; ability to share risks, responsibilities, resources and rewards; ability to share decision-making and power in organizational/consortium processes; and in engaging in and supporting consortium leadership development activities, both informally and formally, to move the processes to higher levels of inclusiveness and effectiveness. The leadership team will use the results of the self assessment to monitor their own abilities and needs for improvement over the course of the project.

Strategies	Activities	Measure	Timeframe
2. Electronic data support and retrieval	2a) Identify a consultant to assess existing data systems and identify strategies for integrating data and/or improving data outputs.	Consultant contract in place for integrating and/or improving data outputs.	18-24 months; April 2011
	2b) Identify method for retrieving patient data and other data for tracking outcomes.	Evaluation undertaken with available data (retrieving patient data for tracking outcomes).	24 months

	2c) Determine who has responsibility for data retrieval across agencies.	Responsible party identified for data retrieval across agencies.	24 months
	2d) Enlist services of evaluator to use data to measure progress toward objectives.	Evaluation contract in place.	2 months; Jul 2009

Progress: The leadership team recognized from the beginning that having an external evaluator would be beneficial to the process. As a result, the evaluator has been engaged in the process from the onset of the grant development process and has been an observer/participant since in leadership team meetings, teleconferences, and task force meetings, to aid in the documentation of progress of both process and performance measures. The evaluator, Community Asset Builders, LLC was engaged by contract to conduct the formal evaluation, beginning May 2009.

One of the greatest challenges that has been identified by the leadership team, and reiterated by the task forces, is the ability to retrieve electronic data across organizations. Each agency has its own data system for tracking patients/clients. In order to proceed with integrated service delivery, the ability to integrate key data elements is essential. The leadership team is in the process of trying to identify specific needs so that services of an outside consulting firm can be used more effectively and efficiently. Efforts are focused on defining what data needs to be tracked, who will be responsible for tracking the data and how the integration of data will be managed.

3. Quality standards (structures and processes)	3a) Determine quality improvement process to be used that includes patient/client satisfaction.	Quality improvement process identified.	12-18 months
	3b) Hold regular meetings of leadership, staff, patients/clients, and providers to discuss quality.	# of quality improvement meetings and number/type of participant.	Ongoing
	3c) Integrate quality standards, particularly those of the health disparity collaborative, into operations.	# of quality standards implemented.	Ongoing
	3d) Meet with evaluator to monitor progress toward overall outcomes on a quarterly basis.	# of meetings held with evaluator; evaluation results shared.	Quarterly
	3e) Collaborate with local community partners in conducting a community assessment and prioritizing results.	Community assessment completed, prioritized and shared with community.	12-18 months
	3f) Implement changes as needed based upon results of quality improvement team meetings and/or community assessment results.	Changes implemented resulting from quality improvement team meetings.	Ongoing

Progress: The quality standards and improvement processes are in the development phase. The leadership team has primary responsibility for oversight of quality, with each task force determining quality improvement processes specific to their issues. Existing quality standards across the partners are currently being reviewed and shared among the partners.

A community assessment was completed early in the process that included input from a diverse array of individuals, agencies and organizations in the community identified several priority issues, including lack of emergency facilities, need for specialty services, dental care and mental health services (including substance abuse programs). In the area of senior services, specific issues identified were in-home care, transportation, meals and a need to plan for the future; i.e., assisted care facilities. Overall, the community participants recognized there is a provider shortage,

need for more public education, particularly in the area of prevention, increased collaboration and outreach. This assessment was the basis for forming Harbor Village and the impetus for the Rural Health Outreach grant.

As part of the quality improvement process, patient satisfaction surveys are distributed quarterly. The results of the surveys for the first year of the grant, which will serve as the baseline, are illustrated in the graph below.

Satisfaction Survey Results 2009-10	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Year 1
Percent of individuals responding to survey	53%	27%	97%	93%	68%
Respondents scoring "ability to get appointment" as good or excellent	100%	88%	100%	93%	95%
Respondents scoring "convenient hours of operations" as good or excellent	100%	88%	100%	96%	98%
Respondents scoring "convenient location" as good or excellent	93%	75%	100%	96%	95%
Respondents scoring "phone calls get through easily" as good or excellent	100%	75%	100%	100%	98%
Respondents scoring "calls quickly returned" as good or excellent	100%	38%	100%	96%	93%
Minutes spent in waiting room was 15 minutes or less	44%	100%	97%	100%	88%
Minutes spent in checkout area was 15 minutes or less	92%	100%	100%	96%	97%
Respondents scoring "payment is reasonable" as good or excellent	79%	63%	100%	96%	91%
Respondents scoring "explanation of charges" as good or excellent	92%	88%	96%	100%	96%
Respondents scoring "facility neat and clean" as good or excellent	100%	100%	100%	93%	97%
Respondents scoring "easy to find clinic" as good or excellent	100%	100%	97%	100%	99%
Respondents scoring "facility handicap accessible" as good or excellent	93%	88%	97%	100%	94%
Respondents scoring "comfort and safety" as good or excellent	100%	88%	97%	96%	96%
Respondents scoring "front desk helpful" as good or excellent	93%	100%	97%	96%	96%
Respondents scoring "nurses and medical assistants helpful" as good or excellent	93%	100%	100%	100%	99%
Respondents scoring "nurses and medical assistants answer questions" as good or excellent	93%	100%	100%	100%	99%
Respondents scoring "providers listen" as good or excellent	100%	100%	100%	100%	100%
Respondents scoring "providers spend enough time" as good or excellent	100%	100%	97%	100%	99%
Respondents scoring "providers answer questions" as good or excellent	100%	100%	100%	100%	100%
Respondents scoring "providers friendly and helpful" as good or excellent	100%	88%	100%	100%	99%
Respondents scoring "providers give good advice/treatment" as good or excellent	100%	88%	97%	100%	98%
Respondents scoring "other staff friendly and helpful" as good or excellent	100%	88%	97%	100%	98%
Respondents scoring "other staff answer questions" as good or excellent	100%	88%	97%	100%	97%
Would send friends or relatives for services.	100%	100%	100%	96%	99%
Center is main source of care.	93%	75%	87%	92%	88%

Note: The percentages are based on a numerator of the total number of respondents responding to the question and a denominator of the total number of completed surveys received.

Objective 2. By 2012, be in a position to establish a sustainable healthcare home model for individuals served that integrates primary care, behavioral health, and wellness.

Strategies	Activities	Measure	Timeframe
1. Evidence-based disease management, prevention and health promotion.	1a) Identify, select and potentially implement evidence-based disease prevention, health promotion and wellness programs.	Evidence-based practice(s) identified and/or selected.	24-36 months
	1b) Identify, select and potentially implement an evidence-based chronic disease self management education program, arranging for training as appropriate and necessary.	Evidence-based practice(s) identified and/or selected; # of training sessions held.	24-36 months
	1c) Begin steps to be prepared to implement the HRSA Depression Collaborative and/or other evidence-based practices, arranging for training as appropriate and necessary.	Evidence-based practice(s) identified and/or selected; # of training sessions held.	12-36 months

Progress:

Disease Prevention and Health Promotion-Enhanced Wellness: As stated previously, the three task forces fall under the umbrella of Disease Prevention and Health Promotion-Enhanced Wellness. The efforts of the task forces are focused on coordinating the collection of the various types of education currently being done and identifying models, best practices or evidenced-based programming to be approved and implemented by the Network partners. Progress of the three task forces follows.

2. Care coordination and continuity	2a) Identify and begin implementing a care team model across partner organizations.	Consensus on care team model and care plan; care team model selected and implementation underway.	24 months; ongoing
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Progress:

Care Management/Outreach: A care manager was hired in July 2009 and began conducting outreach and education in the community beginning in July. For the period July 2009 through April 2010, outreach was conducted with a total of 57 different agencies/organizations, with 523 individuals participating. Katy Trail Community Health also implemented the Show Me Healthy Women program, which provides a qualified woman with free breast and cervical cancer screening at no cost or for a nominal co-payment. Since implementing the program in July 2009, 43 women have received mammograms.

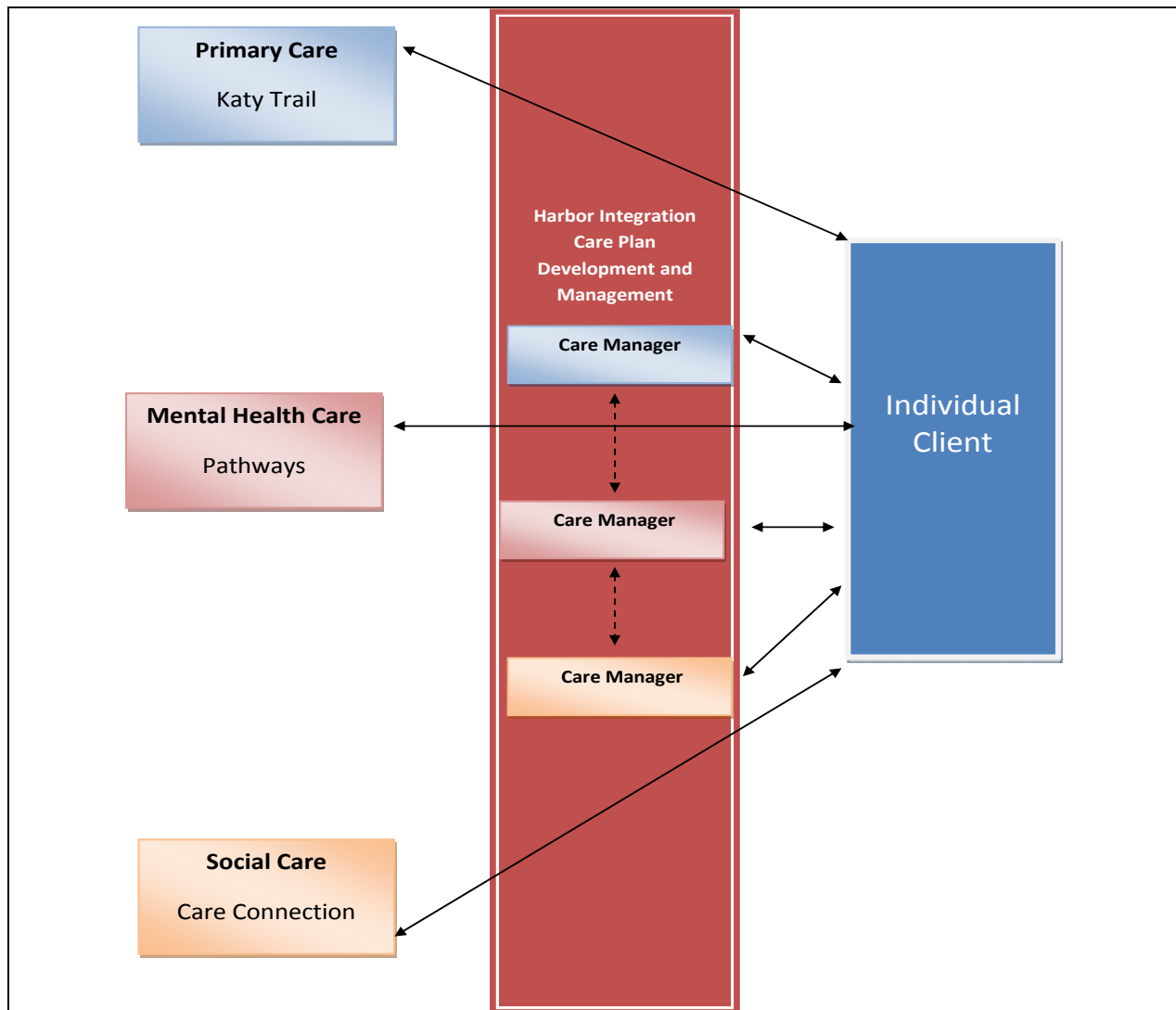
Because diabetes is such a significant issue, there was discussion about whether or not to have a Diabetes Collaborative Task Force. After much discussion, it was determined that a separate task force was not necessary at this time. The Care Plan Task Force recommendations will be used to determine how the collaborative can best be incorporated into the care plan policy.

Two outreach and education group sessions specific to diabetes education were held, one in November 2009 and another in March 2010. Although turnout was small, two individuals attended the first session and another ten attended the later session. As more extensive outreach is conducted and information about the availability of this service is communicated in the community by word-of-mouth, it is anticipated the number of individuals attending these education sessions will grow. The sessions are conducted by a nutritionist with University Extension and, if she is not available, by a clinician. At this time, group sessions are slated to be held quarterly.

Care Plan Task Force: The Care Plan Task Force has developed a policy/procedure for integrated care referrals. The policy is based on the participant meeting four specific criteria during the intake process. If one or more of the criteria are met, the individual will be informed of the availability of services through the new model for integrated care service delivery. The Care Plan Task Force has met five times in the past 12-month grant period and is now working on the care plan design. Throughout this process, the patient/client is the center of focus. The most difficult challenge for this committee was coming to agreement on the definition of “integrated service delivery”. After numerous discussions and significant research, the Care Plan Task Force recommended the following interdisciplinary model for integration within the Harbor Village partnership:

In an interdisciplinary model of teamwork, clinicians from different professions assume roles and carry out responsibilities that share common goals for the client. Potentially, over time, the roles of these partners could overlap and become more flexible. Interdisciplinary primary team members understand the educational background of one another, know each others’ areas of expertise and are aware of the roles assumed by each profession. Goal planning and the implementation of tasks are undertaken in an integrated manner by all team members. Communication among the professions is frequent and ongoing. Roles and tasks are assigned according to levels of expertise rather than solely on the basis of traditional professional responsibilities.

It is anticipated that this model will result in an integrated approach that can implement and achieve a close collaboration/partly integrated program with some shared systems, shared space in the same facility, face-to-face consultation, coordinated treatment plans, basic appreciation of each others’ roles and cultures, and influence sharing. The illustration below depicts the model framework.



In the end, Network partners agreed that complete service integration was not feasible. However, it was agreed that through close collaboration, partial integration could occur by modifying specific programs and models. It was agreed that this would also entail a culture shift in the partnering organizations and that significant education and training will need to be a priority. To begin the process of partial integration, the Care Plan Task Force has undertaken 1) a review of the assessment tools used by each partnering agency, 2) identifying specific barriers that will need to be addressed and overcome, and 3) identifying education and training needs within each agency.

Care managers play the lead role in implementing this integrated care plan process. Together individual care managers comprise the integrated care team. It is the recommendation of the Care Plan Task Force that each Network partner participating in delivering integrated care, clearly identify or designate the "Integrated Care Managers" within their respective organizations. When warranted, these individuals will comprise the integrated care team. The integrated care plan has four basic components and includes recognition, patient education, treatment and monitoring. As part of the recognition component, the care team is working to identify tools for recognition of need or diagnosis. Recognition of need includes the whole picture of integrated client/patient need, whether physical, mental, behavioral, psychosocial, or economic. Once the recognition screening tools have been identified, a formal assessment will be conducted with the individual. With regard to the patient education component, the care team identifies the most appropriate education medium(s) (materials, tools, health and wellness classes and/or programs). Specific areas identified for education include the Depression Collaborative,

Health Disparities (Diabetes Collaborative), Healthy IDEAS, Enhanced Wellness, the Entrepreneurial Center, and clinical treatment (primary care, dental, and mental health). Relative to the treatment component, the care team selects the treatment approach in partnership with the patient/client, using motivational case management to improve compliance. The care team also connects the patient/client to community resources through the care manager. The fourth component relates to monitoring. The care team acknowledges that it is essential to monitor client/patient response to the care plan. The monitoring intervals are dependent upon patient/client needs and diagnosis. The Care Plan Task Force is working toward identifying monitoring tools and implementing systems for monitoring referrals to outside resources and clinical specialists.

Depression/McArthur Initiative Task Force: The Depression Task Force (subsequently named McArthur Initiative Task Force) has met ten times in the past 12-month grant period. This task force has been working to identify a specific model to be used by all network partners. After much consideration and task force review of various models, a decision was made to pursue the McArthur Initiative's model. The mission of the MacArthur Initiative on Depression and Primary Care is to enhance the ability of primary care clinicians to recognize and manage depression. The Three Component Model (3CM) is a specific clinical model for depression management. The 3CM is a systematic approach that includes certain tools, routines, and a team approach to patient care. The three components include the prepared primary care clinician and practice, care management, and collaborating mental health specialist.

The three components include elements shown to improve depression outcomes in recent randomized controlled trials. Telephone support for the depressed patient from a care manager is one central element as is periodic quantitative feedback about the patient's response to treatment from the care manager to the clinician. The feedback is provided through depression severity scores based on PHQ-9. Another element is closer relationships between the primary care clinician and mental health specialists including informal psychiatric advice when needed from a psychiatrist. In the model, the psychiatrist also provides weekly supervisory support for the care manager. These elements are integrated into a systematic approach, an office system, for depression diagnosis and management as endorsed by the US Preventive Services Task Force.

The office system includes tools such as the PHQ-9 and patient education materials; defined responsibilities for the primary care clinician and staff, the care manager, and the mental health professionals involved; and routines including a schedule of care manager follow up calls. The PHQ-9, a nine-item depression scale of the Patient Health Questionnaire will be used as a tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment.

After the patient has completed the PHQ-9 questionnaire, it is scored by the primary care clinician or office staff. There are two components of the PHQ-9:

- Assessing symptoms and functional impairment to make a tentative depression diagnosis, and
- Deriving a severity score to help select and monitor treatment.

The PHQ-9 is presently used by Katy Trail Community Health. Because patients, particularly elderly patients, will seek primary care, but not behavioral health care, Katy Trail will be the primary vehicle for assessing patient behavioral health; therefore, using an existing, proven-effective tool, is logical.

The McArthur Initiative Task Force is also in the process of mapping the process for individuals seeking services for depression and other behavioral health disorders. The task force is attempting to understand how patients/clients access services and the best point of entry for the target population. To support Harbor Village efforts, Care Connections applied for and was awarded a grant from the Missouri Department of Mental Health to conduct Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) training for the care managers. Healthy IDEAS is an evidence-based program that integrates depression awareness and management into existing case management services provided to older adults. Healthy IDEAS ensures older adults get the help they need to manage symptoms of depression and live full lives. Healthy IDEAS improves quality of life by screening for symptoms of depression and assessing their severity; educating older adults and caregivers about depression; linking older adults to primary care and mental health providers; and empowering older adults to manage their depression

through a behavioral activation approach that encourages involvement in meaningful activities. To further collaborate, licensed workers from Pathways Community Behavioral Health serve in a consulting capacity for the Healthy IDEAS program.

Strategies	Activities	Measure	Timeframe
3. Aging and Disability Resource Center (ADRC)	3a) Establish ADRC and identify needed resources.	Resource data base compiled and utilized for resource identification and referrals.	12 months; ongoing
	3b) Maintain a resource database that includes information for both publicly assisted and private pay participants.	Resource data base used by ADRC and partner agencies.	Ongoing
	3c) Identify and implement a process for financial and functional eligibility screening for public programs.	Screening process identified and approved by partners.	18-24 months
	3d) Link individuals or families to the resources.	# of individuals/families linked to needed resources.	Ongoing
	3e) Routinely assess whether resources are meeting needs.	Resource assessments completed and results shared.	Annually

Progress:

ADRC Task Force: The ADRC Task Force has met five times during the 12-month grant period. Work that is presently underway is an updating of the website, www.moaging.com. This update entails contacting aging partners throughout the county and region to ensure that information about their organization is current and correct. A review of the information is also being undertaken to determine if there are other partners or agencies that should be included to make the system more comprehensive.

To assess readiness to implement ADRC, an organizational/readiness assessment was completed by the three Network partners and an additional collaborator (Independent Living Center). The results of this assessment identified where additional work and education among the partners is required and is summarized later in the report. In discussions of the task force and at the leadership team level, and as a result of the readiness assessment, it was determined that there was a need for additional training among the partner organizations, specifically about the programs, capabilities and scope of services each of the network partners provides. As a result, the ADRC Task Force is planning a training session that will allow each network partner to provide information about their agency so that all staff is better informed about the services available.

The ADRC Task Force is also in the process of developing a marketing initiative for the ADRC and will be presenting a proposal to the Harbor Village board for review.

Strategies	Activities	Measure	Timeframe
4. Cultural competence	4a) Define “cultural competence” and implement standards for competency across partner organizations.	Cultural competency standards agreed upon.	18-24 months
	4b) Develop a method or process for evaluating competency standards implemented by the partner agencies.	Cultural competency standards implemented.	36 months; April 2011

Progress:

The leadership team has had several conversations about cultural competency standards, but was in agreement that standards could not be developed until the integrated services and programs were defined. Progress for these strategies is anticipated in the next 12-18 months. The leadership team will be reviewing forms, processes, data and best practices to derive the standards that will be implemented for Harbor Village integrated services.

OUTCOME EVALUATION

In addition to the above measures, at the outset of the initiative, a leading set of health indicators were identified to be tracked and monitored over time. The following data illustrates changes to these key indicators.

10-Year Trended Death Rate for Diabetes (per 100,000 population)

	Benton County	Missouri
1996-2006	35.3	24.6
1997-2007	35.4	24.6
1998-2008	35.8	24.2

Death Rate for Heart Disease (per 100,000 population)

	Benton County	Missouri
2006	249.0	222.6
2007	238.5	212.4
2008	221.3	213.0

Percent of Adults Age 50 and Older with No Fecal Occult Blood Test within Last Year

	Benton County	Missouri
2003	76.7%	77.5%
2007	91.0%	87.1%

Adult Asthma Hospital Admission Rate (age 65 and over)

	Benton County	Missouri
2002-2006	27.2	16.7
2003-2007	26.4	17.1
2004-2008	25.7	17.5

Chronic Obstructive Pulmonary Disease Hospital Admission Rate (per 10,000 population)

	Benton County		Missouri	
	Entire Population	65 and Older	Entire Population	65 and Older
2005	30.1	183.7	24.4	124.5
2006	31.1	189.8	21.8	106.5
2007	32.1	169.3	21.0	103.4
2008	33.9	148.3	25.5	126.6

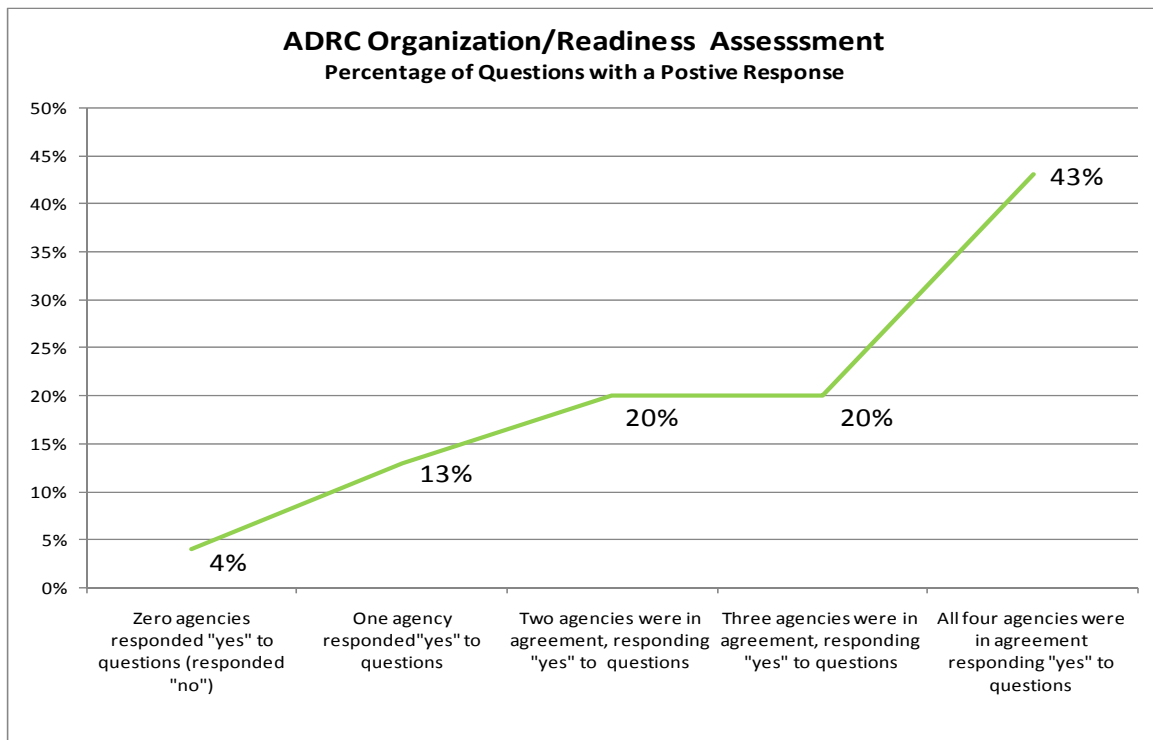
Suicide (Age Adjusted Death Rates)

	Benton County	Missouri
2005	21.3	12.6
2006	17.3	13.5
2007	11.7	13.5
2008	13.9	12.9

Ambulance Services

	2009
Percent of Ambulance Runs without Apparent Illness/Injury	4.89%
Percent of Trips Requiring No Treatment	27.15%
Percent of Trips Made (age 65 and older)	33.88%
Percent of Trips Not Reported as a Transport or were not Transported	33.31%

As discussed previously, in preparation for meeting Objective 2, Strategy 3, implementation of the ADRC, a baseline organizational/readiness assessment was conducted in 2009. The assessment was completed by the three network partners and an additional collaborator (Independent Living Center). The results show that the four respondents were in agreement 43% of the time, with positive responses to a comprehensive series of questions. Following is a graph that illustrates the results of the assessment. While this chart does not reflect the detail relating to the assessment questions, nor does this report, it does set a baseline for improving collaboration and understanding of ADRC implementation. The desire is to have 100% consensus with a “yes” response from all four respondents for each question. The graph illustrates that for 4% of the questions, there was 100% consensus with a “no” response, meaning these questions should be reviewed critically to identify reasons for this response. Another 33% had consensus with a “yes” response from 2 or fewer agencies. Where there is a divergence in responses to questions there is either further need of education by one or more partners or action steps are required to move forward with implementation.



PERFORMANCE IMPROVEMENT MEASURES

Katy Trail Community Health, on behalf of Harbor Village Consortium must comply with the Rural Health Care Services Outreach Program’s Performance Improvement Measurement System (PIMS) measures. Following are key data elements that will be tracked through PIMS for the three-year grant period compared to the 2009 baseline.

ACCESS TO CARE	2009	2010	% Change
Number of counties served in project	1	1	No change
Number of direct unduplicated encounters served	620	865	↑ 39.5
Total number of indirect unduplicated encounters served	na	368	na
Total number of non-duplicated encounters served	620	1,233	↑ 98.9
Total number of duplicated encounters	1,196	2,303	↑ 92.6
Number of people in the target population with access to new/expanded programs/services	n/a	7,938	na
Number of people in the target population	7,938	7,938	0
Number of new and/or expanded services provided	n/a	7	na
Population Demographics	2009	2010	% Change
Number of People Served by Ethnicity:			
Hispanic or Latino	12	18	↑ 50.0
Not Hispanic or Latino	608	847	↑ 39.3
Total	620	865	↑ 39.5
Number of People Served by Race:			
African American	1	1	No change
Asian	0	1	↑
White	602	830	↑ 37.9
American Indian/Alaska Native	2	9	↑ 350.0
Native Hawaiian/Other Pacific Islander	0	0	No change
More than one race	1	4	↑ 300.0
Unknown	14	2	85.7 ↓
Total	620	847	↑ 36.6
Number of People Served by Age Group that Received Services:			
Children (0-12)	88	87	1.1 ↓
Teens (13-17)	33	54	↑ 63.6
Adults (18-64)	467	665	↑ 42.4
Elderly (65 and over)	32	59	↑ 84.4
Total	620	865	↑ 39.5
Underinsured & Uninsured	2009	2010	% Change
Under/Uninsured people receiving preventive and/or primary care	198	329	↑ 66.2
Under/uninsured who now have a medical home	198	329	↑ 66.2
Total people enrolled for public assistance, i.e., Medicare, Medicaid, and SCHIP	217	418	↑ 92.6
People who pay out-of-pocket for all or part of the services received	620	865	↑ 39.5
People who use third-party payments to pay for all or part of the services received	130	536	↑ 312.3
People who receive charity care	0	0	No change
Workforce Recruitment & Retention	2009	2010	% Change
Number of new clinical staff recruited to work on project	0	1	↑
Number of new non-clinical staff recruited to work on project	0	1	↑

Number of staff positions shared between two or more network partners	0	0	No change
Environment & Technology	2009	2010	% Change
Number of non-profit network partners	3	3	No change
Number of for profit network partners	0	0	No change
Number of member organizations in the network	3	3	No change
Annual project revenue made through the new or expanded services offered through the project	0	\$154,288	↑
Additional funding secured to assist in sustaining the project	0	0	No change
Estimated amount of cost-savings due to participation in the network	0	0	No change
Number of clinical guidelines/benchmarks adopted	0	3	↑
Number of network members using shared standardized benchmarks	0	0	No change
Annual number of people receiving prescription drug assistance	0	82	↑
Annual average amount of dollars saved per patient through joint purchasing of drugs	0	\$532,893	↑
Number of health promotion/disease management activities offered to the public through this project.	0	2	↑
Number of health screenings conducted	0	0	No change
Measures	2009	2010	% Change
Percentage of children by 2 years of age with appropriate immunizations	0	0	No change
Percentage of adolescents 13 years of age with appropriate immunizations documented according to age group	0	0	No change
Percent of adult patients with Type 1 or Type 2 diabetes with most recent hemoglobin A1c (HbA1c) greater than 9.0% in the last year (adequate control)	0.65	0.67	↑ 3.1
Percent of adult patient, 18 years and older, with diagnosed hypertension whose blood pressure was less than 140/90 mm/Hg (adequate control)	n/a	0.66	↑
Percent of adult patients, 18 years and older, diagnosed with diabetes, whose blood pressure was less than 130/80 mm/Hg (adequate control)	0.47	0.46	2.1 ↓
Percent of adult patients in the target population who have been screened for depression	n/a	0.13	↑
Percent of patients with a comprehensive oral exam and treatment plan, completed within a 12 month period	0	0	No change
Percent of patients with a BMI indicating overweight or obesity who have received healthy weight counseling and/or other related interventions or treatment	0	0	No change
Number of total encounters provided to teen females surrounding teenage pregnancy prevention.	0	0	No change
Number of people receiving mental and/or behavioral health services in target area	194	530	↑ 173.2
Number of network members integrating primary and mental health service	0	2	↑
Number of people receiving dental/oral health services in target area	0	0	No change
Number of network members integrating primary and dental/oral health services	0	0	No change

FISCAL ACCOUNTABILITY

Actual Expenditures Compared to Budget

The Rural Health Outreach grant was awarded for \$150,000 for the first year grant period (May 1, 2009 to April 30, 2010). Due to delayed hiring of the case manager/outreach worker and reframing of the work plan, expenditures were under budget, with 62.04% of the funds expended. The balance of \$50,845.62 has been approved for carryover to the second year grant period, increasing the amount available for year two to \$175,845.62. The following table depicts the actual expenditures compared to budget.

Actual Expenditures Compared to Budget
May 1, 2009 to April 30, 2010

Revenue/Expense	Grant 4-30-10 Actual	Budget	% Variance
Revenue			
Rural Health Outreach Grant	\$99,154.38	\$150,000.00	33.90%
Total Grant and Contract Revenue	\$99,154.38	\$150,000.00	33.90%
Expenses			
Total Personnel	\$27,435.38	\$38,080.00	27.95%
Total Travel	\$4,155.00	\$14,225.00	70.79%
Total Supplies	\$1,084.87	\$1,500.00	27.68%
Total Contractual	\$52,869.13	\$71,275.00	25.82%
Total Other	\$13,610.00	\$24,920.00	45.39%
Total Expenses	\$99,154.38	\$150,000.00	62.04%

As a measure of success, Katy Trail Community Health monitors increases in patient revenue for the Warsaw site. From fiscal year 2008 to fiscal year 2009, Katy Trail Community Health experienced a 66% increase in net patient revenue (less adjustments).

Staffing Implementation Compared to Plan

Staffing levels were close to full implementation as described in the original plan. Staff to initiate the activities as described in the grant proposal included a contracted Project Coordinator at .4 FTE, contracted Service Coordinator at .4 FTE, and a full-time Care Manager/Outreach Coordinator to be employed by Katy Trail Community Health. The Project Coordinator was hired immediately with only slight delays in hiring the Service Coordinator and Care Manager. Of the total personnel funds budgeted, 27.95% will be carried over to year two.

Sustainability Concepts

While Harbor Village has not had extensive conversations about sustainability, the strategies outlined in the grant application are still being employed with a focus on integrating services of the three partners. Current sources of funding include Medicaid reimbursement, Medicare reimbursement, third party insurance, and HRSA Rural Health Care Services Outreach Program grant funding. The Harbor Village Consortium will continue to provide ongoing in-kind contributions for purposes of planning, fundraising and grant development.

By integrating primary care and behavioral health services and co-locating the three partners of the Harbor Village Consortium into one location, costs to provide services will be streamlined. Additionally, Medicaid funding will be maximized through community health center funding received by Katy Trail Community Health for both primary and behavioral health services. Pathways Community Behavioral Healthcare and Katy Trail Community Health have explored this enhanced reimbursement for behavioral health services through a successful contractual relationship. Katy Trail is now exploring the partnership with Care Connection for Aging Services and its funding mechanisms, which are very different. The goal is to implement a sustainability strategy that focuses on the success of the partnership and the key points of integration. The leadership team is still analyzing ways to leverage the enhanced reimbursement to support the staff required to sustain the Harbor Village integrated services.

It is anticipated that by identifying a medical home for the population served, severity of need may reduce for some patients, reducing cost of treatment. Funds for specific evidence-based programs and services continue to be accessed through local, state and foundation grant opportunities and/or state contracts as they become available. Because Katy Trail provides services on a sliding fee scale and serves patients with private, third party insurance, collections through these avenues are also being pursued along with community fund raisers, as necessary.



Report Prepared By:

Community Asset Builders, LLC
606 Dix Rd.
Jefferson City, MO 65109
573-632-2700
573-632-6678 (fax)
cabllc@earthlink.net
www.cabllc.com