City of Lawrence
Outside Agency Annual Report
For Calendar Year 2017

Reports on activity should be submitted electronically to Danielle Buschkoetter, at dbuschkoetter@lawrenceks.org by Thursday, February 15th 2018 at 5:00pm. For the following questions please refer back to your 2017 application for funding.

Reporting Period: Calendar Year 2017

Agency Name: Heartland Community Health Center

1. **Refer to the program in which your agency received funding; provide a participant success story that helps demonstrate the accomplishments of the program**. Non-alcohol funding ($31,167). A recent success story for this program acknowledges the benefit of offering an integrated care team – which includes both primary care and mental health providers. A young female met with her PCP for a preventative exam and learned of the integrated services offered. She begin to describe recent grief that she has been experiencing due to a loss in her life. The PCP was able to get this individual connected to the integrated services available at the community health center and respond to the needs of the whole patient.

2. **Refer to your 2017 application for funding; provide a brief narrative of the activities funded with City funds.**
   Heartland exist to provide high-quality, affordable comprehensive health care to *all* people in the community regardless of income or insurance status. Special focus is on the uninsured, underserved and those who live below 200% of the Federal Poverty Guidelines. In order to provide high-quality, affordable health care, Heartland champions a health care model that utilizes a multi-disciplinary team or care team to meet the needs of patients. A care team includes a prescriber or provider, a medical assistant or RN, a Behavioral Health Consultant, or mental health provider, and health coach. These funds were used to pay a portion of a APRN's salary with a focus on chronic disease management.

3. **Refer to your 2017 application for funding; provide specific detail (use supportive documents, if needed) to demonstrate what progress was made toward your proposed outcomes.**

   The program objectives described in the 2017 non-alcohol funding application represents the collaboration and work required of a multi-disciplinary care team to effective meet the needs of patients seeking care and providing chronic disease management. Progress was made toward the proposed outcomes by increase access to an integrated care team, increase of new patients served, and improved health outcomes.

   The objectives are as follows:

   1. The APRN will empanel 1000 new patients into her care.

   In July 2017, the APRN funded by this grant increased her FTE to 0.8 from 0.54. This was to ideally allow her panel to increase to the 1,000 patients as stated in the objectives. At the end of September 2017, Heartland experienced a sudden and unforeseen staffing change. This APRN immediately became the Director of Primary Care. This limited her ability to take on as many new patients as originally planned. Per a consultant, Health Team Works, it was determined that the APRN's adjusted panel should be 504 for the end of the calendar year. Due to her new capacity in a joint clinical and administrative role, the APRN's panel was 84 patients with 1,709 visits during the year. Because of this change, Heartland

created an efficiency workgroup to expand the productivity of all care teams and expand the panels of all providers. This led to an increase in patients per day per PCP approximately from 13% to 41%. In 2017, 3,485 unique medical patients were seen by providers (compared to 2,994 in 2016) which is a 16% increase in unique patients and also reflects a 19% increase in number of encounters with a PCP. Between 2016 and 2017, there were an additional 1,696 patients seen by PCP's that had not previously been seen. This exceeds the goal set for a single panel increase by almost 70%.

2. The APRN will manage her panel so her A1c below 9 is 71%.

Heartland has reported overall increases of diabetes management and improved A1c in 2017 while experiencing immense growth. Because of Heartland's safety net status, many patients who seek care have not seen a primary care provider for chronic disease management on a regular basis if at all in the past year. As a result, Heartland uses an integrated approach with primary care, case management, and behavioral health services to assess barriers to care and develop a plan with the patient in order to manage their condition.

In 2017, Heartland reported a total patient population with A1c (<9%) management of 67.1% (n=386). This rate is not as high as we originally projected because of an increase in number of diabetic patients by nearly 17%. In comparison, A1c <9% was 64.85% for the total diabetic patient population of Heartland in 2016. The APRN funded through this grant was able to manage her panel with 82.9% with A1c <9% (n=76). While we were not able to expand the APRN's panel to the full 1000 patients, we were able to expand *all* of the patient panels beyond this goal and still achieve a small increase in diabetes control even with an expanding diabetic population. The APRN funded by this grant has gone has focused on to efforts to provide population based methods to improve diabetes management in the panel through better medication management, identifying food security issues and adapting diet and exercise plans to improve diabetic outcomes.

3. The APRN will manage her panel so that 69% of her hypertensive patients have controlled BP.

As discussed above, we expanded panel capacity across all providers in 2017 due to unforeseeable changes in our provider FTE's and clinical leadership roles at Heartland. In 2017, Heartland also experienced an increase in hypertensive patients of nearly 11%. In 2017, 57.5% (n=729) of hypertensive patients at Heartland had managed their blood pressure to below 140/90. This is a slight decrease from 2016 with a reported 59.8% (n=658) blood pressure management.

The APRN funded by this grant, however, has managed her panel with 77%% (n=111) BP control, and experienced an growth in her panel of 20 hypertensive patients, all of which were added as new patients just in the last quarter of 2017. Provider quality meetings were implemented in November 2017 to address the issue of increasing chronic disease patients on panels and how to best manage diseases and their co-morbidities. Since the inception of provider quality meetings, blood pressure control has risen to 59.29% (n=747) of all hypertensive patients (as of 2/28/2018).

As Heartland continues to grow, we are developing better ways to improve care management. The APRN funded has been able to provide examples of best practices (e.g. motivational interviewing, workflow improvement, pre-visit planning) that are being implemented across other care teams since the development of provider based QM.

4. **Refer to the line-item budget provided in your 2017 application for funding; is this accurate to how your allocation was actually spent? If no, what changed and why?** Yes; this is accurate. All non-alcohol funds granted were spent on a APRN at Heartland.