Philanthropy Profile

The Cone Health Foundation:
Expanding Integrated Care for the Uninsured

Since 1997, the Cone Health Foundation has focused on improving the health of people in the greater Greensboro area by funding projects in 4 strategic areas: access to health care, adolescent pregnancy prevention, HIV, and substance use and mental health. This mission has resulted in the investment of over $82 million over the past 21 years, as well as the creation of a strong network of partners working together to measurably improve the health of the larger community.

Through a strategic planning process in 2014, the foundation identified the need to expand access to integrated care, particularly for uninsured individuals. According to Antonia Monk Richburg, Cone Health's vice president and senior program officer, at the time, health care providers could document fewer than 500 uninsured patients in the greater Greensboro area who were receiving comprehensive, coordinated care (oral communication, April 2018). In response, the foundation worked with local primary care and behavioral health providers to fund a 3-year learning collaborative of health care clinics to implement an integrated care model coordinating primary care, mental health, substance use, and oral health services for uninsured adults. Ultimately, the foundation sought to use this initiative to build capacity in participating clinics to deliver integrated care to 5,000 uninsured patients by 2020—a 10-fold increase over 5 years.

The initiative originally brought together 5 clinics in 2015, although that number has since grown to 8: Alcohol and Drug Services, Cone Health Community Health and Wellness Center, Cone Health Family Medicine Center, Evans Blount Total Access Care, Family Service of the Piedmont, the Interactive Resource Center, Mustard Seed Community Health Clinic, and Triad Adult and Pediatric Medicine. To be involved in the initiative, each clinic had to create a plan for integrated care implementation and identify a specific number of uninsured individuals it could serve over the next 3 years. Richburg led efforts to hold listening sessions with groups of uninsured and homeless populations to better understand the barriers to accessing care in the Greensboro area.

The Cone Health Foundation contracts with the NC Center for Excellence in Integrated Care to provide technical assistance and training to the clinics as they implement an integrated care delivery model. Quarterly meetings create an opportunity for the clinics to receive joint training on topics relevant for all sites, such as organizational leadership, referral and follow-up coordination, policy change, and principles of patient-centered care. Each site also receives individualized technical assistance based on the needs identified in annual evidence-based assessments. Through this process, the NC Center for Excellence in Integrated Care has been able to collect data as the sites progress along the continuum of integrated care to inform its evaluation of the learning collaborative and the skills, knowledge, and core competencies that are essential to integrated care service delivery.

The implementation of integrated care throughout the learning collaborative is facilitated by key partnerships with community agencies and programs that frequently interface with the uninsured population, known as connector sites. The Guilford Community Care Network (GCCN) serves as the hub for the initiative. There, newly identified uninsured patients are screened for insurance eligibility. Those who are ineligible for public insurance or for whom private insurance is unaffordable are able to benefit from GCCN's Orange Card Program—a

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network of primary care, specialty care, and dental providers who provide care at little to no cost. Upon enrollment in the network, individuals are assigned to a primary care provider and scheduled to receive an initial screening that includes behavioral health and oral health assessments. Primary care providers can refer patients to specialists who accept the Orange Card. This centralized intake process reduces the burden of navigating complex systems.

Uninsured patients—especially individuals who are experiencing homelessness, immigrants, and refugees—are often difficult to engage as they must overcome mistrust, transportation limitations, and language barriers. The Congregational Nurse Program, a partnership between Cone Heath and local faith communities, works with the learning collaborative, enabling nurses who are engaged in various faith communities to provide screenings and referrals to GCCN and participating clinics. A similar model, the Congregational Social Worker Program, utilizes social work students who can provide initial behavioral health screenings, deepening the 2 programs' reach into local churches, synagogues, shelters, and other community settings. Another connector organization is the Center for New North Carolinians' Immigrant Health Access Project. Eight community health workers engage with the immigrant and refugee populations to help them navigate an unfamiliar health care system and connect them to community resources, including the Orange Card Program. By engaging connector sites such as GCCN, the Congregational Nurse and Social Work Programs, and the Center for New North Carolinians, Cone Health Foundation has been able to link grantees together in mutually reinforcing activities across diverse communities and service settings.

According to Richburg, as of September 2017, the 2nd year of funding for the project, the clinics had reached 91% of their goal, identifying and delivering care to over 4,500 people (oral communication, April 2018). The Center for New North Carolinians alone engaged over 2,000 individuals during that time. An evaluator at the University of North Carolina at Greensboro is tracking the common metrics reported by each of the sites, which reflect the number of individuals who have received screenings and services, as well as whether patients have utilized the emergency department or been admitted to the hospital since their first primary care visit. Collaborative members aim to look more closely at patient health outcomes as they evaluate the impacts of implementing integrated care. Richburg reports that effective community engagement strategies have connected individuals who have gone 20 years without access to oral health services to a dentist, intervened with individuals who have developed suicide plans, and provided other life-saving care (oral communication, April 2018).

GCCN hopes to continue to convene collaborative members through monthly network meetings after the 3 years of technical assistance funding ends in September 2018. The Center for Excellence in Integrated Care has provided training on maximizing billing and coding for the clinics so they can finance integrated care for their insured patients and contribute to the sustainability of the integrated care model. In the spring of 2018, the Cone Health Foundation began a pilot program on an integrated care response to opioids that it aims to incorporate into the clinics involved in the collaborative. As the foundation continues to fund projects under the most recent strategic plan and beyond, it looks forward to catalyzing systemic changes that will give health care providers and other stakeholders the tools they need to create a community that promotes health for all. NCMJ

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