



# Reimagining Approaches to Improve Access to Care Grantees

## Affinia Healthcare

### Managing Medications and Follow-Up Care for Hypertensive Adults

This project increases access to care for hypertensive adults by having an underutilized PhD-level pharmacist assist medical providers in providing follow-up care and education. It pilots systemic change using a team approach so organizations can address provider shortages that currently don't allow for timely follow-up care for hypertensive patients.

**Project level learning question:** *How does an expanded scope of practice (refining duties) for pharmacists affect access to care for people with hypertension?*

**St. Louis City/St. Louis Metropolitan Region**

## Casa de Salud

### Allied for Access: Transforming the Health Care Landscape for Immigrants and Refugees

Casa de Salud will expand its mission and services beyond the Hispanic population to other foreign-born individuals to become a single health care portal providing culturally competent primary, behavioral, and complex care for low-income, uninsured, and foreign-born adults. This project aims to transform Casa de Salud into a trusted House of Welcome for all foreign-born, with a focus on African, Middle Eastern, and Southeast Asian peoples who face particularly significant access barriers.

**Project level learning question:** *How does leveraging the skills and expertise of multiple organizations to create a single health care portal providing primary, behavioral, and complex care affect access to care for foreign-born people in St. Louis?*

**St. Louis City/St. Louis Metropolitan Region**

## Criminal Justice Ministry

### Reentry Collaborative Network (Direct Service & Referral Network)

Criminal Justice Ministry will be housed inside the Transition Center of St. Louis to provide efficient and effective health services for the reentry population. Through evidence-based assessments, the organization will identify interventions and use their collaborative health network to help this population overcome identified social determinants of health including high recidivism, low employment, and lack of housing.

**Project level learning question:** *How does integrating reentry, social, and health services for returning citizens residing in the Missouri Department of Correction's (MODOC) Transition Center of St. Louis (TCSTL) affect access to care for people living in and transitioning out of the TCTL?*

**St. Louis City/St. Louis Metropolitan Region**



## Freeman Health System

### Community Care for Individuals with Complex Needs

Freeman Health System is working to redesign the health and social service environment for individuals with complex needs, so they are at the center of a high-functioning system and receive high-quality health care and the social supports needed to improve their health outcomes and quality of life. The project will be led by a team of relevant Care Partners that surround the individual with integrated, coordinated, and accessible services aligned with their health and social needs, values, and preferences.

**Project level learning question:** *How does redesigning the health and social service environment and coordination of partners to address the social and health needs for individuals and families with complex case needs improve their access to care?*

**Newton/Southwest Region**

## Jefferson County Health Department

### Healthy Jefferson County

Jefferson County will launch a mobile wellness clinic for the county's most vulnerable populations. Staffed by a nurse practitioner, registered dietician, community resource navigator (health educator), and behavioral health specialist, the clinic will provide affordable and accessible locally based entry points for health care to residents experiencing barriers to care.

**Project level learning question:** *How does a mobile wellness clinic staffed with a multidisciplinary team affect access to care for medically underserved Jefferson County residents experiencing access to care barriers?*

**Jefferson/St. Louis Metropolitan Region**

## Jordan Valley Family Health Foundation

### Reimagining Opioid Abuse Treatment and Recovery

Jordan Valley Community Health Center will increase access to care for individuals with substance abuse disorders, particularly individuals who abuse opioids, in southwest Missouri. It will accomplish this through a holistic care model that includes physical and behavioral health, medication-assisted treatment, and wrap-around services (housing, legal, and employment) provided on-site by community partners.

**Project level learning question:** *How does an enhanced Patient-Centered Medical Home, combining housing and employment service models with integrated clinical support and legal aid opportunities, affect access to care for individuals addicted to opioids?*

**Greene/Southwest Region**



## Randolph County Caring Community Partnership

### Accountable Health Communities Project

The project will consist of the design, development, and delivery of an accountable health community (ACH) model that will utilize care coordination services and systems navigation through the incorporation of community health workers. The AHC model addresses health-related social needs that impede clients from sufficiently and effectively accessing health care. The project will also utilize a web-based information sharing system to enhance communication and collaboration among providers and clients.

**Project level learning question:** *How does systematically identifying and addressing the health-related social needs of beneficiaries through screening, referral, and community navigation services affect access to care in rural communities?*

**Randolph/Northeast Region**

## Saint Louis University

### Promoting Child Health Equity by Addressing Resource Insecurities in Pediatric Clinical Settings

SLU and Cardinal Glennon are partnering to develop, implement, and evaluate a clinic-to-community (CCI) model that will provide robust case management services to Medicaid patients accessing well-child visits. Major activities include: the creation of a community advisory committee to inform the model, training for pediatricians to implement resource need screenings in a culturally appropriate manner, expansion of available resources and services for patients to access (including safety net programs and health advocates who follow up with families for one year to ensure referral success). If successful, these activities will result in an increased number of low-income children completing well-child visits, an increase in the number of successful referrals, and a decrease in food insecurity.

**Project level learning question:** *How does a clinic-to-community model that emphasizes early intervention and connects families with programs and services for which they are eligible affect access to care for children and their families who are Medicaid beneficiaries?*

**St. Louis City/St. Louis Metropolitan Region**

## Spectrum Health Care

### Access for All

Spectrum Health Care will enhance access to care for low-income, uninsured, and marginalized mid-Missouri residents by expanding its primary health care services, strengthening patient navigation into care provided by Community Health Workers, and training rural health providers to establish a structured network committed to providing patients a safe, affirming, and culturally competent care experience.

**Project level learning question:** *How does creating a safe, welcoming, and affirming health care experience affect access to care for LGBT and HIV-positive individuals in rural areas?*

**Boone/Central Region**



## St. Louis Integrated Health Network

### Community Health Worker Workforce Partnership to Advance Access to Care

This project works to coordinate the community health worker (CHW) field, streamline internal and external understanding of CHW roles, and demonstrate health impacts and financial sustainability at scale. This includes a multi-pronged strategy for workforce development: formalize and build capacity for the St. Louis region's CHW infrastructure, develop effective messaging and messengers, and organize a bi-annual regional outcomes report to serve as the regional policy platform. In partnership with the Missouri Community Health Worker Advisory Committee, IHN will engage payers and develop and implement standardized CHW metrics at the statewide level.

**Project level learning question:** *How does scaling and sustaining the community health worker workforce affect access to care for people and communities who are medically underserved?*

**St. Louis City/St. Louis Metropolitan Region**

## University of Missouri - Columbia

### ParentLink - Navigator System of Care

Navigators, co-located at public health departments, will facilitate connections for people in-need in six Bootheel counties. The project will increase access to physical/mental health resources and services as well assist in overcoming barriers that negatively impact social determinants of health such as housing, transportation, legal services, and job training.

**Project level learning question:** *How does in-person navigator assistance to help families access services and the identification of common problems across families affect access to care for underserved families?*

**Boone/Southeast Region**

## Washington University

### Implementing a Community-Based Model to Provide Healthcare for the Community

This project is working to create a state-of-the-art primary geriatric and subspecialty care clinic staffed by Washington University geriatricians at Covenant Place. The new medical clinic will increase referrals to subspecialists, key interdisciplinary team members, and reduce emergency room visits and re-hospitalization rates.

**Project level learning question:** *How does incorporating a geriatric health clinic as part of an affordable senior housing development affect access to care for residents and seniors in the surrounding community?*

**St. Louis City/St. Louis Metropolitan Region**