

# Fostering Partnerships with the Safety Net: An Evaluation of Kaiser Permanente's Community Ambassador Program in the Mid-Atlantic States

Lorella Palazzo, PhD<sup>1</sup>; Juno Matthys<sup>2</sup>; Craig Sewald, MPA<sup>2</sup>; Natasha Arora, MS<sup>2</sup>; Maggie Jones, MPH<sup>2</sup>; Jacqueline Bradley, MSN, MSS, CRNP<sup>3</sup>; Sallie Eissler, RN, MSN, CPNP<sup>4</sup>; Mindy R Rubin<sup>5</sup>; Tanya M Edelin<sup>5</sup>; Maya Nadison, PhD, MS<sup>6</sup>

Perm J 2020;24:19.010

E-pub: 03/13/2020

<https://doi.org/10.7812/TPP/19.010>

## ABSTRACT

**Introduction:** Kaiser Permanente (KP) Mid-Atlantic States has partnered with communities in its service area since 2011 to provide health services to underserved individuals. As part of KP's Community Benefit investment, the Community Ambassador Program places KP advanced-practice clinicians in safety-net clinics to share best practices and to improve access and quality of care.

**Objective:** To report program outcomes and disseminate lessons learned.

**Methods:** Using data from participating clinics, we retrospectively evaluated the program and estimated Community Ambassadors' contributions to clinic capacity, patient access, evidence-based care, and clinical quality measures. Furthermore, we conducted 29 semistructured phone interviews with stakeholders. Questions focused on program benefits, challenges, learning, and sustainability.

**Results:** From 2013 to 2017, Community Ambassadors filled up to 32.8 full-time equivalent positions and conducted 294,436 patient encounters in 19 clinics. In certain years and for subsets of clinics, Community Ambassadors performed above average on 2 high-priority quality measures: Cervical cancer screening for women aged 21 to 64 years and diabetes (blood glucose) control. Interviews with 15 Community Ambassadors, 15 health centers leaders, and 7 KP Mid-Atlantic States staff members revealed that Community Ambassadors improved patient access, clinic capacity, and care quality. Ambassadors also exported KP best practices and supported KP's community relations. Challenges included patient acuity, clinic resources, staff turnover, and long-term sustainability.

**Conclusion:** The Community Ambassador Program achieved its goals and had clear benefits, offering a model for large health care systems wanting to collaborate with community-based clinics. Careful planning is needed to ensure that positive results are sustained.

## INTRODUCTION

*America's Health Care Safety Net: Intact but Endangered*, the title of a 2000 report by the Institute of Medicine (now the National Academy of Medicine),<sup>1</sup> captures the fragility of the health care infrastructure that serves the nation's low-income people. The safety net is made up of a collection of hospitals, Federally Qualified Health Centers (FQHCs), free clinics, and other organizations that deliver health services regardless of the patient's ability

to pay.<sup>1</sup> The threats to the system highlighted in the Institute of Medicine report persist, but new challenges have also arisen to stress the safety net further. Along with financial struggles, competitive pressures, and demands for performance, health care organizations in the safety net feel increased strain from regulatory changes<sup>2</sup> and shifting insurance markets after the implementation of the Patient Protection and Affordable Care Act.<sup>2-4</sup> At the same time, the safety-net clientele has grown more diverse and is often challenged by multiple comorbidities and conditions of social need.<sup>2</sup>

To survive and even thrive in a fast-changing environment, safety-net providers are going beyond traditional support through grant funding<sup>5</sup> by joining forces with health organizations and other local allies to grow capacity, increase patient access, and improve care quality in their communities.<sup>6</sup> Across the country, partnerships have led to the development of direct specialty referrals and resource-sharing systems between community-based clinics and local hospitals.<sup>6</sup> Academic health centers and research networks have joined with FQHCs to support adoption and sustainment of evidence-based practices in mental health<sup>7</sup> and cancer<sup>8</sup> care. Other collaborative efforts have focused on providing financial assistance with coinsurance and copays for low-income people newly eligible for health insurance coverage under the Patient Protection and Affordable Care Act.<sup>3,9,10</sup> Despite the emergence of creative partnerships to strengthen the safety net, little is known about their effectiveness and potential to sustainably improve health care delivery to vulnerable populations.

To start filling this knowledge gap, we present the results of the evaluation of a multiyear effort to support the safety net through a partnership between an integrated delivery system and community-based clinics in Kaiser Permanente's (KP's) Mid-Atlantic States (KPMAS) Region. Since 2011, the KPMAS Community Benefit Program has implemented the Community Ambassador

## Author Affiliations

<sup>1</sup> Kaiser Permanente Washington Health Research Institute, Seattle

<sup>2</sup> Center for Community Health and Evaluation, Kaiser Permanente Washington Health Research Institute, Seattle

<sup>3</sup> Community Ambassador Program, Kaiser Permanente Mid-Atlantic States, Rockville, MD

<sup>4</sup> Community Operations, Kaiser Permanente Mid-Atlantic States, Rockville, MD

<sup>5</sup> Community Benefit, Kaiser Permanente Mid-Atlantic States, Rockville, MD

<sup>6</sup> Community Health Evaluation and Research, Kaiser Permanente Mid-Atlantic States, Rockville, MD

## Corresponding Author

Lorella Palazzo, PhD (Lorella.G.Palazzo@kp.org)

Keywords: access to health care, community health centers, program evaluation, quality improvement, safety-net providers

*Editor's note: Please also see: Let's Care for Those in Need—Today: Collaborating to Solve the Uninsured Crisis in America, by Lee Jacobs, MD (page 106); and Addressing the Health Needs of the Uninsured: One Community's Solution, by Lynne M Hutchison, DNP, FNP-BC and Raymond L Cox, MD, MBA (page 102)*

Program (CAP), which places KP advanced-practice clinicians in community-based health centers to boost capacity and to improve patient access. Trained by KP and salaried by the KP Health Plan, the Community Ambassadors spread KP best practices to community settings, to improve population health beyond KP membership and in such critical areas as preventive medicine, chronic illness management, pediatrics, and women's health.<sup>10</sup> We are not aware of other programs that take a similar workforce-based approach to supporting the health care safety net.

An assessment of the CAP's first year (2011-2012) suggested that the program had a positive effect on care delivery and some key evidence-based quality measures; opportunities for improvement also were acknowledged.<sup>11</sup> With an encouraging start and some early challenges, the CAP must be evaluated further to determine its overall impact and potential value as a model for health systems wanting to support community health. In this article we describe the CAP and our evaluation methods, report program outcomes, and discuss implications for partnerships with the safety net.

## METHODS

### Program Description and Setting

Following an earlier pilot, KPMAS established the CAP in 2011. Through a collaboration of the KPMAS Community Benefit Program and KP's Labor Management Partnership, the CAP placed KP nurse practitioners, midwives, and physician assistants to work as Community Ambassadors in FQHCs and other community-based health centers, such as free clinics, faith-based

organizations, and hospital-based programs. The initiative reflected KP's stated mission to support the communities it serves beyond its membership.<sup>12</sup> The approach to community health by KP includes using its health system assets to meet community needs identified through Community Health Needs Assessments. The CAP is an example of addressing an important access gap in the safety net by placing KP advanced-practice clinicians in community clinics subsequent to KP internal workforce restructuring.

While practicing in the safety net, the Community Ambassadors remained KP Health Plan employees (although for most of the program they did not identify as KP practitioners to patients) and retained their salaries, benefits, and seniority. Knowing the CAP would eventually end because of attrition, KPMAS wanted lessons learned from the program to serve as a blueprint for similar initiatives that could be expanded to other areas to improve capacity and expand coverage in the safety net.

At the start of the program there were up to 40 Community Ambassadors working at 18 safety-net clinics in Washington, DC; Northern Virginia; and suburban Maryland. As of this writing, the CAP continued to operate in a reduced form as Community Ambassadors lost to attrition (primarily retirement) were not replaced, causing some clinics to drop out. In 2017, there were 15 Community Ambassadors staffing the program at 9 partner clinics: 5 in Maryland and 4 in Virginia. Table 1 summarizes characteristics of those clinics.

The CAP's goals are unchanged: Expanding clinic capacity and patient access to care for the underserved within KPMAS service

**Table 1. Clinics active in the Community Ambassador Program (CAP) in 2017**

Clinic	Clinic type	Clinic location	CAP-supported services	Community Ambassadors
Maryland				
Clinic A	FQHC	Montgomery and Prince George's Counties, MD	Centering Pregnancy Program Colposcopy services Ultrasonography level 1	2 women's health nurse practitioners
Clinic B	Other clinic type <sup>a</sup>	Montgomery County, MD	Implementation of behavioral health integration <sup>b</sup> Implementation of ALL/PHASE <sup>c</sup>	1 part-time physician assistant; 1 full-time women's health nurse practitioner (retired in 2017)
Clinic C	Other clinic type <sup>a</sup>	Montgomery County, MD	Support for the only clinician in one of the clinic's locations	1 adult medicine nurse practitioner
Clinic D	FQHC	Prince George's County, MD		1 adult medicine nurse practitioner; 1 women's health nurse practitioner
Clinic E	FQHC	Baltimore, MD	Support for 2 clinic locations	1 women's health nurse practitioner
Virginia				
Clinic F	FQHC	Prince William County and Fairfax	Centering Pregnancy Program Prenatal ultrasonography	2 part-time women's health nurse practitioners
Clinic G	Free clinic	Prince William County	Adult care services	1 physician assistant retiring at end of first quarter 2018; 1 part-time adult medicine nurse practitioner
Clinic H	FQHC	Alexandria and Fairfax	Implementation of behavioral health integration <sup>b</sup>	1 women's health part-time nurse practitioner; 1 adult medicine part-time nurse practitioner
Clinic I	Other clinic type <sup>a</sup>	Arlington County	Pediatric services	2 part-time pediatric nurse practitioners

<sup>a</sup> Includes 501c3 nonprofit health care organizations, hospital-based clinics, clinics serving special populations, and partially free clinics.

<sup>b</sup> Kaiser Permanente's initiative to integrate primary care and behavioral health services.

<sup>c</sup> Kaiser Permanente's ALL/PHASE (Preventing Heart Attacks and Strokes Every day) protocol uses low-cost and generic medications and clinical interventions to reduce the incidence of heart attacks.

FQHC = Federally Qualified Health Center.

**Table 2. Community Ambassador full-time equivalent (FTE) and total encounters, 2013-2017**

Measure	2013	2014	2015	2016	2017
Community Ambassador Program FTE	32.8	27.7	23.2	20.7	15.3
Total Community Ambassador encounters	67,867	46,701	67,163	55,970	56,735
Encounters per FTE	2057	1610	2920	2799	3782

area and improving quality of care through sharing best practices with community-based health care professionals. On the basis of the 2012 study findings,<sup>11</sup> the Community Ambassadors made early progress toward most program goals by enabling higher patient volumes, expanded services, and better quality of care in their assigned clinics. Specifically, clinic-level performance improved on 2 quality indicators: Adult asthma therapy and adult weight screening. At the Community Ambassador level, performance was at or close to 90% on adult weight screening and adult tobacco-use assessment. Gains on other quality measures were lower, however. Capacity did not grow as expected, and there were challenges with integrating the KP advanced-practice clinicians into their new settings. Low clinic resources made it difficult to address language barriers with patients, and inadequate systems affected some reporting of program data.<sup>11</sup>

In this evaluation, we expand on those preliminary findings by taking a more extensive look at the CAP.

### Evaluation Design

Using mixed methods, we conducted a retrospective evaluation of the 18 clinics taking part in the CAP from 2013 to 2017. Our assessment combined an extensive review of program documents; regular meetings (facilitated and documented by the evaluation team) with KPMAS program leads, executives, and evaluators; analysis of quantitative data submitted by clinics and Community Ambassadors during their CAP participation; and interviews with Community Ambassadors, health center leadership, KPMAS program staff, and Community Health leaders.

Data from each source were analyzed concurrently.<sup>13</sup> Background documents were synthesized to create clinic profiles. The KPMAS program staff and Community Health leaders provided historical context and helped refine interview guides and validate emerging findings. *Although quantitative analyses spanned several years, we focused our qualitative data collection on the clinics participating in the CAP in 2017.* A detailed description of quantitative and qualitative data collection and analyses follows.

### Data and Analytic Strategy

#### Quantitative Data Collection and Analysis

Throughout the program, KPMAS collected 2 sets of Community Ambassador data: 1) service utilization data (including the number of patient encounters and unduplicated patients served) and 2) performance data in 19 measures from the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS)<sup>14</sup> and the Health Resources and Services Administration Uniform Data System<sup>15</sup> clinical quality measures.

Working with our KPMAS partners, we obtained and analyzed utilization and clinical quality data from 12 clinics for the years 2013 to 2017.<sup>a</sup> Clinical quality data were included in analyses

if they met the following criteria: 1) were discussed by program stakeholders as related to clinical priority areas during interviews, 2) included measurements for multiple timepoints between 2013 and 2017, 3) had a sample size of at least 50 patients per clinic or Community Ambassador per year, and 4) were reported annually. The resulting clinical quality dataset allowed 2 sets of analyses: 1) Community Ambassador performance on 9 measures was compared with overall clinic performance for 2013 to 2015 (Community Ambassadors were included in overall clinic data), and 2) Community Ambassador performance on 10 measures was compared with statewide FQHC averages for Virginia; Maryland; and Washington, DC.

#### Qualitative Data Collection and Analysis

We conducted 29 semistructured telephone interviews with KPMAS stakeholders and with Community Ambassadors and health center leadership at 9 active CAP clinics. Interview guides focused on core domains of interest: Benefits and challenges of program participation, program goals and the health centers' relationship with KP, and prospects for the CAP's sustainability. Subsets of questions were tailored to specific stakeholder groups (eg, Community Ambassadors, health center leaders). The 1- to 2-hour interviews were recorded with permission and professionally transcribed. Analysis was assisted by Atlas.ti software (version 7.5.2, Berlin, Germany).<sup>16</sup> Two team members who were experienced in qualitative methods coded transcripts using a code list developed a priori.<sup>17</sup> Preliminary themes identified through content analysis were reviewed, and their interpretation iteratively refined, by the evaluation team.<sup>18</sup> Quotes were edited for clarity and length while preserving participants' voice and intent.

## RESULTS

### Clinic Data

Between 2013 and 2017, Community Ambassadors conducted 294,436 in-person patient encounters in 18 clinics and provided both preventive and acute care. The number of full-time equivalent (FTE) positions filled by Community Ambassadors began at 32.8 in 2013 and decreased to 15.3 in 2017 because of attrition. Using encounters per FTE as a productivity measure, Community Ambassadors had an average of 3782 encounters per FTE in 2017—their most productive year. Encounters and productivity data are summarized in Table 2.

In 2017, Community Ambassadors in 9 clinics conducted 23% of all patient encounters in their assigned departments (Figure 1). The proportion of patient encounters by Community Ambassadors was even higher in some clinics. For example, the 2 Community Ambassadors at Clinic G conducted more than 7000 encounters, or 40% of the total in their departments. (Program staff confirmed that 2017 data were consistent with the percentage of patients seen by Community Ambassadors throughout the program.)

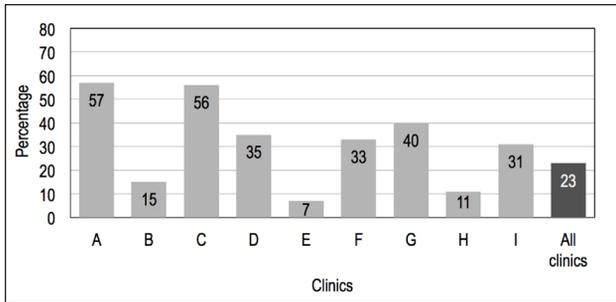


Figure 1. Community Ambassador encounters as percentage of total encounters (N = 1,234,550) in assigned clinic departments, 2017.<sup>a</sup>  
<sup>a</sup> Total encounters include both in-person and phone encounters.

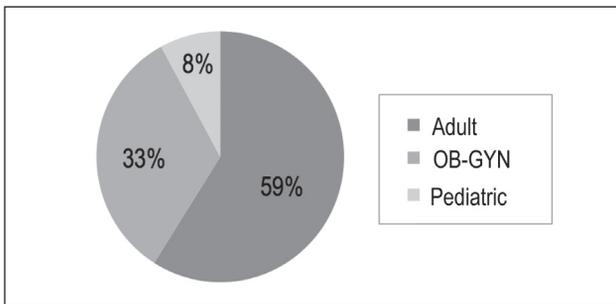


Figure 2. Percentage of Community Ambassador encounters by type, 2013-2107<sup>a</sup> (N = 335,157).  
<sup>a</sup> Data were not available by patient type for 2016; includes data for 2013-2015 and 2017. Total encounters include both in-person and phone encounters.

Community Ambassadors primarily saw adult patients, with approximately one-third of encounters serving obstetrics/gynecology patients and less than 10% of encounters serving pediatric patients (Figure 2).

Data on selected clinical quality measures suggest that the Community Ambassadors’ performance was consistent with the average quality of care provided by their health centers and FQHCs across the Region. In 2 areas—cervical cancer screening and diabetes (blood glucose) control—Community Ambassadors provided enhanced quality of care to their patients.

From 2013 to 2015, Community Ambassadors demonstrated higher performance relative to their clinics on cervical cancer screening rates for women aged 21 to 64 years (Table 3). The Community Ambassadors’ average screening rate for participating clinics. In 2016, Community Ambassadors placed at FQHCs achieved an average cervical cancer screening rate of 63%, compared with average statewide screening rates of 45% to 59%.<sup>19</sup> Some Community Ambassadors’ performance was up to 40% higher than that of their clinics (data not shown).

Compared with statewide averages for FQHCs in Virginia; Maryland; and Washington, DC, in 2016, Community Ambassadors working in FQHC demonstrated higher performance in diabetes control (Table 4). Their patients had a 21% rate of uncontrolled diabetes (as measured by hemoglobin A<sub>1c</sub> values greater than 9.0%), whereas statewide FQHC averages ranged from 27% to 38%.<sup>19</sup> (Because of changes in reporting requirements, diabetes control data were available only for 2016.) Community Ambassadors at some clinics had rates of uncontrolled diabetes for their patients as low as 9%.

**Interviews**

We interviewed Community Ambassadors (N = 15), health center leaders (N = 15), and KP program leads, executives, evaluators, and Community Health leadership (N = 7). Coded interviews were analyzed to identify themes relative to 4 predetermined evaluation domains: 1) accomplishment of program

Metric	Community Ambassador		Clinic	
	No. of patients	Average performance (%)	No. of patients	Average performance (%)
Patients (aged ≥ 18 y) screened for tobacco use 1 or more times within 24 mo	24,270	72	109,303	76
Patients (aged ≥ 18 y) identified as tobacco users who received cessation counseling intervention	7177	82	70,324	77
Patients (aged ≥ 18 y) with diagnosis of coronary artery disease prescribed lipid-lowering therapy	284	73	1730	67
Patients (aged 50-75 y) who received appropriate screening for colorectal cancer	7845	30	50,855	28
Patients with diabetes who received hemoglobin A <sub>1c</sub> assessment	4367	55	12,685	74
Patients with controlled hypertension	6897	65	20,783	68
Women (aged 21-64 y) who received cervical cancer screening	27,259	68	100,545	61
Women (aged 40-69 y) who received mammography screening	12,001	44	49,656	36
Pregnant women receiving prenatal care in first trimester	7255	54	4639	50

goals, 2) program benefits, 3) program challenges, and 4) program sustainability and prospects.

### Accomplishment of Program Goals

*Increased Access to Care for Underserved Populations:* Stakeholders reported that Community Ambassadors have increased the access to preventive and acute care for patients who have no other health care resources. They emphasized how the program had benefited many underserved groups, including uninsured or underinsured individuals, immigrants and refugees, incarcerated women, and religious and ethnic minorities. Increased access occurred at existing clinic sites and, in some cases, by opening new sites. Both Community Ambassadors and health center leaders identified increased access as one of the CAP's most important contributions. This was underscored by health center leaders who anticipated that the loss of their Community Ambassadors would lead to reduced clinic operating hours and fewer visits and patients seen.

*[T]he bottom line is if these practitioners would not have been here, those patients would very likely not be getting access to care. I think it's truly as simple as that.* —Health center leader, free clinic

*Increased Health Care Centers' Capacity:* The Community Ambassadors have increased the health centers' capacity in various ways. Many interviewees discussed Community Ambassadors' impact on women's health, including improved delivery of gynecologic care in general and of specialized services such as long-term reversible birth control.

*We have a GYN nurse practitioner; she brought to the clinic a new approach and comprehensive care for the female GYN patient . . . We saw the number of mammograms and [Papanicolaou tests] increase significantly as a result.* —Health center leader, other clinic type

Other outcomes were increased capacity for preventive services (eg, screening) and chronic care management (eg, diabetes education and management, HIV education and treatment), and easier access to medications through on-site dispensing.

*Kaiser [Permanente Community Ambassadors] being there has helped [the clinics] have services that they didn't have before. I was helpful in creating a diabetes education program there . . . I responded to a proposal to get mental health services at the clinic, so now we have behavioral health there on a regular basis.* —Community Ambassador, free clinic

Moreover, Community Ambassadors helped clinics build stronger systems and processes. They improved scheduling and workflows, promoted productive use of the electronic medical record, and generated revenues that boosted the clinics' bottom line and enabled infrastructure development.

*Improved Quality of Care at Clinics:* Community Ambassadors have helped health centers improve their quality of care by providing more comprehensive care options. They have also enabled spreading the workload across a greater number of practitioners (thus carving more time with complex patients) and mentored and modeled best practices to other staff. Both Community Ambassadors and health center leaders perceived quality of care improvements as being directly tied to the skills and expertise of KP advanced-practice clinicians.

**Table 4. Community Ambassador performance on select quality measures compared with clinic averages and state averages, 2016**

Metric	Community Ambassadors at all clinics		Community Ambassadors at FQHCs <sup>a</sup>		Clinic performance, % (FQHCs only)	Statewide averages, % <sup>a</sup>		
	No.	Average performance (%)	No.	Average performance (%)		VA	MD	DC
Patients (aged ≥ 18 y) screened for tobacco use 1 or more times within 24 mo	29,252	81	22,079	80				
Patients (aged ≥ 18 y) identified as tobacco users who received cessation counseling intervention	15,479	88	14,267	90	96	82	91	89
Patients (aged ≥ 18 y) with diagnosis of CAD prescribed lipid-lowering therapy	1464	88	136	79	88	78	84	89
Patients (aged 50-75 y) who received appropriate screening for colorectal cancer	8044	39	5242	39	41	36	40	40
Patients with uncontrolled diabetes (HbA <sub>1c</sub> > 9.0%)	4599	16	2542	21	30	33	27	38
Patients screened for depression with a standardized tool	16,084	52	6526	84	84			
Patients screened for depression with documented follow-up plan	1475	93	1040	96		60	76	49
Women (aged 21-64 y) who received cervical cancer screening	16,601	60	14,074	63	54	45	49	59
Pregnant women receiving prenatal care in first trimester	1558	54	1558	54	57	60	74	65
Children who received appropriate vaccines by second birthday	1144	37			31	38	41	53

<sup>a</sup> Blank cells mean the data were not available.

CAD = coronary artery disease; DC = Washington, DC; FQHC = Federally Qualified Health Center; HbA<sub>1c</sub> = hemoglobin A<sub>1c</sub>; MD = Maryland; VA = Virginia.

*I think the [Community Ambassadors] give very high-quality care ... They came from an organization [KP] with such clear guidelines and clear protocols for the highest quality care, and then they've brought that to the center. I think it has impacted our culture ... They're both wonderful role models for young nurse practitioners. —Health center leader, free clinic*

Community Ambassadors have exported KP health care by implementing practices, procedures, and protocols that were either not in place or not performed to KP standards. Examples include KP medication guidelines for patients at high risk of cardiovascular disease and clinical guidelines for prenatal care, cervical cancer screenings, and intake screening for depression and anxiety. Time management skills, patient empanelment, infection control practices, and after-visit summaries in multiple languages were often introduced or improved by the Community Ambassadors.

*At Kaiser [Permanente], as a patient you are asked to schedule your appointments with your primary care provider. That kind of philosophy about seeing your primary care provider for your visits is definitely supported by the [KP] nurse practitioners here, and that's good because I want us to move in that direction. —Health center leader, free clinic*

#### Benefits of Community Ambassador Program

Beyond achievement of program goals, there were additional program benefits for health centers, patients, Community Ambassadors, and KPMAS.

*Benefits for Health Centers and Patients:* Community Ambassadors and health center leaders reported that the Community Ambassadors formed trusting, ongoing, and stable relationships with patients. Community Ambassadors are trained to build supportive rapport with their patients. Often, they have worked at the health centers longer than other clinical staff and are most reliably present on-site. More effective care and better health outcomes may be important results of the continuity of care the Community Ambassadors have enabled.

Health center leaders noted the advantage of relying on Community Ambassadors whom KP had vetted and trained, and whose salaries were not paid by the clinics. These savings in salaries have allowed some clinics to see more uninsured or underinsured patients, and others to invest in infrastructure and equipment.

*With the revenue savings from [2 Community Ambassadors], we were able to purchase inexpensive ultrasound machines and colposcopes for each center. We were able to extend our services to include LEEP [loop electrosurgical excision procedure<sup>20</sup>] services and purchase that equipment. That equipment probably would have been unaffordable to us and our practice if we didn't have the Community Ambassadors. —Health center leader, free clinic*

*Benefits for KPMAS:* Further benefits of the CAP include enabling KPMAS to fulfill its mission of improving health in the communities it serves beyond its members while helping burnish the health system's reputation in the Region.

*I think it should be promoted that we work for Kaiser Permanente, and [KP is] paying me to be here at this clinic to provide care for you. —Community Ambassador, free clinic*

The KPMAS stakeholders stressed that the program has reinforced relationships with the safety net, aiding the kind of reciprocal learning and understanding that can support further KP engagement with community-based clinics.

*Benefits for Community Ambassadors:* Many Community Ambassadors voiced strong satisfaction with the care they provided and the opportunity for professional development afforded to them by the CAP. They talked about their pride in serving vulnerable patients, the improvements they made in the health centers, and the growth they experienced in their jobs while working in challenging environments.

*I'm very proud of the fact that I'm providing care to people who really need health care. I'm keeping them out of the hospital, keeping them out of the Emergency Rooms. I'm keeping them healthier.*

—Community Ambassador, free clinic

#### Challenges for Community Ambassador Program

Interviewees were clear that the CAP's benefits far outweighed problems. When asked about challenges they encountered, many talked about caring for patients with complex medical and social needs, and doing so in clinics with limited resources and a shortage of qualified staff. Lack of affordable, reliable access to specialty care was the most often cited challenge by both Community Ambassadors and health center leaders. A few interviewees said the dual management structure for Community Ambassadors (as KP employees working elsewhere) and quarterly data reporting to KP were cumbersome aspects of the CAP.

#### Program Sustainability and Prospects

Community Ambassadors and health center leaders said that many of the CAP's practices, programs, and standards of care had become embedded in routine operations and were likely to be sustained.

*The prenatal program at this clinic is profitable, so I think they would sustain the program as it is ... It may not grow any larger ... If we both left, there would only be 1 person to do sonograms, but I'm sure that they would find a way. —Community Ambassador, free clinic*

However, they also worried about persistent funding problems and being unable to replace the Community Ambassadors if they left.

*[W]ithout this program, I would have a very difficult time running the clinic that I'm running and [ensuring] the quality that we provide to the patients and the number of patients that we see. It would be humanly impossible. —Health center leader, other clinic type*

Part of the CAP's value to participating health centers is a funding structure unlike that of traditional grants. Health center leaders cited the high skill level, training and retention of KP advanced-practice clinicians, more active involvement by KP, and lower administrative burden as clear advantages of the CAP over other forms of financing.

*What we got with the ambassadors and this type of grant [were] seasoned, experienced professionals. Other grants might give us money that we then have to look for those staff, [but] we have had difficulty finding that level of experience and expertise that fits our salary structure. So, I think that experienced staff is something that's very different about this grant. —Health center leader, FQHC*

Given the CAP's perceived benefits, it is no surprise that Community Ambassadors and health center leaders overwhelmingly hoped the program would last and perhaps grow, continuing to expand patient access and promote KP in the community.

*I would say that to be true to their mission of feeling that the community is not just the Kaiser [Permanente] patients but the community that they live in is important and that having the Ambassador program is really fulfilling that mission. I wouldn't shortchange that, because I think that's really woven into the essence of [KP], and it's something to be proud of.—Community Ambassador, other clinic type*

However, many acknowledged that the CAP staffing has been shrinking, and because KPMAS no longer employs nurse practitioners (most of the Community Ambassadors) in primary care, there is no clear pipeline for staffing the program.

## DISCUSSION

This study provides new insights into the characteristics and contribution of a KP effort to bolster the health care safety net through a partnership with community-based health centers. The main innovation of the KPMAS CAP is its workforce-based approach, which employs KP advanced-practice clinicians to work in safety-net clinics and directly boosts health care services through adding staff with advanced clinical expertise.

The CAP showed encouraging outcomes shortly after its launch in 2011.<sup>11</sup> The current evaluation of the CAP's mature phase—from 2013 to 2017—confirms preliminary findings. Access to several years' worth of data and key stakeholders with vast program knowledge have enabled us to gain an in-depth understanding of the CAP, to describe its trajectory, and to consider its future. These are clear strengths of this study.

The CAP model amounts to a large commitment of financial and human resources, suggesting that programs should consider sustainability options early on to preserve and maximize benefits from their investments. Well-designed data reporting systems can support measuring the impact of the intervention accurately and feasibly for community-based clinics. A “refresh and rebuild” of the CAP to bring it into the future should ensure leadership buy-in, alignment with organizational priorities, and clear long-term goals along with strategies to achieve them. Just as important, program stakeholders should work with participating clinics to ensure that any new solutions fit clinic needs. Because KPMAS is committed to continuing to support its safety-net partners, it is exploring future directions by assessing how clinic priorities align with KPMAS Community Health goals and strategies.

Our study encountered some limitations. First, because this was a community-based evaluation rather than a research study, we relied on quantitative data that were sometimes of uneven quality across program years and participating clinics. Potential bias in self-reported information by clinic staff and Community Ambassadors, inadequate local data collection systems, and KP-mandated changes in reporting schedule and definitions could have affected the accuracy and reliability of measures. We believe that regular review and validation of quantitative results by KPMAS stakeholders helped to avoid errors in our estimates.

Second, this study encompassed 5 years of the CAP; however, our interview sample was drawn only from clinics engaged in the CAP in 2017. It is possible that failing to interview stakeholders from health centers no longer in the program biased our qualitative findings, but the context and long-range perspective offered by KPMAS staff partly addressed this limitation.

Finally, we evaluated a program supported by an integrated health care system, and our findings may not be generalizable to partnerships in the safety net involving other types of large health care organizations.

## CONCLUSION

As a partnership between KPMAS and safety-net clinics, the CAP achieved its goals to improve access to care for underserved populations, increase the clinics' capacity, enhance quality of care, and export KP health care. The program has also strengthened relationships between KP and participating safety-net organizations. However, there are concerns that a dwindling work force could not sustain the CAP in its current form, with potential negative effects for patient access to care. As KPMAS assesses its next steps, the CAP's experience contains valuable lessons for health care organizations interested in working together with safety-net providers to sustainably improve community health. ❖

<sup>a</sup> Some data were missing for clinics that closed or dropped out of the program. Consistent data were not available for all measures because of changes in data reporting requirements and methods between years. For the years 2013 to 2015, data were collected on the performance of Community Ambassadors' clinics or clinic departments (eg, Pediatrics, Adult Medicine). For 2016 to 2017, only data on Community Ambassador performance were collected. Several measures selected for reporting by Kaiser Permanente Mid-Atlantic States were changed in 2016.

## Disclosure Statement

*The author(s) have no conflicts of interest to disclose.*

## Acknowledgments

*Kathleen, ELS, of Loudon Communications performed a primary copy edit.*

## How to Cite this Article

Palazzo L, Matthys J, Sewald C, et al. Fostering partnerships with the safety net: An evaluation of Kaiser Permanente's community ambassador program in the Mid-Atlantic states. *Perm J* 2020;24:19.010. DOI: <https://doi.org/10.7812/19.010>

## References

- Lewin ME, Altman S, eds. *America's health care safety net: Intact but endangered*. Washington, DC: National Academies Press; 2000.
- Lewin ME, Baxter RJ. *America's health care safety net: Revisiting the 2000 IOM report*. *Health Aff Millwood* 2007 Sep-Oct;26(5):1490-4. DOI: <https://doi.org/10.1377/hlthaff.26.5.1490>.
- The Patient Protection and Affordable Care Act of 2010. Public Law 111-148, 111th Congress, 124 Stat 119, HR 3590, enacted 2010 Mar 23.
- Chokshi DA, Chang JE, Wilson RM. Health reform and the changing safety net in the United States. *N Engl J Med* 2016 Nov 3;375(18):1790-6. DOI: <https://doi.org/10.1056/NEJMhpr1608578>.
- Bachrach D, Braslow L, Karl A. *Toward a high performance health care system for vulnerable populations: Funding for safety-net hospitals* [Internet]. New York, NY: The Commonwealth Fund; 2012 Mar [cited 2019 May 15]. Available from: [www.commonwealthfund.org/publications/fund-reports/2012/mar/toward-high-performance-health-care-system-vulnerable](http://www.commonwealthfund.org/publications/fund-reports/2012/mar/toward-high-performance-health-care-system-vulnerable).
- Young ME, Wallace SP, Bonilla A, Pourat N, Rodriguez M. Partnership strategies of community health centers: Building capacity in good times and bad. *Policy Brief UCLA Cent Health Policy Res* 2017 Jul;(PB2017-6):1-8.

7. Hunt JB, Curran G, Kramer T, et al. Partnership for implementation of evidence-based mental health practices in rural federally qualified health centers: Theory and methods. *Prog Community Health Partnersh* 2012 Fall;6(3):389-98. DOI: <https://doi.org/10.1353/cpr.2012.0039>.
8. Friedman DB, Young VM, Freedman DA, et al. Reducing cancer disparities through innovative partnerships: A collaboration of the South Carolina Cancer Prevention and Control Research Network and Federally Qualified Health Centers. *J Cancer Educ* 2012 Mar;27(1):59-61. DOI: <https://doi.org/10.1007/s13187-011-0272-5>.
9. Emerson H, Zur J, Brantley E, Schrag J. Removing barriers to coverage and access: Third party foundations offer premium and cost-sharing assistance. Issue Brief [Internet]. Washington DC: National Partnership for the Health Care Safety Net; 2016 Feb [cited 2019 May 31]. Available from: <https://essentialhospitals.org/wp-content/uploads/2019/03/REMOVING-BARRIERS-TO-COVERAGE-AND-ACCESS.pdf>.
10. Schrag J. Project overview: The National Partnership for the Health Care Safety Net [Internet]. Washington, DC: America's Essential Hospitals; 2019 Jan 1 [cited 2019 May 3]. Available from: <https://essentialhospitals.org/institute/the-national-partnership-for-the-health-care-safety-net/>.
11. Maeda JL, Bradley JJ, Eissler SR, et al. Expanding access to care and improving quality in the Mid-Atlantic States safety-net clinics: Kaiser Permanente's Community Ambassador Program. *Perm J* 2015 Spring;19(2):22-7. DOI: <https://doi.org/10.7812/TPP/14-109>.
12. Community health [Internet]. Oakland, CA: Kaiser Permanente [cited 2019 May 3]. Available from: <https://about.kaiserpermanente.org/community-health>.
13. Castro FG, Kellison JG, Boyd SJ, Kopak A. A methodology for conducting integrative mixed methods research and data analyses. *J Mix Methods Res* 2010 Sep 20;4(4):342-60. DOI: <https://doi.org/10.1177/1558689810382916>.
14. HEDIS (Healthcare Effectiveness Data and Information Set) and performance measurement [Internet]. Washington, DC: National Committee for Quality Assurance [cited 2019 May 14]. Available from: [www.ncqa.org/hedis/](http://www.ncqa.org/hedis/).
15. UDS (Uniform Data System) resources [Internet]. Rockville, MD: Health Resources & Services Administration; updated 2019 Apr [cited 2019 May 14]. Available from: <https://bphc.hrsa.gov/datareporting/reporting/index.html>.
16. ATLAS.ti 7.5.2 software [Internet]. Berlin, Germany: ATLAS.ti Scientific Software Development GmbH [cited 2019 May 14]. Available from: <https://atlasti.com/>.
17. Saldaña J. The coding manual for qualitative researchers. Thousand Oaks, CA: Sage Publications Inc; 2015.
18. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res* 2005 Nov;15(9):1277-88. DOI: <https://doi.org/10.1177/1049732305276687>.
19. 2016 National Health Center Data, Program Grantee Data [Internet]. North Bethesda, MD: HRSA (Health Resources and Services Administration) [cited 2019 June 3]. Available from: <https://bphc.hrsa.gov/uds2016/datacenter.aspx?q=d&year=2016>.
20. Kim HS, Kwon JE, Kim JH, et al. Efficacy of loop electrosurgical excision procedure with cold coagulation for treating cervical intraepithelial neoplasia: A two center cohort study. *Obstet Gynecol Sci* 2017 Mar;60(2):200-6. DOI: <https://doi.org/10.5468/ogs.2017.60.2.200>.

## A Thousand Fibers

We cannot live only for ourselves.  
A thousand fibers connect us with our fellow men.

—Herman Melville, 1819-1891, American novelist, short story writer,  
and poet of the American Renaissance period