Community Access Program: The First Six Months

Denise Davis, Dr.P.H.
Carrie Bogert, M.P.H.
Joel C. Cantor, Sc.D.
Sue Kaplan, J.D.
John Billings, J.D.

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Executive Summary

In an effort to develop and strengthen the infrastructure necessary for integrated health care systems for the under- and uninsured, the Health Resources and Services Administration launched the Community Access Program (CAP) in September 2000. The premise of this program is that providing federal support for infrastructure development to local community coalitions will lead to increased safety net capacity and improved quality of health services. The CAP initiative does not promote particular activities but enables community coalitions to define their own objectives within broad program guidelines. CAP initially funded 23 local coalitions in demonstration activities focused on improving the financial stability of the local safety net, increasing access to care for the under- and uninsured, and increasing the overall capacity of the health care delivery system. The expectation is that investments in these activities will lead to more integration among local service providers, more client-focused responsive systems, and greater efficiency and stability.

The Health Resources and Services Administration (HRSA) is monitoring and measuring the progress of the CAP grantees. Information from the six month progress monitoring reports, which asked grantees to document progress on planned activities, will serve to describe program processes and activities; underscore notable accomplishments; highlight innovative, effective system changes taking place; and identify areas for improvement. The information provided in this progress report describes CAP achievements as of the first six months of activity and lays the foundation for future program tracking.

A research team from New York University and Rutgers, The State University of New Jersey, is assisting HRSA in monitoring the program. As part of the monitoring process, each site was required to visually display its program goals and activities by the completion of a program "logic model," articulate the underlying assumptions that support the program and its expected outcomes, and provide activity status reports. This allowed the NYU/Rutgers team to create a baseline of all CAP grantee program activities and the ability to measure outputs across the sites.

This early implementation report describes the experiences and activities of the initial 23 funded grantees over the first six months of the project ending in February 2001. At the six-month mark, we found that the grantees are engaged in a wide range of activities that directly address the intent and goals of the CAP initiative. Grantees are seeking to integrate and improve service delivery systems, expand service capacity, increase enrollment in health insurance plans, implement community and patient education programs, and inform and educate state and local policy makers. The most common activities include elimination of administrative barriers, information sharing and standardization, case management coordination, increased enrollment in existing coverage plans, development of new or enhanced services, and the creation of outreach programs. Fewer grantees are engaged in activities to improve financial and administrative systems. As expected, the majority of grantee activities are in the initial phases of program development, and as yet, few sites report programmatic impacts.

The ability to collaborate across multiple partners committed to the process, the establishment of good working relationships, and staff commitment were frequently identified as important facilitating factors. Noted barriers to progress were communication and organizational differences, the complexities of information system design and implementation, data inconsistency, and an inability to recruit and retain adequate numbers of safety net providers (specifically, physicians).

The nature and structure of the CAP coalitions are varied in size, programmatic focus, and types of members and lead agencies. Even at this early stage of project development, most grantees reported leveraging new funds to support CAP activities and many are broadening their partnerships by recruiting various types of new members. Some grantees have been striving to

strengthen their support base by engaging policymakers within their coalition structure and by educating decision makers about CAP and related activities.

Monitoring report information confirms that the majority of grantees are developing tools and products under the CAP grant. These products can be categorized as information technology activities, training protocols or manuals, patient education packets and patient-centered management systems. The development of these tools and products is viewed as an early marker of CAP accomplishments.

This report describes CAP grantee program accomplishments during the first six-month reporting period, identifies technical assistance needs, and provides a baseline for understanding the progress of these and additional CAP grantees. Future waves of six-month progress reports will assist HRSA in monitoring program grantees, cataloging program accomplishments and targeting technical assistance resources to maximize program impact.

Community Access Program: The First Six Months

Introduction

In 2000 there were approximately 42.1 million people in the United States without health insurance.[1] Of these, 25 million were employed but had insufficient resources to obtain coverage for medical care. Compared with insured populations, the uninsured and underinsured are more likely to lack a regular source of care and as a result are also more likely to use the emergency room inappropriately. They depend heavily on expensive emergency room care and often do not receive needed follow-up services. Many of the uninsured and underinsured rely on "safety net providers" —health systems, institutions, and health professionals that provide a significant volume of services without regard for the patient's ability to pay. According to the Centers for Disease Control (CDC), emergency room visits across the United States are up by about 14%; as the population ages and expands, these visits are expected to continue to rise.[2]

Increasingly, community health service providers are challenged by the uneven distribution of uncompensated care, fragmented services and unmet need, a shrinking safety net system, and reduced Medicaid revenues. Recent findings from the Center for Studying Health System Change indicate that between 1997 and 1999 the proportion of physicians providing charity care declined from 76 percent to 72 percent.[3] As health care costs and insurance premiums continue to increase even as the economy slows, the number of uninsured persons in the United States will continue to grow. Thus, incremental programs to improve capacity, develop and strengthen infrastructure, improve quality, and heighten efficiency are critical to serving more numbers of the under- and uninsured.

For fiscal year 2000, Congress provided $25 million for the Community Access Program (CAP). In September 2000, the U.S. Department of Health and Human Services launched CAP funding 23 coalitions of community organizations and safety net providers to develop integrated health delivery systems for the uninsured. The integrated system would provide new models to fill existing service gaps, improve system efficiency, and enhance access and quality of care. The Health Resources and Services Administration is the administrative agency overseeing the grant initiative. To date, three rounds of grantees have been funded: 23 grantees in the first round were funded in September 2000, 53 grantees were funded in the second round in March 2001, and 60 grantees were funded in the third round in September 2001. This report reflects the first six months of activity for the first round of grantees.

Goals

The goals of CAP are to encourage community level coalitions through federal support for infrastructure development to design integrated health delivery systems for the under- and uninsured. Sites are encouraged to pursue a variety of investments including the improvement of the efficiency and financial stability of their safety net, enhance access and care to the under- and uninsured, and expand the capacity of the safety net through continued population outreach and increased enrollment in health coverage plans. In addition, coalitions are expected to establish models that are sustainable after CAP funding is no longer available. Effective collaboration, information gathering, clinical and financial coordination among care levels are some of the expected characteristics of funded programs under this initiative.

Description of Program Demonstration Models

In funding CAP, Congress was seeking to support a variety of program models that have been proven to work within communities.[4] Funded programs, according to the CAP grant solicitation, will contain several common elements: (a) collaboration among existing safety net providers building on previous community investments, (b) comprehensive services within an existing system, (c) coordination with public insurance programs, e.g., Medicaid, (d) community involvement that assures accountability, and (e) long-range program sustainability.

Researchers from Rutgers Center for State Health Policy (CSHP) and the Center for Health and Public Services Research (CHPSR) of the Wagner School of Public Service at New York University are assisting HRSA with CAP monitoring and providing technical assistance. The research team's initial CAP review of the 23 original grantees yielded the development of seven main intervention approaches – each with multiple subcategories:

1. Integration of service delivery systems
2. Improvement of business practices and integration of financial systems
3. Increased enrollment in health insurance plans
4. Expansion of the delivery system
5. Implementation of community/patient education programs
6. Improvements in service delivery
7. Informing public policy

These approaches were used to categorize grantee proposals. Grantee program demonstration models include building partnerships across organizations; instituting and coordinating new coverage schemes that cover at-risk and underserved populations; developing management information systems across service providers to increase access and efficiency; instituting program improvements such as sharing protocols, quality assurance programs, and utilization management systems; improving and consolidating business practices; and creating patient and provider education programs. It is hoped that the use of such innovative and expansive approaches will prove competitive within the existing marketplace and sustainable after federal grant funding no longer exists.

Methods

Development of the Logic Model

Aware of program design issues around capturing the array of CAP activities, HRSA required each site to develop a logic model or a causal map that graphically illustrates how program activities lead to specific outcomes. This approach requires the communities to identify their inputs, activities, and expected outcomes in clear and measurable terms. The logic models also elucidate the theory and assumptions that underlie each program, and highlight any gaps in the logic of how results are to be achieved. Benefits of the logic model process include explicitly showing the relationship among what the community intended to do (goals), what needs to happen to accomplish the goals, as well as the level of resources required (activities), and what results are intended (expected outcomes). The first phase of monitoring required the CAP grantees to attend a training session conducted by members of the CAP research team on the definition, uses, and development of a program-specific logic model. Grantees were then asked to develop a program logic model and

submit this information to the research team for review. The research team responded to each submission with written comments, questions, and suggestions. The research team's assessment of this logic model development process appears in a separate document.[5]

Describing and Categorizing Approaches

The second task in documenting program activities and system changes was to determine common definitions or classifications by type. Once these classifications were agreed upon by the research team and HRSA program staff, grantees' specific initiatives—either illustrated in their site logic model, or described within their initial proposals—were categorized or grouped together in terms of the overall identified project goal. Another task in documenting program activities and system change was to develop a typology of intervention approaches. Relying on the site logic models, the research team and program staff developed a single logic model for the entire CAP initiative that grouped the community activities into seven broad categories, each with multiple subcategories providing an overall snapshot of all CAP-funded program initiatives (See Figure A). This mapping provides a picture of how CAP is expected to work—and what outcomes are anticipated—given its resources and planned activities. It also provides a baseline of information concerning CAP grantee activities and allows for the identification of interim benchmarks that cut across the multiple sites. The logic model process also provides a shared understanding among grantees, participating federal agencies, and the research team of how and why CAP is expected to work.

Establishing and Verifying the Baseline

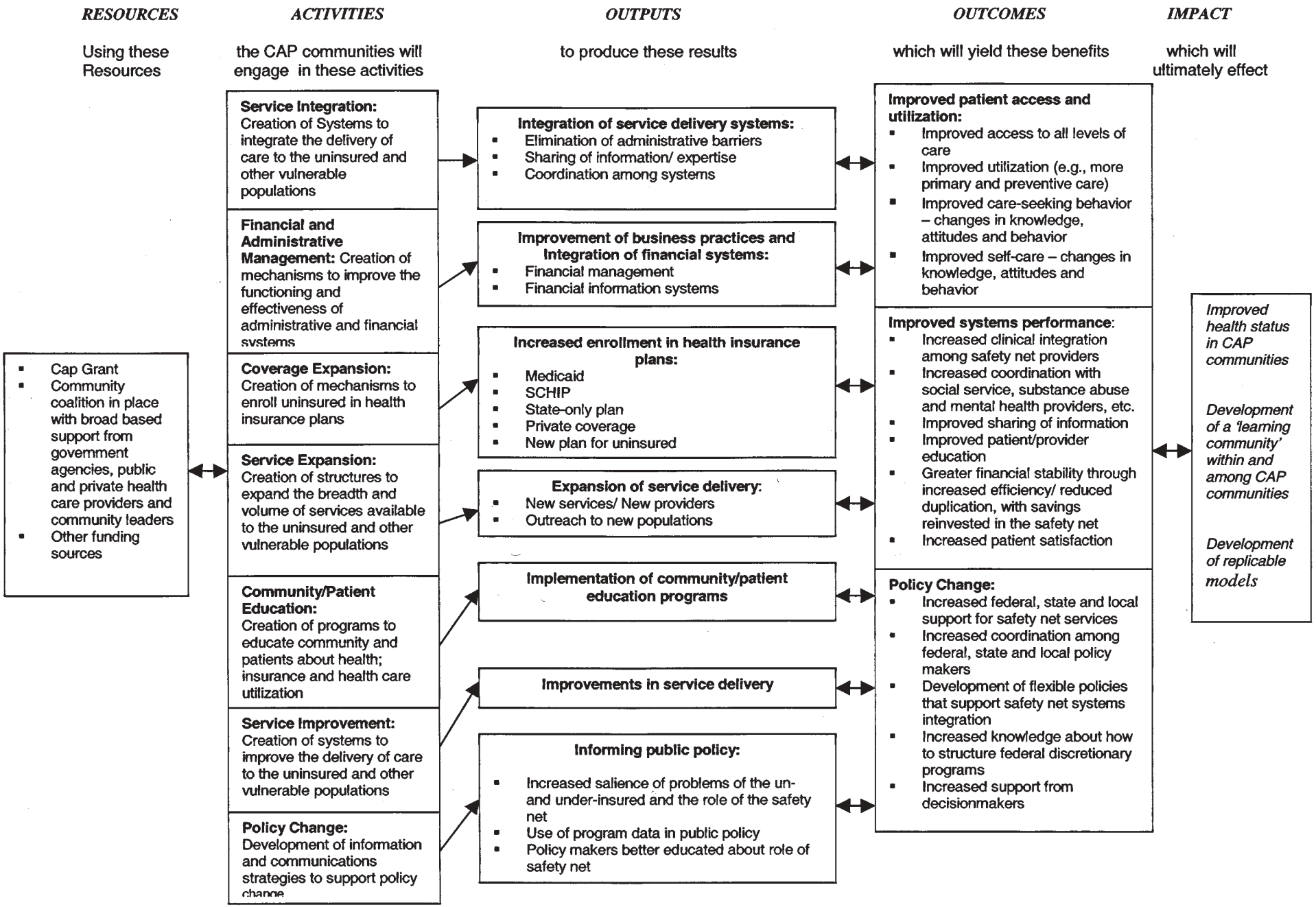
Task three of the monitoring activity involved the development of a CAP grantee draft matrix of site outputs. Upon the receipt and synthesis of individual logic model information into the larger CAP logic model, research team members developed a program matrix that identified previously defined broad logic model categories and incorporated all grantee-reported activities under these categories. The end result was a large program matrix that identified program activities by grantee site. All grantees were asked to review, correct and update this matrix accordingly, noting if activities reported for their site were presented correctly. This information became the basis for the site-specific six-month progress monitoring report.

Progress Monitoring Report

In order to better grasp and categorize approaches taken by the sites, an appreciation of the structure and operation of the coalition was deemed essential. As the composition and functioning of coalitions differ, identifying their ability to provide leadership, control resource allocation, enhance service delivery, improve system performance, or impact change agents, has proven difficult to measure. Part A of the CAP progress monitoring report form attempts to identify specific characteristics of the coalitions by determining the individual structure and membership of each, categorizing the overall type of coalition, measuring coalition activities, assessing the organizations' ability to fund-raise, and determining the amount of coalition growth or shrinkage occurring within the reporting period. Information from program grant applications was used to augment Part A Reports.

Part B of the CAP progress monitoring report used the established broad logic model categories (identical categories to those within the CAP matrix) and once again asked grantees to verify and/or correct specifically identified program activities, characterize program status within the

Figure A: CAP Logic Model



reporting period, and provide qualitative and quantitative information on patients served and programs provided. In addition, a number of questions accompanied each broad section that asked for a further description of system activities, an explanation of barriers or facilitators, and change effects on providers or consumers. (See Appendices A-C for the six-month progress report forms and instructions. The full text of the grantee responses are available in a supplement to this report.

Categories of Progress Report

Many approaches were noted by sites in order to improve access, strengthen existing health systems and improve service delivery to the under- and uninsured. Site-specific baseline measures were identified under the broad categories defined within the CAP logic model and matrix. These measures enabled research team members to assess and monitor the operation of grantee coalitions within the context of their operation. They also allow individual grantee comparisons as well as overall program assessment status. The report format utilized allows the semi-annual collection of site-specific information on seven measures or program outputs as previously noted in Figure A.

This next section of the report presents a review of the early accomplishments of the initial HRSA CAP grantees as observed by the research team during the first reporting period of the grant. It is intended to assess the status of grantee progress, measure early impacts, identify CAP-wide themes by category, provide notable case examples and predict sustainability of grantee initiatives. Part A of the report provides research team observations of grantee coalition activities while Part B identifies and explains patterns of CAP activities and assesses early programmatic impacts. Additionally discussed within Part B are what barriers have served as impediments to the process as well as what facilitators have enabled progress. Finally, conclusions and discussions about the CAP demonstration program are presented.

FINDINGS

Part A —The CAP Coalitions

Coalition Structure

This section presents the findings of Part A of the report and covers topics related to coalitions' composition, leadership, representativeness, recruitment experience, collaborative activities and fund-raising efforts.

How many of each organizational type were members of the CAP coalition at the start of this reporting period, how has that changed during the reporting period, and why (Question A1)?

The nature and structure of the 23 funded CAP coalitions varied in size, orientation, member type, and lead agency designation. In addition, they varied by geographic location, population density, an urban versus rural designation, and the size and characteristics of the target population identified.

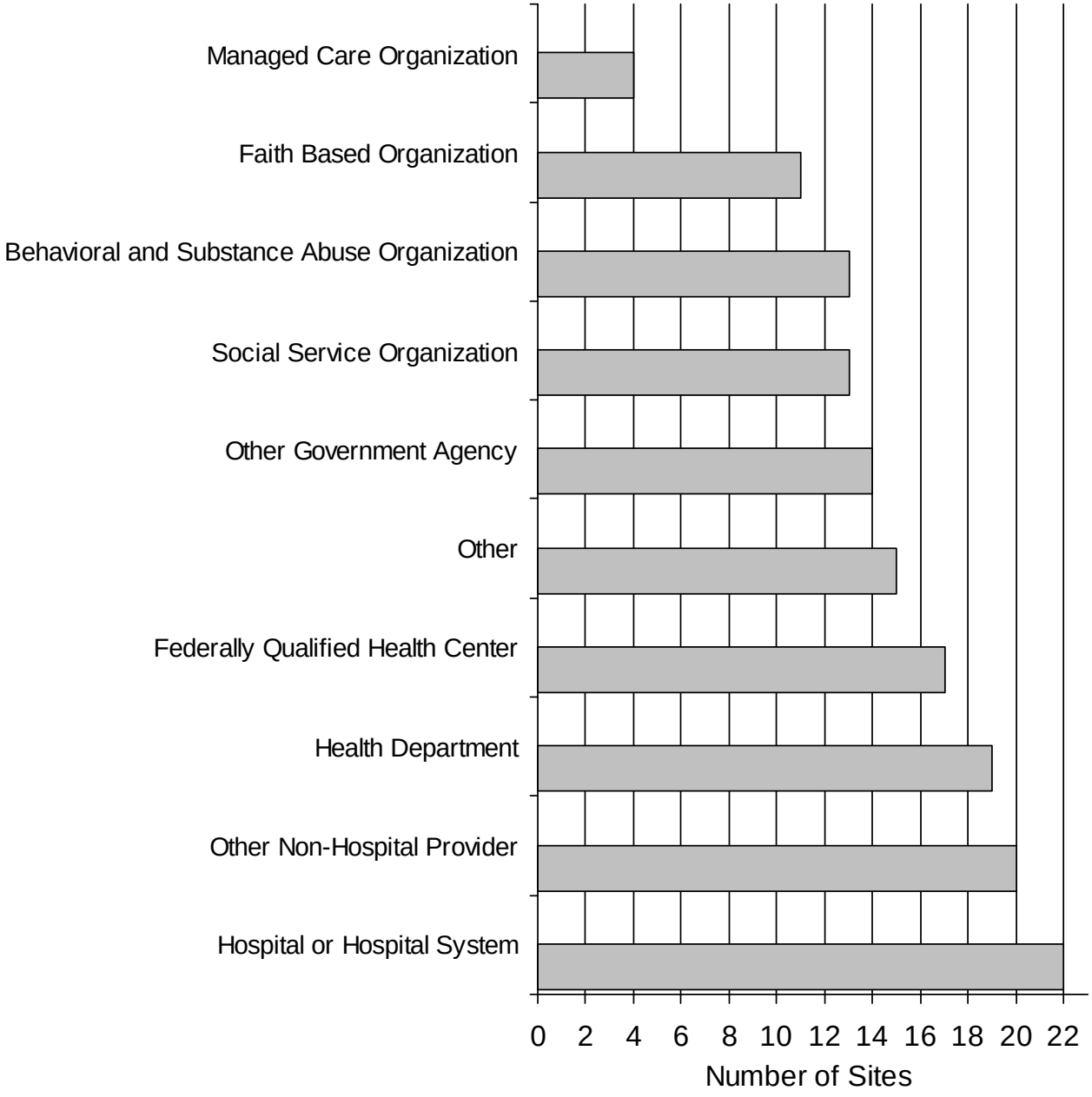
The size of the coalitions ranged from as few as four members (identified by the coalition in Minneapolis, Minnesota) to as large as over 180 members (reported by the grantee in Dover, Delaware)(Table A1-a). The total number of coalition members from non-hospital providers (257)

Table A1a: CAP Coalitions by Type of Lead Agency and Membership

			Number of Coalition Members by Type[2]									
						Other Organizations and Partners						
Site	Total Coalition Members	Lead Agency Type[1]	Hospital or Hospital Systems (HOSP)	Federally Qualified Health Center (FQHC)	Other Non-Hospital Providers (NHP)	Health Depts. (HD)	Other Gov. Agencies (GOV)	Managed Care Orgs.	Social Service Orgs.	Faith-Based Orgs.	Behav. & Subst. Abuse Orgs.	Other[3]
Sitka, AK	11	GOV (Tribal)	2	9								
Tuscon, AZ	18	FQHC	7	6	3	1				1		
Los Angeles, CA	6	HD	1		3	1						1
Dover, DE	189	Consortium	7	2	160	3	3		1		1	2
Tallahassee, FL	8	GOV	2	1	2	1						2
Chicago, IL	44	Consortium	3	13		1	2		5	13		7
Manhattan, KS	31	NHP	3		5	1	2	1	3	1	3	14
Hazard, KY	61	GOV	5		27	2			4	4	2	17
New Orleans, LA	46	GOV	28	4	5	2			6	8		2
Yarmouthport, MA	15	Consortium	3	1	2		2				3	4
Detroit, MI	36	NHP	3	3	4	1			19	2	1	
Minneapolis, MN	4	HD	1			1						2
Clarksdale, MS	18	FQHC	5	4	3	2	2				1	1
Santa Fe, NM	13	Consortium	3	3	1	1	2		1		2	
New York, NY	20	HOSP	1	5	2				6		5	1
Raleigh, NC	20	GOV	2		3	1	1		1	4		8
Cincinnati, OH	59	FQHC	19	7	12	3	3		4	5		6
Portland, OR	19	Consortium		9	2	5	1	1				1
Memphis, TN	9	HOSP	1	1	1	1	1		1		3	
Austin, TX	11	NHP	3	1	4	2	1				1	
El Paso, TX	22	HOSP	2	2	2		3	1	10	1	1	
Falls Church, VA	49	HOSP	6		6	2	1	1	10	5	3	15
Milwaukee, WI	29	GOV	11	5	10	1	1			1	1	
TOTAL	738		118	76	257	32	25	4	71	45	27	83

[1] From original grant proposal, see columns for abbreviations
[2] Reported in six month progress report
[3] Examples of other includes: consortia, schools, community foundations, CBO's, business organizations, and dental clinics.

Figure A1a: CAP Coalitions by Member Type



outnumbered the total number of coalition members from a hospital or hospital system (118), or with other organizations and partners (Table A1-a). The most common lead agency type noted was that of a government authority such as a state, county, or municipal entity. Six out of twenty-three grantees reported that a government entity was their lead agency. The designations of hospital or a consortium tied for the second most-common lead agency noted by grantees. Five grantees reported that a consortium was the lead agency of their HRSA CAP initiative, while four grantees indicated that a hospital was the lead agency. The designation of a non-hospital provider or a Federally Qualified Health Center was tied with three grantees each reporting either entity as their lead agency type. Finally, a health department was identified by two grantees as the lead agency (Figure A1b).

Grantees were also asked to report by type the numbers of coalition members that were added or left by type. In the first six months, there were few changes. As can be seen by Table A1-b, grantees are continuing to add coalition members. Ten hospital or hospital system members, four federally qualified health centers and eleven other non-hospital providers were added to existing CAP coalition groups. Four coalition members in total were reported as having left a coalition. The members that left the coalitions include one hospital system, two behavioral substance abuse organizations, and one social service organization. Most growth in coalition membership is occurring within organizations and partners other than hospitals, federally qualified health centers, and other non-hospital providers (specifically noted in thirty-five total additions of social service, faith-based, behavioral and substance abuse organizations, and others). However, hospital systems and other non-hospital providers also appear to be exhibiting growth (ten and eleven additions noted respectively).

Coalition Adequacy

Do the participating representatives have enough seniority and authority from their organizations to make commitments of resources and other support for the coalition (Question A2)?

Most of the coalitions (21 of 23) indicated that representatives of member organizations were sufficiently senior and committed to the coalition.

Are you actively seeking to recruit new members and, if so, of what kinds and to fulfill what roles (Question A2)?

In reviewing grantee activities associated with member recruitment, most coalitions reported that they are actively seeking new members but the type of new member coalitions sought for involvement in the CAP project varied. The majority of coalitions reported that they are seeking to involve more health providers, i.e., hospitals, specialty physicians, behavioral health providers, community clinics, FQHC's, pharmacy programs, and members of the medical society. About one quarter of the grantees indicated efforts seeking active engagement of representatives from the business community, i.e., labor union, chamber of commerce, employers and local business members. Few coalitions noted actively seeking recruitment of members from academic, governmental or consumer groups. Eight coalitions did not report any changes at all this reporting period nor did they identify future member-seeking activities. Three coalitions noted that they were not actively seeking new members as noted in Table A2.

Collaboration Outside the Coalition

Please describe collaborative activities in which the CAP project has engaged with organizations and agencies in your community or state that are not members of your CAP Coalition (Question A3).

Most CAP grantees reported engaging in numerous collaborative activities with non-member organizations during this period. Many activities described involved volunteer and outreach

Figure A1b: CAP Coalitions by Type of Lead Agency

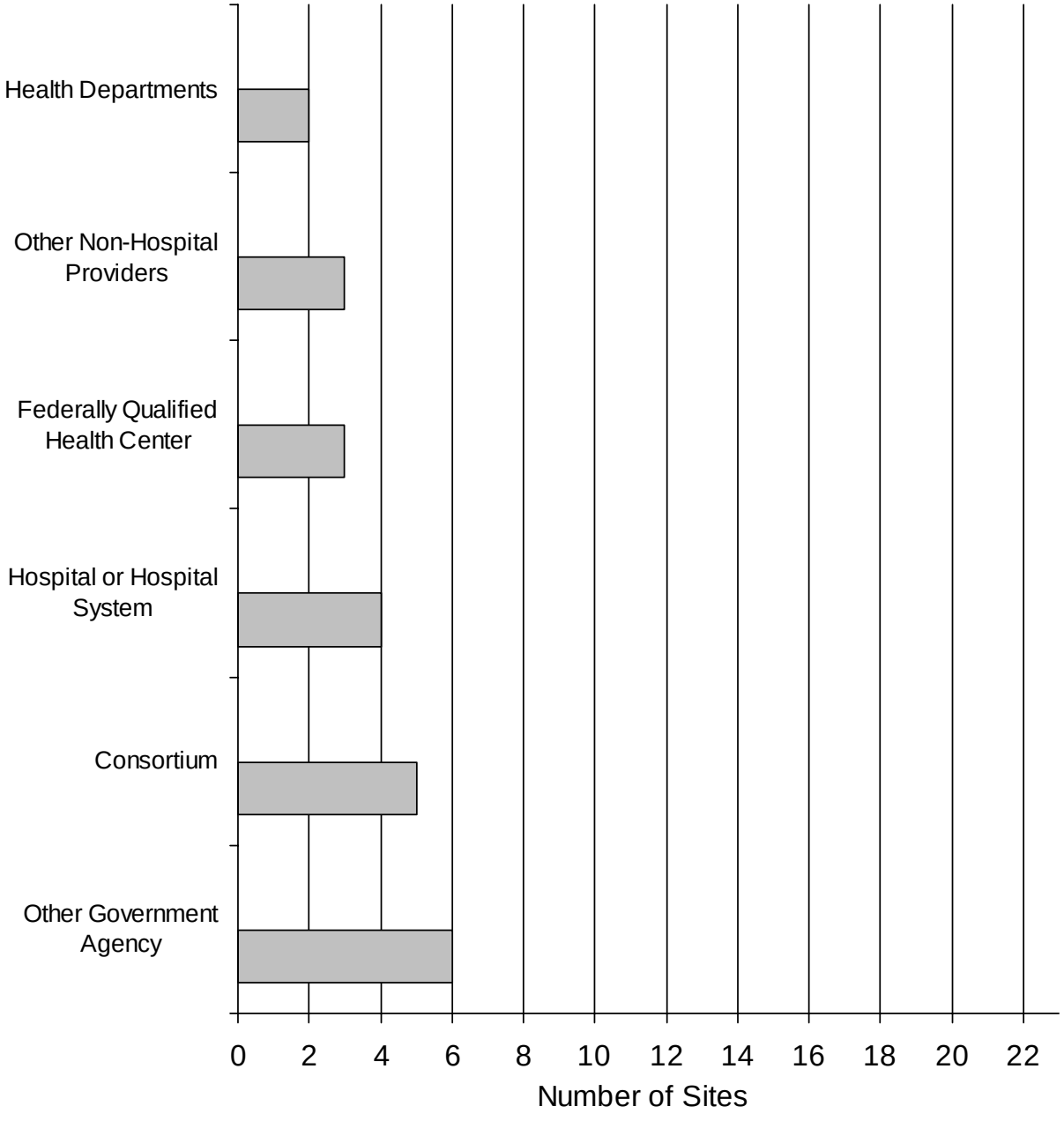


Table A1b: Coalition Members Added or Left by Type, September 2000 to February 2001

Site	Hospital or Hospital Systems		Federally Qualified Health Center		Other Non-Hospital Providers		Other Organizations and Partners											
							Government Agencies		Managed Care Org.		Social Service Org.		Faith-Based Orgs.		Behavioral & Substance Abuse Orgs		Other	
	# Added	# Left	# Added	# Left	# Added	# Left	# Added	# Left	# Added	# Left	# Added	# Left	# Added	# Left	# Added	# Left	# Added	# Left
Sitka, AK																		
Tuscon, AZ	1																	
Los Angeles, CA																		
Dover, DE	3																2	
Tallahassee, FL																	1	
Chicago, IL							3											
Manhattan, KS	2				2				1		1		1				1	
Hazard, KY					6													
New Orleans, LA	1														1			
Yarmouthport, MA																		
Detroit, MI			3		1								1					
Minneapolis, MN																		
Clarksdale, MS																		
Santa Fe, NM	2				1		3								2			
New York, NY												1						
Raleigh, NC					1										1		1	
Cincinnati, OH													4					
Portland, OR																		
Memphis, TN																		
Austin, TX	1						1											
El Paso, TX																		
Falls Church, VA							1				8		2		3	2	6	
Milwaukee, WI		1	1															
Total	**10**	**1**	**4**		**11**		**8**		**1**		**9**	**1**	**8**		**7**	**2**	**11**	

[1] Reported in six month progress report

Table A2: Members CAP Coalitions Sought to Add, by Type

	Type of Coalition Memebers											
Site	Not Seeking New Members	State and/or Local Government Units	Hospitals	Health Providers	Involvement from Universities	Behavioral Health Orgs. and Providers	Pharmacy Related Members	Clinics	Chambers of Commerce	Local Labor Union	Consumers in Community	Local Businesse
Sitka, AK												
Tuscon, AZ			✔									✔
Los Angeles, CA								✔		✔		
Dover, DE												
Tallahassee, FL					✔							
Chicago, IL		✔										
Manhattan, KS		✔		✔				✔	✔			
Hazard, KY				✔								
New Orleans, LA				✔			✔				✔	
Yarmouthport, MA												
Detroit, MI												
Minneapolis, MN	✔											
Clarksdale, MS		✔										
Santa Fe, NM			✔	✔		✔						
New York, NY												
Raleigh, NC												
Cincinnati, OH						✔						✔
Portland, OR						✔		✔				
Memphis, TN	✔											
Austin, TX												
El Paso, TX			✔			✔						
Falls Church, VA												
Milwaukee, WI	✔											
TOTAL	3	3	3	4	1	4	1	3	1	1	1	2

worker training initiatives. Examples of these activities were reported by CAP grantees in Tallahassee, Florida where student volunteers are being recruited to assist in primary care sites in the community; in Santa Fe, New Mexico where a training curriculum development is occurring for the outreach workers-*promotoras*; and in New York, N.Y. where culturally appropriate volunteers are being recruited with the assistance of senior centers, and faith- and community-based organizations. Other activities include data warehousing or the development of management information systems for safety net clinics and on-line eligibility systems as noted by Portland, Oregon and the development of disease management protocols by several local community clinics in Los Angeles, California (Table A3 & Figure A3). Collaborative activities and status levels vary among grantees.

Coalition Funding

Has the coalition been able to leverage any additional funds to support the CAP initiative or other joint initiatives during the reporting period (Question A4)?

Most of the grantees (17 out of 23) have been able to leverage new funds to support CAP activities. The total amounts of new cash funds leveraged reported by CAP grantees during this period is at least $4.5 million (in some cases, dollar amounts were not reported). An additional $285,000 was committed for in-kind services and resources. Among the sites raising the most money were Chicago, Illinois which will receive over $1.12 million within the next three years and New Orleans, Louisiana which is slated to receive about $1.14 million over the next three years. Both of these sites have leveraged funding from multiple sources. Others who raised lesser but still sizeable amounts were Raleigh, North Carolina with foundation funding totalling $750,000; Santa Fe, New Mexico with foundation funding and legislative commitments totaling $600,000; and Yarmouthport, Massachusetts and Detroit, Michigan both attaining multiple source funding totaling approximately $418,000 and $300,000 respectively. Others raised more moderate funding such as Clarksdale, Mississippi and Tallahassee, Florida with pharmacy grant funding of $250,000 and $200,000 in-kind pharmacy and dispensing services respectively; Minneapolis, Minnesota with funding from multiple sources totalling $180,000; Falls Church, Virginia with $100,000 from a national foundation for education and outreach; Los Angeles, California with $20,000 from a health system for diabetes prevention and education; and Tucson, Arizona reporting $85,000 of in-kind contributions from the host community health center. Additionally, it should be noted that over half of the CAP grantees reported having been recipients of foundation funding prior to the CAP initiative and thus have demonstrated experience with leveraging funding from governmental agencies, local health systems and national foundations in the past. Figure A4 is a visual depiction of new funding sources raised by CAP grantees during this reporting period.

Coalition Products

What tools and products have been produced under the CAP grant during this reporting period (Question 5)?

Tools and products developed under the CAP grant can be categorized as information technology activities, resource referral directories, training protocols or manuals, patient education packets and patient management systems. In many instances, it is still too early for full product development to have occurred, however, some progress is noted. For example, Arizona reports the development of a practice management and managed care software system used to organize and coordinate their community health network. The development of patient management systems by grantees is also described by many (Manhattan, KS, Dover, DE and Tucson, AZ) as being operational as of this report period. Information technology systems, training protocols and disease management protocols are also reported as being in early operational phases by many grantees (Los Angeles, CA, Tallahassee, FL, Hazard, KY, Yarmouthport, MA, New York, NY, Raleigh, NC and Cincinnati, OH). For the most part, grantee reported products and tools are being developed wholly (12) or partially (5) as a result of receiving CAP funds (Table A5 & Figure A5).

Table A3: CAP Coalition External Collaborative Activities and Status of Activity

Site	Coalition External Collaborative Activity	Status of Activity
Sitka, AK	Data merge with medical center patient info. System	Planning
Tucson, AZ	Loan program for patients for medical bill payback	Planning
Los Angeles, CA	Diabetes disease management: retinal-screening telemedicine project	Planning
Dover, DE	Volunteer recruitment activities across agencies; community outreach/education	Development
Tallahassee, FL	Volunteer recruitment activities across agencies; community outreach/education	Development
Chicago, IL	Volunteer recruitment activities across agencies; community outreach/education	Early Operational
Manhattan, KS	Health resource management model contracts; small business health insurance development	Planning
Hazard, KY	Enrolment of individuals in home health	Early Operational
New Orleans, LA		
Yarmouthport, MA	Expansion of interpreter training program; development of outreach worker training program	Early Operational
Detroit, MI	Enrollment of applicants in Medicaid or county insurance programs	Development
Minneapolis, MN		
Clarksdale, MS	Development of MIS systems	Planning
Santa Fe, NM	Expansion of interpreter training program; development of outreach worker training program	Early Operational
New York, NY	Volunteer recruitment activities across agencies; community outreach/education	Early Operational
Raleigh, NC	Volunteer recruitment activities across agencies; community outreach/education	Development
Cincinnati, OH	Inviting outside groups to participate in the CAP coalition process	Planning
Portland, OR	Development of MIS systems	Planning
Memphis, TN		
Austin, TX	Telemedicine project	Development
El Paso, TX	Inviting outside groups to participate in the CAP coalition process	Planning
Falls Church, VA	Inviting outside groups to participate in the CAP coalition process	Planning
Milwaukee, WI	Patient education and access improvements	Planning

Figure A3: CAP Coalitions Engaging in Collaborative Activity by Type of Activity

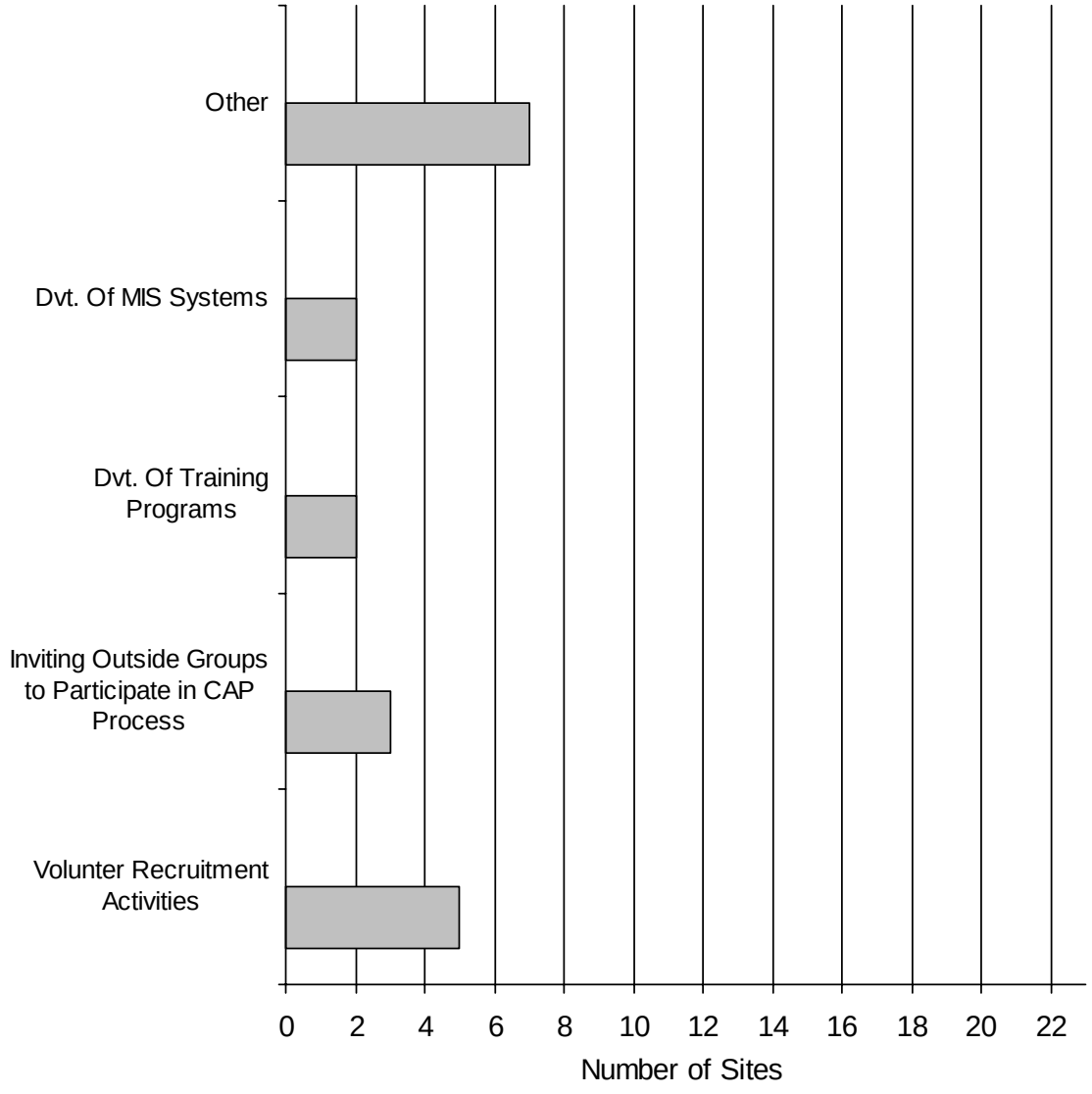
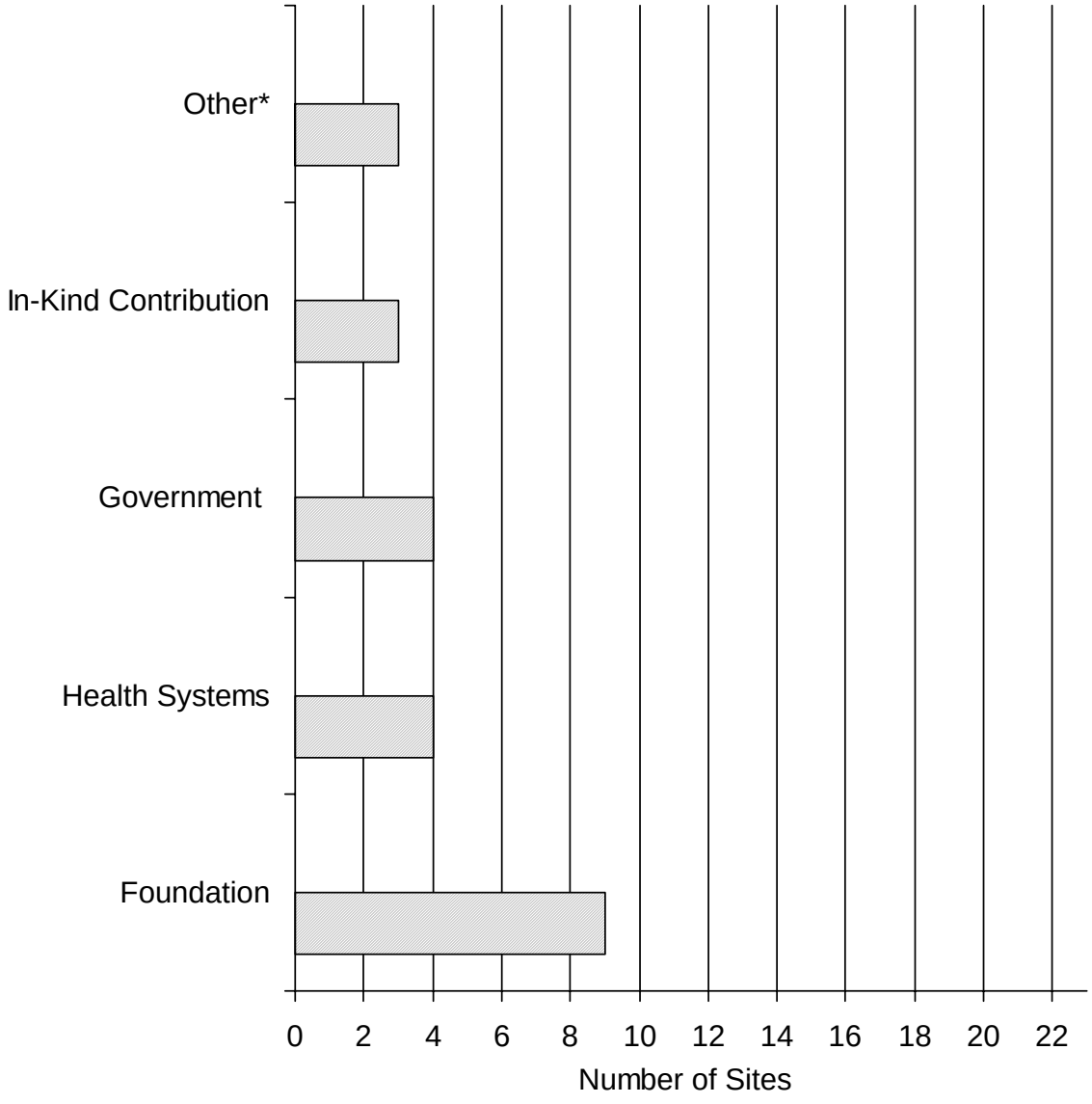


Figure A4: CAP Coalitions with New Funding by Source

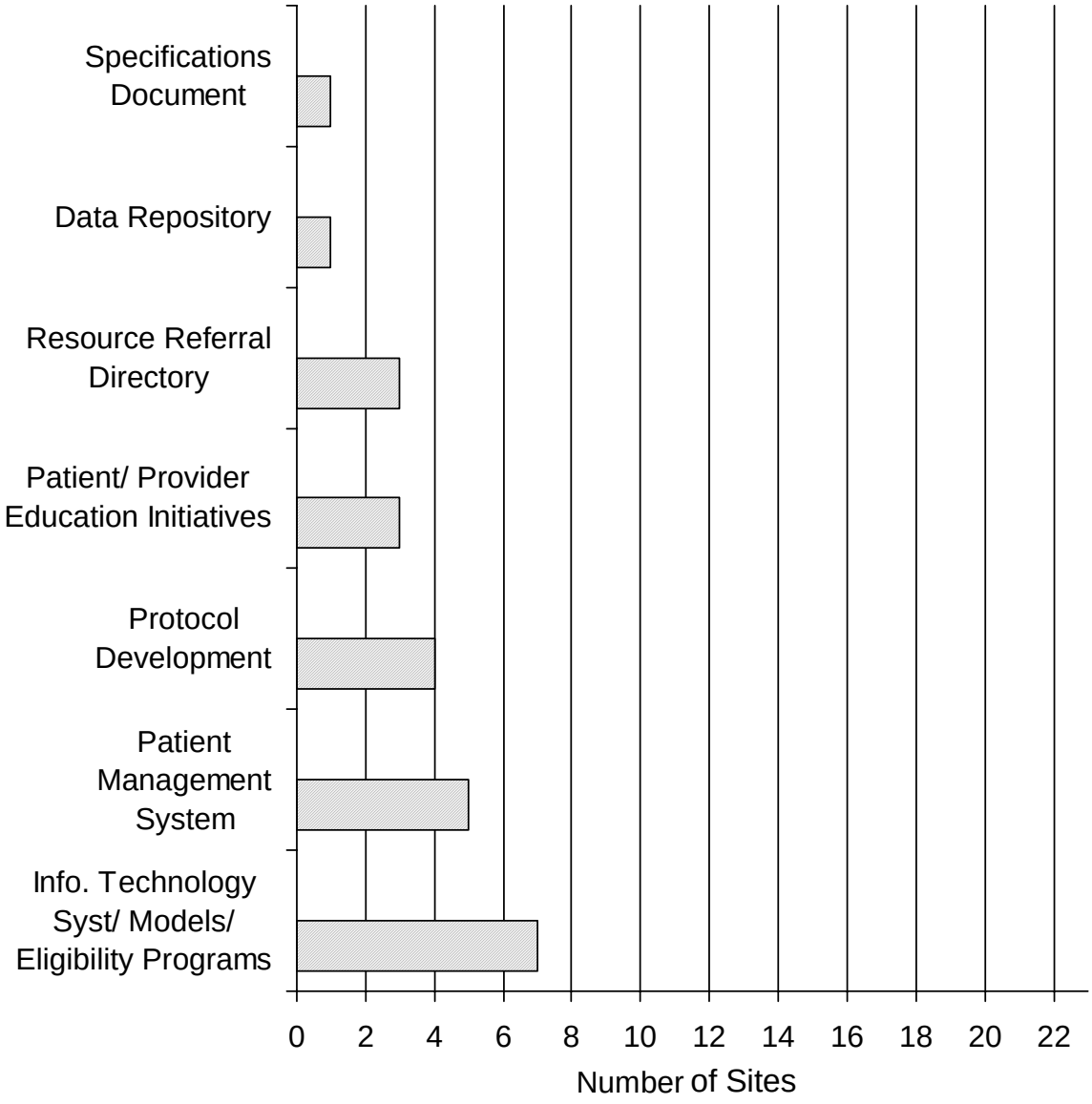


*Other sources include hospitals, corporations, and non-profit organizations

Table A5: CAP Coalition Products and Tools

Site	CAP Coalition Products and Tools
Sitka, AK	
Tuscon, AZ	Information Technology Systems / Models/ Eligibility Programs
Los Angeles, CA	Information Technology Systems / Models/ Eligibility Programs
Dover, DE	Information Technology Systems / Models/ Eligibility Programs, Patient Management System
Tallahassee, FL	
Chicago, IL	Patient Management System
Manhattan, KS	Patient Management System
Hazard, KY	Information Technology Systems / Models/ Eligibility Programs
New Orleans, LA	Resource Referral Directory
Yarmouthport, MA	Information Technology Systems / Models/ Eligibility Programs
Detroit, MI	Patient / Provider Education Initiatives
Minneapolis, MN	Resource Referral Directory
Clarksdale, MS	Resource Referral Directory
Santa Fe, NM	Patient Management System, Protocol Development (Management Protocol Development)
New York, NY	Patient / Provider Education Initiatives, Protocol Development (Management Protocol Development)
Raleigh, NC	Protocol Development (Clinical Protocol Development)
Cincinnati, OH	Protocol Development (Clinical Protocol Development)
Portland, OR	Information Technology Systems / Models/ Eligibility Programs
Memphis, TN	
Austin, TX	Patient Management System, Data Repository
El Paso, TX	Information Technology Systems / Models/ Eligibility Programs
Falls Church, VA	Specifications Document
Milwaukee, WI	Patient / Provider Education Initiatives

Figure A5: Grantees Developing Products and Tools by Type



Part B- CAP Grantee Activities

This section presents the results of Part B of the CAP Activity Report, describes program activities of the CAP grantees, discusses individual as well as group stage of development and provides a visual depiction of all intervention approaches noted. First, summary information about major categories is presented, followed by detailed descriptions of specific activities within each major category.

Overview of CAP Activities

Site-specific information collected in broad categories, originally defined within the program matrix, allowed the research team to aggregate grantee activities and report them by classification. This enables an overall assessment of early activities and provides an opportunity to highlight any notable impact of the CAP initiative to date. Because CAP encompasses such a broad range of potential activities and projects at each site, the state of program development among sites varies greatly. In order to compare and assess grantee progress across program activities, a bar chart depicting the full array of program activities is presented (Figure B1).

In the first half of the grant year, much effort was placed on planning and development. Of the 23 grantees in Phase I of the CAP initiative, virtually all were engaged in activities related to eliminating administrative barriers; sharing information and/or expertise; developing or enhancing provider and patient education, systems integration and coordination; and increasing enrollment in health insurance plans. More than half of the grantees were found to have activity in developing new services and engaging new providers, informing public policy, improving service delivery, and promoting outreach to new targeted populations. Fewer than half of the group was found to be engaged in activities to improve business practices and financial systems.

When assessing grantee activity in the operational stage, a slightly different pattern emerged. Just about half of grantees were found to have operational activity related to the elimination of administrative barriers, sharing information or expertise, and developing community and patient education programs. Just under half were involved in system coordination, increasing enrollment in health insurance plans, and developing new services and engaging new providers. Fewer than half of the grantees reported activities of informing public policy, improving service delivery, conducting outreach programs to new populations, and improving business practices and financial systems.

In order to assess the stage of development of CAP activities during the reporting period, each grantee was asked to rate the operational status of each of their programmatic activities. The grantee applied one of four stages of development to each of their activities: planning only; in development/not operational; early operational/not full to scale; and fully operational. The following sections summarize these ratings for each of the CAP activities.

Integration of Service Delivery Systems

In this category, the majority of grantees were engaged in the integration of a standardized screening or registration system for program enrollment, creating a medical home for the uninsured, and the development of a community resource databank. However, further examination showed three activities as having the largest number of grantees documenting fully operational status. These activities include the development of a standardized registration system (4 grantees), integration of primary care systems (3 grantees), and the creation of a patient referral line (2 grantees). Other grantees in this category described activities as early operational/not full to scale (4 grantees) or in development or not fully operational (number of grantees varied by reported activity) (Figure B1a: Integration of Service Delivery Systems - Elimination of Administrative Barriers).

Figure B1: CAP Grantee Activities in Each Category by Stage of Development

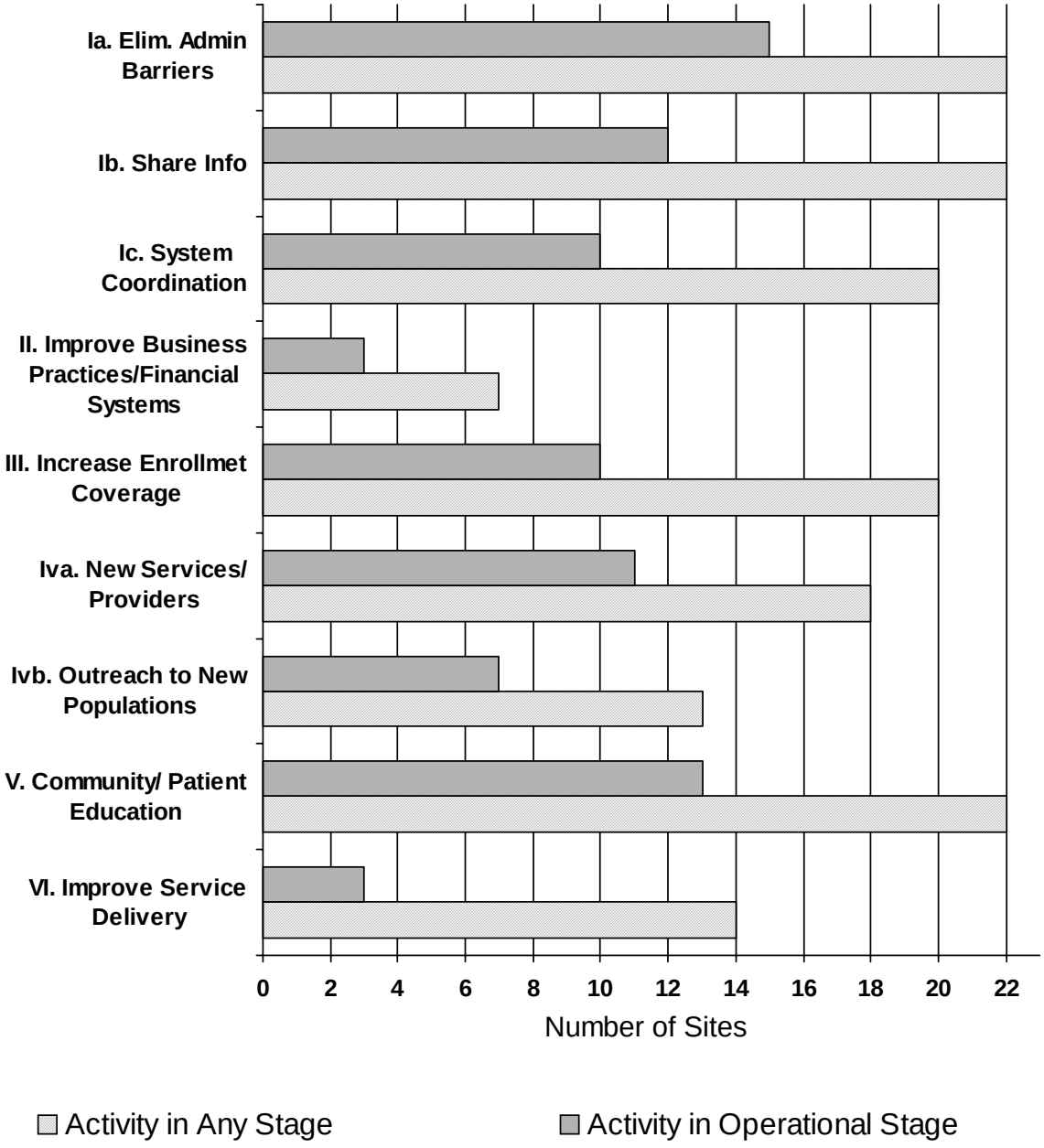
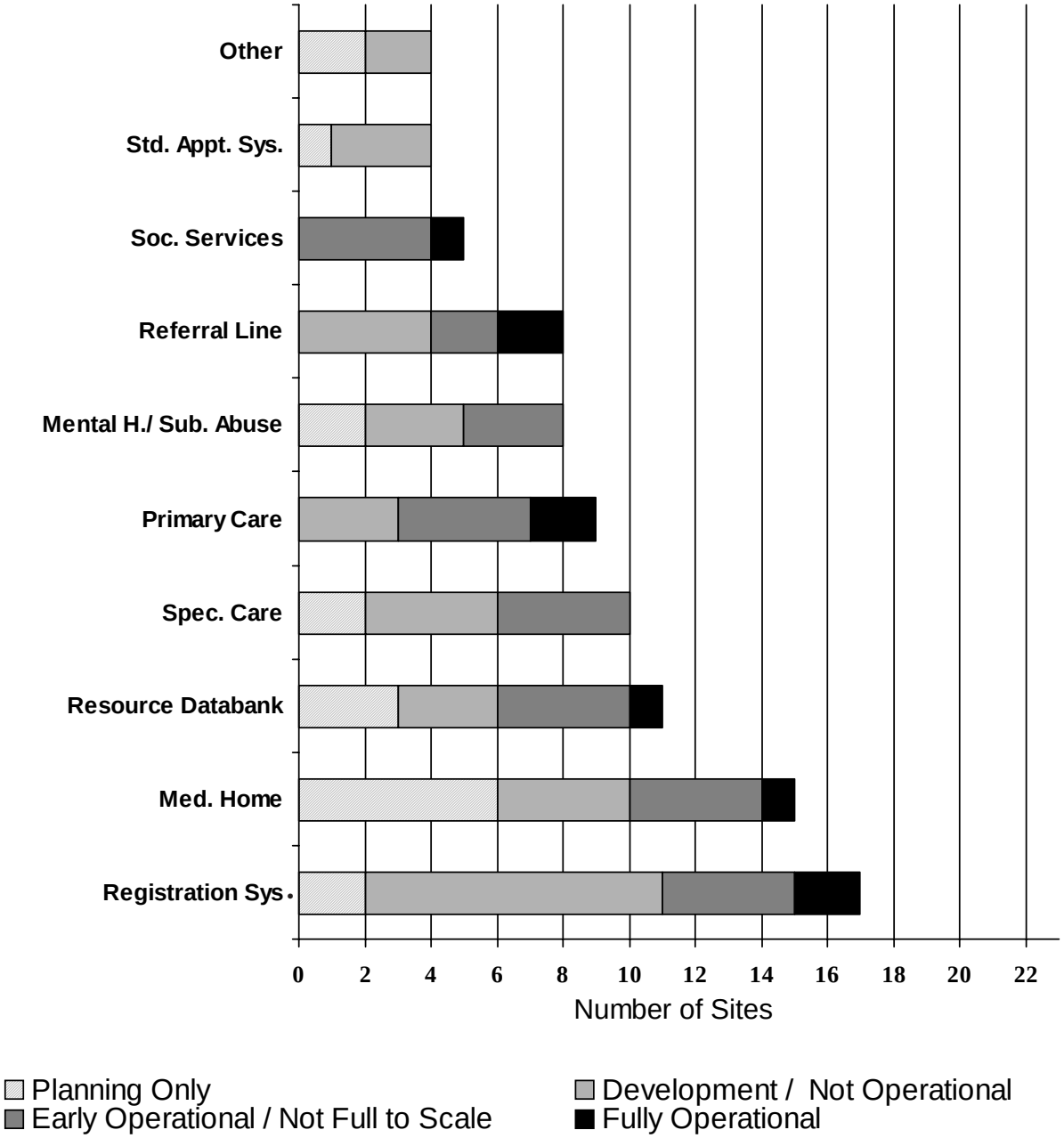


Figure B1a: Integration of Service Delivery Systems - Elimination of Administrative Barriers



Under the sub-category "Sharing of Information/Expertise," few grantees reported being fully operational in many identified activities. Two grantees each noted full operation in standardization of information systems and the development of disease management protocols. One grantee each noted full operation in sharing of patient information, development of a data repository and the standardization of the medical record. A slightly larger group of grantees reported activities in early operational stages, however, the majority of grantees reporting in this category were found to be still planning or in the early operational stages (Figure B1b: Integration of Service Delivery Systems – Sharing of Information/Expertise).

Similarly, under the sub-category "Coordination Across Systems," very few grantees reported full operation in any of the identified activities. Case management, emergency room or primary care provider coordination, and coordination with government agencies were the activity areas noted as fully operational by one to two grantees each. A few more grantees reported early operational activity in some areas but the majority of grantees reporting in this category described their stage of development as in development but not operational. Of this group of grantees, many were working on coordination activities with primary care providers and specialists, clinics, emergency rooms, and government agencies (Figure B1c: Integration of Service Delivery Systems - Coordination Across Systems).

The majority of the challenges reported by grantees in the integration of service delivery systems were related to organizational and communication issues (7 grantees). For example, the Chicago site reported their "*most important challenges were related to the incorporation of a large variety of organizations representing different cultural backgrounds and modes of operation under a single organizational roof.*" Other reported challenges were related to multiple data resources (6 grantees), issues dealing with mental health and substance abuse (2 grantees), and difficulties recruiting providers for Medicaid or discounted plans (2 grantees).

The most frequently reported facilitating factor is the ability to collaborate with multiple partners that are committed to the process (14 grantees). Massachusetts provides a good example of factors that facilitated and helped sustain their efforts:

> *Bringing organizations together in an IS Working Committee and keeping them at the table is a result of the genuine commitment to come together and try to develop an IS that can work for all levels of providers. It has been important for each Working Committee participant to identify the benefits that will result to their organizations' IS and the people they serve. Discussing coordination for the first time in the context of information systems and technologies, partners have been able to envision new improvements in service/care provision.*

Additional facilitators reported are related to funding to support efforts (2 grantees), information sharing (5 grantees), and previously existing collaborations (4 grantees).

Improvement of Business Practices and Integration of Financial Systems

Very little activity is noted by grantees in this category. One grantee noted being fully operational in improvement of business practices. Approximately half of the grantees reporting on activities within this category, such as improvements to financial management, billing systems, and management information systems were noted to be in the early operational stage (one to two grantees each). Lesser numbers of grantees reported their stage of progress on activities as in development but not operational.

Various barriers were reported regarding improvement of business practices and integration of financial systems. Oregon provides a good example of barriers associated with network issues: *"Network design complexity has been in the high end of our original projections for project complexity. This is in part due to the great geographic area covered by this effort."*

Figure B1b: Integration of Service Delivery Systems - Sharing of Information/Expertise

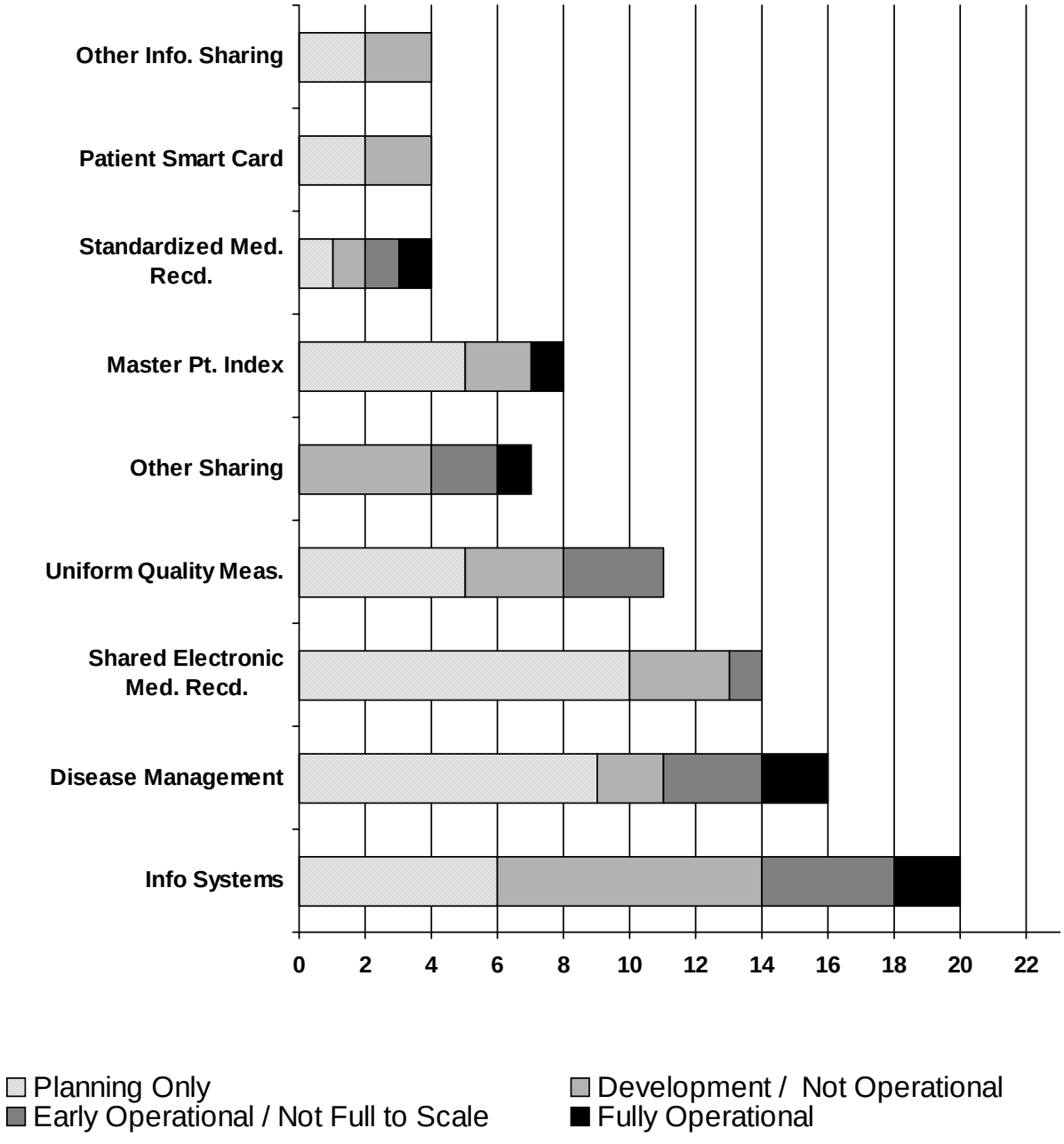
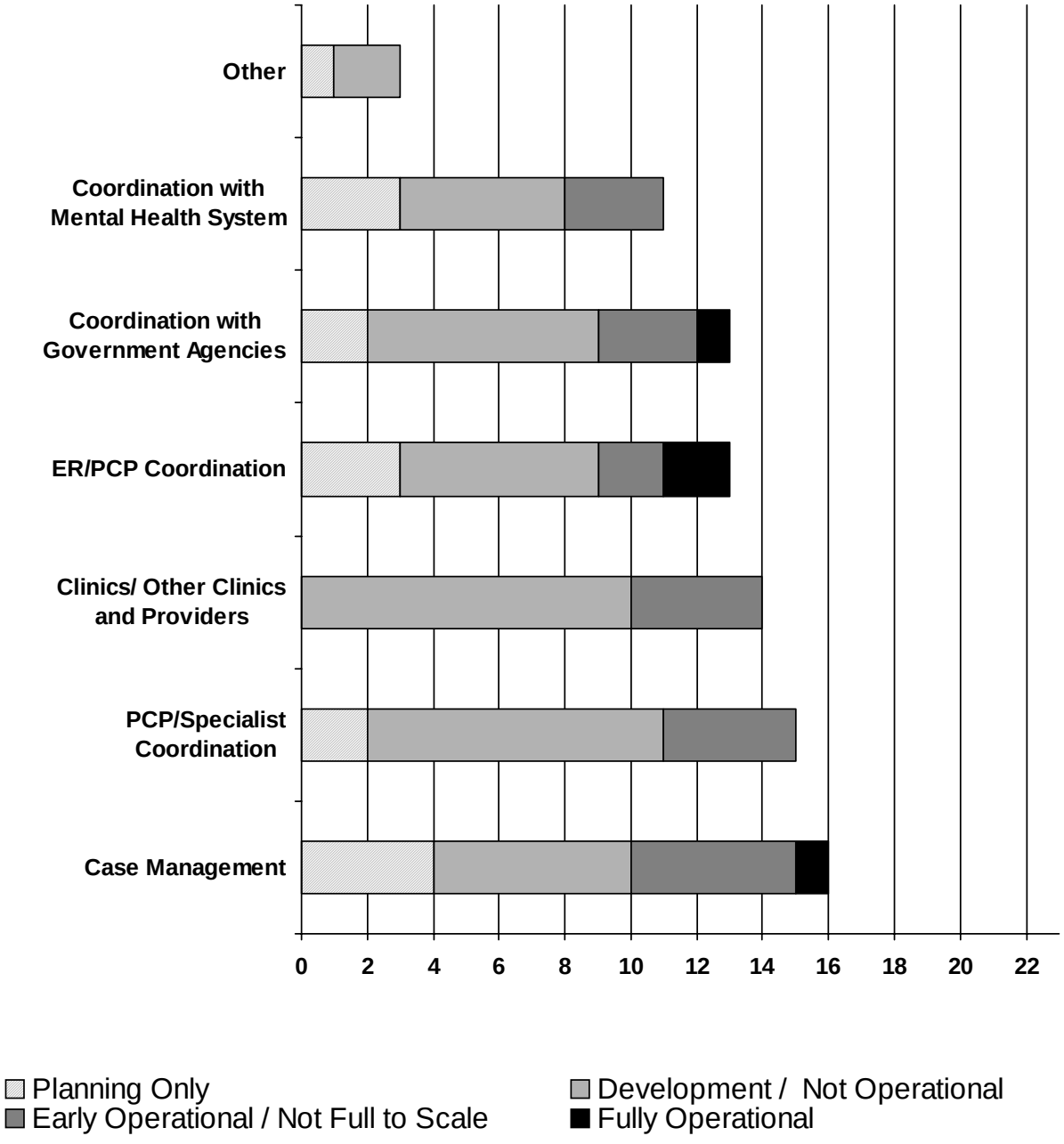


Figure B1c: Integration of Service Delivery Systems - Coordination Across Systems



Other barriers were related to the difficulties of development and implementation of new patient data tracking systems, limited knowledge about technical aspects of information systems on the part of CAP staff, and the communication required for this component.

The facilitating factors also varied across grantees in this category of activity. One example of consultation and funding support of a disease management system is described by New Mexico as follows:

> *Consultation support from the Los Alamos National Laboratories. McCune Foundation support toward the purchasing and implementation of the PhDx system. The knowledge and experience gained by staff in the use of the PhDx software enhances their ability to develop health profiles for disease management efforts of the Sangre-CAP.*

Other facilitators included coalition cooperation and desire of the beneficiaries to be part of the process of improving access to health care (Figure B2: Improvement of Business Practices and Integration of Financial Systems).

Increased Enrollment in Health Insurance Plans

CAP grantees engaged in activities to increase health insurance plan enrollment were found to be fully operational in mainly three plan areas; increasing enrollment in state children's health insurance plans (SCHIP) (6 grantees), increasing enrollment in Medicaid (4 grantees) and increasing enrollment in existing coverage initiatives (3 grantees). The majority of grantees reported their status within this category as early operational and not full to scale in increasing enrollment activities in both Medicaid (10 grantees) and SCHIP (6 grantees).

The most frequent barriers noted in this category of activity were related to the complexity of public health insurance enrollment systems. For example, El Paso reported:

> *State of Texas regulations require that enrollment into either CHIP or Medicaid be done by an authorized agent of the State. As a result, we have not been able to participate in a streamlined application process or have we been able to directly enroll individuals determined to be eligible. This has proven to be a barrier in our outreach efforts. We are able to provide a timely indication of an individual's or family's eligibility status for these programs but staff are unable to truly impact the time required to make application to either of these publicly funded programs.*

Other reported barriers dealt with multiple data resources (2 grantees), limited time and resources (2 grantees), and the negative perception of public health insurance programs (2 grantees).

The most frequent facilitating factors reported in this category were good working relationships, as noted by eight grantees. CAP grantees in Minnesota described these relationships:

> *The Minnesota Department of Human Services allowing the Community Life Line Project (CLLP) to be authorized representatives in assisting people with governmental insurance coverage. Our data has provided us with a baseline from which we can grow and the ability to access individuals on site at HCMC…hiring of exceptional culturally competent personnel and numerous educational tools for all staff. Existing programs such as 489-CARE and MNCare tie in exceptionally well with this program. MNCare is a governmental insurance program that Neighborhood Health Care Network (NHCN) has had tremendous experience with, and we are able to use our project to strengthen MNCare.*

Other reported facilitators included the hiring of culturally competent personnel, private funding, and assistance from other agencies such as Medicaid programs, Americorps members, and a chamber of commerce (Figure B3: Increased Enrollment in Health Insurance Plans).

Figure B2: Improvement of Business Practices and Integration of Financial Systems

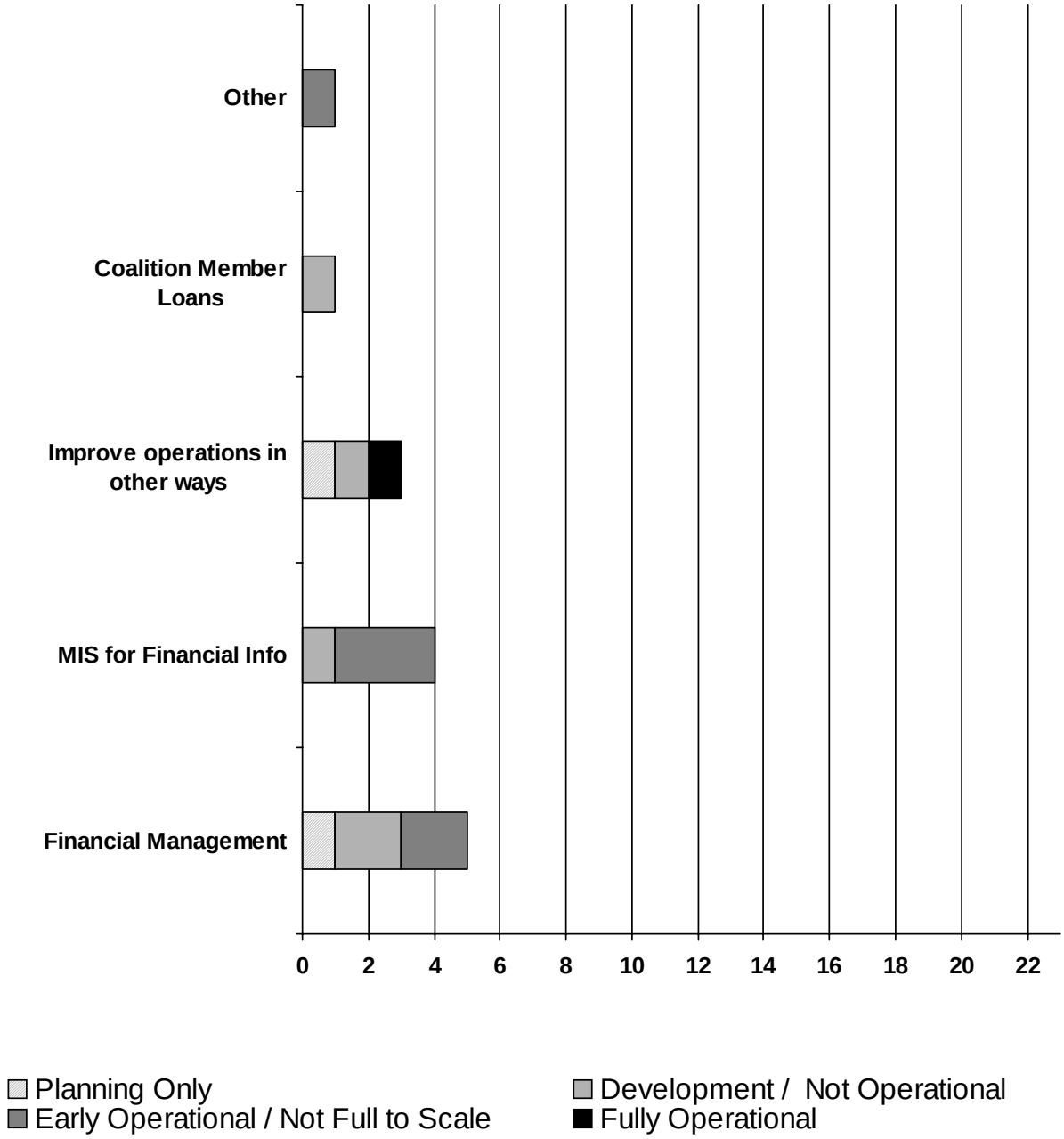
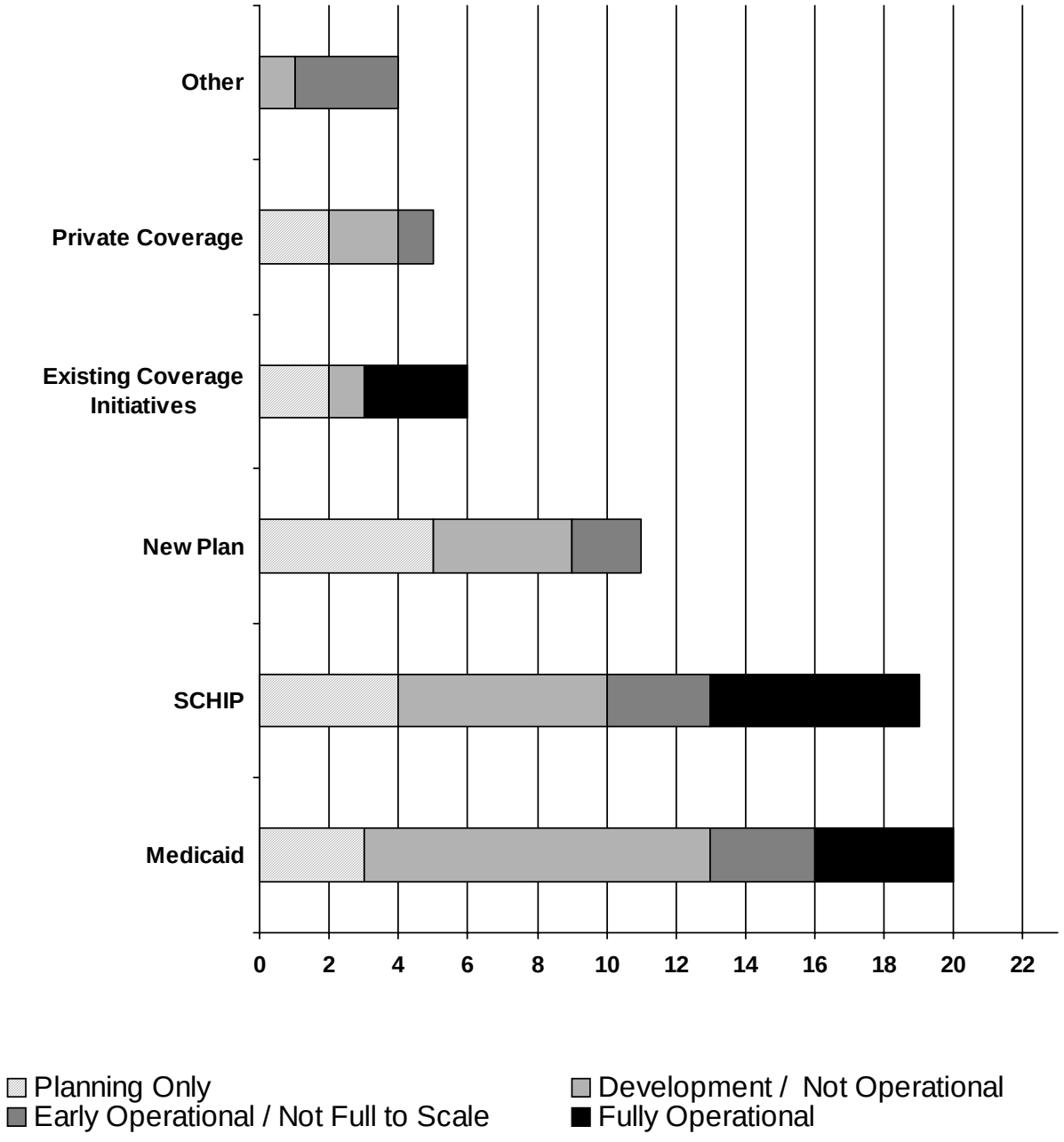


Figure B3: Increased Enrollment in Health Insurance Plans



Expansion of the Delivery System

On average, one grantee reported full operational status in each delivery system expansion activity: patient navigation, outreach, volunteer doctors, pharmacy, dental, primary care, and the development of a nurses' information line. Virtually all delivery system expansion activities within this category have small numbers of grantees (approximately 1 to 3) reporting early operational status; however, larger numbers of grantees reported being in development/not operational or in planning stages within this category (Figures B4a1 & B4a2: Expansion of Delivery System – New Services or New Providers).

Small numbers of grantees (ranging from 1 to 3 each) reported full operational status in seven of the ten activities associated with outreach to new populations. Slightly larger numbers of grantees (ranging from approximately 2 to 3) in all measured activities reported being in an early operational status. However, approximately half of all grantees reporting on outreach activities to new populations were observed as being either in development or in a planning stage (Figure B4b: Expansion of Delivery System—Outreach to New Populations).

Regarding the expansion of delivery systems, the most frequently noted barriers to CAP activities were related to physician recruitment. Virginia was among the six grantees reporting this type of barrier. Grantees at this site noted,

> *One ongoing challenge is recruitment and retention of providers for uninsured and Medicaid patients. Due to reimbursement rates and other issues, providers are reluctant to participate in Medicaid.*

Also reported were structural and cultural barriers, uncertainty of CAP funds, and administrative barriers such as finding office space.

Many of the CAP grantees (6) reported good working relationships as the most important facilitating factor in this category of activity. Assistance from other organizations and agencies was also frequently reported by grantees involved in the expansion of delivery systems. Two grantees reported assistance from universities as facilitating their progress. Florida provides the following example:

> *Florida A&M University's (FAMU) involvement with our pharmacy component has had a very positive impact on our program. The knowledge, skills and abilities FAMU made available to us resulted in the opening of a pharmacy to meet the specific needs of our patients. The patient counseling and immediate access to a pharmacist when needed has improved the quality of care our patients are receiving.*

Implementation of Community/Patient Education Programs

Small numbers of grantees exhibited full operational status in community/patient education programs (on average 1 to 2). Four grantees were noted to be in full operational status in programs developed to assist patients in navigating the health care system. On average, slightly larger numbers of grantees reported being in an early operational/not full to scale status in various patient education programs. However, more than half the grantees reporting on patient education programs (either newly created or enhanced as a result of CAP funding) are in development or in the planning phase (Figure B5: Community/Patient Education Programs).

Figure B4a1: Expansion of Delivery System — New Services or New Providers

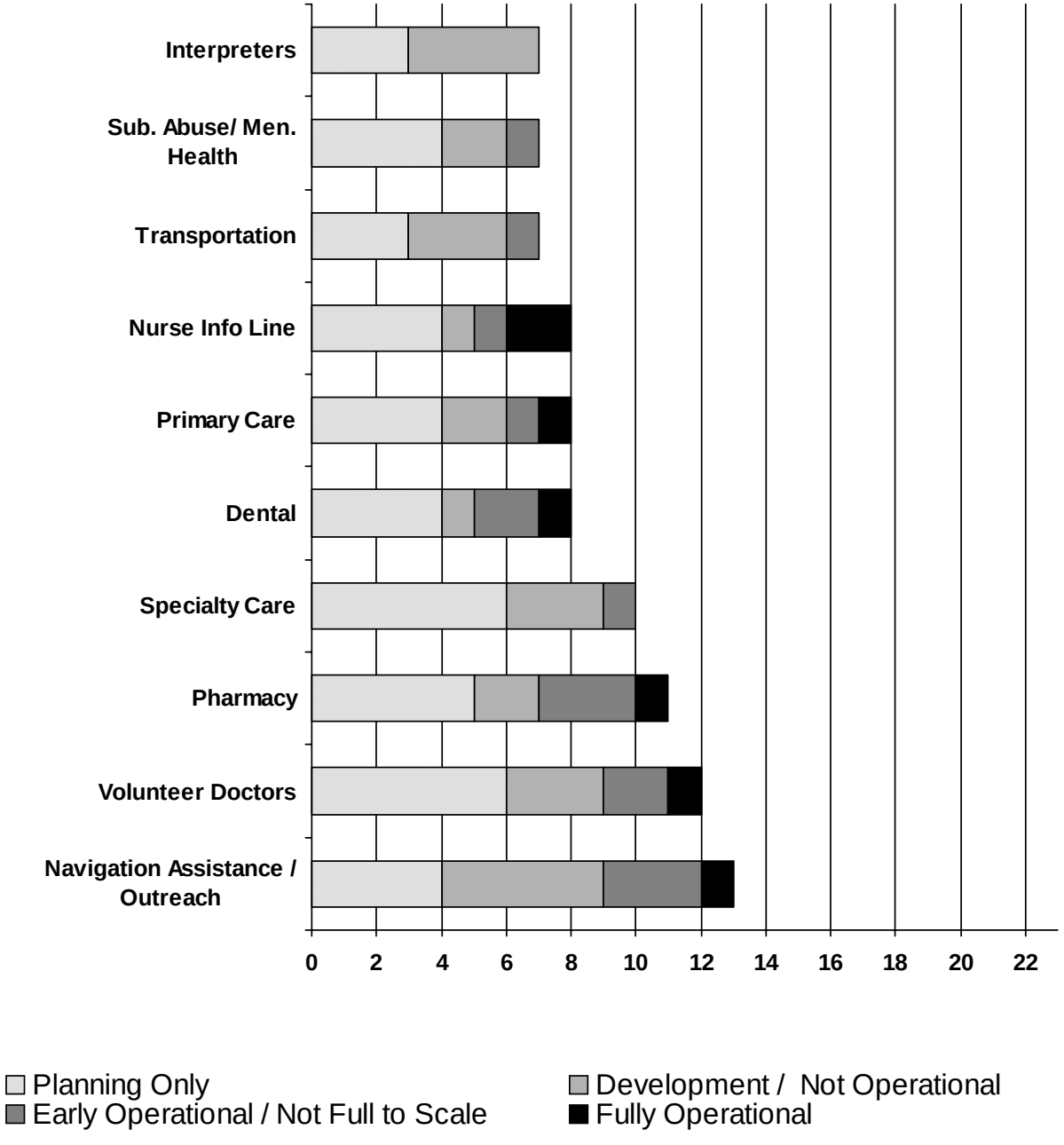


Figure B4a2: Expansion of Delivery System — New Services or New Providers (Continued)

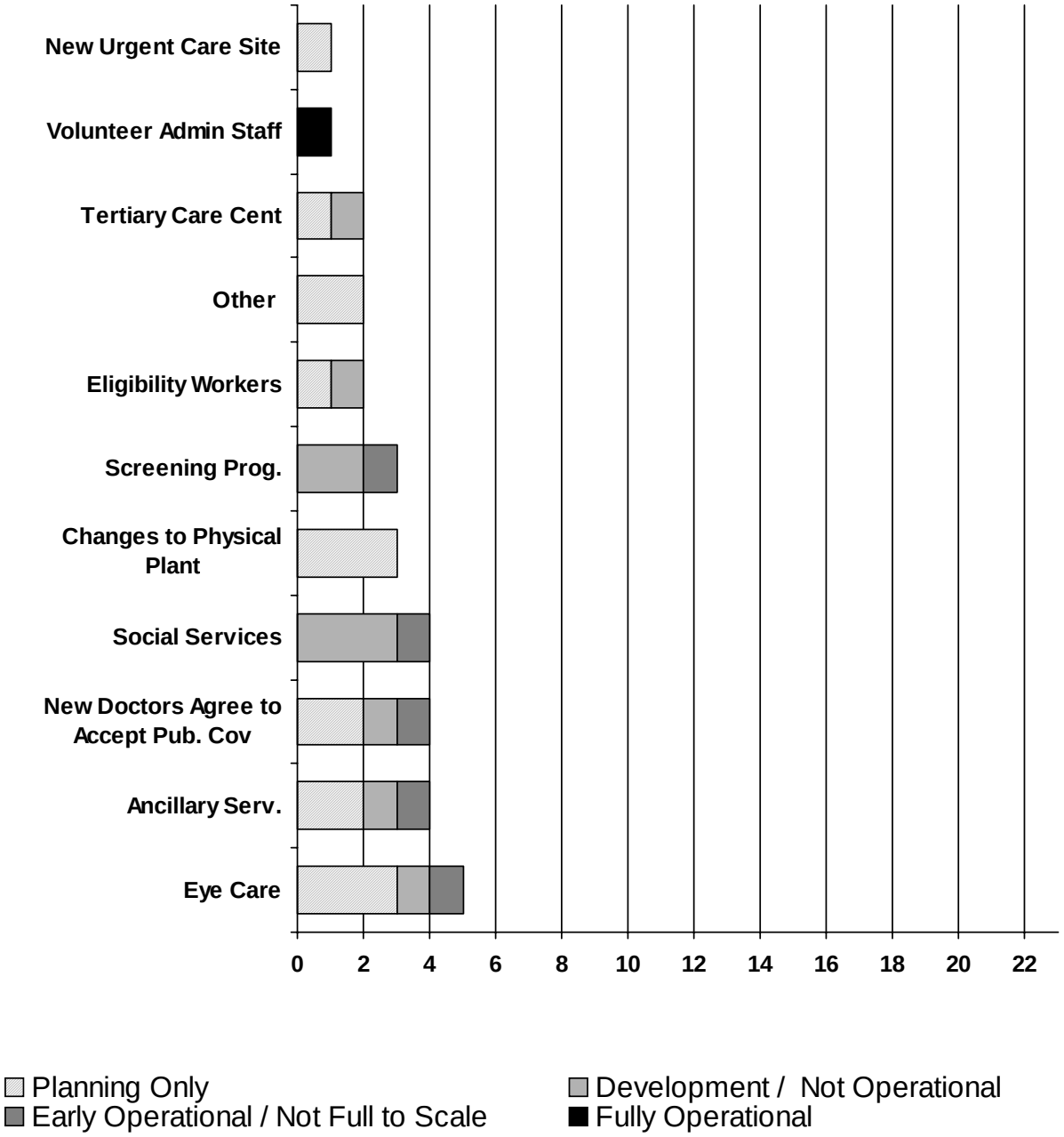


Figure B4b: Expansion of Delivery System—Outreach to New Populations

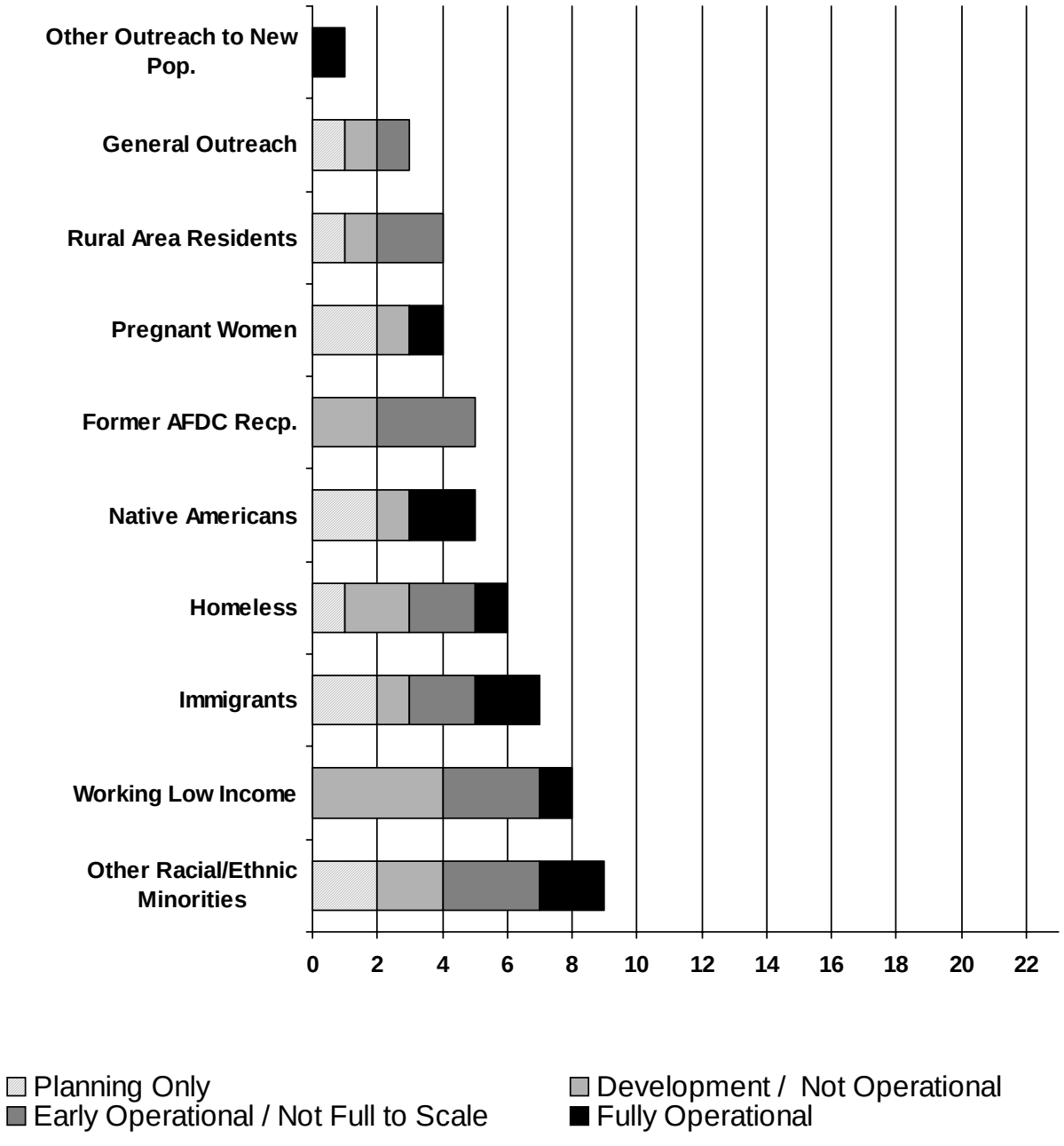
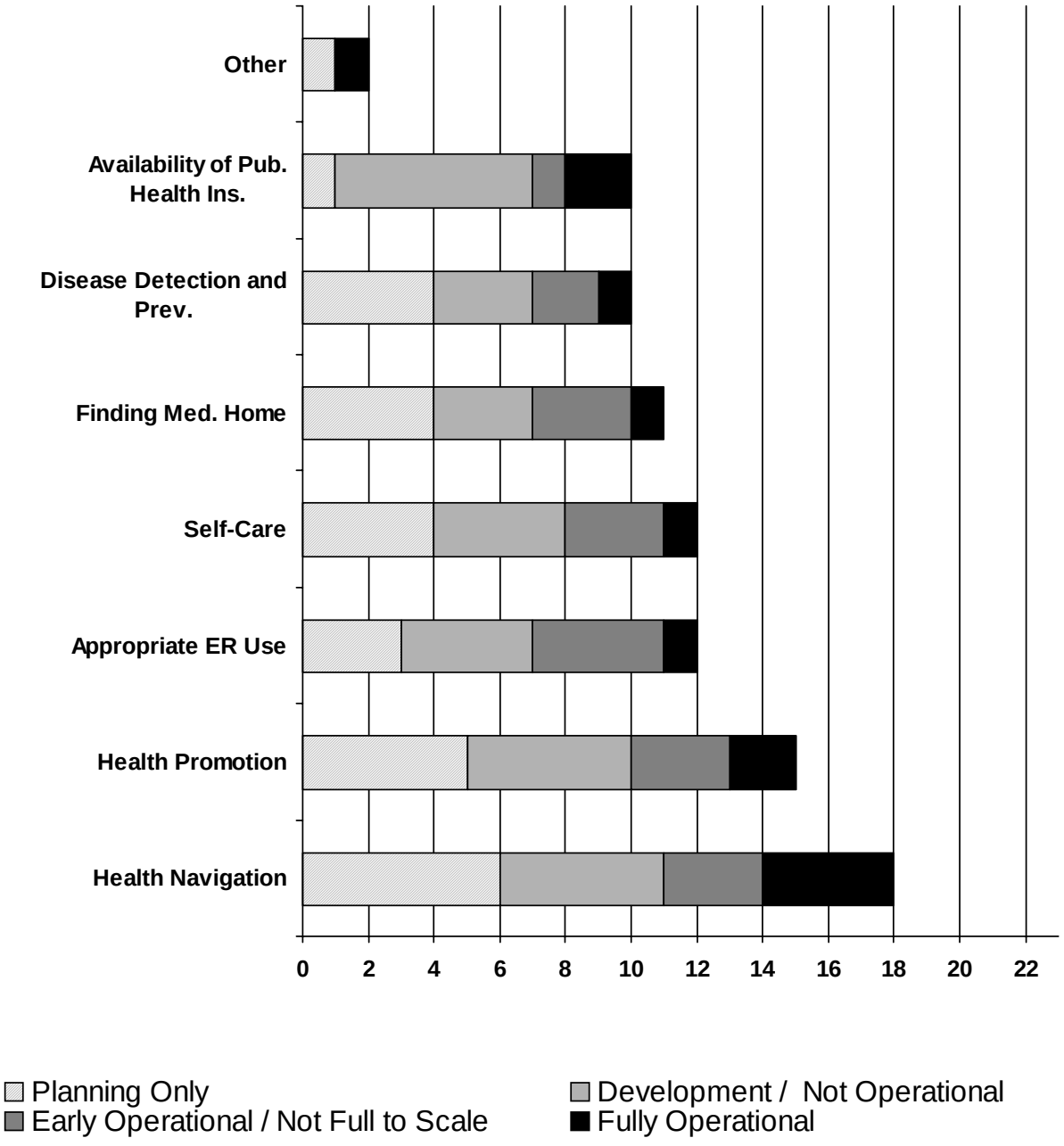


Figure B5: Community / Patient Education Programs



Grantees involved in implementation of community/patient education programs encountered various barriers to program development. These barriers included registration fees as a barrier to enrollment, cultural and structural barriers, and difficulty filling certain positions. Massachusetts reported structural and enrollment challenges due to the limited number of safety net providers on the Cape and Nantucket willing to participate in a reduced-fee program for eligible low-income residents. Enrollment of Cape Codders in health insurance and the linkage of the insurance-ineligible to affordable services and primary care are at the core of the program. The use of community health outreach educators (CHOEs) trained to guide clients through bureaucratic systems constitutes the cutting edge of this effort. Massachusetts noted enrollment and coordination challenges:

> *On Nantucket, we are finding few MassHealth-eligible adults* [Medicaid]*, although due to the high cost of living on the Island, many are struggling to make ends meet. Nantucket also has few affordable health care resources and a limited number of safety net providers* [with whom CHOEs can coordinate their efforts, and forge necessary agency and client links].

Factors facilitating CAP activities in this category included staff commitment, accessibility of training tools, strength of Community Health Outreach Educators (CHOEs) and Community Health Workers (CHWs), and interest from providers. Several grantees (4) reported cooperation from other agencies as the most important facilitating factor for their program activities. Michigan provides an example of assistance from a local health department:

> *The Detroit Health Department offers a wide range of health education programming and preventive services. The care management team and other Voices of Detroit Initiative (VODI) staff will continue to work on making these programs accessible to our clients and promote awareness of available services.*

Improvements in Service Delivery

Grantees reporting activities in service delivery were predominately found to be in the planning and developmental phases of operation. Such service delivery activities included improvements in cultural competency, customer service, provider education, re-engineering primary care delivery and re-engineering referral systems. A few grantees reported being in the early operational stages in the primary care activities and improvements to customer service.

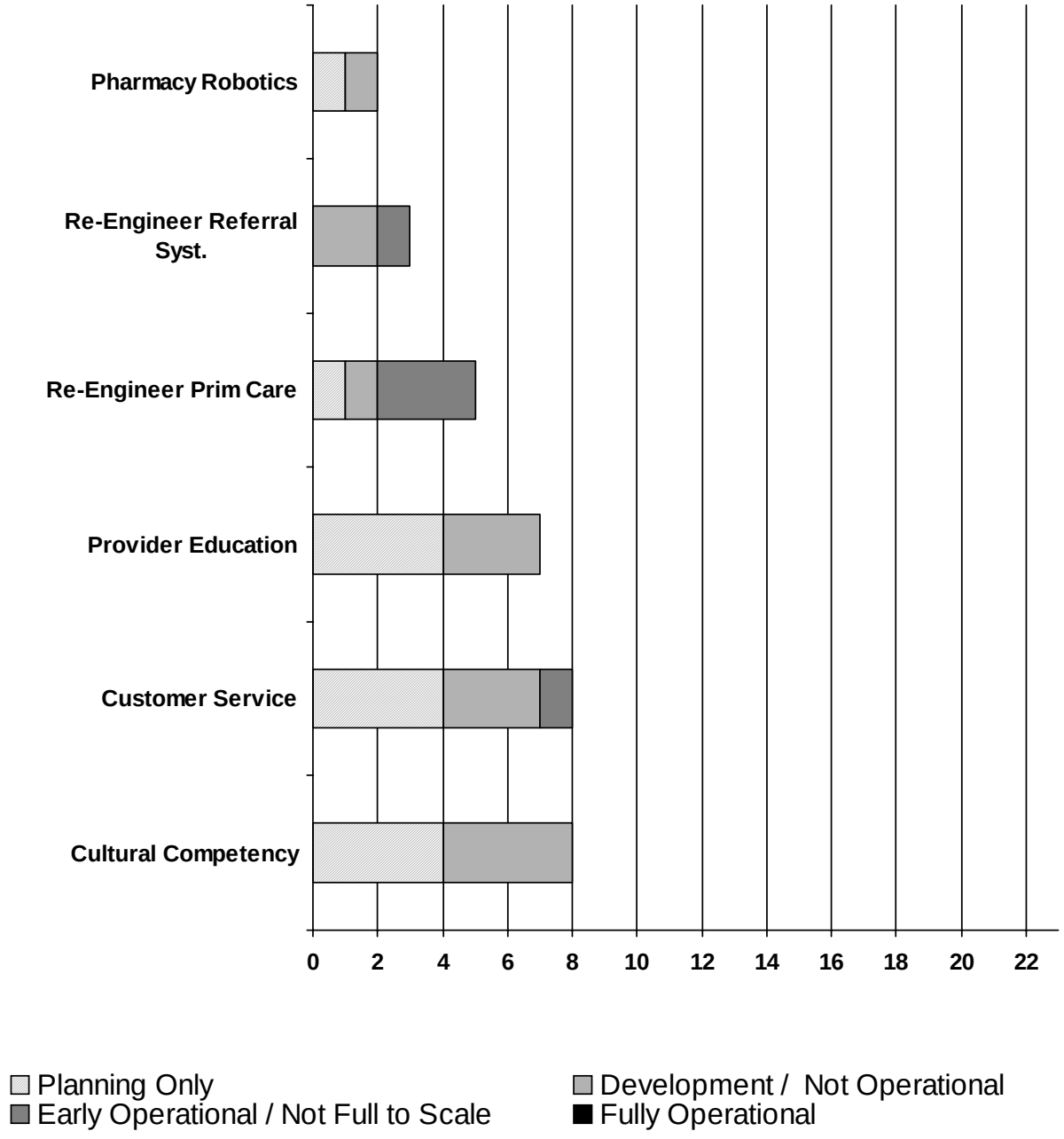
Of the grantees reporting activities in service delivery, several noted program barriers related to physician recruitment. Virginia reported that a major barrier is, "…recruitment and retention of providers for uninsured and Medicaid patients. Due to reimbursement rates and other issues, providers are reluctant to participate in Medicaid."

Although physician recruitment was a barrier for some grantees, physician cooperation was a facilitator to four grantees. Kansas reported "having one physician who championed our cause" as a factor facilitating their activities in this area. Strong community commitment and involvement were also noted by two grantees as important facilitators in this category of activity (Figure B6: Improvements in Service Delivery).

Informing Public Policy

Five grantees reported that projects to inform public policy by educating policy makers were fully operational as of this period. Two grantees each reported being in the early operational stages with programs to educate policy makers and improve program data. However, the majority of grantees reporting activities within this category were observed in the planning or developmental stages and noted that it was too early in the initiative for their programs to have a policy impact.

Figure B6: Improvements in Service Delivery



Grantees with activity in the area of informing public policy reported barriers in several areas, most frequently relating to data problems. Virginia reports,

> *The safety net system is large and complicated. Many Alliance members need extensive education on the scope of the problem and the components of the safety net. Focusing on data, each safety net provider maintains substantial data, but in different systems and formats.*

Other barriers reported in this category of activity were related to support or funding, and political leaders lack of confidence to effect change.

Four of the grantees reported cooperation from policy makers as an important facilitator to efforts in this area. Kansas reported that *"…the state leaders did attend the council meeting and encouraged the Council to move forward with this initiative."* Other grantees reported that having a diverse Board of Directors and knowledge of the legislative process also facilitated program activities in this area (Figure B7: Informing Public Policy).

Early Impact of the CAP Initiative

In this section, a summation of findings and observations about CAP is provided. As grantee activities observed in this report occur early in the implementation period, it is still too soon to assess the overall system effects of the CAP initiative.

Effect on Safety Net Providers

Several grantees report it is too early to see the effect of CAP activities on how safety net providers operate and relate to each other. Most of the improvements reported have been internal to the consortium. Typical of internal improvements, New Mexico describes the effect of CAP activities in the integration of service delivery systems by noting:

> *We believe that the Sangre-CAP has afforded the opportunity for partners, providers and personnel to meet in a formal forum on a consistent basis to coordinate and share their ideas, vision and expertise. Most importantly it has allowed these individuals and groups to work toward resolution of common health problems facing each of them in their work—something which they have not been able to do before CAP.*

Other sites reporting changes in safety net provider relationships included improved communication among providers, increased collaborative efforts among partners, and sharing of resources.

Effect on Patient Access and Use of Health Care System

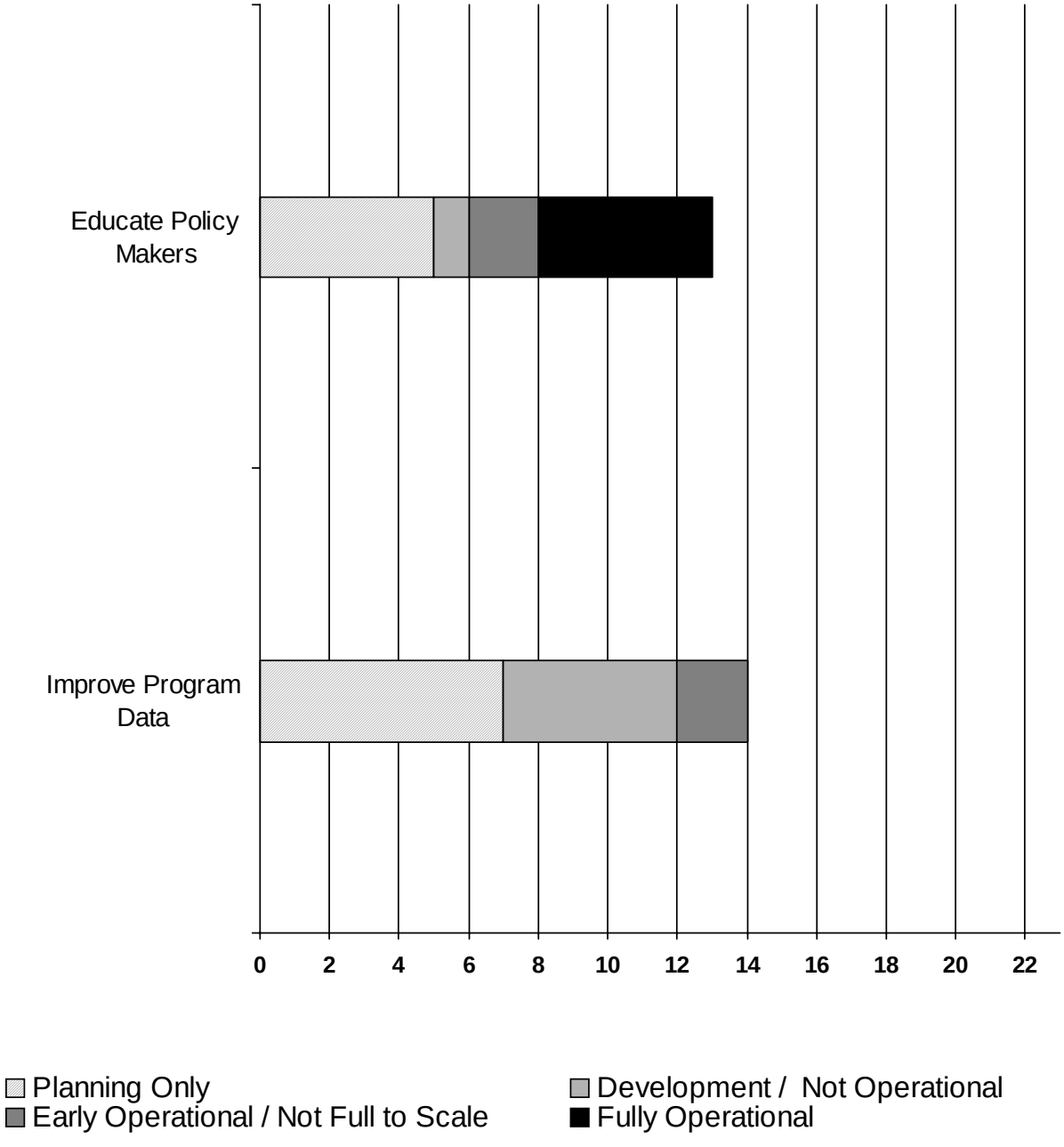
Most of the grantees report that it is also too early to see how the CAP activities have affected patient access and use of the health care system. Some of the grantees report improved access to primary care providers including Kentucky where grantees noted, "*there has been a decrease in ER visits as a result of the project and patients are accessing the health care system through primary care.*"

Additionally, grantees report that access to the health care system has been made easier for Medicaid patients, individuals excluded from mainstream health care, and children.

CONCLUSIONS

The first round of funded CAP coalitions are broad-based. The grantees report that their members are committed to the coalition, with most member organizations represented by senior-level staff with the authority to make necessary decisions and resource commitments to achieve coalition goals. Moreover, many of the coalitions have begun to "leverage" CAP funds to raise additional financial support for other CAP activities. HRSA sought to select mature coalitions for this round of grant making, a strategy that engaged leading communities in the initial CAP wave.

Figure B7: Informing Public Policy



During the first six months of projects, grantees focused mostly on the planning, development and early implementation of specific activities. Among the most popular CAP activities are:

- Reducing administrative barriers to care,
- Sharing information across health care providers,
- Improving system coordination (e.g., case management),
- Increasing enrollment in existing coverage programs (e.g., SCHIP), and
- Community and patient education.

Some CAP sites are also adding new services (e.g., pharmacy discount programs) or new providers (e.g., medical specialists). Across the board, the coalitions are focused on enhancing efficiency, filling service gaps, and making the system more accessible for patients. For example, many of the sites are creating unified information and enrollment systems across providers and educating the community members on how to "navigate" the health care system. Fewer sites are focused on improving financial systems or business practices at this time. Program logic models tie these activities together into strategies with specific outcome objectives. The sites appear well positioned to begin to achieve project impacts as their grants progress.

Although most sites are focused on planning and developing their projects during the early stages of their grants, half or more of the sites had begun operations in some program areas. These include projects designed to eliminate administrative barriers, share information across providers, educate members of the community and patients, and add new services or providers. A few sites even reported early project impacts in areas such as emergency room utilization and ease of access to services.

Discussion

This first report of CAP grantee activities provides a snapshot of the program achievements during the first six months of activity. It discusses grantee development status and accomplishments during this reporting period and clearly outlines what they state they are doing. Although informative about the processes and activities, reporting of this type only begins to describe program accomplishments, and this report is therefore not evaluative. Assessing the degree to which the activities reported here contribute to the overall capacity of the safety net in CAP communities, the degree to which networks of safety net providers are truly becoming integrated, or the extent of programmatic impacts on providers (e.g., financial sustainability) and patients (e.g., improved access and health status) will require other types of information and analysis.

This report on grantee activities is intended to be useful to HRSA for monitoring grantee progress, identifying needs for technical assistance, and describing the sites' progress in project implementation. Future activity reports for the later grant waves and longitudinal analysis of future progress will add more detail to the description of "what is CAP" and permit a source of basic analysis of what enables some sites to progress faster or further than others.

ENDNOTES

[1] Schroeder, SA.(2001). Prospects for Expanding Health Insurance Coverage. *New England Journal of Medicine,* 334 (11), 847-851.

[2] The Henry J. Kaiser Family Foundation. (June 21, 2001). Coverage and Access: Number of Emergency Room Visits Increases 14% from *1992 to 1999. Kaiser Daily Health Policy Report.* http://www.kaisernetwork.org/Daily_reports/rep_index.cfm?DR_ID=5462.

[3] Physicians Pulling Back from Charity Care. (2001). *Health System Change,* (Issue Brief No. 42).Washington, DC: Reed MC, Cunningham PJ, Stoddard J.

[4] Federal Register Announcement. (2000, February). *Availability of Funds for Grants for the Community Access Program.* Vol.65, No.24, Washington, DC: U.S. Government Printing Office.

[5] Garrett, K., Kaplan S., Billings J., et al., (2001). *Community Access Program. Report on the Logic Model Process*. New York University, The Robert F. Wagner Graduate School of Public Service, Center for Health and Public Service Research.