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HRSA Community Access Program: Local Achievements and Lessons Learned

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Table of Contents

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Executive Summary

The Community Access Program (CAP), funded by Congress and implemented by the Health Resources and Services Administration (HRSA), commenced in September 2000 in an effort to strengthen safety net services for uninsured and underinsured Americans. By providing federal support to local coalitions for infrastructure development, CAP is designed to equip communities to initiate systemic changes leading to increased safety net capacity and the provision of improved quality of health care services to resident area populations. As grantees of the CAP initiative, community coalitions may define their individual project objectives within broad program guidelines. As of this writing, HRSA had awarded CAP funding to four distinct groups of grantees representing 158 individual grants across the country. The broad program guidelines are structured to focus grantees on activities related to health delivery system improvement, including strengthening the financial stability of the safety net, increasing access to care for vulnerable populations, and increasing the overall capacity of the system. The expectation is that investments in these types of coalition activities will render more integrated, efficient systems that encompass greater provider participation, leading to improved system capacity and access to health care, particularly for the uninsured and underinsured.

To assess the level of progress made over time by CAP grantees, HRSA initiated a monitoring process. A research team from New York University (NYU) and Rutgers, the State University of New Jersey was asked to devise a questionnaire for program monitoring. The CAP grantee progress monitoring questionnaire asks grantees to document program activities, underscore change, note system improvements, and highlight accomplishments. Information taken from grantee-completed questionnaires of the first two funded cohorts serve as the basis for this report.

As part of the monitoring process, each site was required to create a logic model that articulates the assumptions underlying the grantee's strategies and explains individual activity goals and expected outcomes. The logic models were used by the NYU/Rutgers research team to create a baseline report of all CAP grantee program activities and to measure progress across the sites.

This report describes the experiences and activities of two groups of CAP grantees, those funded in 2000 and 2001, during several six-month monitoring periods. In general, we find that

CAP grantees have made substantial progress within a short period of time. Grantees are engaged in broad activity areas in the service and system integration, expansion and improvement of service delivery, increased enrollment in health insurance plans, and implementation of community and patient education programs. Specific common activities include developing standardized registration and screening systems, creating "medical homes" for the uninsured, developing information systems, coordinating among providers, and enrolling the uninsured in Medicaid and the State Children's Health Insurance Program (SCHIP) promoting healthy behaviors, and providing health system navigation assistance. Conversely, few grantees are engaged in specific activities to improve financial and administrative systems. In addition, grantees are less involved in activities related to service improvement and informing public policy.

Although difficult to measure, collaborative activities among coalition members appear to have resulted in more integrated systems that are conducive to improving the target population's access to primary care. Despite the constrained funding environment during this initiative, CAP grantees appear to have made substantial progress within a limited time period. In addition to a high level of progress, CAP grantees also had high levels of participation and implementation in certain activities and developed many products and tools as part of this initiative. A report describing product and tool accomplishments (with grantee-provided examples by type) appears in a separate document.[1]

Compared to the first cohort of grantees funded in 2000, the 2001 grantees are involved in more activities that became operational at a faster rate. Although it is difficult to determine with any degree of certainty what conditions or circumstances lead to grantee progress, the findings from this report support the notion that larger coalition size and the level of experience of coalition members may begin to explain the improvement noted in some program areas. The intersection of multiple factors—e.g., knowledge, coalition experience, and size—the frequency and amount of technical assistance provided as well as local environmental factors may affect grantee progress over time. The dynamics associated with good collaboration across multiple partners committed to the process, the establishment of superior working relationships, and staff commitment may be important facilitating factors as well. How these and other factors interact can directly influence grantee progress; yet, without additional research, more conclusive explanations are difficult to provide.

This report provides a detailed description of CAP grantee program accomplishments from a series of six-month monitoring periods and presents trend and comparative data for two grantee groups. The report focuses on the types of grantee activities undertaken and the degree to which the activities have been implemented, and it assesses the conditions under which grantee progress has been achieved. This report focused on program implementation only and

does not address the level of cost savings realized by CAP activities, the extent of program effectiveness and efficiency, the degree of improved system capacity, or the impact on quality of care as a result of CAP existence.

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Introduction

Despite more than a trillion dollars spent on health care each year within the United States, more than 43 million individuals today remain uninsured.[2] People who are of a lower socioeconomic status, minorities, and those who live in rural or urban areas continue to experience problems attaining medical services. With the movement from fee-for-service to a managed care system, many belt-tightening measures have been introduced by health care insurers and providers to achieve cost savings. These measures sometimes involve avoidance or coverage exclusion of persons with chronic and costly conditions. Insurance carriers often decline to cover people with pre-existing conditions and frequently impose severe limitations on coverage for any expenses related to such a condition or charge more to cover these expenses. Subsequently, insurance is priced out of the reach of many consumers in poor health or a coverage gap is created, resulting in increased numbers of uninsured.[3] Thus, the problem of access is heightened for the poor, who often have multiple conditions requiring expensive services. Although the issue of access to care has long been on the national policy agenda, the development of an effective mechanism that would pay for care for the growing number of uninsured Americans remains a work in progress.

Recently, several national demonstrations have been launched by agencies within the Federal government and private foundations to test different approaches to the problem of providing access to the underserved. The focal point of activity for these programs has been at the local level, where a disproportionate share of the responsibility for caring for this population is sustained by local providers, including community hospitals, community-based clinics, local health departments, coalitions, and other community-focused institutions. This "safety net" or loosely fragmented system of providers that varies across communities is in the unique position of developing effective strategies to improve the level of access to and coverage for health care services for the underinsured and uninsured.

One such national initiative funded by Congress and administered by the Health Resources and Services Administration (HRSA) is the Community Access Program (CAP). First funded in

fiscal year 2000, CAP focuses on improving service integration models to help local providers improve community-wide systems that serve the underinsured and uninsured. CAP grants are designed to improve access to care by eliminating fragmented health care delivery systems, enhance efficiencies among safety net providers, promote disease prevention and education among community members, and encourage greater private as well as public sector involvement. CAP funding, as envisioned in the initial stages, provides additional financial support to communities already engaged in reorganizing and integrating their health care delivery systems and assists them in furthering their infrastructure development. Based upon the scope of the project and the size of the defined service area, the level of CAP funding provided to each grantee varies.

Scope of Community Access Program

Funding of approximately 100 communities within five years was envisioned at the inception of this initiative. To this end, Congress committed funding for three subsequent groups of grantees. Through continued financial support of these types of demonstrations across wider sets of recipients, HRSA can achieve its goal of expanding innovative program models. The fundamental underlying principles of this national program are the promotion of collaboration and coordination across analogous nationally funded projects and the ability to build upon investments that promote sustainable system improvements resulting from engagement in the CAP experience.

In federal fiscal year (FY) 2000, HRSA provided funding for the first cohort of CAP grantees. Twenty-five million dollars was made available to assist 23 model communities. These grantees were safety-net providers and other stakeholders with a track record of building partnerships. CAP funds supported their infrastructure development, further integration of their delivery systems, and their work toward filling service gaps. CAP funds were expected to increase efficiency in the delivery system and improve quality of care for the uninsured as well as the underinsured. In addition, many grantees focused on increasing enrollment of the uninsured through reduced fragmentation, improved coordination, simplified and streamlined enrollment processes, improved community outreach activities, enhanced eligibility screening, and the creation of comprehensive referral networks. Many grantees within this initial cohort were recipients of earlier national and regional foundation funding (from the W.K. Kellogg and Robert Wood Johnson Foundations) or had received support from other contributors (e.g., health systems, corporations, or non-profit organizations). This earlier funding allowed grantees to establish an initial strategy in areas of interest prior to CAP funding. Many of these previous projects focused on coverage demonstrations

for the uninsured and provided technical support and grantee exposure to other capacity-building initiatives that promoted integrated services.

In FY 2001, HRSA funded two additional rounds of CAP grantees. Cohort II, consisting of 53 grantees, was funded in March, and Cohort III, with 60 grantees, was funded in September. Cohort II grantees had been approved in the same application cycle as Cohort I but were not funded until 2001. This group generally had both prior experience working within coalitions and the opportunity to learn from the Cohort I experience in the year prior to receiving their funding. Cohort III grantees were identified in a subsequent call for proposals and were expected to be a less experienced group of applicants. Finally, a fourth group of 22 applicants was approved and awarded funding under CAP in September 2002. Currently, CAP grants support 158 communities in urban, rural, and tribal areas.

In FY 2001, HRSA contracted with researchers within the Center for Health and Public Service Research (CHPSR) at New York University and Rutgers Center for State Health Policy (CSHP) to monitor CAP grantee activities and capture useful data to assess and describe grantee activities and development. Based on this information, the first monitoring report, which was issued in March 2002, documented Cohort I's early stages of program development.[4] Information from this progress report served to describe program processes and activities, underscore notable accomplishments, highlight innovation, and document effective system changes taking place.

Each funded CAP cohort completes a project monitoring questionnaire biannually. The timing of questionnaire completion is dictated by the program funding cycle. Tallied information from this questionnaire is used by HRSA staff to assess the level and extent of CAP grantee accomplishments, group trends, and notable activities. HRSA has administered and collected the monitoring questionnaire from all grantees every six months; however this report examines only a portion of the questionnaire data. Table 1, below, shows the CAP funding periods for all CAP cohorts to date. The numbers in the table represent the periods of CAP funding for which grantees are required to submit a monitoring questionnaire: "1" indicates the first six months of funding for the grantee, "2" up to 12 months of funding, "3" up to 18 months of funding, and so forth. The bold outline indicates the cohorts and funding periods covered in this report. For the remainder of this report, we will refer to these periods as time 1, time 2, and time 3 (or T1, T2, and T3).

Table 1: HRSA CAP Grantee Funding and Reporting Periods

Grantee Cohort	March 2000	Sept. 2000	March 2001	Sept. 2001	March 2002	Sept. 2002	March 2003
I (23 Grantees)	0	1	2	3	4	5	6
II (53 Grantees)		0	1	2	3	4	5
III (60 Grantees)			0	1	2	3	4
IV (22 Grantees)					0	1	2

Note: Public Law No: 107-251 (initiated by the President's signing of Health Care Safety Net amendments in 2002) authorizes the new Healthy Communities Access Program (HCAP) for FY 2002–2006. HCAP has received FY 2003 appropriation.

The Logic Model

To aid grantees in planning for use of CAP funds, HRSA required that each grantee create a logic model that casually mapped a plan for the program activities. During the initial stage of funding, CAP grantees attended a training session conducted by members of the CAP research team on the definition, uses, and development of a program-specific logic model. Following this training session, grantees were required to submit a logic model depicting their particular goals, activities, and expected outcomes of their projects to the research team for review. The research team responded to each submission with written comments and suggestions for process improvement.

Based on all the planned activities reported by CAP grantees, the research team developed common definitions or classifications by type to document grantee-specific program activities. These classifications, which were agreed upon by HRSA program staff, were then grouped and illustrated in a single logic model for the entire CAP initiative. This resulting single logic model grouped all community activities into seven broad categories, with each subcategory providing an

overall snapshot of CAP-funded program activities (See Figure A). This model offered a baseline standard on the types of activities CAP grantees would undertake. The standard logic model also provided grantees with a shared understanding of how and why CAP is expected to work.

The broad logic model activities in which grantees are engaged aim to improve patient access and utilization as well as system performance and promote programmatic support from decision makers. These activities include the integration of existing delivery systems, the creation of mechanisms to expand insurance coverage for the under- and uninsured, coordination and improvement of services available to patients, enhanced community and patient education, and policy change.

Overview of the Report

This report provides a synopsis of the activities and accomplishments of the first two cohorts of CAP grantees. We first explain the methods used to gather and analyze grantee questionnaire data. Next the report covers a description of cohort characteristics, such as organizational structure, location of operation, and size of coalitions. The findings on grantee progress in their CAP activities with a comparison of the cohorts is followed by findings on "themes" in grantee activities and predictors of their progress. Finally, the report ends with a summary and discussion of the findings, including the barriers and facilitators to progress cited by grantees in their survey responses.

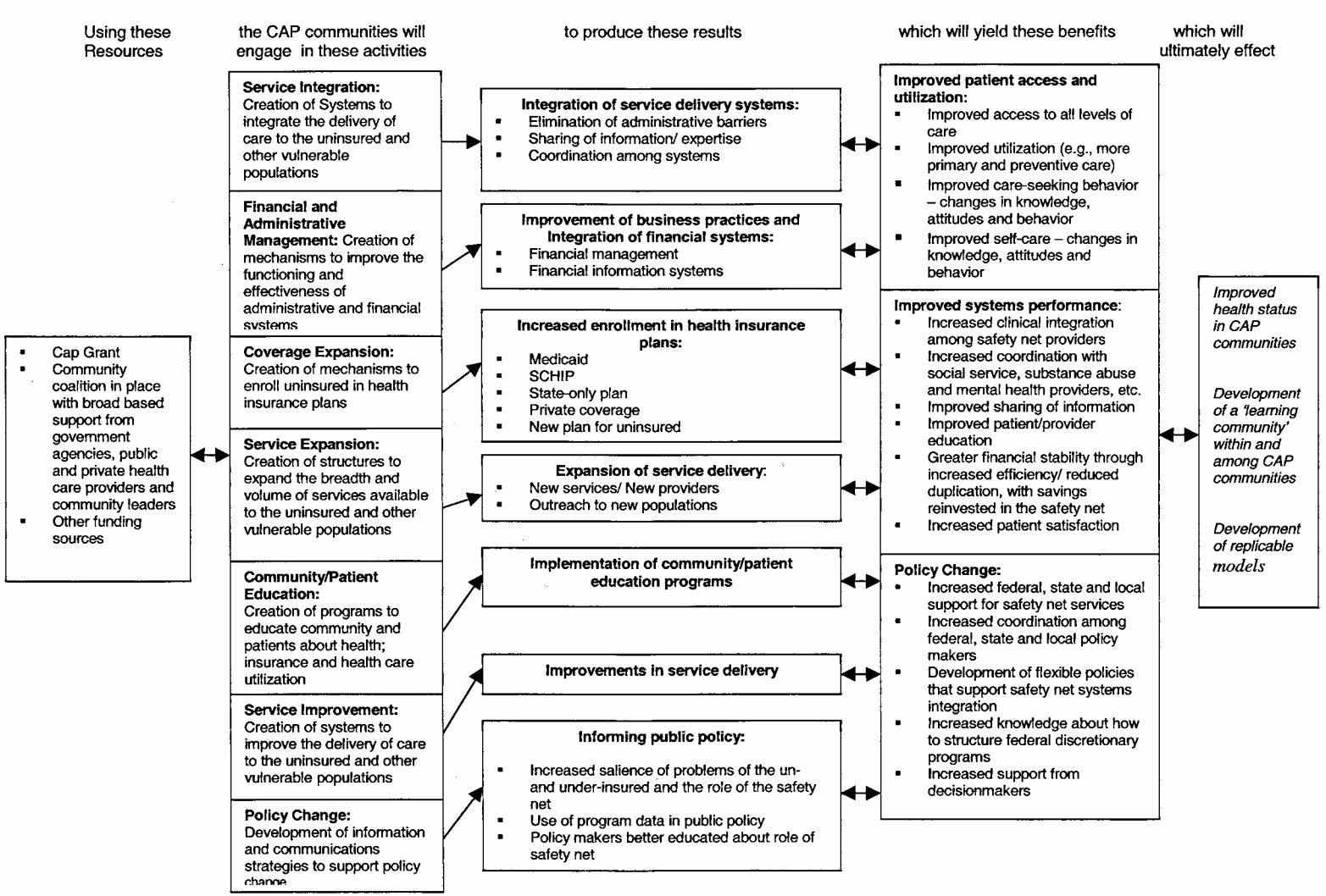
Methods

Design of the Progress Monitoring Questionnaire

As previously mentioned, HRSA required grantees to develop a logic model plan displaying how program activities will lead to specific outcomes. The logic models shows what the community intends to do (goals), what needs to happen to accomplish the goals (activities and level of resources required), and what results are intended (expected outcomes). To assess CAP grantees' success in implementing logic models, their progress, and differences between cohorts funded at different times, the Rutgers and NYU research team developed a CAP progress monitoring questionnaire. This two-part survey covers changes in coalition membership structure and size and measures grantee progress in the seven logic model activity areas (see Appendix A for the six-month progress monitoring questionnaire and instructions).

Figure A: Logic Model

Figure A: CAP Logic Model



Part A of the questionnaire provides information on the composition and functioning of the individual coalitions by asking grantees to identify particular coalition characteristics, such as size, lead agency, structure, and growth as well as their progress in developing replicable products or tools. In Part B of the questionnaire, grantees are asked to verify their programmatic activities and record their progress during the funding period. Grantees can also qualitatively explain the barriers or facilitators that have affected their progress in this section. Finally, Part B provides qualitative and quantitative information on the number and kind of patients served, providers participating, and programs offered through the CAP initiative.

Each logic model area is covered separately in the survey, with questions about all possible activities that would be included in this area. The questionnaire asks grantees to report their status for individual activities using the following codes: P = planning only, D = development but not operational, EO = early operational/not full to scale, or FO = fully operational. HRSA requires CAP grantees to complete this progress questionnaire at the end of every six months of the grant period. The analysis for this report includes data from the six (T1), 12 (T2), and 18 (T3) month questionnaires for the first cohort of CAP grantees (funded in September 2000), and the six (T1) and 12 (T2) month questionnaires of the second cohort of CAP grantees (funded in March 2001). We were therefore able to look at the progress of both cohorts. We did not analyze data for the group of 60 CAP grantees funded in September 2001 nor the most recent cohort of 22 CAP grantees, who were funded in September 2002.

The CAP monitoring questionnaire was administered by the CSHP research team for the first funding period for Cohort I only and by HRSA project staff in all subsequent reporting periods. Grantees were provided with electronic as well as hard copies of the monitoring tool and were encouraged to submit completed electronic progress questionnaires to the CSHP research team and/or HRSA program staff within one month of the original request. Upon receipt of all completed CAP questionnaires, CSHP research team members reviewed these submissions for completeness and clarity. If follow-up was necessary to complete or clarify the questionnaire, the specific CAP grantee was contacted and asked to provide the needed information. As a result of this submission review process, few of the CAP questionnaires used in this analysis were incomplete.

Descriptive Analysis

Quantitative data from the CAP progress monitoring questionnaire was entered, verified, and cleaned in SPSS data analysis software. The program status codes defined above were entered on a 1–4 scale with 1 = planning only and 4 = fully operational. We analyzed all variable frequency

distributions for the entire group of 76 grantees as well as for Cohort I (23) and Cohort II (53) separately in all time periods. Using these frequencies, we determined similarities and differences between the cohorts in their areas of focus (what they are doing), levels of activity (how much they are doing), program status (stage of development), and progress over time (based on reported status codes from all time periods). We also examined progress at the broad logic model level by counting how many activities within each area were in an operational stage for every grantee. For example, a grantee might be active in four of the eight possible activities within community/patient education and in an early operational or fully operational stage in two of those. We used these counts to calculate the percentage of grantees who were operational in each logic model area and presented these in bar charts.

Identifying Grantee Themes

In addition to looking at progress in the logic model areas, our research team was also interested in discovering if grantees were active in particular clusters of activities that cut across logic model areas. For example, if a coalition is highly focused and advanced in an integration activity, is it more likely to be advanced in a particular community/patient education activity? In order to search for clusters or activity "themes" among the grantees, we used a process called principal components factor analysis. First, we tapered the number of activities included in the analysis to those 13 where at least 50% of grantees in each cohort were active at 12 months of CAP funding. These 13 variables were entered into a factor analysis. The outcome, reported in a later section, revealed groupings of activities that grantees are pursuing that are at similar levels of development (a more detailed, technical description of this analysis is presented in Appendix III).

Predictors of Progress

In order to potentially explain patterns found in the descriptive analysis of grantee status, CSHP researchers identified and tested the impact of a group of predictors on grantee level of development. We identified five predictor variables available from the progress monitoring questionnaire and additional demographic information provided by HRSA that might impact grantee status in the logic model activities. The predictors are: type of coalition lead agency, geographical region of operation, size of the coalition, whether the grantee had received other types of funding, and amount of other funding received. These variables were selected because they were of particular interest to HRSA staff or because we expected that general effects as well as differences

in the two cohorts would result from these variables. Linear regression was used to determine the relationship between these predictors and the level of progress made in a set of commonly pursued activities. The results of these analyses will be covered in detail in the findings section.

Limitations

The data used for this CAP evaluation have several limitations. First, the progress questionnaires used as the basis of evaluation are self-administered by the grantees and are not subject to independent verification of accuracy. Our research team did not interact directly with local evaluators or field officers for the CAP initiative, who oversee grantee activity. Second, the monitoring questionnaires request only a limited amount of information. It is possible that characteristics of coalitions or their environments that we did not measure—for example, the local political and social supports for health care improvements or the unanticipated difficulty of attaining sufficient provider cooperation—significantly affected the level and speed of progress.

The final study limitation derives from the limited number and diversity of grantees studied. The monitoring questionnaire covers a large number of activities, but each grantee is engaged in different activities. Therefore, the number of grantees involved in each activity was often too small to apply statistical procedures to and limited much of our analysis to the descriptive level.

Findings

The CAP Coalitions

The nature and structure of the 23 CAP coalitions in the first cohort varied by the size of their memberships and type of organizations leading the grant activities (lead agency). Coalitions can also be differentiated by whether they work in urban, rural, or both types of geographical areas and whether they receive non-HRSA funding for related improvement activities. This cohort's coalitions ranged from as few as four members to as large as more than 170 members, with a mean coalition size of 27.4 organizations. The most common lead agency type was that of other hospital or community health center and public hospital; local government or health department tied for the second most popular lead agency among the grantees. Community-based providers, state governments, and foundations were less likely to be the lead agency for grantees in this cohort. The

majority of grantees in this cohort operated in both urban and rural areas, and a large percentage had received outside grant funding concurrent with CAP funding (78%).

The grantees that made up Cohort II were also diverse. The size of this cohort's coalitions varied from as few as five to as many as 816 members. The average coalition size for this group (without two large outliers) is 34.8. Lead agency types varied, with the designation of federally qualified health center (FQHC) noted to be the most common lead agency. Local government agencies or health departments tied for the second most popular lead agency designation. Lastly, public hospitals, provider networks, and foundations were observed to be the least common lead agency types identified by these grantees. Cohort II grantees were most likely to be working exclusively in urban areas or in both urban and rural locations. Finally, many of these 2001 coalitions also received external funding from non-HRSA sources (68%). A comparison of the two CAP grantee cohorts by lead agency designation, coalition size, area of operation, and external funding is provided in Table 2.

Cohorts I and II represent 76 of the 158 total CAP grantees and are geographically located in 35 states. Cohort I consists of 23 grantees located within 22 states (see Figure B). Cohort II is a much larger group, with 53 grantees located in 25 states (see Figure C). Multiple grantees were funded in some states (range, two to eight grantees in a given state); an overlap of same-state grantees was observed in 14 states. Grantees from both cohorts were asked to identify the site operation location of their CAP project by indicating whether operations occurred within urban, rural, or both urban and rural locations. The number of states where CAP grantees operate and the type of geographic locations in which they work are displayed by cohort in the following maps. Please refer to Appendix B for a full list of grantee names and locations.

Table 2: HRSA CAP Coalition Composition and Structure

	Cohort I		Cohort II	
Type of Lead Agency	**No. of grantees**	**% of grantees**	**No. of grantees**	**% of grantees**
Hospitals (Including Academic Medical Centers, public hospitals, and other hospitals)	7	30.4	14	26.4
Providers (including Federally Qualified Health Centers, community-based providers, Primary Care Associations, Provider Networks)	6	26.1	21	39.6
Governments (state and local, including health departments, Health Authorities, tribal organizations, and State governments)	6	26.1	9	17.0
Non-profit Organizations (including foundations)	2	8.7	6	11.3
Other (Universities, Area Health Education Centers, Managed Care Organizations)	2	8.7	3	5.7
Coalition Size				
Very small (1–10)	4	17.4	12	22.6
Small (11–20)	8	34.8	18	34.0
Medium (21–40)	5	21.7	12	22.6
Large (41–100)	6	26.1	4	7.5
Very large (more than 100)	0		7	13.2
Area Of Operation				
Urban	8	34.8	20	37.7
Rural	5	21.7	13	24.5
Urban and rural	10	43.5	20	37.7
External Coalition Funding				
Did Not Receive Outside Funding	5	21.7	17	32.1
Received Outside Funding	18	78.3	36	67.9
Total	**23**	**100.0**	**53**	**100.0**

Grantee Project Activity

By Geographic Location

Figure B:
Grantee Project Activity By Geographic Location
Cohort I

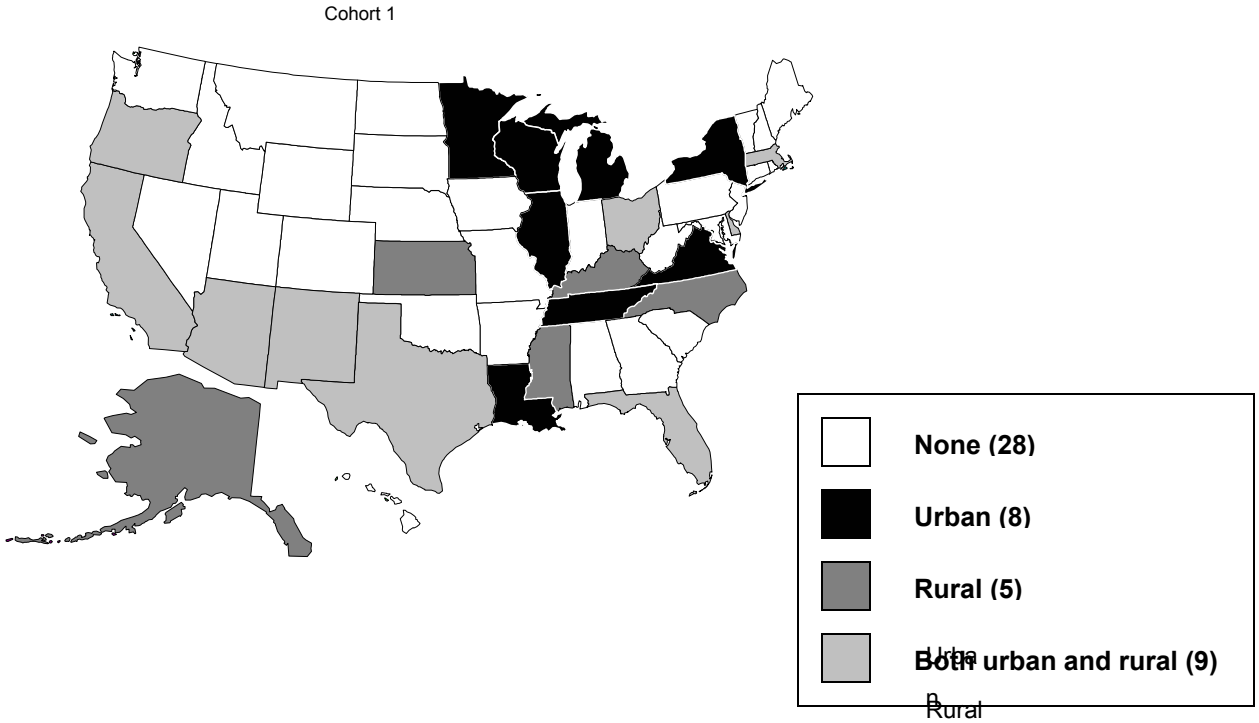
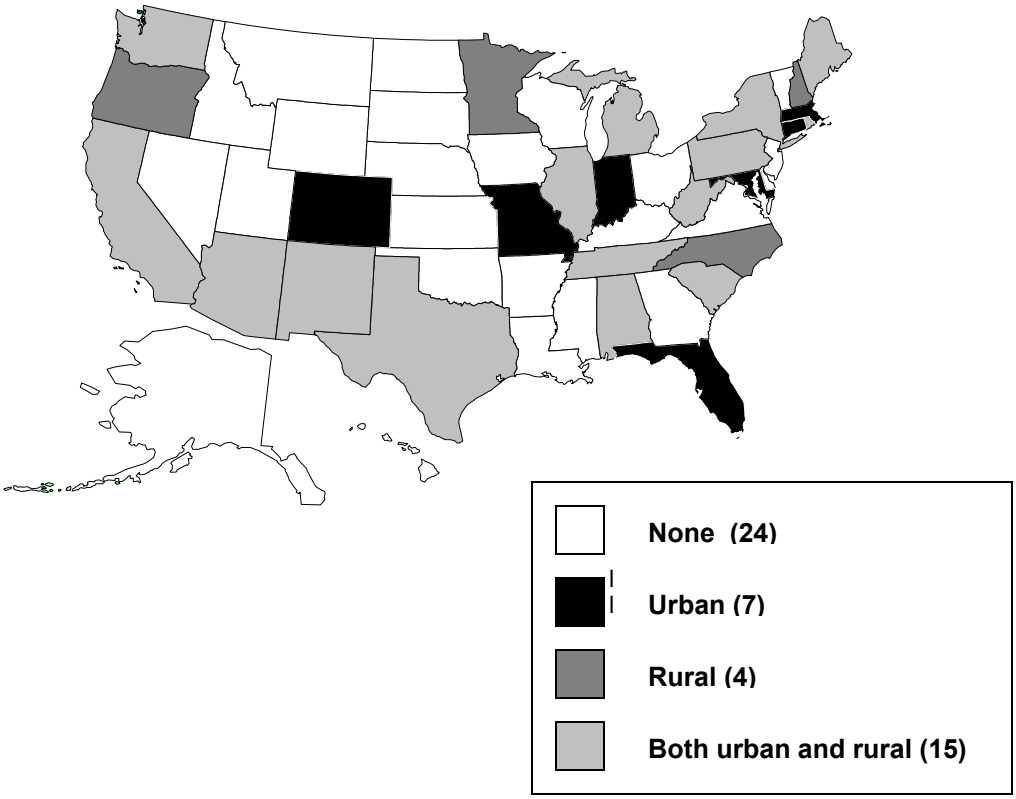


Figure C:
Grantee Project Activity By Geographic Location
Cohort II



Grantee Activities

In addition to the development of the single logic model, the research team developed a matrix to catalogue the activities each grantee intended to pursue. This matrix presents grantee-proposed goals for the CAP grant. Table 3 shows a summary of these proposed activities categorized by the broad logic model areas. This matrix provided a baseline status for the first and all subsequent CAP grantee cohorts.

Table 3: CAP-Planned Activities at Baseline by Cohort
No. of Grantees Planning Activity in Logic Model Areas

Activity	Cohort I (2000)	Cohort II (2001)	Total
Ia. Integration: Elimination of Admin. Barriers	23	48	71
Ib. Integration: Sharing of Information/Expertise	21	43	64
Ic. Integration: Coordination Across Systems	18	46	64
II. Financial and Administrative Management	6	41	47
III. Increase Enrollment in Health Coverage	19	41	60
IVa. Expansion: New Services or New Providers	19	39	58
IVb. Expansion: Outreach to New Populations	13	41	54
V. Community and Patient Education	20	44	64
VI. Service Improvements	14	39	53
VII. Inform Policy	14	41	55
Total Grantees	23	53	76

As can be seen in the above table, grantees in both cohorts were quite ambitious at the outset of the grant funding. High numbers of grantees within both cohorts planned to be engaged in many of the logic model areas during the course of this grant. Specifically, the greatest number of grantees planned to work in the areas of integration, enrollment, community and patient education, and expansion.

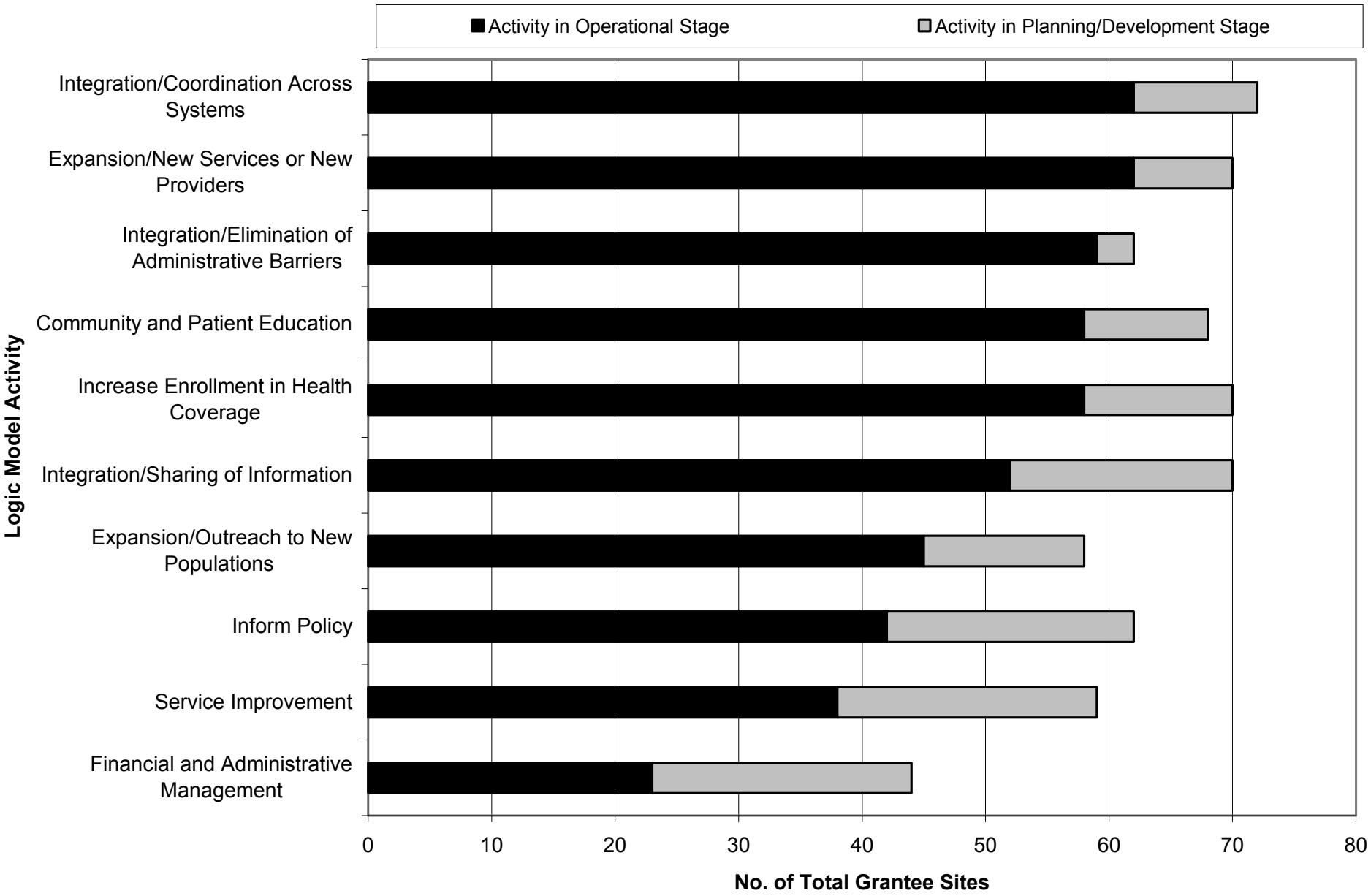
General Grantee Progress

CSHP investigators examined the operational stage grantees achieved in each of the logic model areas based on the program status codes reported in the individual monitoring questionnaire. Bar charts were then created to visually display the participation and stage of development data for the broad CAP logic model program categories. The first bar chart, Figure D**,** shows the number of grantees in an operational stage of development versus those in a planning/development stage for all 76 CAP grantees, using their most recent reporting periods (T3 for Cohort I and T2 for Cohort II). The size of the bars indicates the number of grantees participating in that area. The bars show that the areas of grantee participation, from most to least, are: integration, enrollment, expansion, education, service improvement, inform policy, and financial and administrative management. Three-quarters or more of the grantees were involved in the integration of service delivery system activities, such as coordination across systems, elimination of administrative barriers, and sharing information/expertise. The categories of coordination and sharing information/expertise exhibited slightly higher levels of grantee involvement compared to another category, the elimination of administrative barriers. Many grantees are also engaged in enrollment of patients into insurance plans, expansion activities related to adding new services and/or providers, and community and patient education activities.

Turning to the stages of development for the overall group, a greater number of grantees are at operational stages in integration, expansion, enrollment, and community/patient education activities. About half of the grantees report an operational stage of activity in service improvement, outreach, and policy change. Only about one-third of the grantees report operational levels in the improvement of business practices and the integration of financial systems.

The next set of charts group the cohorts by funding period. In this way, comparisons across reporting periods (for example from six to 12 months) reveal movement in the stage of development or progress in CAP program activities for each cohort. Following this, a comparison across cohorts at the same funding period (T2 = 12 months of funding) is provided to reveal valid differences in the amount of development for the groups. Also, because each grantee is not expected to be engaged in all activities, the percentages shown in all subsequent charts are based on the number of grantees who are working in a particular area and not the percent of the total group. This gives a more accurate reflection of the level of participation and development for each logic model area.

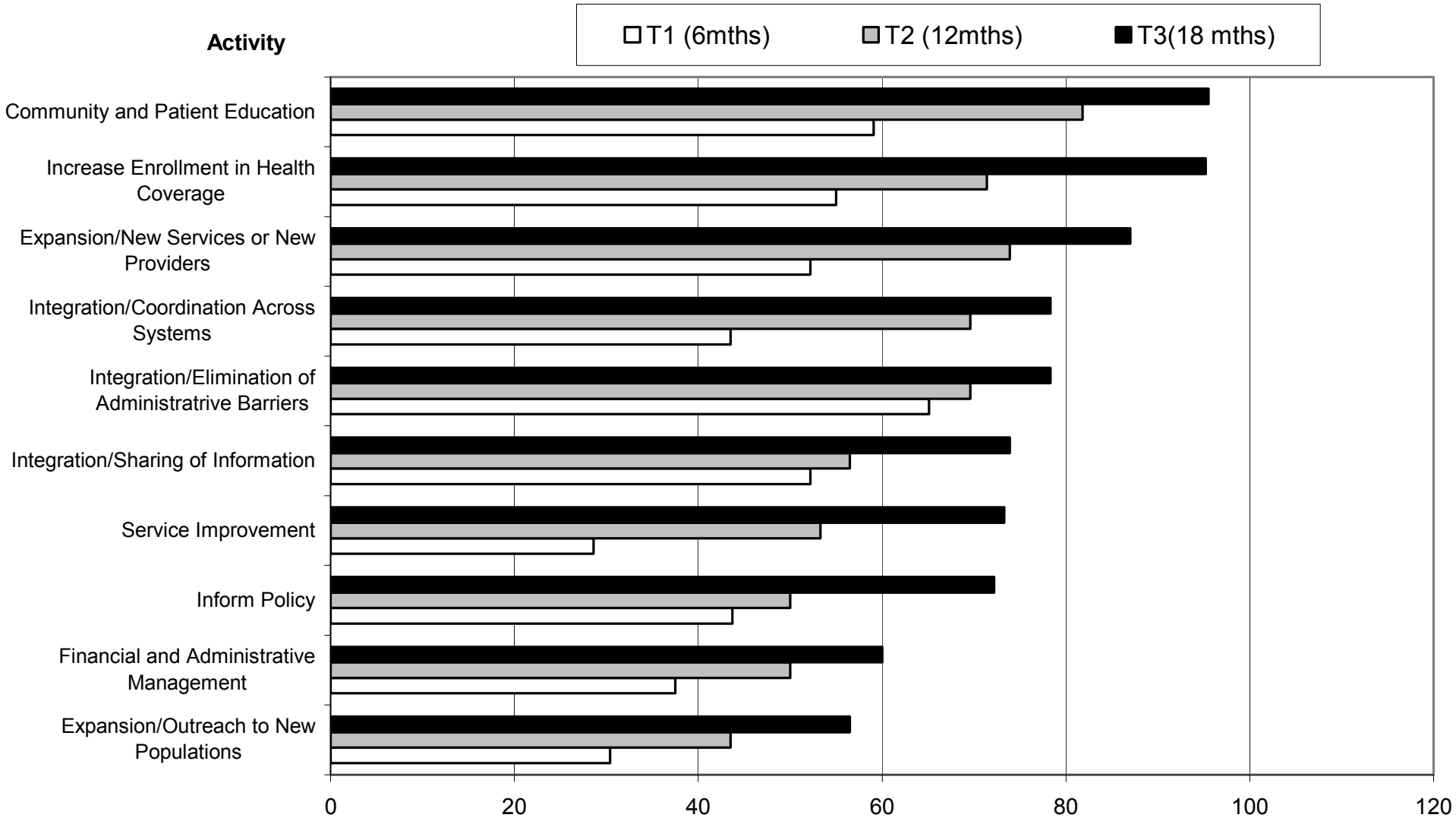
Figure D. CAP Grantee Stages of Development



When assessing grantee progress by time period across the broad logic model activity areas by cohort, a different pattern emerges. Figure E displays operational progress by activity area of Cohort I grantees during three distinct funding periods and reflects changes in the collective grantee priority area over time. At T1 (the six-month period of funding), a high percentage of CAP grantees within Cohort I reached operational stages in each of the following areas (in order of highest level): integration/elimination of administrative barriers, community and patient education, increasing enrollment in health coverage, expansion/new services or providers, and integration/sharing of information. Specifically, the percentage of grantees reporting an operational stage of development at T1 ranged from a high of 65% in integration/ elimination of administrative barriers to a mid level of 52% in integration/sharing of information to a low of 30% in expansion/outreach to new populations. By T2 (12 months), the highly operational activity areas had shifted. The highest percentage of grantees were at the most operational stage in areas such as community and patient education activities at 82%, followed by expansion/new services or new providers (74%), increasing enrollment in health coverage (71%), integration/coordination across systems(69%), and integration/elimination of administrative barriers (69%). At T3 (18 months), the activities at the most operational stage for this grantee cohort remained in similar order as those noted in T2 with the exception of the increasing enrollment in health coverage activity. In this activity area (which moved to second in order of highest level), a greater percentage of grantees reached operational status from the 12-month to 18-month report period. Overall, however, a greater degree of progress was noted by Cohort I grantees in each of the 10 broad activity areas from T2 to T3. Ninety-five percent of the grantees are now in operational stages in community and patient education activities and increasing enrollment in health coverage, 87% of grantees are operational in expansion/new services or new providers, and 78% each report operational status in integration/coordination across systems and integration/elimination of administrative barriers activities.

Cohort II grantees, observed during two funding periods, exhibit a different priority order when assessing operational status levels of broad CAP activities (Figure F). At T1, 55% of these grantees reported operational status in integration/coordination across systems and expansion/new services or new providers. Fifty-two percent of grantees are operational in the area of increasing enrollment in health coverage, and about 49% of grantees report operational status in the areas of community and patient education and integration/elimination of administrative barriers. Finally, in order of operational stage: expansion/outreach to new populations, service improvement, informing public policy, integration/sharing of information, and financial and administrative management.

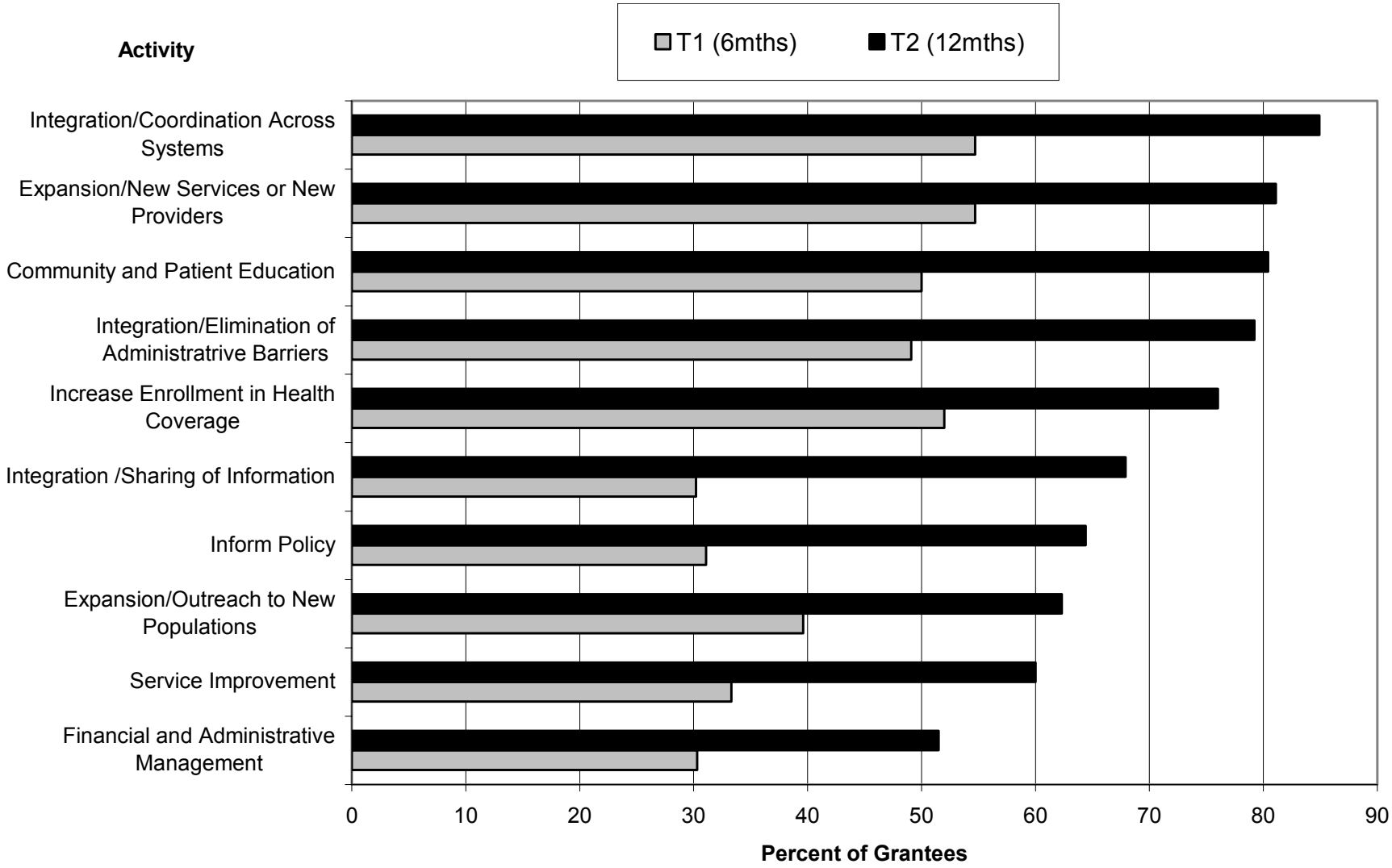
Figure E. CAP Grantee Activities Reaching Operation Stage
Figure E. CAP Grantee Activities Reaching Operationa
Cohort I (n=23 Grantees)
=23 grantees)



*Note – Bars represent percent of grantees participating in that logic model area

Footnote - Bars represent percent of grantees participating in that logic mod

Figure F. CAP Grantee Activities Reaching Operational Stage



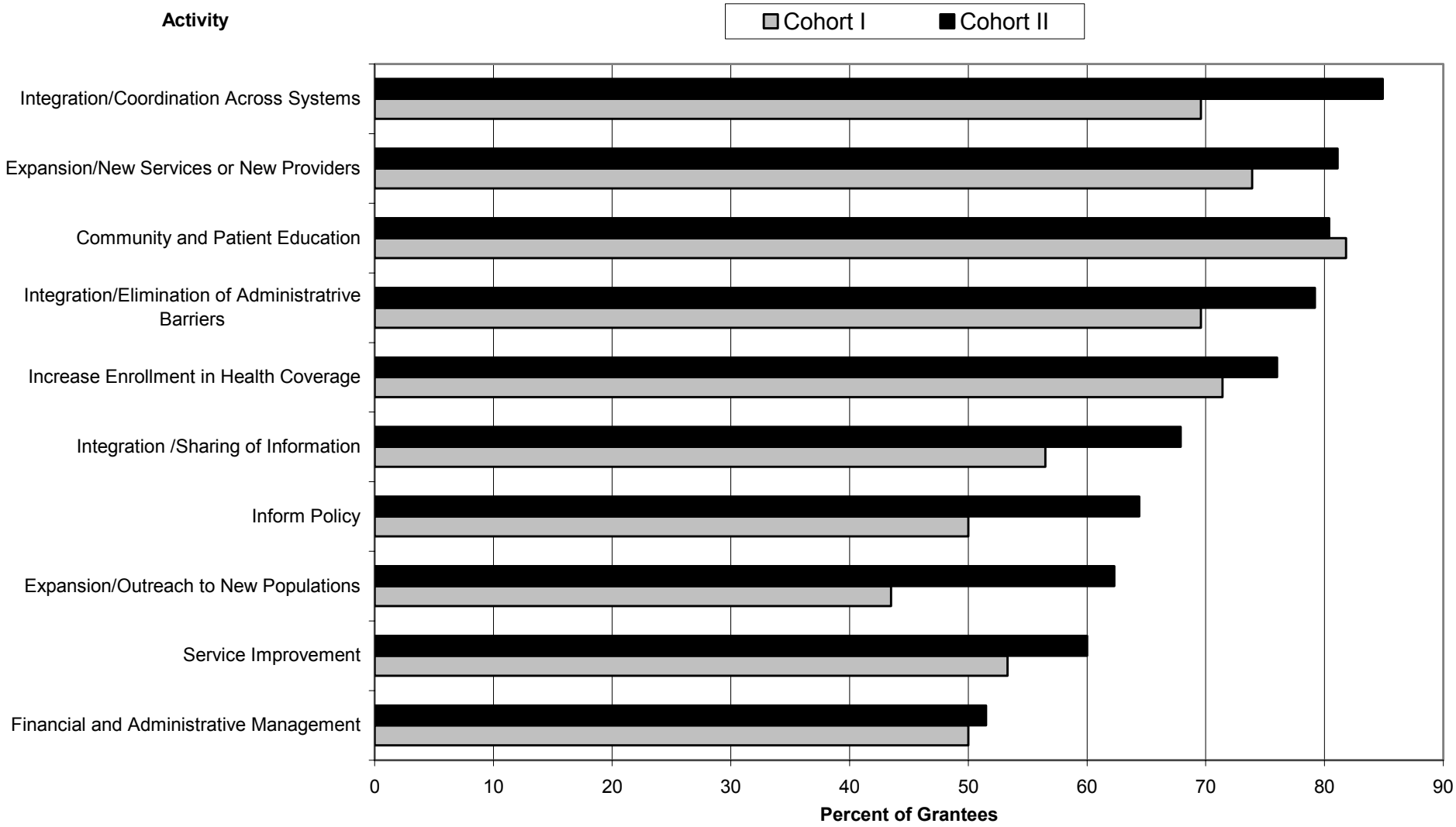
* Note- Bars represent percent of grantees participating in that logic model area.

At T2, minor differences are noted that affect activity priority areas defined by the level of operational status. From T1 to T2, the order of activities grantees are focused on changes very slightly: however, substantial progress is observed in all areas as grantees became increasingly operational at the 12-month funding period. The areas in which a higher percentage of grantees reported operational status include: integration/coordination across systems (84%),

expansion/new services or new providers (81%), community and patient education (80%), integration/elimination of administrative barriers (79%), and increasing enrollment in health coverage (76%). Although extensive progress is observed in all activity areas, substantial gains are particularly visible in the areas of integration/sharing of information and informing policy (68% and 64%, respectively). Finally, at the lower level of the activity spectrum, increased operational activity is observed in expansion/outreach to new populations (62%), service improvement (60%), and financial and administrative management (51%).

At T2 of grant funding, more grantees in general move from a planning and development stage to the operational stage, and much more progress is observed in all broad activity areas. A comparison of operational status of the two grantee cohorts at T2 provides an interesting observation (Figure G). During this time period, in every CAP activity except one, Cohort II grantees are more operational than grantees within Cohort I. Not only are grantees from Cohort II more operational in the broad activity areas, a greater number of grantees are observed to be engaged in each of the activities. The activities of greatest involvement include: integration/coordination across systems (84%); expansion/new services or new providers (81%); community and patient education (80%); integration/elimination of administrative barriers (79%); increasing enrollment in health coverage (76%); and integration/sharing of information (65%). In these same activity areas, the operational status of Cohort I ranges from a high of 82% in community and patient education to a low of 43% in expansion/outreach to new populations.

Figure G. Cohort I versus Cohort II - Operational Grantees at T2



* Note - Bars represent percent of grantees participating in that logic model area.

Community and patient education is the one activity in which Cohort I grantees are observed to be slightly more operational (82%) than Cohort II(80%). Thus, it appears that grantees in Cohort II are more system focused, as noted by their engagement in integration/coordination–related activities as opposed to grantees in Cohort I, who appear to be more individually focused, as evidenced by this group's patient education priority.

When compared to the broad list of activities, the areas of informing policy and expansion/outreach to new populations rank lower in terms of grantee involvement; yet, the largest percentage difference between Cohorts I and II are observed in their involvement in these activities. Overall, grantees of Cohort II are more highly engaged in these areas, with operational status noted at 63% and 61%, respectively, as compared to 49% and 43%, respectively, in Cohort I. The activity areas of service improvement and financial and administrative management are also at the lower end of grantee-reported operational status, with Cohort II again displaying a higher degree of engagement at 59% and 51%, respectively, compared to slightly less grantee activity observed by Cohort I at 52% and 49%, respectively.

From the end of six months to the 12-month mark, Cohort II progressed further than Cohort I in all program areas (but particularly in previously established patterns of grantee activity at T1), as evidenced by the shift of more grantees to an operational status than observed in the previous reporting period.

Grantee Progress in Specific Activities

So far we have presented CAP grantee progress at the aggregate level for 10 broad logic model areas. We will now discuss what and how grantees are doing in the individual activities. Table 4 shows the participation and operational rates for the 10 most popular activities for each cohort; that is, those in which the largest number of grantees are participating. From this table, you can see which activities the cohorts are focused on, how many grantees are participating in each, and their achievements in those specific pursuits.

As the table shows, there is some overlap in the most commonly pursued activities for the cohorts. Development of standardized registration systems, information systems, public clinic/other provider coordination, Medicaid enrollment, and informing policy, are among the most popular activities for both groups. For all of these overlapping items, Cohort II has higher participation rates than Cohort I. This pattern of higher participation holds for most other activities as well. A general finding of our analysis of the specific activity areas is that Cohort II is involved in more activities overall; moreover, for each activity, a larger percentage of the group is involved

compared to Cohort I. (See Appendix C for complete table of number of grantees participating in every activity).

Table 4 also shows some differences in areas of concentration for the grantee groups. For example, Cohort II is more active in integration activities targeted at system improvements, whereas Cohort I is more focused on enrollment and education pursuits to benefit patients, facilitate their learning and personal improvement, and improve access.

Turning to grantee achievement, each cohort is highly operational in the activities that are most commonly pursued by that group. In all but two cases, more than half of grantees participating in these activities are in an operational stage; in many cases, 75% or more of those involved are at the operational stage. For example, 92% of the grantees from Cohort I who are active in health navigation education have reached an operational stage at the end of 12 months of CAP funding.

Table 4: Grantees Participating and Operational in Selective Activities, by Cohort at 12 months

	Cohort I		Cohort II	
Activity Name	**% of Grantees Participating in Activity**	**% of Grantees Operational in Activity***	**% of Grantees Participating in Activity**	**% of Grantees Operational in Activity***
Ia2. Standardized Registration System	65	60	74	59
Ia3b. Primary Care			72	63
Ia6. Create Medical Home			77	68
Ib3. Info. System/ Data Standardization	78	56	85	49
Ic3. PCP/Specialist Coordination			75	63
Ic5. Public Clinic/ Provider Coordination	70	69	83	66
Ic6. Coordination with Govt. Agencies			74	59
III1. Medicaid Enrollment	78	72	81	70
III2. SCHIP Enrollment	74	82		
Iva7. Health Navigation assistance	57	92		
Ivb1. Working Low-Income			72	76

Table 4: Continued

	Cohort I		Cohort II	
Activity Name	**% of Grantees Participating in Activity**	**% of Grantees Operational in Activity***	**% of Grantees Participating in Activity**	**% of Grantees Operational in Activity***
V2. Navigation Education	74	88		
V3. Healthy Behaviors Education	57	62		
Viia. Inform Policy	61	57		
Viib. Improve Program Data	57	54	75	43

* Percentage of those participating in activity not of total grantee group.

Emergence of Four Themes

The CAP guidelines accorded grantees wide latitude in selecting which activities to pursue and adapt to their local circumstances. To measure whether different grantees have pursued different "clusters of activities" and, if so, whether the activity clusters reveal broad grantee strategies or themes, we employed a statistical technique called principal components factor analysis. This technique measures the extent to which different variables (in this case, variables indicating the pursuit and level of development of grantee activities) occur in common and look similar to one another (see Appendix III for a technical description of the factor analysis). Unlike the earlier description of activities, this analysis focuses on individual activities unconstrained by their classification in the CAP logic model. We entered 13 of the most commonly adopted activities—those that are being pursued by at least half of the grantees in both cohorts—into the factor analysis.

The factor analysis revealed four separate activity clusters for the HRSA Cap grantees. Table 5 shows the 13 activities and the clusters and logic model areas into which they fall.

Table 5: CAP Grantee Activity Clusters and Themes

Cluster 1 Standardization	Logic Model Area	Cluster 2 Enrollment	Logic Model Area
Healthy Behaviors Education	Education	Medicaid Enrollment	Enrollment
Clinical Protocols and Disease Mgmt.	Integration	SCHIP Enrollment	Enrollment
Health Navigation Assistance	Expansion		
Info. System/Data Standardization	Integration		
Standardized Registration Sys.	Integration		
Cluster 3 Coordination	**Logic Model Area**	**Cluster 4 Educ/Case Management**	**Logic Model Area**
PCP/Specialist Coordination	Integration	Case Management	Integration
Pub. Clinic/Provider Coordination	Integration	Availability of Pub. Health Insurance	Education
Create Medical Home	Integration	Navigation Education	Education

Within the clusters presented above, four themes in grantee activity emerge from the particular groupings of variables. We have labeled the themes: Standardization, Enrollment, Coordination, and Education/Case Management. Specifically, several of the activities in Cluster 1 are clearly directed at achieving standardization and consistency across providers (e.g., clinical protocols, data standardization, and standardized registration system), but the other two activities in this grouping (healthy behaviors education and health navigation assistance) are less about standardization and more about assisting patients. This indicates that those grantees successfully developing standardization mechanisms, which often take place at a distance from actual patients, are also successfully implementing health care improvement strategies that involve direct contact with individual patients; for example, through health care navigation assistance.

The three other clusters also show themes in grantee activities. Cluster 2 involves promoting enrollment in public coverage (Medicaid and SCHIP). The factor analysis indicates that, on average, coalitions highly active in this cluster are not as involved in activities that are part of the other clusters. The third cluster consists of coalitions that emphasize improved care coordination between primary care and specialty providers and between public clinics and private providers. Also falling into this group are grantees who are promoting "medical homes" for individual patients. The final cluster of activities shows coalitions focusing on educating patients as well as improving their case management.

Overall, the factor analysis revealed that CAP grantees tend to gravitate toward particular sets of activities. What remains unanswered, however, is why grantees may move toward certain "themes" in their approach to serving the under- and uninsured. In other words, we do not know if certain grantee characteristics predict particular approaches to serving vulnerable populations.

Predictors of Progress

As described in the methods section, we tested the impact of five predictor variables on coalition progress after 12 months of CAP funding. The variables, each representing a characteristic of the CAP coalitions, are: lead agency type, region of operation, coalition size, other non-HRSA funding, and amount of funding received. The number of potential predictor variables was limited by the data available in Part A of the monitoring questionnaire and by additional information gathered by HRSA about grantee characteristics (for example, grantees reported their geographical region of operation). The coalition lead agency types include hospital, provider, government, non-profit, and other types. The regions of operation are urban, rural, or both urban and rural settings. The coalition size variable is a scale ranging from 1 (very small, 1–10 members) to very large (more than 100 members). Other funding is a dichotomous variable indicating if the grantee received other funding. Finally, funding size represents the amount of other, non-HRSA funding the coalition received and is a scale variable ranging from 1 ($5,000–$200,000) to 4 ($2,000,001–6,000,000).

For this analysis, a measure of grantee progress was developed using the same set of high-volume activities used for the factor analysis. Each grantee was assigned a score representing their level of development for the set of activities at 12 months (T2), adjusted for operational stage and participation rates. We used linear regression to test the influence of the predictors on this progress measure.

The only significant association in the regression model was for the coalition size predictor. Specifically, very small and small coalitions were not as highly developed as larger ones. In other

words, the size of a coalition makes a difference for grantee progress and larger coalitions are likely to become operational more quickly than their smaller equivalents. (See Appendix D for a technical explanation of the development of the progress measure and the regression analysis.)

We hypothesize that larger coalitions, due to the extent of their networks, may have a greater ability to reach underserved populations and connect a sizeable number of patients to services. Larger coalitions may also have a greater opportunity for integration activities between the many organizations in the network than smaller coalitions with less members in their coalitions.

Conclusions

In the three-year period since the creation of the Community Access Program, much grantee progress is evident in all seven broad areas of the original program logic model. Overall, CAP monitoring questionnaire data show that grantees have moved very quickly into operational phases in many of these areas. An analysis over three semi-annual grantee questionnaires provided as part of the CAP monitoring process suggests that the most advancement has occurred in four major areas of activity for both observed cohorts: integration, enrollment, expansion, and community and patient education. Other areas that showed steady but more modest progress include service improvement, financial and administrative management, and informing public policy. Fewer grantees are pursuing these activities, and their work has advanced more slowly.

The coalitions of the first 76 CAP grantees vary widely in terms of their operating environments, the character of their members, and their size. Most of these coalitions were similar however, in setting ambitious goals for their time as recipients of CAP grants. Grantees from both of the first two cohorts funded planned on being active in many tasks across different types of activities related to health care access, system performance, and informing policy.
The focus of CAP grantee activity was similar for the first two cohorts receiving funds. Both groups were highly active and made swift progress; however, some differences between the cohorts in terms of the focus of their CAP work is evident. Cohort I, for example, showed a stronger interest in working with patients directly and improving patient health care knowledge and their ability to advocate for themselves in the often complicated health care and benefits system. Cohort II, on the other hand, demonstrated more interest in improving the performance of its delivery systems to simplify processes and utilize more efficient technology.

The two cohorts were also somewhat different in terms of the activities in which they demonstrated the most progress. Cohort I, after 18 months of funding, was the most developed in its community and patient education efforts, which were followed by enrollment initiatives. Cohort

II, after 12 months of funding, instead had become the most developed in its actions aimed at coordinating across health care systems, an integration activity. On average and as a group, Cohort II developed its CAP activities at a faster rate than Cohort I; however, Cohort I made significant progress in its third reporting period (18 months or T3) and had reached full implementation in many of its initiatives.

CAP grantees demonstrated some tendency to pursue particular sets of activities that represented their focus as coalitions. Grantees were likely to engage in activities that followed one of the following "themes": standardization, enrollment, coordination, or education/case management. Perhaps in order to maximize the impact of CAP funding, grantees pursued groups of related activities. Further research will be required to learn the reasons why grantees pursued certain themes in their work toward serving and improving care for populations at risk in health care markets.

Although the coalitions varied in characteristics such as their type of lead agency and composition of their membership, the size of their coalitions is the only element that helps to predict the level of achievement by CAP grantees, we found. For the 76 grantees in this analysis, larger coalitions consistently reached a higher level of development than smaller ones in a sub-set of the most popular activities. It is possible that larger coalitions are able to develop quickly due to the multitude of skills and expertise present in their group of organizations. Development in particular types of activities—for example, those that involve integration or expansion—may be easier for large coalitions, who have the potential to use resources from many different organizations. Again, additional examination of CAP grantee work will be required to determine exactly why coalition size makes a difference for success in efforts toward improving patient access, health care systems, and health policy. Coupled with specific environmental and inter-organizational factors, these findings may begin to explain the substantial progress observed in some logic model activity areas as opposed to others.

Implications for the Future

Programs such as CAP are important, particularly now, when the economy and state budget constraints have limited other sources of support for safety net providers. CAP funding has allowed local coalitions to improve coordination among organizations, expand outreach strategies, and better educate the populations they serve. CAP grantees have also been successful in implementing strategies to increase patient enrollment in SCHIP, Medicaid, and other state and local coverage programs. All of these efforts have the potential to positively impact the health outcomes and quality of life of underserved groups.

Yet safety net providers continually face new challenges in meeting the health needs of those they serve. For example, in the current environment, the Health Information Protection and Portability Act is challenging providers to modify information systems and assure patient privacy even as they seek to streamline and coordinate systems across agencies. Technical assistance and financial resources assisting grantees in adapting to new regulations could be an important feature of future grant funding.

Starting in fiscal year 2003, this federal initiative to strengthen integrated community health care delivery systems was renamed the Healthy Community Access Program (HCAP). The new program continues to emphasize improving coordination and integration of health care services for the uninsured and underinsured but has the added goal of improving care for patients with chronic health conditions. Moreover, HCAP is focused on the quality and efficiency of health care service delivery. Our results show that grantees under CAP clearly focused on integration and were able to quickly reach implementation in many coordination activities. On the other hand, CAP grantees showed less focus and development in the areas of disease prevention and management activities. Projecting from these trends, new HCAP grantees may need less technical assistance in their integration and coordination efforts but more help in service improvement and in developing strategies to reach and effectively manage chronically ill patients.

In conclusion, our study documents significant progress reported by CAP coalitions in the implementation of a broad array of program activities. Although measurement of outcomes and the impact on served populations is beyond the scope of this analysis, our results reflect a positive picture of the work toward improving health care access and health status in CAP communities and provide some guidance for how best to facilitate the work of future HCAP grantees.

Endnotes

[1] Davis, DA, Tiedemann, A. (2003 , June). HRSA Community Access Program: Resource guide of products and tools: selected inventory. Center for State Health Policy Report.

[2] Issacs, SL. Knickman, JR.(Eds) To Improve Health and Health Care, The Robert Wood Johnson Foundation Anthology, (2002) Vol. V. pp xiii.

[3] Pollitz, K.; Sorian, R.; Thomas, K. How accessible is individual health insurance for consumers in less-than-perfect health? 2001 Menlo Park, CA: The Henry J. Kaiser Family Foundation.

[4] Davis, DA, Bogert, C, Cantor, J., Kaplan, S, Billings, J. (2002, March). Community Access Program: The First Six Months. Center for State Health Policy Report.Appendix A

Name of Site:_____ Date: May 2001

Appendix A

CAP Evaluation Report – Six Month Project Update Part A

A1. How many of each of the following types of organizations were members of your CAP coalition at the start of this reporting period, how has that changed during the reporting period, and why?

Type of Coalition Member	Start of Reporting Period	Change in Membership During Reporting Period		Explain why members left or were added
	# Members (agencies or organizations)	# added	# leaving	
Hospitals or hospital systems:				
Public				
Private				
Academic Health Centers.				
Non-hospital providers:				
Fed. Qualified Health Ctrs.				
Other health centers				
Private physicians /groups				
Other organizations and partners:				
State Health Dept.				
Local Health Dept.				
Managed Care Orgs.				
Social Service Orgs.				
Faith-Based Orgs.				
Behavioral and Substance Abuse Orgs.				
Government Agencies				
Other (specify)…				

Name of Site:_____ Date: May 2001

A2. Please reflect on the membership and structure of your coalition: Is the membership of your coalition broad enough to accomplish its objectives? Do the participating representatives have enough seniority and authority from their organizations to make commitments of resources and other support for the coalition? Are you actively seeking to recruit new members and, if so, of what kinds and to fulfill what roles?

A3. In which counties does your project currently operate (include all counties where any CAP-funded activities are planned or underway)?

County Name	State

A4. Please describe collaborative activities in which your CAP project has engaged with organizations and agencies in your community or state that are *not members of your CAP Coalition*. What non-member organizations have you worked with? What have been the nature of collaborative activities with non-member organizations (e.g., using volunteers, exchanging information, enrolling patients)?

A5. Please identify the source, purpose, amount and period of funds received in addition to HRSA CAP grant that have been received to support the CAP initiative or other joint initiatives of your coalition during the reporting period.

Source of funding	Purpose of funding	Amount received	Period of grant/contract (start and end dates)

Name of Site:_____ Date: May 2001

A6. What products or tools (e.g., model RFP for MIS, referral database format, etc.) will be produced under your CAP grant that might be of value to other communities undertaking similar tasks? Please list the following information for *each* product or tool: (1) a brief description, (2) the approximate dates that they would be available to share with other CAP sites, and (3) indicate whether they were developed in full or in part using funds from the CAP grant.

A7. Please provide suggestions for improving the CAP Grant Monitoring Report forms (both Parts A and B) and process.

Name of Site:_____ **Date: May 2001**

A8. Please provide names and contact information for all existing coalition members in the space below (add more lines as needed or attach a membership roster).

Name/Title	*Organization*	Complete Address	*Telephone*	*E-mail*	*Type**

*Please indicate the type of member, using categories from the table in Question A1.

A9. Who at your site was responsible for completing this report?

Name:
Title:
Organization:
Address:

Telephone:
E-Mail Address:

Name of Site:_____ Date: May 2001

CAP Evaluation Report Six Month Project Update – Part B

I. SERVICE INTEGRATION

CAP coalitions are seeking to improve access to or delivery of care by integrating program enrollment, clinical or other functions among community safety net providers. Please address the following items about your CAP coalition service integration activities for the current reporting period.

I1. Please review and update the CAP activities (i.e., "outputs" in your logic model) identified for your project (Column A). For each component please provide:

- Column B: the appropriate status code (see footnote) that best describes the level of development or implementation of each program activity.
- Column C: counts of the number of patients actually served using grant resources (not just the potential client-base) and/or the number of units of services provided (e.g., appointments or referrals processed) during this reporting period. If you track more than one output for a given activity (e.g., number of individual patients served and total visits provided), include each of them.
- Column D: specify the units of services given in Column C.

Ia.	**Integration of service delivery systems -- *Elimination of administrative barriers:***	A Program Status Code Last Period	B Updated Program Status Code *	C Patients served or services provided (#)	D Identify the TYPE of services referred to in Column C (e.g., patients, visits, referrals or appointments)
Ia1	Standardized appointment system				
Ia2	Standardized registration/ screening for program enrollment				
	Referral systems:				
Ia3a	Specialty care				
Ia3b	Primary care				
Ia3c	Social services				
Ia3d	Mental health/ Substance abuse				
Ia4	Patient referral phone line				
Ia5	Community resource databank				
Ia6	Create medical home for uninsured/assign PCP				
Ia7	Other administrative system (specify)…				

* Program Status Codes (Column B): P = planning only; D = in development but not operational; EO = early operational/not full to scale; FO = fully operational.

Name of Site:_____ Date: May 2001

Ib.	**Integration of service delivery systems – *Sharing of information/expertise:***	A Program Status Code Last Period	B Updated Program Status Code*	C Patients served or services provided (#)	D Identify the TYPE of services referred to in Column C (e.g., patients, visits, referrals or appointments)
Ib1	Standardized medical record				
Ib2	Shared electronic medical record				
Ib3	Information systems/data standardization for patient tracking &/or utilization management				
Ib4	Patient smart card				
Ib5	Clinical protocols and disease management				
Ib6	Uniform quality measures or outcome indicators				
Ib7	Other sharing of patient information (specify)				
Ib8	Master patient index/data repository				
Ib9	Other info. sharing (specify)				
Ic	Integration of service delivery systems – *Coordination across systems*:	A Program Status Code Last Period	B Updated Program Status Code *	C Patients served or services provided (#)	D Identify the TYPE of services referred to in Column C (e.g., patients, visits, referrals or appointments)
Ic1	Case management				
Ic2	ER/PCP coordination				
Ic3	PCP/specialist coordination				
Ic4	Coordination with mental health system				
Ic5	Coordination between public clinics and other providers or clinics (e.g., IHS, FQHC,…)				
Ic6	Coordination with government agencies				
Ic7	Other coordination? (specify)				

* Program Status Codes (Column B): P = planning only; D = in development but not operational; EO = early operational/not full to scale; FO = fully operational.

Name of Site:_____ Date: May 2001

I2. Do the notations in Column A accurately reflect your project activities? If not, please note changes on the table above and explain below in detail.

I3. Please describe your progress to date for each of the referral systems listed above. Please indicate whether this is a single system or multiple systems that are linked together.

I4. What barriers/challenges have you encountered in creating these systems as compared with your expectations?

I5. What factors have enabled or facilitated your system integration efforts?

I6. Have these activities changed how safety net providers operate and relate to each other? If so, please explain how.

I7. Have these activities changed how patients access and use the health care system? If so, please explain how.

Name of Site:_____ Date: May 2001

II. FINANCIAL AND ADMINISTRATIVE MANAGEMENT

Many CAP coalitions are seeking improved business practices and integrated financial systems to advance the financial health of safety net providers. If your coalition has activity in this area, please address the following items for the current reporting period.

II1. Please review and update the CAP activities (i.e., "outputs" in your logic model) identified for your project (Column A). For each component please provide:

- Column B: the appropriate status code (see footnote) that best describes the level of development or implementation of each program activity.
- Column C: counts of the number of units of services provided by the system (e.g., the number of member loans provided) during this reporting period. If you track more than one output for a given activity include each of them.
- Column D: specify the units of services given in Column C.

	II. Improvement of business practices and integration of financial systems:	A Program Status Code Last Period	B Updated Program Status Code *	C Patients served or services provided (#)	D Identify the TYPE of services referred to in Column C (e.g., patients, visits, referrals or appointments)
II1	Financial management and billing systems (including cost accounting and electronic billing systems)				
II2	MIS for financial information				
II3	Coalition member loans				
II4	Improve operations in other ways (specify)				
II5	Other program components (specify)				

* Program Status Codes (Column B): P = planning only; D = in development but not operational; EO = early operational/ not full to scale; FO = fully operational.

II2. Do the notations in Column A accurately reflect your project activities? If not, please note changes on the table above and explain below in detail.

II3. Please describe your progress to date in each of the program components listed above (i.e., mechanisms to improve the functioning and effectiveness of administrative and financial systems).

II4. What barriers have you encountered compared with your expectations?

II5. What factors have promoted or facilitated your efforts?

II6. Have these activities changed how safety net providers operate and relate to each other? If so, please explain how.

II7. Have these activities changed how patients access and use the health care system? If so, please explain how.

Name of Site:_____ Date: May 2001

III. INCREASE ENROLLMENT IN HEALTH COVERAGE

Many CAP coalitions are seeking improve coverage for low income and other vulnerable populations. If your coalition has activity in this area, please address the following items for the current reporting period.

III1. Please review and update the CAP activities (i.e., "outputs" in your logic model) identified for your project (Column A). For each component please provide:

- Column B: the appropriate status code (see footnote) that best describes the level of development or implementation of each program activity.
- Column C: the patients/clients enrolled as a direct result of CAP activities during this reporting period.

III. Increased enrollment in health insurance plans:	A Program Status Code Last Period	B Updated Program Status Code *	C # of clients enrolled as direct result of CAP activity
III1 Medicaid			
III2 SCHIP			
III3 Existing State and local coverage initiatives			
III4 Private coverage			
III5 New plan for the uninsured			
III6 Other? (specify)			

* Program Status Codes (Column A): P = planning only; D= in development but not operational; EO = early operational/not full to scale; FO = fully operational.

III2. Do the notations in Column A accurately reflect your project activities? If not, please note changes on the table above and explain below in detail.

III3. Please describe your progress to date in each of the program components listed above (i.e., mechanisms to enroll the uninsured in health insurance plans). In addition, please describe what mechanisms you are using.

III4. What barriers have you encountered compared with your expectations?

III5. What factors have facilitated your efforts?

III6. Have these activities changed how safety net providers operate and relate to each other? If so, please explain how.

III7. Have these activities changed how patients access and use the health care system? If so, please explain how.

Name of Site:_____ Date: May 2001

IV. EXPANSION OF THE DELIVERY SYSTEM

Many CAP coalitions are seeking to add new services, recruit new providers or reach out to new patient populations. If your coalition has activity in this area, please address the following items for the current reporting period.

IV1. Please review and update the CAP activities (i.e., "outputs" in your logic model) identified for your project (Column A). For each component please provide:

- Column B: the appropriate status code (see footnote) that best describes the level of development or implementation of each program activity.
- Columns C and D: check (X) whether you are adding *new providers* (e.g., who had not previously provided free/discounted services) and or adding *new/expanded services* through providers that already serve a safety net function during this reporting period. (Under outreach, provide the number (full-time equivalent) of outreach workers added.)
- Column E: the number of patients served under the CAP initiative during this reporting period.
- Column F: provide the number of services (e.g., exams or outreach events) provided during this reporting period.
- Column G: identify the type of services for the counts given in F, (e.g., dental exams or outreach events)

Name of Site:_____ Date: May 2001

IVa	**Expansion of delivery system -- New services or new providers:**	A Program Status Code Last Period	B Updated Program Status Code *	C Adding <u>providers</u> (X)	D Adding <u>services</u> w/existing providers (X)	E Number of patients served	F Number of services provided	G Identify TYPE of services referred to in Column F (e.g., visits)
IVa1	Pharmacy							
IVa2	Dental							
Iva3	Substance abuse/mental health							
IVa4	Social services							
IVa5	Ancillary services							
IVa6	Nurse information line/triage							
IVa7	Health navigation assistance/ outreach							
IVa8	Transportation							
IVa9	Eye care services							
IVa10	Expansion of primary care							
IVa11	Specialty care							
IVa12	Screening program							
IVa13	Changes to physical plant (new facilities or equipment)							
IVa14	Volunteer doctors							
IVa15	Tertiary care centers							
IVa16	Volunteer administrative staff							
IVa17	New urgent care site							
IVa18	Interpreters							
IVa19	New doctors who agree to accept public coverage							
IVa20	Eligibility workers							

Name of Site:_____ Date: May 2001

IVa	**Expansion of delivery system -- New services or new providers:**	A Program Status Code Last Period	B Updated Program Status Code *	C Adding <u>providers</u> (X)	D Adding <u>services</u> w/existing providers (X)	E Number of patients served	F Number of services provided	G Identify TYPE of services referred to in Column F (e.g., visits)
IVa21	Other new services or providers? (specify)							
IVb	**Expansion of delivery system – Outreach to new populations:**	A Program Status Code Last Period	B Updated Program Status Code *	C Number of outreach workers added	Not Applicable	E Number of patients served	F Number of services provided	G Identify TYPE of services referred to in Column F (e.g., outreach events)
IVb1	Working low income							
IVb2	Pregnant women							
IVb3	Native Americans							
Ivb4	Other racial/ethnic minorities							
IVb5	Immigrants							
IVb6	Former AFDC recipients							
IVb7	Homeless							
IVb8	Rural area residents							
IVb9	General outreach to other vulnerable populations							
IVb10	Other outreach to new populations? (specify populations)							

* Program Status Codes (Column A): P = planning only; D = in development but not operational; EO = early operational / not full to scale; FO = fully operational.

IV2. Do the notations in Column A accurately reflect your project activities? If not, please note changes on the table above and explain below in detail.

IV3. Please describe your progress to date in each of the program components listed above (i.e., structures to expand the volume of services available to the uninsured and other vulnerable populations).

IV4. What barriers have you encountered compared with your expectations?

IV5. What factors have facilitated your efforts?

IV6. Have these activities changed how safety net providers operate and relate to each other? If so, please explain how.

IV7. Have these activities changed how patients access and use the health care system? If so, please explain how.

Name of Site:_____ Date: May 2001

V. COMMUNITY/PATIENT EDUCATION

Many CAP coalitions are creating programs to educate the community and patients about health, insurance, health care utilization and other health related topics. If your coalition has activity in this area, please address the following items for the current reporting period.

V1. Please review and update the CAP activities (i.e., "outputs" in your logic model) identified for your project (Column A). For each component please provide:

- Column B: the appropriate status code (see footnote) that best describes the level of development or implementation of each program activity.
- Column C: the number individual patients, clients or community members who participated in each type of event/program (e.g., course registrants, web site "hits") during this reporting period.
- Column D: the estimated number of persons reached through community-level education efforts (e.g., media campaigns) during this reporting period.

	mplementation of community/patient education programs:	A Program Status Code Last Period	B Updated Program Status Code *	C # Individual program participants reached	D Estimated # reached through community education
V1	Self-care				
V2	Navigation of health care system				
V3	Healthy behaviors/ health promotion / wellness				
V4	Disease detection and prevention				
V5	Availability of public health insurance				
V6	Appropriate use of emergency room				
V7	Finding medical home				
V8	Other? (specify)				

* Program Status Codes (Column B): P = planning only; D = in development but not operational; EO = early operational/ not full to scale; FO = fully operational.

Name of Site:_____ Date: May 2001

V1. Do the notations in Column A accurately reflect your project activities? If not, please note changes on the table above and explain below in detail.

V2. Please describe your progress to date in each of the program components listed above (i.e., programs to educate the community and patients about health, insurance, health care utilization and other health related topics).

V3. What barriers have you encountered compared with your expectations?

V4. What factors have facilitated your efforts?

V5. Have these activities changed how safety net providers operate and relate to each other? If so, please explain how.

V6. Have these activities changed how patients access and use the health care system? If so, please explain how.

Name of Site:_____ Date: May 2001

VI. SERVICE IMPROVEMENT

Many CAP coalitions are seeking to create systems to improve the delivery of care to the uninsured and other vulnerable populations. If your coalition has activity in this area, please answer the following questions for the current reporting period.

Please review and update the CAP activities (i.e., "outputs" in your logic model) identified for your project (Column A). For each component please provide:

- Column B: the appropriate status code (see footnote) that best describes the level of development or implementation of each program activity.
- Columns C and D: the number of *patients* and *providers* participating in or affected by service improvement activities (e.g., staff cultural competency courses or customer service contacts) during this reporting period.
- Column E: Describe the nature of the activity provided and its target audience.

VI.	**Improvements in service delivery**	A Program Status Code Last Period	B Updated Program Status Code *	C Number of Patients participating or affected	D Number of Providers participating or affected	E Describe activity and who is participating or affected
VI1	Cultural competency					
VI2	Customer service					
VI3	Pharmacy robotics					
VI4	Provider education					
VI5	Re-engineering primary care delivery					
VI6	Re-engineering specialty/acute referral system					
VI7	Other? (specify)					

* Program Status Codes (Column B): P = planning only; D = in development but not operational; EO = early operational / not full to scale; FO = fully operational.

Name of Site:_____ Date: May 2001

Do the notations in Column A accurately reflect your project activities? If not, please note changes on the table above and explain below in detail.

Please describe your progress to date in each of the program components listed above (i.e., systems to improve the delivery of care to the uninsured and other vulnerable populations).

What barriers have you encountered compared with your expectations?

What factors have facilitated your efforts?

How have these activities changed how safety net providers operate and relate to each other?

How have these activities changed how patients access and use the health care system?

VII. POLICY CHANGE

Many CAP coalitions are seeking to develop information and communications strategies to support policy change. If your coalition has activity in this area, please answer the following questions for the current reporting period.

VII1. Please review and update the CAP activities (i.e., "outputs" in your logic model) identified for your project (Column A). For each component please provide:

- Column B: the appropriate status code (see footnote) that best describes the level of development or implementation of each program activity.
- Column C: the number of *coalition member organizations participating* in each activity
- Column D: the number of policy education events or activities participating in or affected by service improvement activities (e.g., staff cultural competency courses or customer service contacts) during this reporting period.
- Column E: the type of policy information event or activity.

VII Informing public policy:	A Program Status Code Last Period	B Updated Program Status Code *	C # Coalition member organizations participating	D # of policy education events or activities	E Type of activity for which counts given in D (e.g., public forums)
VIIa Increase salience of problems of the un- and under-insured and the role of the safety net					
VIIb Improve program data for use in policy decisions					
VIIc Other? (specify)					

* Program Status Codes (Column A): P = planning only; D = in development but not operational; EO = early operational / not full to scale; FO = fully operational.

VII2. Do the notations in Column A accurately reflect your project activities? If not, please note changes on the table above and explain below.

VII3. Please describe your progress to date in developing information and communications strategies to support policy change.

VII4. What barriers have you encountered?

VII5. What factors have facilitated your efforts?

VII6. Have these activities changed how safety net providers operate and relate to each other? If so, please explain how.

VII7. Have these activities changed how patients access and use the health care system? If so, please explain how.

Appendix B

HRSA Cap Grantee Names and Locations

Cohort I

Grantee City	Grantee Name	Geographic Location*
Austin TX	Daughters of Charity Health Services of Austin (ICC)	Both
Chicago IL	Gilead Outreach and Referral Center	Urban
Cincinnati OH	Cincinnati Health Network (Southwest OH Cap)	Both
Clarksdale MS	Aaron E. Henry Community Health Center	Rural
Detroit MI	St. John Health System	Urban
El Paso TX	Community Voices, Inc.	Both
El Rito NM	Sangre de Cristo Community Health Partnership	Both
Falls Church VA	Inova Health Care Services	Urban
Hazard KY	University of Kentucky Research Foundation	Rural
Los Angeles CA	County of Los Angeles (LA County of Health Services)	Both
Manhattan KS	Community Health Council	Rural
Memphis TN	Regional Medical Center at Memphis (Shelby Cnty Hlth)	Urban
Milwaukee WI	Milwaukee County Health Related Programs	Urban
Minneapolis MN	Hennepin County Medical Center (Comm Life Line)	Urban
New Orleans LA	Louisiana Public Health Institute	Urban
New York NY	New York City Health and Hospitals Corporation	Urban
Portland OR	Care Oregon (OCHIN)	Both
Raleigh NC	NC Department of Health and Human Services	Rural
Sitka AK	Southeast Alaska Regional Health Consortium	Rural
Tallahassee FL	Leon County Health Department	Both
Tucson AZ	El Rio Santa Cruz Neighborhood Health Center	Both
Wilmington DE	Delaware Health Care Commission	Both
Yarmouthport MA	Community Foundation of Cape Cod (Lighthouse)	Both

Cohort II

Grantee City	Grantee Name	Geographic Location
Albuquerque NM	First Choice Community Healthcare (Cap Central NM)	Both
Alexandria MN	Prime West Health System	Rural
Amherst NY	Research Foundation State University of NY	Both
Binghamton NY	Our Lady of Lourdes Memorial Hospital	Rural
Birmingham AL	Jefferson County Department of Health	Both
Bisbee AZ Part B	Bisbee Hospital Association (Cooper Queen)	Rural
Blossburg PA	Bradford/Tioga Housing Authorities	Rural
Boston MA	Boston Medical Center	Urban
Brooklyn NY	Lutheran Medical Center (Brooklyn Alliance)	Urban
Brooklyn NY _2	Brooklyn Alliance (President, Northern Brooklyn Healthcare)	Urban
Cambridge MA	Cambridge Public Health Commission	Urban
Chattanooga TN	Erlanger Medical Center	Both
Chicago IL	Hektoen Institute for Medical Research (Cook Cnty)	Urban

Columbia SC	Palmetto Health Alliance	Both
Concord NH	Bi-State Primary Care Association	Rural
Cranston RI	Rhode Island Health Center Association (CHC Enterprise)	Both
Denver CO	Denver Health and Hospital Authority	Urban
Ft. Lauderdale FL	Broward Regional Health Planning Council	Urban
Galveston TX	University of Texas Medical Branch	Both
Greenville SC	New Horizon Family Health Services	Both
Houston TX	Harris County Hospital District	Urban
Huntington WV	Valley Health Systems	Both
Indianapolis IN	Health and Hospital Corporation of Marion County	Urban
Kalamazoo MI	Healthy Futures	Both
Kansas City MO	Kansas City Care Network	Urban
Lansing MI	Ingham Health Plan Corporation	Urban
Lompoc CA	Lompac Valley Community Healthcare Organization	Rural
Martinez CA	Contra Costa County Health Services Department	Urban
Martinsburg WV	Shenandoah Valley Medical System	Rural
Medford OR	Health Care Coalition of Southern Oregon	Rural
Middletown CT	Middlesex Hospital	Urban
New York NY	The NY and Presbyterian Hospital (AmbCare Network)	Urban
Olympia WA	Choice Regional Health Network	Both
Orangeburg SC	Family Health Center	Rural
Philadelphia PA	Health Federation of Philadelphia	Urban
Pittsburgh PA	Coordinated Care Network	Urban
Portland ME	Maine Health (Care Partners)	Both
Prescott AZ	County of Yavapai	Rural
Rockville MD	Primary Care Coalition of Montgomery County	Urban
Salinas CA	Natividad Medical Center	Both
San Francisco CA	San Francisco Community Clinic Consortium	Urban
San Leandro CA	Alameda County Medical Center	Urban
San Mateo CA	San Mateo County Health Services Agency	Both
Spokane WA	HIP Spokane County (INIC)	Both
Springfield IL	Springfield and Sangamon County	Both
Talbott TN	Cherokee Health Systems (East Tennessee)	Both
Tarrytown NY	Westchester Prepaid Health Services Plan	Both
Tucson AZ	AZ Board of Regents – University of Arizona (CAPAZ)	Both
Uvalde TX	Community Health Development (Southwest Texas)	Both
Vallejo CA	Solano Coalition for Better Health	Urban
Warrenburg NY	Hudson Headwaters Health Network	Rural
Washington NC	Metropolitan Health Services	Rural
Wenatchee WA	Community Choice	Rural

* Both indicates grantee operates in both urban and rural locations

Appendix C

Specific Grantee Activities

The following table displays the number of grantees participating and the number in an operational stage for every activity covered in the monitoring questionnaire at the 12 month reporting period. The numbers are shown independently for each CAP cohort.

Grantees Participating and Operational for all Activities, by Cohort, at 12 months

	Cohort I		Cohort II	
Activity Name	# of Grantees Participating in Activity	# of Grantees Operational in Activity	# of Grantees Participating in Activity	# of Grantees Operational in Activity
Ia1. Standardized Appt. System	5	1	20	9
Ia2. Standardized Registration System	15	9	39	23
Ia3a. Specialty Care	11	7	37	23
Ia3b. Primary Care	9	8	38	24
Ia3c. Social Services	6	6	32	20
Ia3d. Mental Health/Sub. Abuse	7	5	34	17
Ia4. Patient Referral Phone Line	6	3	27	16
Ia5. Community Resource Databank	9	7	30	17
Ia6. Create Medical Home	12	9	41	28
Ia7. Other Administrative System	5	3	19	17
Ib1. Standardized Medical Record	5	2	9	4
Ib2. Shared Electronic Medical Record	7	1	13	4
Ib3. Info. System/ Data Standardization	18	10	45	22
Ib4. Patient Smart Card	2	1	8	1
Ib5. Clinical Protocols	12	5	37	16

Ib6. Uniform Quality Measures	10	5	37	16
Ib7. Other Sharing of Patient Information	8	3	28	10
Ib8. Master Patient Index/Data Repository	7	2	36	13
Ib9. Other Info. Sharing	3	1	9	6
Ic1. Case Management	13	9	37	22
Ic2. ER/PCP Coordination	10	5	36	16
Ic3. PCP/Specialist Coordination	12	8	40	25
Ic4. Coordination with Mental Health Sys.	9	7	35	17
Ic5. Public Clinic/ Provider Coordination	16	11	44	29
Ic6. Coordination with Govt. Agencies	11	8	39	23
Ic7. Other Coordination	1	0	19	13
II1. Financial Mgmt. And Billing Systems	8	5	10	4
II2. MIS for Financial Information	6	4	17	7
II3. Coalition Member Loans	1	0	1	1
II4. Other Operations Improvements	4	2	10	4
II5. Other Program Components	2	1	11	8
III1. Medicaid Enrollment	18	13	43	30
III2. SCHIP Enrollment	17	14	36	25
III3. Existing State and Local Coverage	7	5	35	23
III4. Private Coverage	4	3	18	8
III5. New Plan for the Uninsured	7	3	24	6
III6. Other Enrollment Efforts	6	5	16	12

Iva1. Pharmacy	10	6	28	13
Iva2. Dental	5	3	15	8
Iva3. Sub. Abuse/ Mental Health	5	3	26	13
Iva4. Social Services	4	3	23	10
Iva5. Ancillary Services	3	2	14	8
Iva6. Nurse Information/Triage	8	6	14	6
Iva7. Health Navigation assistance	13	12	35	23
Iva8. Transportation	5	4	15	8
Iva9. Eye Care Services	5	2	9	4
Iva10. Expansion of Primary Care	10	5	25	11
Iva11. Specialty Care	8	3	25	13
Iva12. Screening Program	4	4	18	8
Iva13. Changes to Physical Plant	3	2	14	6
Iva14. Volunteer Doctors	9	6	16	9
Iva15. Tertiary Care	2	2	6	3
Iva16. Volunteer Administrative Staff	2	2	3	0
Iva17. New Urgent Care Site	1	1	3	0
Iva18. Interpreters	5	4	16	7
Iva19. New Doctors Accepting Pub. Cov.	3	2	14	2
Iva20. Eligibility Workers	5	4	27	17
Iva21. New or Expanded Clinics	3	2	17	7
Iva22. Other New Services or Providers	2	1	13	12
Ivb1. Working Low-Income	7	5	38	29

Ivb2. Pregnant Women	4	2	26	15
Ivb3. Native Americans	5	4	12	4
Ivb4. Other Racial/ Ethnic Minorities	7	4	26	16
Ivb5. Immigrants	6	4	22	13
Ivb6. Former AFDC Recipients	4	2	20	10
Ivb7. Homeless	5	3	16	7
Ivb8. Rural Area Residents	3	2	22	14
Ivb9. General Outreach to Others	3	2	36	20
Ivb10. Other Outreach to New Populations	1	1	8	5
V1. Self-care	9	6	27	18
V2. Navigation Education	17	15	37	24
V3. Healthy Behaviors Education	13	8	36	24
V4. Disease Detection and Prevention	7	4	33	18
V5. Availability of Pub. Health Insurance	12	11	32	23
V6. Appropriate Use of the ER	9	5	33	17
V7. Finding Medical Home	9	8	34	22
V8. Other Education	2	2	10	7
VI1. Cultural Competency	6	2	29	12
VI2. Customer Service	4	3	35	16
VI3. Pharmacy Robotics	1	1	4	1
VI4. Provider Education	7	5	33	18
VI5. Re-engineering Primary Care Delivery	7	4	16	7

VI6. Re-engineering Spec./Acute Ref. Sys.	3	2	12	3
VI7. Other Service Improvements	0	0	11	5
VIIa. Inform Policy	14	8	37	24
VIIb. Improve Program Data	13	7	40	17
VIIc. Other Policy Change	1	1	13	9

Glossary of Terms

Standardized appointment system - Uniform system for patient appointments used by two or more CAP member organizations.

Standardized registration/ screening for program enrollment - Uniform recording of all patient scheduling /detailed criteria required to be met for program enrollment by CAP organizations.

Referral System – A formal process whereby a patient is referred to another physician, provider or a healthcare facility within the community network.

Specialty Care – An individual or set of providers who specialize(s) in one clinical area.

Primary Care – An individual or group who provide routine care, examinations and preventative services and within a network serve to coordinate all care.

Social Services – Non-clinical services that are supportive in nature, focused on the advancement of human welfare.

Mental Health/ Substance Abuse – An individual or set of providers who offer clinical, mental health or addiction services for the psychologically distressed and emotionally disordered.

Patient Telephone line for referrals – Telephone line established solely for the purposes of supporting a patient referral network.

Community Resource Databank - Databank of health resource information for those within a specific community to identify available health care and social service resources in the community.

Create medical home for uninsured/assign PCP – The assignment of a primary care provider to an uninsured individual to case manage or oversee the provision of all health care services and provide consistent contact for service delivery.

Standardized medical record - Uniform record fields across systems and/or service providers within the CAP initiative.

Shared electronic medical record – Privileged access to one electronic medical record by multiple users within the CAP program.

Management Information System for patient tracking/utilization management – Management Information System (e.g., a collection of computer programs designed to present and report) that tracks patient access to and utilization of medical services.

Patient Smart Card – Patient identification card entitling the bearer to care within a health care system and allowing for the tracking of all services.

Clinical protocols and disease management – Guidelines for clinical practice and specified conduct in handling all stages of disease.

Uniform quality measures – Standardized measurement for determining quality of patient care and/or services rendered.

Uniform data standards - Data that adheres to a set of characteristics as determined by specific practice standards.

Master patient index/data repository – A complete system database that indexes physician and patient data from a master file that is stored in a central location.

Shared patient info - Patient information that is shared among providers and others with approved access.

Case management - Management of health care and social service needs of a patient throughout an integrated care system by a single provider.

ER/PCP coordination - Emergency Room and primary care provider coordination to properly case manage patient care and eliminate unnecessary emergency admissions and department utilization.

PCP/specialist coordination – Coordination of care and sharing of information between a primary care provider and specialists within the CAP program.

Coordination with mental health system – Coordination of care and sharing of information between the health and mental health system.

Coordination between public clinics and other providers – Organization of care network that includes public providers (e.g. , FQHC's) as well as other providers of service within a community.

Coordination with government agencies – Interaction within a health system among providers of service including governmental agencies.

Financial management and billing systems - (including cost accounting and electronic billing systems) - Management of financial costs in the system as well as automation and integration of the billing system.

MIS for financial information – Use of a management information system for patient payor data and other relevant cost data.

Member loans - Structured borrowing for CAP coalition members.

Medicaid – A federal insurance program for eligible low income/ poor population.

SCHIP – State Child Health Insurance Program – State program structured to provide health insurance coverage for children not covered under Medicaid or other insurance vehicles.

Existing state and local coverage initiatives – Pre-existing state and local insurance programs prior to CAP demonstration funding.

Private coverage – Health insurance coverage from a private third-party carrier.

New plan for the uninsured – Health insurance coverage plan that is newly structured to cover the targeted uninsured population.

Pharmacy - Location for dispensing prescription medications that can exist independently or in a hospital or clinic setting.

Dental – Medical service that focuses on teeth and gums.

Substance abuse/mental health – Services that address excessive use of harmful and addictive substances as well as psychological distress and mental disorders.

Ancillary services – Support services that are complementary to clinical services (e.g., laboratory, imaging).

Nurse information line/ triage – Specific information line provided for patients to call into nurses for medical information and assistance. Information provided by the patient also allows for the proper staging of cases according to severity.

Health navigator assistance/ outreach - Lay health advisor who provides outreach into the community to help patients access care and navigate through the health care system.

Transportation - Provision of a system of conveyance for patients.

Eyecare services – Service system that encompasses all care to eyes.

Screening program – Assessment of whether certain conditions exist within a patient that if present, require additional medical intervention or testing.

Volunteer doctors - Physicians who donate their services for a new system.

Tertiary care centers – Centers of care that provide tertiary (specialized) care.

Volunteer administrative staff - Office staff that donates their time to the system.

New urgent care site – Free standing site that provides certain levels of emergency care.

Interpreters – Individuals who translate or decipher information from one language form to another.

Eligibility workers – A cadre of employees who determine through the use of specified guidelines, whether an individual is qualified to receive certain benefits and/or services.

New clinic- New location for the provision of medical care services.

Working low income – Working population that is unable to afford health insurance coverage.

Racial/ethnic minorities – Hispanics, African-Americans, Chinese, Native Americans, etc. – considered non-dominant cultures.

Immigrants – Individuals from another country who are considered non-natives.

Former AFDC recipients – Those individuals previously eligible to receive Aid for Families with Dependent Children.

Homeless – Individuals who lack housing.

Self-care – Program that teaches individuals how to properly care for themselves.

Navigation of the health care system – Program to facilitate the proper maneuvering and guidance of patients through the health care system.

Healthy behaviors/health promotion – Education of patients to establish healthy lifestyles and behavior patterns to promote wellness and ward off disease.

Disease detection and prevention – Education program for the early identification of illness and ways to prohibit sickness.

Cultural competency - Sensitivity to and respect for individuals' culture and belief systems.

Customer service –Special attention is paid to consumer needs and concerns.

Pharmacy robotics - Use of an automated system for drug dispensing.

Provider education - Training for medical staff and other professionals in the system of care.

Re-engineering primary care delivery system - System improvement of routine care provision through restructuring.

Education of opinion leaders - Instruction of policy makers about Community Access Program project issues (e.g., access, coverage, and the solvency of the safety net).

Improve use of program data for use in policy decisions – Cultivation of increased use of program information packaged in a meaningful way and disseminated in a timely fashion to policy makers for ongoing decision-making.

Appendix D

Factor Analysis

Factor Analysis

The research team chose factor analysis as a method to reveal patterns in grantee activity across the logic model areas. For this analysis, data from all 76 grantees at their 12 month reporting period (T2) was used. We were most interested in understanding patterns between activities in which large numbers of grantees were working. Therefore, those variables where fifty percent or more of grantees in both cohorts were active, were entered into principal components factor analysis. Two variables that met the criteria in the Informing Public Policy logic model area were excluded due to inaccuracies in the data. Thirteen other variables met the inclusion criteria and were used in the analysis.

The principal components analysis resulted in a four factor solution using the Kaiser criterion. The table below shows the factor loadings for the solution with the variables in each factor indicated by bold typeface. (Note: in the main report text the factors are referred to as "Clusters")

Factor Analysis: Fifty Percent Participation Variables

	Standardization Factor 1	Enrollment Factor 2	Coordination Factor 3	Education/Case Management Factor 4
Healthy Behaviors Education	**.835**	.113	-.168	.264
Clinical Protocols/ Disease Mngmt.	**.735**	.147	.050	.122
Health Navigation Assistance	**.608**	-.394	-.001	-.051
Standardized Registration Sys.	**.542**	-.094	.193	-.182
Info. System/ Data Standardization	**.515**	-.069	.324	-.304

SCHIP Enrollment	.029	**-.897**	.085	.039
PCP/Specialist Coordination	-.056	.092	**.809**	.031
Public Clinic/ Provider Coord.	.091	-.029	**.803**	.037
Create Medical Home	.099	-.367	**.622**	.113
Case Management	-.001	.141	.421	**.696**
Availability of Insurance Educ.	.090	-.443	-.110	**.581**
Navigation Education	.375	-.241	-.035	**.561**
Percent of Variance	33.0	14.3	10.2	8.0

Extraction Method: Principal Component Analysis. Rotation Method: Oblimin with Kaiser Normalization.

Factor 1 contains five variables from the service integration, community and patient education, and expansion categories. Several of these variables have to do with standardizing systems and procedures (info. system/data standardization, standardized registration system, clinical protocols and disease management) and the remaining two involve assisting patients (healthy behaviors education and health navigation assistance). Because of the focus on creating standards in this factor, we have labeled it Standardization.

The activities in Factor 2 (labeled Enrollment) are both in the increase enrollment in insurance plans area. The coefficients for this factor are negative which indicates an inverse relationship with the other positive loading factors. Grantees with high factor scores on Enrollment are likely to have low scores on the other factors, pointing to strong progress and focus on enrollment to the exclusion of other activities.

All three variables in Factor 3 (Coordination) are in service integration, two focused on coordination and one on creating a medical home for the uninsured. Grantees with high scores for this factor are concentrating on fostering consistent and integrated care for underserved populations. Factor 4 (Education/Case Management) combines variables from the community and patient education and service integration areas. Grantees who are more operational in educating patients on the availability of insurance and on how to navigate the healthcare system, are also highly operational in case management activities.

Regression Analysis

An adjusted summary score was calculated for use as the dependent variable in our regression model. First an unadjusted score was assigned to each grantee based on their program status codes for the fifteen variables where fifty percent or more of grantees in both cohorts were active. The status codes were simply added up across these variables at T2. These scores were then adjusted for the proportion of grantees (a) operational and (b) active across those variables where, Adjusted score = (a/b)*unadjusted score. All the predictor variables were recoded into dummy variables and entered into a regression model as independent variables with the adjusted summary score as the dependent variable. The results of the model are presented in the table below.

Coefficients(a)

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	32.967	16.792		1.963	.057
	LOCURBAN	-1.674	6.818	-.056	-.245	.807
	LOCBOTH	-7.098	6.898	-.247	-1.029	.310
	VSMALL	-22.023	9.633	-.609	-2.286	.028
	SMALL	-18.142	8.667	-.577	-2.093	.043
	MEDIUM	-15.100	9.235	-.470	-1.635	.111
	LARGE	-10.558	11.001	-.253	-.960	.343
	FUND1	4.963	11.127	.154	.446	.658
	FUND2	5.716	10.825	.182	.528	.601
	FUND3	-.838	10.239	-.028	-.082	.935
	HOSPITAL	6.490	9.530	.197	.681	.500
	PROVIDER	-1.847	8.779	-.062	-.210	.835
	GOVT	3.855	9.661	.102	.399	.692
	NONPROF	2.042	11.182	.049	.183	.856

a Dependent Variable: ADJSCORE