Nongovernmental Program Replication and Implementation: What Can Community-Based Programs to Support the Uninsured Learn from Other Communities?

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NONGOVERNMENTAL PROGRAM REPLICATION AND IMPLEMENTATION:
WHAT CAN COMMUNITY-BASED PROGRAMS TO SUPPORT
THE UNINSURED LEARN FROM OTHER COMMUNITIES?

by

Raymond J. Higbea

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
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Dr. James A. Visser, Advisor

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I would like to thank Patricia Dalton, the Grand Rapids Project Access Board of Directors, and Project Access staff for their willingness to allow me to evaluate their program and their provision of the information and resources necessary to complete such a task.

Second, I would like to thank Matthew Mingus, Ph.D., for guiding me through the conceptual phase of this research study. I would also like to thank James Visser, Ph.D., for guiding me through this process as my dissertation committee chair; Amy Curtis, Ph.D., for her assistance with the quantitative portion of this research study; and Victoria Ross, Ph.D., for her assistance with the qualitative portion of the study and with some general writing tips.

Third, I would like to thank my wife Linda and our new son Matthew for giving me the gift of time necessary to complete a project such as this.

Raymond J. Higbea
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CHAPTER I

INTRODUCTION

Background and History

The topic of this research study is the replication, implementation, and evaluation of the first year of operations (April 2005 to March 2006) of Project Access in Grand Rapids, Michigan. Project Access is a nongovernmental, structured program sponsored by the Grand Rapids Medical Society and Osteopathic Association whose mission, in this program, is to increase access to physician and health care services by the working-poor. Qualifying criteria for Project Access include: (1) an individual or family whose income is at or below 150% of the federal poverty level, and (2) no access to governmental or private health insurance. Based upon U.S. Census Bureau data (2004) and analysis of these data by DeNavas-Walt, Procter, and Mills (2004), there are approximately 70,000 uninsured individuals in Grand Rapids with approximately 55,000 of them at or below 150% of the national poverty level.

Currently, Grand Rapids has 15 physician-based charity care clinics providing primary care for the uninsured working-poor. Kent Health Plan is the primary source of physician and health care services for the uninsured working-poor and in 2004 provided various levels of care for approximately
10% of this population (Kent Health Plan, 2004). The Kent Health Plan is a cooperative health plan funded by the Grand Rapids hospitals through the disproportionate share funds they receive from the federal government. Part A of the Kent Health Plan provides physician and health care services for low income and governmentally insured individuals and families, and Part B provides physician and health care services for the uninsured working-poor. However, due to limited funding, Kent Health Part B annually reaches maximum capacity with approximately 6,000 enrollees, thus leaving approximately 49,000 individuals without access to physician or health care services (Kent Health Plan, 2004). Project Access is an attempt by the Grand Rapids Medical Society and Osteopathic Association to remedy this situation through the donation of services by Kent County physicians and hospitals in a joint effort to eliminate the physician and health care gap that Kent Health Plan Part B is unable to fulfill.

This research study will evaluate (1) whether or not Project Access was successful in increasing access to physician and health care services of the uninsured working-poor, (2) whether or not increased access to physician and health care services has resulted in an improvement in lifestyle function by this population, (3) how much this population is able or willing to pay for physician and health care services similar to those received through Project Access, (4) the implementation process followed by Project Access in Grand Rapids, Michigan, and (5) the implementation and
replication barriers addressed during the implementation process. The above evaluation questions are answered through the following three research questions:

• Has Project Assess increased access to physician and health care for the Grand Rapids working-poor not covered by Kent Health Plan Part B?

• What replication barriers did Grand Rapids Project Access program staff encounter and how were they addressed?

• What implementation barriers did Grand Rapids Project Access program staff encounter and how were they addressed?

These research questions are addressed by the use of quantitative and qualitative research methods. The quantitative method used in this study is a self-administered, mailed survey of Project Access enrollees. The qualitative methods include (1) a document review of implementation documents such as board minutes, budgets, and an implementation timeline; (2) focus groups and telephone interviews of participating physician office managers; and (3) interview of the Project Access administrative director. For comparative purposes, the administrative directors of the Project Access programs in Salt Lake City, Utah, and Buncombe County, North Carolina, were interviewed regarding how their programs were implemented, the implementation barriers they encountered, and how these barriers were addressed. The consultant to
the Grand Rapids program was also interviewed in order to provide an additional view of how the Grand Rapids program was replicated and implemented.

Definitions

This study defines the uninsured working-poor as any individual or family (1) without some type of governmental or private health insurance including Medicaid, and (2) with an annual income less than 150% of the federal poverty level. Throughout this study, physician care is defined as any care provided by a physician or physician extender (i.e., Physician Assistant or Nurse Practitioner), regardless of the physical setting, and health care is defined as all other types of health care, e.g., hospital visits, laboratory, or radiology exams. Finally, charity care is defined as care provided without monetary cost to the patient and without remuneration to the provider.

Stakeholders

Project Access has five major stakeholders: the uninsured working-poor, small businesses, physicians, hospitals, and Project Access staff. Each of these stakeholders is interested in the achievement of two operational objectives: (1) increased access to physician and health care services, and (2) improved health of the uninsured working-poor. A goal for the uninsured working-poor is increased access to physician and health care
services, improved health, and increased lifestyle productivity (e.g., self-care, work, or recreation). Small businesses are the primary employers of this population and have the goal of increased health and productivity from the working-poor due to their being healthier and requiring fewer days off for health care reasons (Michigan Department of Community Health, 2001, 2003). Physicians involved in charity care often do so privately and without recognition of their contribution by the community; Project Access will provide a means of quantifying and recognizing this contribution to the community by Kent County physicians. Historically, physicians have provided 4.4 hours per week of undocumented charity care to the working-poor; Project Access will quantify their charitable efforts, remove the burden of being “the only one providing charity care,” and demonstrate their commitment to the community (Fairbrother, Gusmano, Park, & Scheinmann, 2003; Kane, 2002). Hospitals have the goal of ensuring that individuals are cared for in the appropriate setting, thus decreasing their annual expenditures on charity care. Hospitals will decrease charity care expenditures by getting the working-poor into the appropriate care venue sooner, resulting in less expensive care and unclogging primary access venues such as Emergency Departments (ER) (Healthcare Access and Affordability, 2003; "Hospitals Share Insights...," 2005). Finally, the Project Access staff has a vested interest in the success of this program due to their
personal and professional involvement in developing, implementing, and administering the program.

Grand Rapids Health Care Political Circumstances and Assumptions

The political circumstances involve two distinct groups: physicians and hospitals. Physicians, as a group, historically provide charity care to patients they know or those referred to them by a colleague; this has historically taken the form of a private, nonquantifiable network (Fairbrother et al., 2003). The private nature of this network has its basis in these cases affecting both personal healthcare and personal finances—both areas most individuals consider as very private. Project Access has sought to remedy these political concerns of becoming known as the “charity care doctor” by tracking and quantifying the number of charity cases each physician cares for and by assigning each physician only the number of charity cases agreed to upon enrollment as a Project Access provider.

The second political consideration comes from the area hospitals that all provide charity care at varying levels and have concerns about Project Access “taking away their patients.” This concern about patient allocation is addressed by the Project Access staff assigning Project Access enrollees to physicians associated with specific hospitals as indicated by who referred the enrollee to Project Access.
The medical community has a long history of helping the disadvantaged; thus, an underlying assumption here is that the Grand Rapids physicians and hospitals desire to provide care to the disadvantaged. Their desire to provide charity care is confounded by the free market nature of the business of healthcare. Since the free market system, as applied to physician and hospital practice, is volume- and intensity-driven, any subtraction from this model by charity care yields a decrease in revenue. Therefore, when physicians or hospitals provide charity care, the level or amount of care they provide may be constrained by the revenue requirements of their office or the hospital. Project Access addresses this concern by assigning only the number of enrollees to a physician during a year that the physician agreed to upon enrollment as a Project Access as a provider.
CHAPTER II

LITERATURE REVIEW

Introduction

This research study is an evaluation of the implementation and replication of Project Access, a national program designed to provide access to physician and health care services to the uninsured working-poor, in Grand Rapids, Michigan. Several areas of literature were reviewed in order to provide appropriate background and perspective to this study. The first area reviewed describes the characteristics most frequently associated with the uninsured from a national and then Michigan perspective. The second area describes why access to health care services is necessary, how access to health care services affects work productivity and lifestyle satisfaction, and barriers encountered (i.e., financial and racial) by the uninsured seeking access to health care services. The third area discusses proposed solutions for increased access to health care services from a federal, state, and local perspective. This area concludes with a discussion of how Project Access originated and has been evaluated in other communities throughout the nation. The final section provides a review of the theoretical literature (i.e., social exchange, replication, implementation, and evaluation) that provides the theoretical basis for this research and evaluation study.
National Characteristics of the Uninsured

Since 1987, the percentage of uninsured in the United States has ranged from a low of approximately 13% to a high of 16%. Currently, 15.7% of the population or 45,800,000 individuals are uninsured. Throughout the literature, the uninsured are defined as anyone who has been uninsured for a period of 1-month during a 12-month period. While the number of uninsured given at one point in time throughout the year is 45 million, the longitudinal number of those uninsured for at least 1 month throughout a 12-month period is closer to 60 to 80 million. The longitudinal number is larger due to the transient nature of one half to two thirds of this population who are uninsured due to job loss and re-employed within 6 months or less. In contrast, the number of chronically uninsured is approximately 15 million at one point in time and 20 to 23 million longitudinally (Bohm, Rafferty, & McGee, 2003; Cohen & Coriaty-Nelson, 2004; McLaughlin, 2004; MDCH, 2001, 2003; Mills & Rhandari, 2003; University of Michigan, 2002).

Problems of the Transitional Group

Several descriptive analyses of U.S. Census data have found that the transitional group of uninsured are characteristically greater than 35 years of age, non-Hispanic, U.S. citizens, greater than high school education, married with children, earn greater than $35,000 per year, work for a firm with greater than 100 employees, and are out of the workforce for less than
6 months due to job loss (Cohen & Coriaty-Nelson, 2004; MDCH 2001, 2003; Mills & Rhandari, 2003). Fairbrother et al. (2003) performed an analysis of surveys mailed to internal medicine physicians that asked if they accepted uninsured patients, how many hours per week they provided charity care, and where they provided the charity care. This study found the transitional uninsured often already have an established a relationship with a primary care physician who will normally work with them by discounting their bill, setting up some type of payment plan, or providing them with free care. Unfortunately, a decision most of the uninsured make is to forego diagnostic treatment, follow-up care, or medications due to their inability to pay for these services. This only exacerbates most medical conditions and makes them more difficult and expensive to treat in the future. When they seek treatment, they are often not able to pay for it until they return to regular work. These additional medical costs only compound an already challenging financial situation. The Consolidated Omnibus Budget Reduction Act of 1985 (COBRA) provides terminated employees the opportunity of purchasing the same health insurance provided by their former employer for up to 18 months. While this population has access to COBRA, it is an option exercised by only about one third of this population due to cost constraints. The other option is to purchase a personal health insurance policy, but this also is of limited value due to cost (Kapur & Marquis, 2003).
Problems of the Long-term Group

Several descriptive analyses of the U.S. Census data have found that the long-term uninsured are characteristically 18 to 34 years of age, non-U.S. citizens (approximately half of the group), Hispanic, high school education or less, single and without children, earn less than $35,000 per year, and work for a firm with less than 100 employees or are self-employed. As a group, they have not established a relationship with a primary care physician and receive their primary care through some type of community-based clinic or the emergency room. They experience the same challenges accessing diagnostic treatments, pharmaceuticals, hospitalization, or specialized physician care as the transitional group but to a greater magnitude due to their lower income level and diminished prospects of long-term health insurance coverage (Cohen & Coraity-Nelson, 2004; MDCH 2001, 2003; Mills & Rhandari, 2003). The Emergency Room (ER) has anecdotally been considered the venue of care for the uninsured; however, McLaughlin and Mortensen (2003) state:

In general we think of the ED (Emergency Department) as a source of care for people without financial access to private physicians’ offices and hospital outpatient departments, poor and near-poor adults ages 18-64 with insurance actually have 30-50 percent higher ED use rates than those without coverage. (p. 150)

Earlier in the same analysis of Medical Expenditure Panel Survey (MEPS) data, McLaughlin and Mortensen (2003) note that the ER usage rate by the uninsured is proportional to the rate of those uninsured in the general
population. Descriptive analysis of U.S. Census data by Daly, Oblak, Seifert, and Schellenberger (2002), DeNavas-Walt et al. (2004), and Mills and Rhandari (2003) found the cost of care to be an inhibiting factor for the chronically uninsured, who, when faced with the need for medical care, often need more expensive care due to their lack of preventive care. There are some in this group who are offered health insurance by their employers but turn it down due to its high personal cost. The other option this group can exercise is the purchase of a personal health insurance policy that is normally cost prohibitive for them.

How Michigan Uninsured Compare to the Nation

From 2000 to 2002, Michigan's percentage of uninsured and the gap between Michigan and the national rate remains essentially unchanged. The percent of employment-based health insurance over these same time periods has increased for both Michigan and the nation (Table 1) (MDCH 2001, 2003).

The percentage of Michigan residents who have employment-based health insurance (Figure 1) has increased, continues to exceed the national percentages, is directly related to the high level of employment-based health insurance, and is attributed with providing Michigan residents with relatively stable health insurance and health care access. However, due to Michigan's historically strong industrial base and loss of manufacturing jobs over the
Table 1

Michigan and National Uninsured and Employment-based Insurance

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured &lt; 65 year age</td>
<td>13.5%</td>
<td>18.1%</td>
<td>11.7%</td>
<td>16.8%</td>
</tr>
<tr>
<td>Employment-based health insurance</td>
<td>70.7%</td>
<td>65.0%</td>
<td>73.5%</td>
<td>66.1%</td>
</tr>
</tbody>
</table>

Source: Michigan Department of Community Health from CPS Data Files, Employee Benefit Research Institute


recent years, it is likely that the Michigan rate of employer-based health insurance will decrease, thereby widening the gap between Michigan and national insured rates.

With the exception of an increase of the number and percentage of young Hispanics, the profile of the uninsured in Michigan has shown
marginal improvement from 2000 to 2002 and continues to be less severe than the national profile (Table 2). Michigan's high rate of employment-based health insurance is directly related to its low uninsured rate (MDCH 2001, 2003).

Table 2

**Michigan and Nation Uninsured Profile**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>23.1%</td>
<td>36.0%</td>
<td>29.4%</td>
<td>34.9%</td>
</tr>
<tr>
<td>Poor or Working-Poor</td>
<td>26.1%</td>
<td>32.8%</td>
<td>23.6%</td>
<td>30.9%</td>
</tr>
<tr>
<td>Less than College</td>
<td>16.3%</td>
<td>22.8%</td>
<td>14.9%</td>
<td>21.6%</td>
</tr>
<tr>
<td>Single</td>
<td>20.3%</td>
<td>25.6%</td>
<td>18.4%</td>
<td>23.8%</td>
</tr>
<tr>
<td>Work Part-time</td>
<td>19.1%</td>
<td>23.1%</td>
<td>21.8%</td>
<td>26.5%</td>
</tr>
<tr>
<td>Work for Firm of &lt; 100</td>
<td>20.2%</td>
<td>27.4%</td>
<td>16.7%</td>
<td>24.9%</td>
</tr>
<tr>
<td>Self-employed</td>
<td>24.4%</td>
<td>24.7%</td>
<td>16.6%</td>
<td>22.0%</td>
</tr>
</tbody>
</table>

Source: Michigan Department of Community Health from CPS Data Files, Employee Benefit Research Institute

The Necessity of Health Care Access and Health Insurance Coverage

Those who have health insurance coverage are more likely to seek preventive care and follow through on prescribed treatments, i.e., diagnostic procedures, pharmaceuticals, specialist physician care, and hospital care.
The importance of preventive and follow-up treatments are directly related to decreased morbidity and mortality, increased worker productivity, increased family stability, and decreased societal cost of medical care (Daly et al., 2002; Fairbrother et al., 2003; Gusmano, Faribrother, & Park, 2002; Hadley & Holahan, 2003; Mainous, Hueston, Love, & Garifith, 1999; Proser, 2004; Sudano, 2003). Individuals who do not engage in preventative treatment behaviors or chronic treatment regimens live shorter lives and are more expensive to care for due to their chronic medical problems exacerbating into acute medical problems that are difficult and expensive to treat (Daly et al., 2002; Fairbrother et al., 2003; Gusmano et al., 2002; Hadley & Holahan, 2003; Mainous et al., 1999; Proser, 2004; Sudano, 2003).

Researchers have studied why the uninsured fail to seek preventative and follow-up treatments from several viewpoints, using several research methods. In 2003, Fairbrother et al. mailed a survey to internal medicine physicians and analyzed using a chi-square technique, "to determine statistical significance of differences in proportions." These physicians reported that patient's inability to pay for office visits was the main reason patients gave for failing to return for follow-up care. This survey also found that patients who were unable to pay for office visits were also unable to secure laboratory or other diagnostic tests (90%) and unable to secure pharmaceuticals (75%). Additional findings in this study indicated that 35%
of the internists provided free care to these patients with the remaining 65% providing care with some type of deferred payment.

Community Health Center (CHC) administrators from 10 states were interviewed by Gusmano et al. (2002) and asked “about the center’s size, organization, and policies toward the uninsured and ... the center’s ability to arrange referrals and ... additional care from specialists.” Forty-three percent of the patients seen in CHCs are uninsured and, while no payment for services is required, a sliding payment scale is available for those with some means to pay. The CHC administrative staff and physicians were successful securing secondary physician and medical care through their professional networks only 30% of the time. While no percentage was indicated, the CHC staff’s inability to secure pharmaceuticals for patients was listed as a major barrier to adherence to prescribed medical regimens. Proser (2004) used descriptive statistics to describe the patient types and volumes seen by CHCs. He notes a 68.5% increase in the volume of patients seen by CHCs nationally from 1998 to 2004 and indicates that CHCs are successful in providing primary, preventative, and chronic disease management; however, he does not indicate if or how CHCs provide for pharmaceutical, laboratory and diagnostic tests, and the need for specialist care.

Sudano (2003) performed a logistic regression analysis on longitudinal data collected from the National Health and Retirement Study.
for the years 1992, 1994, and 1996. These studies had 9,824 respondents aged between 51 and 61 years and demonstrated that 40% of the respondents were without health insurance at some period during the study periods. The study tested the use of five preventative services (mammography, cholesterol test, influenza vaccine, prostrate examination, and breast examination) during the study period and found the uninsured population had a usage rate that was approximately 20% lower than a similar insured group. These studies indicated that all uninsured individuals have access to some level of primary physician care, but virtually all lack access to pharmaceuticals and diagnostic or secondary health care services. The primary reason indicated for patients' lack of access to care is their inability to pay for the services out-of-pocket.

Financial Barriers to Health Care

Becker (2004) interviewed 176 uninsured African Americans and Latinos and found that, as a group, they avoided accessing the health care system due to cost. Another study that analyzed secondary data corroborates with Becker's results and found that due to their avoidance of the health care system, the uninsured are often more sick than if they had sought care earlier, thus requiring more expensive care. This leads to a quickly deteriorating financial situation that often leads to medical bankruptcy (Daly et al., 2002). Himmelstein, Warren, Thorne, and
Woolhandler (2005) found, through an analysis of questionnaires and telephone surveys, that medical expenses were the leading cause of bankruptcy in the United States. This survey also found that 75.7% of the respondents had health insurance at the onset of their illness and that 42% had a lapse of health insurance coverage sometime during their bankruptcy saga.

Racial Barriers to Health Care

Seidler (2001) examined national health care data for the years 1977, 1987, and 1996 using logistic regression and ordinary least squares regression and found that African Americans were less likely to pursue health care than whites. The African Americans deselected themselves from the system due to perceived racial discrimination by the system. Bass (2003) performed probit and logit regressions on U.S. Census data from 1996 and 2000 and determined that immigrants were 10% less likely to have health insurance than their U.S. born counterparts. Bohm et al. (2003) performed a descriptive analysis of U.S. Census data and found that Hispanics are overtaking African Americans as the minority with the largest percentage of uninsured. Finally, Becker's (2004) interviews with African Americans and Hispanics also found that, in addition to cost barriers, they avoid the health care system due to perceived racial and financial discrimination.
Proposed Solutions to Lack of Access to Healthcare Services and Health Insurance

Based upon the solutions proposed by a number of researchers and scholars, most Americans desire a health insurance system similar to our current system with some minor variations and increased federal financial, statutory, or regulatory participation (Becker, 2004; Chavkin, Romero, & Wise, 2000; Dubay & Kenney, 2004; Himmelstein, 2003; Holahan, Wiener, & Lutzky, 2002; Jonk, 2001; Kapur & Marquis, 2003; Marquis & Kapur, 2003; McClellan & Baicker, 2001; Politt, 2004; Reimer, 2003; Short & Grarfe, 2003; Tunzi, 2004; Wellner, 2001). The proposed solutions include universal, single-payer coverage, expansion of current government programs, premium subsidies, tax credits, expansion of work place coverage, decreased government regulation, and local initiatives.

Universal, Single-Payer Coverage

Whether or not the United States should enact a universal, single-payer health care system was introduced as a national policy question by the progressives during the 1912 election by Theodore Roosevelt; however, it was never acted upon legislatively due to vigorous lobbying by manufacturing groups. Subsequently, Presidents Franklin Roosevelt, Harry Truman, and William Clinton have all unsuccessfully considered or proposed that the United States enact a universal, single-payer health care
system (Starr, 1982). Scholars' and practitioners' views on enacting a
universal, single-payer health care system in the United States range from
embracing to deploring the idea. The most common argument for such a
system is financial (i.e., lack of financial resources by the poor) and resource
allocation with the most common arguments against such a system being
lack of timely access to health care services and poor quality of care (Berry,
2004; Hinkel, 2005; Relman, 2005; Wilsford, 1995). One novel proposal
posits that all Americans be mandated to possess a health insurance policy
purchased either by their employer or on the private market (Seidman,
2005). Two authors contend that switching the U.S. health care system to a
single-payer system would be cost neutral to the U.S. economy due to
decreased insurance overhead and decreased bureaucracy (Hadley &
universal, single-payer system may seem reasonable and desirable, it is not
a viable solution for the ills of the U.S. health care system due to lack of
political will by the actors involved.

Expansion of Current Federal and State Programs

Reimer (2003) found, through analysis of current federal and state
program enrollments, that current programs could be expanded if all eligible
adults and children were automatically enrolled. The result of this automatic
enrollment would be decreased stigma and increased access to physician
and health care services. A descriptive and multivariant analysis of survey data by Duby and Kenney (2004) indicates there is unused funding in current State Children's Health Insurance Program (SCHIP) programs that could be used to enroll parents of children in the same program. Blendon, Benson, and DesRoches (2003) analyzed telephone survey data and found strong support for expansion of federal and workplace health insurance programs.

*Premium Subsidies, Tax Credits, and Decreased Regulations*

Yondorf, Tobler, and Oliver (2004) performed a comprehensive analysis of programs offered throughout the 50 states. These federal- and state-sponsored programs took a variety of approaches including expanding private sector coverage, expanding public sector coverage, targeting specific populations (e.g., college students), targeting health delivery programs, and developing new programs. This study defined program effectiveness as increasing regular access to health care services for those who formerly had access only to emergency care and determined that federal and state government-sponsored premium subsidies (e.g., subsidizing employer sponsored coverage and tax credits) were the most effective programs. Other programs deemed effective by this study include building on existing programs and structures, streamlining eligibility and enrollment requirements, and allowing family members to enroll in the same
program. Kapur and Marquis (2003) analyzed panel survey data and found that subsidies of COBRA premiums would benefit only a small portion of the uninsured and would not be cost effective; however, tax credits or other subsidies to low income workers who become involuntarily jobless are effective. A cost benefit analysis of the cost of healthcare regulations versus the cost of providing health insurance coverage for the uninsured by Brostoff (2004) found the cost of regulations to be three to six times greater than the cost of providing health insurance coverage for the uninsured. The regulations quantified include costs related to the tort system, Food and Drug Administration, and health facilities regulations. These regulations yielded a net cost of $128 billion, while the cost of health insurance coverage for the uninsured is estimated to be between $34 billion and $69 billion.

**Federal Involvement in Expanding Access to Health Care Services**

All of the above proposed solutions for the expansion of health care coverage for the uninsured require some level of expansion of federal involvement or funds. Yondorf et al's (2004) comprehensive study of current programs indicates that the states are all actively seeking local solutions to the provision of health care services to the uninsured; however, most of these programs require the completion of some federal program waiver. One group of researchers (Aaron & Butler, 2004) established a model that would
increase federal support for state program experiments by increasing federal funds and decreasing federal documentation.

Local Initiatives

Three local initiatives were described by Lando (2004) as programs other communities might consider replicating. In 1991, Hillsborough County, Florida, established Hillsborough HealthCare funded with a one-half cent sales tax. This program provided a managed system approach to care and resulted in decreasing the hospital stays of the uninsured to a rate equivalent to the general population and decreased healthcare costs by an estimated $44 million per year. In 1998, Ingham County, Michigan, pooled its local, state, and federal disproportionate funds and created a health plan for the community's uninsured. This health plan was then administered through a network of primary care clinics and the county health department and provides primary and secondary care for the county's uninsured. Finally, in 2004, Wellplan of New Mexico was established through the pooling of unused SCHIP, Medicaid, and state funds. The originators of this plan coordinated the efforts of local and state governmental officials with those from the commercial insurance industry to come up with an insurance plan similar to commercial plans including employer and employee contributions.
Project Access

In 1992, the Robert Wood Johnson Foundation launched a local, physician-led initiative grant project called Reach Out: Physicians' Initiative to Expand Care to Underserved Americans. This was a 5-year, $12 million grant that received over 400 applicants of which 40 were chosen to participate in the study. Of these 40 chosen applicants, 39 completed the development process and went on to implement their programs. The programs fell into seven categories: free clinic, network referral, clinic networks, rural primary care networks, public health private partnerships, managed care look-alikes, and insurance look-alikes. The grant evaluation does not list the categories of programs it deemed successful; however, it does categorize the programs as stable or those it expects to continue for at least 2 years after the close of the grant funding (13), semi-stable or those who have the potential for continuation with strong community support (21), and unsuccessful or those it does not expect to continue after grant funding stops (4). The study closed in 1998 and found the uninsured to have needs in two common major areas of care: dental health and access to pharmaceuticals (Wielawski, 2004).

Project Access is the only project from this study that has been replicated in other communities. This program is based in Buncombe County, North Carolina, and was the model for this study’s program. Project Access was a physician-led program where the area physicians and
hospitals agreed to accept varying levels of charity care to ensure that all Buncombe County residents had access to primary and specialists physicians and health care services. During its first year of operations, 85% of Buncombe's working-poor were seen by a primary care physician, and 100% of those requiring specialists care were seen. The results from 1993 to 1998 include 5,000 specialty care referrals, 11,000 clinic visits, 80% of the patients reported better health, and $2.5 million annually in free physician care (Wielawski, 2004).

*Project Access in Buncombe County*

Landis (2002) provided a description of how Project Access was developed in Buncombe County and how the developmental process engaged both the physicians and community. This author, who is a physician, sets Project Access up as a model that other communities should follow and as an example of how to implement the 1999 recommendations from the American College of Physicians Task Force on local physician activism. Two organizational hallmarks of this program highlighted by Landis are (1) the structure that Project Access provides to physicians so they can provide charity care in their offices, and (2) the increased community awareness and response that resulted from the planning process. An evaluation of Project Access indicated that physician participation has increased from 25% during its first year to a current participation rate of
90%, and that, as a result of Project Access, the Health Department has doubled its capacity since 1995. From a patient standpoint, this evaluation demonstrated a 20% point decrease in Emergency Department use with 80% of the participants reporting improved health, and 25% stating that involvement with Project Access has helped them either to return to work or to perform their job better.

*Project Access Nationally*

Currently, there are 27 established Project Access programs across the country with the majority of them concentrated across Southern and Midwestern states, an additional 30 programs in the initial implementation stage, and another 75 sites considering use of the program in their communities (Communities, 2005). A survey of electronically available data from the current programs indicated that, in the 3 years following the implementation of Project Access, while the venue of where health care services are provided shifts, the total community amount spent on services remains neutral. This may be due to a better-perceived level of health by those enrolled in Project Access who now have more money spent on their health care needs through regular physician visits and the availability of pharmaceuticals (Access Emanuel, 2004; Health Access Project, 2002; Wetta-Hall & Ablah, 2003).
Additional electronically available national data from Project Access programs are limited due to lack of publication either on program websites or in the literature. However, the information that is available indicates that most programs have been initiated since 2000, the first year enrollment ranges from 35 to 1,484, and by the fifth year of operations the enrollment ranges from 800 to 3,670 (Table 3). Programs that started out with larger first-year populations were built upon the foundation of existing community programs to provide care for low income individuals and families. These websites indicate that mature programs evolve from patient advocacy to active case management ensuring that Project Access enrollees have access to the appropriate set of services that can include primary care physicians, medical specialists, surgeons, medications, diagnostic tests, durable medical equipment, and disease management services (e.g., cardiovascular and diabetes). Additional indicators of program maturity are recognition of population-specific needs such as diabetes care, establishment of a formulary, and establishment of a secure source of program funding.

*Project Access in Sedgwick County*

The first community to replicate Project Access was Sedgwick County (Wichita), Kansas. Cherches (2001) indicated that it took this community 1 year to develop Project Access and begin operations. Within the first 16
Table 3

Project Access Communities

<table>
<thead>
<tr>
<th>Program Name</th>
<th>City</th>
<th>State</th>
<th>First Year of Operations</th>
<th>Enrollment Year One</th>
<th>Enrollment Years Two-Five</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCMS Project Access</td>
<td>Asheville</td>
<td>NC</td>
<td>1996</td>
<td>3,000</td>
<td></td>
</tr>
<tr>
<td>Care Partners</td>
<td>Portland</td>
<td>ME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCMS Reach Out</td>
<td>Charlotte</td>
<td>NC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Access Project</td>
<td>Daviess County</td>
<td>KY</td>
<td>2004</td>
<td>154</td>
<td></td>
</tr>
<tr>
<td>Project Access</td>
<td>Dallas</td>
<td>TX</td>
<td>2001</td>
<td>35</td>
<td>800</td>
</tr>
<tr>
<td>Access DuPage</td>
<td>Carol Stream</td>
<td>IL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access Emmanuel</td>
<td>Swainsboro</td>
<td>GA</td>
<td>2000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCAC</td>
<td>Marquette</td>
<td>MI</td>
<td>2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.O.I.N.S.</td>
<td>Oklahoma City</td>
<td>OK</td>
<td>2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Access</td>
<td>Danville</td>
<td>VA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RCMS</td>
<td>Augusta</td>
<td>GA</td>
<td>2002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Access Project</td>
<td>Salt Lake City</td>
<td>UT</td>
<td>2001</td>
<td>584</td>
<td>1335</td>
</tr>
<tr>
<td>Santa Fe Project Access</td>
<td>Santa Fe</td>
<td>NM</td>
<td>2002</td>
<td>1300</td>
<td></td>
</tr>
<tr>
<td>MSSC</td>
<td>Wichita</td>
<td>KS</td>
<td>1999</td>
<td>1,484</td>
<td>3670</td>
</tr>
<tr>
<td>SCMS</td>
<td>Topeka</td>
<td>KS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCMS</td>
<td>Spokane</td>
<td>WA</td>
<td>706</td>
<td>803</td>
<td></td>
</tr>
<tr>
<td>TCMS Project Access</td>
<td>Austin</td>
<td>TX</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Connect</td>
<td>Provo</td>
<td>UT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Access</td>
<td>Henderson</td>
<td>NC</td>
<td>2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Access of Wake County</td>
<td>Raleigh</td>
<td>NC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appalachian Healthcare Project</td>
<td>Boone</td>
<td>NC</td>
<td>2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Access</td>
<td>Roanoke</td>
<td>VA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRPA</td>
<td>Spruce Pine</td>
<td>NC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Access</td>
<td>Grand Rapids</td>
<td>MI</td>
<td>2005</td>
<td>430</td>
<td></td>
</tr>
</tbody>
</table>

Source: American Project Access Network, 2006
months of operations, physician and healthcare services had been provided to 1,800 patients with an estimated donated cost of $8.25 million. In general, the program was well received by the community, physicians, and uninsured. This claim is further collaborated by Ablah, Wetta-Hall, and Burdsal (2004), who performed an analysis of the patient satisfaction surveys performed by Project Access in Sedgwick County. These researchers surveyed patients and providers in Sedgwick County with separate satisfaction surveys. The response rate for the surveys was 164 returned surveys for the patients or a response rate of 12%, and 125 returned surveys for the physicians or a response rate of 23%. These survey results were analyzed by a factor analysis approach using the Kaiser-Guttman and Scree tests to determine the relationships between various aspects of Project Access and the satisfaction of patients and physicians. The patient results indicated a strong relationship between respect and satisfaction with the physician results indicating a strong relationship between program administration and satisfaction. The final recommendations of the authors included investigating patient and provider satisfaction in greater detail than provided by these 15-question patient and physician surveys in order to better understand the origins of patient and provider satisfaction and dissatisfaction.
Project Access in Grand Rapids

Of the communities with established Project Access programs, Grand Rapids, Michigan, compared most closely to Salt Lake City, Utah, with similar demographics listed below (Table 4) than any of the any other communities with current Project Access programs. These cities were not similar in the minority makeup of their populations and are the headquarters of conservative religious organizations that have an effect upon their ethical and humanitarian climate.

Table 4

Demographic Comparison of Study and Established Cities – Year 2000

<table>
<thead>
<tr>
<th>City</th>
<th>Census</th>
<th>Percent of High School Graduates</th>
<th>Percent of College Graduates</th>
<th>Percent in Labor Force</th>
<th>Percent Below Poverty Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Rapids</td>
<td>197,800</td>
<td>78.0</td>
<td>23.8</td>
<td>65.8</td>
<td>15.7</td>
</tr>
<tr>
<td>Salt Lake City</td>
<td>181,743</td>
<td>83.4</td>
<td>34.9</td>
<td>68.4</td>
<td>15.3</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, Fact Sheet, 2004

Additionally, Grand Rapids has one large nonprofit hospital system and two much smaller nonprofit hospital systems, whereas Salt Lake City has one large nonprofit hospital system, one smaller nonprofit system, and two smaller proprietary hospital systems. In Grand Rapids, clinic-based charity care is provided through one major program sponsored jointly by all three hospital systems and several independent and faith-based clinics that
provide primary care, dental, case management, and counseling services.
The patient volume seen by these clinics is uncertain since only two of the clinics indicate on their website how many patients they serve annually. However, if the other clinics are each assigned 500 patients annually, this calculates to approximately 26% of the community's uninsured (Table 5). In comparison, Salt Lake City has three major clinics and several neighborhood and faith-based clinics that provide primary care to approximately 27% of the community's uninsured. In both communities, the unique aspect that Project Access brings to the provision of charity care for this population the addition of medical specialists, surgeons, pharmaceuticals, and diagnostics tests.

Physician services are provided in both communities through a combination of hospital-based group medical practices, independent group medical practices, and independent practitioners. Hospital and clinic leadership is currently stable in both communities; however, during the implementation of Project Access, Grand Rapids experienced the change in leadership of one major clinic, and Salt Lake City experienced a rapid turnover of several hospital leadership positions. Beyond basic census data, socioeconomic conditions were not studied for this research project.

Comparison Grand Rapids Project Access and Kent Health Plan

Both Grand Rapids Project Access and Kent Health Plan have missions to provide health care services to low income residents of Kent
Table 5

*Grand Rapids Clinics for the Uninsured*

<table>
<thead>
<tr>
<th>Name</th>
<th>Services</th>
<th>Annual Volume</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Access</td>
<td>Primary Care, Medical Specialists, Surgery, &amp; Medications</td>
<td>340</td>
<td>None</td>
</tr>
<tr>
<td>Kent Health Plan</td>
<td>Primary Care &amp; Medications</td>
<td>6,000</td>
<td>Sliding Scale</td>
</tr>
<tr>
<td>Belknap Commons Health Center</td>
<td>Primary Care, Medications, Dental, &amp; Counseling</td>
<td>Not Indicated</td>
<td>Not Indicated</td>
</tr>
<tr>
<td>Breton Health Center Residency Clinics</td>
<td>Family Practice, Internal Medicine, Urology, Surgery, OB/Gyn, Ophthalmology</td>
<td>Not Indicated</td>
<td>Not Indicated</td>
</tr>
<tr>
<td>Browning-Clayton Health Center</td>
<td>Family Practice, Counseling, &amp; Case Management</td>
<td>Not Indicated</td>
<td>Insurances and Sliding Scale</td>
</tr>
<tr>
<td>Burton Health Center</td>
<td>Primary Care, Dental, Counseling, &amp; Case Management</td>
<td>Not Indicated</td>
<td>Not Indicated</td>
</tr>
<tr>
<td>Cherry Street Health Services</td>
<td>Primary Care, Dental, Vision, &amp; Counseling</td>
<td>Not Indicated</td>
<td>Not Indicated</td>
</tr>
<tr>
<td>Clinica Santa Maria</td>
<td>Primary Care, Dental, &amp; Counseling</td>
<td>Not Indicated</td>
<td>Not Indicated</td>
</tr>
<tr>
<td>Ferguson Adult Health Center</td>
<td>Internal Medicine, Mental Health, Medications, &amp; Case Management</td>
<td>Not Indicated</td>
<td>Not Indicated</td>
</tr>
<tr>
<td>Health Interventions Services</td>
<td>Primary Care, Vision, &amp; Counseling</td>
<td>5,400</td>
<td>Not Indicated</td>
</tr>
<tr>
<td>McCauley Health Center</td>
<td>HIV</td>
<td>Not Indicated</td>
<td>Not Indicated</td>
</tr>
<tr>
<td>Salvation Army Booth Family Services</td>
<td>Primary Care, Dental, &amp; Counseling</td>
<td>Not Indicated</td>
<td>Not Indicated</td>
</tr>
<tr>
<td>Sparta Health Center</td>
<td>Family Practice</td>
<td>Not Indicated</td>
<td>Insurances and Sliding Scale</td>
</tr>
<tr>
<td>Spectrum Health Internal Medicine Residency Practice</td>
<td>Internal Medicine</td>
<td>Not Indicated</td>
<td>Not Indicated</td>
</tr>
<tr>
<td>Spectrum Health OB/Gyn Residency Practice</td>
<td>OB/Gyn</td>
<td>Not Indicated</td>
<td>Not Indicated</td>
</tr>
<tr>
<td>West Side Health Center</td>
<td>Primary Care, Dental, Lab, &amp; Case Management</td>
<td>Not Indicated</td>
<td>Not Indicated</td>
</tr>
</tbody>
</table>

Source: Project Access, Grand Rapids, Michigan, 2006
County; however, they differ in both their approach and the scope of services offered (Table 6). Additionally, neither organization directly provides physician nor health care services; rather, both organizations broker these services through established providers. Kent Health Plan provides these services through a series of clinics, whereas Project Access provides services through clinics, private physician, and hospitals. The breadth of their enrollment differs, with Project Access serving the uninsured working-poor who are 18-64 years of age, have no health insurance, and have an income less than or equal to 150% of the federal poverty level. In contrast, while Kent Health Plan provides services to this population, they also provide services to the Medicaid and small business populations; thus, the breadth of enrollment is broader at Kent Health Plan. The financial obligation of enrollees is the next difference between these two organizations, with Kent Health Plan requiring a $5 co-pay for most services and Project Access providing all services free-of-charge. These two programs also differ in the number of enrollees, with Kent Health Plan having 2,258 enrolled during 2005 in their plan that is most similar to Project Access. In contrast, Project Access had 340 enrolled during the same time period. Finally, these two programs differ in funding sources, with Kent Health Plan receiving federal, state, and local governmental funds in addition to funds from the United Way and local grants. In comparison, Project Access receives no direct federal, state, or local governmental funds,
### Table 6

**Comparison of Programs and Services Offered by Kent Health Plan and Project Access**

<table>
<thead>
<tr>
<th></th>
<th>Kent Health Plan</th>
<th>Project Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Population</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Small Businesses</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Working-Poor</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Eligibility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>150% Federal Poverty Level</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>18-64 years age</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Kent County Resident</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No Insurance</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Coverage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Specialty Physician</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Outpatient Lab</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Outpatient Radiology</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Outpatient Medications</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient Days</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient Lab</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient Radiology</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient Medications</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Co-pays for Services</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Providers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinics</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Private Physicians</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Hospitals</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Annual Enrollment –Part B</strong></td>
<td>2,258</td>
<td>340</td>
</tr>
</tbody>
</table>

*Source: Kent Health Plan 2005 Annual Report and Project Access Internal Documents*
but rather is funded by grants from small foundations, small philanthropic organizations, and insurance companies. In summary, Kent Health Plan provides a shallower program for a greater number of individuals, whereas Project Access provides a deeper program for fewer individuals.

Theoretical Literature

The theoretical literature for this research study is a synthesis of literature from four disciplines of study. Social exchange and distributive justice describe the social phenomenon that occurs between the physician and patient and assists in understanding why a physician may be compelled to provide services free-of-charge to patients that are uninsured and why a patient who receives physician services free-of-charge may be compelled to be adherent to physician office policies and to the treatment plan or regimen established with the physician. This social phenomenon is also described by Dillman (2000) as one of the reasons individuals complete and return mailed surveys. Replication theory describes the process necessary for replicating social programs. The replication literature is used to compare how the program studied for research project was replicated from the original program site to an established program in another state and to the program under study for this research project. Implementation theory is the third body of theoretical literature studied for this research project and examines how programs progress from conception to operations. Again, the theoretical
literature was used as a means to compare how this program was implemented in Grand Rapids, Salt Lake City, and Buncombe County sites. Finally, the evaluation literature was reviewed to provide a general framework for this research project. This literature was used in developing a research plan and determining the appropriate research methodologies and techniques necessary to appropriately conduct this research project.

**Social Exchange and Distributive Justice**

Homans (1961), in his classic work on social behavior, defines distributive justice as, "justice in the distribution between men and the rewards and costs of their activities." He goes on through his lengthy discussion of distributive justice to equate it with fair exchange or the idea that those who take the greater risk will receive a greater reward. Fifty years later, however, the definition has shifted to mean the redistribution from those who have taken risks and acquired more to those who have not taken risks and acquired less. While the definition of distributive justice has shifted, the action of the social exchange that occurs between two actors remains the same regardless of whom the actors are (e.g., an individual and society or two individuals). Chatterjee and D'Aprix (2002) discuss five types of social justice (corrective, protective, distributive, representational, and restorative) and how these five types of justice balance each other out when viewed over a continuum. Morris (2002) discusses social justice using John
Rawls' theory of justice as the framework and couples with it the capabilities model developed by Amartya Sen. Finally, Caputo (2002) seeks to balance social justice, care giver needs, and market economics. All four of these social scientists describe social justice as caring for the marginalized and less-well-off in society and redistributing back to them goods and services from those who have more. Three other social scientists, Galarneau (2002), Rice (2001), and Wikler (2002), describe health care as a social good that society has a responsibility for distributing back to those of lesser means. Finally, several social scientists and medical doctors (Beach, Meredith, Halpren, Wells, & Ford, 2005) looked at how physicians view their responsibility toward their patients under the framework of distributive (or redistributive) justice. This group found that all physicians had some sense of need to give back to their patients who had little to give them in return. An additional finding from this study was that physicians who were older and in independent practices sensed a greater need to give back to those with less to give in return than physicians who were younger and in less independent practices such as staff model managed care practices. What is striking in all of the above articles and approximately 200 additional studies scanned very briefly using several social science and health care databases is that the focus is consistently on redistributing from those who have more to those who have less. In contrast, there is no literature that describes what those who have less are willing to give in order to obtain health care insurance.
and, thus, increased access to physician and health care services. Therefore, this study will evaluate (1) the attitude of physicians toward providing charity services to this population, (2) how adherent the working-poor are to physician office policies, (3) how adherent the working-poor who receive physician services free-of-charge will be to prescribed medical regimens, and (4) how much the working-poor would be willing to pay for health insurance.

Program Replication

Replication of social programs has been studied across several disciplines within the social sciences and found to be a successful strategy of implementing social change. Brown and Carner (2000) performed a study of five grant projects for the Robert Wood Johnson Foundation and found replication projects to be of either a simple or developmental type. Simple types were programs that had tested, proven strategies with expected outcomes. In contrast, developmental types were programs where strategies were being tested and outcomes were not consistent. They also found that the grantees agreed on the need for technical assistance, access to national meetings, access to templates and other associated materials, and that the importance of outside funding diminished over time. The authors listed seven keys to successful replication of social programs: (1) perseverance, (2) credibility, (3) an unchanging environment, (4) flexibility and adaptability,
(5) good will is more important than money, (6) organizational commitment, and (7) technical assistance. These seven keys to successful replication are a good example of what O'Toole (2004) was referring to when he posited the need to develop an implementation heuristic.

Card (2001) lists a variety of social intervention programs that were developed and made available to social workers as replication kits for problems such as adolescent sexual health, HIV prevention, and youth substance abuse. These programs were found useful by practitioners who often did not have time to research and develop programs and could quickly implement these ready-to-use programs. Another group of researchers studied the replication of the Ladders in Nursing Careers program developed for underprivileged New York City youth. These researchers sought to replicate this program at sites in Iowa and North Dakota, and while they achieved their goal of replication, they also had to make considerable modification to the program to fit the Midwestern cultures and populations of these two states (Westmoreland, Grigsby, Brown, Latessa, & Huber 1998).

Finally, the commercial world has sought to lend its franchising expertise to the social sciences and has coined the term social franchising. The International Franchise Association was invited to a conference in Malaysia to work with this Indonesian country to develop a "model for systematic replication" to assist practitioners as they develop this country's social support system (Amies, 2000).
Program Implementation

Implementation of social programs has been studied for as long as there have been social programs, with the most recent formalization of implementation studies by public policy scholars since approximately 1970. These scholars have studied program implementation as a part of public policy implementation which they succinctly define as "those events and activities that occur after the issuing of authoritative public policy directives, which include both the efforts to administer and the substantive impacts on individuals and events" (Mazmanian & Sabatier, 1983). Sabatier (1986) further breaks down research on implementation of public policy into three generations: case studies (first generation), analytical and comparative studies (second generation), and process analysis (third generation).

The first generation literature of case studies was not reviewed for this research project; rather the focus was upon the second generation of analytic and comparative studies and the third generation of process analysis studies. Second generation studies debated whether a top-down or bottom-up method of policy implementation was more effective, with scholars ultimately concluding that a synthesis or adaptive approach is most effective. This approach combines the authority held by legislators and senior administrative officials with the normative approach of street-level bureaucrats. Whether an implementing agency or organization use a top-down or bottom-up approach depends upon the organization's administrative
structure with tall hierarchical structures functioning better under the top-down approach and flat hierarchical structures functioning better under the bottom-up approach (Manzmanian & Sabatier, 1983; Paulmbo & Calista, 1990; Sabatier, 1986). Matland (1995) describes the differences between a top-down and bottom-up approach by how each approach measures success. Top-down organizations seek to measure success by quantitative measures directly tied to the program objectives. In contrast, the bottom-up organizations measure success through broader qualitative measures such as positive impacts or effects upon the targeted population. Several scholars described the need for the policy formulation and implementation to be conceptually clear and emphasized the importance of the implementing administrator's managerial and political skills (Paulmbo & Calista, 1990). Mazmanian and Sabatier (1983) have developed six conditions of effective implementation:

1. Clear and concise policy objectives;
2. Sound theory, understanding principal factors and causal links, and sufficient jurisdiction;
3. Structured to ensure the target agency and populations will perform as desired;
4. Leaders committed to the statutory goals and possessing sufficient managerial and political skill;
5. Active program supported by legislators, executives, and supported with court neutrality;
6. Statutory objectives not undermined by conflicting public policies or changes in socioeconomic conditions.

Third generation policy implementation has been described as process analysis (Sabatier, 1986), hypothesis testing, comparative and longitudinal analysis of operationalized variables (Paulmbo & Calista, 1990), and intraorganizational relations (Sinclair, 2001). O'Toole (2004) speaks of developing a heuristic for implementing managers to follow versus predicting behavior through rigorous data analysis. Third generation scholars focus their various analytic techniques upon describing and analyzing the implementation process or describing and analyzing the behaviors necessary for individuals and organizations to undergo change. While third generation policy implementation research takes a more scientific approach to analyzing and understanding the implementation process, second generation top-down, bottom-up, or a synthesis approach is the normative, leadership view of how policies are implemented—both are necessary and neither should be used to the exclusion of the other.

Program Evaluation

Social programs are evaluated for one reason: to determine whether they are providing, in a quality manner, the services they were designed to
provide (Posavac & Carey, 2003). Posavac and Carey contend that there are four common types of program assessments:

- Evaluation of need – is there a documented need for the program;
- Evaluation of process – was the program implemented and is it performing as designed;
- Evaluation of outcome – how are those receiving the services performing; and
- Evaluation of efficiency – how efficient or cost effective is the program.

These two scholars then discuss the steps necessary to tailor a program evaluation with the appropriate research method(s) (1) identify the population; (2) select a research design; (3) oversee day-to-day data collection; and (4) present the findings in a simple, concise, and, preferably, graphical format regardless of the sophistication of research methods and data analysis used.

When developing the research design, the first thing the researcher needs to understand is the purpose of the evaluation, i.e., need, purpose, outcome, or efficiency. Once the researcher understands the purpose of the evaluation, the type of research method can then be determined, i.e., qualitative or quantitative, that best suits the purpose of evaluation. Qualitative and quantitative methods may be used individually or in combination depending upon the evaluation goals and purposes. Next, the
researcher needs to understand the preferences of the stakeholders, the
time to target completion date, and the level of funding available. Several
other scholars echo the guidance provided by Posavac and Carey (2003)
corroborating their call for using research methods that are appropriate for
the evaluation and the need to use more than one method in order to
develop a more robust and complete picture of the program (Glasgow, Vogt,
& Boles, 1999; Lipsey & Cordray, 2000).

Several process evaluations were reviewed for this study. Peterson
(2002) used home visits to study a program designed to provide parents of
children from underprivileged homes an understanding of child development
and parenting skills. This scholar discussed the importance of establishing
goals, delivering efficiently, and understanding the social and political
context of the interventions and evaluation. Another study (Collins, 2003)
used interviews and document review to evaluate a program designed to
 teach teen mothers life skills such as meal planning and budgeting. Helitzer,
Wallerstein, and Garcia-Velarde (2000) studied the training of facilitators for
an adolescent health education program through use of a self-administered
questionnaire, training evaluation forms, program implementation check-off
lists, and observation. These scholars indicate that process evaluation "is
the key to understanding the internal dynamics of an intervention trial and
quality control." The above small sample of process evaluations all used a
combination of qualitative and quantitative methods that were appropriate for
understanding their target populations, program purpose, and program goals.

Outcome evaluation literature was also reviewed for this study. Lipsey and Cordray (2000) discussed method for evaluating social interventions and indicated that implementation evaluation is part of outcome evaluation that requires multiple methods in order to understand if a program was efficiently implemented. These scholars listed the four steps of program implementation as startup, growth, stabilization, and stabilized program. They also pointed out the importance of the theory of causal mechanisms as the "key to explaining how problematic social conditions are transformed by the interventions of the program with those conditions" (p. 12). Another group of scholars (Heckman, Tobias, & Vytlacil, 2001) used the estimated earnings gained from a college education to explain four common treatment parameters: the average treatment effect, the effect of the treatment on the treated, the local treatment effect, and the marginal treatment effect. Finally, Horowitz, Davis, Palermo, and Valdek (2000) used literature review and expert interviews to explore remedies for eliminating sociocultural disparities in health and found little empiric evidence of any program directly impacting or eliminating this disparity. These scholars also identified four barriers to effective evaluation as lack of appreciation of the importance of evaluation, lack of technical expertise, lack of resources, and lack of sensitive evaluation tools.
CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

Introduction

This research project used process and outcome evaluation methodologies to evaluate the first research question regarding increased access to physician and health care services by the uninsured working-poor. The process portion of this research study tested the process developed by Project Access that provided the uninsured working-poor with a mechanism for gaining access to physician and medical charity care (i.e., no monetary cost to the patient and no reimbursement to the provider) and to decrease their use of the emergency room as their primary care provider. The outcome portion of this research study determined if or how the enrollee's health perception and lifestyle function changed due to increased access to physician and medical care. Additionally, the outcome portion determined how much Project Access enrollees were adherent to prescribed medication regimens and how much they are able or willing to pay for physician and medical care equivalent to the care they received through Project Access. A process methodology was used to evaluate the second and third research questions regarding social program replication and implementation. The actual replication and implementation processes used by the Project Access
programs in Grand Rapids, Salt Lake City, and Buncombe County were compared to the replication heuristic developed by Brown and Carner (2000) and the implementation heuristic developed by Mazmanian and Sabatier (1983).

Mixed Methodology

This research project used both quantitative and qualitative research methodologies or a mixed methodological approach as an attempt to triangulate this program and provide as complete and robust of an evaluation as possible (Creswell, 2003; Posavac & Carey, 2003). The quantitative portion of this research study was performed to answer research question one regarding increased access to physician and medical care by the uninsured working-poor and is both outcome and process focused. A self-administered mailed survey of all Project Access enrollees was used to gather the data for this portion of this research project. These data were then analyzed using a frequency distribution and the Wilcoxon signed rank sum test to statistically compare the responses to several pairs of questions tested by the survey. The qualitative portion of this research study was performed to answer research questions two and three regarding replication and implementation of social programs and is process focused. Document review, focus groups, and interviews were the qualitative research
methodologies used to gather the data for this portion of this research project.

The use of both of quantitative and qualitative methodologies has provided a robust evaluation that more completely described the implementation and first year of operations of Project Access in Grand Rapids, Michigan, than either of these two types of methodologies could if used in isolation. The quantitative portion of this research study described the program participants and the care they received from the providers, whereas the qualitative portion described the process used to establish the program. Not using either type of methodology in this study would result in an incomplete description of Project Access and inaccurate conclusions regarding its first year of operations.

Quantitative Methodology

The quantitative portion of this study partially answered the first research question regarding access by the uninsured working-poor to physician and health care services. These quantitative measurements determined if there was (1) increased lifestyle productivity of the uninsured working-poor, (2) increased perceived health of the uninsured working-poor, (3) adherence to prescribed medical regimens, (4) barriers to physician services, (5) satisfaction with the program, and (6) the amount enrollees are willing or able to pay for equivalent physician and health care services. It is
important to distinguish between improved health and perceived improved health. It is neither the design nor intent of this research study to measure clinical improvement of health. Measurement of improved health is a clinical measurement that requires a release of medical information consent from each enrollee studied submitted to each physician, hospital, or ancillary health care provider involved in providing health care services to each enrollee; access to and coordination of medical records; physician judgment of improvement in clinical measurements; and possibly bringing several physicians and ancillary health care providers to consensus regarding whether or not an enrollee’s health has improved. In contrast, perceived improved health is a perception that potentially has no basis in clinical fact. The enrollees in Project Access may perceive an improvement in health when clinically there has been no improvement. For this study, the perceived improved health was based upon (1) improved lifestyle productivity, (2) increased access to physician and health care services, and (3) increased adherence with prescribed medical regimens.

Qualitative Methodology

Second, a mixed assortment of qualitative methods was used to evaluate various aspects of how this program was replicated and implemented. Three focus groups were held with physician office managers (primary care, secondary care, and surgical) to determine commonalities,
differences, and suggested improvements in the implementation of Project Access. Due to low attendance (5 out of an anticipated total of 12) at the focus groups, this aspect of this study was studied using telephone interviews with physician office managers. While setting up appointments for the focus groups, several of the office managers indicated that they were unable to attend the focus groups; however, several indicated a willingness to participate in a telephone interview. Since this methodology (i.e., telephone interviews) was not a part of the original research protocol, it was not pursued at the time. Due to the low focus group attendance mentioned above, telephone interviews were scheduled and pursued. In an attempt to equate the questions and time allocated for each question, (1) the telephone interviews followed the same question guide that was developed for the focus groups, (2) the questions were asked in the same sequence and manner as asked of the focus group, and (3) the interviews were scheduled for 30 minutes or proportionately the same amount of time as the focus groups (i.e., focus groups provided 20 minutes for each participant to answer questions plus 20 minutes for discussion; telephone interviews provided 20 minutes for each participant to answer questions plus 10 minutes for discussion). The two aspects of the telephone interviews that were not able to be replicated were the personal face-to-face contact and group interaction of participants. Additionally, no telephone interviews were conducted with focus group participants. Prior to analysis of focus group and
telephone interviews, all responses were entered onto a side-by-side table with the responses listed under each interview question. Once the summary interview template was prepared, the data were analyzed.

Next, a series of interviews was conducted with Project Access leaders from the Grand Rapids, Salt Lake City, and Buncombe County programs and with the consultant to the Grand Rapids program to discern any differences and barriers or problems encountered in the implementation processes from the Buncombe County program and the replications and implementations in the Grand Rapids and Salt Lake City programs. Finally, archival or document review was designed to be performed on first year documents from all three program sites to help illuminate differences in the implementation process; however, only the Grand Rapids program provided these documents. Since neither the Salt Lake City nor Buncombe County programs provided any documents, a limited amount of summarized material was reviewed from their websites. Despite the limited amount of material obtained, these documents prompted probing during the interviews about the level of technical support provided by the national organization and undermining implementation concerns.

Hypotheses

The hypotheses of this study are:
H 1: Enrollees in Project Access will have a perceived improved level of health one year after enrollment into the program.

H 1a: Enrollees in Project Access will report performing activities of daily living (e.g., self-care, work, or recreation) with greater frequency in the year after enrollment in Project Access than the year before.

H 1b: Enrollees in Project Access will report having chronic medical conditions better controlled (i.e., increased performance of activities of daily living, increased adherence to prescribed medical regimens, decreased emergency department use) due to increased access to physician services and pharmaceuticals in the year after enrollment in Project Access than the year before.

H 1c: Enrollee in Project Access will report having perceived improved health in the year after enrollment in Project Access than the year before.

H 2: Enrollees in Project Access will report having less difficulty getting to a physician’s office appointments in the year after enrollment in Project Access.

H 3: Enrollees in Project Access will be able or willing to pay $5 to $20 per week for health care services similar to those received through Project Access.
H 4: Enrollees in Project Access will report being satisfied with the services they received through the program.

H 5: Project Access physicians and office staff will report being satisfied with Project Access in the year after its implementation.

H 6: Project Access participating physician offices will report having an increased sense of community in the year after agreeing to be a Project Access provider.

H 7: Replication of the Grand Rapids and Salt Lake City Project Access programs will follow the replication of public program heuristic described by Brown and Carner (2000).

H 8: Implementation of the Grand Rapids and Salt Lake City Project Access programs will follow the heuristic (modified) described by Mazmanian and Sabatier (1983).

H 9: The implementation barriers encountered by Grand Rapids and approaches used to overcome these barriers are the same barriers encountered by and approaches used by the Salt Lake City program.

Self-Administered, Mailed Survey

The quantitative portion of the first year evaluation included a single-group, nonexperimental outcome and process evaluation. A mailed survey was sent to all 340 first year Project Access enrollees that assessed the
enrollee's (1) current and past health, (2) barriers to health care access, (3) how much they would be able or willing to pay for equivalent health care, (4) satisfaction, and (5) demographic data (Appendix B). The survey of Project Access enrollees was prepared based upon Dillman's (2000) tailored design method and was mailed weekly during the last week March and first two weeks of April 2006.

*Mailed Survey Sample Size*

The potential population that the enrollees for the first year was drawn from is 49,000 (those not covered by Kent Health Plan Part B). Even though 49,000 is a large population based to draw upon, the population for this survey was the 340 first year enrollees in Project Access. The small population of 340 is consistent with the enrollment of other Project Access sites from similar size cities with similar demographics during the first year of operations. These other sites saw their enrollment grow to several thousand over a 3- to 5-year period and there is no reason to expect anything different for the Grand Rapids Project Access population. For this research project, a population of 340, 14% probability of one of seven responses chosen for each question, 95% confidence level, and 3% sampling error yields a necessity of 63 completed surveys for statistical significance (Table 7). When 63 completed surveys are coupled with a returned survey rate of 30%, the resultant sample size is 67. Despite the small number of returned
Table 7

*Dillman (2000) Completed Sample Formula*

<table>
<thead>
<tr>
<th>Ns</th>
<th>Calculated completed surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Np</td>
<td>Population size</td>
</tr>
<tr>
<td>P</td>
<td>Probability of answering to each question (modified from original Dillman equation)</td>
</tr>
<tr>
<td>B</td>
<td>Sampling error</td>
</tr>
<tr>
<td>C</td>
<td>Z statistic associated with confidence level</td>
</tr>
</tbody>
</table>

Ns = \[
\frac{(Np) (p) (1-p)}{(Np-1) (B/C)^2 + (p) (1-p)}
\]


Surveys required to achieve statistical significance, a 100% survey was performed due to the small survey population of 340. This research study yielded a total of 165 returned surveys, a return rate of 52% or a return rate two and one-half times greater than required for statistical significance.

Dillman (2000) notes two nonintuitive aspects of sampling a large population that include (1) a small sample size, and (2) that few completed questionnaires can yield accurate results (pp. 205-206). For example, using the formula in Table 7 and parameters a population of 1,000 requires 344 completed surveys, whereas a population of 500 requires 256. As the population size increases, the required number of completed surveys decreases, and conversely, as the population size decreases, the required
number of completed surveys increases to the point where a complete or 100% survey is required.

Survey Preparation

Posavac and Carey (2003) indicate that a pretest before and a posttest after completion of a program provide the best means for comparison and do not cause the individual completing the questionnaire to rely upon memory of previous events to answer questions. However, administering a pretest to enrollees was not possible for this study. Therefore, the majority of survey questions were focused on assisting enrollees in recalling, as accurately as possible, their perceived health pre-Project Access enrollment by using cognitive recall design techniques as described by Dillman (2000). This technique asked enrollees a series of questions about specific aspects of their health care and alternated between the year prior to and the year after enrollment in Project Access. Aday (1989) further discusses the use of this technique and demonstrated its use with examples of surveys used by the United States Department of Commerce and University of Illinois.

The enrollees were questioned about their perceived health post-Project Access enrollment by use of the same cognitive recall technique described above. The pre- and post-Project Access enrollment questions were worded as closely as possible in order to ensure a direct comparison of
the results. Another series of questions asked enrollees about the quality of services received through Project Access. These questions queried topics such as accessibility to physicians, transportation needs, the hours the physician is available as compared to the hours the enrollee works, and general program satisfaction. These questions were asked to assist the Project Access staff in developing programmatic changes necessary to better serve their clients. A final question asked enrollees how much they would be willing to pay to purchase services equivalent to those received through Project Access.

Once the questionnaire was developed and approved by the Grand Rapids Project Access administrative director and Western Michigan University (WMU) Human Subjects Institutional Review Board (HSIRB), the survey questions were pilot tested by a small group of Project Access enrollees and Project Access staff for qualitative reasons such as:

- Are the questions understandable and easy to read?
- Are the questions formatted in a manner that makes them easy to follow?

This pilot test resulted in changes to how race and work questions were asked in the demographic section and how questions about medications were worded.

The survey used the tailored design method described by Dillman (2000) that included a multiple step mailing process that consisted of a
survey pre-notice, survey packet, and two subsequent re-mailings of notices and survey packets to enrollees that did not respond to previous mailings. Program enrollees were asked to complete a self-administered mailed survey of 6 demographic and 25 survey questions (Appendix B). Each enrollee completed the survey without assistance from the program staff and was provided a self-addressed, postage paid envelope to return the survey.

*Mailed Survey Data Analysis*

Upon receipt of the completed surveys, a privately contracted firm entered the data into a database. In order to ensure accuracy of data entry, every 10th survey was audited by comparing received surveys to data entry results. Only one data entry error was detected during this quality audit and it was easily remedied. After the data were received, they were reviewed and formatted as appropriate for a variety of data analysis procedures that were performed using Microsoft Excel® and STATA® version 8.0 as the statistical analysis software. The statistical analysis included a frequency distribution of all survey responses and a Wilcoxon signed rank sum test (the nonparametric analog of the parametric paired t test) of the pairs of pre- and post-Project Access enrollment questions. Upon completion of the data analysis, the results were complied using tables and narrative text that described the results, answered research question one, and answered hypotheses one through six.
These data are nonparametric due to their ordinal, categorical nature; the nonparametric nature of these data was validated by four tests of normality performed on each variable that confirmed they were not normally distributed. A Wilcoxon signed rank sum test was performed on the pre- and post-enrollment data pairs. This test uses a ranking process to test for the differences between two sets of nonparametric data and is the nonparametric analogue of the parametric paired $t$ test used to test for a difference between the means of the two variables.

Qualitative Research Design

The research design of this project included several qualitative methodologies: (1) document review of implementation documents and data; (2) focus groups with participating physicians' office managers; (3) telephone interviews with participating physicians' office managers; and (4) interviews with Salt Lake City, Grand Rapids, and Buncombe County Project Access administrative directors and the consultant to the Grand Rapids program (Denzin & Lincoln, 2000; Lincoln & Guba, 2000; Lofland & Lofland, 1995).

Document Review

The documents requested from the Grand Rapids, Salt Lake City, and Buncombe County Project Access programs included board minutes,
budgets, implementation timelines, and any other documents the program administrative director deemed appropriate for giving insight to how the program replication and implementation progressed from conception to the first day of program enrollment. The documents from the Grand Rapids program and the websites of the Salt Lake City and Buncombe County programs were used along with the heuristics developed by Brown and Carner (2000) for replication of social programs, and Mazmanian and Sabaiter (1983) for implementation of social programs to develop the question guide for these interviews. Prior to requesting and analyzing these documents, consent was obtained from the program directors for their use and analysis. The documents received assisted in focusing on the questions regarding technical assistance for program replication and assessing undermining implementation concerns.

**Office Manager Focus Groups and Interviews**

The second qualitative methodology planned was a series of focus groups consisting of office managers form Project Access participating physician offices. The office managers from Project Access participating physician offices were invited to one of three 2-hour focus groups that met in conference room of the Kent County Medical Association and Osteopathic Society (no staff was allowed in the offices during the focus groups). Participating Project Access physicians did not participate in these focus
groups. Due to a number of group physician practices involved in Project Access, one office manager had the potential of representing the views of more than one physician. Written consent providing permission to use data obtained from the session for this research project and subsequent publications was obtained by all focus group participants prior to commencing the sessions. The focus groups were divided into primary care, internal medicine, and surgical groups in order to assist in discerning differences and similarities based upon medical practice types. The data from the focus groups were compiled by notes taken directly under each question on the focus group question guide template.

These managers were questioned about (1) what the office staff and physician(s) expected from Project Access, (2) what the experience of their office was with Project Access enrollees, (3) what prompted their physician(s) to become Project Access providers, (4) Project Access enrollees' adherence to office standards, (5) Project Access enrollees' adherence to prescribed medical regimes, (6) how quickly Project Access enrollees are able to get appointments, and (7) any suggested changes for Project Access or its enrollees (Appendix C). The focus groups were conducted with office managers instead of physicians due to the difficulty of getting physicians to attend such events and the greater availability of the office managers. While the office managers had the ability to speak for their office, they were not expected to speak directly for the physician. The
interaction of the office staff and the physician with Project Access enrollees are on different levels, with the staff’s interactions with the enrollees not as intimate as those between the physician and the enrollee.

Due to low response to the focus groups (5 participants), the office managers were studied using telephone interviews (11 participants). These 16 participants represent approximately 5% (16 out 350) of participating Project Access physicians and are an equally distributed cross section of physician groups (large multi-specialty groups, small specialty groups, independent practitioners, and clinics). Prior to each interview, the office manager was provided with a consent form and given the option of signing and mailing or faxing the consent back to the student researcher, or by responding in agreement to the consent by electronic mail. In an attempt to equate the questions and time allocated for each question, (1) the telephone interviews followed the same question guide that was developed for the focus groups, (2) the questions were asked in the same sequence and manner as asked of the focus group, and (3) the interviews were scheduled for 30 minutes or proportionately the same amount of time as the focus groups (i.e., focus groups provided 20 minutes for each participant to answer questions plus 20 minutes for discussion; telephone interviews provided 20 minutes for each participant to answer questions plus 10 minutes for discussion). The two aspects of the telephone interviews that were not able to be replicated were the personal face-to-face contact and
group interaction of participants. Additionally, no telephone interviews were conducted with focus group participants. These data were then summarized on a side-by-side table and used to answer hypotheses five and six and partially answer research question one.

Analysis of Office Manager Focus Group and Interview Data

The focus group and interview results were displayed in side-by-side tables that made comparison of these focus group and interview responses easier, and a lengthy narrative section that focused upon describing the focus group and interview response differences and similarities. These results were analyzed for themes, similarities, and differences, with the results displayed in narrative form under each question from the interview guide. Discussion of the analysis results, determination of whether or not research question one regarding increased access to physician services by the uninsured working-poor was answered, and determination of whether or not the criteria for hypotheses one through six was met is discussed in the discussion and recommendation chapter.

Program Administrator Interviews

Interviews of the Grand Rapids, Salt Lake City, and Buncombe County administrative directors and the consultant to the Grand Rapids program was the last of the methods used and only after the material
described above was reviewed in order to give the researcher a sense of context within the three programs. The Grand Rapids interview was face-to-face, whereas the Salt Lake City, Buncombe County, and consultant interviews were by telephone. Preparation for the interviews included a complete review of all relevant materials and preparation of an interview guide. An interview guide (Appendices D & E) was prepared in order to keep the interview on track and to obtain comparable data or responses to each question (Esterberg, 2002; Fontana & Frey, 2000; Kvale, 1996; Rubin & Rubin, 1995). The questions were developed based upon the results of the document review, the replication research by Brown and Carner (2000), and the implementation research by Mazmanian and Sabatier (1983). Prior to each interview, the administrative directors signed or agreed by electronic mail to the consent form, giving permission to use data obtained for this research project and any subsequent publications. The focus of each interview was (1) barriers encountered in the replication and implementation process, (2) how these barriers were addressed, and (3) what the outcome was as related to how the barrier was addressed.

Analysis of Program Administrator Interview Data

The interview results were displayed in side-by-side tables that make comparison of the three programs easier, and a lengthy narrative section that focused upon describing the program’s differences and similarities.
These data were then analyzed with the results displayed in narrative form below each question from the interview guide. Discussion of the analysis results, determination of whether or not research questions two and three regarding social program replication and implementation were answered, and determination of whether or not to reject or not reject hypotheses seven through nine is discussed and displayed in tabular form in the discussion and recommendation chapter.

Integration of Research Questions, Theory, and Methodology

The first research question regarding increased access by Project Access enrollees to physician and health services is integrated with social exchange theory by evaluating how much physicians, other health care providers, and Project Access enrollees are willing to give in exchange for the outcome of increased health and lifestyle function of Project Access enrollees (Table 8). The outcome of increased access to physician and health services is linked to the number and provider of visits (e.g., increased number of private physician visits and decreased number of ER visits) and is evaluated by a self-reported mailed survey of all Project Access enrollees. The attitude of physicians toward providing these services is part of the process evaluation; unless physicians possess an attitude that causes them to desire to provide charity care to this population, this program is doomed for failure. Physician attitude is linked to the physician office manager focus...
Table 8

Integration of Research Questions, Theory, and Methodology

<table>
<thead>
<tr>
<th></th>
<th>Social Exchange</th>
<th>Replication</th>
<th>Implementation</th>
<th>Evaluation – Outcome</th>
<th>Evaluation – Process</th>
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<tr>
<td>Q1 – Increased access</td>
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<td></td>
<td>Mailed Survey</td>
<td>Focus Groups &amp; Telephone Interviews</td>
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<tr>
<td>Q2 – Replication</td>
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<td>X</td>
<td></td>
<td>Document Review, Director Interviews</td>
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<tr>
<td>Q3 – Implementation</td>
<td></td>
<td></td>
<td>X</td>
<td>Document Review, Focus Groups &amp; Telephone Interviews; Director Interviews</td>
<td></td>
</tr>
</tbody>
</table>

Source: Project Access Evaluation, 2006

groups and telephone interviews through a question regarding what compelled physicians to participate in Project Access. The attitude of Project Access enrollees toward receiving these services is linked to their willingness to adhere to physician office policies, adhere to prescribed medical regimens, and complete the mailed survey. Project Access enrollees' attitudes toward the above were evaluated by self-administered mailed surveys of all Project Access enrollees and physician office manager focus groups and telephone interviews.
The second research question regarding program replication barriers is a process evaluation that compares the replication of Project Access by a national organization in Grand Rapids and Salt Lake City with the replication literature (Table 8). This comparison is evaluated through office manager focus groups and telephone interviews and program director interviews.

The third research question regarding program implementation barriers is a process evaluation that compares the implementation of Project Access in Grand Rapids, Salt Lake City, and Buncombe County, North Carolina with the implementation literature (Table 8). This comparison is evaluated through office manager focus groups and telephone interviews and program director interviews.

Limitations

Despite the best efforts in research design preparation, all research methods have their limitations. Even though a variety of methods were used in this research study in an attempt to control for these limitations, these methodological limitations continue to exist. The limitations of the quantitative and qualitative methods used in this research study are discussed below.
Quantitative

The quantitative approach has a number of inherent limitations. First, improved health after enrollment in Project Access is not always an indicator of improved health due to enrollment in the program; rather it may be due to the natural, cyclical nature of a disease process or maturation. Second, any generalization resulting from this study would have to be corroborated through the comparison of similar results from similar studies. Third, within all of the data collected for this research project, there is the possibility of a confounding variable that can augment or suppress true observations. Fourth, there is always the possibility of bias in the answers provided to the investigator. Fifth, recall by the enrollees, even using the cognitive recall method, will not be as accurate as if the questions were asked at the time the event occurred or if a pretest and posttest were administered. Sixth, responses to self-administered surveys have the potential of being low and thus not fully representing the opinions of the population. Seventh, the enrollees and their responses from the first year of operations of a program such as Project Access have the potential of demonstrating more initiative and being more motivated than the majority of this population. Eighth, enrollee ability or willingness to pay for physician or medical services similar to those received through Project Access is a measurement of social exchange and not a measurement of risk aversion; however, these data may
be a starting point for further research regarding the amount of risk aversion this population is willing to endure.

**Qualitative**

The qualitative approach is not without its weaknesses. First, the results of the data analysis are subjective, open to interpretation, and require corroboration with other similar studies. Second, the document review was of limited value due to the small number of documents provided by the three organizations. Third, group-think can occur in the focus group despite efforts to control this phenomenon, such as asking the same question in different ways. Fourth, there is always the potential that focus group members will provide the answers that they anticipate the interviewer desires to hear. Finally, the limitations during the interview include faulty or incomplete recall, lack of being forthcoming with barriers and how they were addressed, and inability to answer questions due to lack of historic documents.
CHAPTER IV

ANALYSIS OF RESEARCH FINDINGS

Introduction

The research activities analyzed in this chapter include a self-administered mailed survey to all Project Access enrollees, a review of documents describing the process from conception of Project Access through its first year of operations, focus groups and telephone interviews with physician office managers, and interviews with Project Access directors in three cities and the consultant to the Grand Rapids program. Analysis of the self-administered mailed survey is the only quantitative analysis performed in this study and consists of the analysis of 6 demographic and 25 survey questions with a final section provided for additional written comments. The 25 survey questions consist of 10 pairs of questions designed to test for differences in perceived health, physician access, and medication use pre- and post-enrollment in Project Access with the remaining 5 questions testing how much Project Access enrollees are able or willing to pay for similar services and program satisfaction. These data are nonparametric (i.e., not normally distributed) due to their ordinal, categorical nature; the nonparametric nature of these data was validated by four tests of normality performed on each variable that confirmed they were
not normally distributed. The first analytic test applied to these data was a frequency distribution that described the data and the changes from pre- to post-enrollment. Next, a Wilcoxon signed rank sum test (the nonparametric analog of the paired \( t \) test) was applied to test for differences between the pairs of pre- and post-enrollment data.

The first of the qualitative methodologies used was a document review that proved to be of limited value due to the limited number of documents the three programs were willing to provide. However, the documents provided did prompt deeper probing during the director interviews regarding the technical support provided for the preparation of these documents. The office manager focus groups and telephone interviews were designed to determine how the Project Access enrollees interacted with the physician office staff and physician, if the enrollees were adherent with their prescribed treatment plan, and the interaction between the physician offices and Project Access staff. Finally, the Project Access directors from three cities were interviewed to determine what, if any, heuristic they followed in the replication and implementation of Project Access in their community. The process each director followed in implementing Project Access was compared to the program replication heuristic developed by Brown and Carner (2000) and the public policy implementation heuristic developed by Mazmanian and Sabatier (1983) and modified for this study.
Quantitative Analysis

A self-administered mailed survey of Project Access enrollees was conducted over the first 3 weeks of April 2006 and yielded a return of 165 surveys or a return rate of 52%. Throughout this research study, a $p$ value less than or equal to 0.05 is considered statistically significant.

**Goodness of Fit**

In order to determine if the returned surveys were a representative sample of total Project Access enrollees, the percentages of gender and race of returned surveys was compared with the percentage of gender and race of Project Access enrollees (Table 9). The comparison of gender between those enrolled in Project Access versus those who responded to the survey is not statistically significant with a $p$ value of 0.695. However, when the races of those enrolled in Project Access are compared with those who responded to the survey, there is a statistically significant difference ($p = 0.000$). When all of the minority groups are included together and compared to whites, the $p$ value between the enrolled versus responded groups is 0.002. Regardless of how the minority groups are broken out or grouped, the probability due to chance alone continues to be statistically significant. The reason for this difference is a lower than expected response rate from white and black enrollees and a higher than expected response rate from Hispanic and mixed groups. Whites show the highest number
difference with 17 fewer than expected responding and blacks with 10 fewer than expected responding. In contrast, twice as many than expected Hispanic and mixed groups returned surveys. Unfortunately, no other comparative statistics were maintained by the Grand Rapids Project Access office, thus other comparisons are not possible to determine how comparative the enrolled group is to those who responded to the survey. In conclusion, the survey responders are representative of the enrolled group when gender is compared. While race demonstrates a statistically significant difference between the enrolled and response groups, in general, more whites were enrolled in Project Access than any other race, and more whites responded to the survey than any other race.

Table 9

*Enrollees and Mailed Survey Respondents – Frequency Distribution*

<table>
<thead>
<tr>
<th></th>
<th>PA Enrollment</th>
<th>PA Returned Surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>36%</td>
<td>35%</td>
</tr>
<tr>
<td>Female</td>
<td>64%</td>
<td>63%</td>
</tr>
<tr>
<td>Black</td>
<td>18%</td>
<td>10%</td>
</tr>
<tr>
<td>Asian</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>White</td>
<td>75%</td>
<td>62%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3%</td>
<td>14%</td>
</tr>
<tr>
<td>Native American</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Mixed</td>
<td>1%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Self-administered survey of Grand Rapids, Michigan Project Access enrollees, April 2006
**Demographics**

The demographics (Table 10) indicate a majority female (63%) and white (62%) population with the mean age range of 41-50 years (31%).

Table 10

*Survey Respondent Demographics – Frequency Distribution*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Percent</th>
<th>Marital Status</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>35</td>
<td>Single – Never Married</td>
<td>35</td>
</tr>
<tr>
<td>Female</td>
<td>63</td>
<td>Single – Divorced</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Single – Widowed</td>
<td>3</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td>Married</td>
<td>29</td>
</tr>
<tr>
<td>Black</td>
<td>10</td>
<td>Married - Separated</td>
<td>1</td>
</tr>
<tr>
<td>Asian</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>62</td>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>14</td>
<td>Full-time</td>
<td>13</td>
</tr>
<tr>
<td>Native American</td>
<td>1</td>
<td>Part-time</td>
<td>31</td>
</tr>
<tr>
<td>Mixed</td>
<td>4</td>
<td>Temporary</td>
<td>10</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td>Not Working</td>
<td>45</td>
</tr>
<tr>
<td>18-24</td>
<td>15</td>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>25-30</td>
<td>7</td>
<td>Less Than High School</td>
<td>15</td>
</tr>
<tr>
<td>31-40</td>
<td>13</td>
<td>High School Graduate</td>
<td>34</td>
</tr>
<tr>
<td>41-50</td>
<td>31</td>
<td>Some College</td>
<td>35</td>
</tr>
<tr>
<td>51-57</td>
<td>17</td>
<td>College Graduate</td>
<td>13</td>
</tr>
<tr>
<td>58-65</td>
<td>16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Self-administered survey of Grand Rapids, Michigan Project Access enrollees, April 2006
Marital status is fairly evenly distributed among single—never married, single, divorced, and married. Employment status is evenly distributed between full-time and part-time (44%) and not working (45%) with the remaining 9% of the population engaged in either temporary or seasonal work. Education level is evenly distribute with high school graduate (34%) and some college (35%) split for the mean, and less than high school (15%) and college graduate (13%) at either end of the distribution.

When Grand Rapids Project Access enrollment and survey respondent data are compared to national data, the results are a unique mixture that does not fit firmly in either the transitional or chronically uninsured categories (Table 11). Age and race characteristics are skewed strongly toward the transitional category, while marital status and income are skewed toward the chronic category. Education is equally divided between greater than and less than or equal to high school. Finally, U. S. citizenship and size-of-employer were not measured. These results characterize Grand Rapids Project Access enrollees as older (mean age 41-50 years), white, single, and with an income of less than or equal to $35,000 per year. When the number and percentage of enrollees of Grand Rapids Project Access enrollees are compared to national data, the results yield a very small population. While the national average of individuals and families that are at or below 150% of the federal poverty level is 12%, the Grand Rapids Project
Access enrollment is 0.059% of the Kent County population and 0.49% of the projected uninsured population.

Table 11

*Grand Rapids Demographics Compared to National Data*

<table>
<thead>
<tr>
<th>Transitional</th>
<th>Chronic</th>
<th>Project Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 35 years age</td>
<td>18-35 years age</td>
<td>41-50 years age</td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td>Hispanic</td>
<td>White</td>
</tr>
<tr>
<td>U. S. Citizen</td>
<td>Non-U. S. Citizen</td>
<td>Not Measured</td>
</tr>
<tr>
<td>&gt; High School Education</td>
<td>≤ High School Education</td>
<td>Equal &gt; &amp; &lt; High School</td>
</tr>
<tr>
<td>Married with Children</td>
<td>Single without Children</td>
<td>Single without Children</td>
</tr>
<tr>
<td>&gt; $35,000 per year</td>
<td>≤ $35,000 per year</td>
<td>≤ $35,000 per year</td>
</tr>
<tr>
<td>&gt; 100 Employees</td>
<td>≤ 100 Employees</td>
<td>Not measured</td>
</tr>
</tbody>
</table>


*Chronic Illnesses*

Enrollees were questioned about whether or not they had any chronic illnesses, with 84% reporting they had at least one chronic illness. The chronic health conditions reported by this population (Table 12) include pain (30%) and high blood pressure (29%) as the most frequent, with bones and
Table 12

Survey Respondent Chronic Illness – Frequency Distribution

<table>
<thead>
<tr>
<th>Chronic Illness</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>30</td>
</tr>
<tr>
<td>High BP</td>
<td>29</td>
</tr>
<tr>
<td>Bones or Joints</td>
<td>22</td>
</tr>
<tr>
<td>Mental Health</td>
<td>17</td>
</tr>
<tr>
<td>Stomach</td>
<td>17</td>
</tr>
<tr>
<td>Diabetes</td>
<td>16</td>
</tr>
<tr>
<td>Heart</td>
<td>7</td>
</tr>
<tr>
<td>Brains or Nerves</td>
<td>6</td>
</tr>
<tr>
<td>Skin</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
</tr>
<tr>
<td>None</td>
<td>16</td>
</tr>
</tbody>
</table>

Number of Chronic Illnesses

<table>
<thead>
<tr>
<th>Number of Chronic Illnesses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero</td>
<td>6</td>
</tr>
<tr>
<td>One</td>
<td>49</td>
</tr>
<tr>
<td>Two</td>
<td>19</td>
</tr>
<tr>
<td>Three</td>
<td>14</td>
</tr>
<tr>
<td>Four</td>
<td>8</td>
</tr>
<tr>
<td>Five</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: Self-administered survey of Grand Rapids, Michigan Project Access enrollees, April 2006

joints (22%) the second most frequent. Mental health (17%), stomach (17%), and diabetes (16%) compose the third group, and heart (7%), brain or nerves (6%), and skin (4%) comprising the fourth and final group of health
conditions. Additionally, other was listed by 19% of the respondents and none by 16%. These data were then further analyzed to determine how many enrollees had only one chronic illness and how many had greater than one chronic illness or comorbidities. Sixteen percent of the enrollees reported no chronic illness. Almost one half of the enrollees (49%) reported only having one chronic illness. Of the remaining 45%, 19% reported having two chronic illnesses, 14% reported three chronic illnesses, 8% reported four chronic illnesses, and 4% reported five chronic illnesses. No enrollees reported greater than five chronic illnesses.

Pre- and Post-Project Access Enrollment Pairs

There are 10 pairs of questions concerning health and 3 pairs of questions concerning barriers to physician access. The health pairs use a 7-point Likert scale to gauge the level of change experienced from the year prior to the year since enrollment in Project Access, whereas the barriers to physician pairs use a 5-point Likert scale ranging from strongly agree to strongly disagree and included do not wish to answer and not applicable categories and tested pre- and post-enrollment transportation, office hours, and child-care barriers to physician services.
Health and Lifestyle Pair

The first pair tested whether Project Access enrollees experienced an increased level in work and lifestyle function since enrollment in Project Access. This pair sought to determine how many months poor health kept enrollees from engaging in normal lifestyle activities (Table 13). The largest percentage point increase (9 percentage points) in these pairs occurred between those who reported no months missed from work or lifestyle functions. The trend for these pairs moved toward fewer months of missed work and lifestyle function with the largest percentage point reduction occurring between enrollees reporting 11 plus months of missed work or lifestyle function due to poor health. This shift in frequencies is further corroborated by the statistically significant $p$ value of 0.000 ($p < 0.05$) calculated by the Wilcoxon signed rank sum test result of pre- and post-enrollment reported results.

Table 13

Health and Lifestyle Comparison – Frequency Distribution

<table>
<thead>
<tr>
<th>Months</th>
<th>0</th>
<th>1-2</th>
<th>3-4</th>
<th>5-6</th>
<th>7-8</th>
<th>9-10</th>
<th>11+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-enrollment months of lifestyle function missed due to poor health</td>
<td>57%</td>
<td>14%</td>
<td>9%</td>
<td>4%</td>
<td>1%</td>
<td>2%</td>
<td>9%</td>
</tr>
<tr>
<td>Post-enrollment months of lifestyle function missed due to poor health</td>
<td>66%</td>
<td>16%</td>
<td>7%</td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Source: Self-administered survey of Grand Rapids, Michigan Project Access enrollees, April 2006

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Physician Access Pairs

The next set of pairs tested the frequency of visits to a variety of physician-type providers and including private physician, PA or RN, clinic, and emergency room (Table 14). The general trend of these data demonstrated fewer enrollees who forsook physician-type treatment, fewer aggregate physician-type visits, and fewer emergency room visits.

Private physician. Visits to a private physician showed the largest percentage point change with enrollees who indicated they had no physician visits decreasing by 11 percentage points or a 24% change (Table 14). The highest percentage point change was a 9 percentage point increase in those enrollees who made 3-4 visits to a private physician. The shift in these data occurs with enrollees reporting 5-10 visits to a private physician indicating no change and those reporting 11+ visits reporting a decrease of 3 percentage points. When the pre- and post-enrollment sets of data were compared by use of the Wilcoxon signed rank sum, the resulting p value of 0.171 (p < 0.05) is not statistically significant and appears to contradict the above frequencies. These data indicate that a greater number of patients are seeking private physician services and reporting fewer visits; however, this increase is not statistically significant.

PA or RN. Project Access enrollee visits to a physician assistant (PA) or registered nurse (RN) trended similar to the physician data although to a
Table 14

Access to Physician Services – Frequency and Statistical Analysis

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Number of Visits</th>
<th>0</th>
<th>1-2</th>
<th>3-4</th>
<th>5-6</th>
<th>7-8</th>
<th>9-10</th>
<th>11+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-enrollment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private physician</td>
<td></td>
<td>36%</td>
<td>27%</td>
<td>12%</td>
<td>6%</td>
<td>3%</td>
<td>1%</td>
<td>7%</td>
</tr>
<tr>
<td>RN or PA</td>
<td></td>
<td>48%</td>
<td>5%</td>
<td>5%</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Clinic</td>
<td></td>
<td>44%</td>
<td>8%</td>
<td>8%</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>ER</td>
<td></td>
<td>42%</td>
<td>22%</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Post-enrollment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private physician</td>
<td></td>
<td>25%</td>
<td>31%</td>
<td>21%</td>
<td>6%</td>
<td>3%</td>
<td>1%</td>
<td>4%</td>
</tr>
<tr>
<td>RN or PA</td>
<td></td>
<td>41%</td>
<td>9%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Clinic</td>
<td></td>
<td>40%</td>
<td>11%</td>
<td>7%</td>
<td>3%</td>
<td>2%</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>ER</td>
<td></td>
<td>50%</td>
<td>11%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Pre-enrollment – no physician visits due to inability to pay</td>
<td></td>
<td>26%</td>
<td>22%</td>
<td>22%</td>
<td>11%</td>
<td>4%</td>
<td>3%</td>
<td>11%</td>
</tr>
<tr>
<td>Post-enrollment – no physician visits due to inability to pay</td>
<td></td>
<td>72%</td>
<td>18%</td>
<td>7%</td>
<td>2%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Statistics</td>
<td>Number of Visits</td>
<td>0-11+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private physician</td>
<td></td>
<td>0.171</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN or PA</td>
<td></td>
<td>0.978</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic</td>
<td></td>
<td>0.574</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ER</td>
<td></td>
<td>0.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No physician visit due to inability to pay</td>
<td></td>
<td>0.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Self-administered survey of Grand Rapids, Michigan Project Access enrollees, April 2006

*p < 0.05.
lesser magnitude (Table 14). Visits to a PA or RN demonstrated percentage decrease (7 percentage points) for those forsaking visits, an increase for enrollees reporting 1-2 visits (4 percentage points) and 5-6 visits (1 percentage point), and decreases of 1 to 2 percentage points for all other categories. When the Wilcoxon signed rank sum test is applied to the pre- and post-enrollment data in aggregate, the reported the p value is not statistically significant (p = 0.978, p < 0.05). These data indicate that a greater number of enrollees are seeking PA or RN treatment and reporting fewer visits, although the shift is not as pronounced as the shift in physician visits and is not statistically significant.

Clinic. Project Access enrollee visits to a clinic trended similar to the private physician and PA or RN data (Table 14). Enrollees reported a decrease of 4 percentage points by those who forsook visiting a clinic; an increase for enrollees reporting 1-2 visits (5 percentage points) and 5-6 visits (1 percentage point); a decrease for enrollees reporting 3-4 visits (2 percentage points), 7-8 visits (1 percentage point), and 11+ visits (1 percentage point); and no change for those seeking 9-10 visits. When the Wilcoxon signed rank sum test is applied to the pre- and post-enrollment data in aggregate, the reported p value is not statistically significant (p = 0.574, p < 0.05). These data indicate that a greater number of enrollees are seeking clinic treatment and reporting fewer visits; however, the change is not statistically significant.
Emergency room. Emergency Room (ER) visits demonstrated a mirror image of the trends for the above three categories of physician-type providers (Table 14). Enrollees reported an increase of 8 percentage points by those who forsook visiting an ER, decreases for 1-2 visits (11 percentage points) and 3-4 visits (1 percentage point), increases for 7-8 visits (1 percentage point), 9-10 visits (1 percentage point), and no change for 5-6 and 9-10 visits. Application of the Wilcoxon signed rank sum test to the pre- and post-enrollment data in aggregate yields a statistically significant p value (p = 0.000). These data indicate that fewer enrollees are reporting that they are seeking physician-type services from the ER and this shift in venue is statistically significant.

Inability to access physicians due to inability to pay. The next set of pairs tested how frequent Project Access enrollees did not see a physician due to lack of funds to pay for the visit (Table 14). Enrollees reported a 46 percentage point change in the frequency of those not forsaking physician visits due to their inability to pay. All categories demonstrated decreases in the frequency of enrollees forsaking physician visits due to their inability to pay for them 1-2 (4 percentage points), 3-4 (15 percentage points), 5-6 (9 percentage points), 7-8 (4 percentage points), 9-10 (2 percentage points), and 11+ (11 percentage points). This set of pairs demonstrated some dramatic changes with all frequency categories showing decreases in the number of times enrollees could not see a physician due to the inability to
pay for the office visit. When the Wilcoxon signed rank sum test is applied to the pre- and post-enrollment data in aggregate, the reported $p$ value is statistically significant ($p = 0.000$).

**Medication Pairs**

The next four sets of pairs tested whether there is a difference in how frequent Project Access enrollees reported they were supposed to take medications, took medications, and did not take medications due to the lack of funds to purchase them. A fourth category, how frequent enrollees missed taking their medications, was calculated as the difference between how often enrollees were supposed to take their medications and how often they reported taking them. This set of pairs demonstrated some of the most dramatic percentage changes with one third of the pairs demonstrating changes in the direction of increased adherence with prescribed medication regimens.

*Prescribed medication regimen.* The categories that tested how frequently enrollees were supposed to take prescribed medications demonstrated a decrease of 7 percentage points between those who reported zero as the number of months they were supposed to take medications pre-enrollment versus post-enrollment (Table 15). Enrollees reported increases in the following categories of months they were supposed to take their medications 1-2 (15 percentage points), 3-4 (8 percentage points),
points), 5-6 (4 percentage points), 7-8 (3 percentage points), and 9-10 (3 percentage points). The category of 11+ months was the only category beside zero months to have a reported decrease (27 percentage points). The Wilcoxon signed rank sum calculated a statistically significant \( p \) value (0.000) when the pre- and post-enrollment sets of data were compared and indicate a statistically significant difference in the frequency enrollees reported they were supposed to take prescribed medications.

*Frequency of taking medications.* The next pairs of questions tested how often enrollees took prescribed medications and demonstrated a 21 percentage point decrease in the percentage of who reported zero as the frequency for missing their medications (Table 15). Enrollees reported increases in the frequency of taking their medications for following categories of months 1-2 (15 percentage points) and 3-4 (8 percentage points), no change for 5-8, and decreases for 9-10 (1 percentage point) and 11+ (3 percentage points). The Wilcoxon signed rank sum calculated a \( p \) value (\( p = 0.609 \)) that was not statistically significant when the pre- and post-enrollment sets of data are compared. These data indicate an increase in enrollees' adherence to their prescribed medication regimen but not a statistically significant change.

*Adherence to medication regimen.* The next pair of pre- and post-enrollment data calculated the difference between the reported frequency of how often enrollees were supposed to take medications versus the
Table 15

**Medications – Frequency and Statistical Analysis**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Pre-enrollment supposed to take medication</td>
<td>35%</td>
</tr>
<tr>
<td>Post-enrollment supposed to take medication</td>
<td>28%</td>
</tr>
<tr>
<td>Pre-enrollment frequency of taking medications</td>
<td>44%</td>
</tr>
<tr>
<td>Post-enrollment frequency of taking medications</td>
<td>23%</td>
</tr>
<tr>
<td>Pre-enrollment frequency of missing medication</td>
<td>68%</td>
</tr>
<tr>
<td>Post-enrollment frequency of missing medication</td>
<td>96%</td>
</tr>
<tr>
<td>Pre-enrollment inability to pay for medications</td>
<td>48%</td>
</tr>
<tr>
<td>Post-enrollment inability to pay for medications</td>
<td>71%</td>
</tr>
<tr>
<td>Statistics</td>
<td>Months</td>
</tr>
<tr>
<td></td>
<td>0-11+</td>
</tr>
<tr>
<td>Supposed to take medications</td>
<td>0.000</td>
</tr>
<tr>
<td>Frequency of taking medications</td>
<td>0.609</td>
</tr>
<tr>
<td>Adherence to medication regimen</td>
<td>0.000</td>
</tr>
<tr>
<td>Inability to pay for medications</td>
<td>0.000</td>
</tr>
</tbody>
</table>

Source: Self-administered survey of Grand Rapids, Michigan Project Access enrollees, April 2006

*p < 0.05.*
frequency of how often they took them (Table 15). These data indicate that 96% of the enrollees reported zero months of missing their medications or a change of 28 percentage points. Enrollees reported increases in the frequency of how often they took their medications in the following categories of months 1-2 (15 percentage points) and 3-4 (8 percentage points), no change 5-8, and decreases 9-10 (1 percentage point) and 11 plus (3 percentage points). The Wilcoxon signed rank sum test calculated a statistically significant $p$ value (0.000) when the pre- and post-enrollment sets of data were compared and indicate a statistically significant difference in the frequency enrollees reported taking the medication prescribed to them by their physician.

*Inability to pay for medications.* The ability to obtain or pay for prescribed medications was the last of the categories to be tested in this group and indicated a general trend of enrollees being able to obtain their medication with greater frequency post-enrollment (Table 15). These data indicate a 23 percentage point increase in number of who enrollees reported zero months of missing prescribed medications due to their inability to pay. Additionally, no change was reported for 1-2 months and decreases were reported for all other categories of months 3-4 (3 percentage points), 5-6 (7 percentage points), 7-8 (2 percentage points), 9-10 (1 percentage point), and 11+ (11 percentage points). The Wilcoxon signed rank sum test calculated a statistically significant $p$ value (0.000) when the pre- and post-
enrollment sets of data were compared and indicate a statistically significant
difference in the frequency enrollees reported not taking prescribed
medication due to their inability to pay for them.

*Enrollee Rating of Health*

A reversal was demonstrated in how enrollees rated their health pre-
and post-enrollment when the years prior to and since enrollment are
compared (Table 16). Enrollees who rated their health excellent increased
by 9 percentage points and those who rated their health as good increased
by 17 percentage points. In contrast, enrollees who rated their health as fair
decreased by 16 percentage points and those who rated their health as poor
decreased by 12 percentage points. When these frequencies are
aggregated as excellent-good and fair-poor, they demonstrate 44% rating for
excellent-good pre-enrollment versus a 70% rating post-enrollment. The fair-
poor category demonstrated 56% rating pre-enrollment versus a 29% rating
post-enrollment. The Wilcoxon signed rank sum test calculated a statistically
significant $p$ value of $0.000$ ($p < 0.05$) when the pre- and post-enrollment
sets of data were compared and indicate a statistically significant difference
in the how enrollees rate their health pre- and post-enrollment.
Table 16

*Health – Frequency and Statistical Analysis*

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior - health</td>
<td>9%</td>
<td>35%</td>
<td>38%</td>
<td>18%</td>
</tr>
<tr>
<td>Since - health</td>
<td>18%</td>
<td>52%</td>
<td>23%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: Self-administered survey of Grand Rapids, Michigan Project Access enrollees, April 2006

*Willingness or Ability to Pay for Similar Services*

The next question tested how much Project Access enrollees would be able or willing to pay for health coverage similar to what they received through Project Access (Table 17). The percentage of those who indicated they were not willing to pay or could not afford to pay for health coverage was 49%. Conversely, 51% indicated they would be willing to pay an amount ranging from $5 to $20 per week for similar coverage. The majority of this

Table 17

*How Much Will You Pay? – Frequency Distribution*

<table>
<thead>
<tr>
<th></th>
<th>$0</th>
<th>$5</th>
<th>$10</th>
<th>$15</th>
<th>$20</th>
</tr>
</thead>
<tbody>
<tr>
<td>How much would you pay?</td>
<td>49%</td>
<td>19%</td>
<td>17%</td>
<td>7%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: Self-administered survey of Grand Rapids, Michigan Project Access enrollees, April 2006

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group (56%) indicated their payment limit to be in the $5 to $10 per week range and the remaining 44% willing to pay in the $15 to $20 range.

**Barriers to Physician Services**

The barriers to physician services questions evaluated transportation, office hours, and childcare as potential barriers to physician services. Enrollees rated each pre- and post-enrollment question on a scale ranging from strongly agree to strongly disagree, do not wish to answer, and not applicable. These pairs indicate that enrollees are experiencing fewer barriers as related to physician office visits.

**Transportation**

Enrollees were questioned about whether or not they had problems with transportation to and from physician offices pre- and post-enrollment (Table 18) with 73% indicating they had no problem pre-enrollment and 78 indicating no problem post-enrollment or a reported decrease in transportation problems by 5 percentage points. Conversely, 10% reported transportation problems pre-enrollment and 7% reported transportation problems post-enrollment or a 3 percentage point change. The Wilcoxon signed rank sum calculated a statistically significant p value (0.030) when the pre- and post-enrollment sets of data were compared and indicate a statistically significant difference in the how enrollees rate transportation to
Table 18

*Barriers to Physician Services – Frequency and Statistical Analysis*

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Do not wish to answer</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-enrollment no problems with transportation</td>
<td>47%</td>
<td>26%</td>
<td>9%</td>
<td>7%</td>
<td>3%</td>
<td>1%</td>
<td>6%</td>
</tr>
<tr>
<td>Post-enrollment no problems with transportation</td>
<td>48%</td>
<td>30%</td>
<td>9%</td>
<td>4%</td>
<td>3%</td>
<td>1%</td>
<td>5%</td>
</tr>
<tr>
<td>Pre-enrollment no problems with office hours</td>
<td>38%</td>
<td>31%</td>
<td>16%</td>
<td>7%</td>
<td>3%</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>Post-enrollment no problems with office hours</td>
<td>48%</td>
<td>36%</td>
<td>12%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Pre-enrollment no problems with childcare</td>
<td>28%</td>
<td>12%</td>
<td>3%</td>
<td>6%</td>
<td>2%</td>
<td>2%</td>
<td>44%</td>
</tr>
<tr>
<td>Post-enrollment no problems with childcare</td>
<td>30%</td>
<td>13%</td>
<td>4%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>43%</td>
</tr>
</tbody>
</table>

Statistics All categories

<table>
<thead>
<tr>
<th>Statistics</th>
<th>Strongly Agree to Strongly Disagree ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>0.030</td>
</tr>
<tr>
<td>Office Hours</td>
<td>0.000</td>
</tr>
<tr>
<td>Childcare</td>
<td>0.811</td>
</tr>
</tbody>
</table>

Source: Self-administered survey of Grand Rapids, Michigan Project Access enrollees, April 2006

*p < 0.05.
and from physician offices pre- and post-enrollment. In summary, fewer enrollees indicated they had transportation problems when going to see a physician post-enrollment.

**Office Hours**

Enrollees were questioned about whether or not they had problems with physician office hours pre- and post-enrollment (Table 18) with 69% reporting they had no problems pre-enrollment and 84% reporting no problems post-enrollment or a 15 percentage point increase of enrollees reporting no problem with physician office hours. Conversely, 10% reported problems pre-enrollment and 2% reported problems post-enrollment or a 9 percentage point decrease of enrollees reporting problems with physician office hours. The Wilcoxon signed rank sum test calculated a statistically significant p value (0.000) when the pre- and post-enrollment sets of data were compared and indicate a statistically significant difference in the how enrollees rate physician office hours pre- and post-enrollment. In summary, fewer enrollees reported problems with office hours post-enrollment.

**Childcare**

Enrollees were questioned about whether or not they had problems with childcare associated with physician visits pre- and post-enrollment (Table 18) with 40% reporting no problems with childcare pre-enrollment and
43% reporting no problems with childcare post-enrollment or a decrease in childcare problems of 3 percentage points. Conversely, 8% answered they had problems with childcare associated with physician visits pre-enrollment and 3% reported problems with childcare post-enrollment or a decrease of 5 percentage points. Unique to this pair of questions was the percent of enrollees answering do not wish to answer or not applicable with 46% answering such pre-enrollment and 45% answering such post-enrollment. The Wilcoxon signed rank sum calculated a \( p \) value of (0.811) that is not statistically significant pre- and post-enrollment sets of data were compared in aggregate. However, when the do not wish to answer and not applicable categories of this group were removed, the Wilcoxon signed rank sum calculated a statistically significant \( p \) value (\( p = 0.008 \)) indicating a statistically significant difference between the pre-and post-enrollment groups and indicating a statistically significant difference in how enrollees rate childcare pre- and post-enrollment. In summary, these enrollees reported fewer childcare problems as related to physician office visits.

**Program Satisfaction**

Three stand-alone questions were asked regarding receipt of the necessary services, recommendation of Project Access to others, and use of Project Access again (Table 19). Enrollees were given the options of rating each question with a 5-point rating scale ranging from *strongly agree* to
strongly disagree, do not wish to answer, and not applicable. These results were very favorable toward Project Access and no statistical tests were deemed necessary beyond the frequencies stated below.

Received the Amount of Services Needed

Enrollees were questioned about whether or not they received the amount of services they needed from Project Access (Table 19) with 82% reporting they received the amount of services they needed and 7% reporting they did not receive the amount of services they needed. These results indicate that the majority of Project Access enrollees received the services that needed from Project Access.

Table 19

Satisfaction – Frequency Distribution

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Do not wish to answer</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received the amount of services needed</td>
<td>56%</td>
<td>26%</td>
<td>6%</td>
<td>6%</td>
<td>1%</td>
<td>1%</td>
<td>3%</td>
</tr>
<tr>
<td>Recommend Project Access</td>
<td>76%</td>
<td>19%</td>
<td>3%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Would use Project Access again</td>
<td>80%</td>
<td>15%</td>
<td>4%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Source: Self-administered survey of Grand Rapids, Michigan Project Access enrollees, April 2006

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Recommend Project Access

Enrollees were questioned about whether or not they would recommend Project Access (Table 19) to a friend or family member with 95% reporting they would recommend Project Access and 1% reporting they would not recommend Project Access. These results indicate that the majority of Project Access enrollees would recommend Project Access to a friend or family member.

Use Project Access Again

Finally, enrollees were questioned about whether or not they would use Project Access (Table 19) again with 95% reporting they would use Project Access again and 1% reporting they would not use Project Access again. These results indicate that the majority of Project Access enrollees would use Project Access again if necessary.

Summary of Survey Comments

One hundred (61%) of the survey respondents included written comments as part of their survey response (Table 20). These 100 responses were divided into three categories of responses with 83% positive, 7% negative, and 10% neutral. Eighty-one percent of the responses expressed gratefulness for the program and made mention of the caring and respectful attitude displayed by the Project Access staff, the physicians, and the
physicians' office staff. The most commonly mentioned positive attribute was access to physicians (28%). Seven percent of the comments were negative with lack of respect and lack of access to medications tied at 2% each. Of the negative comments, the two most common problems noted were lack of access to dental care (4%) and transportation problems (3%).

Table 20

*Mailed Survey Comments – Frequency Distribution*

<table>
<thead>
<tr>
<th>Comment</th>
<th>Percent</th>
<th>Comment</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gratefulness</td>
<td>75</td>
<td>Request for dental services</td>
<td>4</td>
</tr>
<tr>
<td>Access to primary care physician</td>
<td>19</td>
<td>Transportation problems</td>
<td>3</td>
</tr>
<tr>
<td>Access to specialist physician</td>
<td>9</td>
<td>Lack of respect</td>
<td>2</td>
</tr>
<tr>
<td>Access to medications</td>
<td>7</td>
<td>Lack of access to medications</td>
<td>2</td>
</tr>
<tr>
<td>Respect and caring</td>
<td>6</td>
<td>Lack of durable medical equipment</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Self-administered survey of Grand Rapids, Michigan Project Access enrollees, April 2006

Qualitative Analysis

The research design of this project included four qualitative methodologies: (1) document review of implementation documents and data; (2) focus groups with participating physicians' office managers; (3) telephone interviews with participating physicians' office managers; and (4) interviews with Salt Lake City, Grand Rapids, and Buncombe County Project.
Access administrative directors and the consultant to the Grand Rapids program.

Document Review

Implementation documents such as timelines, board minutes, or budgets were requested from the Grand Rapids, Michigan; Salt Lake City, Utah; and Buncombe County, North Carolina Project Access sites. The rationale for reviewing these documents was to elicit a more comprehensive understanding of how the implementation process progressed and to develop interview questions as a result of this analysis. Only the Grand Rapids site responded by supplying documents for this portion of the research. The Salt Lake City site deemed the documents as too confidential to share and the Buncombe County site gave no reason for not supplying documents; however, a brief history of the implementation is documented on their website.

The Grand Rapids site provided 12 documents of which 11 are operations documents and 1 is a timeline. The operations documents add little to understanding the implementation process; however, they do demonstrate systems thinking that covers all aspects of operating a program such as this and range from documents delineating each patient’s responsibilities to communication with hospitals and physicians to a form for physicians to use when referring patients to the program. The breadth of
these documents raises an implementation and program replication question of how these forms were developed and if any technical assistance was provided by the national organization that was consulting with the Grand Rapids site throughout the implementation process. The timeline was useful in understanding the various steps the organization took to implement Project Access; however, it is very brief and does not provide the depth of understanding of the implementation process that access to board meeting minutes and budgets might provide.

The publicly available documents available on the websites of the Salt Lake City and Buncombe County sites are outcome-oriented documents and give no indication of whether either site had any technical assistance. While these documents provide little direct information regarding how these two programs were implemented, they do raise the question, especially in Salt Lake City, of how much of the implementation process was devoted to making contact with the area hospitals and physicians and securing their participation.

The rationale for performing the document review was to gain a better understanding of the implementation process for each organization and to use this information to assist in developing interview questions. The only implementation information gleaned from these documents was indirectly derived and includes the question of technical assistance provided in the
development of these operations documents and the question of how the physicians and hospitals were engaged in participating in Project Access.

Focus Groups and Telephone Interviews

Sixteen physician office managers participated in three focus groups (5 participants) and 11 telephone interviews (11 participants). These focus groups and telephone interviews used the same interview guide with the questions asked in the same sequence. Additionally, the focus groups and telephone interviews were allocated the same amount of time proportionally to answer and discuss each question. These office managers were questioned about (1) what the office staff and physician(s) expected from Project Access, (2) what the experience of their office was with Project Access enrollees, (3) what prompted their physician(s) to become Project Access providers, (4) Project Access enrollees' adherence to office standards, (5) Project Access enrollees' adherence to prescribed medical regimes, (6) how quickly Project Access enrollees' are able to get appointments, and (7) any suggested changes for Project Access or its enrollees (Appendix C).

Focus and Telephone Interview Responses

Responses to the nine questions or statements posed during the physician office manager focus group and telephone interview are
summarized below each question or statement asked during the focus group or interview.

*Describe the experience of your office with Project Access patients.*

All participants indicated that accepting Project Access patients into their office has been a positive experience. Several did note, however, that they were skeptical when they were first informed that their office would be participating in the program and that even after they began accepting Project Access patients, some of the staff members were not aware of the office's participation. The office managers stated that getting their staff oriented to the program was problematic and resulted in some errors on their part, such as not getting accurate contact information and addresses; however, these problems were immediately remedied and they have not reappeared. One recommendation this group has for the Project Access staff is increased frequency of an orientation program targeted to office staff.

Another participant indicated that she was responsible for processing Project Access patients in her office and, due to the part-time hours she worked, she had difficulty communicating with the Project Access office. Her recommendation was for greater availability to the Project Access staff and more timely communication.

The office managers each stated how they and their staff members have been pleasantly surprised at how well the Project Access patients have been prepared and presented themselves. This group cited only one
incident where a patient could not find her Project Access card and, after working with the patient for a few minutes, staff members found the patient was unaware she had the card in her purse. All of the office managers indicated that the patients have been grateful for the services provided to them and, as a group, thank the physician and staff several times for providing them with care during each visit. The office managers indicate that working with Project Access patients has been personally gratifying since they are now able to provide their primary care patients with access for pharmaceuticals, radiology, laboratory, and specialist physician services that were not available to them or difficult to obtain prior to Project Access. The availability of these services relieved both the patients and the office staffs of the burden involved in seeking and providing ancillary and specialist physician care for these patients. The other positive, stated unanimously by the office managers, is that these patients show up on time for their appointments and are adherent to their prescribed medical regimens.

What expectations did your office have of Project Access patients? Were these expectations met? The responses from the office managers regarding expectations included (1) none, (2) ungrateful and demanding patients, (3) show up on time for appointments, and (4) follow prescribed treatment plan. The office manager who indicated she had no expectations of Project Access enrollees works in an office that cares for a large low-income population, and while she hoped Project Access enrollees would be
different, she was not certain what to expect. Only one office manager expected Project Access patients to be ungrateful and demanding and stated, "... these patients did not meet my expectations because they didn't act like our Medicaid patients." The remaining 14 out of 16 office managers all stated that their expectation was that the patients arrive on time for their appointments and have the necessary documents with them, an expectation that Project Access patients have met with only a few exceptions. The final expectation was that these patients would be adherent to their prescribed medical regimens and again the Project Access patients have met this expectation. One office manager stated, "Project Access patients have been more compliant with appointments and adherent to their prescribed medical regimens than our patients who have health insurance."

*What prompted their physician(s) and office to become involved in Project Access?* Physician participation in Project Access in all cases was prompted by a physician from the Kent Count Medical Society or Osteopathic Association approaching either an individual physician or an administrative member of a physician group about participating. When office managers were questioned about what prompted their physician to become a Project Access provider, the initial response from each office manager provided an insight into each physician's attitude toward treating uninsured patients. The physicians' attitudes can be broken into those who view treating Project Access patients as part of fulfilling their personal mission (10
or 63%) and those who view treating these patients as part of fulfilling an organizational mission (6 or 37%). The group of physicians expressing the personal mission attitude can then be equally divided into two groups with half of the office managers stating, "how nice it is to work for a physician with this attitude." The other half of this group stated that without some office manager controls placed on the number of charity care patients seen, this physician would have difficulty meeting financial obligations. All of the office managers of physicians expressing the organizational mission attitude expressed a request to assist them in determining when they had met their agreed to quota of Project Access patients and expressed a desire to have them spread out throughout the year as opposed to clustered during one time period.

An attractive feature offered by Project Access is the financial screening they perform to ensure that patients do not qualify for other insurance programs and that they meet the financial criteria of having an annual income of less than to equal 150% of the federal poverty level. However, two offices stated that their staff routinely performs an insurance screen and that they had discovered a few (the office managers would not definitively quantify "few") Project Access patients who had access to insurance. In spite of the discoveries by the two previously mentioned office managers, all of the managers agree that the financial screening provided by Project Access is one of the strengths of the program, even though it
might need a little “tightening” to avoid patients with insurance from entering the program. Finally, several of the primary care office managers noted that their physicians' view Project Access as an avenue for providing patients with ancillary and specialist care without the physician having to spend prolonged periods of time seeking out favors from colleagues.

Is there anything you would like to change about how Project Access enrollees present themselves? All of the office managers had to pause to think about how to answer this question. In general, the office managers are pleased with how Project Access has been administered and they are pleased with the patients whom they claim present themselves well kept, have all of the necessary information, and bring with them an attitude of gratefulness. Despite their initial favorable remarks, they did have some suggested changes for the program. Two office managers from surgical practices noted that referring physicians have been good about sending records of patients referred to their office; however, two office managers from different surgical practices countered the above by indicating that patients do not always come to them with all the patients’ medical records. The section of the medical record these office managers find missing are the diagnostic tests; their concern is that it prolongs the patient’s treatment and adds an extra nonpaying visit to their office and payor mix. Next, as indicated earlier, there is a need to tighten the financial screening to ensure that no patients have access to health insurance. Third, four office managers
indicated either they or their physician would like to see some type of scorecard or report published at least quarterly indicating where they are on meeting their agreed to “quota” of patients. Finally, one specialist office questioned whether there was some method in which they could be reimbursed for supplies.

*Have Project Access patients been compliant with office policies and prescribed medical regimens?* The office managers stated that generally Project Access patients have been adherent to their prescribed medical regimens. One office manager stated that only “3 out of 100” Project Access patients were not adherent to their prescribed medical regimens and went on to note that as a group Project Access patients are equally if not more adherent than their non-Project Access patients. Five office managers stated that the Project Access staff was quick to contact the patient and either remedy the problem or remove the patient from the program when patients were not adherent to either office policies or prescribed medical regimens.

*How quickly are Project Access patients given appointments? How accommodating is your office to working them in for an appointment?* The office managers all stated that Project Access patients have been worked into the normal patient flow and are treated as any other patient seeking treatment from their office. The quickness of when Project Access patients obtain an appointment depends upon the urgency of their need. Generally, patients have been seen in 2 to 6 weeks for routine needs and within 24
hours for emergency needs. This group noted two impediments to getting patients in to see specialists: (1) the logistics of patients receiving Project Access cards and necessary paperwork (this process can take up to 2 weeks), and (2) specialist offices' lack of familiarity with Project Access.

One office manager stated that her office took a Project Access patient over a paying patient due the Project Access patient's urgent need as opposed to the non-urgent need of the paying patient. This office manager stated, "working Project Access patients into the normal patient flow provides them (Project Access patients) with respect and basic human dignity."

If you could change anything about Project Access and its enrollees, what would it be? As previously stated, the office managers are generally pleased with how Project Access has been managed and how the patients present themselves. One office manager would like to see Project Access placed under an authority other than the Kent County Medical Association and Osteopathic Society and that the boundaries were more constrained to Grand Rapids as opposed to the entire county. The other negative comment was that there could be increased communication and orientation to and for the offices. One participant suggested a newsletter that provided general statistics, a listing of how many physicians are participating with an accompanying breakdown of the number of physicians by specialty, a Project Access success story, and something about the Project Access staff.
From the positive view, the other office managers stated that they would change nothing and that data and documents from Project Access are accurate and timely with the turn around time normally 2 to 3 days. Another of the office managers' only proposed change for Project Access is that the program expand in order to provide the ability to care for more people.

*What changes do you have to recommend to the program?* One office manager requested quicker turn-around times for the assignment of specialists physicians and increased communication about normal office hours and days out of the office, e.g., vacation days or holidays. Four of the office managers requested a newsletter with the same criteria as noted above. Four office managers again requested either a scorecard or report indicating where their office was in meeting their agreed "quota" of patients. Ten office managers requested increased use of electronic transmittal of patient documents as opposed to faxing paper documents back and forth between Project Access and physician offices (some offices are attempting to go paperless). Additionally, this group indicated that having access to forms on a website would be helpful and potentially enhance efficiency. One office manager indicated that it would enhance her office's efficiency if Project Access patients arrived with new patient packets completed. Finally, there was unanimous agreement with the office managers of the need for the development of a Project Access equivalent for the provision of dental care.
Has involvement with Project Access increased your office's sense of community involvement? Half or eight of the office managers stated that involvement with Project Access has not increased their community involvement due to their office's current involvement with low income patients; however, it has increased their ability to care for more patients due to the availability of ancillary and specialist physician care. One office manager stated that involvement with Project Access makes her physician "feel good," but that the office staff has no idea of what is involved with Project Access patients. Another office manager stated that programs such as Project Access should be "more the norm than the exception." Finally, one office manager commented on how involvement with the working-poor has changed her attitude toward them. She now gets frustrated with individuals who mischaracterize the working-poor as lazy and shiftless and instead now sees them as a group of hard-working, grateful individuals.

Focus Group and Telephone Interview Summary

Overall, Project Access has filled a void in service to the uninsured working-poor by (1) providing a structure for financially screening them to ensure that they qualify for assistance; (2) preparing them for their appointment with the physician; (3) equally distributing the patients among the physicians; and (4) providing a process for patients to obtain necessary (a) specialists physician services, (b) radiological studies, (c) laboratory
studies, and (d) pharmaceuticals. When questioned, the office managers see all of the above services as equally important in providing physician and health care services to this patient population. The uniqueness about what Project Access has provided to the provision of care for the uninsured working-poor is structure and coordination of services. The structure of the financial screen and the coordination of services has either enhanced or made possible the ability for the physician offices represented in these focus groups and interviews to care for this patient population.

The negative comments and recommendations for change all fall under two categories: (1) communication, and (2) expanded services. The comments about communication fall under a broad range and include (1) expanded accessibility to Project Access office staff and communication how the patient’s application is processing; (2) increased communication about how the program is progressing (e.g., how many patient encounters and referrals, how many patients enrolled, how many physicians participating, a breakdown of the physician specialties participating); (3) increased and targeted orientation (e.g., general orientation for office staff versus more specialized orientation for staff processing billing and referral documentation); and (4) increased use of electronic transmittal of patient documents as opposed to the current process of faxing documents. The comments about expanded services include (1) increased staff to facilitate
increased volume and quicker turn around time for specialist physician referral, and (2) development of a dental version of Project Access.

**Program Director Interviews**

Interviews were conducted with Project Access administrative directors in Grand Rapids, Michigan; Salt Lake City, Utah; Buncombe County, North Carolina; and the consultant to the Grand Rapids program. These interviews were conducted to determine (1) how Project Access was replicated and implemented in each of these communities, (2) the replication and implementation barriers encountered by each of these communities, (3) how each of these communities addressed these barriers, and (4) a comparison of the barriers encountered and how they were addressed in Grand Rapids as opposed to the barriers encountered and how they were addressed in Salt Lake City and Buncombe County. One unanticipated response from each of the interviewees was their statement at the end of the interview about the refreshing aspect of how the interview process caused them to reflect upon their past experiences of implementing Project Access.

The questions for the consultant are parallel to those asked the other three participants, although they are worded slightly differently to reflect the consultant's experience with the Grand Rapids program. The other two programs were selected for comparison purposes with Salt Lake City.
selected due its similarities to Grand Rapids, and Buncombe County selected due to it being the original Project Access program.

Program Director Interview Responses

Responses to the 10 questions or statements posed during the program director interviews are summarized below each question or statement asked during the interview.

From the time the idea for implementing Project Access was conceived through the first year of operations, what were the challenges you faced? The Grand Rapids program faced three challenges during the first year of operations: (1) funding, (2) physical space, and (3) lack of community understanding. There was no start-up money for this program, so the Kent County Medical Association and Osteopathic Society provided a loan to the program with additional funds secured through a local grant. These funds were short-term and resulted in a large amount of time spent raising funds during the first year instead of marketing the program to the community. The Project Access Board of Directors, which is primarily made up of physicians, took the lead in securing physician participation in the program. However, with the focus on raising funds and physician recruitment, marketing the program to the community and hospitals was not confronted aggressively and caused some deleterious effects. One of the hospitals and one of the community groups proved problematic in convincing
them of the unique process Project Access was offering and how their organizations could benefit from participating with it. The time taken to convince these two organizations of Project Access's unique benefit to their organization and the community resulted in a 6-month delay in the commencement operations. The consultant to Grand Rapids acknowledged the above as a strategic error made in the initial planning phase due to the emphasis placed upon physician organization and recruitment. The consultant also indicated that the national program has changed its approach due to the Grand Rapids experience and now seeks to engage physicians, hospitals, and other related community organizations from the onset of the project.

The other problem related to funding was the inability to hire staff to develop and operate the program that resulted in the program director performing all operational duties during the first months of the program. As the program matured, more grants were secured which resulted in a steady stream of funds and staff was hired and lent to Project Access from other social service programs in the community. The additional staff highlighted a problem of lack of office space which resulted in the staff doubling up in offices and working out of a file room and conference room.

In contrast to the above, the Salt Lake City program had no problem with funding the first couple of years due to a large grant that provided more than adequate funds. Rather, the first year problems at this location
included: (1) lack of an organizational home, (2) lack of legal protection for physicians, and (3) difficulty in arranging participation with the four hospital systems. Originally, the program was to become part of the county health department similar to how the original Project Access program was established in Buncombe County, North Carolina. However, prior to beginning the first year of operations, the county health department director reversed an earlier decision and refused to allow the program to become a part of the health department. The program organizers then quickly found a new organizational home for the program with a nonprofit organization that manages some of the community's primary care clinics. When Project Access debuted in Utah, there was no law to protect physicians who provided charity care in their offices from legal retribution. This problem was remedied 18 months after initiation of the program following some heavy lobbying of the state legislature. Finally, it took 3 years to solidify the concept of charity care and the operational arrangements with the four hospital systems. In addition, the hospitals have been very secretive with their information and unwilling to share data such as true cost versus billed data.

The first year problems in Buncombe County revolved around bringing the right group of individuals together that had the influence necessary to lead a project such as this. While the Buncombe County program was part of the county health department and thus had a more
secure source of funding, it still had to convince the community of the legitimacy of the program and secure physician and hospital participation. Even after 10 years of operations of a successful program, the program administrators and physician leaders have to continually remind the community, hospitals, and county health department of the legitimacy of the program in order to secure continued funds and maintain community support.

The first year challenge common to all three of these programs was securing community and hospital support. Even when support was secured, it took several years to solidify, and even when solidified, support needs to be continually managed in order to meet the dynamic changes inherent to the uninsured population. The organizational problem of where to physically and organizationally house the programs was the next most common theme to these three organizations. Finally, funding is a continual problem for these programs, with Grand Rapids having difficulty with start-up funds, versus Salt Lake City, which had more than adequate start-up funds but finds itself in a funding crisis after 5 years of operations. Contrast these two sets of funding challenges against the Buncombe County model where the program is housed and funded by the county health department. Even though this seems to be a more secure funding arrangement, the Project Access program continues to have to defend itself in the annual county budgeting process.
Describe, throughout the implementation process, how the organization demonstrated commitment to Project Access. All three program directors and the consultant agreed that one of the keys to successful implementation of Project Access is physician leadership. Thus, regardless of where Project Access was housed, the organization of physicians supported Project Access by (1) attending early morning meetings, (2) recruiting physicians, (3) leading the way in convincing the hospital(s) they are associated with to participate, and (4) being good will ambassadors for the program. The other way the Grand Rapids site supported Project Access was by the physicians allowing the program to be physically housed in their joint Medical Association and Osteopathic Society offices and providing the program with a start-up loan. Throughout the implementation, the Grand Rapids' charity care clinics and social service agencies supported Project Access by seeking to understand how they could work together with Project Access to provide comprehensive care for their patients and clients.

From a nonsupportive standpoint, Grand Rapids had one community organization and one hospital which took a great deal of negotiating with in order to secure their participation in Project Access. Both of these organizations deemed that they were already carrying out a function parallel to what Project Access was seeking to provide, and both had to be convinced of the unique approach taken by Project Access and how these two organizations could benefit from supporting Project Access. Salt Lake
City had difficulty negotiating support from the four hospital systems and ultimately negotiated a unique agreement with each system. Buncombe County had full community support, including the hospitals when the program was implemented.

Describe the community and healthcare environment throughout the implementation of Project Access and how, if at all, the environment changed. All three of the sites described communities that were seeking answers for how to increase access to care for the uninsured. The experience of Grand Rapids in the year prior to and subsequent years is parallel to the experiences of the other two programs. In Grand Rapids, the primary care charity clinics were doing a good job providing primary care to the uninsured working-poor; however, they had difficulty securing specialist physician services, pharmaceuticals, and diagnostic tests. In addition, some human service organizations within the community had difficulty securing charity primary care for their clients. Finally, area physicians provided an undetermined amount of charity care through their offices and sought to secure ancillary and specialist services on their own time or through their office staff.

The unique aspect in providing care to the uninsured working-poor that Project Access was able to offer was an organized, structured method of processing these individuals and their needs. The structure includes recruitment of physicians from all specialties, avenues for securing
pharmaceuticals and diagnostic tests, and screening of individuals to ensure they qualify for the program and are not eligible for Medicaid or have any other health insurance. The structure provided by Project Access has caused it to become a community resource and leader in providing care for the uninsured working-poor. The consultant to the Grand Rapids program concurs with the above and adds that the Project Access leadership in Grand Rapids has increased in strength and influence within the community.

The other two programs cite similar evolution of their programs, with the Salt Lake City program noting that little has changed since the inception of Project Access. In contrast, the Buncombe County program, that now has 10 years of experience, notes that while their mission and goals have not changed, the environment they are working in has changed and they have adapted how the program is administered in order to meet the changing need. The Buncombe County program director states, “Project Access is only a temporary solution to the bigger access to care problem” and that the change they have had to adapt to is an increase in the unemployment rate in their community over the past 10 years.

*What flexibility and adaptability was required during the implementation of Project Access?* When asked this question, the director of the Grand Rapids program summed up her response by stating she had to become “Gumby.” The first need for flexibility was identifying the patient population. Initially, the Grand Rapids program anticipated the need for a
large number of primary care physicians and then realized that while they
needed primary care physicians, a large portion of this population already
receives primary care through the various primary care clinics within the
community. The other model that was discussed and rejected by the clinics
was to make all clinic patients Project Access patients. The final model
agreed to was the need to provide primary care to patients who were not a
part of the system of clinics and provide specialty care, access to
pharmaceuticals, and diagnostic testing to all Project Access patients as
necessary. The other action requiring flexibility was recognizing that the
consultant’s rigid top-down approach to program replication and
implementation did not provide the Grand Rapids program with the bottom-
up flexibility necessary in negotiating participation with two organizations
who failed to see how participation with Project Access would enhance their
established missions of providing health care services to low-income
individuals and families. Ultimately, Project Access terminated continued
consultation due to the rigidity of the consultant’s top-down approach. Due to
the Grand Rapids experience, the consultant now recognizes the importance
of being more flexible during the replication and implementation process in
order to adapt to community needs. Prior to working with Grand Rapids, the
stakeholder analysis focused upon physician participation; since Grand
Rapids, the stakeholder analysis has shifted to a broader community focus.
Additionally, Project Access was successful in convincing the two above-
mentioned community organizations that participation with Project Access would add to their ability to care for low-income individuals and families. Flexibility and adaptability were demonstrated by the Project Access staff's willingness to terminate the consultant relationship and to use several approaches in negotiating program participation with the two above-mentioned organizations.

The Salt Lake City program had to undergo a number of operational changes during the first year before they settled upon an operations model. The other change they had to address was a frequent change of hospital leadership, thus requiring a large amount of rework of relationships, education, and commitments. In Buncombe County, the need for flexibility was in how patients were tracked with the leaders spending a large amount of time analyzing and reanalyzing how patients were enrolled and then developing a tracking system that met the needs of both Project Access and the physician practices.

The common theme among these requirements for flexibility is that most of them should have been identified in the initial strategic planning phase of the program and not after the operations had begun. It appears that these programs received either weak or inappropriate guidance on these operational problems from whoever was guiding them through the start-up process, and that more comprehensive analysis of undermining factors.
would assist future start-up programs from having to work through problems similar to those encountered by these three organizations.

*What technical assistance did you receive through the implementation process?* The Grand Rapids site had several technical needs that were met locally through either volunteered services or hired staff. One volunteer assisted the program in developing a data tracking system and has remained in consultation with them to provide system upgrades as needed. The other problem they had was how to manage an operation such as Project Access. Initially, they had no designated system of operations, forms, or documentation process. All of the above were developed by a volunteer who (1) eventually became an employee, (2) developed a procedural manual reflecting the above processes, and (3) currently manages this system. In addition, some consultation was held with other sites that shared their forms and provided other operational tips.

The consultant promotes technical assistance through coaching and interaction with peers and does not see the need for any type of tool kit with examples of forms or other start-up documents. Rather, the consultant has chosen a model that puts organizations in contact with each other and views the development of relationships as an important part of the implementation process as opposed to providing a set of forms and processes that can copied and emulated.
The Salt Lake City program staff visited some other Project Access sites after the first year of operations and saw little need for any type of start-up tool kit. They hired technical assistance with communications, medical records, and creation of a web page. Primarily, they learned from the experiences of other organizations and emulated their management systems and documents as much as possible. The Buncombe County program used a committee to agree upon an administrative system and created its own computer system for tracking data.

In summary, little technical assistance was provided by the national organization to either the Grand Rapids or Salt Lake City programs. The model chosen by the national organization seems to be assistance with start-up talks and providing contact with other Project Access programs, but little, if any, meaningful technical operations or managerial systems building assistance. All sites indicated that a great amount of time and effort was expended developing managerial systems, documents, and tracking systems that may have otherwise been spent establishing the program in the community.

How were the goals and objectives for implementing Project Access developed and were they followed or modified throughout the first year of implementation? The Grand Rapids program indicated that they were handed their goals and objectives by the national organization and then modified them to fit their situation. While the goals and objectives are still in...
place, they are currently under review and focused upon sustainability as opposed to program implementation. Two goals that had to be modified were (1) how to communicate with patients, i.e., all materials had to be written to the sixth grade level; and (2) funding that was not as well developed as initially planned. In contrast, the consultant states that in the Grand Rapids program (1) the goals were not well developed, and (2) they had a different strategy and agenda in place than the one provided by the consultant.

The Salt Lake City director was not present during the first year of operations and thus did not have first-hand knowledge of how the initial goals and objectives were developed. However, he did mention that when he arrived during the second year of operations, the program was not operating under any historical framework and that the focus was on meeting grant requirements. The director of the Buncombe County site reviewed the original goals and objectives developed in 1995 and noted that while some of the operational aspects of the program have changed, the goals and objectives have remained unchanged since the program's inception.

While the goals and objectives developed by the Buncombe County program have remained unchanged, it appears that the other organizations have struggled with developing viable goals and objectives. The divergence of answers to this question raises the question of why there is such as divergence of answers. Are these programs confusing operational goals and
objectives with mission and vision? Are they getting appropriate guidance on the development of goals and objectives?

*Describe the differences in your understanding of theory, principal factors, and causal links relating to the uninsured working-poor and program implementation prior to implementing Project Access and after the first year of operations.* The Grand Rapids director voiced a good understanding of principal factors and causal links related to the uninsured working-poor, the challenges that physician offices and hospitals have in providing access to care and treatment to the uninsured working-poor, and an intuitive understanding of program implementation. Her understanding comes from personal experience with 18 years in healthcare administrative roles where she has worked with physician offices, hospitals, and ancillary healthcare organizations as opposed to the theoretical literature. She had little previous personal exposure to the uninsured working-poor and found that the biases she brought to this position all had to be abandoned and redeveloped. As a result of working with this population, she now realizes that most of the individuals in this population are not here by choice but rather are there as a result of a series of poor choices, untaken or unavailable opportunities, or a combination of both. She sees this population as a group that has been wounded by life and without the resources or life skills (e.g., communication and financial management skills) that are necessary if these individuals are ever to recover from these wounds and emerge from their current life setting.
As a group, this population is not looking for a handout; rather they are looking for someone to listen and for a way out of their current situation. She sees them as a group that needs to be listened to and she seeks to energize and empower them.

The consultant’s understanding of program replication, program implementation, and the principal factors and causal links related to uninsured working-poor was based upon personal work experience. She has worked with the individual who originated Project Access and has based her replication and implementation model established by this individual. Her understanding of the working-poor is that “this population does what they can with whatever resources they have.”

The leaders of the Salt Lake City program claim that everything they expected to happen occurred. What they came to understand about the uninsured working-poor came from working with them and, similar to how the view of the Grand Rapids director was changed, caused the Salt Lake City program staff to change their view of this population.

The director of the Buncombe County program saw principal factors and causal links as having a correlation with medical liability and unaffordable health insurance. Physicians are often reluctant to care for this population due to the lack of legal protections available for providing charity care to these patients in their offices. Therefore, until some legislative remedy is provided to protect physicians, several will remain reluctant to
offer free services only to find themselves set up for a law suit by a disgruntled patient. Unaffordable health insurance is the other major principal factor and causal link related to this population. While several of the uninsured working-poor would like to obtain health insurance, they can neither afford individual policies nor their portion of an employer-sponsored health insurance plan. This director also noted that the current health care system rewards the "wrong things," such as compensating for illness care but providing no compensation for wellness and preventative care.

The four individuals interviewed are passionate about providing access to health care services for this population and all expressed an intuitive and experiential understanding of the need that this population has for access to health care services. Additionally, these individuals expressed an experientially based understanding of program replication and implementation. None of the interviewees made unprompted references to the theoretical literature during the interviews and, when asked about theory, two of the four interviewees stated they had "no need" for theory. An increased theoretical knowledge of program implementation and replication could have potentially assisted these program directors in avoiding some of the mistakes made by others and resulted in fewer start-up problems. Based upon personal and professional experience, most managers do not have the time or resources necessary to search the theoretical literature; therefore, one remedy for their limited understanding of theory could be a digested
review of the literature and current research. This type of digested review could be a function coordinated by the national organization and become a benefit of participation with Project Access.

Describe the process of recruiting physicians and hospitals for Project Access. In Grand Rapids, the Project Access physician leaders took an active role in recruiting peer physicians, resulting in 200 participating physicians at the commencement of operations and the addition of another 150 during its subsequent first year (approximately one third of the Grand Rapids physician population). Two of the three hospital systems were readily recruited to participate in the program, with the third hospital system requiring some negotiating due to their lack of understanding of how Project Access could enhance their mission of providing health care services to low-income individuals and families. Once officials from this hospital system understood how Project Access could enhance and increase their ability to care for low-income individuals and families, they readily agreed to participate and support the program. The consultant has only words of praise for how the Project Access physician leaders were actively involved in establishing the program and engaging their peer physicians to join them and participate in Project Access. The consultant also acknowledges the difficulty in engaging the one hospital and acknowledges that this experience has caused the national organization to change how they approach a community when establishing a Project Access program by
engaging both the physicians and community stakeholders from the onset of the program.

Both the Salt Lake City and Buncombe County programs attribute their successful implementation to strong and engaged physician leaders who actively recruited their peers and engaged their hospitals. While it took 3 years of negotiating with the Salt Lake City hospitals in order to firm up their commitment to the program, one hospital was ultimately so pleased with how Project Access was handling charity care that the hospital turned all charity care decisions over to them.

Describe how you had to use your managerial and political skills during the implementation of Project Access. The Grand Rapids director had to pull from her strong interpersonal strength to overcome the objections she had to confront. She had 18 years of experience in the Grand Rapids health care community, thought she knew everyone, and thought this would be an easy sell to all of them. What she discovered was just the opposite; she found she was on her own and that while her previous contacts were personally impressed with her, they questioned her depth of knowledge on the topic of the uninsured working-poor. This reaction drove her to deepen her knowledge, increase her diplomatic action, and ultimately prove her doubters wrong. She has since strengthened her position within the community and is now seen as a leader in working with the uninsured working-poor. The consultant acknowledges the above evolution of this
director’s strength and standing in the community. Additionally, there were
two stakeholders in Grand Rapids that were very difficult to convince of the
added value Project Access could bring to their organizations and the
community. In both cases, tenacity and using a variety of approaches to gain
access to organizational leaders ultimately resulted in these two
organizations agreeing to participate with Project Access. The consultant
again acknowledges these events and deems their occurrence as a result of
an incomplete pre-implementation stakeholder analysis of all potential
community participants. In addition to the above, this director had to secure
operational funds and supervise development of an operational system.

The Salt Lake City director indicated that the managerial skills of the
initial director were tested significantly in that everything to operate the
program had to be developed from scratch while managing the external
stakeholders, internal stakeholders, and staff. The original director had to
use political skills in order to get each of the hospital systems to agree to
participate in Project Access, including the negotiation of special conditions
of participation for each hospital. For example, one hospital only agreed to
participate with those patients in the hospital and not its physicians referred
to Project Access. Another need for the use of managerial and political skills
occurred when the director had to begin negotiating with the various
stakeholders and funders for replacement funds as the initial funds became
depleted. Finally, this director became involved in successfully lobbying the
state to change its law regarding physician liability for treating patients in their offices.

The original director of Project Access in Buncombe County and the originator of the program had to use considerable managerial and political skills to convince the stakeholders involved to develop and implement the original Project Access program. The skills he used in performing this task were his well-developed relationship building skills and his ability to negotiate and problem solve while always keeping whoever was involved focused upon the goal. In summary, he was said to be flexible with focus.

Describe conditions that seemed to undermine the implementation of Project Access. In Grand Rapids, there are two organizations that were difficult to work with and undermined the implementation of Project Access. Both of these organizations initially viewed Project Access as a competitor to providing health care services to the uninsured working-poor; however, after a lengthy process of negotiations with each organization, Project Access leaders were successful in convincing these two organizations that the mission of Project Access was to collaborate with them in providing health care services to this population and enhance, not detract, from their ability to fulfill their mission. This was a lengthy and difficult process for Project Access leaders and ultimately resulted in a 6-month delay in implementing the program.
The consultant corroborates with the above events and also interjects that one of the reasons for these difficulties was that Grand Rapids, as a community, did not have a comprehensive understanding of what Project Access had to offer in providing physician and health care services to the uninsured working-poor. Within Grand Rapids there are several groups that provide access to health care services to small segments of the poor with each group focused upon the their segment of this population. Project Access needed to convince each of these groups that they were coming in to work with them as collaborators in addressing the access to health care service needs of the uninsured working-poor and that they had no intention of excluding or replacing them. Additionally, Project Access leaders needed to assure each of these groups that the implementation of Project Access would enhance their ability to care for their segment of the uninsured working-poor. The other undermining problem was that Project Access leaders chose to work through the current community leaders and groups who, at times, seemed to turn the focus away from Project Access.

In Salt Lake City, there were two problems that undermined the implementation of Project Access. First was a series of difficulties with the hospitals. Within Salt Lake City there are proprietary hospitals that do not project as generous a view toward providing charity care and even question the appropriateness of providing it, as opposed to the more generous attitude of the nonprofit hospitals that generally see providing charity care as
a part of their mission. Then there was a problem within one of the hospitals with a group contracted by the hospital to enroll patients in Medicaid. This organization saw Project Access as a competitor and refused to refer patients to them. It ultimately took the involvement of hospital leadership to resolve this problem and get the contracted organization to understand the collaborative as opposed to competitive nature of Project Access. The other problem within the community was the question posed by physicians who were willing to assist this population but wanted to know what the long-term plan was for these patients. The attitude displayed by several within in the physician community was a willingness to assist short-term to get patients over a crisis, but a lack of willingness to provide these patients with a long-term medical home. The Salt Lake City Project Access director indicated that the biggest undermining problem faced by the Salt Lake City problem was attitudinal and "directly related to the self-sufficiency mentality prevalent in this section of the country."

In Buncombe County the problem is also attitudinal. Despite the success of Project Access in this community, its leaders realize that Project Access is a short-term solution to a long-term problem. It is this question of how and when a long-term solution is going to be developed and implemented that undermines the sustainability of Project Access. The current approach taken by the Project Access leadership is to maintain a constant and fruitful conversation with all stakeholders about possible long-
term and more permanent access to health care services solutions not limited to the working-poor.

Additional comments. One of the interviewees emphasized that further expansion of Project Access needs to be sensitive to cultural diversity and seek to meet the cultural needs of the community. Another interviewee indicated that there were no dramatic changes in his community; however, as a result of Project Access, his community is now better educated about the problem of access to health care services experienced by the uninsured working-poor. Finally, an interviewee discussed the importance of measuring and publicizing the community's return on investment in Project Access. In measuring the community's return on investment, she asked questions regarding physician ownership of the process, unintended consequences, and community benefits from Project Access.

Summary of Program Director Interviews

Based upon the above interviews, the Grand Rapids Project Access program has had to confront some funding and community challenges that delayed the commencement of operations but that are not unique when compared to the other two sites. The Grand Rapids program did not progress as the consultant anticipated it would based upon a normal progression pattern mapped out by the national organization; however,
despite its not progressing as the consultant anticipated, she considers it to be a unique success. Establishment of an administrative system for processing patients, recruitment of physicians and hospitals, and human resource needs seem comparable among the three organizations. The lack of a detailed analysis of undermining factors appears to have contributed to the delayed start-up in Grand Rapids and problems encountered in Salt Lake City. Each of these programs had difficulty negotiating with at least one hospital in their respective communities. Grand Rapids also had difficulty with a community group that provides similar services, and Salt Lake City had difficulty with physician recruitment due to there being no law to protect physicians while providing charity care in their offices.

The other problem that all three program directors mentioned was securing appropriate funding. Buncombe County has the most stable funding of the three programs with their funding coming from the county. The unstable aspect of Buncombe County's funding is that they have to prove the continued legitimacy of their program and compete with other county programs for adequate operational funds. Salt Lake City commenced with a generous grant that provided necessary start-up capital for the program. This program started to struggle in its third year and currently is in a financial situation that has forced the administrative leaders to furlough some of the employees. Grand Rapids commenced with a loan from the
Medical Association and Osteopathic Society, received funds from a local grant, and has to struggle for funds to continue operations.

The other area in which all of the interviewees were weak was understanding theory as related to the uninsured working-poor, program implementation, and program replication. What these leaders could have gained from an understanding of theory as related to the above topics is how others have approached the same or similar problems, how to avoid these problems, and potential remedies when problems are encountered. Both the Grand Rapids and Salt Lake City programs experienced difficult implementations; the potential that an understanding of replication and implementation theory had to offer these programs was a smoother program implementation with fewer problems.
CHAPTER V

CONCLUSIONS, DISCUSSION, AND RECOMMENDATIONS

Introduction

This chapter is designed to discuss the research findings and bring each of the three research questions regarding (1) increased access to physician and health care services by the uninsured working-poor, (2) Project Access replication, and (3) Project Access implementation to a conclusive answer. The structure of the chapter includes a statement of the research question with a brief introduction, each hypothesis associated with the research question and discussion of the research findings related to the hypothesis, and a conclusion that will indicate whether or not the research question has been answered. Once the three research questions have been answered, the chapter will conclude with a listing and brief discussion of the recommendations derived from this research.

Research Question 1: Has Project Assess Increased Access to Physician and Health Care Services for the Grand Rapids Working-Poor Not Covered by Kent Health Plan Part B?

The first research question was evaluated through the use of six hypotheses and three subhypotheses that evaluated Project Access enrollees' perceived health and lifestyle function, access to physician

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services, access and adherence to medication regimens, ability or willingness to pay for similar services, barriers to physician services, and satisfaction with the program. This research question also evaluated whether Project Access enrollees adhered to the office policies of participating physician offices, adhered to prescribed medical regimens, the attitudes of enrollees toward the physicians and physician office staff, the attitude of physicians and physician office staff toward this population, physician office staff satisfaction with the program, and whether physician office staff had an increased sense of community due to participation with Project Access enrollees.

**H1: Enrollees in Project Access Will Have a Perceived Improved Level of Health One Year After Enrollment Into the Program**

This hypothesis was evaluated through the use of three subhypotheses that evaluated (1) whether enrollees reported improved lifestyle function one year after enrollment in Project Access, (2) whether enrollees reported better control of chronic health conditions one year after enrollment in Project Access, and (3) whether enrollees reported having improved health one year after enrollment in Project Access.

**H1a: Enrollees in Project Access Will Report Performing Activities of Daily Living (e.g., Self-Care, Work, or Recreation) With Greater Frequency in the Year After Enrollment in Project Access Than in the Year Before**
Enrollees who completed the mailed survey reported they missed fewer months of work and lifestyle function in the year since enrollment in Project Access. Thus, based upon these reported responses, Project Access enrollees have met this subhypothesis and are performing activities of daily living with greater frequency in the year since enrollment in Project Access. The rationale for this increase in lifestyle function is discussed below and is linked to increased access to physician services, medications, and control of chronic medical conditions. However, consideration must be given to the possibility that this improvement in lifestyle function is a result of the cyclical nature of some chronic medical conditions, disease maturation, or that the illnesses have not changed in severity; rather, this improvement in lifestyle function is a result in knowing that physician services, health care services, and medications are available (a comment written by several enrollees in the comments section of the mailed survey).

*H1b: Enrollees in Project Access Will Report Having Chronic Medical Conditions Better Controlled (i.e., Increased Performance of Activities of Daily Living, Increased Adherence to Prescribed Medical Regimens, Decreased Emergency Room Use) Due to Increased Access to Physician Services and Pharmaceuticals in the Year After Enrollment in Project Access Than the Year Before*

Project Access enrollees who responded to a survey mailed to all first year enrollees reported increased performance of activities of daily living, increased adherence to medical regimens, and decreased emergency room
use. All 16 physician office manager focus group and telephone interview participants corroborate with the enrollee-reported results of adherence to medical regimens and report that Project Access enrollees have been adherent to prescribed medical regimens.

Responses to the above survey regarding physician services indicate that enrollees forsook physician visits less frequently, had fewer aggregate physician visits, and had fewer emergency department visits. Physician services include visits to private physicians, physician assistants (PA) or registered nurses (RN), and clinics. When the types of physician visits are divided into categories, enrollees reported increases in all categories of physician services with the greatest increase in private physician visits and the least increase in clinic visits.

*Private physician.* The private physician categories include primary care, medical specialist, and surgeons. When the Project Access leadership was establishing the model for Grand Rapids, they found that many potential enrollees had access to primary care (most frequently through a clinic); however, few, if any, had access to medical specialists and surgeons. Thus, the recruitment effort was shifted from primary care physicians to medical specialists and surgeons; therefore, the increase in physician services could imply an increase in visits to medical specialists and surgeons. These physicians would be the ones who would normally resolve acute physical needs (i.e., medical specialists and surgeons) or establish long-term plans.
of treatment (i.e., medical specialists) that could then be managed by primary care physicians.

Clincs. In contrast, clinics demonstrated the smallest increase. This category is most closely associated with primary care and is the category, based upon preliminary research by Project Access staff, that fewer enrollees needed; thus, it is understandable that this category had the smallest increase.

PAs and RNs. Finally, the survey results indicate that the volume of visits to PAs and RNs is less than the increased volume of visits to private physicians and greater than the increased of visits to clinics. It is understandable that this category demonstrates results between these other two categories of physician services since PAs and RNs work for primary care physicians, medical specialists, and surgeons. PAs and RNs have the ability of providing primary care, managing medical treatment regimens, and giving follow-up care for surgical procedures. Thus, future research may find it beneficial to understand the type(s) of services PAs and RNs provided this population, since a more thorough understanding of the services these providers offer may result in an avenue for expanding Project Access.

Emergency room. The use of emergency room services by Project Access enrollees is the mirror image of the use of physician services. Fewer enrollees reported using the ER and those who used the ER reported using it less frequently. The reason enrollees visited the ER either pre- or post-
enrollment in Project Access was not a topic of this study; thus, it is not clear whether enrollees visited the ER post-enrollment for acute exacerbations of chronic medical conditions (an appropriate use of the ER), acute medical needs unrelated to existing chronic medical conditions (an appropriate use of the ER), or routine management of chronic medical conditions (an inappropriate use of the ER). Since the nature of the ER visits is not known, whether these ER visits are appropriate or inappropriate remains unknown and is a topic that could be explored in future studies. Regardless of the reason for the visit, enrollees reported a decrease in ER visits and an increase in physician visits.

Medications. The next related area of treatment of chronic medical conditions was access to and adherence to prescribed medication regimens. Enrollees reported increased access to their medications and that they regularly took their medications when they had them. Access to medications is a function of both access to physician services to get the prescription for the medications and the ability to acquire or purchase medications. One of the services Project Access coordinated for enrollees was the acquisition of medications at substantially reduced or no cost. Once enrollees had the medications, they reported taking them as prescribed. Adherence to prescribed medication regimens is an integral part of any treatment plan for any chronic medical condition; thus, it is understandable that enrollees have chronic medical conditions better controlled due to taking their prescribed
medications. This study demonstrates a potential correlation among reported increased adherence to medication regimens, better control of chronic medical conditions, and reported decreased emergency room use for the treatment of chronic medical conditions, a correlation that is well supported by the literature (Daly, Oblek, Seifert, & Schellenberger, 2002; Fairbrother et al., 2003; Gusmano, Faribrother, & Park, 2002; Hadley & Holahan, 2003; Mainous, Hueston, Love, & Gariffth, 1999; McLaughlin & Mortensen, 2003; Mills & Rhandari 2003, Proser, 2004; Sudano, 2003).

Several examples of social exchange are occurring with the activities described above. For the enrollees social exchange occurs when they seek out physician services and then when they follow the treatment plan prescribed by the physician. Whereas the physicians portion of this social exchange equation includes the provision of services to this population and development of a treatment plan. The provision of services to this population free-of-charge is an example of redistributive justice or one who has more giving back to one who has less. Finally, the pharmacies and pharmaceutical companies who provide medications to the population at minimal to no cost are additionally engaged in redistributive justice.

Hypothesis 1b Summary

This hypothesis defines better control of chronic medical conditions as (1) increased performance of activities of daily living, (2) increased
adherence to prescribed medical regimens, and (3) decreased emergency room use. Based upon results of the survey mailed to all first year Project Access enrollees, all three of the above criteria have been met thus, as defined by this hypothesis, chronic medical condition are better controlled for this population and the criteria for this hypothesis have been met. The actual determination of better control of chronic medical conditions is a clinical determination that requires measurement and interpretation of clinical data. However, clinical data was not available for this study thus the choice of the three proxy measures of better control of chronic medical conditions listed above. Additionally, the measurement of these proxy measures is provided by enrollees one year after enrollment in Project Access; therefore, even though a cognitive recall method was used, the consideration of faulty or inaccurate memory must always be given as a limitation of this type of measurement.

\textit{H1c: Enrollees in Project Access Will Report Having Perceived Improved Health in the Year After Enrollment in Project Access}

Enrollees reported a significant shift in those reporting excellent or good health in the year after enrollment in Project Access. A plausible reason for this shift could to be related to better control of chronic medical conditions defined in this study as increased access to physician services, the ability to obtain and take prescribed medications, and decreased ER
use. There is supporting correlation between what enrollees reported on the mailed survey (increased use of physician services and adherence to medication regimens) and what physician office managers reported during the focus groups and telephone interviews (enrollees displayed an attitude of gratefulness for the ability to see a physician and were adherent to prescribed treatment plans a medication regimens). Additional possibilities for perceived improved health include the cyclical nature of some chronic illnesses, disease maturation, and the mental component of knowing that access to physicians and medications is available if needed even if not used (a written comment on several of the surveys). Regardless of the reason, enrollees reported improved perceived health thus the criterion for this subhypothesis has been met.

Summary of Hypothesis 1 – Perceived Improved Health

In summary, the three subhypotheses discussed above support the primary hypothesis of enrollees having perceived improved health in the year post-enrollment in Project Access. The results of the mailed survey and physician office manager focus groups and telephone interviews indicate increased access to physician services, increased access prescribed medications, increased adherence to prescribed medication regimens, better control of chronic medical conditions, assurance of knowing access to physicians and medications is available if needed, and increased lifestyle
function (activities of daily living) in the year post-enrollment in Project Access. All of the above are defined, through the subhypotheses, as proxy measurements of perceived improved health. These findings correlate with the literature that describes how the uninsured frequently forsake preventive medical treatment, diagnostic tests, and medications which are all distinct portions of prescribed treatment plans (Daly et al., 2002; Fairbrother et al., 2003; Gusmano et al., 2002; Hadley & Holahan, 2003; Mainous et al., 1999; Proser, 2004; Sudano, 2003). Thus, there is sufficient evidence to support that hypothesis 1 regarding perceived improved health in the year post-enrollment in Project Access has been met.

Despite the above results, perceived improved health may not equate to a clinical judgment of improved health. This study did not measure clinical improvement in health nor was it designed to do so. The clinical measurement of improved health requires access to clinical records and assessment of a clinician trained in their assessment. Perceived improved health could be due to the cyclical nature of a chronic medical condition, disease maturation, or simply due to the knowledge that access to physician and health care services is available if necessary. Additionally, the survey of enrollees for this study occurred 1 year after implementation of the program; therefore, despite a cognitive recall method used in the survey, enrollees may have faulty or inaccurate memories regarding their health in the previous year.

This study evaluated three barriers to physician services (i.e., transportation, office hours, and child care) and found that while none of the three were reported as significant barriers pre-enrollment, they all became even less significant barriers (statistically significantly) post-enrollment. During the planning phase for Project Access, there was concern that these barriers could increase due to the shift in the area where enrollees would receive their physician services. The rationale behind this concern was that physician care would shift from clinics that are generally located in areas where enrollees live or on bus lines to outlying physician offices, often located in suburbs, that are not where enrollees live and often are not on bus lines. This concern proved unfounded and the exact opposite occurred.

**Transportation**

Transportation was reported by enrollees as the least of the barriers pre- and post-enrollment in Project Access. Despite enrollees reporting that transportation was the least of the barriers, it still demonstrated a positive and small but statistically significant shift. The reason for this improvement was not evaluated in this study; however, the most plausible reasons include (1) fewer enrollees used mass transit (buses) than anticipated, (2) physician
offices were closer to bus lines than anticipated, or (3) more enrollees had access to private transportation than anticipated.

*Physician Office Hours*

Physician office hours was also a concern during the planning phase of Project Access with the concern being that most physician office hours occur during the hours that most of the enrollees would be working. However, this again proved to be an unfounded concern with a statistically significant shift in enrollees reporting no problem with physician office hours post-enrollment. The reason for this shift is not clear and was not evaluated in this study; however, the most plausible reasons for this include (1) enrollees took time off work in order to meet physician appointment times; (2) while the type of work performed by enrollees was not evaluated, it is likely that most of them are shift workers and possibly not working during office hours; or (3) enrollees were not employed, thus office hours were not a constraining factor.

*Child Care*

Finally, child care was evaluated as a barrier to physician services and it also proved to be an unfounded concern for the majority of enrollees. Child care was not reported as a problem by 40% of the enrollees pre-enrollment and 43% of the enrollees post-enrollment. The mean age of
Project Access enrollees (41-50 years) correlates with an age when households do not normally have small children and is thus one potential reason child care was not reported as a problem for this population. Unique to this satisfaction variable was the 45% who responded that they either did not wish to answer or found the question to be not applicable. It is not clear in this study why so many enrollees chose these two options; however, as indicated above, the mean age group for this study (41-50 years) would not normally have child care concerns. When enrollees who chose not to answer or indicated not applicable (45% of responders) are removed from the survey results and the remaining 55% are analyzed, there is a distinct and statistically significant shift from disagree to strongly agree; thus, enrollees who had child care concerns pre-enrollment reported statistically significant fewer concerns post-enrollment.

**Barriers to Physician Services – Summary**

The question that arises from the above mentioned barriers (i.e., transportation, office hours, and child care) to physician access is, what changed? Why did Project Access enrollees encounter fewer barriers post-enrollment than pre-enrollment? Project Access did nothing to address these potential barriers to physician services, yet enrollees reported fewer barriers. Although it was not evaluated in this study, one potential answer to this question could be the attitudes of enrollees. Enrollees' attitude appears
to be that they have been given an opportunity to gain access to physician services, diagnostic services, and pharmaceuticals, and that they are going to expend whatever resources are necessary to make this happen; thus, they make some type of personal arrangement for transportation, office hours, and child care. If enrollees’ attitude is a source for the changes reported in this study, this shift in attitude correlates with social exchange theory, with enrollees displaying an attitude of taking whatever action necessary to achieve improved perceived health. The other potential reason that could have caused these shifts is that nothing actually changed; rather, they were either unfounded concerns from the onset or their magnitude diminished once enrollees knew they had access to physician and health care services, even if these services were never used. Despite these positive results, there is still room for decreasing each of these three barriers. Potential solutions for decreasing these three barriers and increasing program satisfaction include bus or cab vouchers donated by the city transportation authority or cab companies, extended office hours, and child care donated by child care providers.

Throughout the discussion of these three barriers to physician services, enrollees have appeared to express an attitude of doing whatever it takes to overcome the barriers to physician services. This attitude is an expression of the social exchange enrollees are willing to expend and take upon themselves in order to gain access to physician services, diagnostic
services, and pharmaceuticals. Conversely, enactment of the above proposed solutions would be an expression of social exchange on the part of the community toward the uninsured working-poor. Ultimately, fewer enrollees have reported barriers to physician services in the year post-enrollment than pre-enrollment; thus, the criteria for this hypothesis have been met.

\[ H3: \text{Enrollees in Project Access Will be Able or Willing to Pay $5 to $20 per Week for Health Care Services Similar to Those Received Through Project Access} \]

All of the social science and medical literature surveyed for this study focused upon how much others were willing to give to the population. Conversely, none of the literature explored how much this population was able or willing to exchange for access to physician and medical services. Thus, the rationale behind the question was social exchange, or how much are enrollees able or willing to exchange for services similar to those received through Project Access. This hypothesis was evaluated through one question on the mailed survey of Project Access enrollees, and the results indicate an approximately 50% split between those who are able and willing to pay for similar physician care service and those who are not. Of those who are able or willing to pay for similar services, there is an approximate 40% to 60% split between those who were able or willing to pay $5 to $10 per month and those able or willing to pay $15 to $20 per month.
The significance of this result is that 50% of this population expressed an ability or willingness to pay for health care services—a finding neglected by the current social science and medical literature. What is not clear from these results is the difference between ability versus willingness to pay for health care services. Regardless, the recognition of approximately half of this survey population of a cost associated with health care services and an acknowledged ability or willingness to pay for similar services is an indication of willing or potential social exchange.

The practical implications of this finding include potentials for development of a commercial or Blue Cross insurance product aimed at this population. Additionally, this finding could have some implications on public policy and how social health care products are structured. There is also the potential of a public and private partnership aimed at providing subsidized health care coverage for this population. One current example of this is Kent Health Plan Part C designed for small businesses. This plan offers health insurance coverage through a Preferred Provider Organization (PPO) at $189 per month. This cost is split three ways with Kent Health Plan, the employer, and employee each paying $63 per month (Kent Health Plan, 2004). The lower dollar amounts of $20 per month would require large subsidies from some larger financial source such as some level of government or some type of community foundation or charity. The higher dollar amount of $80 per month is similar to the amount employees of large
employers pay. Smaller businesses would need to develop some type of consortium in order to have the negotiating power necessary to purchase health care insurance that both they and their employees can afford. In summary, the criteria for this hypothesis has been met since approximately half of this population indicated either an ability or willingness to pay for health care services similar to those received from Project Access. While 50% may not seem to be a significant population, it is when taken in context of the current literature that would lead one to conclude that none of this population has ability or willingness to pay for health care services.

H4: Enrollees in Project Access Will Report Being Satisfied With the Services They Received Through the Program

This hypothesis was evaluated by three questions in the mailed survey to Project Access enrollees and indicates that enrollees are very satisfied with the program. Ninety-five percent of survey respondents indicated that they would recommend Project Access to a relative or friend and would use the program again if necessary. Eighty-two percent indicated they received the amount of services they need which, while respectable, may be an area for further investigation in order to ensure that a greater percentage of these needs are met in the future. These results correlate with the written comments of survey respondents that were positive (83%) and expressed gratefulness to the Project Access staff and physicians for allowing them to participate in the program. The results from the physician
office manager focus groups and interviews continue with this theme of gratefulness and adherence to office policies and treatment plans. This satisfaction with the program, willingness to recommend it to others, and willingness to use it again are another example of the social exchange that took place between the enrollees and Project Access staff and between the enrollees and the physicians. The exchange taking place here is attitudinal and states, “You've given to me and I'm giving back to you an attitude of gratefulness” and “You've given to me and I would like to share your gift to me with others.” Thus, most enrollees are satisfied with this program and the criterion for this hypothesis has been met.

**H5: Project Access Physicians and Office Staff Will Report Being Satisfied With Project Access in the Year After Its Implementation**

Eight of the nine questions of the physician office manager focus groups and interviews explored various aspects of this hypothesis. Physician office managers report satisfaction with Project Access enrollees and program administration. Regarding enrollees, the office managers are satisfied with how the enrollees are prepared for office visits, how they present themselves (i.e., clean, pleasant, and with the appropriate documents), and how they adhere to office policies and treatment plans. The office managers had few negative comments regarding enrollees and indicated that the Project Access program staff was quick to address negative enrollees’ concerns. The social exchange taking place among
these three groups was that the physicians would provide free professional services in exchange for Project Access enrollees who were adherent to office policies and treatment plans and who were prepared for their visits. In exchange, the Project Access enrollees were to abide by office policies, be adherent to treatment plans, and present an attitude of gratefulness. The Project Access staff’s involvement in this exchange was to broker the access to physician services for the enrollees and perform an advocacy function with the enrollees by preparing them for the physician office visits and bringing enrollees to an understanding regarding the personal responsibility they had for adhering to treatment plans.

All 16 of the physician office managers were satisfied with how Project Access had been administered and complimented the program leaders and staff for a job well done. However, when questioned, all of the office managers provided program administration-related recommendations. In an effort to keep the recommendations for program changes in perspective, all 16 of the office managers interviewed had to ponder or engage in some limited discussion before they could come up with any suggested program changes. The recommended changes include program efficiencies (e.g., quicker turn-around times, increased use of electronic document transfer) increased communication with offices (e.g., newsletters), and program expansion (e.g., greater physician participation, dental services). The social exchange taking place between these two groups can
be described as physicians providing professional services free-of-charge in exchange for efficient program administration and enrollee preparation by the Project Access staff.

The physician office managers reported they were surprised by how responsibly and pleasantly Project Access enrollees conducted themselves. Additionally, the physician offices were pleased with how the program was administered. The above indicates that the physicians and their office staff were pleased with Project Access in its first year of operations; thus, the criteria for this hypothesis have been met.

**H6: Project Access Participating Physician Offices Will Report Having an Increased Sense of Community in the Year After Agreeing to Be a Project Access Provider**

All of the 16 physician office managers indicated that their physicians and office staff "feel good" about participating in Project Access and being able to provide services to Project Access enrollees. However, "feeling good" is not equivalent to having an increased sense of community due to involvement with Project Access. In fact, half (8) of the physician office managers stated they had no increased sense of community due to their offices already being involved with other programs that provide services to low income populations. Another consideration has to be given to the attitude of the physicians toward this population with two distinct attitudes reported by the office managers. Those physicians who view involvement
with programs such as Project Access as a personal mission most likely already have an increased sense of community, although their increased sense of community is more likely aligned to providing services to the underprivileged than to Project Access. Conversely, those physicians who expressed an organizational mission most likely "feel good" about fulfilling and completing an obligation with little if any sense of community connected to the completion of this obligation. Additionally, the office managers reported a variety of staff attitudes from no change, not understanding what was involved with providing services to Project Access enrollees, to feeling good about being able to offer more than primary care services to Project Access enrollees. The social exchange that was anticipated with this hypothesis was the satisfaction of knowing that the redistribution of a community good (health care services) had been provided; however, this was not clearly evident through the physician office manager focus groups and interviews. Thus, the criteria for this hypothesis have not been met.

Research Question One (Access to Care) Summary

Research question one asked if Project Access increased physician and health care access to the uninsured working-poor not covered by Kent Health Plan. Six hypotheses and three subhypotheses were proposed to evaluate whether or not this research question was answered. The criteria for five of the six hypotheses and all three of the subhypotheses have been
met, with the sixth hypothesis regarding an increased sense of community being the only hypothesis that was not met. Thus, based upon the hypotheses, Project Access enrollees have achieved increased access to physician and health care services. However, there are two limitations causing the affirmative answer to research question one to become qualified. First, while Project Access enrollees have reported increased access to physician services and enrollees and physician office managers have reported adherence to treatment plans, the only direct data collected on access to non-physician health care services were access to pharmaceuticals. Thus, while increased access to health care services appears to have an implied affirmative answer, no direct data were collected on access to diagnostic services, and no data were collected or available from the hospitals, thus qualifying the access to health care services portion of this question. The other aspect of this question that causes the affirmative answer to be qualified is the statement in research question one that "Project Access will increase access to the Grand Rapids working-poor not covered by Kent Health Plan Part B." Project Access had 340 enrollees in its first year of operations and can make the affirmative statement that increased access was provided to those 340 individuals. However, there are approximately 49,000 Grand Rapids uninsured working-poor not covered by Kent Health Plan Part B, and Project Access provided for 0.7% of this population. Even if Project Access were to grow over the next 3 to 5 years to
6,000 enrollees (the same size as Kent Health Plan Part B), that would be only 12% of this population. With a number as large as 49,000, it is difficult to understand how even the best administered program can make a sizable impact in this population without some broader, better funded public approach. In conclusion, this study will consider it as significant that Project Access increased the access to physician and health care services for 340 uninsured working-poor and consider the answer to research question one as affirmative.

Research Question 2: What Replication Barriers Did Grand Rapids Project Access Program Staff Encounter and How Were They Addressed?

This research question compares the replication barriers encountered by the Grand Rapids, Michigan Project Access staff with those encountered by the Salt Lake City, Utah Project Access program staff. Since both of these Project Access programs were replications of a national program, they will both be compared with the replication heuristic developed by Brown and Carner (2000). Brown and Carner developed their heuristic as the result of a study performed to evaluate how programs sponsored by the Robert Wood Johnson Foundation were replicated. The barriers encountered by the Grand Rapids program will also be compared to the barriers encountered by the Salt Lake City program to determine if there are barriers and approaches to overcome these barriers that are common between the two programs.
The replication heuristic developed by Brown and Carner (2000) included the following seven elements: (1) perseverance, (2) credibility, (3) unchanging environment, (4) flexibility and adaptability, (5) good will is greater than money, (6) organizational commitment, and (7) technical assistance. These seven elements will be discussed below and applied to how Project Access was replicated in Grand Rapids and Salt Lake City.

Perseverance

Both the Grand Rapids and Salt Lake City Project Access programs persevered and overcame barriers to replicating and implementing Project Access in their communities. The Grand Rapids program director indicated that two organizations in Grand Rapids that were integral to implementing Project Access were resistant to the program until they understood and were assured that Project Access was not a duplication of their organizational missions, that Project Access would enhance their mission, and that Project Access was a collaborator and not a competitor. The process the program director had to engage in was very time-consuming and ultimately resulted in a 6-month delay in implementing the program. The other barriers that the program director encountered were uncertain finances and a lengthy search for grant money to fund the program. Additional barriers included a lack of
administrative staff, no operational system, and a change in the model from a primary care focus to a medical specialist and surgical focus. The fact that an administrative director and board of directors collaboratively worked through the details of these barriers is a testimony of persevering in order to see a program replicated and implemented.

The Salt Lake City program director was not present until the second year of operations; however, he was very familiar with the history of the organization. The original director demonstrated perseverance by negotiating individual agreements with all four of the hospital systems in Salt Lake City, working to resolve a conflict with one organization within one hospital that viewed Project Access as a competitor, lobbying for and being instrumental in getting legislation passed to protect physicians who provided charity care in their office from legal retribution, and re-educating frequently changing hospital administrative staff. Both of these organizations persevered to see Project Access replicated and implemented in their communities, and both have become established in their respective communities.

Credibility

Both the Grand Rapids and Salt Lake City Project Access programs had some initial credibility due to the success Project Access programs have demonstrated in other communities throughout the country. Additionally,
both programs have grown in credibility within their respective communities as the programs have matured. The consultant stated that the Grand Rapids program director has grown in credibility and is now considered a local expert regarding access to physician and health care services by the uninsured working-poor. The Salt Lake City program director indicated that one hospital was so pleased with the process Project Access established and the results it was demonstrating that this hospital turned over all charity care decisions to Project Access. Thus, both organizations have demonstrated credibility within their respective communities.

*Unchanging Environment*

An understanding of the health care delivery environment is best understood by dividing it into four sections: (1) health care delivery, (2) health care leadership, (3) competitive institutional environment, and (4) socioeconomic conditions. During the implementation of Project Access, the *health care delivery system* in Grand Rapids and Salt Lake City was stable with the only addition or major change to the system being the addition of Project Access. *Health care leadership* was not stable in either community with Grand Rapids experiencing a change in leadership at the major provider of charity care in the community (the founding leader departed and was replaced by an individual who served directly under him) and Salt Lake City experiencing a rapid turnover of hospital administrative personnel. In
Grand Rapids, the departed leader refused to work with Project Access, whereas the new leader quickly resolved the differences her organization had with Project Access and is currently a supporter of the program. In Salt Lake City, this rapid turnover of hospital administrative staff caused a great deal of re-work for the Project Access leadership who had to re-educate the new leaders and re-secure commitments to work with Project Access. In both communities, the health care delivery system demonstrated competition for these patients. The unique aspect that Project Access brought to providing care for the uninsured was the addition of medical specialists, surgeons, diagnostic tests, and pharmaceuticals. Despite this unique addition, both programs had to endure delays in providing services to the uninsured due to competition for these patients by hospitals, clinics, or both. The competition for these patients was rooted in these established organizations viewing Project Access as a competitor and not as a collaborator in providing care that they were not able or willing to provide. Once these hospital and clinic leaders were convinced that Project Access desired to collaborate in providing more comprehensive care for these patients than previously available, they all agreed to work with Project Access and are all active supporters of the program. Socioeconomic conditions were not studied for this research project. In summary, while both communities had stable health care delivery systems, both communities experienced changes in leadership
and a competitive environment for these patients; thus, the criteria for this element have been partially met.

**Flexibility and Adaptability**

Both the Grand Rapids and Salt Lake City program directors indicated that they had to be very flexible and adaptable during the first year of operations. The Grand Rapids director indicated that she had to become flexible due to a change in their model from a primary care focus to a medical specialist and surgical model, a quest for grant funds for current and future operations, and the difficulty in negotiating with the two organizations who did not initially understand how Project Access would complement their organizational mission. The Salt Lake City director indicated that, based upon his knowledge of the first year, it was primarily spent meeting grantee requirements and that the operations model was changed several times before a final model was established. While both of these directors indicated the need for flexibility during the replication and implementation of Project Access in their respective communities, the same cannot be said for how the consultant viewed the implementation of the Grand Rapids program (the Salt Lake City program director had no knowledge of the role of a consultant). Ultimately, the Grand Rapids program and consultant terminated their relationship largely due to the rigid, top-down approach the consultant sought to impose without consideration of the bottom-up needs of the Grand
Rapids program. The Salt Lake City program director was not aware of whether or not a consultant assisted in the replication and implementation of Project Access in Salt Lake City. In summary, the program directors indicated the need for flexibility and adaptability and demonstrated such throughout the program implementation process; thus, the criteria for this hypothesis have been met.

**Good Will Is a Greater Need Than Money**

Both Grand Rapids and Salt Lake City Project Access programs appeared to have the good will and support of their communities behind their programs. Despite the barriers both organizations had to overcome, they both indicated general community support and good will for their programs that seemed to grow as their programs matured and the community witnessed positive results. While the good will and support is gratifying to both organizations, they have both had to struggle for program funds and would dispute this element. The Grand Rapids program has had to struggle from conception to current for funds with the director spending a great amount of time securing grant funds for continued operations. In Salt Lake City, the program began with a large grant that has not been replaced, has had to struggle for funds since the third year of operations, and this year had to reduce their staff due to the lack of funds. While this element has been met by both organizations, they would both dispute its validity.
Organizational Commitment

The Grand Rapids and Salt Lake City Project Access program directors both indicated that they had strong support from their parent organizations. The Grand Rapids Project Access program is operated out of the Kent County Medical Society and Osteopathic Association. This organization has supported Project Access by providing operational support through a start-up loan, office space, and clerical staff as well as support of the physician members of both of these organizations. The Salt Lake City Project Access program has experienced organizational support through local physician leadership and the nonprofit organization that provides it with support for office space and payroll processing support. Due to the support provided by the local organization in both of these communities, the criteria for this element have been met.

Technical Support

Technical support is defined as (1) support provided for the development and implementation of operational systems, and (2) support provided by contact with experts. For this program, it was anticipated that technical support would be provided by the national organization; however, both the Grand Rapids and Salt Lake City Project Access programs received no technical support from the national organization and either purchased or received donated technical services locally. The Grand Rapids program had
services donated by an individual who established their database and provides technical assistance for database upgrades and technical maintenance. Additionally, they have a staff member who established their operational system, operational documents, operational manuals, and maintains their database. In comparison, the Salt Lake City program hired consultants to assist them with establishing a website, database, and communications plan. When the consultant was questioned about the provision of technical support, she indicated that the national organization saw the development of relationships among its programs as more important than the provision of technical support. This attitude from the national program is directly contrary to that of Brown and Carner (2000) and is an organizational philosophy they should consider modifying. When the time, energy, and funds necessary to develop and purchase technical support is considered and coupled with the barriers related to lack of hospital and community support both programs had to overcome, this is one area where the national program could assist the local programs. However, the national program does not currently have the infrastructure necessary to assist or provide technical support to the local programs. If the national program were to assume this role, the national and local programs would have to negotiate the details, such as what level of technical support and maintenance of that support the national program would provide. Despite the national organization not providing technical support, the local organizations sought
out and developed their own local technical support; thus, the criteria of this element have been met.

**H7 Summary of Brown and Carner (2000) Replication Heuristic**

Overall, the Grand Rapids and Salt Lake City programs met the elements of Brown and Carner’s (2000) replication heuristic. The Grand Rapids and Salt Lake City programs both met the elements of perseverance, credibility, good will is greater than money, organizational commitment, flexibility and adaptability, and technical support and partially met the element of unchanging environment. The national program might consider assisting programs by (1) the provision of technical assistance, (2) assistance with the establishment of a steady source of operational funds, and (3) changing their replication approach from top-down to synthesis in order to be more sensitive to unique community needs.

**H9: The Implementation Barriers Encountered by Grand Rapids and Approaches Used to Overcome These Barriers Are the Same Barriers Encountered by and Approaches Used by the Salt Lake City Program**

The Grand Rapids and Salt Lake City programs were compared on three barriers encountered by the Grand Rapids Project Access program. These barriers include (1) funding, (2) hospital endorsement and participation, and (3) community awareness.
Funding

The Grand Rapids Project Access program received initial funding through a loan provided by the Kent County Medical Society and Osteopathic Association and community based grants. In contrast, the Salt Lake City program received a large grant that funded them through the third year of operations; however, since then they have struggled to maintain operational funding. Both programs continue to struggle to ensure stable operational funds and both have sought such finding through grants. These programs differ in the availability of operational funds for the first year of operations and differ in how they obtained their funds. Thus, the first year funding of these programs is not comparable.

Hospital Endorsement and Participation

In Grand Rapids, two of the three hospital systems immediately endorsed Project Access and ensured participation, with one hospital delaying endorsement and participation until it was ensured that Project Access was not duplicating the hospital's mission and that Project Access was positioned as a collaborator and not competitor. The Salt Lake City program had difficulty ensuring hospital endorsement and participation and ultimately had to negotiate separate operational agreements with all four hospital systems. Thus, both programs had to overcome the barrier of hospital endorsement and participation with each program approaching the
hospitals through individual negotiations; therefore, these programs are comparable on this barrier and differ only on the order of magnitude with Salt Lake City negotiating with four hospitals and Grand Rapids with one.

Community Awareness

Both the Grand Rapids and Salt Lake City Project Access programs indicated the need to develop community awareness; however, both programs had different approaches in how to achieve this need. In Grand Rapids, the program director oversaw the development of community awareness through her personal attendance at a large variety of community meetings and through the Project Access board members who are primarily physicians and who personally spoke about Project Access to their colleagues and hospital executives. In contrast, while the Salt Lake City physicians also personally spoke with their colleagues and hospital executives, the program director hired a communications consultant to assist the program in developing a communications plan. Thus, these programs were similar in their need for developing community awareness and in using physicians as part of the communications plan; however, they differ in how they developed and administered their respective communication plans.
Research Question Two (Replication) – Summary

This research question regarding the replication of Project Access was evaluated through the evaluation of hypotheses 7 and 9. Hypothesis 7 compared the replication of Project Access to the replication heuristic developed by Brown and Carner (2000) and found both organizations meeting six of seven elements and both partially meeting the seventh. Hypothesis 9 evaluated how the barriers encountered by the Grand Rapids program compared to those encountered by the Salt Lake City program and how each program addressed these barriers. The Grand Rapids program encountered three barriers to replication while the Salt Lake City program encountered only two barriers. While both programs encountered the same barriers, hospital endorsement and participation is the only barrier where they used the same method (negotiations) to address the barrier. The other common replication barrier was community awareness, which the Grand Rapids program director chose to personally develop and administer as opposed to Salt Lake City’s approach of hiring a consultant to develop a communications plan. Program funding was and continues to be a challenge for the Grand Rapids program. In contrast, implementation funding was not a problem for the Salt Lake City program; however, it has become a sustainability barrier since the third year of operations.
Research Question 3: What Implementation Barriers Did Grand Rapids Project Access Program Staff Encounter and How Were They Addressed?

The third research question regarding implementation of Project Access was evaluated through hypothesis 8, which compares the implementation of Project Access in Grand Rapids and Salt Lake City to the implementation heuristic Mazmanian and Sabatier (1983) developed for implementation of public policy and modified for this study. The heuristic developed by Mazmanian and Sabatier had six elements focused upon the implementation of public policy. The modification of Mazmanian and Sabatier's (1983) heuristic for this research study maintains six elements; however, the wording of the elements has been modified to reflect implementation of a nongovernmental social program.

H8: Implementation of the Grand Rapids and Salt Lake City Project Access Programs Will Follow the Heuristic (Modified) Described by Mazmanian and Sabatier (1983)

The implementation heuristic developed by Mazmanian and Sabatier (1983) and modified for this study included the following six elements: (1) clear and concise program objectives, (2) understand sound theory, principal factors, and causal links, (3) program structured to ensure the target organization(s) and population(s) will perform as desired, (4) leaders committed to program goals and possessing sufficient managerial and political skill, (5) program supported by stakeholders, and (6) objectives not
undermined by conflicting programs or changes in socioeconomic conditions. Each of these elements and how the implementations of Project Access in Grand Rapids, Salt Lake City, and Buncombe County compare will be discussed below.

Clear and Concise Program Objectives

The Grand Rapids Project Access program objectives were not available for review; however, the program director indicated that they were handed the goals by the national organization and then modified them to meet their needs. She also indicated that the program goals and objectives are currently under review as the organization moves from implementation to stable program performance and growth. In contrast, the consultant states that the Grand Rapids program goals were not well developed and that their strategy and goals were different than those of the national organization. The Salt Lake City program director was not aware of any first year goals or objectives other than the focus the organization had on meeting grant requirements. In contrast to the above, the Buncombe County program director reviewed the original goals and objectives and commented that while the environment they are working in and application of the goals have both changed, the organizational goals and objectives have not changed. The overall objective of all three of these programs is to provide physician and health care services to the uninsured working-poor. However, since
none of the programs provided operational goals indicating specific goals, strategies, targets, and how and when these targets would be measured, it is impossible to determine whether these goals were clear, concise, or met. Thus, the criteria for this element have been partially met due to the lack of relevant documents or material necessary to make a judgment.

Understanding Sound Theory, Principle Factors, and Causal Links

When Mazmanian and Sabatier describe this element, their contention is that through the understanding of sound theory an understanding of principle factors and causal links to whatever the topic is will emerge. Several elements related to this point need to be discussed in order to determine whether this element was met in the implementation of Project Access in Grand Rapids and Salt Lake City. The first distinction that needs to be made is the definition of sound theory, which can refer to either (1) a theoretical framework, or (2) the theoretical literature related to a topic or discipline. Regarding a theoretical framework, Project Access has a loosely defined framework that consists of physicians organizing themselves to provide professional services to the uninsured working-poor. This framework takes on what would be categorized as chaotic or participatory leadership paradigm with the participants (i.e., physicians) organizing and providing care to the uninsured working-poor and the administrative staff available for guidance and support. While none of the interviewees
articulated the above as a theoretical framework, they all articulated the understanding that Project Access is a physician-led initiative.

Next, the distinction of what constitutes theoretical literature needs to be determined. Theoretical literature is the literature of the discipline or topic and is where researchers and practitioners learn the history of their discipline or topic, the successes and failures of others, the steps taken to further advance the successes, and the steps taken to address the failures. These success and failures are frequently referred to in the literature as best practices and lessons learned. In the context of Project Access, there are five bodies of theoretical literature that need to be considered: (1) the uninsured, (2) social exchange, (3) replication, (4) implementation, and (5) evaluation.

Social exchange and evaluation theories are bodies of theoretical literature that practitioners would most likely not be familiar with unless they had an interest in understanding behaviors between groups and individuals and evaluating programs. None of the interviewees articulated references to these bodies of literature; however, due to their length of time as administrators, they have most likely witnessed both of these theories and could most likely discuss them from an experiential view.

Regarding theoretical literature on the uninsured, none of the interviewees articulated any references to the literature; however, they all described the uninsured in fairly accurate detail. However, one example of
how knowing the literature could have assisted in avoiding a misstep occurred with the Grand Rapids Project Access program. Initially, the program leaders determined the need to focus on the recruitment and development of a program to provide primary care to the Grand Rapids uninsured working-poor. However, when they reviewed what was available in Grand Rapids for this population, they discovered that they needed to change direction and develop a program that provided the uninsured working-poor with access to medical specialists, surgeons, medications, and diagnostic services. This misstep could have been avoided by familiarity with the theoretical literature, which indicates that this population normally has access to primary care but lacks access to medical specialists, surgeons, medications, and diagnostic tests.

The next area of theoretical literature that needs to be considered is replication theory. This is an area of theoretical literature that spans several broad areas and includes replication of social (governmental and nongovernmental), nonprofit, and proprietary programs. Project Access falls under the category of a nongovernmental social program. Brown and Carner (2000) provide a heuristic for replicating social programs that comes from studying the characteristics of successfully replicated social programs and consists of seven elements. Technical assistance was one element that Brown and Carner (2000) indicated is an element of successfully replicated programs and that both the Grand Rapids and Salt Lake City programs
found to be troublesome. When Brown and Carner (2000) discuss technical assistance, they are referring to the parent organization providing the local program with technical assistance that includes access to experts and assistance in resolving technical operational problems. With regards to the replication of Project Access, the national organization provided no technical support and actively sought to not provide such support with the rationale that not providing support encourages the programs to learn from each other. This is a position that is directly contrary to the replication heuristic developed by Brown and Carner (2000). Since technical assistance was not provided by the national organization for neither the Grand Rapids nor Salt Lake City programs, these programs generated their necessary support locally at the cost of monetary and time resources.

The final body of theoretical literature relevant to Project Access is implementation theory. Public policy researchers have devoted a considerable amount of time and research effort to understanding the most successful methods of implementing public programs. In 1983, Mazmanian and Sabatier developed a heuristic for implementing public policy that was modified for this research study to more closely reflect the implementation of a nongovernmental social program. One element of this heuristic is the assessment of undermining factors and socioeconomic conditions. Undermining conditions expands on theme of a stakeholder analysis and additionally seeks out cultures, customs, practice, or laws or other potential
impediments to the successful implementation of a program. Both the Grand Rapids and Salt Lake City programs provide examples incomplete stakeholder assessments. In Grand Rapids, the potential concerns of two stakeholders were not adequately assessed and these concerns resulted in a 6-month delay in implementing Project Access, whereas in Salt Lake City, all four hospital systems and one social agency had concerns that were not adequately addresses and while it did not impede program implementation, it did take Project Access leaders 3 years to complete negations with all five agencies. Ultimately, all of these organizations that caused difficulty for the programs leaders resolved their differences and are active supporters of these programs. However, these problems could have been avoided with a more thorough stakeholder analysis. An additional problem encountered by the Salt Lake City program was that when Project Access was implemented, there was no law to protect physicians from litigious claims against them while providing charity care in their offices. This also took 3 years to negotiate with the state legislature and get a law passed protecting physicians in their offices from litigious claims. Again, this is an undermining factor that was not immediately recognized, and while it did not impede implementation of Project Access, it did place its participating physicians in potential legal jeopardy.

The above are examples of how familiarity with the theoretical literature can be a resource for avoiding the missteps of others and
concomitantly building on their successes. Despite the above cited lack of knowledge of the theoretical literature, all of the interviewees were articulate especially on the principal factors and causal links related to the uninsured. The source of this articulate knowledge was experience which, while a powerful source, is also often an incomplete source as indicated above. Thus, the criteria for this element have been partially met.

**Structured to Ensure the Target Organization(s) and Population(s) Will Perform as Desired**

This element has five populations that need to be considered: (1) the uninsured working-poor, (2) hospitals, (3) the community, (4) physicians, and (5) participating physician offices. The Buncombe County Project Access program director indicated that the original program went to great lengths to ensure that all of the necessary community and health care leaders were involved with the implementation of Project Access. In contrast to the original program, the Grand Rapids and Salt Lake City programs both indicated that they were so strongly focused upon physician involvement and participation that they did not spend sufficient time ensuring hospital and community support, which cost both programs delays and rework. Additionally, while all three programs focused upon physician involvement and participation, at least in Grand Rapids, the transition of this involvement to the physician offices was not smooth. A frequent comment in the office manager focus groups and interviews was that either their office was not
initially aware of their involvement in Project Access or that certain members of their staff were not oriented to the program. Therefore, one recommendation for the Grand Rapids program is more frequent and focused physician office staff orientation. Finally, all three programs were designed to ensure that enrollees performed as desired. Detail on how this is achieved is available from the Grand Rapids program where staffers spent time with each enrollee to ensure the enrollee understood the importance of arriving at the physician's office on time, clean, groomed, with a pleasant attitude, and that the enrollee was not to leave the physician's office without understanding the treatment plan and having all questions answered. In summary, there are populations of this element such as physicians and enrollees that functioned as desired, and there are populations such as hospitals, community groups, and physician offices that did not consistently function as desired; therefore, this element can be considered to be only partially fulfilled.

Leaders Committed to Goals and Possessing Sufficient Managerial and Political Skill

The leadership skills displayed by the physicians and program directors in these three communities can best be described as committed and superb. Every leader demonstrated commitment to the principle of increasing access to physician and health care services for the uninsured working-poor and flexed and adjusted their leadership style in order to
ensure that this principle was met. In each of the three communities, the physicians demonstrated leadership by their commitment to frequent, early morning meetings, personal recruitment efforts, and intervention with hospital executives when necessary. While the physicians were busy recruiting other physicians, the program directors were busy establishing offices, preparing for operations, securing operational funds, and negotiating participation with hospital and community leaders. All of these leaders displayed commitment to ensuring access to physician and health care services for the uninsured working-poor and possessed sufficient managerial and political skill necessary to accomplish their assigned task. Thus, the criteria for this element have been met.

*Program Supported by Stakeholders*

The major stakeholders for Project Access include (1) the uninsured working-poor, (2) physicians, (3) hospitals, (4) similar programs providing health care services for low-income individuals and families, (5) small business owners, (6) the community, and (7) funders. During the first year of operations, Project Access provided physician and health care services to 340 uninsured, working-poor individuals. While this is a small number when compared to the estimated 49,000 uninsured working-poor in Grand Rapids, it is comparable to the number enrolled in other Project Access programs in similar size communities during their first year of operations. If the Grand
Rapids Project Access progresses as other Project Access programs have, they can anticipate providing charity physician and health care services to 2,100 to 2,500 individuals within the next 5 years. The Grand Rapids physicians have provided support for Project Access by agreeing to participate in the program and provide physician services free-of-charge to this population. On the first day of operations, Project Access had 200 physicians signed up to provide charity care for the uninsured working-poor. After 1 year of operations, Project Access has 350 participating physicians (approximately one third of the Grand Rapids physician population) who have agreed to provide professional service free-of-charge for this population. Thus, physicians are stakeholders who support Project Access. Grand Rapids hospitals are the third stakeholder and despite initial reluctance by one hospital, all three hospital systems are currently supportive of Project Access. Charity health care and social service programs that work with the uninsured working-poor are the fourth stakeholder, and despite the initial reluctance of one charity health care program, all programs are currently supportive of Project Access. Small businesses and the community are the fifth and sixth stakeholders. While support from small business owners and the community were not explored for this research study, it is difficult to imagine why either of these two groups would not support Project Access since the program seeks to remedy a negative community problem and produces community members who
report to be more productive in the year after enrollment in Project Access than in the year before. Finally, funders must be considered with a program such as Project Access. The current method of funding the Grand Rapids Project Access program is through a series of grants. One question that has to be raised is how sustainable is the current system of funding? Additionally, will funders continue to support a program that at its peak development (i.e., 2,500 enrollees) will coordinate care for only 0.5 percent of the community’s uninsured? Despite program successes, appropriate levels of funding will be one of the keys to the success and sustainability of Project Access. Thus, Project Access leaders will need to consider large sources for core funding such as United Way, governmental funds, or possibly some type of community reimbursement for the funds saved thorough providing care through lower cost venues (e.g., physician offices instead of hospital ERs). Five of the seven stakeholders currently support the program, two of the stakeholders have not been assessed, and the future support of at least one stakeholder (i.e., funders) has not been assessed; therefore, the criteria for this element have been only partially met.

Salt Lake City initially met resistance with several stakeholders; however, all stakeholder concerns were allayed and all stakeholders are currently supportive of Project Access. The Buncombe County program director indicated that while all of the stakeholders were supportive of
Project Access on its first day of operations, they had to be managed in order to ensure continued support.

_Program Objectives Are Not Undermined by Conflicting Programs or Changes in Socioeconomic Conditions_

Both the Grand Rapids and Salt Lake City program directors described how they had to negotiate with hospitals and similar community organizations to assure these organizations that they were not duplicating their mission and were collaborators not competitors. The Buncombe County program has had to adapt their operations to accommodate for the economic downswing their region of the country had recently had to endure. The Grand Rapids and Salt Lake City socioeconomic conditions were not evaluated for this study. One factor common to both the Grand Rapids and Salt Lake City programs is the large amount of time that each program director expended to secure support from potentially undermining organizations. A more thorough community and stakeholder assessment prior to implementation could have potentially brought these organizational concerns forward sooner and potentially could have resulted in smoother implementations. Thus, the criteria have been partially met due to the lack of timely assessment of the concerns raised by two organizations in Grand Rapids and all of the hospitals in Salt Lake City.
H8 Summary of Mazmanian and Sabatier Implementation Heuristic and Research Question Three

Two of the six elements of this heuristic were met, and four were partially. While all three of the programs evaluated for this portion of this research study are currently functioning, two of the three programs experienced difficulties and delays in the implementation process. Two of the above elements that were partially met were related to two organizations that resisted supporting Project Access until their concerns were allayed. These concerns could have possibly been addressed earlier in the process leading up to implementation if they had been recognized earlier as a result of a comprehensive stakeholder assessment. Another element that was partially met is related to understanding sound theory. While the lack of theoretical understanding did not inhibit these programs from being implemented, an understanding of theoretical literature had the potential of providing a historical perspective to program implementation, the avoidance of the missteps of others, and the replication of their successes. Ultimately, the criteria for this hypothesis have been met but not as robustly as they could have been met if all of the actors involved in the implementation process would have followed an implantation heuristic such as the one developed by Mazmanizan and Sabatier (1983).
Recommendations

This research study has evaluated the process of replicating and implementing Project Access and the perceived health outcome of program participants. As a result of the program replication, implementation, and perceived health outcome evaluation, 16 recommendations have been developed and are briefly discussed below. Fifteen of the recommendations are listed as considerations for the Grand Rapids Project Access program and 1 is provided for consideration by the national program.

   Based upon surveys of other Project Access programs, the Grand Rapids program is on target with other programs of comparable size and demographics and can anticipate growth up to approximately 2,100 to 2,500 enrollees (i.e., 2.1 to 2.5 enrollees per physician) within 5 years. This will require larger office space in order to accommodate increased enrollment addition of case management staff to coordinate the needs of increased enrollee volumes and increased funding.

2. Eighty-six percent of Project Access enrollees that responded to the mailed survey reported having 1-4 chronic illnesses; therefore, the development of a disease management program administered by the case management staff and designed to coordinate care for these individuals has the potential for (a) adding depth to the
program, (b) increasing lifestyle function of enrollees, (c) saving community health care funds, (d) development of a niche market, and (e) potentially securing patient management funds from governmental or insurance sources.

3. Develop a more secure, consistent, and increased stream of funding. Potential sources of such funding include (a) becoming a United Way charity; (b) grants from local and national foundations and philanthropic organizations; (c) grants from governmental agencies; (d) direct funding from governmental agencies; (e) grants from local businesses and insurance companies; (f) developing a formula where the hospitals, governmental agencies, or insurers reimburse Project Access a predetermined proportion for the amount the health care expenditures they save the community; or (g) some type of annual fund raiser.

4. Development of a formulary for Project Access and rationale for formulary exceptions such as pharmaceutical company waivers. Continue the work of finding avenues to provide access to pharmaceuticals through local pharmacies and pharmaceutical companies.

5. Continue the advocacy work with enrollees regarding life skills, e.g., show up on time, be grateful, know your medical plan, and adhere to treatment your plan.
6. Develop community based plans to further reduce enrollee barriers to physician services such as securing bus vouchers, cab vouchers, and day care vouchers distributed by Project Access as necessary. Additionally, request that physician offices consider extended hours as necessary to accommodate enrollee needs.

7. Increased communication with the physicians, offices, hospitals, and other affiliated organizations. The focus groups suggested a newsletter published on a regular basis that included current statistics, names of participating physicians, a personal corner about one of the staff members, a testimonial from a Project Access enrollee, and other relevant program information. Development of an electronic newsletter would be an economical method of publishing and delivering such a newsletter.

8. Development of a scorecard that is published at least quarterly and assists physicians and office managers with knowing where they are in meeting their agreed to enrollees goals.

9. Development of a website that gives pertinent static information such as office hours and telephone numbers and access to documents and reports.

10. Increased use of electronic media and decreased reliance on paper. Some of the offices mentioned they are attempting to go
electronic and would appreciate electronic as opposed to paper forms.

11. Development of a dental version of Project Access. Brown and Carner (2000), the focus groups, and mailed survey responses from enrollees all indicate the need for some type of dental care. Development a dental version of Project Access would be an innovative approach to this problem and could result in the receipt of grant money to fund the development of such a program.

12. Leadership development on topics such as (a) how to manage and lead a chaotic and participatory organization; (b) development of program infrastructure; (c) development of program funding; (d) best practices and lessons learned from other organizations; (e) development of program sustainability; (f) development of operational objectives, goals, and milestones; (g) development and management of community support; (h) development of public policy analytical skills; and (i) development of lobbying skills.

13. Development and coordination of a local coalition of organizations providing health care services to low income individuals and families. This group could monitor the community for trends, learn from each others success and failures, coordinate approaches for identified low income needs within the community, and coordinate lobbying efforts for additional funding and legislative support.
14. Development and coordination of state or regional Project Access programs to learn from each others successes and failures, potentially coordinate approaches for securing long-term funding, explore avenues of program sustainability, and coordinate lobbying efforts for additional legislative support.

15. Encourage health care insurers to develop and small business owners to offer health care insurance coverage with modest premiums. Over half of the mailed survey respondents indicated a willingness to pay for services similar to those they received through Project Access. On the low end they agreed to $20 per month and on the high end $80 per month. This may purchase only primary care access with some form of prescription coverage and require continued access to a Project Access for specialist coverage. It may also require a change in the criteria for participating in Project Access. One example of an attempted approach to this problem is Kent Health Plan Part C. This program is targeted at small businesses and provides a comprehensive health care plan administered through Kent Health Plan for $189 per month. This fee paid in equal $63 portions by Kent Health Plan, the employer, and employee. Plans such as this could be affordable for individuals willing to pay $40 to $80 per month and could be a pattern for some type of public and private partnership.
Plans for individuals able or willing to pay only $20 per month would require significant subsidization from some governmental or private source. Another approach for this population is to provide them with some type of governmental or privately sponsored health plan at no cost but charge them small co-pays for services and medications that total $20 per month. The above approaches may require some level of legislative encouragement or relief or some coordination of services with current governmental or privately sponsored programs.

16. The national organization needs to consider softening its current top-down approach to program replication and consider a synthesis approach that is sensitive to the bottom-up needs of the local community. This may require the national organization to consider either (a) shifting to a new business model, or (b) expanding its current consulting model into a new business model such as social franchising. Implementation of a social franchising model could be structured as an expansion of the consulting model by including both consulting and technical support services such as an implementation start up kit, grant-writing services, theoretical and public policy newsletter related to this population, development of a patient tracking system, and development and maintenance of program site web pages. Further investigation of
the support needs of the other Project Access sites around the country and the amount they would be willing to pay to support such services would have to be conducted in order to gain an accurate picture of the contents of a social franchising package. Once the needs of the Project Access programs around the country have been established, the national program would have to collaboratively determine with the program sites the level of support that could be funded and maintained.
REFERENCES


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Appendix A

Human Subjects Institutional Review Board
Letters of Approval
Date: March 28, 2006

To: James Visser, Principal Investigator
    Raymond Higbea, Student Investigator for dissertation

From: Mary Lagerwey, Ph.D., Chair

Re: HSIRB Project Number: 06-02-33

This letter will serve as confirmation that the change to your research project "Nongovernmental Program Replication and Implementation: What Can Community based Programs that Support the Uninsured Learn from Other Communities?" requested in your memo dated 3/27/2006 (final version of the interview guides) has been approved by the Human Subjects Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: March 10, 2007
Date: July 17, 2006

To: James Visser, Principal Investigator
    Raymond Higbea, Student Investigator for dissertation

From: Mary Lagerwey, Ph.D., Chair

Re: HSIRB Project Number: 06-02-33

This letter will serve as confirmation that the changes to your research project
"Nongovernmental Program Replication and Implementation: What Can Community Based
Programs that Support the Uninsured Learn from Other Communities?" requested in your memo
dated 7/13/2006 (request for change from focus groups to individual interviews) have been
approved by the Human Subjects Institutional Review Board.

The conditions and the duration of this approval are specified in the Policies of Western
Michigan University.

Please note that you may only conduct this research exactly in the form it was approved. You
must seek specific board approval for any changes in this project. You must also seek reapproval
if the project extends beyond the termination date noted below. In addition if there are any
unanticipated adverse reactions or unanticipated events associated with the conduct of this
research, you should immediately suspend the project and contact the Chair of the HSIRB for
consultation:

The Board wishes you success in the pursuit of your research goals.

Approval Termination: March 10, 2007
Appendix B

Mailed Survey
## Mailed Survey

*Directions: Mark the box that best describes your current or present experience.*

### A. Gender
- □ Male
- □ Female

### B. Age (years)
- □ 18-24
- □ 25-30
- □ 31-40
- □ 41-50
- □ 51-57
- □ 58-65

### C. Marital Status
- □ Single – never married
- □ Single – divorced
- □ Single – widowed
- □ Married
- □ Married – Separated

### D. Employment status
- □ Full-time (36-40 hours/week)
- □ Part-time (less than 36 hours/week)
- □ Temporary or Seasonal
- □ Not working

### E. Education level
- □ Less than high school
- □ High school graduate
- □ Some college
- □ College graduate (bachelor degree or greater)

### F. Race or Ethnicity
- □ Black (non-Hispanic origin)
- □ Asian or Pacific Islander
- □ White (non-Hispanic origin)
- □ Hispanic – Latino
- □ Native American
- □ Mixed

### 1. Do you have a health condition? (check all that apply)
- □ Heart
- □ Brain or Nerves Disease
- □ High Blood Pressure
- □ Stomach or Intestines
- □ Diabetes
- □ Skin
- □ Bones or Joints
- □ Pain
- □ Mental Health
- □ None
- □ Other

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2. In the year prior to enrollment in Project Access, how many months did poor health keep you from performing usual activities such as bathing, brushing your teeth, work, or recreation?

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3. Since enrollment in Project Access, how many months have poor health kept you from performing usual activities such as bathing, brushing your teeth, work, or recreation?

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4. In the year prior to enrollment in Project Access, how many times did you go to any of the following for health concerns?

- a. Private Doctor
- b. Nurse or Physician Assistant
- c. Clinic
- d. Emergency Department

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<thead>
<tr>
<th></th>
<th>0</th>
<th>1-2</th>
<th>3-4</th>
<th>5-6</th>
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<th>11+</th>
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5. Since enrollment in Project Access, how many times have you gone to any of the following for health concerns?

- a. Private Doctor
- b. Nurse or Physician Assistant
- c. Clinic
- d. Emergency Department

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<th>1-2</th>
<th>3-4</th>
<th>5-6</th>
<th>7-8</th>
<th>9-10</th>
<th>11+</th>
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6. In the year prior to enrollment in Project Access, how many months were you supposed to take medication for health?

7. In the year prior to enrollment in Project Access, how many months did you take your medication for your health?

8. In the year prior to enrollment in Project Access, how many months did you not take your medication because you were unable to pay for it?

9. Since enrollment in Project Access, how many months have you had medication you are supposed to take for your health?

10. Since enrollment in Project Access, how many months have you taken medication for your health?

11. Since enrollment in Project Access, how many months did you not take your medication because you were unable to pay for it?

12. In the year prior to enrollment in Project Access, how many times did you needed to see a doctor but could not because you were unable to pay for it?
13. Since enrollment in Project Access, how many times have you needed to see a doctor but could not because you were unable to pay for it?

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<th>1-2</th>
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<th>7-8</th>
<th>9-10</th>
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14. How would you rate your health in the year prior to enrollment in Project Access?

<table>
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<tr>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
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15. How do you rate your health since enrollment in Project Access?

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16. If you lived in an area where Project Access was not available, how much would you be willing to pay for health insurance to provide you with the same care as you received through Project Access?

- □ $0 – cannot afford any payment
- □ $5 per week □ 15 per week
- □ $10 per week □ $20 per week or more

17. In the year prior to enrollment in Project Access, I had no problem with transportation when going to the doctor.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Do not wish to answer</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
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<td>□</td>
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</table>

18. In the year prior to enrollment in Project Access, I had no problem office hours when going to the doctor.
19. **In the year prior to enrollment in Project Access, I had no problem with child care when going to the doctor.**

20. **Since enrollment in Project Access, I have had no problem with transportation when going to the doctor.**

21. **Since enrollment in Project Access, I have had no problem with office hours when going to the doctor.**

22. **Since enrollment in Project Access, I have had no problem with child care when going to the doctor.**

23. I received the amount of service I needed from Project Access.

24. I would recommend Project Access to a friend or family member.

25. If I had to do it over again, I would choose to participate in Project Access.

Additional comments (**Do not identify any people by name or position in these comments**):
Appendix C

Focus Group Question Guide
Focus Group Question Guide

1. Describe the experience of your office with Project Access patients.

2. What expectations did your office have of Project Access patients? Were these expectations met?

3. What prompted their physician(s) and office to become involved in Project Access?

4. Is there anything you would like to change about how the Project Access enrollees present themselves?

5. Have Project Access patients been compliant with office policies and prescribed medical regimens?

6. How quickly are Project Access patients given appointments? How accommodating is your office to working them in for an appointment?

7. If you could change anything about Project Access and its enrollees, what would it be?

8. What changes do you have to recommend to the program?

9. Has involvement with Project Access increased your office's sense of community involvement?
Appendix D

Interview Guide – Grand Rapids, Salt Lake City and Buncombe County
Interview Guide – Grand Rapids, Salt Lake City and Buncombe County

1. From the time the idea for implementing Project Access was conceived through the first year of operations, what were the challenges you faced?

2. Describe, throughout the implementation process, how the organization demonstrated commitment to Project Access.

3. Describe the community and healthcare environment throughout the implementation of Project Access and how, if at all, the environment changed.

4. What flexibility and adaptability was required during the implementation of Project Access?

5. What technical assistance did you receive throughout the implementation process? Was the technical assistance what you needed? Who provided the technical assistance? What technical assistance was not provided that would have been helpful? Was a tool kit or start up kit available?

6. How were the goals and objectives for implementing Project Access developed and were they followed or modified throughout the first year of implementation?

7. Describe the differences in your understanding of theory, principal factors, and causal links relating to the working-poor, uninsured and program implementation prior to implementing Project Access and after the first year of operations.

8. Describe the process of recruiting physicians and hospitals for Project Access?

9. Describe how you had to use your managerial and political skills during the implementation of Project Access?

10. Describe any conditions that seemed to undermine the implementation of Project Access?

Note: The above questions will act as a guide for these interviews. A question will not be asked if the information under pursuit is described while the interviewee is answering another question. If necessary, the student researcher will ask probing questions not listed in this guide to elicit a more complete or deeper understanding of answers provided by the interviewee.
Appendix E

Interview Guide for the Grand Rapids Consultant
Interview Guide for the Grand Rapids Consultant

1. What were the challenges you faced with the implementation of Project Access in Grand Rapids?

2. Describe, throughout the implementation process, how the Kent County Medical and Osteopathic Societies demonstrated commitment to Project Access.

3. Describe the community and healthcare environment in Grand Rapids throughout the implementation of Project Access and how, if at all, the environment changed.

4. What flexibility and adaptability was required by the Grand Rapids Project Access staff during the implementation of Project Access?

5. What technical assistance did you provide throughout the implementation process? How do you determine what technical assistance is needed? What technical assistance do you not provide that may be helpful? Do you provide a tool kit or start up kit?

6. How were the goals and objectives for implementing Project Access developed in Grand Rapids and were they followed or modified throughout the first year of implementation?

7. Describe the differences in your understanding of theory, principal factors, and causal links relating to the working-poor, uninsured and program implementation and those of the Grand Rapids Project Access staff.

8. Describe the process of recruiting physicians and hospitals for Project Access in Grand Rapids.

9. Describe how you had to use your managerial and political skills during the implementation of Project Access in Grand Rapids. Describe how you assisted those implementing Project Access in Grand Rapids in developing and using their managerial and political skills.

10. Describe any conditions that seemed to undermine the implementation of Project Access in Grand Rapids.
11. How does what you experienced in Grand Rapids compare to what you have experienced in other, similar communities? In your experience, how long does it take for a Project Access program to mature? Do you provide PA sites with on-going support? How well does the GR PA site and other sites understand the maturation process and expected time for a program to grow to maturity?

Note: The above questions will act as a guide for these interviews. A question will not be asked if the information under pursuit is described while the interviewee is answering another question. If necessary, the student researcher will ask probing questions not listed in this guide to elicit a more complete or deeper understanding of answers provided by the interviewee.