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Evolution of the 2003A Major Grants Program of the Maine Health Access Foundation

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Executive Summary

In the 2003A major grants cycle, the Maine Health Access Foundation funded 18 program, planning and policy/data grants. In the Fall of 2005, The Foundation engaged the Margaret Chase Smith Policy Center, University of Maine, and Tish Tanski, President of T² Strategy, to conduct an evaluation of the grants and grantmaking process of the Foundation's 2003A major grants program, with collaboration from the Center for Community Inclusion and Disability Studies, University of Maine.

This evaluation of the 2003A grants program provides an analysis, recommendations and observations that will provide the Maine Health Access Foundation with a way of assessing the 18 funded grants. It also offers an alternative, but complementary way of systematically incorporating evidence-based knowledge into the design, implementation and evaluation of programs in a dynamic and continuous way.

The evaluation team employed a conventional approach to evaluating individual grants, and applied the Evaluation Practice Model (DePoy and Gilson, 2003) to the MeHAF grant program and the grant categories (program, planning, and policy/data) as a way of understanding the structural elements of the grant program in 2003. We reviewed all documents in the MeHAF grant files for each project, and interviewed representatives from all 18 grants, and other relevant participants as needed (a total of 36 individuals).

In the 2003A grant cycle, MeHAF awarded $2,499,470 for 18 grants: a total of $1,921,173 for ten program grants, $283,915 for six planning grants, and $294,382 for two policy/data grants. Of the 18 organizations that received funding, nine (50%) provided direct service; four (22%) were CarePartners[1] (or similar) programs serving the uninsured, which are affiliated with hospitals but do not provide direct care themselves; four (22%) were advocacy, education or technical assistance organizations; and one was a university research unit. The most significant target populations included the underinsured/uninsured (six grants, or 33%), medical providers (four grants, or 22%), and the mentally ill (three grants, or 17%). Other target populations included teens, immigrants, individuals with disabilities, and those who were terminally ill.

Analysis of 2003A Grants: The conventional approach evaluated individual projects based on requirements that MeHAF outlined in its Request for Proposals (RFP) for 2003, and on elements MeHAF included in the RFP for this evaluation. We also analyzed changes that were made in projects after the grant was awarded.

Most proposals included some reference to professional literature regarding need, but only one included a strategy to conduct a specific needs analysis for the population to be served in Maine. Seventeen grants (94%) had a primary focus on increasing access to health care. One specifically had improvement in quality as a major focus. Thirteen grants (72%) focused directly on providing access to patients; four (22%) addressed a perceived need for provider training.

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[1] CarePartners programs enlist volunteer medical providers who provide no- or low-cost health care services to uninsured or underinsured individuals who cannot afford to pay for health care themselves. These programs also assist patients in getting pharmaceuticals that they need for free or at reduced cost.

Our analysis examined the articulation and accomplishment of process and outcome goals and objectives set forth by each grantee in their proposals, reports, interviews, and supplementary communications. Grantees reported process and outcome goals and objectives and results and accomplishments in regular reports using the Grantmakers Evaluation Framework (GREF) and in our interviews. We organized process and outcome goals, objectives and accomplishments using a classification system developed by the W. K. Kellogg Foundation in its *Evaluation Handbook* (1998), which provides a framework of four categories: (1) individual client-focused outcomes, (2) program and system level outcomes, (3) broader family or community outcomes, and (4) organization impact.

Half of the 18 grantees reported *client-focused outcomes*, most frequently increases in access. MeHAF was not expecting grantees to report health outcome measures due to the limited time frames of their projects and communicated this to grantees, but twelve grants (67%) had the potential to measure health outcomes. Only one grant included a formal methodology that provides information on the impact the project is having on rates of hospitalization.

All 18 projects reported some level of *program or system change.* Nine of the 18 projects (50%) reported delivery system change, including expanding services or the introduction of new services. Seven (39%) reported provider-related outcomes, including new skill acquisition, adoption of new practices and procedures, and a needs analysis. Other system level changes included development of a knowledge base and policy change or influence.

Three of the 18 grants (17%) included *community level outcomes,* including increased community awareness and perception, and greater visibility within the community.

Eleven of the 18 grants (61%) reported *organization impact.* Most cited were expanded services to underserved populations, greater visibility and credibility for their organization, the addition of staff, greater funding. One organization reported a negative fiscal impact.

We analyzed the use of the Grantmakers Evaluation Framework (GREF) in order to understand the model itself, the extent to which the instructions and forms were clear and likely to provide needed information, and the extent to which grantee reports provided needed information. We only analyzed the use of GREF in 2003. Our review suggested that there were some areas of ambiguity in the model itself, and in the forms/instructions.

Sustainability: Our interpretation of program or project sustainability for purposes of this evaluation is that (1) grant funded activity continued beyond the grant period; and (2) the grant resulted in a process, product or service that benefited the target population beyond the period of the grant. Our analysis indicates that 66-85% of the projects designed to be sustainable either continued at some level and/or provided a product or service that benefited the target population beyond the period of the grant. All of these programs struggled with the issue of longer term sustainability. Of particular concern was their ability to find funding for innovative programs or approaches, given that reimbursement systems for direct service do not support innovation to the extent that some MeHAF grants require if they are to sustain themselves in the future. None of

the planning grants evolved into MeHAF-funded program grants. Two did continue, however, with other sources of funding.

Collaboration: Collaboration was "essential" for 16 of the 18 projects (89%). Of these projects, we considered nine (56%) to be completely successful in their collaborations. The success of collaboration had a significant impact on the ability of projects to achieve their goals.

Changes in work plans or budgets: Ten of the 18 projects (56%) had to make changes after the grant was awarded. The most common changes were in end dates or budgets. The biggest challenges were in staffing projects and in loss of continuity when there were changes in key project staff.

Grantee Perceptions of MeHAF and MeHAF Requirements:

<u>MeHAF</u>: We asked grantees for their perceptions about the problems MeHAF seeks to address, MeHAF's impact, MeHAF's grant process (application and reports) and communications, and the Grantmakers Evaluation Framework (GREF). All grantees articulated "access to health care" as a problem that MeHAF is trying to address. Some specifically linked that access to underserved populations. Representatives of 12 of the projects believed that MeHAF is making a significant impact, but few cited specific examples. Others did not know if MeHAF was making an impact. The most frequently mentioned impact was increased focus on and visibility of health priorities, and the expansion or creation of programs.

The respondents who had been involved in the original application process reported that it "worked very well" or "worked extremely well" (based on a four-point scale). They also reported that they understood MeHAF's priorities for the 2003 grant cycle "very well" or "completely."

Respondents were overwhelmingly positive about MeHAF. They praised every member of the staff, and particularly recognized Dr. Wolf. A few reported minor communication problems, but even those respondents were very positive about communications with the Foundation overall.

<u>MeHAF Requirements</u>: There was more diversity of grantee opinion about MeHAF requirements, including the report format and the GREF Framework. A majority thought that the report format was appropriate and concise, but representatives from six out of the 18 projects expressed some level of frustration with it.

The Grantmakers Evaluation Framework (GREF) was less well understood. Representatives from ten of 15 projects (67%) who provided ratings responded that they understood the framework "very well" or "completely," but five (33%) said that they "did not understand" it or only understood it "somewhat." Respondents generally characterized workshops and technical assistance from staff as helpful.

Six projects (33%) incorporated formal evaluation. All of the grantees utilizing formal evaluation reported that the evaluation provided essential information that they used to inform the program implementation.

Additional observations: We observed that major barriers to sustainability for many programs are limitations on current reimbursement formulas and systems (insurance

and public programs). The reimbursement structure generally does not provide ongoing funding for innovative approaches. Two examples are case management and early intervention. Another major barrier can be state regulations that are not flexible enough to allow innovation.

Applying the Evaluation Practice Model: In an effort to understand the underlying structure of the MeHAF grant program and of the grants themselves, we used the Evaluation Practice Model (DePoy and Gilson, 2003), an evidence-based approach to developing, evaluating and implementing programs. The Evaluation Practice Model provides a framework for understanding the structure of the project and program design and for assessing results.

Our use of this model suggests that the 2003A MeHAF grant program had many elements of the model, but that the linkages between problem, need, implementation, and evaluation could be strengthened in future grant solicitations.

Discussion and Recommendations: Our analysis includes a number of recommendations that relate specifically to the 2003A grant program and others that are more general in nature. In the full report, we offer recommendations on the following: definition of underserved populations, MeHAF communications with grantees, planning grants, reporting requirements, sustainability, data dilemmas, evaluation, conveying MeHAF's mission, system change, accessibility, and divergent grantee values relating to MeHAF funding priorities. Major recommendations are highlighted here:

MeHAF's communication and role with grantees: Our interviews with grantees impressed on us how much grantees value the communication and support that MeHAF provides—from technical assistance to convening meetings on specific topics. Grantees would like MeHAF to do more of this. They want to connect to each other, to experts in their fields, and to potential funders. MeHAF has done this successfully, and could expand its role in this area.

Grantmakers Evaluation Framework: MeHAF is to be commended for including a results-based reporting framework as part of the program design. Our review of the reports, as well as our interviews with grantees indicate that the reports do not capture some of the information that is potentially available and could be important in demonstrating the results of the 2003A grant program. Confusion on the part of a significant number of grantees in the 2003 grant cycle leads us to suggest that MeHAF consider engaging all of its grantees in a discussion of the GREF Framework to determine if (a) the current framework meets the needs of both MeHAF and grantees, (2) the framework should be revised or (3) an alternative framework should be used.

Sustainability of innovation: Sustainability of innovation is a challenge for grantees, as well as for MeHAF as an organization. The nature of reimbursement systems for innovative delivery of care presents a major obstacle to long-term sustainability. MeHAF could expand its role as a convener of *public and private payers, with the specific purpose of exploring ways to achieve greater flexibility in existing public and private reimbursement for successful innovative projects or initiatives it undertakes. We*

recognize that the current funding climate makes changes difficult to achieve, but believe that MeHAF is in a unique position to bring players together to work on possible solutions. In addition MeHAF serves as an important link between grantees and other funding sources, a role it should continue, and even expand in the future.

Formal evaluation: MeHAF requires grantees to use a logic model (the Grantmakers Evaluation Framework [GREF]) to track progress and measure outcomes. We recommend that MeHAF consider building formal evaluation capacity into individual grants from the beginning, rather than solely as an external, retrospective activity after the end of the grant period. This formal internal evaluation should not replace external evaluation, but would be an important step to providing the information that a future external evaluator of the entire grant program (a "meta" evaluation) would need in order to begin to understand the results of individual grants and of MeHAF's grant program as a whole. We also recommend that MeHAF consider conducting an evaluation five years after the end of each grant period to understand and document project impact and whether projects have achieved program and financial sustainability.

Grant design requirements: In order for MeHAF to begin to understand the results its grant program is having, the projects themselves must be based on a comprehensive, evidence-based model that links problem, need, goals and objectives, implementation, outcome assessment and dissemination. The current grant requirements contain many of these elements, but not all, and the linkages between the elements could be strengthened.

MeHAF grants: MeHAF has done a remarkable job of establishing its credibility and visibility with grantees themselves. The challenge now is to understand the results of the grants themselves and to share that information with broader constituencies. This report includes a number of strategies for MeHAF to consider with its many audiences: grantees, policymakers, potential grantees, actual and prospective populations served and the general public.

Introduction

In the 2003A major grants cycle, the Maine Health Access Foundation funded 18 program, planning and policy/data grants. In the Fall of 2005, the Foundation engaged the Margaret Chase Smith Policy Center, University of Maine, and Tish Tanski, an independent consultant, to conduct an evaluation of the grants and grantmaking process of the Foundation's 2003A major grants program, with collaboration from the Center for Community Inclusion and Disability Studies, University of Maine. As described in the Request for Proposals (RFP) for the evaluation, the Foundation's objectives for this evaluation were to:

- Assess the Foundation's 2003A major grants reporting processes and requirements;
- Assess project sustainability including impact of MeHAF funds in leveraging other resources;
- Identify the quantitative and qualitative results of individual 2003A major grants, and identify the impact of clusters of 2003A grants (planning, program and policy/data). Specific objectives for 2003A funding categories include:

    - *Program Grants:* Assess the program's effectiveness by considering practical outcomes such as demonstrated impact on clinical or administrative practice, or replication of the model by additional private or public entities;
    - *Planning Grants:* Assess the project's effectiveness by considering practical outcomes of the process such as success in forging new partnerships, or subsequent implementation of the plan;
    - *Policy/Data Grants:* Assess the research's value by considering practical outcomes, such as demonstrated impact on policy development, programmatic activity or clinical practice.

- Identify procedural or programmatic issues outlined in the final grant reports that warrant the Foundation's attention or action;
- Identify exceptional projects and develop a strategy for highlighting them; and
- Consider, to the extent possible, the impact of 2003A major grants funding in fulfilling the Foundation's mission.

The evaluation findings presented in this report are based on review of project documents in MeHAF's files and interviews with representatives from all of the funded projects and with a MeHAF Board member who is also a member of the Grants Committee. Our analytic approach included content analysis of the documents and interview notes; compilation of data from proposals reports and other documents; and ratings by two members of the project team of selected project elements from proposals, reports and interviews.

The evaluation presented in this report provides an analysis, recommendations and observations that will provide the Maine Health Access Foundation with a way of

assessing the 18 funded grants. It offers an alternative, but complementary way of systematically incorporating evidence-based knowledge into the design, implementation and evaluation of programs in a dynamic and continuous way.

Evaluation Methodology

Here, we describe the general overall methodology used by the evaluation team. Specific information on methodology also is provided in relevant sections of the report. We employed a multi-method approach, which included the following:

- Review of written documents, including letters of intent, proposals, reports, budgets, and communications;
- Interviews with 36 individuals, including representatives from all 18 grantees. Additionally, we interviewed one MeHAF Board member, who is also a member of the Grants Committee;
- Consultations with MeHAF staff and the consultant working with us on behalf of MeHAF (Sharon Rosen);
- Content analysis of both the written (document) materials and the interview notes;
- Respondent ranking of some items in the interview on a four-point scale in order to have some quantitative measurements; and
- Scoring of selected project elements. Two of the project team members (Acheson and Tanski) scored selected project elements, e.g., the problem statements and process and outcome objectives, as presented in the proposals, reports and interviews, using a four-point scale. This yielded additional quantitative analysis.

Document Review

MeHAF provided the contents of all files pertaining to the projects being evaluated. We reviewed copies of the concept letter scoring and proposal scoring (with evaluators' names removed); the proposals themselves and any questions addressed or modifications made by grantees; all reports and attachments submitted by grantees (interim, final, and financial); correspondence and any other relevant materials in the files (e.g., evaluation reports or any other supplementary materials the grantees had provided to MeHAF). In some cases, grantees gave us additional written information during the interview. Examples include brochures, annual reports, or more recent data from their projects. We drew upon this supplementary information in our analysis.

Grantee Interviews

Population and Method

Two members of the evaluation team conducted open-ended interviews with representatives of all 18 funded projects. We interviewed a total of 36 individuals: 28 in person and eight by phone. In two instances, the project manager was no longer with the organization and was unavailable. In those cases, we interviewed organizational administrators. We conducted interviews with project managers for the remaining 16 grants, as well as with other staff affiliated with the project in a number of instances.

Table 1 shows the number of interviewees, their roles in the funded projects, and the type of interview (phone or in-person).

TABLE 1.   Grantee Interview Summary

Project Role	In-person Interview	Phone Interview	Total Individuals Interviewed
Project Administrator	14	2	16
Organizational Administrator	8	2	10
Clinician	3	0	3
Grant Writer	1	1	2
Project Evaluator	0	2	2
Partner Organization Representative	1	1	2
Other Subcontractor	1	0	1
Total	28	8	36

Most in-person interviews were conducted by two members of the evaluation team (Acheson and Tanski), with notes taken by both. In two instances, in-person interviews were done by a single interviewer. All the phone interviews were done by a single person. In-person interviews ranged in duration from 45 minutes to over two hours; the longer interviews were usually ones where more than one respondent participated. The average length was about 1.25-1.5 hours. Telephone interviews were somewhat shorter, generally 45 minutes or less. All respondents were assured that their responses would be treated as confidential, and that no one would be identified by name or other characteristic that could reveal their identity.

Interview Content

In designing the interview, we drew in part upon questions developed by Sharon Rosen who was in the process of doing the evaluation of MeHAF's discretionary grants awarded from 2002-2004 (Rosen, 2005). We included additional questions to more fully explore elements related to the Evaluation Practice Model we use here. Having the evaluations of both sets of grants using at least some of the same interview questions should yield additional comparative information which will be of use to MEHAF and others. The interview had four sections.

- *Background and overview*: We asked respondents to give us a brief description of their organization and to describe how the funded project related to their organization's mission. We then asked (1) what the respondent's role was in the project, (2) about the organization's budget, (3) the problem the project was seeking to address, (4) why they had chosen to address that problem, and (5) how the respondent saw that problem relating to MeHAF's mission.
- *Implementation:* We asked if the grantee had made any changes in the project design, timetable or budget after the grant was awarded, and why. We asked

about the importance to the project of collaboration with other organizations or groups.

- *Impact:* We asked respondents to tell us about the most significant outcomes or achievements of the project, whether they had achieved the intended outcomes, and how they measured this. For planning grants, we asked if the grantee had applied for an implementation grant from MeHAF, or sought other funding. For program grants, we asked about sustainability of the project since the end of the grant period.
- *Respondents' perceptions and understanding:* We asked respondents about the problems MeHAF is addressing, MeHAF's impact, and their opinions about the application process, communications with MeHAF, reporting and the GREF framework.

Evaluation Approach

We used two evaluation approaches to assess and understand the grants and the grantmaking process. We first used a conventional evaluation approach to assess the extent to which funded projects addressed the issues that they had set out in their proposals and the degree to which they were in compliance with MeHAF's expectations for grantees. That analysis is found in the section of this report titled "Grant Summary and Findings."

In addition, we did a retrospective analysis using the evaluation design and methodology described in *Evaluation Practice* (DePoy and Gilson, 2003). That model provides a comprehensive framework that integrates systematic evidence and analysis into the development and implementation of programs. We applied the model retrospectively to both MeHAF and to grant clusters as a way of understanding the structure of the grant process itself. That analysis is found in the section of this report titled "Applying the Evaluation Practice Model."

It is important to note that MeHAF did not require applicants for the 2003A grant program to use the Evaluation Practice Model. It would not be fair or accurate to retrospectively evaluate the performance of either individual grants or MeHAF against the model. Rather, the model provides a way of thinking that will hopefully benefit MeHAF, 2003A grantees and prospective applicants as they move forward to address the most pressing issues in health care in Maine.

MeHAF 2003A RFP and Grant Process

MeHAF began its grantmaking program in 2002, when it awarded only one-year grants. In its 2003A major grants cycle, the Foundation offered one-year or two-year grants: (1) to support integrated and comprehensive models of coverage or care delivery that promoted evidence-based and outcome-effective practices, and (2) policy and data projects that promoted or expanded new models of health care coverage, or improved the quality and delivery of care. In the original RFP, the maximum amount for program and policy/data grants was set at $150,000 per year. That amount was subsequently reduced to $135,000 when grants were awarded. Grantees were asked to reduce their budgets accordingly.

The RFP solicited proposals for projects in three categories:

- *Program Grants:* Up to two years, with funding between $10,000 - $135,000 per year. The projects were supposed to develop new models of coverage or care that have been fully articulated and for which a compelling evidence basis existed, or to expand or replicate existing proven or promising models which had been piloted in Maine or elsewhere.
- *Planning Grants*: One year, with funding between $10,000 - $50,000. Planning grants were given for projects that promoted integrated and comprehensive models of coverage and care that were evidence-based and outcome-effective. Planning projects were supposed to focus on strengthening the linkages between primary care, follow-up and specialty services, and to expand or enhance existing linkages.
- *Policy or Data Grants*: Up to two years, with funding between $10,000 - $135,000 per year. These grants were given to develop policy studies or data collection to support the development of evidence-based and outcome-effective models of coverage and care.

Application Process and Requirements

Applicants first submitted a letter of intent, which was postmarked by February 14, 2003. The letters of intent were scored, and selected organizations were invited to submit full applications, which were to be postmarked by April 25, 2003. The RFP set out specific full proposal requirements, which are detailed in Appendix B of this report. Following are the required elements for the full proposal, and the scoring for each.

- Organization description
- Project Description
  - Needs statement (10 points)
  - Target population (5 points, 10 bonus points for projects that focus on serving uninsured or underinsured, or that address health disparities)
  - Work plan (25 points)
- Evaluation (15 points)
- Collaboration and integration (15 points)
- Staffing (5 points)

- Sustainability (10 points)
- Budget (15 points)

The full proposals were scored by internal and external reviewers, who made recommendations to the MeHAF Grants Committee and Board of Trustees for final approval. Both the staff and the representative of the Board and Grants Committee stressed that they seek objective input from a broad range of experts and that funding decisions are made based on that input. During the review process, reviewers were able to raise questions about the proposals or budgets. MeHAF's Senior Program Officer forwarded those questions to the applicants. The applicants' written responses were included in the file, and reviewers took those responses into consideration in their final scoring of the proposals.

Post-Award Process and Requirements

Once the grants were awarded, grantees were required to attend a MeHAF training session. They received instructions on the required process and outcome reporting; on budget reporting and budget changes; and on publicity and dissemination. The required evaluation and reporting format is based on a logic model and was designed for the Maine Health Access Foundation by Michele Polacsek, Ph.D. of the Maine Center for Public Health. As described by MeHAF on its website, "This Grantmakers' Evaluation Framework (GREF) is the method by which MeHAF grantees are to evaluate their programs through the systematic collection, analysis and reporting of information about a program to assist in decision-making."

Grantees were required to submit interim reports mid-way through each project year; recipients of planning grants in 2003 were not required to submit interim budget reports. Reports were required at the end of each project year, and all grantees had to submit budget reports at the end of each year. Reports by grantees provided information for the reporting period, but often did not include cumulative program or budget data.

Grantees were permitted to reallocate up to ten percent of their project's total budget without permission from the Foundation, but were required to provide an explanation of those changes in their grant reporting. MeHAF standard operating procedures were that grantees submit requests for written approval by the Senior Program Officer for (1) reallocations of expenses among budget categories by more than 10%, and (2) changes in program scope or objectives. Budget reallocations that exceeded $20,000 or twenty percent of the approved current year funding (whichever was greater) required review by the Senior Program Officer and approval by MeHAF's Grants Committee.

Grants Funded

MeHAF's 2003A major grants are shown in Table 2 on the following page.

TABLE 2. 2003A Individual Grants by Type, Duration, and Amount

Organization	Project Title	Duration	Type	Amount
Common Ties Mental Health Coalition	Primary Care/Mental Health Service Integration Initiative	2	Program	$270,000
Franklin Memorial Hospital	Franklin Health Access Project: Phase II	2	Program	$270,000
Maine Medical Center	Portland Intervention and Early Referral Program	2	Program	$270,000
Maine Primary Care Association	Maine Collaborative Network	2	Program	$269,557
MaineGeneral Medical Center	CarePartners Program	2	Program	$225,000
Medical Care Development	Improving End-of-Life Care	2	Program	$269,945
Penobscot Community Health Center	Oral Health Care for Low Income, Underserved Population	1	Program	$130,936
Pine Tree Society for Handicapped Children and Adults, Inc.	Video Relay Interpreting Project	1	Program	$30,000
St. Andrews Hospital & Healthcare Center	Preventive Oral Health Care Program	2	Program	$50,735
Sweetser	The Behavioral Health Network - Maine Telepsychiatry Initiative	1	Program	$135,000
Family Planning Association of Maine, Inc.	Integration of Care and Education: Improving Access to Reproductive Health Services in a Rural School-Based Health Center Setting	1	Planning	$50,000
Maine Center for Public Health	Integrating Primary Care and Mental Health Services Project	1	Planning	$45,000
Maine-Dartmouth Family Practice Residency	Preventive & Emergency Dental Care Training for Family Physicians	1	Planning	$49,999
Maine Hospice Council	Maine Center for End-of-Life Care	1	Planning	$45,000
USM/Edmund S. Muskie School of Public Service, Institute for Health Policy	Improving Health Care Access for Portland's Immigrant Populations	1	Planning	$43,916
Western Maine Health Care Corporation	Implementation of a New CarePartners Program to Serve Oxford County	1	Planning	$50,000
Maine Children's Alliance	Maine School-Based Health Care Access Project	2	Policy/Data	$204,382
MaineHealth	Profiles of the Uninsured: Utilization Patterns, Rural Access and Care Management Experiences of CarePartners	2	Policy/Data	$90,000

2003A Grant Profiles

This section provides a brief summary which highlights project activities, impacts and any obstacles encountered.

Program Grants

Common Ties Mental Health Coalition (2-year program grant, $270,000)*.* Common Ties Mental Health Coalition is a small agency in Lewiston that provides a range of services for the mentally ill such as case management, shelter and care, and a social club. They partnered with the Sisters of Charity Health System to provide a range of targeted specialty mental health services integrated with primary care medical services on a multi-disciplinary treatment team model at the Bates Street Family Health Center (a "look-alike" Federally Qualified Health Center,[2] locally known as "B Street Health Center"). The two populations served were (1) the mentally ill clients of Common Ties, who were believed to have poor access to primary care and (2) B Street primary care patients with mental health problems requiring some level of intervention.

The project was very successful in achieving one of its most important objectives: to achieve effective integration of primary care and mental health care through close collaboration between the two organizations, which is highly likely to continue successfully in the future. Staff of the health center received extensive education and support regarding mental illness and dealing with mental health clients. An RN case manager hired by Common Ties with grant funds worked in the B Street Health Center as an integral member of the practice's treatment team. Outcome evaluation conducted by an outside consultant found that, over the course of the two-year grant, there was a near doubling of registered patients at B Street. The number with a primary or secondary behavioral health diagnosis had likewise doubled, and remains at 60% of the population (compared with a national average of 25% in primary care practices). To quote, "health center staff have advanced their knowledge, beliefs and skills in working with patients who have behavioral health diagnoses;" and that patients appear to be mostly satisfied with the services received from the "integration project." Information from the evaluation completed by the consultant as part of the project suggests that patients with a diagnosis of severe mental illness may still use the emergency room even though they have a medical "home," a finding that could be explored more fully in the future.

Since the end of the grant, Common Ties has been working to set up a system to continue to fund case management services, and has submitted a license application to provide "Intensive Community Integration" (ICI) and medication management services,

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[2] Federally Qualified Health Centers (FQHCs) receive special designation from the U.S. Department of Health and Human Services. They are health clinics, centers, and programs which provide health care to underserved populations. FQHCs qualify for "enhanced" Medicaid reimbursement, and are eligible for federal operating grants. FQHC "look-alikes" meet the qualifications for FQHCs and receive "enhanced" reimbursement, but do not receive federal operating grants.

which are reimbursable under MaineCare. They plan to locate the ICI program in a suite adjacent to the health center.

Franklin Memorial Hospital/Franklin Health Access (2-year program grant, $270,000). The Franklin County Healthy Community Coalition had received one-year MeHAF funding of $94,925 in 2002. In 2003 this second grant was given to Franklin Health Access to expand enrollment in the program. This 3-year-old collaborative initiative links low-income, uninsured residents of greater Franklin County to a comprehensive range of "charity care" services,[3] a program similar to, but separate from the several CarePartners programs in the state. Using a wide range of outreach strategies, Franklin Health Access was successful in increasing enrollment, and the project manager reports now having over 700 enrollees, more than double what they had at the start of the grant period. The hospital chief operating officer estimates that this is a very substantial percentage of those eligible in the area. They also report 100% primary care provider participation in the area. They have expanded services to include eye care, podiatry and some dental services for clients on a sliding fee scale.

Increased quality of care and improved patient outcomes for enrollees were additional project objectives. Funding from the grant helped support the ScoreHealth Risk Assessment, a screening tool completed by enrollees at admission to the program and intervals thereafter. Health outcomes tracking is not being done systematically, but was being developed at the time of the interview.

Sustainability of the program, as for similar programs, is an issue, but there is strong support from Franklin Memorial Hospital, which has set aside endowment funds. Franklin Health Access also received a three-year federal grant late in 2005 from the U.S. Department of Health and Human Services' Healthy Communities Access Project (HCAP) of close to $1 million to support a project that expands access to affordable prescription drugs. Respondents were very grateful to MeHAF for providing technical assistance (a contracted grant writer) to the organization in preparing the grant proposal.

Maine Medical Center/PIER Program (2-year program grant, $270,000). MeHAF funding was used as a match for the Robert Wood Johnson Local Initiative Funding Partners program to support the innovative "Portland Intervention and Early Referral Program" (PIER) aimed at prevention of psychotic disorders through identifying and providing targeted intervention to young people exhibiting prodromal symptoms[4] of schizophrenia or other psychotic disorders.

The project, which received an extension on its end date until June 30, 2006, has had very successful, carefully evaluated outcomes so far. There has been extensive outreach to professionals and organizations involved with teens and young adults (e.g., primary care physicians, schools, college counseling centers and community groups),

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[3] "Charity care" refers to unrecovered costs of health care that hospitals and medical providers give to patients. This occurs when patients do not have insurance or other coverage, and the patient cannot pay for the care.

[4] "Prodromal" symptoms are the first observable behavioral changes and other symptoms that precede the development of symptoms of a full-blown disorder. For schizophrenia, these may be specific symptoms such as impairment in personal hygiene and grooming or unusual perceptual experiences, or may be non-specific, such as sleep disturbances or increased social withdrawal.

combined with an extensive public media campaign to heighten awareness about prodromal symptoms of psychotic disorders. In the interview, one respondent mentioned that over 4,000 people have been trained so far. Referrals to the program have increased steadily. Project director Dr. William McFarlane estimates that they are reaching two-thirds of the population in the greater Portland area, based on the known prevalence rates for schizophrenia. The project uses evidence-based practices in treatment, and has had a high success rate so far. Dr. McFarlane reports that they had expected to stop the deterioration characteristic of schizophrenia, but were pleased to find that many patients actually get better, as evidenced by increasing scores on a standardized checklist for functioning (Global Assessment Functioning). On the epidemiologic level, the rate of first inpatient psychiatric admissions for Portland-area young people has taken "a big drop." The project included an internal mechanism for quantifying the change in these admissions, and is able to demonstrate a 40% reduction in new cases of hospitalized schizophrenia and a 69% reduction for all psychotic disorders compared to people from other catchment areas in the state of Maine. Sustainability remains a problem. Outreach activities have no reliable funding source, and many interventions provided are prevention-focused, so are difficult to cover through usual insurance reimbursement mechanisms.

Maine Primary Care Association (MPCA) (2-year program grant, $269,557). The aim of the project was to assist all of Maine's federally qualified health centers (FQHCs) to advance and sustain the application of the chronic care model, an evidence-based, patient-centered approach to improve the quality of care for chronic diseases (e.g., diabetes, cardiovascular disease, asthma and depression). One major specific aim was to assist additional FQHCs to gain acceptance in the National Health Disparities Collaborative (HDC), established by the Health Resources Services Administration, a major funder of MPCA and its members. Kevin Lewis, MPCA Director, points out that the principal focus is to build capacity for successful application of the chronic care model's six interrelated components: the use of clinical information systems, delivery system redesign, decision support, community resources, health care organization, and self-management support, and that entrance into the HDC is only a byproduct of that larger goal.

The project had mixed results. A diabetes information clearinghouse to support patient self-management was developed, but usage to date was reported to be disappointingly low. There were some initial delays in hiring the project manager, and there were problems with a key patient survey of cardiovascular health. A consultant from the Muskie School was hired to redesign the survey and to develop additional surveys for depression and diabetes. A positive outcome is that these surveys will be made available to all member practices. MPCA also improved its capacity for data analysis. Using data collected by the Maine Health Information Center from MaineCare for 2003-2004, were able to demonstrate that cost per MaineCare patient was lower for the FQHCs participating in the Healthcare Disparities Network than for other MaineCare users. The MPCA did not use all the funding awarded and returned $12,773 to MeHAF (4.5% of the original budget). It continues to support the project through partial use of a position funded by other sources.

MaineGeneral Medical Center/CarePartners (2-year program grant, $225,000). The medical center sought to expand its CarePartners program, which provides access to free or very low-cost comprehensive care to low-income uninsured or underinsured Kennebec County residents. Services are donated by area physicians and hospitals, and pharmaceuticals paid for by the program or through free and reduced cost drug programs available through pharmaceutical companies. The project also focused on developing targeted care management interventions and on doing outcome analysis in several key areas, especially emergency room and pharmacy utilization, and health status (using self-reported health status and selected Health Plan and Employer Data Information Set [HEDIS] measures).[5]

The initial goal of expanding to 600 enrollees by the end of the first year of the grant and 700 by the second year was not met, due to changes in the external environment (MaineCare expansion and then capping of enrollment of "noncategorical adults"; and the fact that many enrollees graduated to Medicare or other insurance, or had increases in income). In the second year of the project, the grantee shifted from focusing on active outreach to internal referrals. They have had to cap enrollment at 500 in order to continue to provide full coverage for pharmaceuticals.

Project staff reports that targeted care management has been very successful, with the focus on depression and diabetes. For both chronic conditions, the program now also uses specific measures which allow the capability of outcome tracking, though this has not yet been done systematically. Monitoring of emergency room and pharmaceutical use was initiated. Findings of the pharmaceutical study indicate that cost per member per month for medications was reduced by over 50% during the course of the second year of the project, due to formulary and co-pay changes. Emergency room (ER) visits by enrollees have not yet shown a dramatic decline over usage prior to enrollment. However, weekly reports to case managers regarding ER utilization by their patients is reported to be an important tool used for both monitoring and patient education about appropriate use of services.

Project sustainability is a major concern, and is heavily dependent on the hospital and on grants. Respondents expressed particular concern about funding for the crucial case manager component of their program.

Medical Care Development (2-year program grant, $269,945). This project aimed at systems change at Maine Medical Center to promote improved end-of-life (EOL) care through increasing dialogue about EOL preferences and promoting greater utilization of hospice services. Effectiveness was to be measured by (1) implementation of system changes; (2) documented changes in knowledge, attitudes, beliefs, behaviors and skills among Patient and Family Services and Care Coordination staff, and (3) number, sources and timing of referrals to hospice.

Though the project's design was evidence-based, there were major implementation challenges in its first year, including resistance from physicians and the departure of several key project "champions" from the hospital. In the second year, the

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[5] The HEDIS measures, developed by the National Committee on Quality Assurance, are a standardized set of measures that allow consumers and providers to compare the performance of managed health care plans.

approach was revamped to focus on social workers, who were provided resources to build skill levels and support their efforts to increase EOL discussions and facilitate referrals to hospice care for appropriate patients.

This project and did not achieve its original goals, which were ambitious. Progress was made in three areas: (1) the care coordinator form was changed to indicate whether the person was discharged with hospice service, which will allow tracking and also compliance with federal law requiring advising people about hospice options; (2) there was significant success in the partner organization in institutionalizing the knowledge and comfort level of social workers in EOL care and planning, which is now a standard part of training, expectation, and practice and (3) though utilization wasn't as high as hoped, there was an increase in hospice referrals. The project manager noted that there was no way of attributing the increase entirely to the project. Many other things could have influenced this increase in referral during the period of the grant.

Penobscot Community Health Center (PCHC) (1-year program grant, $130,936). This FQHC received funds to add additional dentists, hygienists and support staff to expand dental services for low-income residents in the greater Bangor region. In 2002, the Penquis Community Action Program (CAP) had received a grant from MeHAF to provide dental services, and had entered into a contract with PCHC, which provided equipment and dental staff for up to one year, for PCHC to run a dental clinic in its facilities. PHCH subsequently applied for MeHAF funding in 2003 to provide the program directly and to expand services in order to reduce a substantial waiting list. The grant therefore provided "seed money" at a crucial juncture in PCHC's expansion plans.

By the end of the project year in 2004, PCHC had recruited a new chief dental officer, and expanded to have six full-time dentists; nine dental hygienists; and additional support staff, for a total of 38 professional staff (up from one dentist and one half-time hygienist at the time of the grant application). They expanded from three to six operatories, and then to 15 by the end of the project year. Because of the expansion and increased workforce, they eliminated their former waitlist for services, which had been up to 4,700 at one point. At the time of the interview, in Fall, 2005, they reported having 18 operatories and seeing an average of 98 patients per day, 70-80% of whom are on MaineCare. Because MaineCare reimburses on a "per encounter" rather than a "per procedure" basis, they have found that having a full-time case manager for the dental clinic is cost-effective in reducing the rate of "no-shows" to 12% (compared with 25% nationally). One ongoing problem they face is recruitment of dentists, which is being tackled with a variety of strategies, including aggressive outreach, use of a "private practice" model within the FQHC, and competitive salary and benefits.

Pine Tree Society for Handicapped Children and Adults, Inc. (1-year program grant, $30,000). In this "Video Relay Interpretation Project," MeHAF funds were used to further expand sign language interpretation services provided via interactive video for the deaf and hard of hearing in order to improve health care access and quality for this population. The proposal noted that "consumers frequently report they often are required to wait, even in emergency medical conditions, unreasonable lengths of time fro interpreters to arrive, or are not provided interpreter services at all." Overall, this

was a 3-year project, with major funding from the Commerce Department's "Technology Opportunity Program." MeHAF's funding was used as a federal match; the Pine Tree Society also had a 2002 MeHAF grant of $60,000 for the project. In 2003, the aim was to expand services to include additional hospitals, and to add medical centers, mental health facilities, and medical services at correctional facilities. The project succeeded in adding a number of mental health and medical center sites, including the Department of Behavioral and Developmental Services regional offices in Portland, Augusta, Lewiston, Thomaston, Bangor and Presque Isle; the Aroostook Medical Center; Northern Maine Medical Center's Eagle Lake Health Center; and the Indian Township Health Center in Princeton. Other sites that came online were the Penquis Community Action Program in Bangor and the medical services of the Maine State Prison in Warren. When the Pine Tree Society discovered that several prospective partners indicated they could not participate because of the $2,000 required match, they received approval from MeHAF to reallocate $6,000 of the grant to provide the "partner cash match offset." The Pine Tree Society trained staff at the new sites in deaf culture, use of American Sign Language interpreters, technology, and ways to change the organization's policies and procedures to accommodate the new service. Evaluation (required under terms of the federal grant) was conducted in partnership with Maine Telemedicine Services (HealthWays/Regional Medical Center at Lubec), which conducted focus groups and surveyed interpreters, staff, and service recipients. Feedback from the evaluation was used to improve the process.

St. Andrew's Hospital and Healthcare (2-year program grant, $50,000). To address the need for dental services for the uninsured and underinsured in the Boothbay region, St. Andrews Hospital and Healthcare received funding from MeHAF to purchase two sets of portable dental equipment which could be used by Prevention Partners, an organization that provides screening, dental hygiene, and dental referral services. The plan was to publicize the service and to hold dental clinics at least twice per month, initially at two sites in the region (St. Andrews Hospital and the YMCA, which had donated space), with later expansion to other sites such as St. Andrew's Village (a retirement community) and local schools. St. Andrews was responsible for the program publicity and patient scheduling, and Prevention Partners' role was to provide the hygienists to staff the service. The project has faced challenges in sustaining a regular schedule of clinics in the region; some have been canceled due to lack of availability of a hygienist, and others because not enough patients had been scheduled to make it economically feasible for Prevention Partners to send a hygienist. From reviewing the year one and two final reports, it appears that 275 patients have been seen, 171 the first year and 104 the second year. Since most have been seen only once to date, measuring patient outcomes is not yet possible. Both partners expressed frustration that the equipment is not yet being used to full capacity and that people are not being served in the region to the best extent possible. At the time of the interviews, they were continuing to meet to try to achieve a workable system. St. Andrews found that some individuals who were not on MaineCare could not afford even the reduced rates of the sliding fee scale, and were not able to afford further dental care for which they were referred. St. Andrews therefore sought and received a grant from the Betterment Fund, which provides a match toward their subsidy of up to $20,000. The project did not reach the level of

service it had anticipated during the grant period, but it has continued and the project director hopes to reach levels projected by the grant in the future.

Sweetser (1-year program grant, $135,000). The "Maine Telepsychiatry Initiative" aimed to address the shortage of psychiatric services in the state through extending psychiatry to existing telemedicine sites, and acquiring four additional telemedicine units. Those units were installed at two Sweetser facilities, Ingraham, and Tri-County Mental Health Services. Sweetser was the lead organization, in collaboration with the Behavioral Network of Maine. The project faced major barriers related to regulatory processes that required a substantial revision in protocols and procedures. Licensing, Health Insurance Portability and Accountability Act (HIPAA) restrictions and liability issues led to changing the original service delivery model to a strict consultative model in which the psychiatrist who interviews the patient advises the primary care physician, who retains responsibility for all aspects of care and treatment, including maintenance of the clinical record. Although the number of clients served was limited, surveys of both patients and physicians indicated a high level of satisfaction with the services, and the telemedicine technology was readily accepted by the patients. The system as originally designed has not been sustained. Sweetser underwent a major reorganization that limited its capacity to provide telepsychiatry, but two other organizations (Aroostook Mental Health Center and Ingraham) were trained, equipped, and licensed to provide telepsychiatry consultations, and they retain that capacity. A strength of the project was the extensive evaluation that was built in from the beginning, conducted by a consultant from Healthways/Regional Medical Center at Lubec.

<u>Planning Grants</u>

Family Planning Association of Maine (1-year planning grant: $50,000). The Family Planning Association of Maine partnered with the Maranacook Student Health Center at Maranacook Community High Shool, which serves an area with teen pregnancy rates that are higher than the state average. Based on information from the 2001 Youth Risk Behavior Survey, grantees worked with key community stakeholders to raise visibility and develop strategies to reduce teen pregnancy and sexually transmitted disease. Grantees held meetings and focus groups, and conducted surveys. The School Board approved the subsequent plan to integrate reproductive health services at the school-based health center. The grantees began implementation during the planning period. In the following year, reproductive health services exceeded expectations and was the primary diagnosis for 23% of the medical visits—the highest of any diagnosis (followed by respiratory conditions at 21%). The program is continuing with support from the Bureau of Health and the Family Planning Association. The grantee is also working with private insurance companies to waive co-pays for reproductive services offered through the school-based clinic.

 Maine Center for Public Health (MCPH) (1-year planning grant, $45,000). Working with the Department of Behavioral and Developmental Services of the Maine Department of Human Services and a number of other collaborating organizations, MCPH focused on the integration of mental health services and primary care for children. Initially, the applicants planned to identify evidence-based practice models for mental health services in the primary care setting. Proposed activities were to identify the most effective models through an assessment of primary care practices, create a research design for testing the models and develop plans for state designation of plans that met criteria established through the project. Internal and external factors led to a substantial project redesign. Internal factors included different perceptions about the purpose of the project and a perceived lack of data important to the project. External factors included an unexpected number of emerging efforts in Maine to integrate mental health and primary health care services, including some funded by MeHAF.

As a result of these factors, MCPH worked with MeHAF and redesigned the project to (a) complete a qualitative needs assessment of primary care providers in terms of integrating mental health care for children, (b) develop an inventory of efforts to integrate mental health and primary care in Maine and (c) convene a symposium on best practices for those involved in mental health/primary care integration in Maine. Several other grantees referred to this symposium as very valuable to their integration projects.

Maine-Dartmouth Family Practice Residency (MDFPR) (1-year planning grant, $49,999). This project involved developing training for primary care medical residents in preventative and emergency dental health care. MeHAF funds supported curriculum development, acquisition of equipment and training primary care residents. The project grew out of the personal experience of the project director, a primary care physician with experience in rural health care in New Guinea. He observed a rising need for preventative and emergency oral health care in the patient population served by

MDFPR, who often do not have access to a dentist. The initial proposal to MeHAF was for a two-year program project. Based on proposal reviews, MeHAF funded the project as a one-year planning grant. Collaborating with the director of dentistry at Togus Veteran's Administration, the project completed its goals of developing and implementing a training program for residents, and began implementation of oral extractions, nerve blocks, some oral surgeries and biopsies. An unexpected result of the project was that the Board of Licensure entered into an agreement with the State of Maine Board of Dental Examiners to allow primary care physicians who have received dental procedure training to incorporate that training into their practice. The MDFPR continues to work with the dental director of Togus, and provides ongoing training of residents. They would like to add fluoridation services but would need a dental hygienist to be able to do so.

The grantees report that the percent of patients diagnosed with oral conditions has doubled in the last year-and-a-half. They also have performed an estimated 80 extractions on patients who had no alternative for dental treatment. The program does not routinely track these statistics, but did so for purposes of this evaluation. The grantee also reports that local dentists are now more receptive to their referrals than previously. Sources of financing for continuing to provide these services include reimbursement, when available, and organizational funds.

Maine Hospice Council (MHC) (1-year planning grant, $45,000). This project provided funding to the Maine Hospice Council to develop a business plan for the legislatively created Maine Center for End-of-Life Care. Collaborators included the Bureau of Health of the Maine Department of Health and Human Services, and other organizations involved in end-of-life care. The purpose of the new center is to "improve the quality of, access to and comprehensiveness of end-of-life care for all Maine residents." The process included a meeting involving 50 stakeholders, and participation by a Center Planning Committee and the Executive Committee and Board of the Maine Hospice Council. A consultant was hired to help develop the plan, and a written document was produced. Ultimately, MHC incorporated the new center into its own operations. The grantee applied for subsequent program funding from MeHAF, but was not successful. The program has continued with funding from the federal Agency on Aging and philanthropic donations.

USM/Edmund S. Muskie School of Public Service, Institute of Health Policy (1-year planning grant, $43,916). This project brought together a coalition of community organizations to address cultural barriers to medical care among recent immigrant populations in the Portland area. The project was based on a successful model for Hmong immigrants in California. The project involved recruiting and training "cultural brokers" and health care workers from the target populations. "Cultural brokers" are members of an ethnic group who are "versed in their own culture and that of their new home, and who are also familiar with the American health care system, particularly at the local level." The project involved: (1) identification of key stakeholders, including medical, community and educational institutions; (2) developing a steering committee and holding monthly meetings; (3) developing briefing materials; (4) adapting an

educational model for training community health outreach workers; (5) recruiting cultural brokers; (6) updating demographic information on the target populations; and (7) developing a specialized English as a Second Language curriculum for medical interpretation. The project successfully recruited and trained 26 cultural brokers. A curriculum for Certified Nurses Assistants was also developed and provided to Maine Medical Center, but it is not clear whether or how that curriculum has been used. The grantee reports that a major outcome of the planning process is that key members of the steering committee continue to work together. The City of Portland Public Health Department also began to use cultural brokers in their clinics, funded by sources other than MeHAF.

Western Maine Health Care Corporation (1-year planning grant, $50,000). The initial proposal was for a two-year program project to establish a CarePartners program in Western Maine (the Norway area), in order to provide access to primary and specialty health services and pharmaceuticals for low-income individuals and families that did not qualify for public programs. MeHAF funded the project as a one-year planning grant because DirigoChoice was in development and there was a question about whether this new insurance product would address the needs of the target population. The planning process included obtaining and analyzing Medicaid statistics and data on "charity care" for the prior three-year period; meeting with representatives of Dirigo Health; and working with established CarePartners programs elsewhere in Maine. At the end of the grant period, the Board of Trustees of Western Maine Health Care Corporation decided not to establish the CarePartners program. Factors influencing the decision included the implementation of DirigoChoice, and concerns about the long-term sustainability of a high quality program.

Policy/Data Grants:

Maine Children's Alliance (2-year policy/data grant, $204,382). This project aimed at assessing the impact that reimbursement (Medicaid and commercial insurance) has on school-based health care services by documenting whether such reimbursement increases health care access, improves clinical outcomes, and increases satisfaction, with cost neutrality.[6] MeHAF funding supported two of the four years of the project. If equal or improved outcomes and cost neutrality could be demonstrated, commercial insurers have agreed to continue to reimburse services at SBHCs (School Based Health Centers). Components of the project included analysis of claims data from the Maine Health Care Claims Data Bank, as well as parent, student, and healthcare provider surveys conducted in 10 communities with school-based health centers in their high schools and in 10 "control" communities, similar in sociodemographic characteristics but without SBHCs. A consultant from the Maine-Dartmouth Family Practice Residency was responsible for data collection, analysis and evaluation. The Maine Children's Alliance convened and coordinated the participating parties, which included representatives from DHHS, the state's four primary commercial insurers, the Maine Assembly for School-Based Health Care, and the Maine Association of Health Plans.

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[6] If there is "cost neutrality," additional, upfront reimbursement costs would be offset by lower expenses resulting from decreased hospitalizations, emergency room visits, and specialty care.

Results to date indicate that there were no statistically significant differences between respondents in the SBHC and comparison communities in either satisfaction or clinical outcomes/processes of care. Survey response rates were lower than desired, even with changing the design to include participation incentives. Analysis of claims data revealed that there are an apparently low number of claims being submitted by SBHCs, which may be due to a variety of causes, including students opting out of insurance for reasons of confidentiality, and SBHCs requiring further training in claims submission. Ongoing funding is being sought for further data collection and analysis, with continued participation and active involvement by the Steering Committee. The MCA was awarded a grant from the W.K. Kellogg Foundation's SBHC Policy Initiative to expand school-based health centers. The project is housed at the Maine Assembly for School-Based Health Care, and some additional funds may be available from that for aspects of this policy/data project.

MaineHealth: (2-year policy/data grant, $90,000). The purpose of this project is to develop a profile and analysis of the uninsured and underinsured served by three existing CarePartners programs (Kennebec County, Greater Portland, and Lincoln County). Partners include Machigonne Benefit Administrators (Anthem Blue Cross and Blue Shield) and Martin's Point. The project plan called for collection of hospital utilization information on members, and conducting an exit survey on disenrolled members to assess whether those members continued with their CarePartners primary care provider six months after disenrollment. The illness and subsequent death of the project director was a challenge for this project. New staffing, consulting assistance from the Institute of Health Policy (USM, Edmund S. Muskie School of Public Service) and a no-cost extension from MeHAF have allowed the project to move forward. Participants in the project encountered difficulties in acquiring data needed for some of the proposed analysis. The final report was not available to us at the time of this evaluation. The grantees had collected data, and completed a preliminary analysis. High turnover in the CarePartners enrollee population made it difficult for the grantees to study long-term trends. They were able to identify a small cohort of 396 members who remained in the program for 18 continuous months. They also were able to use benchmark data from the Health and Employer Data Information Set and commercial insurance. Those data show drops in the following: (1) Medical cost went from $336 to $173 per member/per month, compared to the commercial insurance benchmark of $200, which remained stable over the same period; (2) Average inpatient length of stay went from 4.6 to 3.4 days, compared to the commercial insurance benchmark of 3.4 which was stable over the same period; (3) Hospital discharges went from 15.0 to 6.3 per 1,000 member months (MM), compared to commercial insurance and Medicaid benchmarks, which were stable at 9.7 per 1,000 MM over the same period and (4) emergency room visits went from 51.7 to 30.4 per 1,000 MM over the same period, which was compared to three benchmarks (2002 HEDIS Medicaid Benchmark, 2003 HEDIS MaineCare Rate, and 2002 HEDIS Commercial Benchmark).

2003A Grant Summary and Findings

The evaluation team reviewed MeHAF's Request for Proposals outlining the requirements for the 2003A grant cycle, reviewed the files of individual grants and interviewed representatives of each grantee organization. In this section, we provide an overview of the 18 grants that received MeHAF funding and an analysis of those grants.

Overview

MeHAF awarded 18 program, planning and policy/data grants, totaling $2,499,470 in the 2003A grant cycle, as shown in Table 3.

TABLE 3. Number of Grants by Category and Total Award Amounts

Category	Number Awarded	Aggregate Amount
Program Grants	10	$1,921,173
Planning Grants	6	$ 283,915
Policy/data grants	2	$ 294,382
Total	18	$2,499,470

Organization Mission

An overall profile of the 2003A grants derived from the proposals, reports and interviews, indicates that the majority of the organizations receiving grants were involved with direct service to clients. There was a significant grantee focus on providing services to un- and underinsured people and to those potentially eligible for publicly funded programs (MaineCare and Medicare), and on the delivery of primary and specialty care. Of the 18 grantee organizations, nine (50%) provide direct service; four (22%) are CarePartners (or similar) programs affiliated with hospitals, that coordinate care but don't provide service directly themselves; four (22%) are advocacy, education, and technical assistance organizations; and one (6%) is a research unit in a university.

<u>Targeted Population</u>

In keeping with MeHAF's priorities, six (33%) of the grants directly targeted the underinsured, uninsured, and those potentially eligible for Dirigo Choice or publicly funded health programs. Medical providers who treat underserved populations were targeted by four grants (22%). Other populations targeted by the 2003 grants were the mentally ill (three grants, or 17%), teens (two grants, or 11%), immigrants (one grant), individuals with disabilities (one grant) and the terminally ill (one grant).

Analysis of the 2003A Grants

In this section, we analyze the 2003A grant program by examining the following:
- Needs statements in the proposals;
- Process and outcome objectives as articulated in the proposal's work plan section, in interviews and in reports to MeHAF;
- Sustainability, included in the reports submitted to MeHAF and reported in interviews;
- Collaboration, as articulated in the proposals, reports and interviews; and
- Changes after the grants were awarded.

<u>Needs Statements</u>

As discussed earlier, MeHAF required grantees to have a needs statement that included a description of the specific health problems or issues the project addressed and how the proposed activities or interventions would address those issues.

Most proposals included some references to professional literature on need, particularly national literature. Fewer articulated a clear, closely related, well documented statement of the specific issue, the reason for choosing that issue, and a specific statement of how the applicant would assess the result that the project had on the target population. Only one specifically included a needs analysis of the target population (primary care physicians).

All of the grants specifically addressed access. Seventeen of 18 (94%) indicated that need for access to health care was a primary focus. One grantee, however, specifically stressed that providing quality care to underserved populations was the primary purpose of their grant.

<u>Work Plans</u>

Work plans included process and outcome goals and objectives. Grantees reported their progress to MeHAF using the Grantmakers Evaluation Framework (GREF) logic model. That framework is discussed in detail later in this report. This section discusses the process and outcome goals and objectives reported by grantees. In some instances, the interviews uncovered process and outcome accomplishments that grantees had not included in the GREF reports that they submitted to MeHAF.

A classification system advanced in the *Evaluation Handbook* of the Kellogg Foundation, (1998: 29-31) was useful in organizing the process and outcome accomplishments reported by grantees in their GREF reports and in our interviews. MeHAF had not required grantees to use this classification, but it offers a way for us to display our findings.

Kellogg Foundation Outcome Classification

Individual client-focused outcomes answer the question, "What difference will this program/initiative make in the lives of those served?"

Program and system level outcomes: service delivery or system outcomes that answer the question, "What difference will this initiative make for the program or system?"

Broader family or community outcomes, which address the question, "What difference will this program/initiative make for the families or communities it serves?"

Individual Client-Focused Outcomes. Ten grantees reported client-focused outcomes. Of those, nine stated that they expected an increase in the number served; three included health outcome/status improvement; and three included client or provider satisfaction, and/or knowledge and behavior changes. (A grantee may have reported more than one kind of outcome.)

MeHAF was not expecting grantees to report health outcome measures due to the limited time frames of their projects and communicated this to grantees. Twelve grants (67%) had the potential to measure health outcomes, including measurements of mental functioning, chronic disease management, and oral health, but the reports and/or interviews indicated that those measures were often not tracked or aggregated. In some cases the data were available, but tracking or measuring the information was beyond the scope of the project. In other cases, there were incompatible reporting systems that would require development of an interface between record keeping systems in order to develop comparable data. Only one program rigorously tracked these measures, and looked at larger population statistics to try to determine if the program was having an impact on the target population. Some of the projects administered surveys to clients or providers to ascertain satisfaction levels or behavioral changes.

As mentioned earlier in this section, an interesting observation reported by the grantees of two dental projects in their interviews indicated that an unintended consequence of their program might be the reduction of narcotics use for dental pain. They had not proposed this reduction as an outcome of their project and documentation and measurement would have required additional funding. Nevertheless, it is interesting that individuals in both projects independently reported that they had

observed a reduction in narcotic use when dental pain can be treated directly, rather than treated with narcotics when dental care isn't available. Neither project had documented their observation, but the issue could be an interesting one for MeHAF to empirically explore further in the future.

System Level Outcomes. Every project reported some level of program or system change as a result of their MeHAF-funded project, although in many cases it was not to the extent envisioned in the proposal. In some cases it also is not documented. Table 4 shows the distribution of responses; in some cases grantees reported more than one kind of outcome.

Table 4. Program/System Level Outcomes

Outcome	Responses*
Provider-related outcomes	7
Delivery system change	9
Knowledge base development	3
Policy change or influence	3

*Respondents could give more than one answer.

Provider-related outcomes included a needs assessment of primary care providers regarding mental health service integration. Several grantees reported new skill acquisition, and adoption of new practices and procedures. Other outcomes included primary care physicians providing dental screening and acute oral care, and integrating mental health services into primary care practice.

Delivery system change included the addition of new service(s) not previously offered, or a change in an existing service. One of the most notable delivery service changes was the introduction of early identification, treatment and support of youth at risk for serious mental illness through an extensive web of community, medical and social service elements. Others included changes in primary care services to add mental or oral health services. Several projects incorporated the use of case managers or social workers to bridge gaps in the medical care system itself.

Knowledge base development included aggregation and interpretation of data collected on programs serving the uninsured and underinsured, development of a cost/benefit analysis of school-based health programs (which is still underway), a needs analysis of primary care physicians who might treat mental illness (which has been completed but not yet utilized), and an evaluation of the CarePartners program (which has been completed, but was not available to the evaluation team at the time of this report).

Two grantees reported using data gathered as part of their 2003A grant to influence public policy. One used information to successfully argue against a legislative proposal to cap reimbursements to providers. Another worked with the Department of Health and Human Services to adopt regulations to make telemedicine delivery of mental health services more feasible. A third reported that an unintended result of the project was a licensing provision that allows primary care physicians to provide specific dental services if they are trained to do so.

Community Level Outcomes. Three respondents included community level outcomes, including more community involvement, increased community awareness and perception (two projects) and greater visibility (one project).

Organization Impact. Organization impact includes changes in the staffing, structure or resources of the grantee. Of the 11 interview responses, five (46%) reported that their organization had fulfilled its mission by expanding services to the uninsured, including primary care, specialist care, mental health services or dental care. Two organizations (18%) reported greater visibility and credibility. Less frequent outcomes mentioned by grantees included hiring more staff and securing greater funding. One organization reported that the project actually cost the organization money. That organization has continued the program at a reduced level with organizational funding because they believe in its importance.

Sustainability

For purposes of this evaluation, sustainability included program continuity beyond the grant period, and financial continuity in instances where sustainability required funding. The evaluation included a two-pronged approach to assessing sustainability. The evaluation team (1) reviewed each file and (2) asked grantees to self-score sustainability.

> Grantee Self-Scoring for Sustainability
>
> (1) Did not sustain (2) Continued but at reduced level (3) Continued at same level funded by MeHAF (4) Expanded
>
> (5) Other (explain)

Program or Project Sustainability. Our interpretation of program or project sustainability for purposes of this evaluation is that (1) grant funded activity continued beyond the grant period and/or (2) the grant resulted in a process, product or service that benefited the target population and/or extended the knowledge base beyond the period of the grant. Of the 18 grants MeHAF funded, six were not subject to scoring for sustainability because of the nature of the grant (four were planning and two were policy/data grants). By their nature, 12 grants had either achieved or had the potential for sustainability at the time of the evaluation. Grantee self-scoring suggested that eight (66%) continued at some level. Based on other data gathered in the interviews, we concluded that the grantees may have underestimated program sustainability. Because we include project or program sustainability as well as financial sustainability, we concluded that the figure could be somewhat higher (11, or 85%). In two of these "additional" cases, a partner in the project continued the program at a reduced level, but the grantee was no longer involved. In the third project, the organization was still supporting some of the program functions at a substantially reduced level.

It is worth noting that two additional grants had the potential for sustainability, but were not at a point that it could be measured at the time this evaluation was conducted.

One of these grantees reported that the program hadn't geared up during the grant period as planned, but that she expected to be able to sustain the program. Another was operating under a no-cost extension, but had been able to fund one of the two grant-funded positions through reimbursements. We did not include these responses as a "sustained" program for purposes of this analysis, though the potential of sustainability is there and could be measured in subsequent evaluations.

Financial Sustainability. Program grants continued with a combination of funding sources, including reimbursements from insurance or public programs, organization funds, donated funds, and in one case, a federal grant. Typically, insurance, MaineCare or Medicare reimbursements did not cover the full cost of the program, and the organization used internal funds to cover unreimbursed costs. Notable examples are prevention programs and case/care management services. In one instance, the program could improve financial sustainability if it chose to assign a diagnosis to its clients, and thus claim reimbursement to cover one element of the program. The project director has resisted doing so, however, because the stigma of a diagnosis could have an adverse effect on the clients and could undermine the significant gains made by the program. Two of the organizations had telemedicine programs that were not eligible for reimbursement. Two others served target populations that were uninsured and not eligible for public programs.

All of the program grantees who continued operations expressed concern about their ability to continue the programs. One of the grantees summed it up by saying, "We are quite desperate." One major impediment to sustainability is that current reimbursement from private insurance or public programs is not sufficiently flexible to provide ongoing funding for programs that provide innovative solutions or those that provide prevention services prior to formal diagnosis. As one applicant said, "We get our funding the old fashioned way. They [MeHAF] are funding their ideas the new fangled way."

Planning Grants. Six of the grants in the 2003A cycle were planning grants. Evaluators asked these grantees whether they had applied to MeHAF for program funding for implementation. Two reported that they had hoped to apply to MeHAF for program funding in a subsequent grant cycle, but that MeHAF staff discouraged their applications. Another project implemented the program it had planned, and three discontinued for other reasons.

Both of the planning grantees that had expressed interest in applying to MeHAF for program grants continued the work, one at a more limited level than originally planned. One used reimbursements to cover patients that qualified and organizational funds to cover those that didn't qualify for some level of reimbursement. The other secured federal and philanthropic grant funding. Two planning grant projects experienced difficulties and did not lead to viable ongoing programs. A third planning grantee used the information gathered during the planning process to conclude that there was not sufficient demand for the program, given changes in the insurance environment.

In total, MeHAF invested $283,915 in planning grants in the 2003A cycle. By nature, planning grants are high-risk ventures that do not necessarily produce a desired

result, so it is not surprising that some did not move on to implementation funding through MeHAF. It is striking, however, that the two grants that did continue did so with funding from other sources.

Collaboration

MeHAF's 2003A major grant RFP strongly supported collaboration, and "collaboration and integration" was one of the elements used in scoring grant applications. In our evaluation, we rated the degree to which collaboration could be considered as *essential* for the project, and the extent to which any essential collaborative effort was *successful,* based both on the views expressed by respondents during interviews and on our analysis of the documents.

We rated collaboration as essential for 16 (89%) of the projects. Of these projects, we considered nine (56%) to be "successful" collaborative efforts, three (19%) were "partially successful" and four (25%) were "not successful." We should note that projects whose collaborative efforts were less than successful did achieve some—or in a few cases, many—of their intended objectives. But, there is clear evidence that difficulty in collaborative efforts definitely was a major contributing factor to the failure of several projects to achieve the outcomes they had anticipated. In one case, at the time of the interview, several months after the official end of the grant, one grantee was still trying to work things out with their partner to provide the services they both hoped to make available.

There are definitely lessons to be learned from respondents who reported collaborative difficulties. Some representative interview comments from these "unsuccessful" collaborations are presented here.

"It was a little weird because [partner representative] thought it was his project, even though [we were] the grantee, which was problematic. He didn't see it the same way I did. There was resistance to some of what was in the work plan. It was a clash of models."

From another project:

Grantee respondent A: "We feel our hands are tied behind our backs. After [we] wrote and obtained the grant, [our partner] seemed to feel it was theirs." "You need to be very clear on who you are collaborating with, their goals and methods."
Grantee respondent B: "Know your partner better! In a situation like this, you don't have the control."

Partner in this same project: "They got all the money, and we were expected to do all the work. I thought we were going to get operating expenses [overhead expenses] but I found out it was only for [Grantee]. They are really nice people. I think it may be just that they have their business and ways it has to be run and we have ours which runs differently."

And another project:

"We were absolutely overwhelmed by the hurdles the state threw at us and we were running a marathon already."

<u>Changes in Work Plans or Budgets</u>

Over half of the grantees (ten of 18, or 56%) had to make changes in their project's end date, budget, staffing, or project design after the grant was awarded. Most of those who made changes did so in more than one of these areas. The most common changes were in end dates or budgets. Respondents reported that MeHAF was very flexible in working with them on program changes. Our conclusion is that this flexibility is essential.

There were a variety of reasons why projects needed to make changes, and most of those who made changes had to do so for several reasons. For those who made project changes, the most frequently mentioned reason (five of the 10 grantees), was hiring difficulties: either not finding a person with proper qualifications, or a delay in hiring. Problems with collaborators, data availability or access, and other problems external to the organization (e.g., interpretation of Health Insurance Portability and Accountability Act [HIPAA] regulations) were each mentioned by three respondents as reasons for needing to make changes. One respondent mentioned an internal organizational problem (waiting to move to new, less crowded quarters) as a reason for delay in the project's start-up and consequent change in end date.

End Date. Seven of the 18 grantees had to change the project's end date. These changes, which had to be approved by MeHAF, ranged from one month up to 11 months in one instance. This finding suggests that MeHAF might want to reconsider its program grant period, particularly when projects propose bringing in new staff, or finding new facilities.

Budget Changes. There were budget changes in seven out of 17 grants (41%). (One project is not yet done, so we cannot evaluate the budget.) In four of these instances, there were budget reallocations approved by MeHAF, necessitated by problems encountered in the projects. Examples include having to hire consultant subcontractors to perform work that had originally been designed to be done by an employee. In another three instances, grantees did not spend the full amount of the grant, and returned more than 2% of what had been originally budgeted, in amounts ranging from $4,584 to $12,804. (Several others returned smaller, less significant amounts.) We conclude that MeHAF has found a good balance between the flexibility that grantees need, and the fiduciary control MeHAF itself must exercise as a foundation.

Staffing and Project Management. Five grantees changed the staffing from what had been proposed. In response to staffing difficulties, some grantees ended up dividing responsibilities among existing personnel (e.g., the project manager did data collection instead of a graduate student who was never hired), using outside consultants, or changing the type of person hired for the position (e.g., hiring an RN instead of an LCSW). A few did a combination of these strategies.

Continuity in staffing the project manager position and having a manager with qualifications that are appropriate to the project was important, though in and of itself did not guarantee project success.

Twelve of the 2003 grants had the same project manager from the proposal stage through to the end of the grant. Another six projects experienced challenges with regard to project management. Three of the grantees that had problems in filling the project manager position followed a strategy of hiring consultants, either in place of or to supplement the duties of the project manager. In one instance, the original manager, who had written the proposal, became ill at the start of the project and subsequently died. Although the project had a substantial delay and received a four-month extension in its end date, the organization's existing management staff successfully handled the challenge by assuming the administrative duties and hiring a consultant to carry out data collection and analysis. In another instance, the project management team decided not to hire a manager after not finding a suitable person, but divided up some of the duties and hired two consultants to carry out others. Both these projects appear to have successfully met their objectives. In a third instance, there was an extended delay in finding a suitable manager, and the new hire then had to be brought up to speed in the organization. The new manager's strengths did not cover all aspects of the project, so the grantee hired a consultant fairly late in the project to complete one component.

In another two instances, managers with little or no prior comparable experience were pressed into service by their organizations. Neither had been involved in designing the project or preparing the proposal, which had been written by someone else. Both projects experienced some delays as a result, and both had some problems with MeHAF reporting and budgeting. One of these managers said, "It was the first grant I coordinated. It was a big learning curve for me." The manager of the other project echoed the first manager's words, "I'd never worked with grants before…. From my past management experience, I've had a learning curve here. I've had to learn to adapt to the changing needs of the community and changing staffing."

In another case, the division of labor on the project was unclear from the start, and never really appeared to be settled. There was an outside consultant grant writer, who also had responsibility for doing the reports, and the person listed as project manager on the proposal and on most of the reports to MeHAF was not from the grantee organization but from its collaborating partner organization.

Our conclusion is that staffing difficulties can threaten the ability of projects to meet their goals. In cases where there are staffing transitions, MeHAF staff might work with grantees more intensively than might otherwise be the case in order to facilitate a smooth transition.

Project Design. Two projects had major changes in their design, and one requested a change that was not approved by staff. Of the two that were approved, one organization, which had a one-year planning grant, originally intended to develop a "model" project in one physician practice. They discovered that many similar "model" projects had already emerged in the state recently, and they also experienced difficulties in obtaining data. They shifted to three new strategies: doing case studies of the new "model" projects, using a consultant to advise on development of key indicators, and adding a needs assessment of an additional category of providers.

Another grantee, which received a two-year program grant to promote systems and staff knowledge/attitude change in end-of-life care approaches at a major medical center, indicated in the interview and reports that this was a "high-risk project" because it required "huge changes" in an established medical culture. They ultimately changed the intervention design to increase the role of social workers rather than medical professionals.

In two cases, revisions to the design allowed the project to address insurmountable challenges. As a result, both were able to achieve some outcomes, though more modest than they originally proposed. In a third case, the project might have benefited if MeHAF had approved the proposed change. Nevertheless, MeHAF must have the ability to make decisions on requests for changes in project design based on the information it has from the grantee. MeHAF appears to be conscientious in considering these requests.

GREF Evaluation Framework

GREF is a logic model designed to focus grantees on desired outcomes and the steps needed to achieve those outcomes. The 2003A RFP required applicants to complete GREF and required that reports be submitted using the GREF framework. We used a multi-pronged methodology for analyzing GREF. We: (1) reviewed materials provided to grantees in 2003, such as instructions, forms and a PowerPoint presentation, (2) interviewed a member of the MeHAF Board and Grants Committee, (3) reviewed reports submitted by grantees using the GREF format, and (4) interviewed grantees directly. This portion of the evaluation includes our findings from our own review, and from our interview with the MeHAF Board member. Grantee perceptions are included in the Grantee Perception section of this evaluation.

Figure 1 illustrates our understanding of the relationship between the proposals submitted to MeHAF, which form the basis for each project, and the GREF reporting format.

Figure 1: MeHAF 2003A Grant Requirements and GREF Framework
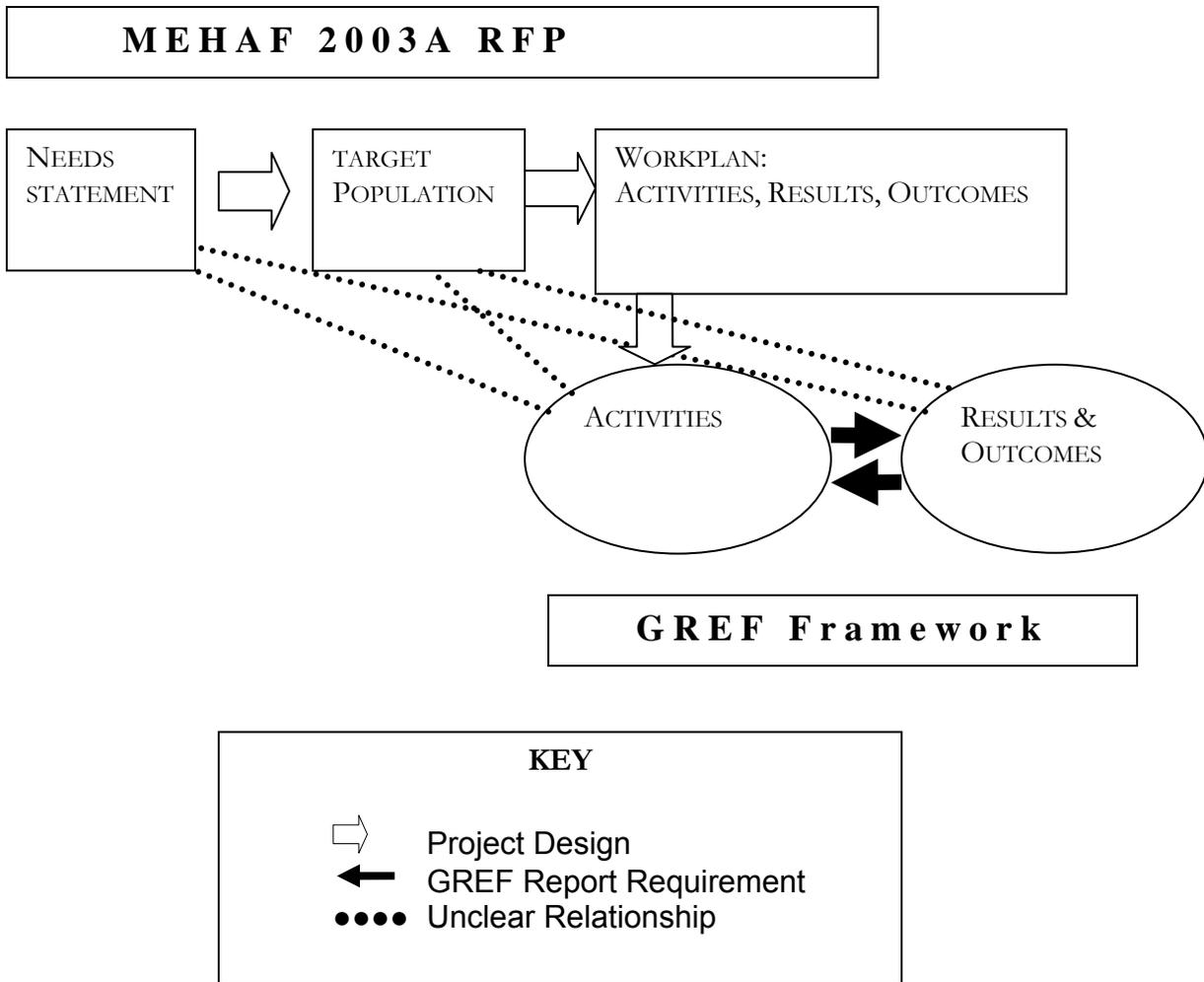
Analysis of the MeHAF 2003A Project Requirements and the GREF Framework

MeHAF 2003 A RFP Requirements. The MeHAF 2003A RFP required all projects to (1) articulate a needs statement, (2) identify a target population and (3) develop a work plan that included strategic activities, results and outcomes.

GREF Evaluation Framework. The GREF Framework begins with strategic activities, and requires that grantees report the results and outcomes of their strategic activities. It does require baseline measures, but not benchmarks. The PowerPoint presentation given to grantees during GREF training did include a description of logic models in general as "a logical sequence of mission, goals, objectives and activities" (slide 10). The presentation does not elaborate on the point, or provide examples of that linkage. Neither the GREF reporting forms nor the instructions reference the linkage either. Our review suggests that the use of GREF in the 2003A grant cycle did not always

rigorously and systematically connect activities, goals and objectives with the need statement and the target population identified in the proposals. The instructions and forms may need clarification in this regard.

Grantee Perceptions

The evaluation team asked each respondent to articulate the problems that MeHAF was trying to address in the 2003A grant cycle, to provide an assessment of the impact that MeHAF has on those problems, and to suggest ways to measure the impact. In addition, we asked for their opinions regarding the application process, communications with MeHAF, and the reporting process.

Problem Addressed by MeHAF

MeHAF's mission statement clearly sets forth three areas of focus: access for the underserved, quality and cost. Representatives of 13 projects either didn't give a direct response or cited only one of the three focal areas in MeHAF's mission statement (access) (See Table 5). Only two respondents articulated all three focal areas. The majority of grantees clearly understood that access is an area of interest for MeHAF, although there was some confusion about the meaning of "underserved" populations among grantees and reviewers alike. One reviewer demonstrated this lack of clarity in scoring a proposal that targeted end-of-life care:

"I didn't give them the 10 bonus points for underserved populations, because the project's target population largely had health insurance (mainly Medicare) and access to medical care. However, one could make the argument that we all are underserved with regard to getting appropriate and timely information about hospice care. It's your indicator, so feel free to reverse me on this point if you think I misinterpreted your definition here."

TABLE 5. Grantee Articulation of the Problems MeHAF Addresses (Cost, Quality and Access)

Problems cited (maximum of three)	Respondents
Three	2
Two	3
One	8
No direct response	5

MeHAF Impact

When asked to assess MeHAF's impact on the problem(s) it seeks to address, 12 responded that MeHAF has a positive impact. Many characterized it as "huge," "big" or "making great strides." When asked for examples, five were able to give one or more, which included references to specific programs, increased access, increased

collaboration, and sustainable long-term change. Grantees most often cited increased focus and visibility on priorities that MeHAF sets, and the expansion or creation of programs.

Several respondents acknowledged the complexity and limitations of measuring impact. Nevertheless, 14 thought MeHAF could measure its impact to some extent, and 11 offered specific suggestions of measures. Process measures included: funding leveraged, new collaborations formed and seeding innovation. The most cited outcome measure was number of people served. Several grantees commended MeHAF for its evaluation efforts to date. As one grantee said, "MeHAF does a good job of evaluation."

MeHAF's Application Process, Communications, and Reporting Requirements

Evaluators asked grantees about their contact with the Foundation, their understanding of the Foundation's priorities and requirements, their communications with Foundation staff, the application process, and their opinions about the adequacy of the final report format. The interviewers also asked for specific recommendations about the final reports. In several instances, the grantee had not submitted a final report at the time of the interview. In those instances, interviewers asked grantees about the reports completed to date, which typically included interim reports, and in many cases final reports for the first year of the grant.

TABLE 6. Respondents' Rating of 2003A Grants Process*

	Avg.	(St. dev.)**	# Responding
Grant Application Process	3.62	(.471)	15
Understanding MeHAF Priorities for 2003A Grants Program	3.89	(.289)	14
Understanding of GREF	3.00	(.982)	15

*   *Application Process Rating:*
      (1) Did not work well (2) Worked somewhat (3) Worked very well (4) Worked extremely well
    U*nderstanding MeHAF Priorities & Understanding of GREF Ratings:*
      (1) Did not understand (2) Understood somewhat (3) Understood very well (4) Understood completely
** Standard deviation is a statistical measure that indicates the extent of variation from the average; the higher the
      standard deviation, the greater the variation there is among the individual numbers on which the average is
      based.

Application Process. Grantees were asked to score how well the 2003A grant application process worked for them. Fifteen of the respondents had been involved in the original grant application process, and three had not. All of those who had been involved reported that the process worked *very well* or *extremely well.* The average rating was 3.62 on the four-point scale. Only one respondent commented that the process "took too long." Comments included:

  "The instructions were very clear."
  "Read the RFP, it's all in there."

"Professionally done."

"We applied for a lot of grants. They were in the midrange to the extent of requirements."

Few respondents had any suggestions for improving the application process. One suggested shortening the time from initial submission of a letter of intent to actual determination and award. One suggested that the Foundation use electronic submissions and reporting to the greatest extent possible, but acknowledged that MeHAF employs electronic submission to some extent already. A recent evaluation of MeHAF's discretionary grants program (Rosen, 2005) indicated that grantees use the web extensively to find out about MeHAF and its programs.

MeHAF Priorities for the 2003A Grant Program. Applicants were asked about their understanding of MeHAF's priorities for the 2003A grant program. All respondents involved in the grant application process reported understanding MeHAF's priorities for the grant program *very well* or *completely.* The average rating on the four-point scale was 3.89. Respondents most often articulated those priorities as increasing access, and some linked that access to underserved populations. Few identified quality or cost as priorities, as presented earlier in our discussion of grantee perceptions.

Communications with MeHAF Staff. The grantees were overwhelmingly positive about MeHAF overall, offering extremely complimentary comments about the grant process and the staff. Many commended Dr. Wolf or particular staff members specifically.

"MeHAF makes it clear that they are approachable and available."

"MeHAF is a model of accessibility."

"They are easy to work with, but you have to be well prepared and not waste their time."

"Working with them is very good. Wendy is very impressive, particularly on the sustainability funding."

"We really felt like we were supported. They wanted us to succeed. They were there as a resource. That was especially true when you [ran] into roadblocks . . . I felt like they all knew what we were doing from Wendy on down."

"Wendy is very helpful, Kim is delightful. . . . I see them as being a resource."

Most respondents described their communications with the staff as "excellent," "outstanding" or "very good," citing the professionalism, knowledge and accessibility of the staff.

"It was always an easy process to contact someone. Phone calls and e-mails were answered promptly. I had several conversations with Kim, and also had good communication with Cathy Luce."

"Communications were terrific. We could always pick up the phone and talk."

"When I was having trouble getting the information I needed from [partner organization] David was very helpful."

Respondents see the staff as supporters, and particularly value the technical assistance that the staff provides. Though many referred to technical assistance without giving examples, some specifically referenced MeHAF's responsiveness to questions, help with reporting formats, and workshops.

"They were very approachable and responsive; we could always get our questions answered."
"Maybe they could check in with grantees, especially new grantees, more often than just the 6-month written report. I've struggled with the reporting process more than anything else. The real turning point for me was when MeHAF [Kim and David] came up to see what we'd done."
"The technical assistance is really helpful."
"The workshops for applicants were very helpful. I appreciated having the ability to call up David, or Kim, or even Wendy."

A few reported occasional friction in communications with a particular staff member. Even in those instances, however, the respondents reported that their overall interactions with that individual were helpful and generally positive.

Reports. Interviewers asked grantees how well the final report covered the outcomes, achievements and issues that they considered most important. Grantees who had not submitted final reports at the time of the interview were asked to comment on interim reports. A majority of respondents thought that the report format was appropriate and concise, but a third of the respondents were less satisfied. One characterized the report as "a little bit over the top" for the funding level. In contrast, a number characterized the report as too restrictive. Several expressed frustration that the format did not allow them to fully report on their project. Many believed that the narrative word limit was a maximum of 250 words, and did not believe that they could provide MeHAF with sufficient information within that limit. Some reported adding pages or materials. Two specifically suggested that MeHAF use a reporting format similar to that used by the Robert Wood Johnson Foundation.

Grantmakers Evaluation Framework (GREF)

In order to ascertain grantee perception of the GREF framework required by MeHAF as part of the reporting process in the 2003A grant cycle, interviewers asked respondents to rate how clearly they understood the process and how they were to use it. Of the 18 grantees, 15 had direct experience with the GREF process. Based on a four-point scale, the average rating was 3.00, somewhat lower than respondents' ratings for the application process or for their understanding of MeHAF's priorities for the 2003A grants (See tables 6 and 7).

TABLE 7. Grantee Understanding of the GREF Framework

Response	Number of Respondents
(4) Understood completely	5
(3) Understood very well	5
(2) Understood somewhat	4
(1) Did not understand	1

Ten respondents scored themselves as understanding the GREF framework *very well* or *completely.* This group often identified themselves as trained in evaluation. Several responded that they themselves understood the framework, though acknowledged that everyone else might not. Five respondents said they *did not understand* GREF at all, or *understood somewhat.* Some of these respondents characterized the framework as "unworkable," "hard to apply" or "sometimes arbitrary." Most of the planning grant applicants reported that the framework did not fit their grants well. One described it as "fitting a square peg in a round hole."

Although a number of respondents reported that they understood the framework, and many reported attending training, the evaluation team noted that the reports themselves were not consistently completed. In many cases, the grantees simply listed the process and outcome measures they would use, but did not include specific information on baselines, targets and benchmarks. It was very difficult to assess changes throughout the project because the reporting format did not specifically ask for progress against baselines or benchmarks. The GREF framework also does not ask grantees to describe or document the reasons change occurred, as would the Evaluation Process Model, in order to understand the link between program goals, objectives and activities, and outcomes.

Some grantees reported using the GREF framework to inform implementation of the grant, but a large number either did not incorporate GREF into operations, or used an external evaluation in lieu of GREF (the following section on evaluation includes a more detailed discussion of external evaluations).

A number of respondents mentioned that they had attended a training session and/or used the materials from that session or online, and found them to be very helpful, though there was a suggestion that MeHAF develop and disseminate more relevant examples.

Grantee comments related to several aspects of GREF, which we group here by the following sub-topics: (1) GREF's usefulness as an evaluation framework or project planning and design tool, (2) reporting limitations, (3) grantee understanding of GREF, and (4) the usefulness of GREF training conducted by MeHAF.

GREF's Usefulness as an Evaluation Framework or Project Planning and Design Tool.

"I don't understand it [GREF] but our data person does. She took a whole course on it." [Note: the data person came from the Edmund S. Muskie School of Public Service] "We used the GREF framework from this project as a basis for our

submission to the XXX Foundation. [Our data person] made a GREF-type matrix for it. That's essentially how she thinks. All our projects are mission-driven and have goals and objectives. Without [data person] it would be hard….She uses GREF to tie the project to our mission."

"Eliminate the logic model! It's my least favorite evaluative approach. GREF is not an evaluative tool, though it's good for program planning. But SAMHSA [Substance Abuse and Mental Health Administration] loves it, MeHAF loves it." [Interviewer probes for elaboration] "I'd recommend almost anything else. RWJ [Robert Wood Johnson] has some wonderful, straightforward, easy tools. . . The [GREF] training meetings were helpful; the problem with the process is that it truly lends itself more to program planning than evaluation and is cumbersome."

"It [GREF] was a process, sometimes it seems arbitrary. GREF didn't drive the program at all. But the evaluation tools we established at the beginning of the program did drive it."

GREF Reporting Limitations (Forms, Formats, Concepts).

"We built a more elaborate framework than GREF. We submitted stuff in addition because the limits on the grid don't let us tell our whole story." [What limits?] "Two-hundred and fifty words, for example. David actually mentioned that it was a minimum. He shared with us that they weren't getting good information from people."

"Having the metric was very helpful to work within. It's a good way to view the project as a whole. Having the additional questions also was good, a good chance to give a picture." [Interviewer asks about the supplemental notebook submitted with the final report.] "Having the notebook as an accompaniment was very helpful. A lot of the visual [aspects of the notebook] came about as a result of needing to communicate [during this particular project]."

"One thing I question is having a couple of different organizing logics in the report, having a chronological time line and having several different activities feed into the same outcomes. It's repetitious. It's a bit of a shuffle."

"There are other issues besides formatting [the report]. I don't think we should have to try to report outcomes that won't reasonably happen for many years. I've been to several trainings and we still have discussions about what is 'result' and what is 'outcome.' Even with training, participants are still unclear. . . .The problem is reporting what's going to happen, when what you want to report is what happened."

"It doesn't allow us to talk about dissemination, what we do. . . . I don't think the forms work. It doesn't allow us to talk about what we want to talk about. The boxes don't work. GREF is unworkable. . . It was confusing and didn't allow us to talk

about the rich outcomes—the products, the deliverables, and reach and impact of the program."

"I understand the logic model. My life is a logic model!" "That said, I prefer my own version. I prefer a simpler version. As I recall, GREF has too much crammed into the left column. I thought it was a great idea to have all the grantees do the same things the same ways, however."

Grantees' Understanding of GREF.

"I understand completely but I'm a sociologist. . . .I think it is good but might not work as well for someone else."

"I understood it completely but I'm not really sure it serves the purpose for planning grants."

"Having gone to GREF training and having a Masters in [a related field] I have a handle on it. Yet it was hard applying to this particular grant. I was telling the project manager what I thought was a result and outcome based on the training [Note: manager was hired after the training.]. Then she'd talk to MeHAF and they'd tell her something different."

"I thought GREF was very clear. I understand the logic model."

"I was clear what the Foundation expected, but I don't understand what the big deal about the GREF framework is. Anyone who understands logic models knows. But some people don't."

GREF Training.

"When I left the orientation, I'd rate myself as a 4 ["understood completely"], but a month later around a 3 ["understood very well"]. Do I feel like I understand it? No, not really."

"Prior to the orientation I thought it was difficult, but orientation made it clearer."

"I would rate [my understanding] as a 3 ["understood very well] after we'd had the training. We had the materials to refer to, and that helped."

"We went to the workshops. I think they are helpful for those who might have known about this kind of evaluation before, but not so much for me."

"I went to the training but didn't find it clear. More concrete examples would help, for example if they gave samples of well-done GREF reports."

"I went to the workshop at the beginning. I think David may have called to straighten me out some."

External Evaluation

Five grantees reported that they had incorporated external evaluation into their projects, and a sixth reported that an external evaluation was part of the funded project, though in three cases the evaluation was funded by a different organization (two were funded by the Robert Wood Johnson Foundation and one was funded by the U.S.

Department of Commerce). Of these six projects, one had a multi-year data grant and five were program grants. All of the grantees utilizing external evaluation reported that the evaluation provided essential information that they used in developing the program design, and that the evaluation findings helped drive the project during implementation. Two of the grantees reported using their external evaluation instead of GREF.

Additional Observations

Barriers

Respondents mentioned a number of systemic and funding barriers to successful program implementation and sustainability. First and foremost, current reimbursement formulas and systems do not allow organizations to provide certain services that they deem are crucial; especially case/care management and interventions that are deemed as "prevention" when there is no specific diagnosis assigned. A few people mentioned that getting reimbursed for any kind of innovative practices was a major hurdle. "Systems" issues—whether on the state level or within large organizations—came up in several interviews. For example, one organization faced a major hurdle when they discovered that DHHS required separate licensing for each site where telepsychiatry was to be delivered.

Case/Care Managers

The importance of case/care management for many of the programs funded by MeHAF in 2003 is a striking, and significant, finding. The value of case/care management—and frustration in getting it reimbursed—was mentioned by three of the access programs: Franklin Health Access, Maine General/Care Partners, and MaineHealth (also a Care Partners program); by Common Ties (and their partner, the B Street Health Center); by the Penobscot Community Health Center; and by the Maine Medical Center/PIER program. Several respondents mentioned that case/care management was not only good for patients in terms of health outcomes, but that having case/care managers could have a financial impact on practices as well. Case/care managers often help in doing client reminders or otherwise ensuring that appointments are kept, thereby reducing the rate of costly "no shows."

Discussion and Recommendations

There are a number of issues and recommendations for MeHAF to consider. Some of these stem directly from our analysis of the 2003A grants and grantmaking cycle. Others are of a more general nature.

Definition of "Underserved" Population

One reviewer and several grantees expressed some level of confusion about the meaning of the term "underserved" populations. While the confusion did not seem extreme in this group, it might be greater for potential applicants, or broader

constituencies of the organization. *MeHAF might consider developing a working definition to eliminate any confusion.*

<u>Communications and Technical Assistance</u>

As discussed in the section on Grantee Perceptions, respondents value their communications with MeHAF and rate staff highly. Staff is to be commended for doing an exceptional job. The technical assistance is particularly helpful to grantees. Many indicated that they would like more technical assistance, such as workshops and help with reporting formats, but acknowledged that there aren't many MeHAF staff members, and they are doing a lot already. *MeHAF might consider ways to expand technical assistance for grantees. (Related recommendations on MeHAF's role are included in the section on Promoting MeHAF Grants.)*

<u>Reports</u>

Grantees were most divided in their opinions on the reports they submitted to MeHAF. Some believed the reports were concise and to the point; others thought they were too limited. Two grantees familiar with the Robert Wood Johnson evaluation format specifically recommended that MeHAF consider incorporating elements of that reporting format. *MeHAF might consider working with grantees to modify the existing reporting format to allow grantees to fully report on programmatic activity, while maintaining the simplicity and efficiency that most grantees value. MeHAF might give grantees an opportunity to participate in the redesign process.*

<u>Sustainability of Innovation</u>

Many of the 2003A grantees are struggling to sustain their programs. A major challenge is the availability of reimbursement for innovative medical services. MeHAF does not have either the formal relationships or the resources needed to address this issue directly. *MeHAF could,* however, expand its role as a convener of *public and private payers, with the specific purpose of exploring ways to achieve greater flexibility in existing public and private reimbursement for innovations that MeHAF projects or initiatives are able to achieve. We recognize that the current funding climate makes it difficult for public and private funders to experiment. At the same time, we believe that MeHAF has a unique role that could help sustainability for successful projects that they have funded. In addition MeHAF serves as an important link between grantees and other funding sources, a role it should continue, and even expand in the future.*

<u>Data Dilemmas</u>

MeHAF was not expecting grantees to report health outcome measures due to the limited time frames of their projects and communicated this to grantees. Twelve projects (67%) had the potential to collect and analyze data to monitor or assess health outcomes, but few did. Six of the 18 projects (33%) reported difficulty with obtaining the data they needed to implement and report on their projects as proposed. Issues included the unavailability of data, incompatible data systems, and record-keeping that made aggregated reporting difficult. *This is an issue that MeHAF might want to explore*

with its grantees in more depth to understand the exact nature of the problems and test possible solutions.

<u>Evaluation</u>

There are several recommendations relating to evaluation. Additional recommendations appear in the section on "Applying the Evaluation Practice Model."

Grantmakers' Evaluation Framework (GREF). A significant number of grantees report that they do not understand or use the GREF framework, and few use it to inform program direction or decisions. The evaluation team also notes that the forms and instructions for GREF do not necessarily rigorously and consistently connect to the requirements of the 2003A RFP. (Our analysis was confined to the 2003 GREF Framework. There may have been changes since that period.) *MeHAF should consider engaging all of its grantees in a discussion of the GREF Framework to determine if (a) the current framework meets the needs of both MeHAF and grantees, (2) the framework should be revised, or (3) an alternative framework should be used.*

Post-grant evaluation
- *At the end of the grant period.* The evaluation reported here was conducted in October-December of 2005, two years after initial implementation of the grants, and immediately after the initial scheduled end of the grant cycle for the two-year grants. In most cases, the timing worked well in that most grants were completed, and most (though not all) of the grantees themselves were available and could reasonably recall important information needed for the evaluation. Three grants were still underway with no-cost extensions. As a result, evaluators did not have comparable information for those grants. *MeHAF might consider scheduling post-grant evaluations six months after the end of each project period. MeHAF might also inform grantees at the outset that there will be an evaluation, and ask grantees to send up-to-date contact information annually after the grant terminates. Finally, MeHAF itself can prepare the documentation needed for evaluation in a less intense way by making an extra copy of all documentation as it is entered into the file.*
- *After five years. Several grantees suggested that MeHAF consider an evaluation five years after the end of the grant period to ascertain the extent to which the initiatives funded in 2003 have been able to continue or expand.* The Bingham Program has conducted a retrospective review that has provided useful information, and could provide a model for this kind of evaluation.

<u>Clarifying and Conveying MeHAF's Message</u>

Grantees are among those closest to MeHAF, and almost universally believed that they understood MeHAF and its mission. Yet, interview responses indicate that many do not completely understand MeHAF's areas of focus, the underlying problems it is trying to address and the impact it is having. This evaluation only included successful grantees. It did not include those who had applied but were not successful, the public or other MeHAF constituencies. *To the extent that visibility is important to MeHAF, it might want to consider a broader branding and public relations strategy than the current system.* Such a strategy could begin with a systematic identification of key audiences

and constituencies, an organized method for understanding their current perceptions of MeHAF, a comparison of those perceptions with the message and identity MeHAF would like to project, an assessment of appropriate outreach mechanisms, a plan to reach those audiences (with process and outcome goals, objectives and benchmarks) and feedback mechanisms to assess whether it is having the impact it would like to have.

System Change

MeHAF grantees are attempting to change complex systems, often in a short amount of time. There are several system change issues for MeHAF to consider:

- Grant period. The one-to-two year limit for MeHAF's grants presents a formidable challenge, especially for those projects that have to hire new staff or develop new facilities. *MeHAF might consider longer-term commitments, particularly for projects like match to Robert Wood Johnson grants, which can be four-year grants.*
- Change within the medical system. Six of the 18 projects (33%) reported that buy-in and participation from physicians is key to successful system change. In most cases, these projects included physician participation in their proposals, but engaging the right physicians in a meaningful way was challenging. *MeHAF might want to consider either providing specialized technical assistance to grantees in this area, or at least the opportunity for grantees to network and learn from each other on this specific issue.*

Accessibility for All

MeHAF's major focus is to provide access for underserved populations in Maine. Several grantees noted that MeHAF models access in its communications and interactions with grantees. A review of the MeHAF website indicates that there are difficulties for individuals with disabilities. As a major player in the health care field in Maine, MeHAF should extend that access to include universal design and compliance with Section 508 of the Americans with Disabilities Act to all of its materials and activities. *MeHAF might consider developing a "universal access" plan to assure that its website, materials, and activities, as well as those used by grantees, are accessible to all of the general public in Maine.*

Divergent Grantee Values About MeHAF Funding Priorities

Respondents expressed some divergence of opinion about what MeHAF should be funding, or the relative "weights" MeHAF ought to give in making decisions about types of programs to fund. Several grantees that had programs in place that incorporated evidence-based practices expressed some frustration that MeHAF, and other private and federal grantors, seemed to focus on innovation and pilot programs. They noted that there is also a tremendous need for ongoing support in situations where

the existing fee-for-service reimbursement would not cover the needed services or programs. As one respondent phrased it,

> "Nobody cares if you've been around for three years; you're just boring. I know MeHAF's ability to support mature programs and to provide operational support is limited. But, I think they really need to think about sustainability. I think they should not support start-ups that have no possibility for sustainability. We've been able to keep going because of hospital and board support, which has been crucial. However, having some predictability of MeHAF support would also be helpful."

By way of contrast, other grantees were strongly supportive, and appreciative of, MeHAF's willingness to fund innovation and to take a chance on high-risk projects. One respondent remarked,

> "We'd love to work with MeHAF again. If you're talking about seeding innovations in our business, you're talking about changing the provider culture."

A respondent who was very pleased with their project's results mentioned, "We were brainstorming possible solutions. The MeHAF grants are the kind of grants you can do that. It's research."

Another grantee, who felt their project had not been as successful as they had hoped, was still very appreciative of the opportunity MeHAF had given the organization.

> "My biggest thing is I am grateful to MeHAF for being willing to take a risk. Otherwise you never get anything innovative that can change the playing field. Someone needs to fund innovative but high-risk projects."

Applying the Evaluation Practice Model

In this section, we describe the Evaluation Practice Model (DePoy and Gilson, 2003) in some detail, and apply it retrospectively as an alternative, but complementary way to look at both MeHAF and individual grants. This exercise is powerful in that it uses a systematic and continuous evidence-based sequence for the design, implementation and evaluation of projects.

As we noted earlier, grant recipients were not required to use this model, and it would not be fair or accurate to retrospectively evaluate the performance of either individual grants or MeHAF against the model. The exercise is valuable in that it has the potential to inform MeHAF's thinking about how it might structure grant projects in the future. These structural issues can either facilitate the success of a project or undermine it.

We caution against using the model to evaluate the effectiveness of individual projects in meeting their goals. Rather, it is a helpful tool to understand the thinking and action framework of MeHAF's grant requirements, and key elements or barriers to addressing the problem(s) and need(s) articulated by MeHAF and the grantees themselves. Similarly, it can also serve a useful purpose in understanding the structure of individual grants. MeHAF and individual grantees might chose to use such an approach as a learning exercise, rather than a retrospective evaluation.

The Evaluation Practice Model is evidence-based. It calls for those developing programs to systematically address the following:

1. *Problem and need statements*: The *problem statement* identifies the issue to be addressed (or the unwanted or undesirable circumstance). It includes a specific statement of the cause(s) and/or consequences(s). A *needs statement* is a systematically supported and well-documented set of actions that are necessary to resolve all or part of the problem as it is stated.
2. *Goals and objectives*: are broad statements about the ideal or "hoped for" change. They look forward in time. They also link directly to the problem and need statements. Objectives are statements that identify how abstract goals will be met and what will result.
3. *Reflexive intervention* occurs during the implementation (intervention) phase, and assesses whether and how implementation is meeting the need(s) and resolving the problem(s) targeted by the project or program. This step requires a systematic, evidence-based assessment of activities, resources and processes, including assessments of environmental change and unintended consequences.
4. *Outcome assessment* includes an evidence-based examination of the results of the project with particular attention to the extent to which the articulated problem(s) was (were) resolved.
5. *Dissemination* is the step in which the project and lessons learned are shared to expand the benefit of an individual effort beyond its direct impact.

Figure 2: Evaluation Practice Sequence
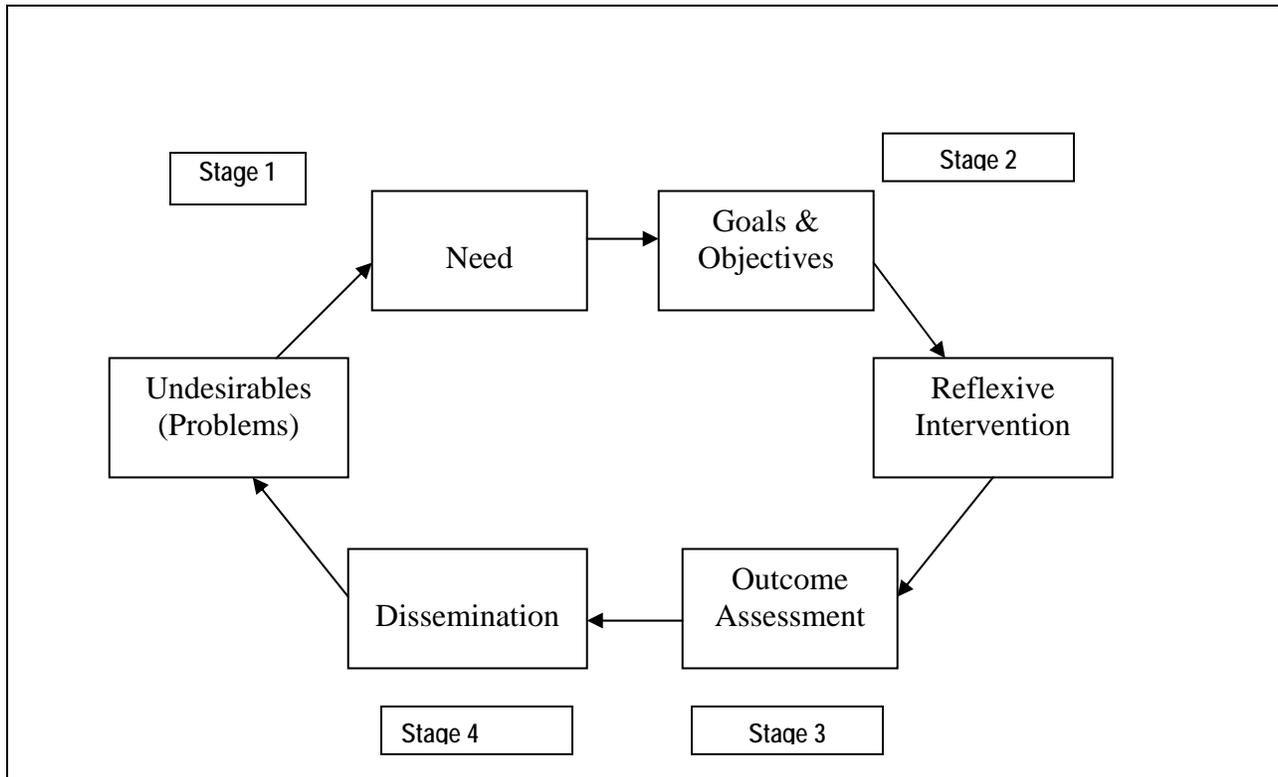
The Evaluation Practice Model is dynamic and continuous. Knowledge gained through the phases of the model are continuously cycled back to inform the problem and need statements, to test the validity of both the underlying assumptions and the specific project activities and to make modifications as necessary.

Here, we apply the Evaluation Practice Model to the Maine Health Access Foundation's grant program, and to the groups of grants (program, planning, and policy/data) funded by MeHAF in 2003.

The Evaluation Practice Model and MeHAF

For the 2003A grant cycle, MeHAF provided a clear statement of the problem(s) and need(s) that grantees should address, but allowed grantees themselves to develop more detailed problem and need statements, goals and objectives, reflexive intervention and dissemination activities. Grantees submitted regular reports to MeHAF staff.

MeHAF's mission addresses three interrelated problems in health care in Maine: (1) limited access to quality health care; (2) high cost of care; and (3) negative health consequences to individuals and communities in Maine. This evaluation applies a comprehensive organizational evaluation framework to fully understand the extent to which individual grants in the 2003A grant cycle addressed these three major health problems. It provides a way of understanding the sum total of the problem(s) or issues, causes and consequences identified by the individual grantees in their initial proposals.

Figure 3. Map of Causes and Consequences Derived from 2003A Proposals
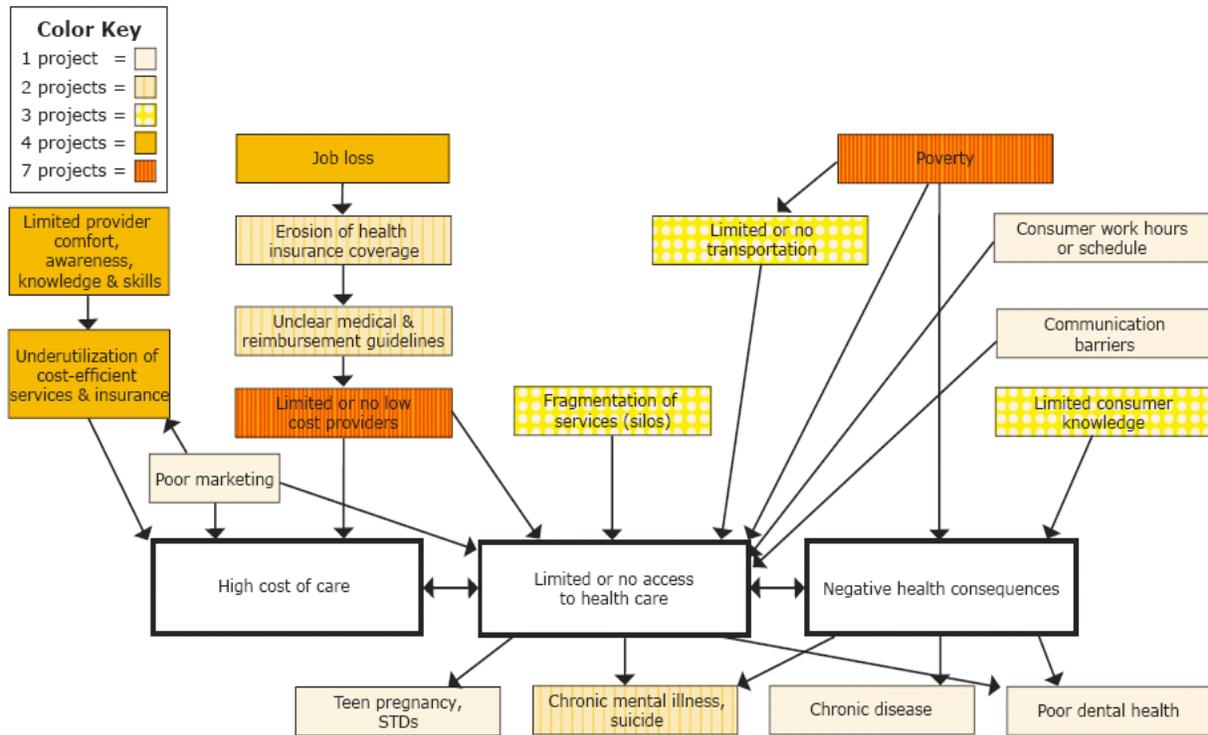
The diagram in Figure 2 is a "problem map" (DePoy and Gilson, 2003) based on the causes and consequences identified by grantees in their proposals. It graphically shows the problems MeHAF seeks to address (white boxes) and the causes that the 18 proposals addressed. There are 13 "causes" identified (upper colored boxes in Figure 2), which are summarized in Table 8. Many proposals referenced health outcomes, particularly in the needs section, but only five proposals listed specific health outcomes (bottom row of colored boxes in Figure 2) in their work plans.

TABLE 8.   Causes Targeted in the 2003A Proposals

Cause	Number of Grants*
Poverty	7
Limited or no low-cost local providers	7
Job loss	4
Underutilization of cost-efficient services and insurance	4
Limited provider comfort, awareness, knowledge and skill	4
Fragmentation of services	3
Limited or no transportation	3
Limited consumer knowledge	3
Unclear medical and reimbursement guidelines	2
Erosion of health insurance coverage	2
Communication barriers	1
Poor marketing	1
Consumer work hours or schedule	1

* Proposals could target more than one cause.

Poverty and limited or no low-cost local providers were the most frequently addressed causes, mentioned by seven grantees. When taken together, the grants specifically addressed reproductive health (teen pregnancy and sexually transmitted diseases), chronic disease, oral health and chronic mental illness (including but not limited to suicide).

Program, Planning and Policy/Data Grants

This section discusses the methodology we used and the results of our analysis of grant categories (program, planning and policy/data) using the Evaluation Practice Model.

Methodology

The scope of the evaluation did not allow extensive analysis of how the Evaluation Practice Model could inform each grant. We therefore developed an abbreviated methodology. Two members of the team independently rated several elements in each project, using a four-point scale. Program and planning grants were rated on four elements (problem statement, extent to which addressing the need is likely to solve the problem, process goals/objectives, and outcome goals/objectives).

Policy/data grants were rated on two elements (problem statement, process goals and objectives). Ratings were averaged between the two evaluators. We then compared actual scores and the maximum number of points for the grant category, and expressed the results as a percentage of the maximum possible score. We completed an analysis of groups of grants by category, as shown below.

Evaluation Team Rating for Application of Evaluation Practice Model

Problem statement: 1=No problem stated; 2=states problem, cause or consequence, no documentation; 3=states problem, cause or consequence, some documentation; 4=states problem, cause or consequence with complete documentation.

Extent to which addressing the need is likely to solve the problem: 1=no evidence given; 2=some evidence given; 3=adequate evidence given; 4=strong evidence given.

Articulation and Accomplishment of process goals and objectives:
  Articulation: 1=no articulation; 2=some articulation, no measurement; 3=articulation, some measurement; 4=clear articulation and measurement.
  Accomplishment: 1=no accomplishment; 2=reports accomplishment, with no documentation; 3=some objectives accomplished, with documentation; 4=all objectives accomplished, with documentation.

Articulation and Accomplishment of outcome goals and objectives:
  Articulation: 1=no articulation; 2=some articulation, no measurement; 3=articulation, some measurement; 4=clear articulation and measurement.
  Accomplishment: 1=no accomplishment; 2=reports accomplishment, with no documentation; 3=some objectives accomplished, with documentation; 4=all objectives accomplished, with documentation.

TABLE 9. Ratings by Grant Categories (Percent of Maximum Possible Scores)

Grant Category	Number of Grants	Problem Statement	Need Statement	Process Goals/ Objectives	Outcome Goals/ Objectives	Overall Rating
Program	10	77%	62%	78%	72%	72%
Planning	6	75%	56%	79%	62%	67%
Policy/Data	2	78%	NA	81%	NA	80%

Program grants

Our overall rating for program grants was that they achieved 72.4% of the maximum possible points. Program grants came closest to the model in two categories: statement of the problem, and articulation and accomplishment of process objectives. They diverged most from the model in articulation of need and in articulation and accomplishment of outcome objectives.

<u>Planning grants</u>

Our overall rating for planning grants was that they met 66.9% of the maximum possible points. Like program grants, planning grants came closest to the model in articulating the problem and in articulating and accomplishing process objectives. This finding is not surprising, since planning grants are typically highly process-oriented. Planning grants were weakest in the articulation of need, which suggests that MeHAF might give greater emphasis to formal needs analysis of the specific target population. Somewhat surprisingly, planning grants scored higher on the articulation and accomplishment of outcome objectives than program grants. Outcomes might be a plan or a decision to purchase a piece of equipment. Two of the grants did involve implementation of the planned programs, and did measure service delivery outcomes to some extent.

<u>Policy/data grants</u>

Our overall rating for policy/data grants was 80%. Policy/data grants came the closest to the model of all grant categories in their statement of the problem and in accomplishment of process objectives. This is not surprising, because these grants are based on standard research methodology, which is incorporated in the Evaluation Practice Model. Neither project was complete at the time of the evaluation, so the evaluation team could not assess outcomes.

Recommendations

MeHAF is a young organization and it is clear that it has dedicated considerable thought and resource to the structure of the major grants programs. *MeHAF can build on these efforts by encouraging and supporting grantees in developing and using sound, systematically-supported, evidence-based program models and evaluation methodologies as part of the initial proposal, design stage and throughout the implementation of the project. One way to achieve this would be for MeHAF to provide grantees with professional technical assistance from trained evaluators as part of the project team from the beginning of the project if the grantee does not already have the capacity. The goal is to build capacity into the project design itself, rather than to try to make all grantees de facto evaluation experts. The potential benefits are that the projects themselves will be more focused and sustainable, and that MeHAF will gain information on the impact it is having through its grant program. Of course, the recommendation will also require additional cost, which would vary depending on the grant. It would be important for MeHAF to help grantees understand that internal evaluation could be very valuable to the program in helping it achieve its goals.*

Recommendations for Promoting MeHAF Grants

MeHAF asked that this evaluation include suggestions for promoting successful MeHAF grants. The scope of this evaluation did not include an assessment of the extent to which MeHAF stakeholders, potential applicants and the broader public is aware of MeHAF's grants, though the evaluation team believes that it is important for MeHAF to understand the extent to which its constituencies are aware of its programs, and to promote the programs. Most of the grants in the 2003A cycle had notable successes that individual programs and MeHAF can share. One of the members of the MeHAF Board and Grants Committee credits MeHAF with doing a good job of public information. Some MeHAF grantees also are successful at raising visibility for their own grants, for MeHAF and for health issues broadly. Both MeHAF and grantees play an important role in working with constituency groups to raise visibility.

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MeHAF has a broad array of constituencies it could potentially target, including grantees themselves, potential grantees, policymakers, potential program participants and the broader public. Mechanisms that MeHAF can employ to reach these audiences include print and electronic media, visibility with professional groups and sectors, and personal contact. Each constituency will be discussed separately below.

Grantees

Grantees rate MeHAF highly on its ability to communicate with individual grantees. At the same time, several indicate that they would like the opportunity to interact more with each other. Several indicated that MeHAF has convened grantees on occasion to discuss topical areas of common interest (the most cited was a meeting on mental health integration with primary care). Grantees expressed an interest in having MeHAF expand its activities in this area for at least two reasons: (1) to allow grantees to network more, learn what each other is doing, forge new collaborations, and (2) to bring expert knowledge or new information that can help current or future grantees be more effective, such as sessions on emerging trends (care management in mental health was cited as an example) or best practice. One grantee suggested that MeHAF provide abstracts of grants to each grantee regularly. MeHAF might also consider a "grantee only" website or section of the website to provide grantees with an opportunity to share information among themselves (notice of events and speakers would be an example).

Potential Grantees

This evaluation did not address this population, but the evaluation team did note that a concurrent evaluation of MeHAF's discretionary grant program (Rosen, 2005) found that most potential applicants find out about grant opportunities through MeHAF's website. A significant number of the applicants in the 2003A grant cycle are direct service providers. If MeHAF wants to reach a greater number or different types of applicants, it might consider employing print and electronic media to announce Requests for Application. It might also work with research and education organizations,

the Maine Association of Nonprofits, the Maine Municipal Association and similar organizations to publicize grant availability through their electronic and print media communication systems.

Policymakers

Most MeHAF grantees *and their constituencies* have a powerful story to tell. Each grantee should have annual personal contact with their legislators, congressional representatives and municipal officials. Grantees can organize tours, visit legislators in their home districts or in their offices, and can stay in contact via phone or email. Because of term limits, there is considerable fluidity at the state level, and there is a constant need to keep contacts current.

Members of Actual or Prospective Target Populations

Because Maine is a small state, MeHAF has a unique opportunity to:
(1) understand the nature of the uninsured and uninsured population in Maine, and (2) reach out both directly and in its grant programs to help the population understand the importance of health and the health care options available to them. MeHAF has already done so by funding projects to understand the demographics of the target population. In the 2003A grant cycle, the two data/policy grants sought to understand high school youth, and the uninsured/underinsured in areas of the state served by CarePartners. MeHAF subsequently funded a project in the 2005 grant cycle to engage citizens in the development of the state health plan. These are examples of the leadership role that MeHAF can play to understand the nature and scope of Maine's underserved, and to frame public dialogue. MeHAF could consider becoming even more proactive in these areas by initiating studies and projects in areas that it considers important.

General Public

A member of the MeHAF Board indicated that, as a "conversion" foundation, MeHAF has a greater responsibility to the public than most foundations, and credited Dr. Wolf and the staff with doing an excellent job of gaining visibility for the organization. As discussed elsewhere in this report, if MeHAF does not have a comprehensive marketing strategy, it should consider developing one. Elements of that strategy could include:

- Extensive use of weekly newspapers and radio, and systematic tracking of media "hits" to assess the extent to which MeHAF is reaching intended audiences.
- Editorial briefings on grant successes, particularly with weekly newspapers.
- Outreach to the public directly by sponsoring or hosting health-related broadcasts and features.
- Development of a specific information outreach program to involve professional journalists or students in publicizing health related issues in Maine. In essence, MeHAF could move beyond delivery to literacy. This might be done through an award for health reporting as part of the professional society annual awards, or

as a specific grant program to support the development of health-related reporting.

MeHAF has achieved significant visibility within certain segments of the health sector in Maine, and credibility with a key constituency, the grantees themselves. It can build on and expand its successes through increased efforts to expand recognition for MeHAF and its importance to Maine citizens.

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Appendix A

Project Team

University of Maine

The Margaret Chase Smith Policy Center is an independent interdisciplinary center, with expertise across a number of disciplines to meet the needs of policy makers in Maine in both the public and private sectors. The Center has extensive experience in needs assessment and program evaluation, including substantive systematic inquiry in health related fields. Recent projects in the health arena include Analysis of Survey Results-Penobscot Nation, Substance Abuse Treatment Facility Needs Assessment for the Maine Lighthouse Corporation (a MeHAF-funded project), Program Evaluation of Rapid Response, the Maine Rural Substance Abuse Partnership, and Drug Deaths in Maine.

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The Center for Community Inclusion and Disability Studies, Maine's University Center for Excellence in Developmental Disabilities Education, Research and Service (UCEDD), has core strengths in interdisciplinary education, exemplary program development, technical assistance, dissemination of information, applied research and evaluation, and public policy analysis committed to the principles of full access to community resources, interdependence, and the inherent abilities of each person to contribute to society. One of the Center's major areas of work focuses on assessing health needs of a range of individuals across the lifespan, developing programs, evaluating outcomes for target populations, clients, and policies, and disseminating process and outcome results to inform further efforts. Past and current work demonstrates not only a commitment to this important mission, but success in developing, bringing to fruition, and globally deploying systematically informed and evaluated work to advance health and wellness, social justice, equal opportunity, and maximization of human potential in our communities. The resources and facilities of the Center for Community Inclusion and Disability Studies, including the use of a state-of-the art computer server for instrumentation, data receipt and analysis, will be fully available to the project.

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T² Strategy

T² Strategy is a privately owned consulting firm providing strategic organizational planning, implementation and evaluation services to nonprofit and government organizations. Health related projects include The Congressionally appointed Citizen's Working Group on Health Care Reform (2005-2006); Tough Choices in Health Care, and the Governor's Listening Tour for the Governor's Office of Health Policy and Finance (Maine, 2004-2005), and "In a Heartbeat", a project with the Maine Quality Forum to improve survival and the quality of life after cardiac events.

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Appendix B

MeHAF 2003A RFP Summary

MeHAF's RFP for the 2003A grant cycle is summarized below, along with the maximum number of points that could be awarded for each section.

1. Agency or Organization Description
2. Project Description:
    A. <u>Needs Statement (10 points):</u> Including a description of the specific health problems or issues the proposed project addressed, and how the proposed activities or interventions will address these issues in a comprehensive or systemic way...

    B. <u>Target Population (5 points; 10 point bonus)</u>: Including a description of the population to be served by the proposed project in terms of relevant factors such as age, location, economic, cultural and ethnic characteristics. The target population may be defined by geographic, demographic or categorical variables. An additional 10 bonus points will be awarded to projects that focus on serving the uninsured or underserved, or that address health disparities by a concentration on appropriate target populations or geographic areas.
    C. <u>Work Plan (25 points):</u>
        a. In a brief narrative, explain the strategic activities you propose to undertake, relating them to your previously identified needs, target population and evidence-base.
            (1) Applicants are also encouraged to briefly discuss how their projects will move Maine's health care system toward attaining the goals described in the Foundation's Mission and Guiding Values (see pg. 5).
        b. Briefly describe how these strategic activities will lead to results and/or outcomes. We differentiate between process results, which stem from how a project is planned or implemented, and project outcomes, which are changes that occur directly from services. We also distinguish between initial, intermediate and long-term project outcomes. Define each result and/or outcome as follows:
            (1) Process results: Project planning or implementation not directly resulting in project outcomes. Generally, process results are accomplished during the grant period;
            (2) Initial or Short-term Project Outcomes: Often these preliminary outcomes focus on changing KABS -- Knowledge, Attitudes, Beliefs, and Skills. They are frequently but not invariably accomplished during the grant period;
            (3) Intermediate Project Outcomes: Often, these objectives or project outcomes focus on actual practices or behaviors. They are frequently but not invariably accomplished during the grant period; or

(4) Long-term Project Outcomes: Often, these objectives or project outcomes focus on sustained system change, improvements in health or disease outcomes, etc. They are typically not accomplished during the grant period.

   c. A short timeline identifying the time horizon associated with each activity and its associated results and/or outcomes.

D. <u>Evaluation (15 points):</u> Identify and describe specific and appropriate results and/or outcomes, with associated measures for each result and/or outcome described in your work plan. Define the data sources and timeline associated with each measure.

E. <u>Collaboration and Integration (15 points):</u> The Foundation encourages productive collaboration, as well as integration within and between existing systems where appropriate.

F. <u>Staffing (5 points):</u> Provide a description of the key staff involved in this project.

G. <u>Sustainability (10 points):</u> How will the project be sustained beyond the terms of this grant? What funding or in-kind support will be available to sustain this project after the termination of MeHAF grant funding?

H. <u>Budget (15 points)</u>