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# From Policy to Practice: Implementation of Georgia's Medicaid Family Planning Waiver Program

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**FROM POLICY TO PRACTICE: IMPLEMENTATION OF  
GEORGIA'S MEDICAID FAMILY PLANNING WAIVER  
PROGRAM**

A Dissertation  
Presented to  
The Academic Faculty

by

Sarah C. Blake, MA

In Partial Fulfillment  
of the Requirements for the Degree  
Doctor of Philosophy in Public Policy

Georgia Institute of Technology  
&  
Georgia State University

May 2013

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**FROM POLICY TO PRACTICE: IMPLEMENTATION OF  
GEORGIA'S MEDICAID FAMILY PLANNING WAIVER  
PROGRAM**

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To my parents, Marcia and Marty Blake

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## LIST OF ABBREVIATIONS

List of Abbreviations	
ABD	Aged, Blind, and Disabled
CMO	Care Management Organization
DCH	Department of Community Health
DPH	Department of Public Health
FP	Family planning component of P4HB <sup>®</sup>
FPL	Federal Poverty Level
GAFP	Georgia Academy of Family Physicians
GOGS	Georgia OBGYN Society
IPC	Inter-pregnancy care component of P4HB <sup>®</sup>
LBW	Low Birth Weight
P4HB <sup>®</sup>	Planning for Healthy Babies <sup>®</sup>
RM	Resource Mother
RSM	Right from the Start Medicaid program
Title X	Title X Family Planning Program
VLBW	Very Low Birth Weight

## SUMMARY

The purpose of this research was to examine the implementation of Georgia's Medicaid family planning program, known as Planning for Healthy Babies<sup>®</sup> or P4HB<sup>®</sup>. This program is the first such program to provide both family planning services and inter-pregnancy care services through a Medicaid expansion to low-income, uninsured women. An evaluative case study design was employed using mixed methods. These methods incorporated process measures to study the implementation of P4HB<sup>®</sup> and to assess whether P4HB<sup>®</sup> was implemented as planned. We incorporated theory from the policy implementation and health care access literatures to understand what served as facilitators or barriers to successful implementation. Findings suggest that despite precise goals and objectives, formal guidance about the program did not incorporate clear implementation planning. Many stakeholders, including advocates, providers, and representatives from implementing agencies felt left out of the implementation process and did not feel invested in the program. Considerable confusion existed among eligible clients and providers about the nature and scope of the P4HB<sup>®</sup> program. This lack of awareness and understanding about P4HB<sup>®</sup> likely contributed to the program's low enrollment and participation in the first year of its implementation. As many states prepare to expand their Medicaid programs under the Patient Protection and Affordable Care Act (ACA), this study provides important lessons for policy planning and implementation.



# CHAPTER 1

## INTRODUCTION

### 1.1 Overview

The purpose of this research was to study the implementation of a new health care program in Georgia aimed at providing family planning and inter-pregnancy care services to low-income, underserved women. This program, known as Planning for Healthy Babies Program<sup>®</sup> (P4HB<sup>®</sup>), is the first Medicaid Section 1115 family planning waiver program to expand health care services to low-income, uninsured prospective family planning clients and mothers of very low birth weight infants. P4HB<sup>®</sup> provides traditional family planning services, such annual exams, contraception, and STI testing and treatment, as well as inter-pregnancy care services, such as primary care and case management services.

The number of implementation studies has grown over the past decade, particularly in public health research, as policymakers take a greater interest in understanding whether health care programs “work” and if not, why not. Findings from such research often point to specific factors inherent in the implementation phase that predict the ability of a program or policy to meet its intended objectives. These factors have included program resources, goal consensus, and leadership. For P4HB<sup>®</sup>, the stated goals are to reduce unintended pregnancies and low birth weight deliveries among underserved women in Georgia. There is much to be learned about whether this program can meet its long-term aims through a close study of how well it is implemented and what factors influence the implementation process.

Due to the researcher's past experience studying Medicaid expansion programs and current work with the Georgia Department of Community Health (DCH) to assist with an outcomes evaluation of P4HB<sup>®</sup>, the researcher was compelled to examine the implementation of this unique program as an important component of its overall assessment. This waiver program began within several months of receiving quick approval from the Centers for Medicaid and Medicare Services (CMS), and thus the researcher was interested in understanding whether and how its implementation might be affected. Luckily, the researcher received interest and approval from Medicaid leadership to study this aspect of the program and encouraged to provide feedback about the study results, which she did.

An approach to the study of implementation usually differs from that of outcomes research, because its orientation is more contextual in nature, and its methodology leans toward qualitative research. Implementation research observes what is "going on" in the early part of a program and the use of process evaluation to study this phase of a program is often included. Thus, we include process evaluation measures to frame the orientation of this implementation study.

In this first chapter, we provide relevant background supporting the dissertation study as well as information related to the nature of the P4HB<sup>®</sup> program. The theoretical framework used for this study is described, as well as the research questions that guided the work.. Finally, a brief summary of the methodology is included.

## **1.2 Background**

### ***1.2.1 U.S. Medicaid and Family Planning Policy***

Long heralded as the founder of the birth control movement, Margaret Sanger is credited for winning women's reproductive freedom. Under her leadership, the birth control pill was developed and a national campaign was launched to strike down conservative state laws, known as the Comstock Laws, which outlawed contraception and abortion (McFarlane and Meier, 2001). Most importantly, perhaps, Ms. Sanger's endless struggle to achieve women's fertility control led to important federal policy decisions to expand family planning services for low-income women. One such decision came in 1972 when the federal Medicaid program required that family planning services be included as mandatory health services (CMS, 2010). All state Medicaid programs were thereafter required to provide basic family planning services and supplies to its mandatory eligible populations, which included pregnant, very low-income, blind, and disabled women. These family planning services are matched financially at 90% by the federal government and must be provided to eligible recipients free of any co-pays (KFF, 2009).

Since the 1980s, Medicaid has remained the largest source of public funding for family planning services and supplies within the United States. This program accounts for 75% of all publicly funded family planning expenditures (KFF, 2012). In 2003, 3.5 million Medicaid beneficiaries obtained a Medicaid-covered family planning service, and 30% of clients receiving services through publicly funded family planning services had their care paid for by Medicaid (Kaiser Family Foundation, 2007). By 2006, 12 percent of women of reproductive age (approximately 7.3 million women ages 15 to 44), relied

on Medicaid for their health care (Kaiser Family Foundation, 2007). Medicaid also plays a large role in maternity care for low-income women. In 2008, pregnancy related hospitalizations and neonatal stays accounted for 50% of all Medicaid hospitalizations, while maternity procedures accounted for five of the top 10 hospital procedures billed to Medicaid (KFF, 2012).

Beginning in the late 1990s, another important development occurred in federal Medicaid policy related to family planning. States began to implement Section 1115 Demonstration waiver programs to expand family planning services to populations not otherwise eligible for Medicaid. These programs, which ‘waived’ certain standards of Medicaid law, increased access to Medicaid family planning services primarily for women losing Medicaid coverage post-partum, women losing Medicaid for other reasons, and uninsured women and men with higher family incomes (Guttmacher Institute, 2011). The Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicaid, requires that Medicaid family planning waiver programs must be cost-neutral, meaning they cannot cost more to the federal government than without such a program, and they are approved initially only for five years.

To date, 31 states have received federal approval to implement Medicaid family planning expansions (Guttmacher, 2013). These states have maintained that the cost of providing family planning services to individuals under the program is far less than the cost of providing pregnancy-related services to beneficiaries who would otherwise become pregnant and eligible for Medicaid-funded prenatal, delivery, and post-partum care (Kaiser Family Foundation, 2007). Thus, states seek Section 1115 Medicaid family

planning waiver programs for their cost benefits and potential to increase access to family planning services for low-income women and men.

On October 27, 2010, Georgia's Medicaid program, administered through the Department of Community Health (DCH), received federal approval to implement a Section 1115 Medicaid Demonstration family planning waiver program. This program, known as Planning for Healthy Babies Program<sup>®</sup> (P4HB<sup>®</sup>), provides family planning services to low-income women and inter-pregnancy care (IPC) services to women who deliver a very low birth weight (VLBW) baby. P4HB<sup>®</sup> marks not only one of the most recent states to have a Medicaid family planning waiver program but also the first to use this Medicaid Demonstration authority to provide IPC services to mothers of low-birth weight infants. P4HB<sup>®</sup> began January 1, 2011 and represents one of the most unique state health care programs aimed at both increasing women's access to family planning services but also improving maternal and child health outcomes. As such, P4HB<sup>®</sup> has received a great deal of attention from policymakers, family planning advocates, and healthcare providers. Georgia's Medicaid family planning waiver program is under a national spotlight, and many hope it can be a model for expanded health care for low-income women.

### ***1.2.2 Planning for Healthy Babies Program<sup>®</sup> (P4HB<sup>®</sup>)***

The Planning for Healthy Babies<sup>®</sup> (P4HB<sup>®</sup>) extends Medicaid eligibility for family planning services to women aged 18 to 44 years who are at or below 200% of the most current federal poverty level (FPL) and provides inter-pregnancy care to women at or below 200% of poverty who have previously delivered a very low birth weight baby

(less than 1500 grams). Family planning (FP) services include medically necessary services and supplies related to birth control and pregnancy prevention. Services include contraceptive management with a variety of methods, patient education, counseling and referral as needed to other social services and health care providers. Inter-pregnancy care (IPC) services include primary care and primary care case management (including the use of a Resource Mother) from delivery of a very low birth weight infant until conception of the next infant (as long as the woman remains eligible for waiver services) with the goal of delaying conception for 18 to 23 months from conception of the very low birth weight infant. The IPC component of P4HB<sup>®</sup> is also available to women who qualify for the Low Income Medicaid (LIM) group (mothers with incomes at or below 48% FPL and who have at least one child) as well as those in the Medicaid Aged, Blind and Disabled (ABD) groups if they have a very low birth weight baby on or after January 1, 2011 (Department of Community Health, 2009).

Enrollment in P4HB<sup>®</sup> occurs through the DCH enrollment process administered by the Georgia Department of Human Services. Pregnant women enrolled in the Right from the Start (RSM) Medicaid Program have facilitated enrollment into the P4HB<sup>®</sup> program upon termination of their RSM eligibility. P4HB<sup>®</sup> program participants select a care management organization (CMO) with its affiliated provider network to provide the family planning and inter-pregnancy care services. Specifically, women enrolled in the IPC component have access to the CMO's primary care and family planning providers. Women enrolled in family planning services only have access to the family planning providers. Primary care services are provided through referrals to federally qualified

health centers, community health centers, rural health centers and public health departments (Department of Community Health, 2009).

### **1.3 Statement of the Problem and Purpose of the Study**

The Department of Community Health (DCH) estimated that 40% of eligible women in Georgia would enroll in P4HB<sup>®</sup> (110, 620) within the first year of the program (Department of Community Health, 2009). However, within the first six months, only 1,375 women enrolled in the family planning component of the program and only three enrolled in the IPC component (DCH, 2011). P4HB<sup>®</sup> enrollment during this time represented less than 2% of the state's goal.

Reports from key public health providers brought additional troublesome news during this time, which was that they were experiencing problems enrolling women in P4HB<sup>®</sup> and there was an overall lack of outreach about the program (personal communication, May 2011). Overall, signs point to serious problems with the early stages of this groundbreaking family planning program.

To combat these early signs of program failure, a study of the implementation of P4HB<sup>®</sup> is warranted. Implementation is an important stage in the policy process that allows for the realization of policy ideas into action (Lester and Goggin, 1998). Understanding the implementation of a program allows for an understanding of the program goals, whether those goals are being met, and how well a program is functioning (Werner, 2004). Assessing a program's implementation addresses the well-known "black box" of evaluation, when outcomes are examined without proper study of the program's implementation (Patton, 1987).

In the case of P4HB<sup>®</sup>, it is not clear whether the Department of Community Health has an implementation strategy and if so, how well this strategy is being carried out. More information is needed about the goals, design, and overall concept of P4HB<sup>®</sup> and what resources are available to operate this Medicaid waiver expansion program as planned. Also, little is known about what outreach and/or educational efforts are in play to inform women and providers about the program. A study is needed to investigate the implementation of P4HB<sup>®</sup>, in order to identify the barriers to the program and suggest possible solutions, so that women are appropriately served by this important Medicaid expansion program.

Thus, this study proposed and carried out an implementation study using process evaluation to study the implementation of P4HB<sup>®</sup>. Process evaluation is an essential component of intervention research as it is critical for assessing fidelity to the intervention as well as for addressing any needed programmatic or implementation improvements. Process evaluations can be used to confirm that an intervention was implemented before using resources to assess its effectiveness (Saunders, Evans, Joshi, 2005). Indeed, the traditional view of program evaluation has been on outcomes and long-term impact. However, process evaluation provides the benefit of early insight into a program's progression and information that can be used to improve the intervention. Process evaluation can also reduce the likelihood of a Type III error: the mistaken assumption that a program was implemented as planned (Steckler et al., 1992; Helitzer et al., 1999; Helitzer et al., 2000).

The overarching goal of the study was to assess whether P4HB<sup>®</sup> was implemented as planned and to identify missed opportunities and specific strategies to



enhance outreach, enrollment, and participation in the program to maximize the likelihood for programmatic success. The study examined the implementation of both the inter-pregnancy care (IPC) and family planning (FP) components of the waiver statewide. Using process evaluation, the study was conducted during the first 18-20 months of the P4HB<sup>®</sup> program. In order for P4HB<sup>®</sup> to achieve its intended outcomes (reduce very low weight births, improve access to family planning services, and reduce unintended pregnancy), it is essential to understand the process of engaging patients and providers and what actions can be reasonably connected to its success.

#### **1.4 Theoretical Framework**

The theoretical framework that guided this research incorporates elements from both policy implementation theory and the health care access literature. The theoretical framework shown below centers on the traditional “top down” approach of policy implementation as identified by Sabatier and Mazmanian (1995) to identify factors that describe how an authoritative agency and its policy planning and capabilities influence the policy implementation process. In addition, the framework draws from the Aday and Andersen model of health care access (1974) to reflect the enabling role that health services systems can play in the implementation process in terms of resources and organization (Andersen and Newnan, 2005).

Overall, the theoretical framework model examines the relationship between policy development and policy implementation in the context of health care utilization. It is based on the premise that the *mere articulation of a policy through legislation or regulation is not enough to achieve the goals of the policy. Rather, policy implementation*

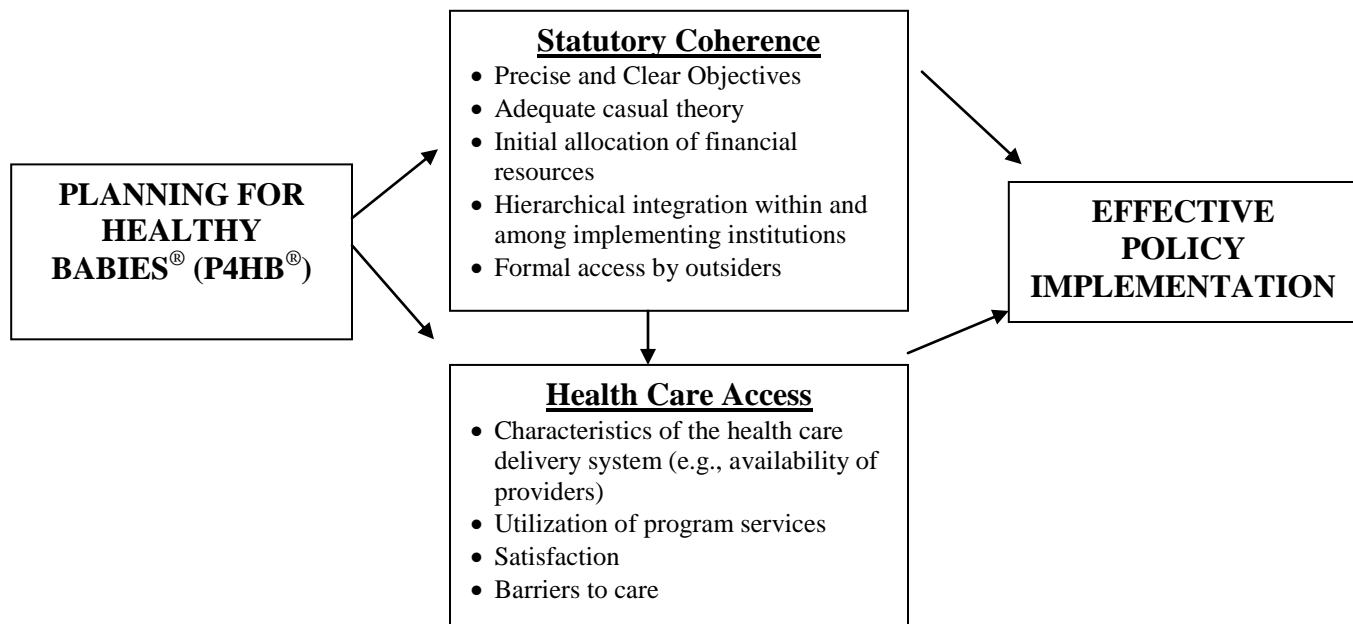
*and the factors that guide the implementation process better predict effective implementation.* In this case, we wanted to understand if P4HB<sup>®</sup> (the policy) was implemented as planned (with fidelity) and has the ability to achieve its intended outcomes (reduce unintended pregnancies, increase contraceptive use, provide inter-pregnancy care to mothers of very low birth weight babies). Two major elements were examined as they relate to the implementation of P4HB<sup>®</sup>: 1) Statutory Coherence; and 2) Health Care Access.

Statutory Coherence: This element, taken from Mazmanian and Sabatier's Policy Implementation Framework, describes the ability of policy decisions to structure implementation. By incorporating this variable in our study, we sought to understand how the legal statute (Medicaid regulation) influenced the implementation process through the provision of legal resources and through regulation of the opportunities for participation by implementing agencies (CMOs, public health/Title X agencies) as well as the participation by non-agency actors (consumers, advocates). Interviews were conducted with key stakeholders (Medicaid, public health officials, providers, CMO representatives) to examine these issues. In addition, a review of key documents (i.e., Medicaid regulation, P4HB<sup>®</sup> Concept Paper) also took place.

Health Care Access: This second element in the theoretical framework has been adapted from Aday and Andersen's Health Care Access framework (1974, 1980) to center on the *enabling factors* of the implementation of P4HB. In order to assess whether the program has the potential to be implemented with fidelity, we examined specific characteristics of health care access. First, we considered the health care delivery system in which the P4HB<sup>®</sup> program operates. Are there enough Medicaid providers to serve

potential enrollees? What role do public health/Title X clinics play in serving P4HB<sup>®</sup> clients? Where do women learn about the program and how do they enroll? For the IPC component of the program, how do Resource Mothers interact with the health care delivery system? These are questions we addressed through our informant interviews, focus groups, and provider surveys.

Utilization of program services is another component of the model that we examined. While utilization of health care often reflects outcomes, for this study, we examined the utilization of P4HB<sup>®</sup> services in the first year of the program to assess whether enrollees were able to access the intended benefits. Other enabling factors in our model include satisfaction (provider satisfaction, enrollee satisfaction), as well as barriers to care.



**Figure 1: Theoretical Framework**

## 1.5 Research Questions

### ***R1: What is the purpose of P4HB<sup>®</sup> and what are its major objectives and goals?***

In order to assess the implementation of P4HB<sup>®</sup>, we examined the program goals and objectives. In particular, we wanted to know if these goals and objectives were clearly articulated in program materials, as well as the Medicaid statute. We reviewed all formal guidance created to describe P4HB<sup>®</sup>, its purpose, and its implementation plan. Such guidance included the DCH Concept Paper, Medicaid regulation, and various P4HB<sup>®</sup> program materials. We paid particular attention to the outreach and education efforts described in these materials, as a way to understand the implementation planning process for the program. We also took note of which agency or agencies/stakeholders had responsibility of implementing P4HB<sup>®</sup>. This information was also gathered through our interviews with key informants, including Medicaid and public health officials, advocates, CMO representatives, and select providers.

### ***R2. What resources are in place and how have they been used to implement P4HB<sup>®</sup> as planned?***

This question pertains to the resource capacity and operationalization of these resources for P4HB<sup>®</sup>. Namely, we examined what type of financial, human, and material resources are available for P4HB<sup>®</sup> implementation. Such resources may be provided by the state and/or local levels and could include resources available through DCH, DPH, CMOs, providers, outreach workers, and community and advocacy organizations. We were particularly interested in understanding whether and to what extent these resources support or hinder enrollee and provider outreach and education as well as enrollment into

P4HB<sup>®</sup>. This information was gathered through our informant interviews, document review, focus groups, and provider surveys.

***R3. Is P4HB<sup>®</sup> reaching its intended target population with the appropriate services? If not, what improvements can be made?***

A major goal of this research was to document whether P4HB<sup>®</sup> is working as planned, reaching its intended audience, and capable of producing its intended outcomes.

Therefore, it was important to assess whether women are receiving services, what barriers to accessing these services might be present, and to suggest recommendations for improvement. We explored related issues of provider availability, health care utilization, and enrollee and provider satisfaction. Based on information gathered from R1 and R2, we examined how P4HB<sup>®</sup> was designed and whether the mobilization of resources for this program has been operationalized to promote effective policy implementation. This information was gathered through the informant interviews, document review, focus groups, and provider surveys.

## **1.6 Overview of Methodology and Scope of Study**

This study used mixed methods in an evaluative case study design to explore the implementation of P4HB<sup>®</sup>. Such methods included individual interviews, document reviews, focus groups (qualitative methods) and provider surveys (quantitative method). Following Creswell's philosophy, the use of both qualitative and quantitative approaches allows for a richer understanding of the research problem rather than one method alone (Creswell, 2007). Qualitative research usually involves the use of open-ended data that

reflects an individual perspective about a particular topic. Data from qualitative research often provides insight into the contextual and procedural influences of the research problem. Indeed, researchers use qualitative methods to answer the “how” and “what” of the research problem. Quantitative research involves the use of close-ended and quantifiable data that are used to reflect a group perspective. Statistical methods are often used to analyze the data for purposes of summarization of the research problem. Rather than be restricted to one type of data collection, we used both qualitative and quantitative methods to gain a broader perspective about the implementation of P4HB<sup>®</sup>. These perspectives came from providers, health care officials, health care organizations, and consumers.

Mixed methods research allows for a more comprehensive approach to the research problem than either method alone (Creswell, 2007). Our goal of using mixed methods was to be able to address each of the three research questions from the perspective of multiple actors involved in the implementation of P4HB<sup>®</sup>. As an example, in order to explore what resources have been used to implement this program, this research question is best answered through the use of multiple perspectives, including state health officials, providers, and the care management organizations. Interviews with each informant type can give the individual perspective, while the provider surveys can also inform this question from a broader view. Focus groups with current and prospective P4HB<sup>®</sup> enrollees highlight how these resources have been put into action (or not) and what effect they may have in enrollment and service utilization.

A case study design frames the overall methodology of this research since it focuses on the implementation experience of a single health care program in Georgia,

Planning for Healthy Babies Program<sup>®</sup> (P4HB<sup>®</sup>). We followed Yin's definition of case study that allows for an in-depth and systematic investigation of a particular phenomenon (Yin, 2009). In our research, that case or phenomenon is the implementation of Georgia's Medicaid family planning waiver program. Within this case, or program, the primary goal was to examine how the program was implemented and whether it had the potential to meet its long-term objectives of reducing the state's unintended pregnancy and very low birth weight rates. Across the data collected, we searched for common themes that aligned with the particular aspects of our theoretical framework, namely statutory coherence and health care access. We used select process evaluation measures borrowed from Steckler and Linnan to operationalize how each of these aspects influenced the ability of P4HB<sup>®</sup> to be implemented as planned and with fidelity. Our secondary goal was to identify what if any barriers to implementation exist and how potential solutions might be formulated. Because P4HB<sup>®</sup> is authorized only through the end of 2013, such resolution to any implementation problems is critical and must be conveyed to the policymakers in a timely manner. Therefore, a case study design using a mix of qualitative and quantitative methods was used to explore the implementation of Georgia's Planning for Healthy Babies Program<sup>®</sup> (P4HB<sup>®</sup>). A detailed description of the methodology is included in Chapter 3.

## **1.7 Summary of Chapter**

As one of the most innovative Medicaid family planning waiver programs, P4HB<sup>®</sup> has the potential to serve the most unique and expansive populations of low-income, uninsured women. P4HB<sup>®</sup> was designed to provide family planning services to

this population as well as inter-pregnancy care services to women who deliver a very low-birth weight (VLBW) baby. Therefore, it has the potential to improve women's health as well as maternal and child health outcomes. As importantly, through our study of the first year of the program, we examined the policy implementation process. Of particular interest were the factors that facilitated or impeded successful implementation. We used mixed methods to evaluate the implementation of P4HB<sup>®</sup> and incorporated theories of statutory coherence and health care access. Given the timing of other state's efforts to implement Medicaid expansion programs in 2014, we hope that our findings will serve as important lessons for these states in their implementation strategies.



## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 Overview**

This study is informed by current literature in the areas of Medicaid family planning policy and programs, program evaluation, policy implementation, and health care access research. In this review, we also introduce related topics relevant to this dissertation on process evaluation, as it is the backbone of the study's methodological design. In the first part of this chapter, we introduce literatures related to current Medicaid family planning policy and programs, program evaluation, purposes and uses of program evaluation, as well as prominent tools created for program evaluation studies. The second part of this chapter defines policy implementation and highlights literatures on implementation research. In the third part of this chapter, we introduce literature related to health care access research, including theoretical approaches that have been developed specifically for the evaluation of health policy studies.

#### **2.2 Medicaid Family Planning Waiver Programs: A Review**

To date, 31 states have obtained federal approval to extend Medicaid eligibility for family planning services to individuals who would otherwise not be eligible for Medicaid. Of these states, 26 states extend eligibility to individuals based on their family incomes (typically 185- 200% of the federally poverty level). Two states provide family planning services to women who lose Medicaid coverage for any reason. And three states extend Medicaid eligibility for family planning services to women losing Medicaid

postpartum, which occurs 60 days after the birth of a child. Fifteen states provide family planning benefits through these expansions to men and women, 22 states include individuals younger than age 19, and two states include 18 year olds but not younger individuals. Ten states have converted their waiver programs to State Plan Amendments (SPAs) which was authorized by the Patient Protection and Affordable Care Act (ACA) to make such expansions a permanent component of the states' Medicaid programs. See Table 1 from the Guttmacher Institute for more detail on the characteristics of these programs (Guttmacher Institute, 2013).

Data indicate that Medicaid family planning expansion programs have increased access to family planning services for low-income women. The number of Medicaid family planning clients served in states with expansions grew by 60% over the first half of the 2000s. This growth has occurred, because the expansions have infused much-needed new funding into states' family planning spending (Gold, Sonfield et al. 2009). And, as Medicaid spending in states with expansions has grown, other sources of family planning funding in these states did not decline, producing an overall surge in available family planning money (Gold et al, 2009).

There have been several reports of the positive effects of Medicaid family planning expansions. For women, these programs have provided increased access to services, namely contraception and counseling services. In some cases, women already seeking family planning services through a provider are able to switch to a more effective method or have assistance in using their current method more effectively (Gold et al, 2009). In Oregon, 29% of new clients received a more effective birth control method in 2010 (Oregon Health, 2010).

**Table 1: Medicaid Family Planning Eligibility Expansions**

MEDICAID FAMILY PLANNING ELIGIBILITY EXPANSIONS								
STATE	BASIS FOR ELIGIBILITY			ELIGIBLE POPULATION INCLUDES		ORGANIZED AS A:		WAIVER EXPIRATION DATE
	Based Solely on Income	Losing Coverage for Any Reason	Losing Coverage Postpartum	Men	Individuals <19	State Amendment Plan	Waiver	
Alabama	133%						X	12/31/13
Arizona			2 years		X		X	9/30/16
Arkansas	200%				X		X	12/31/13
California	200%			X	X	X		N/A
Connecticut	250%			X	X	X		N/A
Delaware		2 years			X		X	12/31/13
Florida		2 years			X		X	12/13/13
Georgia	200%		*		‡		X	12/31/13
Illinois	200%	*					X	5/31/13
Indiana	133%			X	X	X		N/A
Iowa	300%		*	X	X		X	12/31/13
Louisiana	200%						X	3/31/13
Maryland	200%		*		X		X	12/13/13
Michigan	185%						X	3/31/13
Minnesota	200%			X	X		X	12/33/13
Mississippi	185%				X		X	2/28/13
Missouri	185%						X	12/31/13
Montana	200%		*				X	12/31/13
New Mexico	185%			X	X	X		N/A
New York	200%		*	X	X		X	12/31/13
North Carolina	185%			X	X	X		N/A
Ohio	200%			X	X	X		N/A
Oklahoma	250%		*	X	X	X		N/A
Oregon	250%			X	X		X	1/31/13
Pennsylvania	185%				‡		X	3/31/13
Rhode Island			2 years		X		X	12/31/13
South Carolina	185%			X	X	X		N/A
Texas‡								
Virginia	200%		*	X	X	X		N/A
Washington	200%			X	X		X	12/31/13
Wisconsin	300%			X	X	X		N/A
Wyoming			Unlimited				X	8/31/13
<b>TOTAL</b>	<b>26</b>	<b>2</b>	<b>3</b>	<b>15</b>	<b>22</b>	<b>10</b>	<b>21</b>	

\* State also extends Medicaid eligibility for family planning services to these individuals.

‡ Includes 18 year olds but not younger individuals.

‡ Texas operates an entirely state-funded program that provides family planning services to women at least 18 years of age with incomes up to 185% of the federal poverty line.

Guttmacher Institute, *State Policies in Brief, Medicaid Family Planning Eligibility Expansions*, As of March 1, 2013.

Ms. Blake, Committee Member Dr. Kathleen Adams, and colleagues worked on a funded that examined six states' Medicaid family planning waiver programs. The project, which was funded by the Office of Population Affairs (OPA), addressed the effects of changes in the organization and delivery of family planning services through these Medicaid waiver programs on three key outcomes: 1) access to services; 2) use of contraceptive/preventive services; and 3) unintended pregnancy. Ms. Blake led a qualitative exploration of these six states' experiences with their Medicaid family planning waiver programs. In a working manuscript, she examines states' motivations for adopting the waiver programs, which centered around three major themes: 1) the desire to improve teen/MCH health outcomes; 2) the desire to increase family planning access for low-income populations; and 3) the need to save state family planning and Medicaid funds.

In a recent publication of the California Medicaid family planning waiver, Adams, Kenney, and Galactionova (2013) incorporated data from the California Women's Health Survey and the Behavioral Risk Factor Surveillance System (BRFSS) and found that the state's waiver led to an 8 percentage-point increase in the receipt of a routine checkup and a 12 percentage-point increase in discussion of birth control. The waiver appears to have led to a reduction in pregnancy rates and increased receipt of reproductive health care, particularly routine check-ups.

Other reports indicate that states have been quite successful in enrolling women and men in these programs. In 2009, California's Medicaid family planning expansion program, Family PACT, served 1.82 million women and men, which was a 12% increase from the previous 5 years of the program (Family PACT, 2010). In North Carolina, the

state Medicaid family planning expansion program served 70,321 females and 8,743 males in 2010 (North Carolina Department of Health and Human Services, 2010). A 2007 evaluation by Bronstein et al. of the first four years of Alabama's Medicaid family planning waiver program, known as Plan First, indicated a 30% increase in the overall publicly funded family planning clientele with the addition of the waiver program. For one state, South Carolina, evaluation data from 2007 indicated that despite successful enrollment growth during the waiver program, negative effects have occurred (SC Department of Health and Human Services, 2007). The evaluation findings reflect the lack of effect of the waiver on pregnancy intention and actual decline of Title X patients seen by the health department, suggesting enrollment did not match actual utilization of family planning services at these sites.

States have also realized the financial benefits to Medicaid family planning expansions. By helping low-income women who would be eligible for Medicaid-funded pregnancy-related care to avoid unintended pregnancies, states have shown that the expansion programs can generate significant cost-savings. A CMS-funded evaluation of six states programs showed that these states produced major savings, including a one-year combined savings of \$19 million for Alabama and \$30 million for Arkansas combined savings of \$19 million (Edwards et al., 2003; Gold et al., 2009).

### **2.3 Family Planning and Maternal and Child Health in Georgia: Creating the Need for P4HB**

According to a 2009 DCH Concept paper, the Planning for Healthy Babies<sup>®</sup> (P4HB<sup>®</sup>) program was borne out of the desire to decrease Georgia's low birth weight rate

(birth weight less than 2500 grams) (Department of Community Health 2009). Between 2003 and 2007, the number of low birth weight babies in Georgia climbed from 12,205 to 14,351. The number of very low birth weight babies increased from 2,387 to 2,780 (Department of Community Health 2009). In southern Georgia, several counties have low birth weight percentages of total births ranging from 14.9% to 22.5%. Racial disparities persist in Georgia's low birth weight (LBW) rates as well. African American (AA) women in Georgia have a low birth weight rate that is twice that of white women (in 2007 – AA = 14.0, White = 7.1; 2006 – AA = 14.4, White = 7.1) and a very low birth weight (birth weight less than 1500 grams) rate that is three to four times the very low birth weight (VLBW) rate of white women (Department of Community Health 2009).

The P4HB<sup>®</sup> is also designed to address Georgia's high pregnancy rate. In 2006, 122,000 Georgia residents had an unintended pregnancy, a rate of 60 per 1,000 women aged 15–44. Births resulting from these unintended pregnancies cost the state and federal governments \$696 million that year. In 2005, there were 24,990 pregnancies among Georgia teens aged 15-19, a rate of 80 pregnancies per 1,000 teen women, compared with 70 per 1,000 nationally. In 2008, 554,500 women in Georgia were in need of publicly supported contraceptive services and supplies (Guttmacher Institute, 2011).

In light of these serious problems in Georgia, the P4HB<sup>®</sup> program has the unique opportunity to improve both maternal and child health outcomes and family planning access through a Medicaid family planning expansion. In order to do so, the program must operate in a manner that is efficient and effective. The implementation phase is the most critical, and a rigorous evaluation of this phase of the expansion program is required.

## 2.4 Program Evaluation: What is It?

Program evaluation is commonly referred to as a method of analyzing a program and providing recommendations for its improvement. Michael Quinn Patton's definition is often cited. He writes, "evaluation is the systematic collection of information about the activities, characteristics, and outcomes of programs to make judgments about the program, improve program effectiveness, and/or inform decisions about future programming" (Patton, 2008). Inherent in the concept of program evaluation is the use of research or evidence to gain insight about a program's operations. Moreover, a common goal is to find out what is working about a program and what needs to be done to improve it.

Once thought of as a research methodology, program evaluation is its own field of intellectual inquiry and professional practice. There are many organizations dedicated to program evaluation, including the American Evaluation Association, whose mission is "devoted to the application and exploration of program evaluation, personnel evaluation, technology, and many other forms of evaluation (American Evaluation Association, 2011)." AEA's *Guiding Principles for Evaluators* has been used by evaluators for almost 20 years to plan, design, and conduct evaluations. Other evaluation organizations include the African Evaluation Association (AFEA), Canadian Evaluation Society, and the European Evaluation Society. Within each organization are local chapters and interest groups dedicated to specific fields of evaluation.

Program evaluation is referenced various ways. Common terms include "evaluation," "evaluation research," "implementation research," "effectiveness research," "intervention research," and "participatory evaluation." Rossi et al (2004) refer to

program evaluation and evaluation research interchangeably as “the systematic application of social research procedures for assessing the conceptualization, design, implementation, and utility of social intervention programs.” Werner’s defines implementation research as a “general term for research that focuses on the question “What is happening?” in the design, implementation, administration, operation, services, and outcomes of social programs.” (Werner, 2004). Carol Weiss, perhaps most well known for her discussion of the meaning and use of research, describes evaluation research as that which describes “what works” about a program or policy (Weiss, 1980). Whatever term used, these forms of program evaluation purport to better understand the “how” and “why” of a program or policy, not just the end results. Conventional approaches to evaluation have focused on program outcomes, but as reviewed below, other modalities of program evaluation, namely process evaluation, are aimed at the mediating processes between a program’s conceptualization, implementation, and outcomes.

## **2.5 Uses of Program Evaluation**

Program evaluation can serve both formative and summative uses. Formative evaluation is exploratory in nature and its focus is program improvement (Rossi et al., 2004). Formative evaluation data are often used to learn more about how to improve the appropriateness and quality of a program (Helitzer et al., 1999). Many process evaluations are used for formative purposes, so that the inter-workings of a program or intervention are understood, and opportunities are presented to improve the program so that intended outcomes are reached.



Summative evaluations are used to make judgments about the overall effectiveness of a program (Rossi et al., 2004; Patton, 2008). Historically, most program evaluations have been summative in nature, because they were often requested by funders who wanted to know if the program achieved its intended outcomes. Summative evaluation data are collected to support a judgment about the program's worth so that a decision might be made about the merit of continuing the program (Patton, 2008).

Program evaluations can and often do incorporate both formative and summative components. How they are used often depends on the availability of resources (staff, time) and intended use. In fact, evaluators discuss in great detail about the use of their research. Use is not only fundamental to a theoretical understanding of evaluation (Shadish et al. 1991), it is core to the standards that guide evaluation practice. Defining "use" and measuring what counts as "use" are key concerns to many scholars and likewise, the central theme of many studies of knowledge utilization theory (Weiss, 1979; Weiss, 1980; Shadish et al., 1991; Machlup, 1993; Porter and Hicks, 1995). According to Patton, "use concerns how real people in the real world apply evaluation findings and experience the evaluation process. Therefore, the purpose in utilization-focused evaluation is on intended use by intended users" (pg. 1) (Patton 2002).

## **2.6 Process Evaluation: Definition and Utilization**

Process evaluation is a specific type of evaluation aimed at monitoring and documenting a program or policy's implementation. "Process evaluations search for explanations of the successes, failures, and changes in a program" (Patton, 2008). While traditional focus has been placed on outcomes evaluation, specifically to determine

*whether* a program or intervention was successful, process evaluation helps to examine *why* that program was or was not successful (Bartholomew et al., 2001; Steckler and Linnan, 2002; Saunders et al., 2005). In fact, one of the advantages of a process evaluation is that it can serve as a bridge between specific program elements and program outcomes. A process evaluation can highlight which component or components of the program contributed to the success (or failure) of a program. Steckler and Linnan (2002) further explain that process evaluation efforts help us understand the relationships between parts of the intervention or program. “Process evaluation can help disentangle the effects of each method singly, and it can clarify the possible interactions that can occur to produce a synergistic effect” (pg. 1).

A process evaluation may also be used to assess a program’s implementation before resources are used to assess its effectiveness (Scheirer et al., 1995; Saunders et al., 2005). Outcomes evaluations are usually time and resource intensive, taking many years to design, collect the data, and assess the program’s effects. A process evaluation can provide rather quick, useful feedback during the early stages of a program so that information about it can be disseminated and used for an effective program (Patton, 2008). The CDC stresses the importance of process evaluation in helping a program achieve accountability. To funders, regulators, or other stakeholders, process evaluation provides accountability in two ways: 1) delivering the data necessary to justify expenditures of time and money (e.g. demonstrating the number of materials produced, the number of people reached through the program, etc.); and 2) documenting compliance with externally imposed standards or criteria by program funders for continued funding of the program (Centers for Disease Control and Prevention, 2008).

Another key component to process evaluations is fidelity. In evaluation overall, we are concerned with whether the intervention or program was implemented as planned. Was there fidelity to the program? “To evaluate fidelity is to assess adherence to the core blueprint specifications of how a model program is supposed to be implemented” (pg. 217, Patton, 2008). Process evaluations allow one to look into the commonly referenced “black box” of a program to assess its fidelity (Hulscheret al., 2003; Patton, 2008; Hasson, 2010).

Several evaluations frameworks have been proposed to assess program fidelity. Carroll and colleagues (2007) developed a conceptual framework for implementation fidelity which includes content, frequency, duration, and coverage of dose as measures of implementation fidelity (Carroll et al., 2007). These components of fidelity act as the “adherence” mechanism in evaluation that links the intervention to its outcome measurement. Pettigrew (1990) developed a model that emphasized context together with content and process as the main determinants of change (Pettigrew, 1990; Hasson, 2010). Steckler and Linnan, whose model of process evaluation is adapted for this research, list fidelity as one eight key process evaluation components (Steckler and Linnan, 2002). And Baranowski and Stables (2000) describe fidelity as a qualitative aspect of implementation. Without fidelity as a composite measure of implementation, one cannot evaluate the extent to which the program was implemented as designed.

## **2.7 Policy implementation**

### ***2.7.1 Defining policy implementation***

Beginning in the mid-1950s, prominent political scientist Harold Lasswell suggested that policy implementation was an essential stage of the policy process.

Implementation was envisioned sequentially as the part of the policy cycle that follows once a policy or program has been envisioned or formulated (De Leon, 1999). It precedes policy impact and evaluation. While policy implementation has been discussed in various fields, such as education, law, and system dynamics, it remains a major topic of discussion among political scientists. Likewise, they have offered various competing definitions of policy implementation.

According to Pressman and Wildavsky (1973), implementation is “a process of interaction between the setting of goals and actions geared to achieving them.” Others have viewed implementation similarly, as “the path between preferred solution and actual performance of the government,” (Allison, 1972, page 268), the stage at which the course of action is put into practice, (Kolbe and Iverson, 1981), and the translation of policies from administrative guidelines to practice (Rein and Rabinovitz, 1977). Yet, some theorists have provided more in-depth analysis of the purpose and role of policy implementation. Carol Weiss suggested that the first kind of intervening variable “between program inputs and outputs has to do with implementation of the program, on how the program operates” (Weiss, 1972, p. 48). Baum (1981) suggests:

*implementation is best defined as the relevant actions and inactions of public officials who are responsible for helping to achieve objectives contained in previously enacted policies, excludes extra governmental activities that help to determine a policy's ultimate impact...treat implementation behavior as one determinant of policy impact, not as synonymous with the process by which impact is determined (Ottoson, 1984).*

Erwin Hargrove is often cited for his take on the importance of policy implementation as “the missing link” in the study of public policy (1975). He described implementation as having two main requirements: 1) that the actions by law are carried

out; and 2) these actions encompass both formal compliance with the law and organizational routines consistent with compliance (1982). The difficulty, however, as suggested by deLeon and deLeon (2002), is that policy makers often battle to determine a correct reading of the original mandate and subsequently to execute the mandate accurately. Robichau and Lynn (2009) suggest policy implementation remains a missing link in the study of government performance and is in need of better theoretical underpinnings.

### ***2.7.2 The Evolution of Implementation Research***

While academics have pondered the purpose and role of implementation in the policy process for several decades, actual studies of policy implementation have evolved slowly over time. Implementation research developed as investigators tried to better understand the apparent failures of many social and public sector programs during the 1960s and 1970s. Often such studies were prompted when traditional outcome evaluations could not explain “why” or “how” programs failed. Indeed most prior public policy evaluation work focused on the outcomes or results of programs and not on the execution or compliance with the policy’s intent or statutory ruling (Shell, 1986).

Paudel (2009) has described three generations of implementation research. The first generation ranged from the early 1970s to the 1980s and was characterized mainly by case studies that focused on how a single authoritative decision was carried out. Two studies, Murphy (1971) and McLaughlin (1976) examined the implementation of the Elementary and Secondary Education Act (ESEA) of 1965 and found issues mainly with statutory compliance (Shell, 1986). Another study during this time, led by Pressman and

Wildavsky (1973), examined the implementation of an economic development agency policy in California. This well-known study focused on interagency collaboration as well as the importance of resource allocation in the implementation process.

The second-generation implementation studies occurred in the 1980s and 1990s and analyzed the relationships between policy and practice (Paudel, 2009). With a more empirically-oriented approach, these studies contributed greatly to the development of implementation theory. As described in more detail below, studies either advocated for a top-down approach, whereby policies are set at the bureaucratic level and controlled to ensure fidelity and compliance (DeGroff and Cargo, 2009; Mazmanian and Sabatier, 1989) or a bottoms-up approach that suggests street-level implementers who engage in policy subsystems are central to successful implementation (Howlet and Ramesh, 2003).

The third generation of implementation studies, from the 1990s forward, seems to take a hybrid view of the first two generations. According to Paudel (2009), this new generation of implementation research incorporates macro and micro level analyses of government structure and aims to provide insight into the explanatory variables and causal patterns of implementation performance. This final generation of research is also designed to incorporate theory better, by testing explicit theoretical models and incorporating both qualitative and quantitative data, an approach that had not been acceptable in previous generations of implementation (Googin et al., 1990).

### ***2.7.3 Implementation Theory***

While suggesting that policy implementation has “swung in and out of fashion during the past quarter century,” University of Georgia Professor Laurence O’Toole

concedes that efforts to synthesize theory in implementation research continue to plague studies of policy implementation (2000, p.263). Furthermore, theoretical disputes exist between advocates of the top-down and bottom-up approaches to policy implementation. As mentioned previously in this chapter, the top-down approach to implementation theory is based on the concept of an ideal bureaucracy where effective implementation occurs through government control and management.

The top-down perspective of policy implementation begins with policy formation that includes agenda setting and the establishment of policy priorities. Once this occurs, goals must be operationalized into programs, regulations, or other “concrete entities” which might include legal tools such as statutes (Rist and Joyce, 1995; Mazmanian and Sabatier, 1989). The top-down approach is situated in institutional theory, whereby policy formation and development depend on institutional action and rational choice (O’Toole, 2000; Parsons, 1995). Policy implementation, thus, occurs through a structured system of government control and compliance, that may or may not include different stages of inter-agency collaboration (Duffy, Binder, Skrentny, 2012). Overall, top-down policy implementation occurs through a linear process that begins at the agency level and includes hierarchical integration with and among the implementing institutions (Meier and McFarlane, 1996). Critics of this perspective feel that it does not take into account the policy history on similar issues, that it describes implementation strictly as an administrative process and fails to incorporate local players who likely have more of an invested interest and role in the policy’s implementation (Schofield, 2001).

Bottom-up theorists view policy implementation as either starting from the local level or at least including players outside the main bureaucracy. Sabatier (1986) argued

that the bottom-up approach is more powerful because it requires bureaucrats to concede to the demands of citizens and consumers. Indeed, local players who are responsible for the actual implementation or workings of the policy or program hold the key role in a bottom-up perspective. Such a decentralized process of policy implementation assumes that the formulation and implementation occur in an integrated, non-linear fashion (Matland, 1995; Schofield, 2001). Other perspectives on this theoretical approach to policy implementation indicate that policy formation and implementation begins with the local players where target groups and service deliverers exist. However, critics of this approach do not support the emphasis that is placed on the autonomy of the local implementers who must in some way adhere to the bureaucracy and government players who exploit a more macro implementation process (Schofield, 2001).

#### **2.7.4 *Implementation Frameworks***

Several theoretical frameworks have been developed over the past two decades, many of these situated in organizational theory and learning. The more well-known frameworks or models include:

1) *Matland's model of policy implementation*. This model creates a typology of implementation approaches based on a policy's level of ambiguity and conflict level (Matland, 1995);

2) *Goggin et al's Communication Model of Intergovernmental Policy Implementation*. This model incorporates both top-down and bottom-up approaches and reflects a dynamic process of intergovernmental communication (between federal and state governments in particular) that takes place in a



complex environment of continual feedback that is also influenced by certain inducements and constraints (Googin et al, 1990); and

3) *Mazmanian and Sabatier's Conceptual Framework of Implementation*. This framework reflects a dynamic process of a top-down approach where statutory and non-statutory variables affect policy implementation (1989). More information about this model is provided below under the discussion of statutory coherence which was incorporated into this study's conceptual framework.

Recent attempts have been made to build theory into the policy implementation process. In 2007, the National Center for Mental health Promotion and Youth Violence Prevention (National Center) produced a synthesis of implementation research that led to the creation of a conceptual framework for policy implementation. This framework lists five essential components of policy implementation:

- 1) a *Source*; an organization or individual who has created and evaluated the program to be implemented;
- 2) a *Destination*; includes the practitioners or organization that will adopt and house the program;
- 3) a *Communication Link*; individuals or a group (purveyors) who will conduct the implementation;
- 4) a *Feedback mechanism*, which provides 'a regular flow of reliable information through partnership meetings, evaluation, and other means of communication; and
- 5) a *Sphere of Influence*; or "the social, economic, political, historical and psychosocial factors that impinge directly on people, organizations, or systems" (p 3, National Center, 2007).

This National Center framework appears to skip any reference to policy formation and adoption and emphasizes more of the implementation and post-implementation

variables inherent in effective policy implementation. Therefore, it might be construed as an incomplete or less instructive model of policy implementation.

The United States Agency for International Development (USAID) created a tool in 2010 for understanding policy implementation. This tool reflects seven key “dimensions” or variables that influence the policy implementation process. These include policy, context, leadership, stakeholders, resources, operations, and feedback. The starting point for this model is *policy* and includes the policy’s content and formulation process.

*Policy content should clearly frame the underlying problem area, the policy goals and objectives, and the population to be benefitted, along with the broad actions and strategies to address the problem..the formulation process also matters. A policy designed without meaning stakeholder engagement may be more difficult to implement because it does not consider the needs or engender buy-in and ownership from those who will implement or benefit from the policy.*

The tool also includes *context* (social, political, and economic context) that influence what policies are developed and how they are put into practice. *Leadership*, including high-level actors and influential leaders, can play a role in communicating the policy’s goals, rationale, and champion the policy to ensure implementation. *Stakeholder involvement* is also a part of this model because these are the groups or individuals responsible for implementation. *Resources* should be sufficient and planned according to the objectives and needs of the policy being implemented. *Operational systems* should be in place to facilitate coordination and mobilization of resources. Finally, the National Center’s policy implementation tool states that *feedback* on the progress as well as results of the policy will help policymakers and implementers “better able to assess interim achievements, make necessary course corrections and see themselves as part of a larger effort.” (p. 9, National Center, 2010). This tool reflects a dynamic mapping of the policy

implementation process that is geared toward a more practical application of evaluating the success of a policy's implementation.

#### ***2.7.5. Factors affecting implementation processes***

Our review of the theoretical foundation of policy implementation reveals a field of study that is still evolving but one that acknowledges the requirement of different actors who work in a complex and often political environment. Whether policy implementation occurs through a structured or non-structured fashion, certain factors have influenced the policy implementation process. For purposes of this examination, we highlight three of these major factors: statutory coherence, tractability, and context.

*Statutory coherence* reflects the belief that a coherent legislative or legal statute improves the odds of successful implementation and therefore, desired outcomes. Conversely, goal ambiguity or the lack of clearly stated goals can derail the policy implementation process. Mazmanian and Sabatier (1989) expressed this idea through a model of statutory and non-statutory variables that, when working together, produce effective implementation. Statutory variables include; 1) precise and clearly ranked objectives; 2) the incorporation of adequate causal theory; 3) the provision of adequate funds for the implementing organizations; 4) hieratical integration within and among implementing organizations; 5) the presence of favorable decision rules for the implementing organization; 6) the commitment of the implementing agencies and officials; and 7) opportunities for formal participation by support of statutory objectives. Non-statutory variables affecting implementing include 1) socioeconomic conditions and technology; 2) public support; 3) attitudes and resources of constituency groups; 4)

legislative support and 5) support from implementing agency officials (McFarlane and Meier, 2001).

Several studies have attempted to test the statutory coherence hypothesis. Rosenbaum (1981) addressed environmental state laws and found strong variation in the statutes and implementation outcomes. Browning et al (1981) examined city government responsiveness toward minority populations and found that “grants characterized by strong statutes directed toward benefiting minorities resulted in more effective implementation” ( p 398). Bullock (1981) addressed statutory governance within the context of four different public education programs and found that several main related variables were essential to successful policy implementation: 1) clear policy objectives; 2) agency support; 3) favorable decision rules; and 4) committed agency officials.

Most notable among the studies that have tested statutory coherence is that conducted by Meier and McFarlane in 1996 of federal family planning programs. In this study, the authors examined the statutory coherence of the four family planning statutes and their effects on policy outputs or outcomes (Meier and McFarlane, 1996). The four statutes that they tested included Title V of the Social Security Act; Title X of the Public Health Service Act, and Titles XIX and XX of the Social Security Act. Each of these programs focuses on low-income, underserved populations. The authors compared each program’s statute with specific characteristics of statutory coherence, including clear policy objectives, adequate casual theory, adequate funding, hieratical integration within and among implementing organizations, favorable decision rules; recruitment of implementing officials, and formal access by outsiders. The authors found that only Title X, which is the national family planning program established in 1970 and the only

remaining federally-funded specific family planning program, achieved statutory coherence. The results provided strong evidence in support of designing policies with coherent statutes.

For this research, we included select factors of statutory coherence in our conceptual framework. To first understand whether P4HB<sup>®</sup> had *precise and clear objectives*, we examined many program materials to learn how the program was conceptualized and designed. We also interviewed key informants at the state and local level and certain advocates who were part of the P4HB<sup>®</sup> planning process. We used these same methods to explore whether P4HB<sup>®</sup> incorporated adequate causal theory. In particular, we reviewed program and policy guidelines to explore whether there was any evidence that the principal *causal linkages* between government agencies and the attainment of program objectives were well understood particularly among the implementing agencies. We also tried to observe whether the implementing agencies were empowered enough and had enough resources to actually obtain the program's goals and objectives. Therefore, we also explored the allocation of financial resources to implement P4HB<sup>®</sup> and to sustain it for the first year (study period) of the program. *Hierarchical integration* was incorporated into our conceptual framework by exploring the relationships of different levels of Medicaid and public health, to assess whether there were coordinated efforts to implement P4HB<sup>®</sup>. Particular attention was paid to the responsibilities that these different levels of government played in providing outreach and education and conducting enrollment into the program. Finally, *formal access* by outsiders was examined by observing whether and how prospective and current enrollees and providers gained access to the P4HB<sup>®</sup> program. Also we observed whether these

outsiders and others, such as advocates or non-participating providers or agencies, had any oversight or involved in P4HB<sup>®</sup>. Were these individuals allowed to collaborate and provide feedback to DCH about the program and if so, did this access affect the implementation process? We conducted informant interviews and focus groups to measure this variable of statutory coherence.

*Tractability* includes a specific set of variables that shapes the understanding of the policy problem and the population that is intended to benefit from the policy or program. It has been included in studies of statutory coherence and also examined independently as predictors of successful implementation.

According to Mazmanian and Sabatier (1989), tractability includes four main variables: 1) technical difficulties, which may include the availability of specific technologies or resources necessary for carrying out the policy or program; 2) diversity of target group behavior, which states that the more diverse the behavior being regulated or the service being provided, the more difficult it becomes to frame clear regulations and the greater discretion which must be given to field-level implementers; 3) target group as a percentage of the population, which means the smaller and more definable the target group whose behavior needs to be changed, the more likely the mobilization of political support in favor of the program and more probably the achievement of statutory objectives; and 4) extent of behavioral change required, meaning the amount of behavioral modification required to achieve statutory objectives is a function of the number of people in the target groups and amount of change required of them.

Tractability of the problem refers to the “solvability of the problem being addressed.” (Dibble, 2002, pg. 25). It is most often evaluated by assessing how much

change will occur by the target population, how different this behavior must be to achieve overall change, how many people must change this behavior in order for the policy to be effective, and the extent of the change required. Dibble (2002) found tractability to be a difficult variable to measure in his study of the Maritime Security Act of 1996. The law required international maritime agreements and practices could not place United States maritime industries at an “unfair competitive disadvantage in world markets.” It was impossible to measure such a goal without clear metrics or guidance or understanding of the nature of this problem. As the author purports, “overly broad goals can hinder the ability of measuring and monitoring progress toward their attainment” (Dibble, 2002, pg. 25; Sabatier and Mazmanian, 1995).

Hoppe and colleagues (1987) support the notion that designating the nature of the problem is the heart of good implementation research. “Implementation theory’s greatest possible contribution to design methodology is its early-warning capacity against efforts to solve the wrong problem” (pg. 581). They propose a method of feasibility testing in which an integral part of the design process is to define the problem, “decompose’ it so that it is clearly understood in the policy model and its objectives, and then demonstrate its tractability by “investing or listing alternative problem solving options” (pg. 587). Indeed, they assert that describing the nature of the problem and the explicit population of interest should be at the heart of any design of policy implementation.

*Context* is also an important factor in policy implementation. Context includes any number of political, social, economic, as well as organizational factors that shape the implementation of a policy or program. Mazmanian and Sabatier include these factors as examples of “non-statutory variables” affecting implementation (1989). They assert that

the socioeconomic conditions and settings in which the policy is to be implemented can affect implementation. Organizational readiness, infrastructure, and technology are also important. Contextual factors can include social support, social networks, norms, and culture as influences on policy implementation. According to Rabin et al. (2008), these contextual factors help clarify the delivery context in which the policy or program will be implemented.

DeGroff and Cargo (2009) assert that sociopolitical context affects contemporary implementation processes. “Implementers’ decisions about whose needs will be served, how they will be served, and which outcomes will be valued are determined in part by social and political factors” (pg. 52). They also describe the effect of context on networked governance when a larger number of third-party actors become involved in the implementation process. Each actor expresses his or her own values, interests, and goals and thus tries to influence decisions made about implementation, such as allocation of resources. The USAID (2010) also expresses support for understanding contextual influences on policy implementation. “The social, political, and economic contexts influence what policies are developed and whether and how those policies are put into practice. Contextual and environmental factors can provide both opportunities and constraints for effective policy implementation” (pg. 14, USAID, 2010). These factors exist at multiple levels and can change over time.

Finally, a number of health care studies have investigated the role of context in policy implementation, Dariotis and colleagues (2008) examined factors related to program adherence of school-based health programs. They describe specific characteristics that may affect the quality of program implementation and specifically



program adherence, or the ability of the program to be carried out as planned. This concept is also known as program fidelity. They assert that the school (principal, teachers, nurses) and community (community members, parents) context are essential factors in program implementation because each has direct or indirect influence on the program's design and dissemination. In a Canadian study of postpartum hospital care, researchers found that organizational and professional context predicted the successful implementation of the program. Patients' level of education and awareness about the policy/program also played a role (Watt, Sword, Krueger, 2005). Isset et al. (2007) found that political and economic factors shaped the implementation of several states' mental health care program. In a study of national health insurance, the environmental context, which includes political power and resources, was shown to be greatly influential on the policy implementation. (Agyepong and Adjel, 2008).

## **2.8 Access to Care**

There is a vast literature dedicated to the study of health care access, particularly in the United States, which, unlike most other westernized countries, does not have a national health care service. Studies of access to care tend to address specific issues related to health care organization, financing, effectiveness, workforce, and delivery of health care. Also, these investigations usually attempt to understand the ability of specific populations to gain access to health care through the supply and availability of health care services. The high cost of health insurance and delivery costs associated with health care has been shown to cause major financial barriers. Organizational barriers to

health care also exist due mostly to a nationally fragmented delivery system and great variation among the network of public and private health care providers. As a result, access to health care is a growing and significant problem in the United States, particularly for the poor and uninsured (Blake, Thorpe, and Howell, 2003).

Several models have been developed to explore the factors that affect health care utilization. Most notable among these theoretical endeavors has been the Health Belief Model and the Access to Care framework. We describe each model below.

Health Behavior Theories: There are basically three types of health behavior theories. These are *individual*, *interpersonal*, and *community-level* theories. *Individual* health behavior theory explains the behavior of individuals. It is considered the most basic type of study of health behavior because it comprises the foundation of group and community-level health behavior. In addition to exploring behavior, individual level theories focus on intrapersonal factors, such as knowledge, attitude, beliefs and motivation. *Interpersonal* health behavior theory assumes individual exist within and are influenced by a social environment. It seeks to understand the individual within this larger context. And finally *community-level* health behavior theory studies how communities and populations as a whole influence individuals' health behaviors. These types of theories most often consider the organizational and process-oriented influences on population-specific health behavior (NCI, 2005; Rosenstock, 1990).

Health Belief Model: The Health Belief Model was developed initially by Hochbaum and his colleagues in the U.S. Public Health Service in the 1950s as a way to explain why people did not participate in disease prevention and detection programs (Rosenstock, 1990). Although the model's primary purpose was to explain preventive

health behavior, such as annual checkups and tuberculosis screening, it was also created to predict compliance with public healthcare recommendations (Gipsh, Sullivan, and O'Dietz, 2004).

According to Rosenstock (1990), the first component of the Health Belief Model (HBM) includes one's subjective perception of risk of contracting a health condition. This first component is best identified as *perceived susceptibility*. "In the case of medically established illness, the dimension has been reformulated to include acceptance of the diagnosis, personal estimates of re-susceptibility, and susceptibility to illness in general" (Rosenstock, 1990, pg. 43).

The second HBM component reflects one's perception of the seriousness of the disease. This is known as *perceived severity* (Rosenstock, 1990). In this scenario, people may act in a certain way (or not act) based on their feelings regarding the seriousness of contracting an illness or leaving it untreated. The next component includes one's *perceived benefits* of taking health action. Rosenstock clarified that neither personal susceptibility to a condition nor perceived severity completely explains or predicts a person's likelihood of taking action about his/her health condition or illness. A health action would likely occur if that person believed that the action was both feasible and efficacious (Rosenstock, 1990). In a study of rural Appalachian women, one third of sampled women did not perceive benefits in doing breast self-examinations (Sortet and Banks, 1997). Although the study focused on a different racial group, many of these women face similar access barriers as African American women (lack of transportation, screening providers, etc.) and hold strong cultural values and beliefs about their health care, as do African American women.

A final major element of HBM is *perceived barriers*. Rosenstock describes “the potential negative aspects of a particular health action, or perceived barriers, many act as impediments to undertaking the recommended behavior.” In an article by Champion and Scott (1997), their research on the breast cancer screening behaviors of African American women used HBM scales to identify that these women abstain from such screening service due to certain perceived barriers. These barriers include distrust of health care providers, dissatisfaction with health care providers, and the lack of understanding about screening services, specifically mammography.

The Access to Health Care Framework, known originally as the Behavioral Model for Health Services Utilization (BMHSU), is a less popular, though more descriptive framework than the Health Belief Model. It was developed by Lu Ann Aday and Ronald Andersen in the late 1960s to explain health care utilization by exploring potential access barriers to care. The model was updated and revised in the 1990s. This framework uses three variables to conceptualize and measure the health care access concept: These variables include: *predisposing, enabling, and need* variables (Champion and Menon, 1997; Aday and Andersen, 1974).

*Predisposing variables* include attitudes, knowledge, and demographic/experiential variables (Andersen et al, 1988; Champion and Menon, 1997). These variables examine an individual’s inclination for utilizing health care services. An individual is more or less likely to use health services based on demographics, position within the social structure, and beliefs of health services benefits (Rebhan 2008).

*Enabling variables*, also important predictors of health care utilization, include health insurance, source of healthcare, and health care costs (Andersen et al, 1988;

Champion and Menon, 1997). This variable was incorporated into the study's conceptual framework because it acknowledges that resources (financial, human, material) and organization factors play an important role in access to care.

*Need variables* are also part of the access to care model. This third category includes the perception of need for health services, whether the perception is individual, social, or clinical (Wolinsky, 1988). All three variables are examined and thought to occur in a linear fashion to affect the utilization of health care services. The model was later updated to include factors related to consumer satisfaction and the type of health care service available (hospital, dental, pharmacy, etc.).

The Aday-Andersen Access to Health Care Framework has been incorporated into an extensive body of recent health policy research. Studies have used this model to examine health care utilization by conducting population-based research to determine whether and to what extent patients have unmet medical needs, delays in accessing medical care, whether they have a usual source of care, and the frequency of their medical care visits (Bindman et al, 1995; Stevens, Seid, Halfon, 2006; Litaker, Koroukian, Love, 2006; Bisgaier and Rhodes, 2011; Carillo, 2011). These studies' findings have demonstrated a strong relationship between the model's characteristics or variables and access to and use of health care (Hall, 2008).

In addition, many studies that use the Access to Health Care Framework focus on health insurance, most finding that the lack of insurance and any financial resources to pay for health care plays a major deterrent to receive of health care (Ross, Bradley, Busch, 2006; DeVoe et al, 2003; IOM, 2001). Being uninsured is associated with delayed access to care and a lack of a regular source of care (Schoen and DesRosches, 2000).

Conversely, having health care coverage is linked to increased medical care utilization (Andersen et al, 1983; Eisert and Gabow, 2002; Kempe et al, 2005). Additionally, recent studies have shown that racial and ethnic disparities in health care access and utilization are affected by health insurance (IOM, 2002; Hargraves, Hadley, 2003; Kirby, Taliaferro, Zuvekas, 2006; Richardson and Norris, 2010).

For purposes of this study, to examine the implementation of Planning for Healthy Babies<sup>®</sup> (P4HB<sup>®</sup>), we were interested in understanding what role the enabling variables played in this health care program. These variables include characteristics of the health care system, utilization of program services, satisfaction, and barriers to care. Our goal was to include variables in our model that reflected characteristics of the health care system and provider network, as well as the potential of P4HB<sup>®</sup> enrollees to utilize covered services. We also examined patient and provider satisfaction. Our primary goal was to include such variables in our consideration of how they might affect the implementation of the P4HB<sup>®</sup> program. For instance, are there enough Medicaid providers to serve the eligible population? How/do public health providers/Title X clinics factor into the provider network? How do IPC-eligible women learn about the program and which providers facilitate their enrollment? Are P4HB<sup>®</sup> enrollees utilizing covered services; if not, why not? What are the barriers to utilization? How providers and patients participating in P4HB<sup>®</sup> satisfied with the program; if not, what can be done to improve the program. Again, these health care access variables were incorporated into the conceptual framework for this study.

## **2.9 Summary of Chapter**

This chapter summarized the literatures related to the proposed study, including those related to Medicaid family planning waiver programs, program evaluation, process evaluation, policy implementation, and access to care. These literatures all provide contributions to the framing of the current dissertation work. Findings from evaluations of current Medicaid family planning waiver programs shed light on the facilitators and barriers to enrollment and outreach, as well as the financial impact these programs have had on states' Medicaid budgets. Program evaluation's main purpose is to analyze a program and its effects. For our study, a program evaluation approach was employed, using process evaluation measures to gain insight into the operation and interworkings of P4HB<sup>®</sup>. Program evaluation's goal is to find out what is working (or not) and to provide recommendations for improvement. Policy implementation provides valuable context for the study and is the core focus of the study. Our conceptual framework uses several elements of statutory coherence to study the goals and objectives of P4HB<sup>®</sup>, how the program was conceptualized, and whether and to what extent implementing agencies understood their role and responsibilities inherent in this Medicaid expansion program. Finally, access to health care is a major focus of many current health care and health policy studies. We incorporated specific systems-based elements of the Aday and Andersen Access to Health Care Framework test whether such enabling variables provide any influence on the ability of P4HB<sup>®</sup> to be implemented effectively.

In the following chapter, we describe the methodology used for this research. More detail is provided about the approach we took to evaluate P4HB<sup>®</sup>, the logic model that was followed to measure the implementation of the program, and the process

evaluation measures that guided this research. We also describe the recruitment of participants, data collection methods, and analysis.



## CHAPTER 3

### METHODOLOGY

#### 3.1 Overview

When selecting the research methods for a study, it is imperative that these methods reflect the nature and purpose of the study. Such methods must also take into account available resources and the expertise of the researcher (Rossi and Lipsey, 2004; Patton, 2002). In evaluation research, social research methodologies are most often used to assess and even improve the ways policies and programs are designed, developed, and implemented. Both qualitative and quantitative methods can be used to monitor these programs, and more frequently, the mix of these methods are being used to investigate health services research (Rossi and Lipsey, 2004).

The field of mixed methods research has grown substantially over the past decade. Federal funding for mixed methods research has increased from such agencies as the National Institutes of Health (NIH), as well as private foundations. Multiple studies have been published using mixed methods, and even a peer-reviewed journal has been established called the *Journal of Mixed Methods Research*, aimed at “empirical, methodological, and theoretical articles about mixed methods research across the social, behavioral, health, and human sciences” (JMMR, 2012). In 2011, NIH commissioned a report on the best practices for mixed methods research in the health services field (Creswell et al, 2011). Mixed methods research was identified as having one or more of the following characteristics: 1) focuses on research questions that call for real-life contextual understandings, multi-level perspectives, and cultural influences; 2) employs rigorous quantitative research assessing magnitude and frequency of constructs and

rigorous qualitative research exploring the meaning and understanding of constructs; 3) utilizes multiple methods (e.g., intervention trials and in-depth interviews); 4) intentionally integrates or combines these methods to draw on the strengths of each; and 5) frames the investigation within philosophical and theoretical positions.

The dissertation work described here employed a mix of both qualitative and quantitative methods in a case study design. This approach was selected to capture the implementation experience of Georgia's Planning for Healthy Babies Program<sup>®</sup> (P4HB<sup>®</sup>) from multiple perspectives. Qualitative methods were selected to explore the "how" and "why" of the implementation experiences, most directly from interviews with stakeholders and other key informants. A document review was conducted using implementation materials, such as education and marketing materials as well as Medicaid quarterly reports in order to further inform the contextual experiences of the program's implementation. Quantitative methods were selected to provide a broader sample and perspective of the implementation experience from health care providers in Georgia. This survey targeted obstetricians/gynecologists, family physicians, nurses, and nurse practitioners, all of whom have the potential to serve P4HB<sup>®</sup> clients. We also focused on specific process evaluation elements delineated through the Steckler and Linnan model during data collection to enable the measurement of program implementation (Steckler and Linnan, 2002).

This chapter summarizes the study's research methods. First, we describe the case study approach and explore its utility in implementation evaluation research. We define the "case" and the specific case study type applied to this research. Then the chapter presents an overview of the data collection methods, process evaluation measures,

analytic approach, and process of “mixing” the qualitative and quantitative data. The chapter concludes with a brief discussion of the study’s rigor, ethical considerations, and study limitations.

As introduced in chapter one, the research questions guiding this study are as follows:

- 1) What is the purpose of P4HB<sup>®</sup> and what are its major objectives and goals?**
- 2) What resources are in place and how have they been used to implement P4HB<sup>®</sup> as planned?**
- 3) Is P4HB<sup>®</sup> reaching its intended target population with the appropriate services? If not, what improvements can be made?**

### **3.2 Methodological Approach: The Evaluative Case Study**

A case study is an empirical inquiry that explores a current phenomenon in depth and within its real-life context. Indeed, the major purpose of conducting a case study is to uncover the “how” or “why” of a research problem (Creswell, 2012; Yin, 2009). The case study approach often relies on multiple sources of evidence and data that converge in a triangulating fashion (Yin, 2009). While qualitative data are often used in case studies to provide rich and detailed information about the case or cases at hand, quantitative data may also be relevant if they help explain one or more of the case study’s key propositions (Yin, 2009). For instance, in the present research, one proposition is that improper resource allocation will result in underutilization by eligible enrollees and providers. A survey of health care providers can address this issue by assessing whether and how providers are informed of the P4HB<sup>®</sup> program and whether they are enrolling women into the program.

Case study begins with the identification of a specific case. The case may be concrete, such as an organization or program, or as diffuse, as a decision process or relationship. The key to defining a case is that it is bound by certain parameters or key characteristics. A case study may be comprised of only one case or multiple case studies that are then compared with one another (Creswell, 2012).

When designing the case study, consideration must also be made about the intent of a case study. Robert Stake is most widely cited for his description of two major kinds of case studies. First, the *intrinsic case study* is one in which the case study is designed to illustrate a single and unique case that is in and of itself so unusual that the entire focus of the research centers on that one case. *Instrumental case study*, on the other hand, is designed to gain a broader perspective on an issue or problem. A case is used as an example for understanding something more general or at a high level (Stake, 1995). Multiple cases may and are often used in the instrumental case study design, which starts with the phenomenon of interest and uses several cases to inform the broader issue or problem (Stake, 2006).

The case study type applied to this research is best described as evaluative. Guba and Lincoln (1981) first identified the evaluative case study as one in which the purpose is to examine what occurs within a single program and whether it achieves its intended results. The evaluative case study has the goal of theory testing and not theory building which is more commonly associated with exploratory case studies (Thomas, 2011). A subtype of evaluative case studies is program implementation. Program implementation case studies are undertaken usually for two reasons: 1) to examine whether

implementation of a program is in compliance with congressional intent; and 2) to explore potential problems with a program's implementation (GAO, 1990).

Program implementation case studies are closely aligned with process evaluations due to their common focus on understanding how a program has been implemented and whether it has the potential to achieve fidelity. In fact, many program implementation studies are designed as case studies using process evaluation measures. We reviewed many of these studies in chapter 2.

Thus, this study incorporates an evaluative case study design to explore the implementation of P4HB<sup>®</sup>. We used a mix of qualitative and quantitative methods to collect process evaluation for P4HB<sup>®</sup>. Process evaluation measures were used to guide the assessment of the implementation of P4HB<sup>®</sup>, specifically the outreach and enrollment procedures in place to inform both patients and providers about the availability of the program, eligibility criteria, and processes for enrolling, accessing and receiving payment for covered services. The overarching goal was to assess whether P4HB<sup>®</sup> was implemented as planned and to identify missed opportunities and specific strategies to enhance outreach, enrollment, and participation in the program to maximize the likelihood for programmatic success. The research examined the implementation of both the inter-pregnancy care (IPC) and family planning (FP) components of the P4HB<sup>®</sup> program statewide. Both qualitative and quantitative measurement was included in the case study through the identification of process measures, which are described in detail below. A logic model framed the organization of the evaluative case study, but also aligns with the theoretical framework identified in chapter one. A description of this logic model is presented in the following section.

### 3.3 Logic Model

Evaluations must be guided by the development of a comprehensive evaluation plan. Such planning ideally includes a collaborative planning team consisting of key stakeholders with a multidisciplinary professional perspective and an understanding of the iterative nature of evaluation planning (Bartholomew, Parcel et al. 2001; Steckler and Linnan 2002; Butterfoss and Francisco 2004; Saunders, Evans et al. 2005). Key areas of understanding that must be addressed in this planning process include: 1) understanding the program or intervention and how it should work; 2) defining the purposes for the evaluation; and 3) considering program characteristics and context and how these may influence implementation (Saunders, Evans et al. 2005).

A logic model is one such way to illustrate the planning of a program evaluation. The purpose of a logic model is to provide a systematic and visual guide to the relationships that exist among resources one has available for a program, activities planned for the program, and changes or results that are planned as a result of the program (Kellogg 2004). Logic models are often used by evaluators to determine: 1) the focus of the evaluation; 2) the evaluation questions, or what is to be measured; 3) the indicators and what information best answer the evaluation questions; 4) timing for data collection; and 5) types of data to be collected using appropriate sources, methods, samples, and instruments (Fanaian 2004).

In this study, our logic model (see Figure 2) served as a guide to our evaluation of the implementation of P4HB<sup>®</sup>. Since we were primarily interested in evaluating whether and how P4HB<sup>®</sup> has been carried out or implemented, our logic model was guided primarily by our research questions.

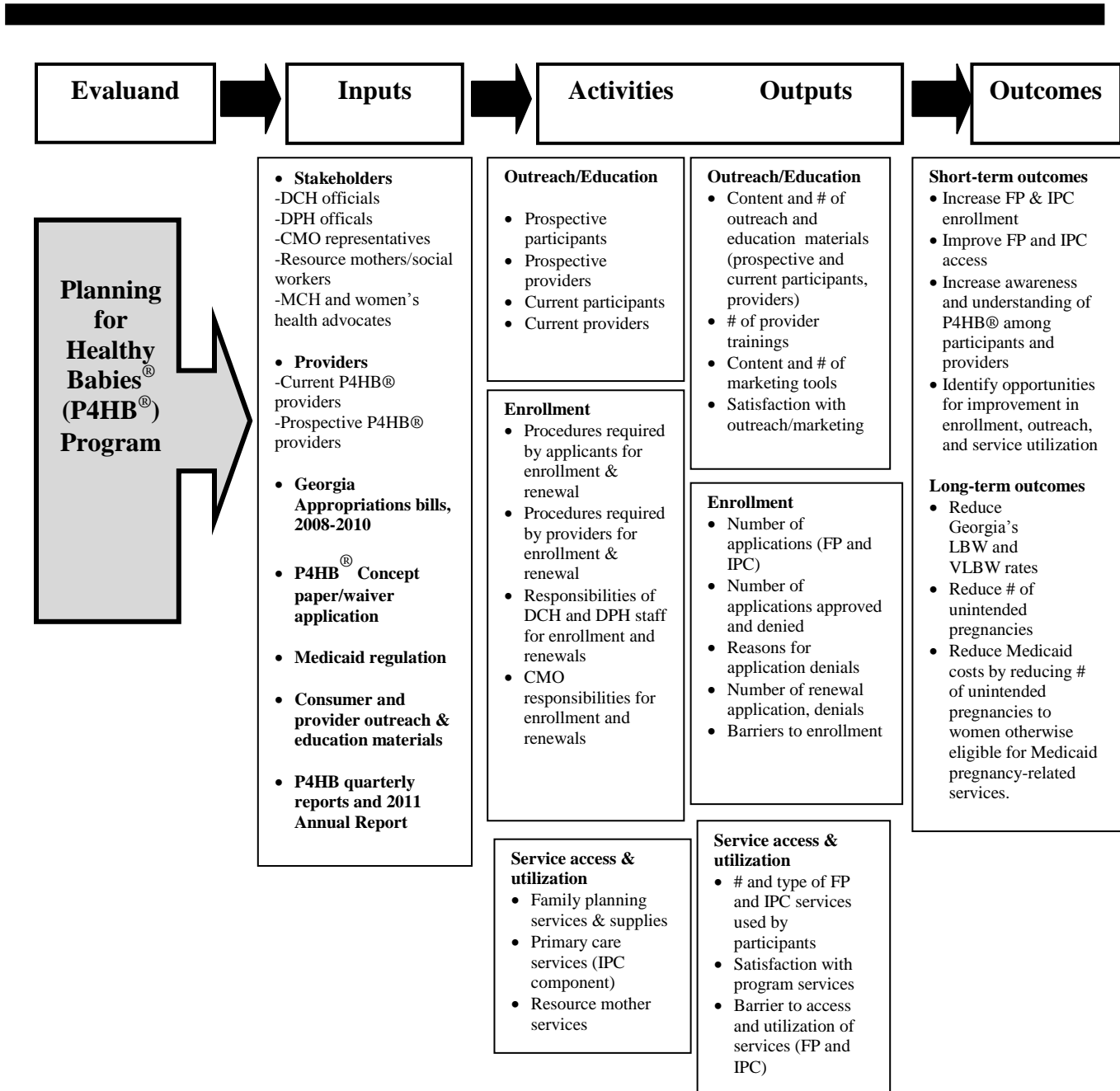
1. *What is the purpose of P4HB<sup>®</sup> and what are its major objectives and goals?*
2. *What resources are in place and how have they been used to implement P4HB<sup>®</sup> as planned?*
3. *Is P4HB<sup>®</sup> reaching its intended target population with the appropriate services? If not, what improvements can be made?*

As predicted in the research proposal, minor changes were made to the original logic model to reflect input from stakeholders and after acquiring new information about the program. These changes are discussed throughout the logic model discussion below.

These changes are discussed throughout the logic model discussion below. Our logic model reflects a specific sequence of evaluation phases that are linked to final outcomes identified by Georgia's Department of Community Health (DCH). However, it is not the purpose of this evaluation to measure the outcomes of P4HB<sup>®</sup>, but rather to monitor and track the program's implementation and progress toward achieving its long-term goals. There, the major focus of this logic model is on the evaluation phases inherent in the process or implementation of P4HB<sup>®</sup>.

We begin by identifying our *evaluand* or, that which is being evaluated. Therefore, our evaluand is the P4HB<sup>®</sup> program. Next we identify the resources or *inputs* required to implement this Medicaid family planning waiver program. The inputs, or resources, include stakeholders, such as Medicaid (DCH) officials, state public health (DPH) officials, representatives from the three care management organizations (CMOs), and maternal and child health and family planning advocates. Also included are providers who serve women in P4HB<sup>®</sup>. In the original dissertation proposal, we included state legislators and Medicaid enrollment specialists as possible stakeholders. However, due to recruitment difficulties, these stakeholders were excluded. We were able to acquire

information about P4HB<sup>®</sup> legislation and enrollment processes through our stakeholder interviews and document review.



**Figure 2: Logic Model**



Georgia's Medicaid program operates through a managed care arrangement, meaning that enrollees must enroll in one of three Care Management Organizations (CMOs). The three CMOs are: Well Care, Peach State, and Amerigroup. All P4HB<sup>®</sup> enrollees must select one of these three CMOs, and if they fail to do so after 30 days, they are automatically assigned to one. Thus, we include as inputs CMO representatives and CMO-contracted providers, which may include family practitioners, OBGYNs, or nurse practitioners.

Medicaid law includes a 'freedom of choice' provision which allows women the ability to seek family planning services from any willing provider (Rosenbaum et al, 1995). Therefore, if a woman chooses to seek services from a Title X provider or private family planning clinic, Medicaid has to reimburse that provider for the services. In some cases, Medicaid may contract directly with these providers for the purposes of serving P4HB<sup>®</sup> clients, but these contractual arrangements may also not be required. Therefore, we included these non-CMO providers as well. More information about these relationships were explored in the qualitative interviews described below.

Other inputs included in our study include P4HB<sup>®</sup> consumer and provider outreach and education materials, as well as the P4HB<sup>®</sup> marketing plan and related materials. We examined these materials in an effort to better understand the nature and content of P4HB<sup>®</sup> outreach and education that was conducted during the implementation stage of the program. Also, we reviewed DCH quarterly reports and the 2011 Annual Report to CMS, to gauge outreach and marketing activities that were conducted and enrollment estimates of P4HB<sup>®</sup> clients during the first year of the program's

implementation. By including this range of inputs, we could operationalize several elements of statutory coherence and health care access from our theoretical framework. For instance, interviews with key stakeholders, such as Medicaid officials and health care providers provided insight into how the policy objectives were developed, the extent to which financial resources were allocated for the implementation of P4HB<sup>®</sup> and any barriers to care that consumers or providers may have experienced to enrollment or service utilization.

The *activities* included in our logic model reflect the processes utilized by the inputs or resources. Our logic model focuses on three major activities or processes utilized by the inputs identified above. These include: education/outreach activities, enrollment activities, and service access and utilization. All activities reflect the major activities required to implement P4HB<sup>®</sup>. Under the category of education/outreach, we identified prospective (or not currently enrolled) P4HB<sup>®</sup> participants, prospective P4HB<sup>®</sup> providers, current P4HB<sup>®</sup> participants, as well as current P4HB<sup>®</sup> providers. Enrollment activities include: procedures for initial enrollment in P4HB<sup>®</sup> as well as renewals (yearly); enrollment procedures/responsibilities of providers for enrollment and renewal; responsibilities of DCH (Medicaid) and DPH (Public Health) staff, and CMO enrollment responsibilities for enrollment. Finally, to examine whether and to what extent P4HB<sup>®</sup> enrollees are receiving services, we include these as activities. We examined the type and nature of services provided to P4HB enrollees, either in the FP or IPC component of the program. The services provided by Resource Mothers were also reviewed in our assessment.

*Outputs* are the direct result of activities, and in our study, include the specific details inherent in each of the three major activities listed above. Under the category of education and outreach, we examined in more detail the content and number of the educational materials provided to prospective participants and providers, as well as those that enroll in P4HB<sup>®</sup>. We also examined the marketing plan and budget that were developed, including any specific resources used to execute this plan. Additionally, we examined participant and providers' attitudes and satisfaction towards these outreach/education materials. The outputs for enrollment include the number of applications for FP and IPC participants, as well as the number of applications that were denied and reasons for these denials. We examined the renewal applications, which occurred toward the end of 2011 and early 2012, as well as any barriers faced by participants and/or providers in enrollment. A last output, services access and utilization, was examined by capturing the kinds of type of FP and IPC services used by participants. Also, we were able to examine enrollee and provider satisfaction with these services offered through P4HB<sup>®</sup>.

By clearly identifying the process link between our inputs to their activities and outputs, we were further able to incorporate elements of our theoretical framework. For instance, the document review of P4HB<sup>®</sup> marketing and outreach materials led to the inventory of such activities. We examine financial resources as an element of statutory coherence and within the health care delivery system, could observe whether such resources were provided in such a way to encourage enrollment into P4HB and possibly utilization of family planning or inter-pregnancy care services. Thus, by mapping our inputs to our activities, and outputs, we were to observe whether our theoretical

framework captured all of the relevant components of the case study evaluation. In addition, this logic model provided an opportunity to not only plan the evaluation but to design it in such a way that we could integrate the main components of our theoretical framework.

We identify two distinct outcomes for the proposed evaluation: *short-term* and *long-term outcomes*. Both types of outcomes describe the benefits or changes of the P4HB<sup>®</sup> program if implemented as intended. In other words, the inputs, activities, and outputs identified in the logic model contribute to the ability to achieve these outcomes. In this study, our goal was to understand what factors of implementation may or may not help DCH achieve these goals for the P4HB<sup>®</sup> program. And while we did not measure the short-term or long-term goals, it is important to keep these outcomes in mind. Being aware of these outcomes is critical, so that improvement to the program can be made in a timely manner. So, the short-term outcomes suggested in our logic model reflect improvements in the operation of the P4HB<sup>®</sup>, namely to increase enrollment, access to services, and awareness of the program. The long-term outcomes reflect goals that not only take time but can only be achieved if the short-term goals are met. The long-term outcomes include a reduction in Georgia's low birth weight and very low birth weight rates, a reduction in the number of unintended pregnancies in Georgia, and a reduction in Georgia's Medicaid costs by reducing the number of unintended pregnancies to women who otherwise would be eligible for Medicaid pregnancy-related services. This last long-term goal makes the assumption that Medicaid would achieve substantial cost savings by not having to pay for pregnancy-related services for women who were able to prevent a pregnancy through increased access to family planning services and/or supplies. As

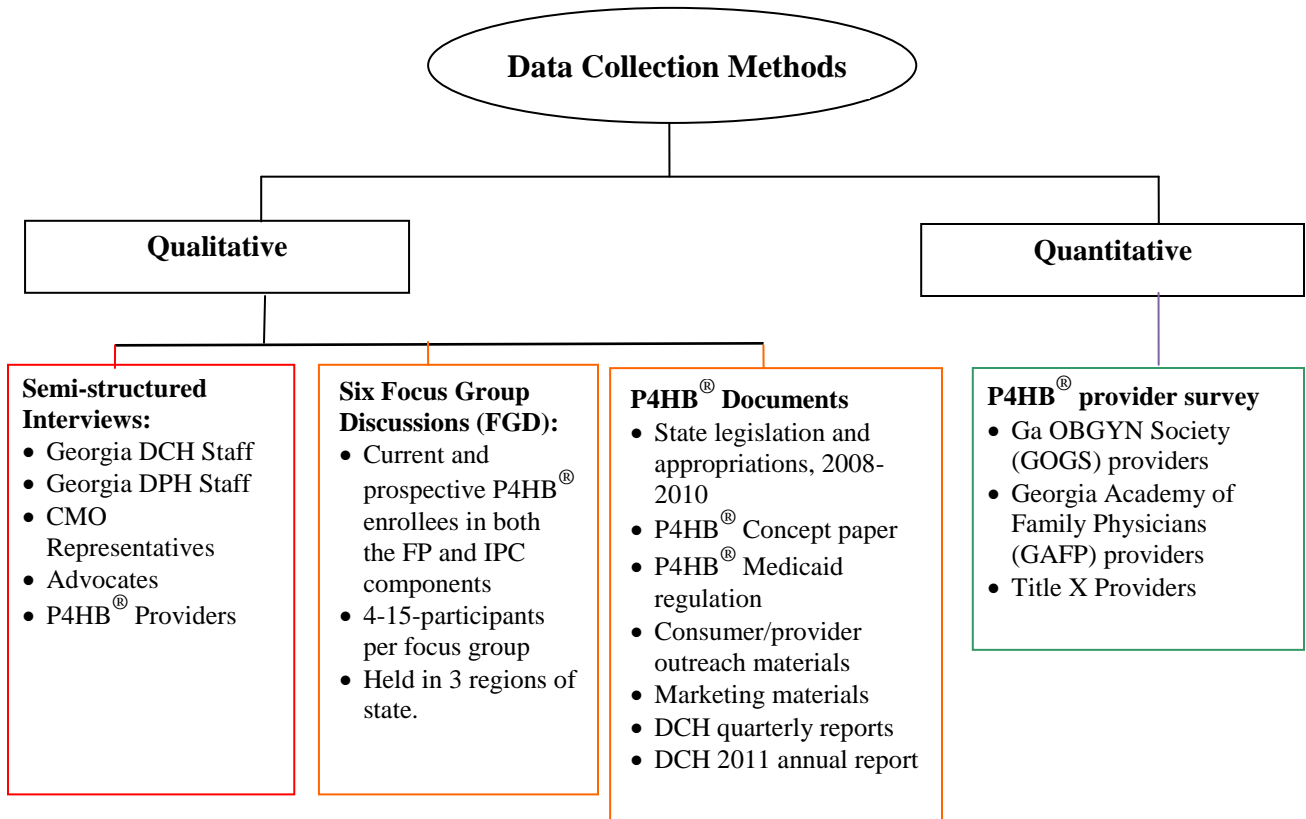
mentioned in chapter one, this is a common goal of most Medicaid family planning waiver programs.

### **3.4 Summary of Data Collection Methods**

This research combined quantitative and qualitative approaches in a mixed methods case study design to evaluate Georgia's Planning for Healthy Babies Program<sup>®</sup> (P4HB<sup>®</sup>). Following the recommendations of Linnan and Steckler (2002), six process items were assessed-fidelity, reach, recruitment, dose received, satisfaction, and barriers. Data were obtained through the use of qualitative methods, including document reviews, interviews with key informants, and focus groups with current and prospective P4HB<sup>®</sup> participants. Quantitative data were gathered through provider surveys collected from providers in Georgia who participate or are eligible to participate in P4HB<sup>®</sup>. This mix of methods is commonly referred to as triangulation, because its purpose is to use qualitative and quantitative data as complementary ways to understand a research problem (Creswell and Clark, 2007).

The methods used in this research were relevant to the purpose and scope of the study. As mentioned above, case study evaluations frequently include both qualitative and quantitative methods. Quantitative methods provide the advantages of quick analyses, brief reports, and relatively straightforward interpretation, but are not often able to provide answers about why and how a particular program component has not been received as intended. Qualitative methods provide the advantage of being able to elicit unanticipated information, suggest intervention solutions, as well as represent the diverse perspectives of different participants or groups. (Schneider, Hall et al. 2009). Integrating

different methods produces rich detail about the program that neither method could achieve alone (Steckler and Linnan, 2002; Tashakkori and Teddue, 2003). Figure 3 below reflects the study's data collection methods.



**Figure 3: Data Collection Methods**

The majority of the data were collected between April and August of 2012, although review of quarterly reports and two interviews with Resource Mothers occurred in November 2012. Prior to data collection, we received approval for the study from the institutional review boards of Georgia State University (GSU), Georgia Tech University (GTU), Emory University (EU), as well as the Department of Public Health (DPH). Letters of these IRB approvals are provided in Appendix A

### 3.5 Process evaluation measures

To guide the proposed evaluative case study, we borrowed concepts from a process evaluation model developed by Allan Steckler and Laura Linnan (2002). Their model was developed out of a need to better define the components of process evaluation as well as to provide a systematic process for planning and developing process evaluations. The authors suggest that there is a considerable overlap in the way prior process evaluations have attempted to measure concepts such as fidelity, reach (who receives the intervention), and dose (amount of intervention received).

In Table 2, we provide a description of the key process evaluation measures that were used for this study. For each of the process evaluation components, we identify the corresponding element(s) of our theoretical framework, a definition, examples of the evaluation measures tied to each process evaluation component, and the data collection instruments that were used.

**Fidelity** of P4HB<sup>®</sup> was connected to several elements of statutory coherence in our theoretical framework, including precise and clear objectives, causal theory, and integration and access among implementers. Fidelity was also measured in several ways. First, we asked informants to describe the purpose of P4HB<sup>®</sup>, the major goals, as well as the objectives they understand were inherent in P4HB<sup>®</sup>. We aligned these answers with data gathered from review of the Medicaid P4HB<sup>®</sup> legislation, DCH Concept Paper, as well as other key policy and program documents. We also addressed design and execution of the P4HB<sup>®</sup> implementation plan by asking informants about their

knowledge of and experience with the implementation of the program. We compared these answers to description of implementation in our documents. Informants were also

<b>Table 2</b>				
<b>Process Evaluation Measures</b>				
<b>Process Evaluation Component</b>	<b>Theoretical Framework Elements</b>	<b>Definition</b>	<b>Process Evaluation Measure</b>	<b>Data Collection Instruments</b>
<b>Fidelity</b>	<ol style="list-style-type: none"> <li>1. Precise and clear objectives</li> <li>2. Causal theory</li> <li>3. Integration and access among implementers</li> </ol>	<p>The extent to which the program was delivered as planned. It represents the quality and integrity of the intervention as conceived by key stakeholders (Medicaid, legislators, advocates) or through legislation and other key policy and program documents</p>	<ol style="list-style-type: none"> <li>1. Purpose, goals, objectives of P4HB</li> <li>2. Design and execution of implementation plan</li> <li>3. Collaboration among key stakeholders in program planning and implementation</li> <li>4. Roles and responsibilities of outside agencies in P4HB implementation</li> </ol>	<p>1-3 Stakeholder Interviews, document reviews</p>
<b>Reach</b>	<ol style="list-style-type: none"> <li>1. Financial resources</li> <li>2. Provider network</li> <li>3. Outreach</li> </ol>	<p>Proportion of intended audience that participates in the program. Includes reach of Family Planning (FP) and Inter-pregnancy care (IPC) participants <u>and</u> providers</p>	<ol style="list-style-type: none"> <li>1. Number of applications received for FP/IPC</li> <li>2. Number of applications denied for FP/IPC</li> <li>3. Reasons for application denials</li> <li>4. Analysis of enrollment, by county</li> </ol>	<p>1-4 DCH Enrollment Data (DED) via 2011 Annual Report and P4HB<sup>®</sup> quarterly reports.</p>
<b>Recruitment</b>	<ol style="list-style-type: none"> <li>1. Integration and access among implementers</li> <li>2. Outreach</li> </ol>	<p>Procedures used to approach and attract participants and providers. Recruitment at the individual, organizational, and community levels will be assessed.</p>	<ol style="list-style-type: none"> <li>1. Visibility of P4HB<sup>®</sup></li> <li>2. Outreach (prospective and current participants)</li> <li>3. Education (provider education and training)</li> <li>4. P4HB<sup>®</sup> Marketing (Medicaid, CMO, other agencies)</li> </ol>	<ol style="list-style-type: none"> <li>1. SI, FG</li> <li>2. SI, FG, Document reviews (DR)</li> <li>3. SI, PS, DR</li> <li>4. SI, DR</li> </ol>
<b>Dose Received</b>	<ol style="list-style-type: none"> <li>1. Provider network</li> <li>2. Utilization of</li> </ol>	<p>The extent to which participants actively sought family planning and/or</p>	<ol style="list-style-type: none"> <li>1. Number of FP/IPC Services Received by participants</li> </ol>	<ol style="list-style-type: none"> <li>1. FG, DR</li> <li>2. FG, PS</li> </ol>



	services 3. Barriers	inter-pregnancy care services through P4HB®.	2.Type of FP/IPC Services Received by participants	
<b>Satisfaction</b>	1. Satisfaction 2. Barriers	Attitudes of participants and providers toward the program’s content and service delivery. Provider satisfaction of program reimbursement system is also included.	1.Participants’ opinions/experiences with P4HB® (FP and IPC components) 2.Providers’ opinions/experiences with P4HB®	1.FG 2. PS
<b>Barriers</b>	1. All access element	Problems encountered reaching participants and also experienced by participants in both enrollment and accessing services. Barriers faced by Medicaid and other agencies (such as Title X) will also be assessed.	1. Barriers to Outreach and education about P4HB® 2. Barriers to Enrollment 3. Barriers to Services 4. Other Barriers (Collaboration among agencies or providers; reimbursement for providers, etc.)	1&4 SI, FG, PS 1 SI, FG, PS, DED 2 FG, PS

asked to share whether and how they collaborated with Medicaid and other agencies to design and implement P4HB<sup>®</sup>. Finally, we assessed whether certain outside agencies (providers, local providers, advocates) had specific roles and responsibilities for the P4HB<sup>®</sup> program. We addressed this process measure in both our informant interviews and review of key documents (Medicaid statute, DCH Concept Paper, provider outreach plan, communication plan, and CMS special terms and conditions or STCs).

The **reach** of P4HB<sup>®</sup> was connected to elements of both statutory coherence and health care access in our theoretical framework, including financial resources, provider network, and outreach. To measure reach, we asked informants to describe their understanding of current enrollment in the program. We also reviewed the 2011 DCH quarterly reports prepared that were submitted to the Centers for Medicare and Medicaid Services (CMS), as required by the terms of the CMS Special Terms and Conditions (STCs). These reports present information on applications as well as enrollment in P4HB<sup>®</sup>. Other types of information, such as reasons for application denials and barriers to enrollment, are also provided in these reports. In order to understand if women are participating in the program, an analysis of these enrollment data was critical.

**Recruitment**, like reach, was connected to elements of both statutory coherence and health care access in our theoretical framework, including integration and access among implementers and outreach. Recruitment was measured by evaluating the visibility of P4HB<sup>®</sup>, the outreach and education efforts directed at both participants and providers, as well as the marketing plan and materials developed by Medicaid and the participating CMOs. In terms of visibility, we used stakeholder interviews to explore

what the state, CMOs, and P4HB<sup>®</sup> participating partners (Title X, MCH, etc.) have done to inform the public about P4HB<sup>®</sup>. In particular, we were interested in general efforts to highlight this new Medicaid program. Focus group discussions also included questions for participants about whether and how they knew about P4HB<sup>®</sup> before enrolling in the program. Who told them about the program/how did they hear about it? Additionally, we will use informant interviews and focus groups to create an inventory of the outreach efforts made to inform prospective and current participants about P4HB<sup>®</sup>. We also reviewed all available outreach materials (posters, flyers, ads, press releases) that were developed. Education of providers about P4HB<sup>®</sup> was the topic of both the stakeholder interviews as well as provider surveys, and reviews of any provider training materials. We were interested not only in the content of these educational efforts, but also the frequency in which they are provided. A final recruitment measure included the P4HB<sup>®</sup> marketing plan and budget. Interviews with key Medicaid officials were conducted to learn about the development of the P4HB<sup>®</sup> marketing plan and budget, as well as the current status of its implementation.

The third evaluation measure, **dose received** was connected to elements of health care access in our theoretical framework, including the provider network and utilization of P4HB<sup>®</sup> services, as well as any barriers. Dose received was measured by the number of and type of services (FP and IPC) received by participants. We assessed services received by participants in both the FP and IPC components of the program. Our focus groups with women asked about the type and frequency of services accessed through P4HB<sup>®</sup>. For the IPC participants, we asked them to describe the Resource Mother

services they have received. In addition, we added questions to the provider survey that asked providers to list the type of services they typically provide to P4HB<sup>®</sup> participants.

**Satisfaction** was connected to two elements of health care access, including satisfaction and barriers. The evaluation measures for satisfaction included participants' opinions and experiences with P4HB<sup>®</sup> as well as providers' opinions and experiences as well. During the focus groups, P4HB<sup>®</sup> participants were asked about their experiences with the program and whether they are happy with the services they have received. They were also asked their opinions about other implementation measures, such as outreach/education and enrollment. The provider surveys provided respondents the opportunity to express their qualitative opinions about P4HB<sup>®</sup>. Many of the comments, as described in Chapter 6, expressed providers' dissatisfaction with components of the program.

Finally, **barriers** was connected to each of the health care access elements in our theoretical framework. Barriers were measured in several ways. We examined barriers to outreach and education about P4HB<sup>®</sup>, to enrollment, to services, and other types of barriers. The informant interviews addressed questions about outreach/education barriers, enrollment barriers, and other barriers. Focus groups included discussion questions that asked participants to describe any and all barriers they have so far experienced in the program. Provider surveys also allowed respondents to identify barriers to the program, such as enrollment, services, and reimbursement. Barriers to enrollment were also be noted through an analysis of the DCH quarterly reports and annual report.

## **3.6 Study Population**

### ***3.6.1 Description and Source of Study Population***

Our study population includes several major categories of participants. We included key stakeholders who are knowledgeable about or have programmatic responsibility for P4HB<sup>®</sup> (policy development, outreach/education, enrollment, service provision). In order to capture an accurate description of P4HB<sup>®</sup>, we interviewed informants who helped design the program, lobbied for it in the state legislature, as well as those who maintain responsibility for the program's oversight. Therefore, we interviewed both state public health and Medicaid staff. Originally, we had hoped to interview key state legislators who were instrumental in providing legislative and economic support in the Georgia legislature. However, these informants could not be recruited, most likely because the legislature was out of session during the recruitment process. We were able, though, to collect rich information from key advocates and DCH officials about the influence of the legislature on the implementation of P4HB<sup>®</sup>.

To gain an understanding of how P4HB<sup>®</sup> works from the managed care side, we interviewed representatives from each of the three CMOs. These informants had primary knowledge and/or responsibility for the P4HB<sup>®</sup> program from their respective organization. Also, we interviewed several key advocates who represented family planning and maternal and child health organizations that were instrumental in designing, advocating for, and participating in the early implementation of P4HB<sup>®</sup>. To explore eligibility and enrollment processes, we planned originally to interview representatives from PSI, Maximus, and Gammas, all of which have distinct responsibilities in processing

P4HB<sup>®</sup> applications, as well as assigning P4HB<sup>®</sup> enrollees to the CMOs. Instead, we captured this information directly from a review of DCH quarterly reports and interviews with key stakeholders as well as providers. Finally, we interviewed providers who have experience serving the P4HB<sup>®</sup> enrolled population. Both public health and private providers were interviewed. Interviews focused on current experience with outreach/education, enrollment, and service utilization within the P4HB<sup>®</sup> program. More detail about the characteristics of all informants is provided in Chapter 4.

We included current and prospective P4HB<sup>®</sup> clients in our study sample. These participants were included in one of six focus groups conducted throughout three regions of the state (Atlanta, Southeast Georgia, and Northwest Georgia). The purpose of the focus groups was to assess women's knowledge of and experience with P4HB<sup>®</sup>.

Finally, we conducted a provider survey to gain a more quantitative picture of the P4HB<sup>®</sup> program. Approximately 104 providers completed a survey that assessed their knowledge and experience with P4HB<sup>®</sup>. The survey also addressed whether providers currently serve P4HB<sup>®</sup> clients, were provided information or outreach about the program, and what barriers they have experienced with the program. Providers represented members of three specific provider groups: 1) members of the Georgia Obstetrics and Gynecology Society (GOGS); 2) members of the Georgia Academy of Family Physicians (GAFP), and 3) current Title X providers. Title X, the national family planning program funded by the Office of Population Affairs, is administered in Georgia through the Office of Family Planning in the Department of Public Health.

### **3.6.2. Participant Recruitment**

We employed three major strategies for recruiting participants in our study. First, we used “formal networks” to recruit an initial list of key stakeholders. Participants of formal networks use particular services or are part of a common community of interest (Hennick, Hutter et al. 2011). In our case, we recruited participants who were connected in some way to the P4HB<sup>®</sup> program. A similar and well-known recruitment strategy is called *purposive sampling*, whereby participants are recruited based on selected set of criteria, which in this case would be the involvement in and knowledge of P4HB<sup>®</sup> (Patton 2008).

We began recruiting participants who were part of Georgia’s state public health and health services community. This list included state DCH (Medicaid) and DPH (Public Health) officials. Due to the researcher’s position at Emory University and past research experience, the research had established relationships with each of these state health agencies. Therefore, this formal network was the most obvious one with which to start recruitment. After introductory emails to prospective informants about the study, initial interviews were scheduled with current Medicaid officials with primary responsibility and oversight of the P4HB<sup>®</sup> program. In addition, a few key interviews with advocates were scheduled based on prior knowledge of their P4HB<sup>®</sup> experience as well.

We used a second recruitment strategy known as the snowball method. “Snowballing” is also known as “chain sampling” whereby participants with specific characteristics who may be difficult to identify or who are unknown to the recruiters can be approached. The snowball strategy involves asking a study participant or key

informant whether they know anyone else who meets the study criteria and asking them to refer this person to the researcher (Hennick, al., 2011). We used this snowballing method during our interviews with public health contacts and some advocates to help us connect to providers and provider organizations, such as GOGS, GAFP, and local title X providers whom we interviewed. Our contacts at DCH provided linkages as well to each of the three care management organizations (CMOs) that serve P4HB<sup>®</sup> clients

We employed a third and final recruitment strategy, which was the use of gatekeepers. Gatekeepers are people who have a significant and recognized role in the local community and knowledge about the characteristics of community members. In our case, we sought gatekeepers who had: a) knowledge of P4HB<sup>®</sup> participants and providers; and b) access to these participants and can communicate with them on our behalf. The CMOs were one type of gatekeepers that assisted us in recruitment of the focus groups. Each of the CMOs mailed DCH-approved flyers advertising the availability of the focus groups to their current P4HB<sup>®</sup> enrollees. One CMO was also instrumental in providing access to one of its Resource Mothers who was interviewed for the study. Another type of gatekeeper we used was the state Title X program, which facilitated access to its family planning women's health coordinators and providers. The Title X women's health coordinators completed the provider survey as well as assisted with introducing us to providers at the local health departments who managed the local family planning programs. With these connections, we were able to establish sites for six of the focus groups, and to conduct four interviews with local Title X providers.

For the interviews, described in more detail below, we recruited study participants and conducted analyses of the information concurrently. Therefore, we stopped



recruitment when data saturation was achieved or further recruitment as not possible. Data saturation in qualitative studies occurs when the researchers no longer “hears” or learns new information (Grady, 2003). Indeed, the saturation of our interview data determined our sample size. However, as noted by Charmaz (2006), oftentimes the sample size is determined by the study aims. Since our aims were relatively straightforward, whereby we asked informants to describe their involvement and experience with the implementation of P4HB<sup>®</sup>, we achieved saturation rather quickly. Also, as noted in the proposal, we used a stakeholder mapping form to help us keep track of our participant recruitment, (see Appendix B). This form was adapted from the USAID Health Policy Initiative (USAID, 2010). More information about data analysis is provided below.

Table 3 summarizes data collection for the entire study, which included a total of 21 interviews with 24 informants, six focus groups with 49 participants, surveys from 104 participants, and over 20 document or web-site reviews. The table describes each of the data collection methods by recruitment strategy (where applicable). Following the table is an in-depth description of each data collection method.

**Table 3: Summary of Data Collection, by Recruitment Strategy**

<b>Data Collection Method</b>	<b>Recruitment Strategy</b>	<b>Number of Participants/Observations</b>
<b>Informant interviews</b>	Formal Networks <ul style="list-style-type: none"> <li>• Medicaid</li> <li>• Title X</li> <li>• MCH</li> <li>• Advocates</li> </ul> Snowball <ul style="list-style-type: none"> <li>• Medicaid</li> <li>• Title X</li> <li>• MCH</li> <li>• Advocates</li> </ul> Gatekeepers <ul style="list-style-type: none"> <li>• CMOs</li> <li>• State Title X program</li> <li>• GA OBGYN Society</li> <li>• GA Academy of Family Physicians</li> </ul>	21 participants
<b>Focus groups</b>	Gatekeepers	6 focus groups with a total of 49 participants
<b>Provider surveys</b>	Gatekeepers <ul style="list-style-type: none"> <li>• CMOs</li> <li>• State Title X program</li> <li>• GA OBGYN Society</li> <li>• GA Academy of Family Physicians</li> </ul>	104 participants
<b>Document reviews</b>	Formal networks <ul style="list-style-type: none"> <li>• Medicaid</li> <li>• CMOs</li> </ul>	20+ observations including the following: <ul style="list-style-type: none"> <li>-P4HB® Concept Paper</li> <li>-P4HB® marketing plans &amp; budgets</li> <li>-P4HB® outreach/communications plan</li> <li>-P4HB® 2011 and 2012 quarterly reports</li> <li>-P4HB® website</li> <li>-Medicaid and CMO P4HB® provider materials</li> <li>-P4HB® advertising materials (postcards, billboards, flyers)</li> <li>-P4HB® application materials</li> </ul>

### **3.7 Interviews**

Twenty-one interviews were conducted with twenty-four informants. We interviewed four public health officials, two from Georgia's Department of Community Health (DCH), which administers Medicaid and the P4HB<sup>®</sup> program, and two from the Georgia Department of Public Health (DPH), which administers the Maternal and Child Health and Family Planning programs. We also interviewed five advocates who were involved in either the conceptualization, design, and or initial implementation of P4HB<sup>®</sup>. These advocates represented family planning, maternal and child health, as well as provider organizations in Georgia. In addition, we interviewed nine interviews with a range of OBGYNs, social workers, resource mothers, and nurses who work in health department family planning programs. We also conducted interviews with representatives from each of the three CMOs.

A semi-structure interview guide was developed to address the major constructs of the theoretical framework and adapted to address the specific type of informant. For instance to address statutory coherence, interview questions for state officials and advocates centered on defining the purpose of the P4HB<sup>®</sup> program and discussing the policy planning process. We asked these informants to describe their knowledge of and experience with the conceptualization of P4HB<sup>®</sup>. Informants provided details about how the idea of P4HB<sup>®</sup> was developed, the motivations for its creation, what stakeholders were involved in the early design phase of the program, as well as the design for long-term goals for P4HB<sup>®</sup>. When applicable and as described during the course of some provider interviews, these domains were also addressed. We examined these same issues through a document review of P4HB related materials, including the P4HB<sup>®</sup> Concept

Paper, CMS STCs, communication plan, provider outreach plan, 2011 quarterly reports, and the 2011 Annual report. Finally, we addressed access to care issues by asking informants to describe certain implementation processes, including enrollment and outreach and education efforts. In most situations, providers and CMO representatives were most knowledgeable about these issues, along with state public health officials. A copy of the standard interview guide is provided in Appendix C.

The researcher led all interviews and took cursory notes during each interview. She also created short summaries after each interview. All but one interview was conducted by phone, and the interviews lasted between 30 and 60 minutes, with an average time of 45 minutes. Each interview was tape-recorded with the informant's permission. Prior to the start of the interview, informants were emailed a copy of the approved informed consent form and asked to return the signed form by fax or email. In some situations, verbal consent was obtained and tape-recorded if the informant did not return a signed consent form. Informants were also provided the opportunity to ask questions about the study prior to the start of the interview. Informants were not compensated for their time, however follow-up communication occurred via email to thank each informant for their time and participation in the study. Informants were also offered the opportunity upon request to obtain a written summary of the interview or the interview transcript. Only one informant made this request after the completion of the interview for both the summary and transcript.

### **3.8 Document review**

A document review, also sometimes called “document analysis,” refers to the systematic evaluation of written or electronic materials. Like other qualitative methods, a document review requires analyzing and interpreting data in order to “elicit meaning, gain understanding, and develop empirical knowledge” (Bowen, 2009, page 27).

There are many reasons one might conduct a document review. Most researchers use documents to supplement other sources of data or to corroborate evidence from other sources (Bowen, 2009). Atkinson and Coffey (2004) warn, however, that document reviews should not be used in place of other valuable sources of information, particularly if the information sought is about how an organization or program operates on a day-to-day basis. Instead, documents can provide useful background information and context and should be used in combination with other materials to investigate a particular research question. Document reviews are particularly useful in case study research when reports and internal correspondence are used as potential sources of empirical data (Mills, Bonner, and Francis, 2006).

For this case study research, we gathered multiple sources of documents to evaluate the implementation of P4HB<sup>®</sup>. The primary goal of our document review was to have supplementary materials that provided insight into the conceptualization, policy guidance, and overall goals of the program. A secondary goal of the document review was to understand what the roles and responsibilities were of implementing agencies and providers and how these responsibilities were integrated with Medicaid, which holds jurisdiction over these agencies for P4HB<sup>®</sup>. Lastly, the document review allowed us to

gather evidence of funding and other resources allocated to the first year of the program's implementation.

We reviewed over 20 sources of materials. We began chronologically with collecting information that was publicly available about P4HB<sup>®</sup>. This included the state appropriations bills for 2008-2010 that reflect the allotment of funding for P4HB in its first year. Next, we reviewed news articles about the program as well as the P4HB<sup>®</sup> Concept Paper that was posted online at the Department of Community Health (DCH, 2009). We also reviewed the CMS STCs, which outlines specific responsibilities of DCH for implementing P4HB and collaborating with implementing agencies. Information from this document also reflects CMS expectations about meeting the program's long-term objectives. Then moving forward, we collected any and all marketing materials such as postcards, flyers, and information posted on the DCH website. The website also contained program information, such as eligibility criteria, application procedures, and provider information. All website information was included in our analysis. Finally, we collected P4HB<sup>®</sup> quarterly reports that were produced in 2011 in the first year of the program. These quarterly reports are required by CMS for all Medicaid demonstration programs. They provided information about certain aspects of the implementation process, including enrollment, outreach, and education, and marketing. We also reviewed internal memos and correspondence that were made available to Ms. Blake through her work on the outcomes evaluation team at Emory. Such memos and correspondence included: marketing budgets and invoices, and internal memos about application and enrollment processes.

We developed a Summary Form to review each document included in the study. This form (see Appendix D) included information about the name, date, and author or source of the document (such as DCH, DPH, CMO). We also noted the category of the documents that were reviewed, including: 1) Policy development; 2) Program guidelines; 3) Marketing/outreach; 4) Quarterly reports; and 5) Provider materials. Policy development documents included the P4HB® Concept Paper, appropriations bills, and Medicaid statute. Program guidelines included the information gathered from the DCH website about enrollment procedures, CMO selection, and service benefits and coverage. Marketing and outreach documents included advertisements, flyers, and marketing budgets. Quarterly reports are those also mentioned above that are required by CMS. Finally, we also reviewed provider guidelines and handbooks available online by each of the CMOs.

The Summary Form was used to capture a general description of each document as well as specific elements of implementation that were pertinent to our study. Such elements included information about 1) The nature of “the problem”; 2) P4HB® goals and objectives; 3) program design, such as provider network and benefits and services; 4) implementation processes, such as outreach, education, and marketing; 5) program access and utilization, including application and enrollment procedures; and 6) barriers to implementation. A list of all documents reviewed for this study is provided in Appendix E.

### **3.9 Focus groups**

Between June and July 2012, six focus groups were held throughout Georgia with current and prospective P4HB<sup>®</sup> clients. Three focus groups were held in two separate public health departments in metropolitan Atlanta, one focus group was held in a public health department in southeast Georgia, and two focus groups were held in two different public health departments in northwest Georgia. These sites were selected in order to provide geographic diversity in the patient population as well as size and location of the public health system.

The overall goal of the focus groups was to learn if P4HB<sup>®</sup> was currently reaching its intended audience and how well the program was working. Focus group discussions centered on the following domains: 1) knowledge and understanding of P4HB<sup>®</sup> 2) outreach, marketing, and other education efforts concerning P4HB<sup>®</sup>: 3) enrollment process and barriers to enrollment; 4) utilization of P4HB<sup>®</sup> family planning and IPC services; 5) recommendations for improvements. Participants also completed an anonymous demographic form that asked them to provide information about their race, age, education, insurance status, source and type regular health care services, including family planning, and P4HB<sup>®</sup> enrollment status. The moderator's demographic form and discussion guide are provided in Appendix F and G respectively.

As described above, we conducted recruitment in two major ways. First, through our connections with the state Title X family planning program, we sought the assistance of local Title X program managers who helped us identify clinics for each of the six focus groups. The locations were selected based on the following criteria: 1) number of P4HB<sup>®</sup> participants seen at clinic; 2) willingness of clinic manager to participate in study and



assist with recruitment; 3) available space for focus group. We deemed the first criteria as essential, because this would help facilitate recruitment as well as clinic and client experience with the P4HB<sup>®</sup> program. To recruit participants, our first effort included posting flyers around the clinics. The flyers advertised the purpose, time, and place of the focus groups. Ms. Blake's contact information was also provided on each flyer for women to use if they wanted to sign up or learn more about the focus groups. Recruitment also occurred through the three CMOs, who mailed flyers to their current P4HB<sup>®</sup> enrollees. This flyer also advertised the purpose, date, and time of all focus groups, as provided my contact information as well. All interested persons were screened for eligibility, either by phone or email. Selection criteria for these focus groups include: 1) Age 19-44; 2) current legal U.S. citizen; 3) Georgia resident and 4) English-speaking. Screening information was also collected about women's P4HB<sup>®</sup> enrollment status (enrolled/not enrolled; FP or IPC patient), and source of regular family planning services. Originally, we had hoped to hold separate focus groups with P4HB<sup>®</sup> enrolled participants according to their FP and IPC status, however, due to the low enrollment of IPC enrollees and women's uncertainty about their status during the screening process, we decided to include all P4HB<sup>®</sup> women in the focus groups.

Focus groups lasted between 42 minutes to one hour, with a mean duration of one hour and 20 minutes. We obtained consent from each participant prior to the focus groups. Ms. Blake moderated each focus group, which was audio recorded. Participants were provided \$25 for their time, and refreshments were also provided during each focus group. Additional descriptive information about the focus group participants is provided in Chapter 5.

### 3.10 Provider Surveys

A survey was developed and administered to both prospective and participating P4HB® providers. The goal of this survey was to assess the knowledge and experiences of providers in Georgia serving women eligible and/or enrolled in Planning for Healthy Babies® (P4HB®), Georgia's Medicaid family planning waiver program. Topics were selected based on specific variables of health care access framework.

The provider survey allowed us to address *characteristics of the health care delivery system* by asking providers whether they were Medicaid-enrolled providers and if they currently served P4HB® clients. We addressed *utilization of program services* by asking participating providers about the types of services they have delivered to eligible P4HB® enrollees. In addition, we asked about *barriers to care* and *satisfaction* and allowed survey respondents to express their opinion about P4HB®. Many respondents provided qualitative data that reflected dissatisfaction with the program and specific barriers to delivering services to P4HB® clients.

The 26-item draft survey was circulated among select provider organizations in Georgia, including the Georgia Academy of Family Physicians (GAFP) and Georgia Obstetrical and Gynecological Society (GOGS). These organizations, as well as the Department of Public Health's Family Planning Program (DPH FPP) agreed to distribute the survey, since a majority of these organizations' providers offer family planning services to women in Georgia. We revised the survey based on feedback and specific guidance as to the content, length, and mode, and the final survey consisted of 13 questions (12 multiple-choice questions and one open-ended, qualitative question).

Originally, we planned to distribute the survey electronically via an online survey program. However, feedback from the organizations strongly suggested that provider response would be enhanced if the survey was only one page and distributed via fax, email, or in person. A final copy of the survey is available in Appendix H.

The survey was shared among the members of several provider groups: 1) Georgia Academy of Family Physicians (GAFP); 2) Georgia Obstetrical and Gynecological Society (GOGS); 3) Georgia Department of Public Health's Family Planning Program (Georgia's Title X program). GAFP handed out copies of the survey to their members at their summer meeting in June 2012, and GAFP mailed the completed surveys to me. GOGS blast faxed the survey twice to its members, first in June 2012 and again in July 2012. Members returned their completed survey to me by fax. For Georgia's Title X program, we emailed the survey to all 18 women's health coordinators. Follow-up with these Title X contacts occurred two additional times, by email. The women's health coordinators were provided the option of returning the completed survey back either by email or fax. There were no financial incentives provided to survey respondents.

### **3.11 Data Management**

Qualitative research tends to produce an enormous amount of data, regardless of the number of methods used. Good organizational skills are necessary before, during, and after the data collection process. Data management can influence the analysis, interpretation, and presentation of the qualitative data (McLellan-Lemal, 2008). Therefore, efficient data management is a prerequisite to effective data analysis.

We employed a number of strategies to manage the qualitative and quantitative data collected for this study. These strategies include:

- 1) Microsoft Word: This program was used to maintain all transcripts, interview and focus group summaries, policy and program documents, codebooks, and drafts of the dissertation.
- 2) Microsoft Excel: This program was used to create numerous spreadsheets for the scheduling of interviews and focus groups. Each spreadsheet captured information about participants, their availability, important interview details, such as type of informant, and dates and times of the scheduled interview or focus group. Another spreadsheet was maintained that reflected the analysis process, including whether transcripts had been produced, cleaned, or coded. We also produced a separate spreadsheet for the interview and focus groups transcripts that allowed us to map the informant to their pseudonym. Finally, a spreadsheet was also produced to maintain the survey data.
- 3) MaxQDA10: This software program is designed to assist with the organization and coding of qualitative data. All transcripts and review documents were stored in MAXQDA and coded and memoing.
- 4) SPSS: SPSS is a statistical software program that data analysis, storage, and management of large data. We used this program for the analysis of survey data, which is described in more detail below.
- 5) Digital audio recordings: All interviews and focus groups were recorded with consent of the participants. These recordings were made using Olympus and Sony audio recorders. The audio files were transferred from the recorders to my computer, where they were stored until transcribed. Once transcriptions were produced, cleaned, and de-identified, the audio files were deleted from the computer.
- 6) File storage: A filing system was maintained in a locked storage cabinet for all hard copies of materials for study. These documents included consent forms, interview and focus group summary notes, and miscellaneous documents.

## **3.12 Data analysis**

### ***3.12.1 Overview of analytic approach***

As is common with most mixed methods research, we collected a vast amount of data for this study. In addition to the management of the data as described above, we employed separate techniques to organize the data. Such organization of data included coding the qualitative data (interview and focus group transcripts, document review summaries), and storing such coding in a qualitative software program. This coding helped to produce themes from the qualitative information about the implementation of P4HB<sup>®</sup>. The quantitative data were entered into a software program so that statistical applications could be applied to provide some descriptive information about providers' experiences and impressions with P4HB<sup>®</sup>. Then we employed a method of "mixing" the data through the use of triangulation, which included concurrent analyses of the two types of data. More information about each step of the analysis is provided in the following sections.

### ***3.12.2 Qualitative data organization and coding***

The interviews and focus groups were recorded using digital voice recorders with permission of the participants and transcribed by a professional transcriptionist. These transcripts and the document summary forms were entered directly into MAXQDA 2010 software, which facilitates the processes of data retrieval and reduction necessary for the analysis of large volumes of textual data including advanced data searching and reporting functions. As when analyzing qualitative data without the use of software, our analysis included the identification of key themes in the data, segmenting text and applying codes

representing each theme to each text segment, writing various annotations about the content of the data and/or patterns that emerge over the course of data analysis, engaging in a systematic retrieval and review of data by theme or sets of themes in order to characterize themes and the relationships between themes in the data.

Data analysis was performed first separately for all qualitative data, including the interviews, focus groups, and document reviews. For each, however, a systematic approach was taken and data analysis proceeded in two phases: 1) preliminary analysis relying predominantly on a set of deductive codes representing the initial objectives of the study (e.g. policy planning, outreach/education, enrollment, service access/utilization); 2) in-depth analysis based on the emergence of key inductive themes, or concepts identified by participants themselves as being important. Also interpretation of key concepts in the data was based on a thorough and systematic exploration of both inductive and deductive themes and the interrelationships between all themes as evidenced in the data.

Preliminary analysis was concurrent with data collection and consisted of applying codes representing the core deductive ‘themes’ representing the process evaluation components included in the study. Once twenty percent of the qualitative data were completed, they were coded with this initial theme list a second time and compared for consistency.

These ‘deductive’ codes provided the foundation for a more focused review of text segments during which I attached ‘memos’ to salient text segments that ‘triggered’ the identification of additional themes that stem from the participant’s responses (Richards, 2009). Separate codebooks were created (see below for additional detail),

which consisted of final inductive and deductive themes that provided the basis for the subsequent in-depth analysis. This second phase of analysis entailed retrieving and reviewing coded text in order to identify patterns and describe the range of experience of participants in the study. Finally, we conducted a comparison of the themes emerging from the interviews and document reviews and presented results together (see Chapter 4). Focus group results are presented separately as these themes are unique to the P4HB<sup>®</sup> enrollees and reflect more post-implementation findings. Focus groups results are presented in Chapter 5.

### ***3.12.3 Codebook development***

Using the approach described in the previous section, coding of the interviews, focus groups, and document reviews occurred separately. As a result, a unique codebook was created for each of these qualitative data components. The codebooks were developed using an iterative approach of reviewing, revising, and rewriting the codes. In addition, definitions were provided for each code to reflect the meaning of each code as well as the information not to be included in each code. Thus, as shown in Appendix I, each codebook included “inclusion criteria” and sometimes “exclusion criteria.” These notations are important for reminding the analyst of not only the meaning of each code but also “because they provide a formalized operationalization of the codes” (DeCuir-Gunby, Marshall, and McCulloch, 2011, page 138). The codebooks were updated regularly through the analysis process and completed only once final coding was finished for all interviews and focus group transcripts and document summary forms.

#### ***3.12.4 Quantitative data organization and analysis***

All survey data were entered manually into an Excel spreadsheet, given unique ID numbers for each survey, and included the source and date received. The possible options for each question were assigned a numeric value and then the choices made on the survey were entered into the spreadsheet by those values. Open-ended questions that required an alphanumeric response were entered directly as-is into the spreadsheet. Qualitative comments were also entered in the spreadsheet and analyzed separately for major themes.

Descriptive analysis of the survey was performed using SPSS. Simple frequencies were run on all of the questions in the database. This was done for all of the surveys entered into the database as a whole and then separately for each of the three occupations classifications (Ob/Gyn, Family Physician and Nurse/Nurse Practitioner). We performed chi square tests to compare provider occupations with select variables, such as primary practice setting, relationship with Medicaid CMOs, and experience with P4HB® enrollees.

#### ***3.12.5 Data “Mixing”***

An important step in mixed methods research is to prepare a clear approach to analyzing the different types of data together. This process is known as “mixing” the data and is the “explicit relating of the two data sets” (Creswell and Clark, 2007, pg. 83). There are several procedures for mixing qualitative and quantitative data; two data types can be merged, one can be embedded within the other, or they can be connected. For purposes of this study, we merged the data during the interpretation/analysis stage. This



mixing design is known as “triangulation.” Analysis of the data was performed concurrently and then merged during the final stages of analysis. Both data sets were given equal emphasis with the intent of drawing valid conclusions about the research problem (implementation of P4HB<sup>®</sup>) (Creswell and Clark, 2007). Triangulation is a well-known research strategy of combining “methodologies in the study of the same phenomenon” (Denzin, 1978, pg. 291). Using this approach in mixed methods research provides the opportunity for cross validation “when two or more distinct methods are found to be congruent and yield comparable data” (Jick, 1979, pg. 1). We present the findings from this triangulation in Chapter 7 and then discuss the implications for theory and policy development in the final chapter (Chapter 8) of the dissertation.

### **3.13 Rigor**

Ensuring rigor is equally important in qualitative research as it is in quantitative research. However, the approach to obtaining the validity of data and results differs for each type. In quantitative research, validity is obtained when a researcher can draw meaning inferences from the results to a specific population and consistently over time (Creswell and Clark, 2007). In qualitative research, rigor is derived from the researcher’s participation and involvement in the data collection process. The researcher’s presence is important as is the researcher’s interaction with the study participants (Merriam, 1995).

As noted above, one important approach we took to ensure the validity and reliability of our mixed methods was the process of triangulation. We employed not only methodological triangulation, which assess data from multiple data collection methods (interviews, focus groups, document reviews, provider surveys), but also data source triangulation in which several data sources (e.g., data from more than one person and

more than one point in time) was used to strengthen the finding (Lincoln and Guba, 1985; Patton, 2002).

Additional steps were taken to ensure the validity and reliability of the qualitative results. First, to strengthen internal validity, we used narrative member checks, or verbal summarizations, with all informants to verify authenticity with the information of the interpretation and analysis of the data (Richards, 2009). These member checks were conducted during and after each of the focus groups and informant interviews. Participants were also given the opportunity to request copies of the focus group or interview summaries. Second, summary reports were maintained after each interview and focus group and compared to the transcripts to assure accuracy of the data as well as conceptualization of emerging themes.

To address external validity, again a concept most commonly assigned to quantitative data, we focused on the “transferability” of the finding, or the ability of the findings to be “transferred” by the reader/user to his or own situation (Lincoln and Guba, 1985). In the case of Planning for Healthy Babies®, we were interested in whether our findings could be found transferable to other states with similar experiences, albeit, Medicaid family planning programs. Given this concern, two techniques were used to strengthen the transferability, or external validity, of the qualitative results. First, we findings from this research provide rich description of the study participants, data, and results that enable readers to determine how well these findings “transfer” to their own situation. (Krefting, 1991). Second, the use of multiple methods and triangulation strategies also provides for a systematic approach to the research that can be applied to similar settings (Slevin, 2000)

Finally, to address the reliability of the data, I produced an audit trail of my data collection methods and sources. Audit trails, first introduced by Lincoln and Guba (1985), are used to establish the “confirmability” of qualitative findings. Audit trails reflect the conceptual mapping of the logic of the researcher (Carcary, 2009; Cutcliffe and McKenna, 2004). Several sources of information were collected to inform the audit process, including 1) listing of all data collection methods (interviews, document review, focus groups, surveys); 2) summary notes of emerging themes; and 3) process notes, that included decisions made through the data collection and analysis stages.

### **3.14 Ethics**

As noted earlier, the study was approved by institutional review boards at Georgia State University (GSU), Georgia Tech University (GTU), Emory University, as well as DPH. These reviews were deemed necessary due to the academic institutions that are affiliated with the researcher’s dissertation work (GSU, GTU), and employment location (Emory University) where a majority of the interview and survey data were collected by telephone or fax. Since the researcher spoke with women who receive health care services at public health clinics and interviews public health providers, approval from DPH was also required.

Other ethical considerations were undertaken during the course of this study. Consent was obtained by all study participants before data were collected. Participants were also provided the opportunity to ask questions about the study, about their participation in the study, and to decline participation even after the data were collected. In addition, participants were offered the opportunity to be given copies of the completed,

de-identified transcripts, field note summaries, and future study publications. To assure anonymity, all interview and focus group participants were given pseudonyms to help protect their names and associations. Also because some informants, particularly state officials could potentially be identified through association, the researcher made special effort to generalize the identity of these informants and limit acknowledgement to the Medicaid or public health agency level.

### **3.15 Study Limitations**

Despite many attempts to ensure the rigor of the research, some study limitations should be acknowledged. First, this study presents the results of one Medicaid family planning waiver program. While we took steps to create transferability of these findings to other states with similar programs, this single state case study precludes necessarily broader generalization of other states' implementation experiences. Second, there are limits given that one researcher conducted all aspects of the study, including analysis of the data. While team-based approaches are often ideal in qualitative research, resources and time limitations prevented this from occurring. Because the researcher has extensive experience (17 years) as a health services researcher and more importantly, as a qualitative investigator, this helped off-set these concerns. The researcher also currently teach a course at Emory University's Rollins School of Public Health on qualitative methods for health services research. Third, there was a relatively low response rate from the provider surveys (15.2%). While this potentially reflects a small proportion of providers who can or do serve P4HB<sup>®</sup> clients, it can also introduce bias into the survey results. Low provider survey response is commonly addressed in the literature, which reflects several potential causes, such as lack of availability, lack of access to survey

methods (email, fax), and lack of interest (Sudman, 1985; Guadagnolie and Cunningham, 1986). Several methods are suggested for improving provider response rates to surveys, such as the use of monetary incentives (VanGeest, Johnson, Welch, 2007). However, due to resource limitations, incentives were not available for the provider surveys. However, as Templeton et al (1997) assert, a high response rate is not necessarily a prerequisite of a valid survey and efforts to increase the response rate may not always result in data that are more representative of the sampled population.

## **CHAPTER 4**

### **INFORMANT INTERVIEWS AND DOCUMENT REVIEW RESULTS**

#### **4.1 Overview**

This chapter presents the findings from the informant interviews and document review. As noted previously, the data collected from the interviews and document review were organized and analyzed separately. However, common themes emerged around key aspects of the implementation of Planning for Healthy Babies<sup>®</sup> (P4HB<sup>®</sup>). The first part of this chapter provides a description of the informants' characteristics. Then, key themes are presented from the informant interviews and includes relevant quotes that highlight these results. Next, the findings from the document review are presented. Examples are also provided from select documents to highlight the results. A final section of this chapter summarizes the key similarities and differences found between the two sources of qualitative data as they relate to findings on the implementation of P4HB<sup>®</sup>.

#### **4.2 Informant Characteristics**

A total of 21 interviews were conducted for this study with 24 informants. In three of the interviews, two informants participated. The informants represented state public health agencies, public and private providers, and women's health and maternal and child health advocates. Because this study focuses on the early adoption and implementation of P4HB<sup>®</sup>, specific recruitment occurred of informants who had knowledge and responsibility for these phases of the program. Also in an attempt to learn more about the current status of P4HB<sup>®</sup>, interviews were sought from health care

providers, which included local Title X staff, hospital based social workers, and a Resource Mother. Table 4 reflects the key characteristics of all 24 interview informants.

**Table 4: Key informant characteristics**

#	Informant	Professional/ agency affiliation	Knowledge Area				
			Policy Problem	Policy Planning	Pre-Implement- ation Program Development	Implement- ation	Barriers
<b>STATE REPRESENTATIVES</b>							
1	State rep. 1	DCH (DCH)	X	X	X	X	X
2	State rep. 2	DCH (DCH)		X		X	X
3	State rep. 3	DPH (Public Health)		X		X	X
4	State rep. 4	DPH (Public Health)		X	X	X	X
<b>ADVOCATES</b>							
5	Advocate 1	MCH organization	X	X			
6	Advocate 2	Women's health organization	X	X			X
7	Advocate 3	MCH organization	X	X	X	X	X
8	Advocate 4	Provider organization		X		X	X
9	Advocate 5	Provider organization	X	X		X	X
<b>PROVIDERS</b>							
10	Provider 1	Private physician	X	X			
11	Provider 2	Private physician	X	X		X	X
12	Provider 3	Title X provider				X	X
13	Provider 4	Title X provider				X	X
14	Provider 5	Title X provider				X	
15	Provider 6	Title X provider				X	X
16	Provider 7	Title X provider				X	X
17	Provider 8	Social worker				X	X
18	Provider 9	Social worker				X	X
19	Provider 10	Resource mother				X	
<b>CARE MANAGEMENT ORGANIZATIONS (CMOs)</b>							
20	CMO Rep 1	CMO 1	X	X	X	X	X
21	CMO Rep 2	CMO 2		X		X	X
22	CMO Rep 3	CMO 2		X		X	X
23	CMO Rep 4	CMO 3				X	X
24	CMO Rep 5	CMO 3				X	X

In addition to their general professional affiliation, Table 4 reflects the type of information the informant shared in the interview about P4HB<sup>®</sup>. While almost all informants were aware of the program, their understanding of the program differed, as their role in the policy implementation process. We captured this variability in several different “knowledge areas,” including 1) the policy problem: was the informant able to describe the purpose of P4HB<sup>®</sup> or the policy problem it was created to address?; 2) policy planning: was the informant involved in designing the program, obtaining funding for it, or developing any program or policy guidelines for P4HB<sup>®</sup>?; 3) Pre-Implementation Program Development: was the informant involved in writing the Section 1115 family planning waiver application or providing any assistance to DCH to prepare for the program’s implementation?; 4) Implementation: was the informant involved in assisting DCH with outreach and education about P4HB<sup>®</sup>? Were informants responsible for enrolling women in the program or providing any information about the program? 5) Barriers: did the informant provide any information or insight into the barriers of the implementation of P4HB<sup>®</sup>?

As an example, one informant, *Provider 1*, shared information on how the policy problem was identified and was involved in the planning of P4HB<sup>®</sup>. The informant, however, was not active in or knowledgeable about the pre-implementation program development or post-implementation of P4HB<sup>®</sup>. The informant exerted influence over how the program was conceptualized and to some degree, designed, but was not part of the process to prepare P4HB<sup>®</sup> for implementation. Provider 1 does not actively serve any P4HB<sup>®</sup> clients and was also not involved in implementing the program.



As reflected in the table, about one third of the informants (8/24) were involved in the identification of “the problem” associated with P4HB<sup>®</sup>. While the nature of the policy problem was reflected differently by some of these informants, the policy problem for which P4HB<sup>®</sup> was designed to address was identified as either: 1) the high rate of preterm births in Georgia; or 2) the lack of family planning and preconception care for low-income women in Georgia. Over half of the informants were involved in the policy planning of P4HB<sup>®</sup>. In 2009, the commissioner of DCH assembled a work group to discuss low birth weight rates in Georgia. Many state public health representatives, advocates, and providers, as well as CMOs participated in this work group, during which the early discussion of a waiver program began. Simultaneously, most of the advocates worked separately to secure funding in the legislature for the P4HB<sup>®</sup> program. Therefore, this policy planning included coalition building, interagency collaboration, as well as legislative lobbying for financing of the program. And, as discussed in more detail below, discussions were held about the design of P4HB<sup>®</sup>, its name, and how the provider network would be structured.

Only a handful (4/24) of informants maintained responsibility for pre-implementation program development. This stage of the implementation process included the development of the P4HB<sup>®</sup> Concept Paper, DCH Communications Plan, P4HB<sup>®</sup> program marketing and outreach materials, and data system development for purposes of enrollment. Nearly all informants, however, were involved and/or knowledgeable about the roll-out and implementation of the P4HB<sup>®</sup> program. Most informants discussed the outreach, enrollment, and utilization of P4HB<sup>®</sup> services that have occurred in the first year of the program. And all informants, whether they had explicit responsibility for the

implementation of P4HB<sup>®</sup> or not, provided insight into program barriers. These barriers addressed outreach/marketing, enrollment and service utilization.

### **4.3 Interview Themes**

#### ***4.3.1 Consensus in Defining the Policy Problem***

As described by a majority of the informants who were involved in the early part of P4HB<sup>®</sup>, the program was designed to address Georgia's increasing problem of low birth weight (LBW) deliveries. Beginning in 2008, the commissioner of the Department of Community Health (DCH) convened a group of advocates, public health and DCH officials, and providers to discuss strategies for reducing the state's LBW rates. This group, referred in various forms as the "process improvement initiative" and "low birth weight workgroup" sought to improve maternal and health care by reducing low birth weight deliveries. One DCH official added that an objective of this group was to figure out why there was a "time lapse" between women enrolled in Medicaid and accessing services." This informant viewed the problem as one of the lack of timely access to prenatal care that results in poor birth outcomes.

Soon after convening for the first time, the work group expanded their scope to address Georgia's low birth weight "problem," though this was never explicitly defined in the interviews. A DCH official explained that the members of the workgroup were charged with "coming up with a plan that could be implemented statewide to reduce Georgia's LBW rates." The group agreed that to reduce LBW rates, women needed to be healthy before they became pregnant and this should be worked on from the time "a woman was born until she became of childbearing age." A second priority was to make

sure women had babies that were wanted and planned and appropriately timed. A third priority for the group was to ensure early access to prenatal care. From this third concern came a specific element of the P4HB<sup>®</sup> program, known as the inter-pregnancy care (IPC) component, which is described below.

Even though the members of the workgroup, eight of whom were interviewed for this study, understood that reducing LBW rates was the main reason for the development of the program, several informants explained that they or their organization wanted the program to also address improving access to family planning services. One informant who represents a provider organization explained that her members experienced problems for years trying to provide family planning to women who delivered through the state's Medicaid pregnancy program, known as Right from the Start (RSM) Medicaid. When DCH began mandatory managed care enrollment of its beneficiaries in 2006, the informant explained that this problem became worse. Managed care "slowed the ability of the pregnant women to get to the obstetrician." This delay, often as long as 90 days, was never an issue under fee-for-service Medicaid. Since the care management organizations (CMO)s began managing DCH beneficiaries, many women were seeking services from their providers who didn't participate in managed care or were not part of the CMO women were assigned to, and so they experienced further delays in accessing a participating managed care provider. According to the informant, these delays often resulted in pregnancies because women delayed the onset of family planning. Therefore, improving family planning for low-income women was the main concern for several informants and their organizations. "Our objective was to be able to provide them (low-income women enrolled in the RSM program) with family planning, with birth control in

order to space pregnancies, in over to keep some contact with them between pregnancies.”

Another informant, a women’s health advocate, was asked to write a paper on causes of low birth weight for a local maternal and health organization. The paper was shared with the LBW workgroup, at which time the role of family planning access was discussed and eventually incorporated into the P4HB<sup>®</sup> program. In light of an effort in the late 1990s to institute a family planning waiver, many DCH officials were hesitant to address family planning again separately as a health care program. This informant believed that couching family planning as one of the strategies to reduce LBW rates in Georgia was better received by members of the workgroup and ultimately by the legislature (more information below).

#### ***4.3.2 Resistance to Waiver as Policy Solution***

Despite consensus among the LBW workgroup to focus on a strategy for reducing LBW rates in the state, there was not an apparent agreement on how this strategy should be configured. Several informants suggested that the idea of a Section 1115 Medicaid family planning waiver was conceptualized by advocates who presented the proposal to DCH officials, who initially rejected it. One advocate said that there was “pushback” from DCH out of concerns that the Georgia legislature would not support it financially. Another informant, a state agency representative, also remembers resistance from DCH about the development of a Medicaid family planning waiver. This informant explained that DCH was most concerned about funding the program and getting financial as well as

political support from the legislature. Another informant explicitly denies the role of DCH in the concept of P4HB<sup>®</sup>. This informant stated

*this was not a DCH idea..it was not a priority for DCH..it was a grass roots push..it was not on the front burner for DCH...DCH said we will not fund this program unless you get the dollars in the budget.*

An interesting finding from the interviews was that once the LBW workgroup agreed on the waiver concept, differences emerged about who developed the program. The state representative mentioned above credits the director of a maternal and child health organization as the lead “in the development of the concept of the program.” Although this informant later explains that most of the advocates were “pushed aside” once policy planning began on P4HB<sup>®</sup>, this director who advocated for funding in the legislature was “the point person” on the development of P4HB<sup>®</sup>. Another advocate, who represents a provider organization in Georgia, also credits this director who “did the heavy lifting and helped write the waiver for DCH.” Ironically, in the interview with this director, the informant describes DCH as having “developed the program.”

#### **4.3.3 Funding and Legislative Support**

All informants who were knowledgeable about the early phases of the development of P4HB<sup>®</sup> acknowledged the importance of gaining legislative support and funding for P4HB<sup>®</sup>. This process was described as occurring over one year, with advocates taking the major responsibility for lobbying certain members of the legislature, explaining the benefits of a waiver program for reducing LBW rates in Georgia, and gaining legislative support. The legislature eventually agreed to provide initial support of \$25,000 in state administrative funds for the writing of the CMS Medicaid family

planning waiver application. This funding was matched with state expenditures in 2009, while additional funding was allocated in 2010 for the state's share of the waiver's first-year expenses (\$225,000). One advocate explained the importance of securing this funding from the legislature:

*It was almost a little bit of the Wizard of Oz with the broom because you know well, we needed to get it in the budget, you know we need to get money, because what's the point of going through this exercise of the waiver application if we're not going to be able to get it funded by the legislature.*

Many advocates worked together to lobby Georgia's legislators. These advocates provided the legislators with a lot of information explaining the potential benefits of the waiver program, the costs of LBW deliveries, the number of unintended pregnancies in the state, and the potential cost-savings of the proposed waiver programs. One advocate said "the legislature understood that if the waiver could prevent 50% of unintended pregnancies that would eventually be paid for by DCH, this would save money."

There were different opinions about whether legislators expressed concern for a program designed to address family planning. One state agency representative who wrote the CMS waiver application explained there was concern that the legislature would not support the program due to the family planning waiver program failure in the 1990s but also because of the connection of P4HB® to family planning. "A family planning waiver may not have been supported as much as a program to reduce Georgia's low birth weight rates." Another advocate agreed that caution was necessary when discussing family planning with the legislature. "Family planning in the state had a bad connotation.(due to ...its associated with abortion and so you had to educate folks about the word, family planning and that it did not mean, absolutely had nothing to do with the word abortion."

This informant's tactic, when lobbying for P4HB<sup>®</sup>, was to explain "from a business perspective of how this (program) will save money..you have to come at it from a different perspective and you have to have the Republicans buy in." Another advocate explained how legislative support for the waiver was obtained. "It really flew under the radar and the reason it flew under the radar was because it was called "Planning for Healthy Babies<sup>®</sup> and it didn't say anything about family planning."

Other informants do not remember such a struggle with the legislature; that in fact, several members of Georgia's legislature were in favor of P4HB<sup>®</sup>. One advocate said that the then-Chairman of the Health Subcommittee of Appropriations was an early ally and supporter of the waiver. This informant said the Chairman wrote a line item in the budget that was 'vague enough' for people not to ask too many questions about the waiver. The Chairman also discussed the waiver 'behind closed doors' and kept the waiver discussions "close to the vest." Another advocate who led the legislative effort to gain funding for the waiver explained that this Chairman was "very sympathetic" with the idea of the waiver program. He asked her to provide data to support the cost savings of the waiver program, which had to be "budget neutral," meaning it would not cost the state more money with the program than without it. In fact, he wanted proof of how the waiver program would save money through unintended pregnancies and through getting women into health care early in their pregnancies.

#### ***4.3.4 Lack of Transparency in P4HB<sup>®</sup> Program Design***

Despite the extensive role that advocates played in the LBW work group and lobbying Georgia's legislature for financial support of P4HB<sup>®</sup>, most described being

excluded from the policy planning phase of the program. Informants learned that a DCH official who was part of the LBW work group was going to apply for a CMS waiver that would, if approved, give the state authority to implement the program. None of the informants, excluding one state agency representative, was included in the development of the waiver application. A “concept paper” was produced prior to this application, which many informants did not read until it was posted on DCH’s website. One advocate explained “we (the advocates) all asked to be involved, but we were not involved.”

The DCH official in charge of the concept paper, the precursor to the CMS application, said the paper was written “based on the LBW workgroup’s recommendations.” This official’s account of this process was that there was a lot of input provided by members of this group and a lot of discussion of the different components that would make up the P4HB<sup>®</sup> program. The official also describes hearing a presentation made by an OBGYN who several years earlier had piloted an inter-pregnancy care program at Grady hospital that provided 24 months of resource mother and primary care services for DCH women delivering a low-birth weight baby. This DCH official explicitly modeled the IPC component of P4HB<sup>®</sup> from this pilot project but limited it to very low birth weight (VLBW) deliveries in order to comply with the waiver’s budget neutrality requirement. This OBGYN was interviewed for the study and was disappointed to find that the IPC component was not organized through public health departments, as recommended to the DCH official. The provider explained “it’s the public health district level (nurse or doctor) that first interacts with a woman and has the power to influence her maternal and child health outcomes. So it was natural to have the program be a part of the health districts.”



Other informants expressed frustration at the way in which P4HB<sup>®</sup> was described in the concept paper and CMS waiver application. Two representatives of provider organizations and one state agency representative who took part in the LBW work group advocated for Title X family planning clinics and county health departments to be explicit providers of care in this new program. Another provider organization representative believed there was a great deal of animosity over the lack of public health representation in the waiver program. This informant was even asked by a public health representative if the informant's organization was "responsible for having Title X omitted from the waiver application." There was a perception that the DCH favored the private providers over the public health providers (Title X in particular) and also that the CMOs, which had already been managing DCH clients, were the only ones to be able to provide input into the waiver application.

One advocate was very disappointed to read in the waiver application that public health providers were "taken out" of the listed providers of care for the program. Another advocate felt that there was not enough leadership within the Department of Public Health to advocate for their Title X and community health providers. This advocate admits to being "hung up on my little thing" about including public health departments as an integral part of the waiver. The advocate remembers speaking with Title X representatives and DCH officials about this issue. "Why would you not do that when you're already providing the services and again a lot of those women..you know like 80% of the women who go to the health departments would have been eligible."

In addition to concerns involving public health and Title X providers, informants expressed concern to DCH about the lack of presumptive eligibility, exclusion of teens,

and limited family planning services in P4HB®. Presumptive eligibility allows patients to be “presumptively eligible” for Medicaid and services to be provided at the time of application, while a final determination is made of their eligibility. Two providers in this study expected presumptive eligibility to be included in the waiver program, just as it is a part of the RSM program. One provider wished teens had been included because there are a number of adolescents, particularly in rural areas of Georgia, younger than 18 who have pre-term and LBW births. Finally, two informants were hopeful that P4HB® would include more gynecologic care, for women who have polycystic ovarian syndrome (POS) and other fertility difficulties. Indeed these services are excluded, and as noted in Chapter 5, was a topic of concern raised by several current P4HB® clients.

#### ***4.3.5 Implementation Time Constraints***

The P4HB® waiver application received official approval from CMS on October 29, 2010, approximately nine months after DCH submitted the initial application. From a Medicaid waiver perspective, this approval process was quick. States have been known to wait years to receive approval for such demonstration programs. Indeed, Georgia’s own attempt to receive a Section 1115 waiver for Medicaid HIV services failed in the early 2000s after CMS took two years to review the application. So from an administrative perspective, the federal approval for P4HB® occurred rather quickly.

Several informants considered this quick timeframe as a hindrance to effective implementation of the program. One CMO representative discussed the difficulty the plan encountered during the time it were expected to prepare for the implementation of P4HB®. The CMO representative described this time as “very intense.” With just a few

months to prepare, the health plan had to develop a lot of new materials, including member cards, brochures, provider guidelines, etc. The CMO representative described P4HB<sup>®</sup> as a “new product...a lot of new things had to be created that impacted all areas.” Although the informant acknowledges being kept informed of the waiver’s status during 2010, the plans worked initially to “cobrand” the P4HB<sup>®</sup> program materials. DCH also provided templates for many of their materials. Later, in the summer of 2012, the CMOs were given permission to develop separate materials that allowed them to tailor these materials to their plan’s design scheme and layout.

The DCH official interviewed for this study who wrote the waiver discussed all the moving parts that were in place before and after CMS approval to prepare for the waiver. Early on, in summer of 2010, the official assembled the DCH communications team and data systems team to prepare for P4HB<sup>®</sup>. The communications team developed the application forms, letters flyers, posters, and report templates. This official describes being concerned mostly with the MMIS system (Medicaid Management Information System) which was undergoing a transformation in the state that would not be “live” until November 1, 2010, only two months before P4HB<sup>®</sup> was to be implemented. As a precaution, the official had a separate enrollment and billing system created just for P4HB<sup>®</sup> that would not interfere with the new MMIS system’s implementation. Also, DCH had to revise their existing contract with each of the CMOs to reflect the plans’ responsibilities for this new program. These final contracts were not submitted until after the CMS approval was received. The DCH official also acknowledges that outreach to the public about P4HB<sup>®</sup> did not occur until after the waiver was approved.

When asked why the implementation of P4HB<sup>®</sup> was not postponed or delayed since so little time existed between the waiver's approval and the implementation (October 29, 2010-January 1, 2011), the DCH official explained that there was too much money at stake. The total budget for P4HBv, with state and federal funds, was \$2 million just for the first 6 months of the program (until the end of the 2010-2011 fiscal year, which is June 30<sup>th</sup>). This funding, or at least part of it, would have been forfeited if the program's implementation was delayed. The official stated "I couldn't afford failure at that point."

#### ***4.3.6 Outreach and Education Barriers***

The biggest concern of almost every informant for this research was the lack of outreach and education about P4HB<sup>®</sup>. These informants cite the lack of appropriate and continual outreach about P4HB<sup>®</sup> as the main reason enrollment and utilization of services has been low. Informants felt that there has not been enough outreach to the public as well as providers about the program. Furthermore, they expressed concern that there is (still) a lack of available information about the scope of services included in the program, the amount of documentation required for enrollment, and the different components of the P4HB<sup>®</sup> program. The barriers identified in the interviews are grouped according to three categories: 1) RSM client outreach; 2) IPC outreach; 3) Provider outreach; 4) General outreach.

RSM Client Outreach: Four out of the five public health providers explained problems with outreach to RSM clients who may be eligible for P4HB<sup>®</sup>. One provider in the Atlanta area who works in a large county health department, has not seen one IPC

enrolled member in the 18 months of the program. This provider thinks DCH “has not done a good job of telling pregnant women in RSM about the program.” She has also noticed that RSM clients who are auto enrolled in P4HB<sup>®</sup> are not aware of their status. In December 2011, DCH began auto-enrolling RSM and Peach Care clients into the program. RSM clients were supposed to be notified in their 8<sup>th</sup> month of pregnancy and again after delivery that they are going to be enrolled in P4HB<sup>®</sup>. The provider wished DCH had done “intense marketing, you know really making sure that whoever and wherever the woman had the opportunity to seek services and get services.”

A CMO representative also worries that women enrolled in P4HB<sup>®</sup> from RSM are not aware of the program. She used a car analogy to describe this confusion: “Women in RSM who are used to the fully loaded option of DCH services are given the car “with no sunroof, a basic radio, and rolled up windows...these women are used to the full flush of benefits under their previous plan and now this plan is more limited.” In addition, women don’t know they are in the program or what services are covered.

IPC outreach: Several informants were worried that women are not being enrolled in the inter-pregnancy care component (IPC) of P4HB<sup>®</sup> due to the lack of patient and provider outreach. One state agency representative thinks that hospital Neonatal Intensive Care Units (NICUs) should have received more training about the program from DCH. The representative feels that these are the locations where most women are located who deliver a VLBW baby. The representative further explained that DPH has contractual relationships with regional perinatal centers, where most of these births occur, these relationships should be explored more and outreach provided on a continual basis. One provider also voiced this concern and has been actively working to provide outreach and

education to Atlanta-area NICUs. The provider has also approached DCH to develop a web-based training for perinatal centers and NICUs throughout the state.

Interestingly, the interview with the Resource Mother revealed a lack of understanding about the IPC component as well. This informant did not know that P4HB<sup>®</sup> women she assists are in a special component of the program that provides access to primary care services. She described her role as providing support to women after they deliver a LBW baby and informing them that they are eligible for family planning. She acknowledged that she works with a case manager who may assist women with accessing medical care. The two social workers interviewed for this study also expressed confusion over the nature of IPC. One social worker who works in a NICU in an Atlanta-area hospital is responsible for contacting women in the hospital after delivery and informing them about P4HB<sup>®</sup>. She had never heard of the Resource Mother services and simply tells women P4HB<sup>®</sup> is a health care program for women who deliver a pre-term baby. Once a woman applied, she hands off the follow-up responsibilities to a hospital case worker. Another social worker who works in an Atlanta-area NICU was only told about P4HB<sup>®</sup> in June 2012, 18 months after the program began. She has worked in the NICU for 4 years. Therefore, there is a lack of information about IPC mainly due to the lack of outreach to appropriate providers.

Provider outreach: Representatives of both the provider organizations as well as some of the providers interviewed for this study described a delay in learning about P4HB<sup>®</sup>. One informant who represents a provider organization in Georgia explains that despite meetings with DCH after the waiver was approved, there was still a lot of confusion about how providers were going to enroll eligible clients, what services were

covered, and how billing of these clients is supposed to occur. The informant indicated that several attempts to get such answers from DCH were fruitless. As a result, the provider organization developed their own outreach materials, which included provider newsletters and a blast fax. This organization still fields questions from providers about the enrollment and billing issues. Another provider organization representative said “our doctors don’t know about this..their patients don’t know about this.” She has joined another provider organization to approach DCH about their concerns about the lack of outreach. This organization has also asked a provider who is knowledgeable about P4HB<sup>®</sup> to do presentations at their physician meetings.

Among the five public health providers interviewed for this study, a majority (3) were informed about the P4HB<sup>®</sup> program in early January 2011 at a women’s health coordinators meeting. At this meeting, they were told that women at their clinics may be eligible for P4HB<sup>®</sup> and were told to distribute flyers to eligible clients. At this time, they were expressly told NOT to assist with enrollment. This mandate later changed, as described below. Only two of the informants knew the program included the IPC component. All providers were aware (and concerned) that eligible women could possibly choose a private physician, and therefore, P4HB<sup>®</sup> would have a negative impact on the Title X program by taking away clients.

General outreach: Comments were made throughout many of the interviews about the overall lack of marketing and outreach about the P4HB<sup>®</sup>. One advocate explained, “I don’t think it was ever effectively marketed. Now everyone’s pointing fingers, like well, you’re not doing your job, we don’t get the information you’re supposed to be providing.” This provider thinks DCH should have done more marketing,

and that other agencies, such as Women Infants Children (WIC), and the Department of Family and Children Services (DFACS) should have been responsible for more outreach.

Several informants explained that their concern about outreach was voiced early to DCH before the waiver application was completed. One state agency representative who was familiar with other state's family planning waivers, recommended to DCH that outreach be a billable service. An advocate voiced this same request to DCH because she knew that "then you're going to have more likelihood of outreach activities occurring to ensure enrollment utilization." This informant was so passionate about the outreach that she felt it was her primary duty to:

*to keep a focus on including outreach as a component of the waiver. One of the things I have learned from DCH consultants that I had spoken with is that it is actually one of the most important things to include in any waiver..and so almost every meeting ,actually every meeting I asked about that..and I was told that yes, you know...and the truth is it (the waiver application) didn't include outreach, which I think is a big problem.*

DCH and CMO representatives described many marketing and educational efforts undertaken to advertise P4HB<sup>®</sup> once the waiver was approved in October 2010. The DCH representative felt that the LBW workgroup was kept well informed during the time the DCH was waiting to receive approval from CMS about P4HB<sup>®</sup>. This DCH official asked these members to spread the word about the program, and specifically asked the CMOs to begin working on their outreach materials. Once the waiver was approved, DCH released a press release and ordered radio and TV ads to be placed throughout the state about P4HB<sup>®</sup>.

DCH also secured funding from the Department of Public Health to conduct marketing for P4HB<sup>®</sup>. DCH "reached out to public health early on and they had agreed to



provide us with funding to market the program.” This funding was discussed prior to the waiver’s approval for the amount of \$150,000. The marketing costs for the first six months totaled \$50,000, with the remaining marketing costs spent before the end of 2011. There were no more funds secured for the continuation of outreach for P4HB<sup>®</sup> beyond the first year. Several informants felt this should have occurred, and that additional and continuous marketing about P4HB<sup>®</sup> is needed. As one state agency representative put it, “especially with a short-term program like this, I think marketing should be something that’d one continuously, ongoing, and then in a mass media format.”

Two of the three CMOs representatives interviewed for this study explained that outreach continue to be conducted for eligible members and providers. One CMO representative described the plan’s current outreach plan as a “no stone unturned” approach. Even though the CMO now has 10,000 P4HB<sup>®</sup> clients due to the auto enrollment process, only 25% of these are using services, so educational efforts are being made to inform these current members to increase utilization. A second CMO representative explained that the plan is currently reviewing several strategies to increase enrollment. They have so few IPC enrolled members, that their particular focus is on how to educate more providers and patients about this component of P4HB<sup>®</sup>.

#### ***4.3.7 Enrollment barriers***

All informants reported that there have been barriers to enrolling women in P4HB<sup>®</sup>. These barriers have caused a delay in women enrolling in P4HB<sup>®</sup> and accessing P4HB<sup>®</sup> covered services. These barriers are associated with the following issues: 1) lack

of awareness and understanding about the program; 2) burdensome documentation requirements; and 3) lack of presumptive eligibility.

As noted above, there remains a lack of awareness and understanding about P4HB<sup>®</sup>. One provider said there is little outreach to providers or women about P4HB<sup>®</sup>. She also thinks Title X providers aren't doing enough to enroll clients. "I think that it (P4HB<sup>®</sup>) has been perceived as a threat to them and that they were perceiving it as "oh this mean women come to us and we'll lose head count." The public health providers interviewed for this research have been providing information to their eligible clients about P4HB<sup>®</sup>. As one public health provider stated "anyone we think might be eligible, we try and get them on the program" However, initially public health departments were instructed only to hand out brochures and flyers to eligible clients. Then, about nine months into the first year of P4HB<sup>®</sup>, when DCH realized few women were enrolled in the program, public health departments were asked to take a more active role in assisting women to enroll in the program. All public health departments now provide women P4HB<sup>®</sup> applications and instruct them about how to complete the application process. Only two of the four public health providers interviewed for this study, however, fax completed applications to DCH for eligible clients. The other providers tell women they must either fax their applications, seek assistance through local welfare offices, or complete the P4HB<sup>®</sup> application process online.

Representatives from all three CMOs acknowledged that the lack of awareness and understanding about P4HB<sup>®</sup> is a problem and critical barrier to enrolling more women into the program. One CMO representative indicated that enrollment of IPC women is the plan's main challenge. Even though the plan has instituted more on-site

outreach and education at area hospitals, women are still not electing to enroll. These women “are not concerned about applying for a program that could possibly stop them, prevent them from having another pregnancy. They’re more concerned about the health of their baby at that time.” Another CMO representative echoed the same concern. This informant thinks women who are eligible for the IPC component have “competing priorities..they have a preemie that they’re dealing with. They have all sorts of family and social issues that they are dealing with.” She confessed that her health plan is still trying to find a way to make more eligible women aware of P4HB<sup>®</sup> and the IPC component and the value this new program offers them. The low IPC enrollment is a concern for another provider who feels that IPC enrollment be coordinated through NICU and perinatal health centers, while women are in the hospital and before they are discharged.

Burdensome documentation requirements: This barrier was most commonly identified by providers who have helped women enroll in P4HB<sup>®</sup>. One representative of a public health department complained about the amount of paperwork women have to provide in order to apply for P4HB<sup>®</sup>. This informant explained that women are required to provide original copies of their driver’s license and birth certificate, as well as copies of paystubs. Many women do not have these documents handy, and women complain about having to travel to multiple locations to get copies of the documents.

Transportation is a major problem for this population, and due to these barriers, women often don’t come back to complete their P4HB<sup>®</sup> applications. Public health department providers also complained that initially they were not allowed to verify women’s documents (birth certificate, driver’s license). It wasn’t until the end of 2011 that DCH decided to allow these representatives to verify the documentation, which allowed for an

easier and faster enrollment process. One social worker interviewed for this study helps women apply for the IPC component. She revealed that the IPC applications are often delayed because of the requirement to have the OBGYN sign off on the paperwork that verifies the woman's VLBW delivery. This informant says that she wished the hospital and DCH data systems could "speak to one another, because all the information is already there" to verify this information.

Lack of Presumptive Eligibility: As noted above, several informants who were included in early discussions of P4HB<sup>®</sup> expressed the desire to include presumptive eligibility in the enrollment process. As one public health clinic provider explained, being able to make a client presumptively eligible for P4HB<sup>®</sup> at the time of her initial appointment would allow the enrollment process to "speed up" but also could give the clinic the ability to be reimbursed for the services. Public health cannot be reimbursed retroactively for services provided to women who are eventually enrolled in P4HB<sup>®</sup>. So essentially, public health clinics have to incur the costs, with their Title X money, for that initial set of services, which may include pregnancy testing and/or an annual exam. Among the informants who advocated for presumptive eligibility, many could not understand why this option was available to women enrolled in RSM but not P4HB<sup>®</sup>. One provider thought DCH decided not to seek presumptive eligibility because CMS was opposed to it. However, in an interview with a DCH official about this issue, presumptive eligibility "means that you receive services under the Fee-for-Service side. And since we had already structured this, that everything happens with the CMOs, we couldn't have fee-for-service." Therefore, due to the earlier decision to structure the P4HB<sup>®</sup> program entirely through the CMO network, presumptive eligibility was not possible.

Beginning in December 2011, after DCH realized that enrollment in P4HB<sup>®</sup> was lower than anticipated, the program began auto-enrolling certain categories of DCH eligible clients into the program. That month, eligible women in RSM and Peach Care were auto enrolled in P4HB<sup>®</sup>. For RSM clients, eligibility ends 60 days post-partum. These women are notified in their eighth month of pregnancy and again one month post-partum about their auto enrollment in P4HB<sup>®</sup>. Women are mailed letters from DCH and given the option to opt-out of the P4HB<sup>®</sup> program. For women in Peach Care who are about to “age out” of the program (turn 18), similar letters are now sent to women a few months before their eligibility ends. In May 2012, 18 months after P4HB<sup>®</sup> began, auto enrollment of IPC also took place. Many informants were pleased to learn that this auto enrollment process was occurring, including one advocate who said “I thought that was a smart thing to do.” Many informants, however are concerned about utilization. As discussed below, utilization of P4HB<sup>®</sup> services has been low, and many attribute this low utilization due to the lack of understanding and awareness about the program.

#### ***4.3.8 Service utilization barriers***

A majority of the informants felt that P4HB<sup>®</sup> is underperforming as a program because women are not being enrolled and thus not accessing the covered services. As one informant stated, “Medicaid simply thought, ‘if you build it, they will come...well, they haven’t come.” Some informants indicated that even participants who are enrolled in P4HB<sup>®</sup> are not using the services, which several feared is because these participants do not know they are enrolled in the program or do not understand what services are covered in the program. As identified earlier, many informants feel that there is a lot of confusion

about the nature and scope of P4HB<sup>®</sup>, that it markets a false identity as a maternal and child health or “healthy babies” program and that women do not know that it provides family planning and inter-pregnancy care services. One informant stated that the name Planning for Healthy Babies<sup>®</sup> is “awful.” Originally the name discussed for the program was “Family Planning for Healthy Babies,” but for political reasons the term ‘family planning was omitted.” The informant further stated “we believe it (the name) is deceptive in terms of people who don’t want to be pregnant...why would they ever think I need to enroll in a program called “Planning for Healthy Babies<sup>®</sup>.’?”

A couple of public health providers explained how the confusion over the name of the program has led to delay in utilization of services. One public health provider mentioned that several clients were approached about applying for P4HB<sup>®</sup> but declined, stating “they’re not interested in NOT having babies.” So there is a population of women who do not want to postpone their pregnancies, that do want to have a baby. Another public health provider echoed a similar problem, that women come to her clinic already enrolled in P4HB<sup>®</sup>. These women come in for pregnancy testing, most already knowing they are pregnant, and then have to be disenrolled from P4HB<sup>®</sup> after their pregnancy test is positive. “There’s a good many women that are coming in who think it is just for not planning and spacing their babies, but to help them have a healthy baby.” Therefore, these women think P4HB<sup>®</sup> is for women who are pregnant.

In addition to confusion over the name and scope of the P4HB<sup>®</sup> program, several providers reported that very few P4HB<sup>®</sup> women sought health care during the first year of implementation. One public health provider indicated she only began to see P4HB<sup>®</sup> clients at her clinic in June 2012, 18 months after the implementation of the program.

Another public health provider feels that perhaps P4HB<sup>®</sup> clients switched initially to seeing private health care providers the first year, and then after being unhappy with their care or simply not having the same kind of relationship with their private physician as they did with their public health nurse, that these clients then came back to public health, but after the first year of P4HB<sup>®</sup>.

Informants shared many other concerns about the coverage of services under P4HB<sup>®</sup>. Informants from two public health clinic described the problem of not being able to provide services to clients who were accepted into P4HB<sup>®</sup> but not yet assigned to a CMO. In these situations, though women can receive services, the clinic will not be reimbursed by Medicaid, so they have to use their public health (Title X) funds for such services. One public health clinic provider complained that follow-up services to an abnormal pap is not covered under the program, so women must either pay out of pocket for a biopsy or ultrasound, or the clinic has to find other funding to pay for the P4HB<sup>®</sup> client's diagnostic service. This provider also wished the program paid for other related services, such as lab tests (blood and urine) and calcium pills, which are prescribed for women who take Depo as their birth control. Another provider who works with IPC women explained that sterilization is a problem for these women. IPC women do not know that if they get a tubal ligation while enrolled in P4HB<sup>®</sup>, that their eligibility will then be terminated. The provider feels that women should be kept in this component of P4HB<sup>®</sup> to promote overall women's health. She also feels that providers do not understand how to code for P4HB<sup>®</sup> services, and therefore, the low utilization rates may reflect errors in coding on behalf of the participating providers. Coding was identified

early in the P4HB<sup>®</sup> implementation process as a concern that many providers felt and still feel is a hindrance to successful utilization of the program.

A few informants have worried that the Resource Mother services have not been well executed under the IPC component of P4HB<sup>®</sup>. One provider was concerned about the nature of the Resource Mother-client interaction when it was first described to the LBW work group. The provider did not feel that a telephone-based Resource Mother system was a good way to maintain contact with the new mothers. According to the Resource Mother interviewed for this study, she makes two attempts to follow up with IPC eligible women if they refuse her services. If after the second attempt to contact the woman by phone, the woman still refuses to enroll in P4HB<sup>®</sup>, the Resource Mother terminates the client from her roster. Another informant was concerned about the type of person the CMOs would hire as Resource Mothers. Indeed, CMOs have each hired Resource Mothers with different professional backgrounds: one CMO has hired former DFACS workers as Resource Mothers, another CMO uses social workers, and a third CMO uses nurses.

Two informants expressed concern about the lack of IPC enrollment and utilization. One of these informants knew that few IPC women were enrolled in the first year. This informant said that original estimates of IPC enrollment was supposed to be 120 (per quarter), and while he did not know that only 27 IPC were enrolled in the first year, the informant knew the real numbers “were nowhere near” the 120 per quarter estimate. The other informant, an advocate, heard that 20 women had been enrolled in IPC in the first year. This informant wanted to “understand what are the reasons for not enrolling..not utilizing” these services.



Informants also expressed concern that the lack of provider understanding of the program may result in low utilization of services. As one informant stated, while auto enrollment has been a positive step toward improving enrollment into P4HB<sup>®</sup>, “if our providers don’t know anything about the program, how are they going to encourage women to seek services.” One advocate feels that DCH should have an advisory board that consists of providers who can learn more about the program but also provide input about the problems they are facing with enrolling and serving women in the program. This advocate felt strongly about engaging providers in order to improve the P4HB<sup>®</sup> program. Finally, one state agency representative cautioned against using enrollment as a measure of success for P4HB<sup>®</sup>. This representative is concerned that with the auto enrollment of women into P4HB<sup>®</sup>, that this was going to be used by DCH to show the program has been a success. “Utilization needs to be the measure of the program, not enrollment. It is standard for other programs to use enrollment or referrals as measures of a program’s success...but it is not.”

#### **4.4 Summary of Informant Interviews**

The informant interviews provided useful information about how P4HB<sup>®</sup> was conceptualized, designed, and implemented. It appears that many stakeholders, including advocates, providers, and DPH and DCH officials initially collaborated to develop the idea for a Section 1115 Medicaid family planning waiver program. This program, which became Planning for Healthy Babies<sup>®</sup> (P4HB<sup>®</sup>), was designed by consensus with precise and clear objectives, to reduce the state’s VLBW rates and to increase access to family planning services for low-income, uninsured women. What is also apparent through these interviews is that DCH maintained control of P4HB<sup>®</sup>, by making all decisions in the

implementation process, such as maintaining the CMO managed care system for P4HB<sup>®</sup> enrollees and excluding presumptive eligibility.

The implementation process followed the traditional top-down approach as reflected in Mazmanian and Sabatier's framework. Once the goals and objectives of P4HB<sup>®</sup> were elucidated and formalized through the Concept Paper, they were operationalized through the CMS waiver application and provider and client materials. In addition, the interviews reflect that several elements of statutory coherence were maintained, as there was an initial allocation of financial resources through the state legislature, and early integration within the implementing agencies, namely the CMOs. It is less clear whether public health providers were well integrated or whether these providers had a clear understanding of the program objectives. So we could not positively determine if there was evidence of causal linkages between DCH and these implementers. We feel more certain that formal access by outsiders (advocates, providers) was not achieved, as these informants expressly attempted to maintain contact with DCH about their concerns regarding P4HB<sup>®</sup>. Such access was denied and therefore we can assume they are not able to provide any oversight or feedback to the state about P4HB<sup>®</sup>.

Finally, the informant interviews provided important insight into the issues of health care access. We learned that the characteristics of the health care system were viewed as less than ideal, particularly among the public health providers and key advocates. These informants expressed concern that providers were not readily available to P4HB<sup>®</sup> clients and that many, including private providers, were not aware and properly educated about the nature and scope of the program. We also gained an

awareness, qualitatively, that utilization of P4HB<sup>®</sup> services has been low in the first year, and that many barriers also exist to enrollment utilization. These issues were also addressed in our document review as discuss below. Overall, the informant interviews provided us rich qualitative information about the policy implementation process and helped us to incorporate our theoretical framework regarding policy implementation.

#### **4.5 Document Review Results**

To further explore the implementation of P4HB<sup>®</sup>, we reviewed many documents pertaining to this program. Documents included P4HB<sup>®</sup> authorizing legislation, appropriations and funding documents, policy and program guidelines, marketing materials and budget, as well as provider guidelines posted on DCH and the CMOs' websites. Additionally, we reviewed promotional materials, such as the P4HB<sup>®</sup> flyer and postcard, as well as the P4HB<sup>®</sup> application. Most recently, the 2011 P4HB<sup>®</sup> Annual Report submitted by DCH to CMS was reviewed for information about the activities undertaken in the first year of the program. As noted in Chapter 3, we used a standard reporting form to review each document that allowed for descriptive information to be gathered on several major topics: 1) Defining “the problem”; 2) P4HB<sup>®</sup> stated goals and objectives; 3) Program design; 4) Implementation processes; 5) Access and Utilization; and 6) Barriers. We summarize our findings for each of these topics below.

##### ***4.5.1. Defining the Problem***

P4HB<sup>®</sup> was sanctioned by a broad grant of authority by the Medicaid program, as administered by DCH. As provided by Section 1115 of the Social Security Act, states can

exercise flexibility in their current Medicaid programs if authorized by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Upon approval from CMS in October 2010, P4HB<sup>®</sup> was incorporated into the DCH Medicaid regulations as one type of the many Medicaid “classes of assistance” (DCH, 2012).

According to this statute’s (2196) policy statement,

*Planning for Health Babies (P4HB<sup>®</sup>) is a Medicaid program that offers family planning services for eligible women in Georgia between the ages of 18 and 44. This program is effective January 1, 2011.*

It is important to note that this statement omits any reference to low birth weight or inter-pregnancy care, which as discussed previously, is the impetus for P4HB<sup>®</sup> and a core focus of the “policy problem.” We do not find specific reference to inter-pregnancy care or the reason for P4HB<sup>®</sup> until the background information provided in the statute. In this section of the regulation, Planning for Healthy Babies<sup>®</sup> is described as:

*a five year demonstration waiver (1115) that covers family planning services to women ages 18 through 44 who are at or below 200% FPL, not otherwise covered by insurance (including Medicare), and not receiving coverage under another Medicaid category. P4HB<sup>®</sup> also covers inter-pregnancy care (IPC) services, including primary care case management, for eligible women who have delivered a very low birth weight baby (VLBW) AS OF January 1, 2011. The primary goals of the P4HB<sup>®</sup> program are to reduce Georgia’s low birth weight (less than 2500 grams or 5 lbs. 8 oz) and very low birth weight (less than 1500 grams or 3 lbs. 5 oz) rates; reduce the number of unintended and high risk pregnancies in Georgia; and to reduce Medicaid costs by reducing the number of unintended pregnancies.*

It is noteworthy that the program is described as a five year program (it was only authorized for three years), and that there is no mention of resource mother services, although “case management” is listed. Also this statute states that reducing LBW is a

primary goal, which was later changed via Medicaid policy guidelines due to the high cost of including these women. So, overall, the statute reflects some inaccurate information. We cannot view this legal tool as having precise and clear objectives.

In addition to the statute, the DCH Concept Paper describes the “policy problem” for which P4HB<sup>®</sup> serves to address. As noted earlier, this paper was written by a Medicaid official to describe the P4HB<sup>®</sup> after recommendations were made by the LBW work group to create a strategy to reduce low birth weight rates in Georgia. The Concept Paper, which is 13 pages, was submitted by DCH to CMS before a formal Section 1115 waiver was filed. This paper includes information that defines the problem of low birth weight and very low birth weight in Georgia. According to the first page of this document, “The Planning for Healthy Babies<sup>®</sup> Program (P4HB<sup>®</sup>) is an 1115 Demonstration Waiver Program borne out of Georgia’s desire to reduce its low birth weight rate (birth weight less than 2500 grams).” The paper also presents information about the planning that occurred with the LBW work group to address low birth weight rates in Georgia, and it also mentions the Grady project that piloted a similar program in the early 2000s. This document provides clear and concisely worded information about the purpose of P4HB<sup>®</sup> and the problem that it aims to solve. However, there is no mention of family planning or the role that access to such services might play in solving the problem of low birth weight deliveries. Also, as noted earlier, due to concerns by CMS about budget neutrality, DCH narrowed the scope of P4HB<sup>®</sup> to focus only on very low birth weight deliveries.

Two additional documents provide information about the nature of the policy problem inherent in the P4HB<sup>®</sup> program. In December 2010, DCH issued a press release that described P4HB<sup>®</sup> as

*...designed to improve Georgia's very low birth weight (VLBW) and low birth weight (LBW) rates. It is the country's first 1115 Demonstration waiver to place particular focus on reducing LBW rates. According to 2007 birth data, the Kaiser Family Foundation ranked Georgia as 38th in the nation (out of 51 – DC was ranked equivalent to a state) in the number of LBW births. (DCH, 2010)*

While this press release is available on the DCH website, (<http://dch.georgia.gov/press-releases/2012-11-07/dch-launches-new-family-planning-program>), it appears that it was forwarded by the CMOs to their providers in early January 2011, after the program had been implemented. It is not clear how this press release was made available to eligible P4HB<sup>®</sup> clients. The Concept Paper described above, is also posted on the DCH website.<sup>1</sup> A second document created for the marketing of P4HB<sup>®</sup> also provides information about the “LBW Problem.” In the November 2010 “Plan for Baby” Communications Plan, low birth weight is described as the main reason for the waiver program. “Guided by its mission, in April 2009, DCH identified Georgia’s poor national standing relative to low birth weight (LBW) rates and initiated a collaborative effort to reduce the state’s LBW rate from 9.5% to 8.6% over the next five years.” This document is interesting, because it clearly states the goals for reducing the LBW rates in Georgia as well as timeframe for the program (five years, although CMS only allowed 3 years for the program, due to the onset of health reform in 2014).

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[http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit\\_1210/33/52/156793595PlanningforHealthyBabiesProgram121709Final.pdf](http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/33/52/156793595PlanningforHealthyBabiesProgram121709Final.pdf).

These are the only documents we found that explicitly present a public explanation for the policy problem inherent in the formulation of P4HB<sup>®</sup>. As described below, however, there are several documents that describe the program's objectives.

#### **4.5.2 Program Goals and Objectives**

The goals and objectives of P4HB<sup>®</sup> are stated in several documents. The earliest available document that reflected the program's goals is the DCH Concept Paper. In this document, P4HB<sup>®</sup> is described as having three main goal:

- 1) *Primary*: Reduce Georgia's low birth weight and very low birth weight rates
- 2) *Secondary*: Reduce the number of unintended pregnancies in Georgia
- 3) *Tertiary*: Reduce Georgia's Medicaid costs by reducing the number of unintended pregnancies in women who otherwise would be eligible for Medicaid pregnancy related services.

Further objectives of the P4HB<sup>®</sup> program are also stated in this document. These objectives include:

- 1) Improve access to family planning services by extending eligibility for family planning services to all women aged 18 – 44 years who are at or below 200% of the federal poverty level (FPL) during the five year term of the demonstration.
- 2) Provide access to inter-pregnancy primary care health services for eligible women who have previously delivered a very low birth weight infant.
- 3) Decrease unintended and high-risk pregnancies among Medicaid eligible women
- 4) Decrease late teen pregnancies by reducing the number of repeat teen births among Medicaid eligible women
- 5) Decrease the number of Medicaid-paid deliveries beginning in the second year of the project, thereby reducing annual pregnancy-related expenditures.
- 6) Increase child spacing intervals through effective contraceptive use to foster reduced low birth weight rates and improved health status of women
- 7) Increase consistent use of contraceptive methods by incorporating care coordination and patient-directed counseling into family planning visits
- 8) Increase family planning utilization among Medicaid eligible women by using an outreach and public awareness program designed with input from family planning patients and providers as well as women who are in need of services but who are not receiving them.
- 9) Estimate the overall savings in Medicaid spending attributable to this project.

In its 2011 Annual Report to CMS, DCH summarized the program's major objectives into five main goals: 1) to reduce Georgia's low birth weight (LB) and VLBW rates; 2) reduce the number of unintended pregnancies in Georgia; 3) reduce Georgia's Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services; 4) provide access to IPC health services for eligible women who have previously delivered a VLBW infant; and 5) increase child spacing intervals through effective contraceptive use. It is unclear why certain earlier program objectives, such as reducing late teen pregnancies and increasing consistent use of contraception, were eliminated and whether they were no longer major goals of P4HB<sup>®</sup>. These goals are also absent from current DCH P4HB<sup>®</sup> program information that is provided on the DCH website ([www.P4HB<sup>®</sup>.org/static/GeneralInfo.aspx](http://www.P4HB.org/static/GeneralInfo.aspx)). It is also interesting to note that the most recent goals stated in the Annual Report specifically mention the IPC component, which is not referenced in the earlier DCH Concept Paper.

Other documents that provide insight into the program's goals and objectives include: the 2010 Communications Plan, 2010 CMS Special Terms and Conditions (STCs), DCH Provider Outreach Plan, and CMO provider updates available on the plans' websites. Among these sources, the goals and objectives vary somewhat. The CMS STCs and DCH Provider Outreach Plan list access to IPC health services and increasing child spacing intervals through effective contraceptive use as major goals of the program. However, these goals are not consistently messaged in other materials. The CMO provider outreach materials do not list IPC services. In fact, in the Well Care Press Release, P4HB<sup>®</sup> is described as a family planning program.



“Planning for Healthy Babies<sup>®</sup> (P4HB<sup>®</sup>) will offer family planning services to women who previously did not qualify for Medicaid benefits. P4HB<sup>®</sup> begins in January 2011.” There is no mention of inter-pregnancy care services or the types of family planning service that are provided.

So despite a few opportunities to describe the “policy problem,” DCH depicts the program’s goals and objectives in various ways in its materials. Also, it appears that CMOs did not describe P4HB<sup>®</sup> accurately, at least at the start of the program’s implementation. There is no mention of the IPC component or focus on reducing Georgia’s low birth weight rates.

#### ***4.5.3 Program Design***

Most P4HB<sup>®</sup> materials provide a general description of the core design elements of the program. These documents, including the Concept Paper, Communications Plan, CMS P4HB<sup>®</sup> STCs, and provider outreach plan, also describe the program’s eligibility criteria and general scope of covered services (Family planning, inter-pregnancy care). In addition, these materials also describe the provider network from which eligible participants may seek services. Namely, the materials, such as the Concept Paper, specifies that “P4HB<sup>®</sup> program participants will be allowed to select a care managed organization (CMO) with its affiliated provider network to provide family planning and inter-pregnancy care services.” This document does not list the specific services available to eligible participants, but it does provide a list of service costs in the appendix. In the Communications Plan, however, a list of services is provided. This list explains that family planning exam, contraception, STD test, sterilization, multivitamins, and select immunizations for 19 and 20 year olds are included. This Plan also provides a

list of covered inter-pregnancy care services, such as primary care, management of chronic disease, substance abuse treatment, case management/Resource mother, dental, and certain prescription drugs. The DCH CMO contract also provides a list of covered services, as does the CMS STCs.

At some point during the first year of the implementation of P4HB<sup>®</sup>, DCH gave each component of the program (family planning, inter-pregnancy care, and Resource Mother-only) a special name. The FP component was called the “Purple Card” program, the IPC called the “Pink Card” program, and the RM-only component, the “Yellow Card” program. These terms show up in the CMO provider guidelines as well as in the provider surveys that were administered toward the end of 2011 and early 2012. Even the Medicaid statute (2196) reflects “three classes of services” as FP, IPC, and RM services. This design element was not incorporated, however, into any of the client outreach or marketing materials. This includes the P4HB<sup>®</sup> postcard, poster, and application. So while internally, among providers and state officials the P4HB<sup>®</sup> has such labeling, these terms are not known to women. This finding was confirmed in the focus groups and provider interviews, as none of the study participants had heard of such terms related to P4HB<sup>®</sup>. In 2012, as provider handbooks were updated, CMO materials made specific reference to the color coded P4HB<sup>®</sup> cards that participants are provided to reflect which type of P4HB<sup>®</sup> coverage they have.

#### ***4.5.4 Implementation Process***

There are many documents that describe the outreach and enrollment process for P4HB<sup>®</sup>. The Concept Paper was the first P4HB<sup>®</sup> document to describe the enrollment

process. This document explains that eligible women will be enrolled “through the DCH Enrollment Process administered by the Georgia Department of Human Services. Point of service enrollment will not be utilized.” Therefore, the document explains that Medicaid affiliated enrollment brokers will be used and that presumptive eligibility (otherwise known as point-of-service) is not an option in the program. In the Medicaid statute, the enrollment process is described in detail, including where applications are to be made available (at DFACS and public health offices) and how applications should be submitted (by DCAFS to PSI), or through the P4HB® online system. In these documents, the eligibility criteria for each component of the program is also explicitly stated.

The client brochures and post cards also provide information about how to apply online or where to pick up applications if preferable (public health departments and DFCS offices). Only the P4HB® application provides detailed information about the documentation that is required for application (proof of income, child support. This document also asks applicants to describe their pregnancy status, history of preterm births, health insurance status, and citizenship status.

Outreach efforts are described in the statute, Provider Outreach Plan, and CMO provider materials. These documents describe different elements of the outreach, however. For instance, the Medicaid statute details the outreach that is provided RSM enrollees during their pregnancy and includes information about the post cards and letters that are sent to these eligible women. The Provider Outreach Plan indicates that each CMO will “outreach to its provider network to build their P4HB® provider network.” No further information is given, however, about how this outreach is defined and will be provided. The November 2010 Communications Plan provides the first details of the

P4HB® marketing plan, and is described in two phases. The first phase includes production of postcards and posters, as well as paid radio ads to be conducted over five weeks. A second marketing phase provides funds for billboards and all health districts and bus and train advertisements over the course of six months. Additionally, this document reflects a five phase marketing strategy of outreach and education to providers, CMOs, and consumers. This marketing strategy later develops into the P4HB® Communications Plan, which is followed and reported on in each of the P4HB® quarterly reports to CMS. DCH provides detailed information about how each phase of this marketing strategy was employed and what strategies are still ongoing.

#### **4.5.5 Access and Utilization**

In the 2009 Concept Paper, data were provided that reflected estimated enrollment in P4HB.® According to this document, the eligible population in Georgia is 276,548 women and is based on 2007 Georgia Population Survey data. The Paper then assumes that 50% of this population will enroll, and of these women, only 50% will utilize P4HB® covered services. The Paper cites the South Carolina Family Planning Waiver as support for this estimation. Interestingly, the document also provides estimates for first, second, and third year enrollment and utilization, citing data provided by the Department of Public Health (DPH). For the first year, which the document states has typically low usage (1.5-2%), DPH data indicates that 40% of eligible women will enroll and 30% will use waiver services. Therefore, approximately 110,620 women will enroll and 33,186 will use services (DCH, 2009; pg. 7). The document later identified about 244 low birth weight deliveries per year. However, this document does not explicitly estimate how

many of these mothers of LBW babies will enroll in the IPC component of the program. The document does, however, provide estimates of how many births will be averted through the implementation of this program and uses Pregnancy Risk Assessment and Monitoring System (PRAMS) data to provide these estimates. The estimation reflects the number of births from an unwanted or mistimed pregnancy that results from not using birth control at the time of pregnancy. In the first year, the number of projected births that would be averted is 2,571.

According to a review of the DCH P4HB<sup>®</sup> quarterly reports for 2011 and the DCH Annual Report, actual enrollment and service utilization fell short of the estimates provided initially in the Concept Paper. As the Annual Report states, while the number of women deemed eligible for the FP component grew steadily in the first year, from 3,000 to over 21,000 women, “only 7,566 women or 6.8% of the 110, 620 women projected to be enrolled were actually enrolled” (pg. ii). The number of women deemed eligible for the IPC component also grew during the first year, but at a slower pace, from 0 to 19 women. All 19 women were enrolled in the IPC component of P4HB<sup>®</sup>. Despite “multiple engagement efforts,” the FP enrollment data represents about 5.3% of the eligible population and the IPC enrollment figures are only 1% of the expected population. The Annual Report, and quarterly reports too, acknowledge the need for enhanced provider and patient outreach.

The CMOs conducted two client and provider surveys during the first 18 months of the program. Findings from the client (or member) surveys suggest that P4HB<sup>®</sup> provides most women the opportunity to access primary care services (54%) and birth control and family planning services. Clients also reported that P4HB<sup>®</sup> has allowed them

to use access preventive care, such as Pap smears and family planning counseling (83%), wider choice of birth control methods (49%), and access family planning at no cost (54%). Members also describe learning about P4HB<sup>®</sup> through word of mouth from health department staff or at WIC offices (28%), and from mailings (22%).

Provider responses to the survey indicated some uncertainty about the nature of the program as well as the eligibility criteria and scope of covered services. Only 61% (38 out of 62 survey respondents) knew about P4HB<sup>®</sup>. Among these providers, most learned about the program from their contracted CMO. Also a majority of these participating providers (79%, or 30 out of the 28 respondents) provided some type of covered service to P4HB<sup>®</sup> clients. However, only seven of these 30 respondents knew the service was explicitly covered as a P4HB<sup>®</sup> service, suggesting there is some uncertainty of the program and its scope of services.

Utilization data were first reported in the quarterly reports to CMS by using CMO participation rates. In the first Quarterly Report, data indicated that while 45 FP participants were enrolled (total), only 19 of these enrollees utilized P4HB<sup>®</sup> covered services. There were no IPC enrollees in this first quarter. The Quarterly Report identified several potential barriers to enrollment (delays in the application procedures), but not in the low utilization rates. By June 2011, the enrollment jumped significantly across all three CMOs, to 1,249 women. Active participation, however, fell short again to about 50% utilization of services. One CMO, however, indicated that its utilization rate was 100%, which was later considered to be a reporting error. IPC enrollment was also still delayed by this time, with only 2 enrollees. This second Quarterly Report also

indicates that CMOs were still hiring Resource Mothers, so it is likely that CMOs were not prepared for this component of the program.

By the 3rd Quarterly report, enrollment of FP clients into P4HB<sup>®</sup> had jumped to 1,898 women total in the FP (1,892) and IPC (6) components. As noted, however, this was a third of the women deemed eligible. Also only 56% of these women were enrolled in a CMO, indicating a delay in women choosing or being assigned to the CMO. As a result, active participation/utilization of P4HB<sup>®</sup> fell short in the third quarter, to only 39%. So despite improvements in enrollment, the implementation of P4HB<sup>®</sup> was delayed in large part to difficulties in the CMO selection process. Outreach and education to provides continued through this period, and RSM Outreach workers were used to advertise the P4HB<sup>®</sup> at multiple health fairs and community events through the state.

Interestingly, starting in the 4<sup>th</sup> Quarterly Report, utilization/participation data were no longer reported by DCH. Instead, only the eligibility and enrollment data were provided. By December 2011, 20, 185 women were deemed eligible for P4HB<sup>®</sup>, but only 7,403 actually enrolled in a CMO. Of those enrolled, 21 were enrolled in the IPC component. This Quarterly Report finds that delays existed in the program eligibility determination process and CMO selection process. As a results, the Report explains that auto-enrollment of FP women began in early December to facilitate enrollment of women in RSM and Peach Care.

#### **4.5.6 Barriers**

The only barriers described in this review of documents are those found in the DCH Quarterly Reports and 2011 Annual Report. As stated above, the barriers include

enrollment, CMO selection, and Resource Mother services, as well as lack of understanding of the program and its scope of services. In the Annual Report, data are provided about the delays in applications received by DCH for P4HB<sup>®</sup>. According to this document, the average number of days from application to referral to a RSM outreach worker for processing the initial application increased from 12.5 days in January 2011 to 16.4 days in December 2011. The Annual Report suggests several reasons for these delays: 1) women's provision of required documentation; verification of documents by designated agencies, women's selection of a CMO, and communication of that selection to the Medicaid agency, and administrative processing of the application and enrollment. As noted earlier, DCH changed its policy towards the end of 2011 to allow public health providers the capability to verify certain documents to assist with the application process.

Findings from the client surveys suggest several barriers to P4HB<sup>®</sup>. The three most prevalent problems experienced by P4HB<sup>®</sup> clients were not getting the family planning services they needed (22%), not getting the referrals or follow-up care that was needed (18%), and not being able to find a doctor or nurse willing to take P4HB<sup>®</sup>. Provider responses also denote certain barriers to the program, including a lack of understanding about program eligibility (40%) and a lack of covered services (range of 23-44% providers answered correctly about P4HB<sup>®</sup> scope of services). Providers also expressed concern that there were certain major barriers for P4HB<sup>®</sup> participation, including that the program does not cover the full scope of family planning services (13%), does not cover referrals or follow-up care (19%) and does not cover complications of family planning services (17%).



#### **4.6 Summary of Document Review Results**

A review of key policy and program documents provide useful information about the design and implementation of P4HB. We learned that several guidelines were developed to describe the program, but these descriptions varied in both the content of the information and ways in which the information was provided. We also note that the DCH Concept Paper, rather than the Medicaid statute appears to be the main legal document that guided the development and implementation of P4HB. We also learned that certain enabling factors, including provider availability and enrollment processes, influence the implementation process. Lack of provider understanding about the program and cumbersome application procedures may have resulted in low enrollment and service utilization. These barriers were noted in particular in the P4HB evaluation reports (DCH quarterly reports and 2011 Annual report), which also suggested strategies for overcoming these barriers (e.g., enhancing consumer and provider outreach).

#### **4.7 Summary of All Results**

Findings from these qualitative components of the research reflect important information about the implementation of Planning for Healthy Babies<sup>®</sup> (P4HB<sup>®</sup>). Informant interviews explored how P4HB<sup>®</sup> was conceptualized, designed, and implemented. The document review reflected not only the planning process inherent in P4HB<sup>®</sup>, but also provided explicit data on the goals and objectives of the program, utilization, and barriers to implementation. Enrollment and utilization of P4HB<sup>®</sup> services were a major topic explored through both approaches and deemed to be a vital part of the implementation of the program. Informants reported that enrollment has been low in

P4HB<sup>®</sup> and thus eligible women have not utilized the services covered through the program. Many informant worried that P4HB<sup>®</sup> would not be effective because of these barriers. DCH Quarterly Reports and the 2011 Annual Report supported this finding and reflect lower-than-anticipated enrollment and utilization of P4HB<sup>®</sup> services, particularly for IPC eligible participants.

Outreach and marketing of P4HB<sup>®</sup> are topics where there was much less consensus among these two investigations. Overall, informants were troubled by the lack of outreach and education pertaining to P4HB<sup>®</sup>, especially among providers and current enrollees. Many of these study participants felt that the lack of enrollment and service utilization for P4HB<sup>®</sup> is due explicitly to the poor marketing and outreach efforts. While informants claimed that these concerns were expressed initially to DCH officials, the outreach and education has not improved. Providers remain confused about the program and its scope of services, and eligible women simply don't know the program or are confused that the program is for pregnancy, not family planning or inter-pregnancy care.

The documents reviewed for this research describe the program's outreach and marketing efforts, and suggest that this has occurred in part throughout the first year of the program. It is important to note that the marketing budget for the first year of the program was expended before the end of the year, and thus outreach and education seems to be now taken on solely by the CMOs and to some extent, RSM outreach workers. Further information about the nature and content of these outreach efforts is not described in available documents and not described elsewhere in the documents reviewed for this study. Therefore, enhanced outreach may be needed and supported directly by DCH to both providers and consumers.

Finally, it should be noted that there appears to be a lack of public health and specifically Title X engagement in the implementation of P4HB<sup>®</sup>. This concern is reflected in the interviews as well as the lack of collaboration noted in the P4HB<sup>®</sup> documents. While public health departments are noted in certain outreach materials as places to obtain P4HB<sup>®</sup> applications, further public health engagement is not noted. One public health agency representative interviewed for this study feels that more collaboration is needed among public health and DCH to enhance the implementation of P4HB<sup>®</sup>. This informant suggested an advisory council would be good way to engage public health providers and officials in finding solutions to the low enrollment and poor outreach about the program. This cross-agency collaboration can be more successful “because you have those who serve the client who have a better understanding of how this could be administered and have a better buy-in to the program.”

#### **4.8 Summary of Chapter**

This chapter provides the first set of data to explore the implementation of P4HB<sup>®</sup>. Through a qualitative lens, the factors important to implementation were examined. Informants shared their experiences with the conceptualization, design, and implementation of the program. Documents provided guidance about the program’s goals and objectives, design, and implementation. In Chapter 5, findings from the focus groups are presented. These data provide important insight into enrollment, service utilization, and overall awareness of P4HB<sup>®</sup> as experienced by prospective and current enrollees.

## **CHAPTER 5**

### **FOCUS GROUP RESULTS**

#### **5.1 Overview**

This chapter presents findings from the focus groups that were held with current and prospective P4HB<sup>®</sup> enrollees. As noted in Chapter 3, the major goal of these focus groups was to understand from current P4HB<sup>®</sup> clients how they learned about the program, were enrolled, and what kinds of services they were able to access. A secondary goal was to assess whether P4HB<sup>®</sup> clients had any positive or negative experience in the program. A third and final goal of the focus groups was to hear from women who were eligible but not enrolled in P4HB<sup>®</sup>.

The chapter begins with a description of the participant characteristics. Then a brief of summary of the findings is presented, followed by a discussion of the results. Finally, the chapter concludes with a list of recommendations provided by the focus group participants.

#### **5.2 Participant Characteristics**

A total of 49 women participated in the focus groups. As shown in Table 5, the mean age of the participants was 24, and the majority (71.5%) had some college education. Most of the participants were African American (73.5%), and about one fifth was Caucasian (20.4%). The majority of the participants had some type of public insurance (61.2%), while about one third had no insurance (36.7%).

<b>Table 5: of Focus Group Participants (N=49)</b>	<b>N (%)</b>
<b>Age</b>	
Mean	24
Range	16-40
<b>Highest level of education attained</b>	
Less than HS/High School Graduate	14 (28.6)
Some College/College Graduate	35 (71.4)
<b>Race/ethnicity</b>	
Asian	3 (6.1)
Black/African-American	36 (73.5)
Caucasian/White	10 (20.4)
<b>Insurance status</b>	
Private	1 (2.0)
Public	30 (61.2)
None	18 (36.7)
<b>P4HB® Enrollment Status</b>	
Enrolled in P4HB®	37 (75.5)
Not Enrolled in P4HB®	12 (24.5)
<b>Length of P4HB® Enrollment</b>	
Mean	6.5 Months
Range	1-12 Months
<b>IPC-enrollment</b>	
Yes	2 (5.4)
No	35 (94.6)

A large majority of the participants (75.5%) were enrolled in P4HB®, with a mean enrollment of 6.5 month. Of those not enrolled in P4HB®, several reasons were given, such as not being aware of the program, not eligible due to high income, or already being insured. Only 2 of the 49 participants appeared to be enrolled in IPC.

Participants were asked to describe how they learned about P4HB®. As shown in Table 6, almost equally, the focus group participants learned about the program either from someone at the focus group clinic or from Medicaid (37.8% vs. 32.4%

respectively). For those who learned about P4HB<sup>®</sup> from Medicaid, it is likely these were women who transitioned from either the Peach Care program or Right from the Start Medicaid (RSM Medicaid). Some women who may have been auto enrolled only found out about being in P4HB<sup>®</sup> after receiving a card or at the time of seeking family planning, while other women remembered receiving information about their eligibility for P4HB<sup>®</sup>. The focus group participants also learned about P4HB<sup>®</sup> from family member (18.9%), from staff at other clinics or provider offices (13.5%) and saw P4HB<sup>®</sup> advertisements (13.5%).

<b>Table 6: P4HB<sup>®</sup> Outreach and Education</b>	<b>N (%)</b>
<b>Informed about P4HB<sup>®</sup> &amp; Enrollment</b>	
Told and Enrolled	30 (61.2)
Told and Not Enrolled	7 (14.3)
Not Told and Enrolled	7 (14.3)
Not Told and Not Enrolled	5 (10.2)
<b>Source of P4HB<sup>®</sup> Information</b>	
From someone at this clinic	14 (37.8)
From someone at another clinic or doctor's	5 (13.5)
From Medicaid (DCH)	12 (32.4)
From Public Health (DPH)	2 (5.4)
From a family member	7 (18.9)
Saw advertising	5 (13.5)
Other	3 (8.1)

Interestingly, while a majority of the women enrolled after they were told about P4HB<sup>®</sup> (61.2%), some chose not to enroll after being informed about the program (14.3%). The qualitative information gathered from the focus groups suggests women were unclear about the purpose of the program or about how to enroll. One woman responded “I want to have more children, just not at this time” as her reason for not enrolling in P4HB<sup>®</sup>, suggesting she thought P4HB<sup>®</sup> was a program aimed at pregnancy.

Another woman did not enroll because she also receives family planning services at the health department and did not feel it was necessary to enroll in P4HB<sup>®</sup>.

Some focus group participants indicated they were not told about P4HB<sup>®</sup> but still got enrolled. They did not find out they were enrolled until they received the flyer about the focus group from their CMO. These women could also have been auto enrolled from Peach Care or RSM Medicaid, but did not receive any information about their enrollment or did not fully understand they were being enrolled into a new Medicaid program. At the end of 2011, the Department of Community Health began auto-enrolling Peach Care and RSM Medicaid beneficiaries into P4HB<sup>®</sup>. The discussions from the focus group often raised a lot of questions about the differences between Peach Care, RSM Medicaid, and “regular Medicaid.” Women often did not understand they did not have access to all health care services, and only after learning from their health care provider that they were allowed access only to family planning services, did they learn that they were in P4HB<sup>®</sup>.

In terms of use of family planning services, about two-thirds of the participants (67%) use publicly funded health clinics for family planning services, while 28.6% use private providers (see Table 7). Of the services P4HB<sup>®</sup> clients access through the program, most (75.7%) receive birth control, while about half receive STD testing (51.4%) and their annual exams (51.4%), which include pap smears and clinical breast exams. A little less than half (45.9%) of the P4HB<sup>®</sup> clients reported getting a pregnancy test while on the program. And finally, a large majority of P4HB<sup>®</sup> enrolled clients (88.5%) have not experienced a change in family planning services since being on the program.

<b>Table 7: Utilization of Family Planning Services</b>		<b>N(%)</b>
<b>Location for family planning services</b>		
Public Provider		33 (67.3)
Private Provider		13 (26.5)
No Previous/Unknown		3 (6.1)
<b>Type of family planning services received</b>		
Birth Control		28 (75.7)
STD Testing		19 (51.4)
Annual Exams (Pap, Breast, etc.)		19 (51.4)
Pregnancy Testing		17 (45.9)
<b>Changes in family planning services since</b>		
Yes		3 (11.5)
No		23 (88.5)

### 5.3 Summary of Findings

The focus group participants described a variety of experiences with Planning for Healthy Babies Program<sup>®</sup> (P4HB<sup>®</sup>). Of the women who knew they were enrolled in P4HB<sup>®</sup> or were in the process of being enrolled, these experiences were deemed overall positive, because women were able to obtain needed family planning services. In addition, women were pleased that they did not have to pay out of pocket for their family planning services, and enrollees were appreciative of the ability to choose a provider, either at the public health clinic or at a private OBGYN. Women who were not in P4HB<sup>®</sup> or who did not know about the program expressed a desire to know more about the program.

Despite the positive experiences of the P4HB<sup>®</sup> enrollees, they experienced several barriers to enrollment and lacked appropriate information about the scope of services covered in P4HB<sup>®</sup>. Some women were frustrated by the amount of paperwork that was required for enrollment, and the level of documentation that was necessary to prove their income and child support status. Delays were often reported in the application process



due to these documentation requirements, with some women experiencing delays of six months or longer. Women were confused about the types of services covered in P4HB<sup>®</sup>, with most being surprised that the program is limited to family planning services. Many women believed the program was full-scope Medicaid. Several women thought P4HB<sup>®</sup> included dental care. Five women in the focus groups reported seeking ultrasounds, due to complications from fibroids, or ovarian cysts. Three were denied coverage of this service through P4HB<sup>®</sup>. Also, participants expressed frustration with their CMOs, specifically trying to contact them to learn more about P4HB<sup>®</sup> and/or their eligibility status.

Public health clinics provide outreach and enrollment assistance for most of these P4HB<sup>®</sup> clients. Of the P4HB<sup>®</sup> enrolled participants, a majority learned about P4HB<sup>®</sup> from a clinic worker who also helped them start their enrollment process. About a third of the participants received information from Medicaid about P4HB<sup>®</sup>, either due to being enrolled at the time in Peach Care or Right from the Start Medicaid. Even though some P4HB<sup>®</sup> clients use private OBGYNs, a majority come to a health department for family planning because it is familiar to them and where they have always gone for family planning services. Having this continuity of care was important to many of the participants.

Participants also expressed confusion over the name of P4HB<sup>®</sup>. Women often associated the name “Planning for Healthy Babies Program<sup>®</sup>” as a program aimed at women with children. Whether they were current enrollees or not, some women thought the program either focused on helping women get pregnant or helping them with well-baby care. These participants expressed such beliefs when they viewed P4HB<sup>®</sup>

promotional materials, such as postcards and flyers, which included pictures of pregnant women and women holding babies.

In the following, we provide more in-depth information about the focus group results. This chapter ends with a summary of recommendations about how to improve P4HB<sup>®</sup>.

## **5.4 Outreach Findings**

### ***5.4.1 Source of Knowledge and Awareness about P4HB<sup>®</sup>***

Findings from the focus groups suggest that outreach about P4HB<sup>®</sup> occurs mainly through word of mouth. A majority of the focus group participants were told about P4HB<sup>®</sup> either by a health clinic worker or by someone they know, such as a family member or friend. Many women found out about P4HB<sup>®</sup> at the clinic when they came in for their children's WIC or health services, or to get on birth control. About two-thirds of the participants access family planning services at public health clinics, therefore, this presented the first opportunity to learn about P4HB<sup>®</sup>. About a quarter of the participants, however, had not enrolled in P4HB<sup>®</sup> and had not heard about the program. Therefore, outreach and education even at public health clinics is limited.

### ***5.4.2 Information through P4HB<sup>®</sup> materials***

About a third of the enrolled P4HB<sup>®</sup> participants reported receiving some materials in the mail from Medicaid about P4HB<sup>®</sup>, but this was most often while they were pregnant or had just delivered their babies. Most of these women did not understand what the materials discussed and therefore threw them away. One woman, "Ilena,"<sup>19</sup>,

from northwest Georgia, received materials about P4HB<sup>®</sup> while enrolled in RSM Medicaid during her pregnancy. “I thought it was through maybe WIC like because I got WIC or something here at the Health Department. I, I’m not sure. It doesn’t say.” Only a handful of women who received P4HB<sup>®</sup> materials in the mail decided to apply for the program. And in a few cases, women understood they could choose not to respond to the mailings and they would be automatically enrolled. This was the case with “Rebecca,”<sup>26</sup>, Atlanta, who said she was just too busy after the birth of her daughter to respond to the P4HB<sup>®</sup> mailing. After finding out she was automatically enrolled, she said “cool, I thought it was great.”

#### **5.4.3 P4HB<sup>®</sup> advertisements**

In about three cases, women heard about P4HB<sup>®</sup> from advertisements. One woman, “Autumn,”<sup>27</sup>, Atlanta, heard a radio commercial on V-103 and remembered that the ad said she could get free birth control through P4HB<sup>®</sup>. So she Goggled the name and proceeded to enroll online for the program. “Gia”,<sup>25</sup>, Atlanta, saw flyers and brochures about P4HB<sup>®</sup> at a health fair located at a local welfare office in Clayton county. She went home and applied online. “Veronica,”<sup>30</sup>, Atlanta, learned about P4HB<sup>®</sup> after attending a health fair at a Fulton county library. She picked up the promotional materials and also proceeded to apply for the program online.

#### **5.4.4 General thoughts about P4HB<sup>®</sup> outreach**

Women expressed doubt that outreach about P4HB<sup>®</sup> is targeting other eligible women. Additionally, participants felt that women who use private doctors or who do not access public health clinics are not being told about P4HB<sup>®</sup>. One woman, “Pamela,”<sup>30</sup>,

from northwest Georgia, said most of her friends don't know about P4HB<sup>®</sup> "because they go to a private doctor. You know for sure they're not going to tell them. ...they (the doctors) want the money." Another woman, "Olivia," 24, also from northwest Georgia, expressed a similar feeling . "I think the doctors do know but they're not going to tell them because they're going to be losing their money. That's what I think. That's what I get from it."

## **5.5 Enrollment/Renewal Findings**

### **5.5.1 Location and process of enrollment**

As stated previously, three-quarters of the focus group participants were current P4HB<sup>®</sup> enrollees. Most of these participants enrolled after being told about the program from health care clinic staff, friends, or family members. Most women started their application online or at the health clinic with the assistance of a staff member. Three participants described applying at a local DFACS office. One woman, "Teresa," 39, Atlanta first learned about the program and received help in enrolling from the health navigator at her son's daycare.

*I leaned on the health navigator when I didn't understand and I had a problem, she faxed all my stuff, she went through and made sure I had everything, she faxed it through, she kept asking me well have you heard anything back, have you heard anything back. So she stayed on top of it.*

It appears that about some participants (approximately 14.3%) might have been auto-enrolled after eligibility for Peach Care or RSM Medicaid ended. Many women described finding out they were enrolled in P4HB<sup>®</sup> after seeking services at their provider's office or receiving a card in the mail. These women were surprised and often

confused about being on P4HB<sup>®</sup> and were not sure whether or not they received information about the program before being auto-enrolled. One woman, “Patricia,” 19, from Atlanta, describes her surprise finding out she was auto enrolled after losing Peach Care.

*They just sent mine in the mail and I didn't really know what it was...I called them (Medicaid) on the phone and you just want to know what's going on why are they sending me a card that I don't know about. I thought it was a scam at first.*

Another young woman, “Beverly,” 19, from Atlanta, indicated she did receive information prior to the auto enrollment. “ I just kept getting mails(sic) from the, the Planning for Healthy Babies Program<sup>®</sup> telling me that I'm eligible and that I'm in the program and things like that but then I wasn't really sure. And then I think they sent me a card.” So whether these women received information prior to the auto enrollment process, it is clear that they did not understand the program or exactly what the enrollment process meant.

Women in two separate Atlanta focus groups appeared to be enrolled in the IPC component of P4HB<sup>®</sup>. Both women who delivered very low birth weight infants were enrolled in the hospital after their delivery. “Quintessa,” 23, Atlanta, was told about P4HB<sup>®</sup> by her midwife who also helped her start the application process. She was enrolled by the next month without any problems. “Yvette,” 38, Atlanta however, was not sure how she enrolled or who helped her. She received a P4HB<sup>®</sup> card in the mail after her delivery and then several months later, was sent a letter from Medicaid apologizing that she had been enrolled in the wrong program and appeared to be switched to the Family Planning (FP) component. “Yvette” lost her baby after 5 months, and was asked by Medicaid to fax a copy of the baby's death record. So it is likely that P4HB<sup>®</sup>

switched her from the IPC component to FP, however “Yvette” was very confused about this process and what services she was entitled to.

### **5.5.2 Documentation requirements for enrollment**

While the overall enrollment process went smoothly for the focus group participants, several women expressed concern about the documentation requirements for P4HB<sup>®</sup> enrollment. They faced challenges verifying their income, either because they worked part-time or did not receive traditional paychecks. “Autumn,” 27, from Atlanta, explained why it took her 2 months to complete her application.

*Because I get money from home so they had to have a paper saying how much I got and it had to be signed by one of my family members who gives it to me. Then because I work as an independent contractor as an aesthetician for a mobile spa company but I don't get like normal paychecks. My boss pays me through PayPal. So they had to see all those statements and it just, I almost gave up...*

Another participant, “Marie”, 21, has waited almost 2 months to complete her enrollment in P4HB<sup>®</sup> because she encountered problems documenting her income and child support. The Department of Community Health (DCH) requires her to get a letter from her boss verifying her salary as a part-time waitress as well as supporting documents about her current child support. “They started my enrollment here (health clinic) ...But just issues with trying to get the OCSS, OSC, child support services to get, find a way to, for here to get my paperwork so they can send them to the applicant and to get my boss to write me a letter.”

A couple of women also expressed concern that they had to provide an original copy of their driver's license and birth certificate. Although none of the documents were lost or damaged and overall the process went quickly, one woman, “Candice”, 23, from

Atlanta, was very nervous about this part of the enrollment process.

*The only thing I did not like was that I had to send my original birth certificate in... And I hated that because I'm like oh my God, it's in the mail, it can be lost in the mail. Something could happen. That's the only thing I did not like about that, original ID, original birth certificate and that was the only thing I did not like was sending my really like someone could steal my identity stuff through the mail. ..And but that you know, it was a pretty easy process. It happened very quickly. Within like two weeks after the application, I was, I got it.*

Interestingly, a handful of women in the focus groups described being able to get their original documents verified by either the health department or local DFACS office. These women were grateful for this option.

### **5.5.3 Provider and CMO selection**

Most women in the focus groups remained with their family planning provider after enrolling in P4HB<sup>®</sup>. In a few cases, however, women changed providers. These changes occurred primarily because women wanted to go to a clinic that was closer to where they lived. In two cases, women decided to switch to a private OBGYN after enrolling in P4HB<sup>®</sup>. These women, “Tracy,” 22, and “Sally”, 20, both from Atlanta, received family planning services at public health clinics prior to P4HB<sup>®</sup>. “Tracy” switched to a private OBGYN because she felt that a private doctor would take better care of her since she often gets irregular Pap results.

In a few cases, women had to find new doctors because their CMO provider network was limited. One woman, “Yasmine”, 30, from Atlanta, was trying to switch doctors because she needed fibroid surgery

*The only challenge that I have is, so far, is a lot of doctors don't take Amerigroup. A lot of them are saying that they don't take Medicaid as well anymore because I*

*have to get like a myomectomy because I have fibroids. So, I've been having a really hard time trying to find a doctor that actually does the surgery.*

Women also reported changing their CMO after enrolling in P4HB<sup>®</sup>. Among the seven women who described switching CMOs, four did so after receiving a letter in the mail asking them to switch from Well Care to Amerigroup. These women, who all lived in the same county in Northwest Georgia, did not understand why they were being asked to switch CMOs. However, they were able to complete the necessary paperwork without any disruption in services. The other three women who switched CMOs did so because they had heard their current CMO was not as good or did not cover their preferred provider.

#### **5.5.4 Renewal**

Only two participants mentioned the P4HB<sup>®</sup> renewal application process. Both of these women were surprised that it was time to renew their application because they were not even sure they were in the program. One of the women, “Violet,”<sup>32</sup> from Atlanta, experienced a delay of one year from the time of her initial application to the time she was asked to renew in P4HB<sup>®</sup>. She explained, “I had to fax my information over. And after that I never heard anything. Then, when I got the letter about renewing benefits, I’m like I don’t even have a card.” Violet further reported that in between the time she applied for P4HB<sup>®</sup> and receiving the renewal letter, she paid for everything out of pocket, including her annual exam. It was unclear why she did not receive notification or a card indicating her enrollment in P4HB<sup>®</sup>. It appears that she did not also follow up with her provider regarding the status of her P4HB<sup>®</sup> application.



## **5.6 Knowledge and Understanding of P4HB<sup>®</sup> Findings**

### ***5.6.1 Overall Lack of Program Information***

Overall, P4HB<sup>®</sup> enrollees and eligible women who participated in the focus group had limited knowledge of P4HB<sup>®</sup> and its covered services. Women seemed confused by the nature of the program as well as the types of services that were available to them. In some instances, women did not know they were in the program until they went to their health care provider for birth control. One woman, “Maureen,” 19, Atlanta was surprised to learn she was in a family planning program, when she went to her local health clinic. “I never knew what it was until when I went to get some birth control and they were like OK well you have Planning for Healthy Babies Program<sup>®</sup> and I’m like OK what does that mean?”

Several women in the focus groups, such as “Maureen”, were unaware they were enrolled in P4HB<sup>®</sup>, likely because they were auto enrolled after their eligibility for Peach Care or RSM Medicaid ended. Yet a few participants were told they were enrolled in P4HB<sup>®</sup> and still seemed confused. “Heather”, 20, from Northwest Georgia, received a call about P4HB<sup>®</sup> after the delivery of her baby and was still unsure about the program. “I was, been kind of confused on the whole, the Planning for Healthy Babies Program<sup>®</sup> thing. I haven’t known much about it and how it works or anything.” Another woman, “Felicity”, 19, Northwest Georgia, was also confused even though she’d received materials in the mail, “Well, I’ve been getting stuff for Planning for Healthy Babies Program<sup>®</sup> and stuff. But I just didn’t even know that I was like am I even in this? Because she’s (her mother) like yes, you got a card.”

### ***5.6.2 Benefits Beyond Birth Control***

Among the women who were aware they were enrolled in P4HB<sup>®</sup>, a majority understood that the program covered birth control and their annual exams. However, there was a clear lack of understanding about the scope of benefits among this group. Women asked a range of questions, such as whether the program covered ultrasounds, tubal ligation, HIV screening, fibroid removal surgery (myomectomy), infertility testing, and abortion. Women also wanted to know the various kinds of birth control that were covered. “Violet”, 32, Atlanta, who does not want any more children, asked if Essure, the permanent birth control implant, was covered. Another woman, “Rebecca”, 26, Atlanta, wanted to know if P4HB<sup>®</sup> covered the IUD even for childless women. “Going back to the birth control methods, I know that here they offering IUDs but they have a waiting list, and they want you to have a child already. Well I would like the IUD, and I don’t have kids...being in Planning for Healthy Babies Program<sup>®</sup> ..would it be covered?” Another woman, “Candice,” 19, Atlanta, asked if calcium supplements were covered, because her doctor told her to take them since she was on Depo.

Some of the confusion about P4HB<sup>®</sup> stems from the materials women received about the program. These materials included CMO materials and DCH-issued P4HB<sup>®</sup> postcards and flyers. Several women read the materials and thought they would receive primary care and dental services. One woman, “Teresa,” 39, Atlanta, said “I didn’t realize I wasn’t getting everything that was on that list on the flyer.” Another woman, “Usha,” 23, Atlanta, read a P4HB<sup>®</sup> flyer she received from Amerigroup:

*As a matter of fact I have a little flyer, oh no I think I left it in my car, but I have a flyer in my car and I was under the impression that I would get dental as well...it*

*said, you know, if you're in Planning for Healthy Babies Program® , blah, blah, blah, blah, inter-pregnancy care is this, and family planning is this, and then it says you may get dental, primary. But it doesn't explain that only the IPC women get it.*

Another woman, “Jaden”, 23, Atlanta, thought dental care was covered and called her CMO, Well Care, to clarify her coverage. “When I called, like and I was looking in a book and I didn't see nothing about no dentist, so I just called and they was like no, you have to have low weight baby, I'm like why I have to have a low weight baby to get dental?” In these instances, women were reading benefit information about the IPC component and did not understand the differences between the two eligibility groups.

There appeared also a lack of awareness about IPC among the two participants who were enrolled in this component of P4HB®. For “Yvette,” who lost her infant after 5 months, the lack of information about P4HB® was frustrating:

*..they didn't explain nothing to me, only that you are eligible and then you just lost the baby so go fill out for Planning for Healthy Babies Program® and that was it. Now I appreciate it, don't get me wrong, but I'm just saying like you put somebody on something, you don't even get it explained on the phone what it covers, and it don't cover, they didn't send no booklet or nothing.*

And for “Quintessa,” she thought she was in a “family planning insurance program” that only covered birth control. After discussing her experience, however, she mentioned receiving calls every three months from a Resource Mother who asks her about her baby. So like “Yvette,” “Quintessa” does not have a complete understanding of the scope and benefits of the IPC component of P4HB®.

### **5.6.3 P4HB® name**

Another source of confusion among current as well as prospective P4HB<sup>®</sup> enrollees was the name of the program. Several women initially thought “Planning for Healthy Babies Program<sup>®</sup>” implied a program aimed at mothers or women who wanted to get pregnant. When asked about her current P4HB<sup>®</sup> experience, one participant said “I’m using Medicaid. I really don’t know much about this. I don’t have a baby.” Another woman, “Ilena,” 19, Northwest Georgia, explains her view on the name of the program,

*Ilena: I thought, you know, that it was only for women who had kids and babies because I never got offered it before, you know.*

*Facilitator. What made you think that?*

*Ilena. Planning for Healthy Babies Program<sup>®</sup>, the name of it.*

One participant, “Felicity,” has been enrolled in P4HB<sup>®</sup> for eight months and has not sought family planning services because she was confused about the program. “I’m confused like because I didn’t think, like Planning for Healthy Babies Program<sup>®</sup> don’t sound like, you know, you’ll be able to get birth control, you know. It sounds like, kind of like the opposite”. These comments provide possible explanation for how, as reported previously, some of the participants (14.3%) may have heard about P4HB<sup>®</sup> but decided not to enroll. Indeed, they may have heard the name Planning for Healthy Babies Program<sup>®</sup> and if after misreading the program materials, as other participants reported doing, the participants declined participation in the program.

## **5.7 Utilization Findings**

### ***5.7.1 Access to traditional family planning services***

Overall, P4HB<sup>®</sup> focus group participants were pleased with the family planning services they received and were thankful these services were provided at no-cost. When P4HB<sup>®</sup> enrollees were asked what health care services they have accessed since enrollment in the program, most reported seeking traditional family planning services. Women received contraception, annual exams (Pap smears), STD testing, and pregnant testing through P4HB<sup>®</sup>. In a few cases, women accessed other related services, including the HPV vaccine, ultrasound, and diagnostic MRI. One participant, “Tracy,” 22, Atlanta, was diagnosed and treated for cervical cancer while on the P4HB<sup>®</sup> program. After enrolling in P4HB<sup>®</sup> in December 2011, “Tracy” was diagnosed with Stage 1 cervical cancer by a private OBGYN, who then treated her via a Loop Electrosurgical Excision Procedure (LEEP). She has also received follow-up care since being treated.

### ***5.7.2 Services from public health clinics after P4HB<sup>®</sup> enrollment***

Another important finding from the focus groups is that most of the P4HB<sup>®</sup> participants seek family planning services from public health providers. A majority of the P4HB<sup>®</sup> enrollees sought family planning services from local public health clinics prior to their enrollment in the program, and once enrolled, preferred to continue using their usual health care providers. These participants expressed preference for their providers because they were conveniently located, familiar to them, and because the participants had been seeking services from them for a long time.

As mentioned previously, there were a few P4HB<sup>®</sup> participants who changed providers after enrolling in the program. A couple of women changed from public health

clinics to private doctors because they thought these providers could give them better care for their family planning needs. Several other P4HB<sup>®</sup> participants, however, switched providers because the health clinics did not accept their health plan. One participant, “Dena,” 30, Atlanta, had to switch from a public health clinic to a private OBGYN to get her birth control, because the clinic did not accept her CMO (Peach State) and made her pay for her contraception. Since switching to the private provider, she had not experienced any problems. Another P4HB<sup>®</sup> enrollee experienced a similar situation, when her local health clinic stopped accepting Well Care. This enrollee, “Candice,” 23, Atlanta, initially received her birth control through a community-based primary care center. However, when this center stopped accepting her health plan, she switched to a nearby federally qualified health center that accepted all Medicaid health plans. A third P4HB<sup>®</sup> enrollee, “Yasmine,” 30, Atlanta, needs fibroid surgery (myomectomy), but can’t find a doctor to perform the procedure. “A lot of them are saying that they don’t take Medicaid as well anymore because I have to get like a myomectomy because I have fibroids. So, I’ve been having a really hard time trying to find a doctor that actually does the surgery. “

### ***5.7.3 Remaining barriers to P4HB<sup>®</sup> services***

Despite the overall findings that P4HB<sup>®</sup> enrollees are utilizing family planning services through the program, some barriers to services were identified. The first barrier is the lack of available family planning-related services. Several women reported that they were not able to access services such as HIV testing, ultrasounds, and gynecological procedures, such as myomectomy. One woman, “Wendy,” 19, Atlanta, sought HIV

testing from her private family practitioner, who accepts P4HB<sup>®</sup> clients. However, she was told by the doctor that HIV tests were not covered under the program and could only receive the test at a public health clinic. For another participant, “Gabrielle,” who was told she needed an ultrasound due to a cyst on her ovary, the procedure was not covered by P4HB<sup>®</sup> but eventually, the provider paid for it. Yet, for “Rachel,” 19, Atlanta, she received a bill for \$75 for an ultrasound that she received at an Atlanta hospital, where she had received pap smears and other P4HB<sup>®</sup> covered services. In all of these instances, women were confused about the scope of coverage under P4HB<sup>®</sup> and where they could access such services free of cost.

A second barrier that was revealed during the focus groups was the low utilization of family planning services among post-partum P4HB<sup>®</sup> clients. Several women who had young children reported not yet seeking birth control or other family planning services since delivering their children. In our southeast Georgia focus group, two of the four participants had not started back on birth control since delivering their children. When asked why she was not using birth control, one participant, “Carmen,” 25, who has 3 children under the age of 4, replied, “Well I’ve been pregnant for the past 5 years (laughing).. I don’t know. We haven’t got really back on schedule yet.” Another participant from this focus group, “Anna,” 22, claimed she had not been back to the family planning clinic since her daughter was born, which was one year ago. Likewise, two of the four participants in one of the northwest Georgia focus groups have not initiated birth control since delivering their children. For one of these participants, “Ilena,” 19, she did not use birth control prior to her pregnancy and has not sought family planning services since delivering her daughter seven months ago. However, “Ilena”

stated she was going to “get on birth control soon..since now I know I have it “(meaning coverage for contraception). A P4HB<sup>®</sup> enrollee in one of the Atlanta focus groups explained she hadn’t used any family planning services since delivering her daughter seven month ago because she was not sure what services were covered under the program. This enrollee, “Quinn,” 29, asked, "Well my question was do you think, you know, because I haven’t utilized the program, do you think it’s worth it to utilize the program for pap smears or whatever ?”

Both types of barriers to P4HB<sup>®</sup> service indicate a lack of awareness about the types of services that are covered under the program as well as the lack of understanding of where they can access family planning services. The findings from the postpartum P4HB<sup>®</sup> enrollees is especially troubling as the women seem to be unaware of the coverage available to them but also of the need to utilize contraception and other family planning services after delivery.

## **5.8 Recommendations of P4HB<sup>®</sup> Participants**

This section provides a summary of recommendations for Planning for Healthy Babies Program<sup>®</sup> (P4HB<sup>®</sup>). The recommendations reflect comments from the focus group participants about how to improve the P4HB<sup>®</sup> program. These comments were expressed by both all participants, including those currently enrolled in P4HB<sup>®</sup>.

### **1) Current P4HB<sup>®</sup> program materials need improving**

Many focus group participants complained about not understanding the materials they were given about P4HB<sup>®</sup>. Such materials, including pamphlets, application materials, and flyers about P4HB<sup>®</sup> should be improved. The participants suggested



developing materials that clearly explain eligibility and coverage, especially the differences in coverage between the FP and IPC components. It seemed once some women read on these materials about having a low-birth weight baby, they didn't think they qualified for P4HB<sup>®</sup>.

Participants provided other suggestions for improving current P4HB<sup>®</sup> materials. A few women indicated that the flyers in particular did not reflect the current eligible population. Women noted that the brochures also included pictures of pregnant women and mothers, so it was not clear that the program provided birth control and other family planning services. One participant, "Abigail," 40, from Atlanta, did not know she was eligible for the program after seeing the materials sent to her 19 year old daughter who enrolled in P4HB<sup>®</sup> after her Peach Care coverage ended. Of the materials, "Abigail" said, "it doesn't grab my attention, it doesn't say that it's aimed to my demographic, the 18-44 year old demographic, it's just, it's aimed to child bearing women, you know, that's all that that says to me, I'm not in those child bearing, I'm in those years but I'm not doing that anymore."

Participants also suggested improving the P4HB<sup>®</sup> website to clarify program eligibility and coverage. One participant said "The website was very stupid. ... It just didn't tell you anything. . There's nothing. There's no information. It was just like here's Planning for Healthy Babies Program<sup>®</sup> . Sign up." The recommendation for better provider information was also suggested. Several participants expressed confusion and frustration about not knowing which providers participated in their health plan. One participant suggested that all CMOs should clearly list the participating providers on all of their P4HB<sup>®</sup> materials, including their websites.

## **2) More outreach about P4HB<sup>®</sup> is needed**

The focus group participants felt that there was not enough information in the community about P4HB<sup>®</sup>. Women felt there was a lack of general outreach about the program. Many commented that they found out about the program from a nurse or other health clinic staff member when they made their appointment to get birth control. Other women were sent materials by DCH once their RSM Medicaid or Peach Care eligibility ended, and several women did not know they were in the program until they received a P4HB<sup>®</sup> card in the mail or until the health clinic informed them. So, women provided several recommendations about how to improve outreach efforts about P4HB<sup>®</sup>.

First, outreach and other advertisements about P4HB<sup>®</sup> should be available in areas that target the eligible population. Such areas include beauty salons, beauty supply stores, and grocery stores. One participant felt that P4HB<sup>®</sup> advertisements should be posted at WIC offices, on Marta trains, and on billboards. Among current P4HB<sup>®</sup> participants, many felt that the outreach efforts should be more personal in nature, and DCH should hold “trainings” or one-on-one meetings whereby Medicaid enrollment personnel are present to provide information about P4HB<sup>®</sup> and can answer questions. These efforts could also be targeted in the beauty salons or stores where young women are more likely to be available. Finally, several women felt that current customer service needed to be improved. Women complained that the Medicaid telephone representatives are not well informed about P4HB<sup>®</sup> and could not answer their questions about eligibility and coverage. Therefore, they suggested retraining these customer service representatives about P4HB<sup>®</sup>.

## **3) P4HB<sup>®</sup> should cover more than traditional family planning services**

Focus group participants, mainly P4HB<sup>®</sup> enrollees, wanted the program to offer more than traditional family planning services. While these participants were pleased to have access to birth control, Pap smears, and STD testing and did not appear to experience any major delays in accessing these services, many were frustrated that they could not access other health care services. As noted earlier, some women thought P4HB<sup>®</sup> included dental coverage because of their interpretation of some of the marketing materials. Other women needed wanted HIV testing or follow up diagnostic services, such as ultrasounds or myomectomy and were frustrated that these services were not considered under the rubric of “family planning.” Other women though the P4HB<sup>®</sup> program offered full-scope Medicaid coverage.

## **5.9 Summary of Chapter**

This chapter provides important insight into the P4HB<sup>®</sup> p experience from the perspectives of currently enrolled and prospective P4HB<sup>®</sup> p clients. We gathered valuable information about the enabling factors of this program’s ability to increase health care access. Specifically we learned that public health clinics, namely Title X clinics, are major providers for P4HB<sup>®</sup> clients, and they assist these client with many tasks related to implementation, such as outreach and education, as well as application help. We also learned that most P4HB clients prefer to seek services with public health clinics, because these are sites they have visited for years for health care and the staff are friendly and knowledgeable. In addition, we learned of the importance that outreach and education can play in this program, and how, the lack of such information may inhibit enrollment and utilization of services. While a majority of the focus group participants were P4HB

clients and reported accessing birth control and traditional family planning services, many did not understand the nature of the program or scope of covered services.

In the next chapter, we examine these same implementation factors through the perspective of providers. We present findings from a survey conducted with over 100 providers. These providers represent different disciplines, practice settings, and health care programs.

## CHAPTER 6

### PROVIDER SURVEY RESULTS

#### 6.1 Overview

In this chapter, we present the findings from a survey of P4HB<sup>®</sup> eligible providers. The purpose of this component of the research was to assess the knowledge and awareness that participating and eligible providers have of Planning for Healthy Babies<sup>®</sup>. While in-depth interviews were held with a select number of public health and private providers, this survey was designed to cast a wider net to providers who serve or have the ability to serve P4HB<sup>®</sup> enrollees. As noted earlier in this research, each of the three CMOs surveyed their participating providers toward the end of 2011 and at the beginning of 2012 to learn more about their experiences serving P4HB<sup>®</sup> participants. However, these surveys did not necessarily reach providers who were not enrolled with the CMOs or were enrolled providers but not participating in the P4HB<sup>®</sup> program. This dissertation survey used a different survey dissemination strategy, that is through the use of provider organizations and the Georgia Title X family planning program, to reach current and prospective P4HB<sup>®</sup> clients. This survey is also considerably shorter than the one distributed by the CMOs and allowed for qualitative input from the providers about the possible benefits and weaknesses of P4HB<sup>®</sup>. We present the findings from the survey and also analyzed the qualitative comments that were provided by a number of the respondents.

## 6.2 Survey Response Rate

As highlighted in Table 8, the survey was shared with a total of 684 providers from the three participating provider groups. We received a total of 104 completed surveys, resulting in a 15.2% response rate. Within the GAFP, the survey was shared with 114 members, and we received 37 surveys, resulting in a 32.5% response rate for this organization. For GOGS, the survey was faxed to 552 members, and we received 49 surveys, resulting in an 8.9% response rate. Among the 18 Title X women’s health coordinators, all surveys were returned, resulting in a 100% response rate.

**Table 8: Survey Distribution and Response**

<b>Provider Group</b>	<b>Sent</b>	<b>Responded</b>	<b>Response Rate</b>
<b>Title X</b>	18	18	100%
<b>GAFP</b>	114	37	32.5%
<b>GOGS</b>	552	49	8.9%
<b>TOTAL</b>	684	104	15.2%

## 6.3 Provider demographics

Select characteristics of survey respondents are provided in Table 9. The occupation of all respondents fell in line with their associated provider organization. All Title X respondents were nurses or nurse practitioners, all family physicians identified as such, and the same is true for the OBGYNs.

<b>Table 9: Select Provider Demographics</b>	Title X (N=18)	GAFP (N=37)	GOGS (N=49)	Overall (N=104)	P- value
Variables	n (%)	n (%)	n (%)	n (%)	
<b>Occupation</b>					
Missing	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	
Ob/Gyn	0 (0.0)	0 (0.0)	49	49 (47.1)	
Family Physician	0 (0.0)	37	0 (0.0)	37 (35.6)	
Nurse/NP	18	0 (0.0)	0 (0.0)	18 (17.3)	
<b>Primary Practice Setting</b>					
Missing	0 (0.0)	1 (2.7)	0 (0.0)	1 (1.0)	.000*
Solo private/small group practice	0 (0.0)	17 (47.2)	34 (69.4)	51 (49.5)	
Group practice of 5+ providers	0 (0.0)	8 (22.2)	14 (28.6)	22 (21.4)	
Public health setting	18	3 (8.3)	0 (0.0)	21 (20.1)	
Other practice setting	0 (0.0)	8 (21.6)	1 (2.0)	9 (4.9)	
<b>Contract with any of the Medicaid affiliated CMOS?</b>					
Missing	0 (0.0)	0 (0.0)	1 (2.0)	1 (1.0)	.002**
Yes	18	21 (56.8)	39 (81.3)	78 (75.7)	
No	0 (0.0)	16 (43.2)	9 (18.8)	25 (24.3)	
<b>How many CMOs do you contract with?</b>					
Missing	0 (0.0)	16 (43.2)	11 (22.4)	27 (26.0)	
1 of the 3	0 (0.0)	4 (19.0)	10 (26.3)	14 (18.2)	
2 of the 3	0 (0.0)	10 (47.6)	19 (50.0)	29 (37.7)	
All 3 of them	18	7 (33.3)	9 (23.7)	34 (44.2)	

The practice settings were divided into 1) solo practice/small group practice, 2) large group practice (of 5 or more providers), 3) public health setting (including public health clinic or department), and 4) other practice setting (which included the options of other non-public health clinic, hospital, or integrated delivery system). While these other practice settings were separated in the survey, due to the small numbers in the results, we rolled these into an “other practice setting” category.

All Title X providers serve in public health departments. Almost half (47.2%) of the family physicians who responded to the survey work in solo private or small group practice settings. About a fifth (22.2%) work in large group practice settings and about one fifth (21.6%) work in other practice setting, such as non-public health clinics (13.9%), hospitals (2.8%) or large integrated health delivery systems (5.6%). A small percentage (8.3%) of the family physicians works in public health settings. Of the OBGYN respondents, two-thirds (69.4%) work in solo private or small group practice settings. Over a quarter (28.6%) of OBGYNs work in group practice settings, and just 2% work in other practice settings, which happen to be in the hospital setting. Therefore, of all the survey respondent, a majority work in solo or group private practice settings and a small percentage work in public or other types of health clinics.

Since 2006, the Department of Community Health (Medicaid) has contracted with three care management organizations (CMOs) to manage and provide care to Medicaid enrollees. These CMOs include Amerigroup, Peach State, and Well Care. Since February 2012, the three CMOs have expanded statewide, meaning each CMO is available to Medicaid enrollees in each of the six Medicaid regions of the state. Results show that all Title X respondents contract with all three CMOs. This is not surprising since all Title X staff work in public health departments, which are contracted Medicaid provider sites. Over half of the GAFP respondents (56.8%) contract with a CMO, and of those, about half (47.6%) contract with at least 2 CMOs. Almost all (81.3%) of the GOGS respondents contract with a CMO, and about half of them contract with at least 2 CMOs. These results suggest that a majority of the survey respondents accept Medicaid clients and have the potential to serve P4HB (®) clients. The data also suggest, however, that



among the providers who contract with CMOs to serve Medicaid clients, those that do not contract with all three CMOs could potentially be excluding a population of P4HB<sup>®</sup> enrolled clients.

## **6.4 Results**

### **6.4.1 Enrollment**

In Table 10, respondents indicated whether they serve P4HB<sup>®</sup> clients, and if so, how many. Due to the skip patterns of the survey, 26% of clients who did not answer this question were those who do not contract with a CMO and therefore cannot serve P4HB<sup>®</sup> or any Medicaid client. Therefore, the “missing” category indicates those providers who do not serve any Medicaid clients. The following results then describe findings from the 74% or 77 providers that are Medicaid participating providers who can potentially serve P4HB<sup>®</sup> enrollees.

Over three-quarters (77.9%) of the respondents serve P4HB<sup>®</sup> clients, and about one fifth (22.1%) were not sure or said no. All but one Title X respondent indicated they serve P4HB<sup>®</sup> clients, and one was unsure. Over half of the GAFFP respondents (52.4%) who serve Medicaid clients serve P4HB<sup>®</sup> clients, and almost half (47.6%) were unsure or indicated ‘no.’ A large majority of GOGS respondents (84.2%) who serve Medicaid clients also serve P4HB<sup>®</sup> clients, while few (15.8%) said no or they were unsure.

Providers who serve P4HB<sup>®</sup> clients were asked to provide the number of current P4HB<sup>®</sup> clients as well as the percentage of those clients that they had served previously through Georgia’s Right from the Start (RSM) Medicaid program for pregnant women. Almost half (48.3%) of the respondents who serve P4HB<sup>®</sup> clients were unsure exactly

how many clients they current serve. Among those who provided an answer, there was a range from 8 to 300 P4HB<sup>®</sup> clients, with a mean of 50.1. Title X respondents serve between 55 and 300 P4HB<sup>®</sup> clients, with a mean of 170. GAFFP respondents serve been 20 and 60 P4HB<sup>®</sup> clients, with a mean of 46.3, and GOGS respondents see the fewest P4HB<sup>®</sup> clients, reporting a range of 8 to 100, and a mean of 23.6 P4HB<sup>®</sup> clients. Overall, the providers were unsure (58.3%) of whether their current P4HB<sup>®</sup> clients were also once RSM clients. However, OBGYNs were more likely to have P4HB<sup>®</sup> clients who they also served through the RSM program.

<b>Table 10: Description of Provider P4HB<sup>®</sup> Enrollment</b>	Title X (N=18)	GAFFP (N=37)	GOGS (N=49)	Overall (N=104)	P value
Variables	n (%)	n (%)	n (%)	n (%)	
<b>Do you serve women enrolled in P4HB<sup>®</sup> program?</b>					
Missing	0 (0.0)	16 (43.2)	11 (22.4)	27 (26.0)	.003**
Yes	17 (94.4)	11 (52.4)	32 (84.2)	60 (77.9)	
No/Not Sure	1 (5.6)	10 (47.6)	6 (15.8)	17 (22.1)	
<b>If yes, how many P4HB<sup>®</sup> clients do you serve?</b>					
Missing	1 (5.6)	26 (70.3)	17 (34.7)	44 (42.3)	
Unsure	12 (70.6)	7 (63.6)	10 (31.3)	29 (48.3)	
Range, Mean	55-300,	20-60,	8-100,	8-300, 50.1	
<b>Of your P4HB<sup>®</sup> clients, what % did you serve in RSM?</b>					
Missing	1 (5.6)	27 (73.0)	28 (57.1)	56 (53.8)	
<10%	1 (5.9)	0 (0.0)	2 (9.5)	3 (6.3)	
10-25%	3 (17.6)	0 (0.0)	3 (14.3)	6 (12.5)	
25-75%	1 (5.9)	0 (0.0)	4 (19.0)	5 (10.4)	
>75%	0 (0.0)	1 (10.0)	3 (14.3)	4 (8.3)	
Unsure	12 (70.6)	9 (90.0)	7 (33.3)	28 (58.3)	
Didn't serve P4HB <sup>®</sup> clients	0 (0.0)	0 (0.0)	2 (9.5)	2 (4.2)	

Almost one-fifth of GOGS respondents (19%) indicated that between 25 and 75% of their P4HB<sup>®</sup> clients were once also RSM clients. Title X respondents also reported having

served their P4HB<sup>®</sup> clients previously through RSM, with 17.6% of respondents indicating that between 10-25% of their P4HB<sup>®</sup> clients were once RSM clients. Almost all (90%) of GAFP providers were unsure whether their P4HB<sup>®</sup> clients were also once RSM clients. These results are important in order to understand what types of providers women choose for family planning services after their RSM eligibility ends.

#### **6.4.2 P4HB<sup>®</sup> Services**

In Table 11, results reflect the types of services respondents provide to P4HB<sup>®</sup> clients as well as the problems they have experienced with P4HB<sup>®</sup>. For both of these questions, respondents could choose more than one answer. Almost all respondents (96.6%) who serve P4HB<sup>®</sup> clients provide birth control. Other common services are annual pelvic exams (87.9%), STI testing and/or treatment (75.9%), and pregnancy testing (65.5%). About one third of respondents (37.9%) who serve P4HB<sup>®</sup> clients provide inter-conceptual counseling and one-fifth (20.7%) provide primary care services. Interestingly, 80% of GAFP respondents report providing P4HB<sup>®</sup> clients chronic care management services, which was almost non-existent among the other two provider groups. GAFP respondents also reported that they provide primary care services (70%) and inter-conceptual care counseling (50%). GOGS respondents' answers aligned more with Title X respondents, which reflected that most provide birth control, pregnancy testing, and STI testing and treatment to P4HB<sup>®</sup> clients.

<b>Table 11: P4HB<sup>®</sup> Services and Challenges</b>	Title X (N=18)	GAFP (N=37)	GOGS (N=49)	Overall (N=104)
Variables	n (%)	n (%)	n (%)	n (%)
<b>What services have you provided to P4HB<sup>®</sup> women? (#, % Yes)</b>				
Missing	1 (5.6)	27 (73.0)	18 (36.7)	46 (44.2)
Birth control	17 (100.0)	9 (90.0)	30 (96.8)	56 (96.6)
Inter-conceptual counseling	12 (70.6)	5 (50.0)	5 (16.1)	22 (37.9)
Pregnancy testing	15 (88.2)	8 (80.0)	15 (48.4)	38 (65.5)
Annual exams	17 (100.0)	9 (90.0)	25 (80.6)	51 (87.9)
STI testing/treatment	15 (88.2)	8 (80.0)	21 (67.7)	44 (75.9)
Primary care services	0 (0.0)	7 (70.0)	5 (16.1)	12 (20.7)
Management of chronic conditions	0 (0.0)	8 (80.0)	2 (6.5)	10 (17.2)
Substance abuse services	0 (0.0)	1 (10.0)	0 (0.0)	1 (1.7)
Mental health services	0 (0.0)	2 (20.0)	1 (3.2)	3 (5.2)
Case management	2 (11.8)	0 (0.0)	1 (3.2)	3 (5.2)
<b>What problems have you experienced with P4HB<sup>®</sup>? (#, % Yes)</b>				
Missing	1 (5.6)	28 (75.7)	20 (40.8)	49 (47.1)
Lack of presumptive eligibility	0 (0.0)	1 (11.1)	6 (20.7)	7 (12.7)
Prior authorization	0 (0.0)	2 (22.2)	5 (17.2)	7 (12.7)
Services not covered by P4HB <sup>®</sup>	13 (76.5)	4 (44.4)	22 (75.9)	39 (70.9)
Patient enrollment difficulties	6 (35.3)	1 (11.1)	7 (24.1)	14 (25.5)
General low reimbursement	1 (5.9)	3 (33.3)	14 (48.3)	18 (32.7)
Low reimbursement for family	3 (17.6)	1 (11.1)	6 (20.7)	10 (18.2)
Low reimbursement for primary	1 (5.9)	3 (33.3)	2 (6.9)	6 (10.9)
Delays with reimbursement	3 (17.6)	2 (22.2)	6 (20.7)	11 (20.0)
Lack of information re: billing for P4HB <sup>®</sup> services	4 (23.5)	1 (11.1)	14 (48.3)	19 (34.5)
General lack of P4HB <sup>®</sup> program information	3 (17.6)	3 (33.3)	16 (55.2)	22 (40.0)
No Problems	2 (11.8)	1 (11.0)	2 (6.9)	5 (9.1)

Several types of problems were identified by the survey respondents. Almost two-thirds of respondents (70.9%) reported that certain services were not covered by P4HB<sup>®</sup>. About 40% of respondents indicated a problem with the general lack of P4HB<sup>®</sup> program information. And one-third of P4HB<sup>®</sup> providers listed general low reimbursement (32.7%) as a problem, as well with lack of information regarding billing procedures for

P4HB<sup>®</sup> services (34.5%). And one-fifth of all respondents (20%) who serve P4HB<sup>®</sup> clients indicated that there were delays with reimbursements.

For Title X respondents, the most frequent problem was that services were not covered under P4HB<sup>®</sup> (76.5%). However, over a third of Title X respondents (35.3%) also indicated problems with helping patient enroll in P4HB<sup>®</sup>. And about one-fifth (23.5%) of Title X respondents experience problems with a lack of information regarding billing for P4HB<sup>®</sup> services. GAFP providers more frequently cited the lack of services covered by P4HB<sup>®</sup> (44.4%), however about a third (33.3%) also reported problems with general low reimbursement, low reimbursement for primary care services, and a general lack of P4HB<sup>®</sup> program information. About one-fifth (22.2%) of GAFP respondents had problems with prior authorization and delays with reimbursement. GOGS respondents also greatly experienced problems with non-coverage of P4HB<sup>®</sup> services (75.9%), but almost half (48.3%) equally cited general low reimbursement and lack of P4HB<sup>®</sup> program information as problems as well. About one-fifth of GOGS respondents indicated problems with lack of presumptive eligibility (20.7%), patient enrollment (24.1%), low reimbursement for family planning (20.7%), and delays with reimbursement (20.7%).

#### ***6.4.3. Outreach and Education***

All survey respondents were asked to indicate if they had been informed about P4HB<sup>®</sup> and if so, from what source. Over one-third (38%) of all respondents indicated they received no information about P4HB<sup>®</sup>, while about a quarter (26.1%) indicated they received information and/or materials about P4HB<sup>®</sup> from the Department of Community

Health (DCH). Almost one fifth of respondents (18.5%) equally reported receiving information from the Department of Public Health (DPH) and from a CMO. Professional organizations provided information about P4HB<sup>®</sup> to about 16.3% of the survey respondents. Title X respondents were more likely to receive outreach from DPH (77.8%), while GOGS respondents received information from a CMO (31.8%), from DCH (27.3%), or from the Georgia OBGYN Society (22.7%). About one third of GOGS respondents (34.1%) did not receive any outreach or information about P4HB<sup>®</sup>. On the other hand, about two-thirds of GAFP respondents (66.7%) received no information or outreach regarding P4HB<sup>®</sup>, while some (16.7%) heard about the program from DCH and their professional organization (10%)-Georgia Academy of Family Physicians. See Table 12 for all results.

Respondents also provided answers to the types of information they were provided about P4HB<sup>®</sup> and what more information they would like to receive. Although about one third of respondents indicated not receiving any information about P4HB<sup>®</sup>, many who did (40.2%) report receiving client brochures. About a quarter of respondents also received P4HB<sup>®</sup> application materials (27.2%) and a provider manual or guidelines (25%). A majority of Title X respondents received P4HB<sup>®</sup> application materials (94.4%), client brochures (83.3%), and provider manuals/guidelines (55.6%). Interestingly, about half of Title X respondents report attending a P4HB<sup>®</sup> training or meeting, and less than half (22.2%) report receiving any provider information from DCH. Almost two-thirds of GAFP respondents (69%) report having received no information on P4HB<sup>®</sup>, although about one quarter (24.1%) indicate they received P4HB<sup>®</sup> client brochures. GOGS respondents received a mix of P4HB<sup>®</sup> program information, ranging from client

brochures (33.3%), to provider manual/guidelines (26.7%), to no information at all (25.7%).

<b>Table 12 P4HB<sup>®</sup> Provider Outreach and Education</b>	Title X (N=18)	GAFP (N=37)	GOGS (N=49)	Overall (N=104)
Variables	n (%)	n (%)	n (%)	n (%)
<b>Have you received information/materials about P4HB<sup>®</sup> from any of the following? (#, % Yes)</b>				
Missing	0 (0.0)	7 (18.9)	5 (10.2)	12 (11.5)
Professional organization	2 (11.1)	3 (10.0)	10 (22.7)	15 (16.3)
Department of Community	7 (38.9)	5 (16.7)	12 (27.3)	24 (26.1)
Department of Public Health	14 (77.8)	1 (3.3)	2 (4.5)	17 (18.5)
CMO	1 (5.6)	2 (6.7)	14 (31.8)	17 (18.5)
Colleague	3 (16.7)	0 (0.0)	4 (9.1)	7 (7.6)
None	0 (0.0)	20 (66.7)	15 (34.1)	35 (38.0)
<b>What information were you provided about P4HB<sup>®</sup>? (#, % Yes)</b>				
Missing	0 (0.0)	8 (21.6)	4 (8.2)	12 (11.5)
Client brochures	15 (83.3)	7 (24.1)	15 (33.3)	37 (40.2)
P4HB <sup>®</sup> application materials	17 (94.4)	2 (6.9)	6 (13.3)	25 (27.2)
Provider manual/guidelines	10 (55.6)	1 (3.4)	12 (26.7)	23 (25.0)
P4HB <sup>®</sup> training/meetings	9 (50.0)	2 (6.9)	4 (8.9)	15 (16.3)
Provider information via	4 (22.2)	0 (0.0)	5 (11.1)	9 (9.8)
None	0 (0.0)	20 (69.0)	12 (26.7)	32 (34.8)
<b>What information about P4HB<sup>®</sup> would you like to get? (#, % Yes)</b>				
Missing	0 (0.0)	16 (43.2)	13 (26.5)	29 (27.9)
Family planning services	11 (61.1)	16 (76.2)	30 (83.3)	57 (76.0)
Inter-pregnancy care services	4 (22.2)	6 (28.6)	20 (55.6)	30 (40.0)
Resource mother services	4 (22.2)	7 (33.3)	20 (55.6)	31 (41.3)
Eligibility	6 (33.3)	16 (76.2)	18 (50.0)	40 (53.3)
How to bill for P4HB <sup>®</sup> services	7 (38.9)	9 (42.9)	21 (58.3)	37 (49.3)
Enrollment process	3 (16.7)	7 (33.3)	11 (30.6)	21 (28.0)
P4HB <sup>®</sup> renewal process	8 (44.4)	4 (19.0)	12 (33.3)	24 (32.0)

Finally, survey respondents were asked to select the type of information they still need or want about P4HB<sup>®</sup>. About three-quarters of respondents (76%) want more information about the types of family planning services that are covered under P4HB<sup>®</sup>. Over half (53.3%) of respondents want more information on P4HB<sup>®</sup> eligibility, while

almost half (49.3%) want more information about how to bill for P4HB<sup>®</sup> services. The results also indicate that many respondents need information about the types of inter-pregnancy services that are covered (40%), as well as resource mother services that are included (41.3%) in the program. Over a quarter of the respondents also wanted information about the eligibility (28%) and renewal process (32%). Title X respondents were more likely to request information on family planning coverage (61.1%), and the P4HB<sup>®</sup> renewal process (44.4%). GAFFP respondents want more information on family planning coverage (76.2%), eligibility (76.2%), and P4HB<sup>®</sup> billing procedures (42.9%). GOGS respondents want more information on family planning coverage (83.3%), inter-pregnancy care and resource mother services (55.6% each), eligibility (50%), and on P4HB<sup>®</sup> billing procedures (58.3%).

## **6.5 Qualitative Survey Results**

Eighteen respondents provided comments about P4HB<sup>®</sup> in the survey. Of these respondents, 10 (56%) were private OBGYNs, 6 (33%) were from health departments, and two (11%) were private family physicians. The first major theme was the **lack of information** on P4HB<sup>®</sup>. Of the seven participants who made this comment, four (2 OBGYNs, one health department nurse, one family practice MD) believed that women are not given enough correct information about P4HB<sup>®</sup>. Comments ranged from “I don’t think many women know about this service” (family physician) to “I think patients were misled about the type of services that P4HB<sup>®</sup> would provide. There are limits on types and number of visits within the year”(health department nurse). Three respondents



claimed that providers are not given enough information about P4HB<sup>®</sup>. One of the three respondents, an OBGYN, wrote in the survey

*Dealing with P4HB<sup>®</sup> is a huge headache. There have been no resources provided about this category of service. Yesterday, was the first time I was able to get any information from Medicaid. On July 1, 2012, they published their FP manual.*

Another OBGYN, wrote “had bad experience with this program right from the beginning due to lack of educational information as to guidelines for certain services.” This comment relates to the second main theme that emerged from the qualitative data gathered from the provider surveys. The theme relates to the **restrictive nature of P4HB<sup>®</sup>**. Seven comments were made that suggest that P4HB<sup>®</sup> is too restrictive in the type of services that are covered under the program. Three of the seven comments came from health department providers who explained that “more services should be covered.” One of the three OBGYNs who felt the same, indicated that P4HB<sup>®</sup> is too restrictive because certain gynecological services are not covered. This provider further elaborated:

*Implanon removals are not covered. Caseworkers give wrong information to members, saying that any GYN services is covered*

Another OBGYN said women think that irregular bleeding is a covered services (it is not), so not only is the program restrictive, but women do not know what is covered and what is not. Another OBYN wrote:

*do not care for P4HB<sup>®</sup>. Cannot take care of patients with problems. Can only see for annual/birth control. Becomes a huge problem telling patients we cannot see them.*

Another, more minor, theme relates to the **lack of reimbursement under P4HB®**. Two providers (one health department nurse, and one private OBGYN) indicated that they were not able to get reimbursed for services provided to P4HB® clients who were not yet assigned a CMO. They indicated that Medicaid regularly declines claims for P4HB® enrollees who are awaiting CMO assignment/selection. One health department nurse wrote:

*it has been frustrating from the start to get clients enrolled and then payment for services was delayed or not received. If a client is enrolled and not assigned to a CMO, any service done during that time is denied payment for the billing.*

Another theme that emerged from the qualitative data was the problem with **P4HB® enrollees who are pregnant**. Two providers (one health department nurse, one private OBGYN) said that newly enrolled members present already pregnant. “Many patients are pregnant already when they present for care with P4HB® coverage.”

## **6.6 Summary of Chapter**

Findings from the quantitative survey results suggest that among providers who serve P4HB® clients, most practice in health departments or solo or group practice settings. More of the OBGYN respondents serve P4HB® clients than family physicians, however all Title X providers serve P4HB® clients. Traditional family planning services are provided to P4HB® enrollees, however, extended services, such as chronic disease management services and inter-conceptual counseling are also offered.

The survey results provide us valuable information about the types of enabling factors that influence health care access through the P4HB® program. First, we learned just as we did through the focus groups, that provider availability is key to enrollment and

service utilization. As stated above, all public health department serve P4HB<sup>®</sup> clients. Also OBGYNs are important providers of care to eligible enrollees as well. Providers also expressed many concerns about the program. Specifically, they identified a general lack of P4HB<sup>®</sup> program information and its restrictive nature as barriers. These barriers were also reflected more broadly in the qualitative survey results. Providers also had major financial concerns about P4HB<sup>®</sup>, namely confusion over billing procedures, low reimbursement for family planning services, and delays with reimbursement. Due to the additional survey results that suggest limited outreach and education to providers about P4HB<sup>®</sup>, additional training is recommended. Such outreach should be provided continuously throughout the demonstration period of the program and incorporate a multi-pronged and collaborative approach between DCH, DPH, and the CMOs.

The qualitative comments reflect the need for better education and outreach to both providers and patients about P4HB<sup>®</sup>, its scope of benefits, as well as its payment and reimbursement policies. Providers also feel that women need to be educated about the types of family planning services that are covered, or not, and women who are pregnant, or even think they might be pregnant, should be better screened before enrollment. Additional feedback from the qualitative survey data suggests that the Medicaid program should consider expanding the types of services covered under P4HB<sup>®</sup>, to include at a minimum, other gyn-related services. Findings from the forthcoming focus groups results indicate that many women were denied coverage for treatment of polycystic ovarian syndrome and other difficulties related to non-family planning gynecological care. In addition, focus group participants expressed interest in seeking help with fertility difficulties and concerns, which are not covered under P4HB<sup>®</sup>.

In the next chapter, we summarize all the data collected for this research. We present our mixed methods findings according to process measures and reflect upon the theoretical framework used for this study.

## CHAPTER 7

### MIXED METHODS RESULTS

#### 7.1 Overview

The previous three chapters summarized findings from different data collection efforts undertaken in this research to examine the implementation of P4HB<sup>®</sup>. These findings reflect multiple perspectives about how this program was conceptualized, planned, and implemented, with explicit details about whether the program was implemented with fidelity and what barriers to successful program implementation still exist. By using a mixture of research methods in an evaluative case study design, we were able to examine whether implementation has occurred in compliance with its statutory goal, as well as the role that resources, and health system factors play into successful implementation. Finally, this approach enabled us to identify facilitators and problems with the implementation of P4HB<sup>®</sup>.

This current chapter presents results from a cross-method analysis of all data collection efforts (qualitative and quantitative). While each component was explored individually, a mixed methods analysis contributes to a deeper understanding of policy implementation as applied to a Medicaid family planning waiver program. In particular, greater insight is achieved by studying the similarities and differences observed across the various methods. Such observations can contribute to a clearer understanding of the different actors involved in policy implementation, the processes required to plan, design,

and implement a program, and the factors that guide or impede successful implementation.

This chapter begins with an overview of our approach to integrate the various qualitative and quantitative data. We describe this process first and then present a clear picture of how the data were used to compare and contrast our study findings. Next, we present a descriptive summary of the findings from each data collection method. Using the process evaluation typology described in Chapter 3, we examine the findings from each methodology by applying these specific measures. Next, we summarize the findings of these process evaluation measures across all three methodologies. Finally, we present the mixed methods results, organized by the research questions identified in Chapter 1. As identified, we use our theoretical framework to identify these research questions. We align our theoretical framework with these research questions and use a matrix to display the intersection of our theory with the study's research questions.

## **7.2 Technique for Integrating Mixed Methods Data**

As described in Chapter 3, we employed concurrent analysis of our data, whereby each source (interviews, document review, focus groups, provider surveys) was analyzed separately and then merged for comparison across themes. This approach, also described as “triangulation,” allowed us to capture a more complete, holistic, and contextual portrayal of the implementation of P4HB<sup>®</sup>. Key to this process, however, is utilizing a strong and consistent technique to integrate the data. As described by Wolf (2010), the “nexus between the qualitative and quantitative analyses needs to be carefully established” (pg. 160). Indeed, we searched for this connection during the analysis phase

but we also searched for divergent findings as well. A common mistake in mixed methods research is to assume that the findings from each data source are simply aggregated and merged only to find common ground (Jick, 1979). We followed the technique described by Creswell and Clark (2007) to transform the quantitative data (provider surveys) into the qualitative data. The advantage of this approach is to allow for the data “to speak” on common ground but also to illuminate similarities and findings in the data (Heese-Biber and Leavy, 2006; Creswell and Clark, 2007).

To prepare for transformation, we first explored and analyzed each source of data and presented the results separately. This stage included conducting the thematic analysis of the qualitative data and the statistical analysis of the provider survey data. Next, we presented the results of each data source, highlighting the major findings and noting which themes emerged across each type of data. For instance, when we reviewed findings about provider outreach and education (from interviews and document reviews for example), we noted what were common themes but also differences. Our interviews with providers revealed an almost complete lack of information sharing from Medicaid and the CMOs; yet, the document reviews indicated that provider outreach had occurred to some extent and throughout the first year of the program. So we noted that provider outreach and education was a major theme throughout our qualitative analysis but that findings about its importance and prominence in the first year of implementation were not conclusive.

Then we were able to move to our next step in the transformation process, which was to examine the provider survey data in a qualitative manner. By transforming our main findings from the statistical analysis of the provider survey, we could compare the

results more easily. Using the example of provider outreach and education, the provider survey data were transformed into themes or factors that were then compared with the themes developed from the other qualitative data. We noted that little provider education had occurred among our survey respondents and that family physicians were the least likely to have received information about P4HB<sup>®</sup>. Title X providers were the group most likely to receive any training on this program, a finding we would not have been privy to, if we had relied only on the interview and document review data. So the data transformation was important for not only observing concordance with some thematic analysis but also to highlight new and unexpected findings as well.

A final stage in our data transformation process was to cross link the findings to our process measures and research questions. This provided the opportunity to map our findings to the theoretical basis of our research as well as a systematic approach to integrate the data. We wanted to make sure that our findings on process measurement and the research questions were addressed using all the data that had been analyzed and appropriately transformed. The next sections present the findings by data collection method, process measure, and research question.

These discussions are aided by matrices that illuminate the key findings of the integrated data. Then we conclude with a summary of the overall findings of this mixed methods approach.



### **7.3 Descriptive Summary of Findings, by Data Collection Method**

#### **7.3.1 Informant Interviews**

As shown in Table 13, several process evaluation measures were applied to the informant interview data. Through this qualitative exploration of implementation, we first observed the fidelity of the P4HB<sup>®</sup> program. The interview data reflects the important role that certain stakeholders played in the conceptualization, design, and planning process of P4HB<sup>®</sup>. In order to understand whether P4HB<sup>®</sup> was implemented as planned, thus had the potential to achieve fidelity, we had to understand how the intervention or program was envisioned, what its goals and objectives were, and how these goals were translated into action. The interview data suggests that many stakeholders- advocates, public health officials, and even providers- worked together initially to identify the policy problem, i.e., low birth weight deliveries and poor maternal and child health outcomes. There was strong initial collaboration among these stakeholders in addressing this issue and formalizing a strategy to combat the policy problem. The solution via a Section 1115 Medicaid family planning waiver program also received support among most collaborators, though some expressed concern that they were not involved in or informed of the final design of P4HB<sup>®</sup>.

Many informants also expressed concern that public health providers, i.e., Title X providers, were not more involved in the planning process and were not explicitly identified in the CMS waiver application as providers of care for P4HB<sup>®</sup> enrollees. Finally, many advocates and providers warned that P4HB<sup>®</sup> has not achieved fidelity due to the lack of awareness by consumers and providers about the program and also because

of low enrollment in the first year. While informants did not expressly provided such data to prove the lack of fidelity, the qualitative information suggests fidelity has not occurred.

<b>Table 13</b>			
<b>Process Evaluation Measures: Informant Interviews</b>			
<b>Process Measure</b>	<b>Definition</b>	<b>Findings</b>	<b>Summary</b>
<b>Fidelity</b>	Extent to which program was delivered as planned. Represents quality and integrity of the intervention. As conceived by key stakeholders or through legislation and other key policy and program documents.	<ul style="list-style-type: none"> <li>• Initial collaboration existed, but top-down approach taken in program design and planning.</li> <li>• Lack of overall enrollment and participation in prevents fidelity</li> <li>• IPC major focus of design, but family planning component better implemented.</li> <li>• Public health providers play major role in serving P4HB clients.</li> <li>• Medicaid statute and program planning documents not adequate sources for observing fidelity. Data on enrollment/outreach/utilization must be included.</li> </ul>	Informants from advocacy and provider organizations expressed concern over not being involved in final design of the program; believed more women would be enrolled, and thus, have access to IPC and FP services within the first year. Data reflect poor visibility of program and low enrollment/utilization of program services prevents fidelity of the intervention.
<b>Recruitment</b>	Procedures used to approach and attract participants and providers. Recruitment at the individual, organizational, and community levels.	<ul style="list-style-type: none"> <li>• Lack of outreach to providers and potential enrollees</li> <li>• Despite advertisements and some educational efforts, confusion exists about nature of program and scope of services</li> </ul>	With exception of Medicaid official, most informants believe more extensive recruitment of clients is needed as well as better outreach to providers who don't understand P4HB.
<b>Satisfaction</b>	Attitudes of participants and providers toward the program's content and service delivery. Also provider satisfaction of program reimbursement system.	<ul style="list-style-type: none"> <li>• Many public health providers happy to be able to serve existing clientele (and new source of funding) but complained about administrative difficulties (enrollment, reimbursement)</li> <li>• Private providers also concerned about reimbursement and limited scope of program services</li> </ul>	Title X clinic providers seeing few clients enrolled in P4HB and acknowledge difficulties with enrollment process.
<b>Barriers</b>	Problems encountered reaching participants and also experienced by participants in both enrollment and accessing services. Also barriers faced by Medicaid and other agencies (such as Title X).	<ul style="list-style-type: none"> <li>• Informants acknowledge major barriers to outreach and education and awareness of program; all have resulted in low enrollment</li> <li>• IPC component not well implemented; lack of understanding and outreach may be biggest barrier to implementation.</li> </ul>	Informants, including Medicaid and public health officials, acknowledge enrollment as biggest barrier to P4HB.

Findings from the informant interviews also suggest that there has been poor recruitment of both consumers and providers. The informants report that consumers are not aware of the program or are confused by the name of the program to mean a program aimed at pregnant women. Also some feel that women are confused about their coverage once they are auto enrolled from the RSM and Peach Care programs. Public health providers report outreach and education of their clientele and assist with enrollment of these women. Providers, however, are confused about the nature and scope of the program and about billing and reimbursement. Most informants believe more extensive recruitment of clients is needed as well as better outreach and education to providers, particularly those who serve women eligible for the IPC component of the program. Informants are pleased that Medicaid has the potential to serve more women for their family planning needs. Public health providers are also happy about the potential to serve these clients and to be able to save their Title X funds. However, many informants were concerned about the lack of awareness in the general population about P4HB<sup>®</sup> and the low enrollment in the first year. Several informants also noted the low utilization of P4HB services, and suggested that better outreach and education to current P4HB<sup>®</sup> enrollees would increase utilization.

Many barriers were identified through the interview data, including problems with outreach and education, enrollment procedures, billing, and the limited scope of covered services. Also informants noted that the IPC component of P4HB<sup>®</sup> has not been implemented well, with few women enrolled in the first year and a general lack of outreach to certain providers in the NICU and perinatal centers throughout the state. Many informants feel these barriers limit the fidelity of the P4HB<sup>®</sup>.

### 7.3.2 Document review

The use of documentary analysis appears to be a useful indicator for measuring policy implementation. However, various types of documents must be considered when assessing implementation. As shown in Table 14, we found that some documents, such as the Medicaid statute and DCH Concept Paper reflect policy and program planning and design and provide the basis for assessing *fidelity*. However, these documents are not complete sources of information because they do not provide information about whether P4HB<sup>®</sup> has achieved its intended results. Accordingly, we relied on the P4HB<sup>®</sup> quarterly reports and 2011 Annual report to provide data on outreach/education, enrollment and services utilization. These documents provide more concrete information about whether the goals and objectives of P4HB<sup>®</sup> have been met.

From a review of the documents, we observe the lack of *reach* for P4HB<sup>®</sup>. Less than six percent of eligible women have enrolled in the FP component of the program, and less than one percent enrolled who were eligible for the IPC component. While enrollment increased through the first year of the program, utilization rates have remained low. Outreach and marketing efforts were in place to initiate reach and *recruitment* of P4HB<sup>®</sup> participants, however, these appear not to be as effective as planned. Additional funding for such outreach efforts are not currently in place, though CMOs and Medicaid RSM workers continue to market the program on their own.

*Dose received*, or the extent to which participants receive services, appears to be lower than anticipated in the first year of the program. The P4HB<sup>®</sup> quarterly reports and 2011 Annual report were reviewed. The FP participation rates, 25%, were lower than anticipated, as were participation rates for the IPC component. Service utilization data are

currently being analyzed for FP participants, however preliminary data of the IPC enrolled member indicate that women received gynecologic care as well as care for the management of chronic conditions.

<b>Table 14</b>			
<b>Process Evaluation Measures: Document Review</b>			
<b>Process Measure</b>	<b>Definition</b>	<b>Finding</b>	<b>Summary</b>
<b>Fidelity</b>	Extent to which program was delivered as planned. Represents quality and integrity of the intervention.	<ul style="list-style-type: none"> <li>• Concept paper first documentation of program goals and objectives. Does not translate as such to Medicaid regulation.</li> <li>• Medicaid statute omits IPC reference in policy statement though this component is referenced later.</li> <li>• Quarterly reports and 2011 Annual report denote lower than anticipated enrollment and utilization</li> </ul>	Concept paper served as basis for P4HB <sup>®</sup> design and policy planning, yet Medicaid regulation reflects different purpose. Basic design and scope of services are enumerated in statute and other guidelines.
<b>Reach</b>	Proportion of intended audience that participates in the program. Includes reach of Family Planning (FP) and Inter-pregnancy care (IPC) participants <u>and</u> providers	<ul style="list-style-type: none"> <li>• Less than 6% of eligible women enrolled in P4HB<sup>®</sup> FP component in first year.</li> <li>• Less than 1% of eligible women enrolled in IPC component.</li> <li>• Enrollment increased throughout first year of program, but utilization rates are considered to be low.</li> <li>• Program experienced growth in number of women deemed eligible for both FP and IPC components.</li> </ul>	P4HB <sup>®</sup> does not successfully reach intended audience in first year of program, in either FP or IPC components. Are Title X enrolled clients not enrolling?
<b>Recruitment</b>	Procedures used to approach and attract participants and providers. Also includes recruitment at the individual, organizational, and community levels.	<ul style="list-style-type: none"> <li>• Marketing budget in place prior to implementation, in amount of \$150,000.</li> <li>• Interagency financing of outreach and marketing suggests potential for cross-agency recruitment</li> <li>• Provider training and client outreach continued through first year of implementation. RSM workers conduct much of outreach.</li> <li>• Budget constraints restricted active recruitment beyond</li> </ul>	Multi-pronged marketing and outreach plan is reflected in many documents. Budget in place prior to implementation suggests resources were available for recruitment. Ongoing recruitment and other strategies may have been needed to reflect health literacy and location/availability of eligible population.

		first year of program.	
<b>Dose Received</b>	The extent to which participants actively sought family planning and/or inter-pregnancy care services through P4HB <sup>®</sup> .	<ul style="list-style-type: none"> <li>• First 3 Quarters of 2011 used CMO data to reflect enrolled members' participation rates. These rates were deemed low, below 25% participation in FP component.</li> <li>• Participation rate later defined through enrollment data of eligible population.</li> <li>• Service use and cost estimates in first year reflect utilization of IPC services for gynecologic care and management of chronic conditions.</li> <li>• Cost estimates for FP enrolled P4HB<sup>®</sup> women not available by end of 2012.</li> </ul>	Challenges exist with measuring dose received, due to availability of data and measure of participation, which changed throughout the first year of program. Current reports suggest low enrollment and therefore, utilization of services in either component of P4HB <sup>®</sup> .
<b>Barriers</b>	Problems encountered reaching participants and also experienced by participants in both enrollment and accessing services. Barriers faced by Medicaid and other agencies (such as Title X) will also be assessed.	<ul style="list-style-type: none"> <li>• Quarterly reports and 2011 Annual report recognize lower-than-anticipated enrollment and service utilization</li> <li>• Delays in application procedures/verification process also noted in these documents.</li> <li>• Provider and consumer outreach is suggested to alleviate difficulties with understanding of the program and enrollment problems.</li> <li>• Partnering with public health district offices also recommended for enhanced recruitment efforts.</li> </ul>	DCH reports submitted to CMS in 2011 and at the end of 2012 (2011 Annual Report) acknowledge these barriers and consider them 'action items' and recommendations for further program improvement.

Our document review reflect certain *barriers* to the P4HB<sup>®</sup> program, namely with low enrollment and participation of enrollees in the first year. The quarterly reports and 2011 Annual Report acknowledge enrollment barriers, specifically with applications being processed and CMO assignments. These documents also suggest further outreach and education is needed to consumers and providers, and such efforts are being made by both DCH and CMO representatives.

### **7.3.3 Focus Groups**

As noted in Table 15, the focus group data provided valuable information about the *recruitment, dose received, satisfaction, and barriers* of P4HB<sup>®</sup>. Focus group participants reported that recruitment efforts occurred mainly by word of mouth, from clinic staff, and also via information letters and flyers received directly from DCH. While auto enrollment has occurred for RSM and Peach Care members, women are still confused about the nature and scope of P4HB<sup>®</sup>, with many uncertain if they were enrolled in the program or not. Overall, women expressed confusion about the nature of P4HB<sup>®</sup>, believing it to be a program for pregnant women or those planning to get pregnancy. Recruitment efforts should be expanded to non-health seeking clients and the broader eligible population. Few focus group participants observed P4HB<sup>®</sup> marketing or mass media materials.

Many enrolled P4HB<sup>®</sup> clients attended the focus groups and reported using the program for birth control, annual exams, and STD testing. However, many clients experienced problems accessing care for gynecological problems, such as fibroids or polycystic ovarian syndrome (POS). Among the two IPC enrolled focus group participants, only one has received Resource Mother services.

Of the P4HB<sup>®</sup> enrollees who attended the focus groups, most expressed appreciation for having coverage of family planning services. As noted previously, some women were frustrated by the limited scope of services included in the program, such as the lack of diagnostic services. Other women expressed frustration with the enrollment process and the burdensome documentation requirements.

<b>Table 15</b>			
<b>Process Evaluation Measures: Focus Groups</b>			
<b>Process Measure</b>	<b>Definition</b>	<b>Finding</b>	<b>Summary</b>
<b>Recruitment</b>	Procedures used to approach and attract participants and providers. Includes recruitment at the individual, organizational, and community levels.	<ul style="list-style-type: none"> <li>• Public health providers conduct outreach and education to clients and community members</li> <li>• Medicaid educates current RSM and IPC enrollees</li> <li>• Focus group participants still confused about P4HB despite education and outreach efforts. Language used in flyers and posters confused participants about the services available in the IPC and FP components.</li> <li>• Few participants observed P4HB<sup>®</sup> advertisements or public marketing efforts.</li> <li>• Many women in RSM and Peach Care were enrolled, without understanding their enrollment status or the purpose/scope of the program.</li> </ul>	Outreach to eligible P4HB clients occurs word of mouth and via Medicaid communication channels. Auto enrollment of RSM and Peach Care women seems problematic as these women do not understand P4HB <sup>®</sup> . Messaging about purpose and scope of P4HB <sup>®</sup> needs improvement, as women do not understand what they are told about the program.
<b>Dose Received</b>	The extent to which participants actively sought family planning and/or inter-pregnancy care services through P4HB <sup>®</sup> .	<ul style="list-style-type: none"> <li>• P4HB<sup>®</sup> participants use program for birth control, STD testing, and pregnancy testing.</li> <li>• Several participants reported difficulty with access to care for gynecological difficulties</li> <li>• IPC enrolled women do not access inter-pregnancy care services. Only one has regular contact with Resource Mother</li> </ul>	Among those enrolled in P4HB <sup>®</sup> , most use program for family planning services. Enrollees experience difficulties with diagnostic services related to infertility and other gyn problems.
<b>Satisfaction</b>	Attitudes of participants and providers toward the program's content and service delivery. Includes provider satisfaction of program reimbursement system.	<ul style="list-style-type: none"> <li>• P4HB<sup>®</sup> enrollees are happy with family planning related services. However, the lack of other non-FP services is a complaint expressed by many enrollees.</li> <li>• P4HB<sup>®</sup> enrollees expressed confusion about scope of program services and thought dental care</li> </ul>	Overall, satisfaction among those enrolled in P4HB <sup>®</sup> is high. However, participants wished more services were covered and that the enrollment process was easier. Many women auto enrolled in the program do not seem to be using the services and were surprised to find out they were in the program.



		<p>was covered.</p> <ul style="list-style-type: none"> <li>• Many enrollees complained about enrollment process, documentation requirements.</li> </ul>	
<b>Barriers</b>	<p>Problems encountered reaching participants and also experienced by participants in both enrollment and accessing services. Includes barriers faced by Medicaid and other agencies (such as Title X) will also be assessed.</p>	<ul style="list-style-type: none"> <li>• While women who use public health clinics learned about P4HB<sup>®</sup> at these sites, or through Medicaid via the auto enrollment process, women do not feel that others know about this program.</li> <li>• Also there were many complains about the limited services, about the confusion over the name of the program, and about how difficult it was to get enrolled.</li> </ul>	<p>Lack of understanding of P4HB<sup>®</sup> and enrollment difficulties seem the biggest complaints. IPC women do not seem to know why they were enrolled or what services they can access.</p>

Focus group participants noted several challenges with the P4HB<sup>®</sup> program. In addition to enrollment difficulties and the lack of diagnostic services, women thought the program should provide more than just family planning services. Many wanted dental and vision services and thought these were included in the scope of services. Women mentioned reading flyers and posters that described such services, but were unaware these services are limited to IPC enrollees.

#### **7.3.4 Provider Surveys**

About one-third of providers surveyed for this research have not been recruited for P4HB<sup>®</sup>. These providers reported that they did not receive any information about the program. However, among the providers who did receive recruitment materials, one-fourth received such information from either DCH or DPH. CMOs have conducted some education and outreach of providers. Public health providers who have participated in

outreach training are expected to assist with enrollment, and are provided by DCH with P4HB<sup>®</sup> applications. Private providers have expressed a desire for more information about the program, specifically on issues related to eligibility, enrollment, and coverage.

<b>Table 16</b>			
<b>Process Evaluation Measures: Provider Surveys</b>			
<b>Process Measure</b>	<b>Definition</b>	<b>Finding</b>	<b>Example of Finding</b>
<b>Recruitment</b>	Procedures used to approach and attract participants and providers. Includes recruitment at the individual, organizational, and community levels.	<ul style="list-style-type: none"> <li>• Surveys asked providers to discuss outreach/education they received about P4HB<sup>®</sup>. Over 1/3<sup>rd</sup> did not receive any info about P4HB<sup>®</sup>.</li> <li>• 1/4<sup>th</sup> of respondents learned about P4HB<sup>®</sup> from DCH. CMOs provided some outreach to providers as well.</li> <li>• Among types of outreach providers received brochures, attended trainings, or other forms of communication.</li> <li>• Public health providers received applications and are expected to help women enroll.</li> <li>• Private providers more likely to ask for additional program information, on topics such as eligibility, coverage and enrollment processes.</li> </ul>	Lack of outreach and education about P4HB <sup>®</sup> is noted with providers. Qualitative comments also reveal confusion about scope of services and frustration with restrictive coverage/benefits of program. Lack of reimbursement also an issue with providers, who wish they could treat other, non-FP services.
<b>Reach</b>	Proportion of intended audience that participates in the program. Includes reach of Family Planning (FP) and Inter-pregnancy care (IPC) participants <u>and</u> providers	<ul style="list-style-type: none"> <li>• Majority of respondents participate in P4HB<sup>®</sup>.</li> <li>• Types of services they provide include birth control, interconception counseling, annual exams, and STD testing and treatment.</li> </ul>	Most providers serving FP clients and providing standard FP services.
<b>Satisfaction</b>	Attitudes of participants and providers toward the program's content and service delivery. Includes provider satisfaction of program reimbursement system.	<ul style="list-style-type: none"> <li>• Satisfaction not expressly addressed, but several barriers noted below.</li> </ul>	

<b>Barriers</b>	Problems encountered reaching participants and also experienced by participants in both enrollment and accessing services. Barriers faced by Medicaid and other agencies (such as Title X) will also be assessed.	<ul style="list-style-type: none"> <li>• Provider noted challenges with limited scope of services, enrollment difficulties, reimbursement, lack of understanding about program.</li> </ul>	Providers have experienced many barriers with the P4HB <sup>®</sup> program.
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A majority of the survey respondents serve P4HB<sup>®</sup> clients. Therefore, there is a good deal of ‘reach’ to the eligible providers who conducted the survey. Respondents indicate that their clients have utilized birth control, STD testing and treatment, and interconception counseling. Providers were not asked specifically about their satisfaction with the program, but qualitative data obtained through the surveys reflect dissatisfaction with specific elements of the program, including the lack of awareness about P4HB<sup>®</sup> in the general population, confusion with the scope of services, low reimbursement, and a frustration with not being able to provide non-family planning services to P4HB<sup>®</sup> enrollees. Unfortunately, we cannot determine strictly through the provider surveys if reach was expansive throughout the state. We only know of those providers who participated in the study. Findings from our informant interviews suggest that provider availability is a problem within P4HB<sup>®</sup> program, as it is across the entire Medicaid program. See Table 16 for an analysis of process measures by provider surveys.

## 7.4 Descriptive Summary of Findings, by Process Measure

In Table 17, we present a summary of the research findings by process measure. We combine the major results from above into specific categories of the process measures to provide a wider view of these measures across the data collection methods. As such, we examine in greater context how process evaluation measures can and have been used to observe the implementation of P4HB<sup>®</sup>.

<b>Table 17</b>			
<b>Process Evaluation Measures: Summary of Findings by Process Measure</b>			
<b>Informant Interviews</b>	<b>Document Review</b>	<b>Focus Groups</b>	<b>Provider Surveys</b>
<b>FIDELITY</b>			
Observed informants' perspectives on the purpose, goals, objectives of P4HB <sup>®</sup> . Examined collaboration among stakeholders in shaping program goals and objectives. Less consensus existed among program design and implementation	Authorizing legislation and program planning documents (Concept Paper, CMS STCs) provide baseline for assessing fidelity, but do not reflect whether program was delivered as planned. Data-specific documents (P4HB <sup>®</sup> Quarterly Reports, 2011 Annual Report) provide more guidance.	Not observed as participants were not involved in design or planning of P4HB <sup>®</sup>	Not observed as survey respondents unlikely to be involved in design or planning of P4HB <sup>®</sup>
<b>REACH</b>			
Not observed through interviews although many informants felt that program is not performing as planned due to low enrollment and participation.	Measured by the number of women enrolled and participated in P4HB <sup>®</sup> . Data reflect lower-than-anticipated enrollment in FP and IPC components. Participation is also low in both, and utilization data are still being analyzed after first year of program.	Not observed, due to limited number of focus group participants.	Observed through surveys that indicate a majority of respondents are participating in P4HB <sup>®</sup> and providing traditional FP services to enrollees.
<b>RECRUITMENT</b>			
Observed through qualitative information about recruitment strategies for both providers and participants Outreach and education as well as marketing data are shared as well.	Measured by the type and number of consumer and provider outreach and education activities. Recruitment also measured by marketing plan and budget.	Measured by how and whether participants learned about P4HB <sup>®</sup> . Most enrollees recruited via word of mouth. Of those who were auto enrolled, few understood the program.	Observed provider outreach and education about P4HB <sup>®</sup> . Respondents indicate the source and type of recruitment they received. Most reported receiving brochures, flyers from DCH and their CMOs.
<b>DOSE RECEIVED</b>			
Not observed.	Observed through P4HB <sup>®</sup> quarterly reports and 2011	Observed through qualitative information	Observed through survey responses to the number

<b>Table 17</b>			
<b>Process Evaluation Measures: Summary of Findings by Process Measure</b>			
<b>Informant Interviews</b>	<b>Document Review</b>	<b>Focus Groups</b>	<b>Provider Surveys</b>
	Annual report, which are required to report enrollment and utilization of covered services. These documents can be compared to planning documents to reflect upon fidelity as well as overall dose received. Lack of fidelity due to low enrollment and participation.	gathered from focus group participants about utilization of the program and types of services received. Most participants report using P4HB <sup>®</sup> for family planning services.	of enrollees served and type of services provided. Exact number of services not gathered through survey.
<b>SATISFACTION</b>			
Observed from informants' perspectives and attitudes about the planning and implementation of P4HB <sup>®</sup> . Provides range of perspectives from public health officials, providers, and advocates..	Not observed.	Observed through qualitative information gathered from focus group participants about satisfaction with the program and services provided. Many participants were pleased to have the coverage and access to family planning services, though they expressed confusion about the scope of services and nature of the program.	Observed through qualitative comments at the end of survey. Several providers expressed frustration with the lack of awareness of the program among eligible women, as well as limited scope of services and low reimbursement.
<b>BARRIERS</b>			
Observed through qualitative information gathered in interviews. Participants identified barriers with awareness of program, understanding the nature and scope of program, as well as problems with enrollment and utilization of services.	Observed in P4HB <sup>®</sup> quarterly reports and 2011 Annual Report. Barriers to enrollment and participation are noted. Recommendations also provided for enhancing consumer and provider outreach and education.	Observed through qualitative information gathered from participants about enrollment, understanding and awareness of program and scope of services. Participants complained about the lack of non-family planning services that are available.	Observed through provider responses to program barriers, which included limited scope of services in P4HB <sup>®</sup> , low reimbursement, and general lack of P4HB <sup>®</sup> program information.

*Fidelity* is defined as the extent to which an intervention has been implemented as planned. This term also denotes the ability of the intervention to achieve its intended outcomes. In a process evaluation, we do not measure the intended outcomes, but rather the ability of achieving such results as demonstrated by the implementation process. For our study, we interviewed stakeholders and reviewed key program materials to learn

about the purpose, goal, and objectives of P4HB<sup>®</sup>. Our specific focus was understanding how the program was designed, its purpose, and major objectives. Our interviews allowed us to observe the conceptualization of the program, which occurred through multidisciplinary collaboration among public health and Medicaid officials, advocates, and providers. Findings revealed that less consensus occurred in the design of the program, and that many informants worried that fidelity has not been achieved due to incomplete outreach and education to consumers and providers, low enrollment among eligible women, and poor utilization of services.

It was more difficult to assess the program's fidelity through our documentary analysis. Several documents, including the Medicaid statute, DCH Concept Paper, and CMS STCs, outline the purpose and goals of the P4HB<sup>®</sup> program, but they do not reflect whether these goals have been achieved. Furthermore, fidelity requires an assessment of the execution of implementation, and as such, these specific documents only reflect the implementation *plan*, or the intention. They do not reflect *results*. Therefore, only by including the data on outreach/education and enrollment did we begin to understand whether these goals and objectives have been met. Therefore, the P4HB<sup>®</sup> quarterly reports and 2011 Annual Report were helpful in assessing fidelity to the intervention.

*Reach* is the proportion of the intended audience that participated in the program. We were able to measure reach primarily through the document review and provider survey. We gathered specific data about the enrollment through a review of the Concept Paper and CMS evaluation reports. Such information indicated that P4HB<sup>®</sup> has experienced lower-than-anticipated enrollment among P4HB<sup>®</sup> clients and delays between applications and CMO enrollment. Provider data also reflects information about the reach

of P4HB<sup>®</sup>. Namely, among the 104 survey respondents, a majority (75%) serve P4HB<sup>®</sup> clients and provide these enrollees traditional family planning services and inter-conception care counseling. Thus, while we can determine that some reach has occurred to the intended audience, we cannot determine whether the full scope of this reach has yet occurred within the first year of the P4HB<sup>®</sup> program

*Recruitment* refers to the procedures used to approach and attract participants and providers to the intervention or program. This process measure was applied to all data collection efforts. Our informants provided information about the type of outreach and education that was expected while P4HB<sup>®</sup> was being planned. We also learned from providers that such outreach and education is not occurring as planned or hoped. Our document review allowed us to review the DCH Communications Plan and Provider Outreach Plan that details the recruitment efforts for both providers and consumers. Focus group participants also provided information about how they were recruited into the P4HB<sup>®</sup> program and what type of recruitment efforts were most successful. Finally, the surveys reflect the type of outreach and education provided to participating providers. Qualitative information from the surveys also expressed the desire to have more education and information about the program since providers felt there was a lack of overall awareness about P4HB<sup>®</sup>.

*Dose received* is a process measure that reflects active participation and utilization of services by both enrollees and providers. So unlike *reach*, which examines mainly applications and enrollment in P4HB<sup>®</sup>, dose received can measure what type of services women have utilized in the program and what services provider give to enrolled P4HB<sup>®</sup> clients. While data are still being analyzed to determine utilization of family

planning and IPC services, available data in the evaluation report for 2011 indicates that some IPC members are accessing primary care services. The surveys do not necessarily give a specific number of services, but the data do reflect the type of services that participating providers deliver to enrolled P4HB<sup>®</sup> clients. These services are traditional family planning services (annual exams, contraception, STD testing and treatment), as well as interconception counseling. Among the focus group participants who know they are enrolled in P4HB<sup>®</sup>, most reported using the program for family planning services. And while only 2 IPC clients participated in the focus groups, only one indicated using IPC covered services. Therefore, it appears that P4HB<sup>®</sup> enrollees do indeed receive services and are active participants in the program. Participating providers also deliver the intended services to enrollees. The difficulty, however, with measuring dose received through the focus groups and surveys is that we are not necessarily capturing the entire eligible population of either consumers or providers who could participate in the program.

*Satisfaction* is simply the attitudes that participating clients and providers have toward the intervention. In our study, we addressed this process evaluation in the informant interviews, focus groups, and provider surveys. Informants shared their attitudes about not only the current state of the implementation process, but also how they felt during the planning phase of the program. Many informants were pleased that the state decided to apply for a Medicaid family planning waiver, but also felt disappointed by the top-down approach to its implementation. Many informants felt excluded in the design of the program as well as implementation and felt there was a lack of transparency fueled mainly from DCH officials. The focus group participants expressed satisfaction



with the type of family planning services they have been able to access, however they also expressed frustration and confusion over the nature of the program and exclusion of non-family planning related services. Providers also expressed their attitudes towards P4HB<sup>®</sup>, with most reporting difficulties in serving eligible clients and frustration with billing and low reimbursement.

*Barriers* was the last process measure applied to this research project. We were able to measure barriers through each of the data collection methods. Informants consistently shared their opinions about the problems inherent in the P4HB<sup>®</sup> program, from the pre-implementation phase to the actual implementation of the program. The document review also identifies barriers to enrollment and utilization among P4HB<sup>®</sup> clients, while detailing the strategies for reducing such barriers. Focus group participants discussed their difficulties with enrollment and access to services (for non-covered services in particular). These participants also discussed the lack of understanding and awareness of P4HB<sup>®</sup> as a major barrier for other eligible women. The surveys addressed barriers, and findings indicate that providers have difficulty understanding the nature and scope of the program, as well as problems with reimbursement and billing.

In summary, our findings reveal that a mixed methods approach provides the opportunity to collect rich data about the implementation process. We are able to observe from multiple perspectives (informants, Medicaid policy and program guidance, enrollees, providers) how the implementation process unfolded and whether this has occurred with fidelity. We learned that the top-down approach to implementation was not well-received outside the Medicaid agency, and that the implementers (providers, public health agencies) have experienced difficulty understanding the nature and scope of

P4HB<sup>®</sup>. Once more, outreach and education about the program is crucial to the implementation process, and for P4HB<sup>®</sup>, this has not occurred broadly enough or with the consistency to reach the fullest possible audience.

## **7.5 Mixed Methods Results**

### ***7.5.1 Results by Research Question***

In this section, we first present our results according to our research questions. We address each of the three research questions, as articulated in Chapter 1, by identifying the data sources and process measures we used to answer these questions (See Tables 18-20). Then we apply certain components of our theoretical framework to each research question to highlight how such theory guided our analysis. Finally, we present a summary of our findings by research question. .

#### **Research Question 1: What policies were developed to plan for the implementation of P4HB<sup>®</sup>?**

Our first research question examined the policies that were developed to plan for the implementation of P4HB<sup>®</sup>. We addressed this question in order to gain an understanding about the goals for the program as well as how it was designed. We were particularly interested in understanding what the program aimed to achieve and how it planned to achieve such goals. In addition, such planning can also reflect the type of infrastructure needed for implementation as well as the types of stakeholders that are involved and/or held accountable for such achieving the program's goals.

As identified in Table 18, we used fidelity as a process measure because it allowed us to gauge the program's design and intended outcomes. It also provided us an

opportunity to incorporate certain components of our theoretical framework, namely statutory coherence and health care access.

<b>Table 18: Results by Research Questions 1</b>			
<b>What policies were developed to plan for the implementation of P4HB®?</b>			
<b>Data Sources</b>	<b>Process Measures</b>	<b>Theoretical Concept</b>	<b>Summary of Findings</b>
Informant interviews, document reviews	Fidelity	<ul style="list-style-type: none"> <li>• <b>Statutory coherence:</b> <ul style="list-style-type: none"> <li>-Clear and concise objectives</li> <li>-Causal linkages</li> </ul> </li> <li>• <b>Health care access</b> <ul style="list-style-type: none"> <li>-Characteristics of the health care delivery system</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Planning process involved multiple stakeholders who attended LBW work group meetings. Information gathered from meetings led to design/plan of P4H® B.</li> <li>• Policy and implementation plans elucidated first through P4HB Concept Paper, then Medicaid regulation, Communications Plan, and Provider Outreach Plan.</li> <li>• Policies not well understood by implementing agencies and representatives.</li> <li>• Lack of hierarchical integration: Public health agencies hold major responsibility for outreach and enrollment of P4HB clients, yet do not receive funding to do such activities.</li> <li>• Funding: While initial funding for program and related outreach was obtained, continued funding for outreach has not been secured.</li> <li>• Officials' commitment: Medicaid and CMO officials are dedicated to P4HB, but some local agencies and providers lack investment due to enrollment/outreach barriers.</li> <li>• Lack of formal access by outsiders: Other than initial collaboration, many advocates, providers and other stakeholders are denied access to information about P4HB. Medicaid maintains complete oversight of P4HB.</li> </ul>

Informant interviews were most helpful in assessing fidelity because certain key stakeholders who were engaged early in the planning process for P4HB<sup>®</sup> could reflect on the purpose and goal of the program. Informants were also able to express their opinions about the planning process, how policies about P4HB<sup>®</sup> were developed and eventually formulated into program guidelines. We also asked informants, particularly providers, whether they understood the program's objectives and their role in obtaining these program goals. Thus, we could assess the program's causal linkages as well as intended planned hierarchical integration within the program. Interviews also provided insight into the characteristics of the health care delivery system, such as the availability of providers as well as the collaboration process. As discussed earlier, one variable of statutory coherence is whether there is formal access by outsiders. We were able to observe this description of the type of collaboration that existed pre-and post-implementation.

Another methodology, document review, was also applied to this research question, and we were able to review the key goals and objectives as articulated through the Medicaid statute and DCH Concept Paper. These documents provided helpful guidance as to the purpose of the program, the resource allocated for the first year of the program's implementation, and the design of provider network. We could explore whether there was any hierarchical integration within and among the implementation institutions as well.

Our findings suggest that the P4HB<sup>®</sup> planning process involved multiple stakeholders who attended the LBW work group meetings. Information gathered from these meetings led to the initial design and plan for P4HB<sup>®</sup>. The policy and implementation plan was formulated via the DCH Concept Paper and eventually

incorporated into the Medicaid regulations as a specific “class” of Medicaid eligibility. Other documents provided insight into the planning phase of P4HB<sup>®</sup>, including the CMS STCs, the P4HB<sup>®</sup>, communication plan and provider outreach plan. There was little hierarchical integration, as implementing agencies and organizations did not seem to understand their role in delivering P4HB<sup>®</sup> services. Also, while public health clinics were explicitly excluded from formal recognition in the planning phase of the program, these providers have major responsibility for assisting women into the program.

Findings also reveal that there was an allocation of funding for marketing in the first year of the program as articulated in several of the policy documents. We learned via the informant interviews, however, that this was not sufficient for sustaining the program beyond the first year. Many informants believed that the low enrollment and utilization of P4HB<sup>®</sup> services in the first year was due to the lack of awareness about the program and inadequate outreach efforts. We also observed that while Medicaid and CMO officials appear to be dedicated to P4HB<sup>®</sup> some local agencies and provider lack investment due to enrollment and outreach barriers. Finally, we observed a lack of formal access to the program by outside entities. Many advocates, providers and other key stakeholders indicated they were not well informed about the status of the Medicaid waiver application or about the program’s implementation. They also reported little post-implementation engagement with Medicaid officials.

**Research Question 2: What resources are in place and how have they been used to implement P4HB<sup>®</sup> as planned?**

Our second research question addresses the type of resources that were in place for the implementation of P4HB<sup>®</sup> as well as the utilization of such resources. As displayed in Table 19, we addressed this question via informant interviews and the document review in order to understand whether such resources were allocated prior to implementation as well as whether and how such resources were used in order to achieve the program's intended outcomes (fidelity). In other words, to assess the program's capacity for fidelity, we aimed to understand whether the program was empowered through an allocation of appropriate financial and human resources. In addition to fidelity, we measured reach and recruitment by observing the type and scope of outreach and marketing that occurred to engage both potential enrollees and providers. The information we gathered on each of these process measure led to identify how such resources were employed in the health care delivery system and used to promote utilization of the program's services. Finally, we noted several barriers to implementation due to the lack of appropriate resource allocation.

<b>Table 19: Results by Research Question 2</b>			
<b>What resources are in place and how have they been used to implement P4HB® as planned?</b>			
<b>Data Sources</b>	<b>Process Measures</b>	<b>Theoretical Concept</b>	<b>Summary of Findings</b>
Informant interviews, document reviews, focus groups, provider survey	Fidelity, reach, recruitment, barriers	<ul style="list-style-type: none"> <li>• <b>Statutory Coherence</b> <ul style="list-style-type: none"> <li>-Allocation of financial resources</li> </ul> </li> <li>• <b>Health care access</b> <ul style="list-style-type: none"> <li>-Characteristics of the health care delivery system</li> <li>-Utilization of services</li> <li>-Barriers to care</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <u>Financial resources</u>: Georgia Legislature committed funds for waiver application and first year state Medicaid matching funds. DPH allocated funds via interagency agreement for outreach and marketing. Funds expended before the first year of program. No additional funding reported for continued or expanded outreach.</li> <li>• <u>Material resources/outreach materials</u>: Medicaid first developed consumer and provider outreach/marketing materials, that were revised in July 2012 to reflect additional information. Focus groups and providers commented that the name and marketing materials send confusing messages to women who interpret the program to be for pregnant women.</li> <li>• <u>Marketing campaign</u>: Multi-pronged marketing approach launched at the start of the program. Ads were placed in buses and trains and select radio stations and magazines. The campaign ended as resources were expended (before end of 2011). Marketing and outreach continues with the assistance of RSM outreach workers and CMOs.</li> <li>• <u>Human resources</u>: Outreach conducted by public health clinic staff who also assist with enrollment. RSM staff conduct outreach via health fairs and other community events on an ongoing basis. CMOs provide communication to new enrollees about program eligibility and service coverage.</li> </ul>

Findings revealed that there were several types of resources in place for the implementation of P4HB<sup>®</sup>. First, there were financial resources, including legislative funding and marketing via an interagency agreement between DCH and DPH. Advocates worked hard to acquire enough funding in the state budget for 2009 and 2010 to support P4HB<sup>®</sup>. First, funding in the amount of \$25,000 was obtained to pay for a Medicaid official to complete the required CMS waiver application. Then, additional state funding was allocated for the first year costs of P4HB<sup>®</sup>. Documents show, and informants corroborate, that a total of \$2 million (state and federal funds) were allocated for P4HB<sup>®</sup>. These costs, however, were secured only for the first year of the program. In addition, there were no specific legislative or federal funds obtained for outreach. Instead, DCH and DPH entered into a one-time interagency agreement that allocated \$150,000 in DPH funds for the marketing of P4HB<sup>®</sup>. These marketing funds were expended, however, before the end of the first year of the implementation of P4HB<sup>®</sup>.

Other resources were developed to prepare for and implement P4HB<sup>®</sup>. DCH developed an initial set of consumer and provider outreach and marketing materials, in the form of an application, P4HB<sup>®</sup> postcards, and flyers/posters. These materials were used throughout the first year of the program, and some informants believed these materials were misleading in terms of the purpose and scope of the program. Focus groups feedback and provider survey results suggest that these materials were also not well developed and sent mixed messages about the P4HB<sup>®</sup> program. Focus group participants, in particular, thought these resources were confusing and reflected a program aimed at pregnant women.



Resources were also used to develop a marketing campaign that was led in large part by DCH. Advertisements were placed in buses and trains and select radios and magazines. The full scope of marketing campaign ended before the end of 2011 as funding was expended. RSM outreach workers and CMO representatives are believed to continue outreach and marketing of the program via health fairs and patient and provider newsletters.

Finally, we learned that health care providers are a type of human resource that has been utilized to promote P4HB<sup>®</sup>. Public health clinic staff (Title X staff in particular) conduct outreach and education to their clients about P4HB<sup>®</sup>. While they were only expected at first to hand out copies of the P4HB<sup>®</sup> application, they have been recently instructed by DCH and DPH to assist women with enrollment in the program. These providers also report conducting intermittent community level outreach about P4HB<sup>®</sup>.

Therefore, there were many types of resources allocated for the implementation of P4HB<sup>®</sup>. Financial resources were available to provide program funding as well as outreach and marketing funding. Human resources were used increasingly throughout the first year of the program to promote P4HB<sup>®</sup> and to engage potential enrollees and providers. Despite the availability and allocation of these resources at the start of the program, they changed significantly by the end of the first year of implementation. Financial resources seemed to have dried up, while there was an increased reliance on human resources for the program. These findings suggest that more financial resources are needed in the form of marketing and outreach funding, so that human resources can be used more effectively.

**Research Question 3: Is P4HB<sup>®</sup>, reaching its intended target population with the appropriate services? If not, what improvements can be made?**

Our third and final question addressed whether and to what extent P4HB<sup>®</sup> reached its intended population with the appropriate services. First, we wanted to know if P4HB<sup>®</sup> was able to enroll the target audience (uninsured women, 18-44, with incomes at or below 200%; women who meet these criteria and delivered a very low birth weight baby of less than 1500 grams). Once enrolled, we wanted to understand if women accessed covered services and whether they encountered any difficulties. If enrollment or utilization goals were not achieved, we wanted to know what improvements are suggested to overcome such obstacles.

We were able to use measures of program fidelity, reach, recruitment, dose received, satisfaction and barriers to care to address this last research question (see Table 20). We explored these measures through informant interviews, document review, focus groups, and provider surveys. We were also able to apply select elements of our statutory coherence and health care access theories. Findings suggest that the goals and objectives of P4HB<sup>®</sup> were not well-understood among current and prospective enrollees (lack of statutory coherence). Study participants reported that they did not understand the nature of and scope of P4HB<sup>®</sup>. While such guidance may have been reflected in program policies and guidelines, this information does not translate well into the target population. The lack of clarity could reflect health literacy problems, or a lack of effective marketing and outreach about the program. Indeed, our findings suggest that while there was a sufficient initial allocation of resources, these have not been sustained through the implementation of P4HB<sup>®</sup> to achieve effective enrollment and reach of the program.

<b>Table 20: Results by Research Question 3: Is P4HB® reaching its intended target population with the appropriate services? If not, what improvements can be made?</b>			
<b>Data Sources</b>	<b>Process Measures</b>	<b>Theoretical Concept</b>	<b>Summary of Findings</b>
Informant interviews, document reviews, focus groups, provider surveys	Fidelity, reach, recruitment, dose received, satisfaction, barriers	<ul style="list-style-type: none"> <li>• <b>Statutory coherence</b></li> <li>-Precise and clear objectives</li> <li>-Initial allocation of financial resources</li> <li>Hierarchical integration</li> <li>Formal access by outsiders</li> <li>• <b>Health care access</b></li> <li>-Characteristics of the health care delivery system</li> <li>-Utilization of program services</li> <li>-Satisfaction</li> <li>-Barriers</li> </ul>	<ul style="list-style-type: none"> <li>• Purpose and scope of P4HB® not well understood among consumers or providers. Suggest that objectives/goals are not clearly articulated in program materials or advertisements.</li> <li>• Initial allocation of financial resources (legislative funding, marketing) appear to be sufficient. Too much reliance on human resources that might prevent effective outreach.</li> <li>• Initial implementation conducted from top-down perspective. Local implementers, such as Title X clinics, were increasingly engaged in the middle of the first year of program.</li> <li>• Advocates and some providers hoped for more transparency in program planning and post-implementation collaboration.</li> <li>• Data reflect low first year enrollment in either FP or IPC. This suggests P4HB® is not reaching its intended audience. Also implies lack of fidelity to the intervention.</li> <li>• While pleased with the overall scope of P4HB®, many consumers and providers wished the program covered more services. Additional requests were made for better information and outreach about the program to increase awareness and understanding of P4HB®.</li> </ul>

Findings also reveal that P4HB<sup>®</sup> has failed to reach its intended audience in part due to the lack of engagement of providers, many of whom expressed frustration and confusion in the program enrollees. Other providers and advocates wished they had more engagement with DCH post-implementation. Thus, there seems to be a lack of formal access by these stakeholders.

Our results also suggest that P4HB<sup>®</sup> has not reached its intended audience because of low enrollment among the FP and IPC clients. As discussed earlier, a review of the DCH quarterly reports and 2011 Annual Report revealed that less than six percent of eligible women were enrolled in the FP component of the program, and less than one percent of eligible IPC clients were enrolled. Increased outreach efforts by DCH and CMOs appear to be addressing this problem. Focus group participants shared their opinions about P4HB<sup>®</sup>. For those who know they are enrolled in the program, they expressed satisfaction gratitude with the opportunity to seek services. These participants also appear to be using the program for traditional family planning services (annual exams, contraception). However, the focus groups revealed that many women did not know they were in the program and thus have not been using the covered services. This finding suggests that awareness and understanding of one's enrollment status (and of the program in general) is linked directly to the reach and utilization of P4HB<sup>®</sup> services.

In summary, P4HB<sup>®</sup> has not reached its intended target population to the degree it had anticipated. While some utilization appears to have occurred, and those who have used the program are satisfied, the program has not achieved fidelity due to low enrollment and utilization. Lack of program outreach and education, and overall awareness of the program, are the major barriers to utilization. Many informants

(stakeholders, focus group participants, and providers) recommend improved outreach and marketing to the target population. Such efforts should be clear as to the purpose and scope of the program. Providing formal access to the implementation process is also recommended, as it engages other key stakeholders who can assist with enrollment and outreach and marketing of P4HB<sup>®</sup>. Also engaging key stakeholders (advocates, providers) in an on-going basis can help provide important feedback to DCH about the program and its progress toward achieving its goals.

## **7.6 Summary**

Our careful approach to integrating the mixed methods allowed us to explore whether and how the data emerged with similar or discordant findings. In addition, through a process of data transformation, we were able to analyze the data comparatively in common thematic form. We then applied these data to our process measures and key research questions to illuminate our major findings. By presenting these analyses in matrix form, we were able to illustrate how the data were used to inform the findings and where similarities or differences occurred.

Overall, our mixed methods findings suggest that implementation is a critical stage in the policy process as it allows for the potential of policy goals and objectives to be transferred into measurable and obtainable outcomes. We learned through our study that implementation must be considered during the development phase of the program. Such planning must consider the necessary and appropriate financial and material resources needed to carry out the program's implementation as well as the human resources or manpower that will be required to achieve effective implementation. In the

case of P4HB<sup>®</sup>, there was an allocation of initial financial resources, but these did not translate well into the outreach and education that was needed to inform consumers and providers about the program. As a result, there was low enrollment participation in P4HB<sup>®</sup> in its first year.

Implementation planning must also involve and actively integrate implementing agencies that are responsible for the program's operations. In the case of P4HB<sup>®</sup>, providers and some public health officials felt shut out or ignored after DCH received approval for the waiver program. These stakeholders also expressed concern about the lack of engagement during the implementation phase of the program when they held major responsibility for recruiting and educating P4HB<sup>®</sup> clients. Other informants, who may have been considered outsiders (without formal implementation roles) wished they also had the opportunity to provide feedback to DCH about the program.

The findings also clarify that the mere articulation of a program's goals and objectives through the provision of legal resources or a regulation does not assure successful implementation. Even a coherent statute, such as the one for P4HB<sup>®</sup>, does not necessarily incorporate all components necessary to implement a program successfully. We learned that the P4HB<sup>®</sup> statute and other relevant policy documents failed to address outreach and education, components that were critical for providing information to consumers and providers about the program. There were no considerations of the resources needed to conduct these program activities and as a result, the lack of such resources resulted in low P4HB<sup>®</sup> enrollment participation.

We also found through our mixed methods results that it is important to consider the health care delivery system in which P4HB<sup>®</sup> operates. While many providers are

eligible to serve these clients, the lack of provider awareness and understanding about P4HB<sup>®</sup> serves as a major barrier. In addition, public health providers, such as Title X clinics, are a key portal into the P4HB<sup>®</sup> program, as many clients traditionally access these sites to obtain family planning services. Title X providers need to be more involved in the outreach and education of P4HB<sup>®</sup> clients, and empowered to serve clients effectively. Title X providers also should have been included in the planning and implementation phase of the P4HB<sup>®</sup> program. Also, more involvement of neonatal providers and NICUs is warranted as these providers are likely to have first contact with eligible IPC enrollees who deliver their VLBW babies at these locations.

In the next and final chapter, we review the study's major purpose and design and summarize its major findings. Then, we discuss the research and its implications for theory, practice, and policy. Finally, we provide recommendations for future research and studies of policy implementation.

## **CHAPTER 8**

### **DISCUSSION**

#### **8.1. Overview**

This final chapter begins with a brief review of the study's purpose, theoretical framework, research questions, and design. Next a summary of the findings are presented and situated within the broader literature related to policy implementation. Third, implications for theory, practice, and policy are discussed and considered within the relevance and applicability to public health programs and policies. Finally, we provide recommendations for future research. The chapter closes with a summary of the study's conclusions and a description of next steps for dissemination of the research findings.

#### **8.2 Summary of Study Purpose and Design**

The purpose of this study was to examine the implementation of an innovative health care program in Georgia, known as Planning for Healthy Babies<sup>®</sup> (P4HB<sup>®</sup>), aimed at providing family planning and inter-pregnancy care services to low-income, uninsured women. Our goal was to understand how this program was implemented and whether it was done so with fidelity. In addition, we wanted to understand what factors influence the implementation process and whether certain barriers to implementation exist. We applied process measures to assess specific components of implementation, including fidelity, reach, recruitment, dose received, satisfaction, and barriers. Process evaluation is an essential component of implementation research as it is key to understanding whether the program is implemented as planned and to identify any needed programmatic or implementation improvements. Indeed, this study focused on the first year of the P4HB<sup>®</sup> to allow for any feedback to DCH. Findings from the focus groups and provider surveys



were presented to DCH in November and December 2012, and may be included in future evaluation reports.

The theoretical framework that guided our research incorporated elements from Mazmanian and Sabatier's Policy Implementation Framework and the Aday and Anderson Access to Care Framework. Specifically, our framework examines the relationship between policy development and policy implementation in the context of health care utilization. We applied select variables of statutory coherence to understand whether a top-down approach influenced the implementation process through the provision of legal resources and regulation. We were also able to examine whether and how implementing agencies participating in the implementation process and whether they understood their roles and responsibilities. We also considered the initial allocation of resources for implementing this program. In addition, we included certain enabling factors of health care access to understand whether they influenced the policy implementation process. In particular, we examined how the characteristics and availability of certain providers influenced utilization, satisfaction, and barriers to care.

Our study included three research questions aimed at the implementation of P4HB<sup>®</sup>. These questions allowed us to explore how P4HB<sup>®</sup> was conceptualized and designed, the stakeholders involved in policy planning, and the types of resources that were in place to implement the program.

- 1. What is the purpose of P4HB<sup>®</sup> and what are its major objectives and goals?**
- 2. What resources are in place and how have they been used to implement P4HB<sup>®</sup> as planned?**
- 3. Is P4HB<sup>®</sup> reaching its intended target population with the appropriate services? If not, what improvements can be made?**

We conducted this research using an evaluative case study design that allowed for the investigation of one state program's implementation experience. Our case study focused on whether P4HB<sup>®</sup> was implemented as planned and as such, has the capability of achieving its intended results. Our study, like most implementation case studies, was undertaken to examine whether implementation was in compliance with regulatory intent and to explore potential problems with the program's implementation. We also wanted to explore the contextual factors that influence policy implementation, such as political and financial support, and stakeholder involvement.

To observe all of these complexities in the implementation of P4HB<sup>®</sup>, we used both qualitative and quantitative methods. The qualitative methods included 21 informant interviews, document review (over 20 policy and program documents), and six focus groups with a total of 49 current and prospective P4HB<sup>®</sup> clients. Our quantitative method was a provider survey that was distributed to over 680 providers in Georgia. The findings from each data collection effort are presented in Chapter 4-6. Then findings from all data collection efforts were combined through a process of triangulation, or "data mixing." Analysis of the data were performed concurrently and then transformed and merged during the final stages of analysis. All data were given equal emphasis by comparing and contrasting by major theme, with the intent of drawing valid conclusions about the research problem. Mixed methods results, presented and discussed in Chapter 8, provided greater insight into the factors that influenced the P4HB<sup>®</sup> implementation process.

### 8.3 Summary of Findings

Our research suggests that implementation is critical in the policy process because it defines the stage at which a program's goals or objectives are transferred into practice. Furthermore, it reflects upon whether this process has occurred as planned (with fidelity), and if not, what barriers exist to implementation. This study took into account how a top-down approach, that is when an authorizing agency maintains control, affects the implementation process.

Our study reflects the following major findings:

1) **Statutory coherence does not necessarily result in successful policy implementation.** The mere articulation of a program's goals and objectives through the provision of legal resources or a regulation does not necessarily guarantee successful implementation. While the goals and objectives of the P4HB<sup>®</sup> program were rather precise and clear, these objectives were not necessarily well translated into program guidelines and materials. Also not all implementing agencies understood the full scope of these goals and objectives or their role in implementing the program to obtain these goals. Therefore, we were able to observe little evidence of any causal linkages between Medicaid and the implementing agencies (CMOs, providers), since many providers in particular were confused about the nature and scope of the program. Only the CMOs seem to be empowered and had enough resources to attempt to obtain the program's goals and objectives, though many are still trying to find ways to enroll eligible clients and encourage current P4HB<sup>®</sup> clients to utilize services. In addition, many informants complained they had little outside or formal access to the P4HB<sup>®</sup> program or to DCH

after implementation of the program had occurred. The lack of transparency was a major complaint by many informants in our study. The only positive influence of statutory coherence is the initial allocation of financial resources by the legislature that funded the waiver application and first-year operational expenses. Marketing funds were also allocated through an interagency agreement between DPH and DCH for the first year of P4HB<sup>®</sup>. Unfortunately, this funding was expended by the end of the first year of the program, and additional funding has not been secured.

**2. A “Field of Dreams” Approach to Policy Implementation Does Not Work:**

As the quote in this popular film goes, “if you build it, they will come.” The idea that you can simply create a health care program, give it a name, and expect patients to enroll did not occur with the P4HB<sup>®</sup> program. Even as one advocate stated, “they thought if you build it, they will come..well, they didn’t come.” This study shows how even with certain enabling factors of health care, such as insurance (via P4HB<sup>®</sup>) access to care is not guaranteed. Neither is successful implementation of a program. One of the goals of the P4HB<sup>®</sup> program was to expand access to Medicaid via the waiver program for low-income and uninsured women. Due to the factors identified through our review of statutory coherence, it appears such access was impeded by several factors, such as the lack of understanding and awareness (by consumers and providers) of the nature and scope of the program. Also the decision by DCH to auto enroll certain women into P4HB<sup>®</sup> did not appear to increase utilization, as many women in the focus groups expressed surprise that they were enrolled and had not sought services through the program. Other states, such as Alabama and Mississippi have attempted this enrollment

tactic and found that most auto enrolled women do not make use of their new coverage (Sonfield and Gold, 2011).

Findings from this study suggest that more expansive outreach and education is needed, and such efforts should continue throughout the life of the program (December 2013). However, due to poor outreach efforts, utilization has been affected, and enrollment into P4HB<sup>®</sup> has been very low, in both the FP and IPC components. Recent studies of state Medicaid family planning waiver program have highlighted the importance of outreach and branding for increasing enrollment and utilization. As noted by Sonfield, Aldrich, and Gold (2008), family planning waiver programs have built upon previous Medicaid tactics to conduct outreach to clients. These strategies include mass media campaigns (radio, TV ads), and the use of internet and web-based education. The authors explain that such expensive outreach efforts usually wane after the start of the waiver programs, just as they did in Georgia. In addition, states usually change their outreach tactics to focus on more community-level efforts, such as through local health programs and providers. In addition, states brand their family planning program by using creative names to reflect the purpose or goal of the program. States have used names like “Women’s Health Waiver,” and “Contraceptive Care” or Ccare, to denote the purpose and goal of the program. Unfortunately, as mentioned in Chapter 4, DCH did not want the waiver program to include family planning in its title, because of the legislature which is conservative and not generally in favor of family planning policy. So while Georgia branded its program, the lack of clear branding may have back-fired to cause poor visibility and thus utilization of the program.

**3. Collaboration is Key during All Stages of Implementation.** Findings reflect the need for ongoing collaboration among practice partners during all stages of the implementation process. Informants, especially advocates, felt there was a lack of engagement in the implementation of P4HB<sup>®</sup> after a decision was made to apply for a Medicaid family planning waiver. These informants, many of whom obtained legislative support and funding for P4HB<sup>®</sup>, felt shut out after the Concept Paper was issued. These and other informants, including DPH representatives, wished they were able to collaborate with DCH while the program was being implemented. Such collaboration would have enabled them to provide outreach and education to their own constituents and to be able to educate others about the purpose and scope of the program. These informants also believe that they should be included as advisory council members so that they can provide feedback and ongoing counseling to DCH about the program. They have expressed this wish to DCH officials, who have not responded to these requests.

Provider collaboration is also key to successful implementation, as it enables them to influence the outreach and enrollment process that was identified as problematic through our study. Some providers were informed of the initial concept of P4HB<sup>®</sup>, but few were consulted during the planning process, and none appeared to be actively engaged in the design of P4HB<sup>®</sup>. In fact, one provider whose IPC program became the model for P4HB's inter-pregnancy care component was never consulted about P4HB<sup>®</sup>. We observed through our interviews and provider surveys that many providers have the potential to serve P4HB<sup>®</sup> as well as to enroll them. However, there seems to be a lack of education and outreach to these providers about the program and about how to assist

clients with enrollment. Provider participation and engagement must be an ongoing process during the implementation of a program.

#### **8.4 Implications for Theory, Practice, and Policy**

While these research findings cannot be generalized beyond Planning for Healthy Babies<sup>®</sup> (P4HB<sup>®</sup>), results still offer insight for public policy and public health research. For states considering a Medicaid family planning waiver program specifically or more broadly, expanding their Medicaid programs under health reform, our findings provide empirical evidence about the facilitators and barriers to policy implementation. In particular, we describe the challenges that can occur when implementation occurs through a top-down approach. In addition, as we stated previously, having a coherent statute or regulation or even formal guidance about how a program will be structured does not guarantee successful implementation. Furthermore, when a state maintains absolute control, or access to the program, and does not collaborate fully with available and willing practice partners, program fidelity will likely not occur.

#### **8.5 Implications for Theory and Research**

As identified above, we incorporated elements of statutory coherence and access to care as guiding theory for our research. We found that even if a program is guided by regulation or a legal doctrine, these tools only provide initial guidance for implementation. They do not necessarily prescribe the processes necessary for implementing a program or policy. Such processes are fluid, require multiple revisions, and are often determined by other agencies. For example, we observed that the DCH

Concept Paper was written first, and that through an iterative process of consultation with CMS, certain elements of P4HB<sup>®</sup> changed, including the scope of the program which was narrowed to just VLBW deliveries. The Medicaid P4HB<sup>®</sup> statute (2196) reflects the goal and objectives of the program and eligibility requirements, but no guidance is provided about how outreach and education is to occur, or best strategies for enrollment. These considerations were later developed, through outreach and communication documents, as well as CMO provider guidelines.

Other elements of the statutory coherence framework fell short in our study, as we were not able to observe clear examples of the program's inclusion of causal theory or hierarchical integration within or among integrating institutions. Due to the lack of understanding and awareness of P4HB<sup>®</sup> among many local and community partners and providers, this integration was not observed. For research purposes, however, the allocation of resources appears to be a positive indicator of the implementation process. We found that financial resources in particular were key to the authorization of P4HB<sup>®</sup>, as well as initial marketing of the program. Human and material resources must be explicitly stated and observed in any studies that incorporate statutory coherence in its framework, as these appeared to be lacking in the P4HB<sup>®</sup>, program.

Finally, our attempt at integrating theories of Aday and Anderson's health care access framework was an important exercise. We learned that statutory coherence (or the lack thereof) can affect the health care delivery system which is vital to the implementation of P4HB<sup>®</sup>. In particular, we learned that due to a lack of collaboration and understanding about P4HB<sup>®</sup> among providers and key implementing agencies, enrollment has been low. As a further effect, low utilization has occurred as well. We



found that incorporating the positive and negative aspects of health care access (satisfaction and barriers to care) were useful as well. Through our interviews, focus groups, and even provider surveys, we captured participants' perspectives about what was working well in the program, and what barriers to care still existed. P4HB<sup>®</sup> enrollees who were aware of their enrollment status seemed pleased to have the added health care coverage and were using the program to obtain contraception and some preventive care services. Providers and some advocates were glad that P4HB<sup>®</sup> was available as an expansion program, though many expressed confusion and doubt about the nature and scope of the program.

## **8.6 Implications for Practice and Policy**

Results of this research may have implications for the practice of state Medicaid expansion programs as well as state health reform efforts to expand access to care for low-income, uninsured population. Even though this evaluation study focused on one case (P4HB<sup>®</sup>), public health officials and researchers can take away many lessons from the implementation of the Planning for Healthy Babies Program<sup>®</sup>. These lessons learned are as follows:

- 1) Involve as many practice partners and interested parties in the policy formation and policy planning process as possible.
- 2) Formal program guidelines and legal tools (regulations in particular) must reflect input and consensus among all collaborating individuals and entities.
- 3) Formal program guidelines should be explicit in the purpose and goals of the program or policy, as well as the allocation and availability of resources. Such

guidelines should also reflect eligibility, recruitment, enrollment, disenrollment, and service coverage and utilization.

- 4) Resources should be available prior to and after implementation. These resources should include financial, human, and material resources to effectively reach the intended audience (or consumers).
- 5) Consumer materials should be developed with input from the consumers and incorporated at an appropriate health literacy level.
- 6) Program names should be branded to adequately reflect the nature of the program and the intended audience.
- 7) The implementation process should be evaluated by the end of the first year of the program so that needed changes can be made efficiently and in time for such changes to take place.

## **8.7 Conclusion and Next Steps**

While this was a narrowly focused evaluation that incorporated one case study, it provides insight into the policy implementation process as well as the factors that influence successful implementation. It also displays the effects of the top-down implementation approach and unfortunately, highlights the many barriers inherent in this strategy. We were also able to shed light on the importance that stakeholder collaboration, outreach and education, and funding play in policy implementation.

This study offers a current view of policy implementation and evaluation. Our focused study of implementation can be valuable for many states that are preparing to

expand their Medicaid programs as allowed under the Affordable Care Act (ACA). Given that many states are just now going through the planning process, we hope that these findings can be useful in helping states develop appropriate implementation strategies. In addition, such strategies should consider appropriate theory to lead their implementation process as well as to evaluate the short and long-term outcomes of these programs.

In addition, using data from multiple sources and methodologies, as was employed through this study, provides a useful exercise in planning for and describing the implementation process. A mixed methods perspective allowed for a more holistic perspective and insight into which stakeholders can and should play a part in implementation and what measures of implementation should be incorporated into the planning process. In addition, we learned through a mixed methods approach that our study was informed by both agreement and discordance across themes. We learned to not only try and reconcile these similarities and differences but also to acknowledge that they provide assistance with identifying the challenges and strengths of policy implementation evaluation.

The next step of this research will include preparing manuscripts from the dissertation work. We anticipate submitting manuscripts to public health and public policy journals upon completion of the dissertation. Such manuscripts will highlight the results from the qualitative and quantitative results, and we anticipate at least one manuscript that will reflect the mixed methods findings. We will also consider submitting manuscripts to public administration and evaluation journals to highlight the methodological and evaluation approaches used for this research.

## **APPENDIX A**

### **IRB APPROVAL LETTERS**

INSTITUTIONAL REVIEW BOARD  
REVIEW BOARD

Mail: P.O. Box 3999  
Atlanta, Georgia 30302-3999  
Phone: 404/413-3500  
Fax: 404/413-3504

In Person: Alumni Hall  
30 Courtland St, Suite 217

February 7, 2012

Principal Investigator: Thomas, John Clayton

Student PI: Sarah Blake

Protocol Department: Public Management and Policy

Principal Investigator Department: Public Administration & Urban

Protocol Title: Planning for Healthy Babies (P4HB) Program: A Process Evaluation

Submission Type: Protocol H12166

Review Type: Expedited Review, Expedited 6, 7

Approval Date: February 7, 2012

Expiration Date: February 6, 2013

The Georgia State University Institutional Review Board (IRB) reviewed and approved the above referenced study and enclosed Informed Consent Document(s) in accordance with the Department of Health and Human Services. The approval period is listed above. Federal regulations require researchers to follow specific procedures in a timely manner. For the protection of all concerned, the IRB calls your attention to the following obligations that you have as Principal Investigator of this study.

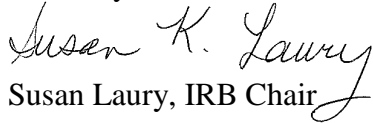
1. When the study is completed, a Study Closure Report must be submitted to the IRB.
2. For any research that is conducted beyond the one-year approval period, you must submit a Renewal Application 30 days prior to the approval period expiration. As a courtesy, an email reminder is sent to the Principal Investigator approximately two months prior to the expiration of the study. However, failure to receive an email reminder does not negate your responsibility to submit a Renewal Application. In addition, failure to return

the Renewal Application by its due date must result in an automatic termination of this study. Reinstatement can only be granted following resubmission of the study to the IRB.

3. Any adverse event or problem occurring as a result of participation in this study must be reported immediately to the IRB using the Adverse Event Form.
4. Principal investigators are responsible for ensuring that informed consent is obtained and that no human subject will be involved in the research prior to obtaining informed consent. Ensure that each person giving consent is provided with a copy of the Informed Consent Form (ICF). The ICF used must be the one reviewed and approved by the IRB; the approval dates of the IRB review are stamped on each page of the ICF. Copy and use the stamped ICF for the coming year. Maintain a single copy of the approved ICF in your files for this study. However, a waiver to obtain informed consent may be granted by the IRB as outlined in 45CFR46.116(d).

All of the above referenced forms are available online at <https://irbwise.gsu.edu>. Please do not hesitate to contact Susan Vogtner in the Office of Research Integrity (404-413-3500) if you have any questions or concerns.

Sincerely,

  
Susan Laury, IRB Chair

Brenda Fitzgerald, MD, Commissioner Nathan Deal, Governor  
2 Peachtree St. NW, 15th Floor  
Atlanta, Georgia 30303-3142  
www.health.state.ga.us

Apr 11, 2012  
Sarah Blake  
Doctoral Student  
Georgia State University  
2643 Willow Cove  
Decatur GA, 30033  
Project: 120304 - Planning for Healthy Babies, A Process Evaluation

Project Status: Approved Until 04/11/2013

Dear Researcher,  
The above-referenced project was reviewed by the DPH Institutional Review Board in accordance with expedited review procedures outlined in 45 CFR 46.110(b)(1), categories 7.

The Board has approved this study until 04/11/2013.

If you wish to continue this project beyond the current approval period, please submit a "Continuing Review Application" before the above expiration date. If you do not submit a renewal application before the expiration date, the approval of your project will automatically terminate. Any involvement with human subjects must cease on the above date unless you have received approval from the Board to continue the project. It is the investigators responsibility to track the deadline.

This approval applies only to the protocol described in your application. IRB review and approval is required before implementing any changes in this project except where necessary to eliminate apparent immediate hazards to human subjects.

If you have any questions regarding this letter or general procedures, please contact the IRB Chair at [lufiedorowicz@dhr.state.ga.us](mailto:lufiedorowicz@dhr.state.ga.us). Please reference the project # in your communication.

Best wishes in your research endeavors,

Luke Fiedorowicz, Ph.D. Digitally signed by Luke Fiedorowicz, Ph.D.  
DN: cn=Luke Fiedorowicz, Ph.D., o=Georgia Department of Public Health,  
ou=Institutional Review Board, email=lufiedorowicz@dhr.state.ga.us, c=US  
Date: 2012.04.11 11:29:36 -04'00'

**APPENDIX B**  
**STAKEHOLDER MAPPING FORM**



## P4HB Process Evaluation Stakeholder Mapping Form

This form, adapted from the USAID Health Policy Initiative, was used to identify and map informants and other stakeholders for the study. These informants identified through our recruitment process were asked to participate in interviews and focus group discussions. This Mapping Form was maintained throughout the course of the process evaluation.

Name (or group)	Organ ization (if applic able)	Level of Authority (e.g., to make decisions that affect policy imple- mentation) 1=Low, 5=High	Role in Policy Process (check <input type="checkbox"/> where appropriate)						Level (e.g., State, City, Distric t, Comm unity)	Geographic region of state	Gender rep. (e.g., female or male)
			Context Recruitment	Reach	Dose Received	Fidelity	Satisfaction	Barriers			
<b>Government Officials (health and non-health agencies)</b>											
<b>State Legislators</b>											
<b>Advocates</b>											
<b>CMO Service Providers</b>											
<b>Non-CMO Service Providers</b>											

Name (or group)	Organ ization (if applic able)	Level of Authority (e.g., to make decisions that affect policy imple- mentation) 1=Low, 5=High	Role in Policy Process (check <input type="checkbox"/> where appropriate)							Level (e.g., State, City, Distric t, Comm unity)	Geographic region of state	Gender rep. (e.g., female or male)
			Context Recruitment	Reach	Dose Received	Fidelity	Satisfaction	Barriers				
<b>Other (e.g., Outreach workers, Resource Mothers, Enrollment Specialists)</b>												
<b>Beneficiaries/Clients (Family planning and IPC enrollees)</b>												

**APPENDIX C**  
**INTERVIEW GUIDE**

## ***Planning for Healthy Babies (P4HB) Study*** **Stakeholder Interview Guide**

Date: \_\_\_\_\_

Name of Interviewer: \_\_\_\_\_

Time Started: \_\_\_\_\_ Time Ended: \_\_\_\_\_

### **Introduction**

*Thank you for agreeing to be interviewed for this study. First, I will ask you to provide some personal and profession background information about yourself. Then I will ask you about any roles and/or responsibilities you have for the Planning for Healthy Babies (P4HB) program. We are interested in learning about the reasons this program was created, what plan was developed to implement it, and how well the program is operating thus far. Our questions will also focus on outreach and education, enrollment, and service delivery issues. Finally, we will discuss barriers to this program.*

### **A. Background Information**

1. What is your current title and position?
2. What are your major responsibilities in this position?
3. How long have you held this position?
4. Please describe any other positions you have held with this agency/organization.
5. What is your educational background?  
PROBES? Last education degree attained? Professional certifications?

### **B. P4HB Knowledge and Responsibilities**

*Now, we would like to know more about your understanding of P4HB and what role or responsibilities you have for the program.*

1. What do you know about the Planning for Healthy Babies (P4HB) Program?  
PROBES? Who is eligible for the program? What services are provided through the program? When did the program begin? How do women enroll in the program? Where can women access P4HB-related services?
2. How did you first learn about the P4HB Program?
3. What role or responsibilities do you have for P4HB?  
PROBES? Provider of services, enrollment assistance, Resource Mother, outreach/education, advocate for its adoption/implementation
4. Are these responsibilities ongoing? If so, please explain.

### **C. History/Context of P4HB Program**

*Next, we would like to explore more about what you know about the P4HB program, including the reasons for the program and who was involved in its creation.*

1. Do you know why the P4HB program was created?

PROBES? High unintended pregnancy in the state? Poor the maternal and child health outcomes? Other reasons?

PROBE? Was there something in particular about Medicaid's existing coverage of family planning services that needed improvement? Were there specific concerns held by the state that new populations needed access to these services?

2. What does P4HB aim to do/provide that is not already being done/provided by the existing Medicaid program?
3. Were there certain people, groups, or agencies that were most influential for creating the P4HB program? If so, please explain.
4. How was the state's proposal to seek a family planning waiver received by other stakeholders?  
*PROBES: Who was supportive of the program? Who was against it?*  
*PROBES: Why do you think these groups held these positions about P4HB?*

#### **D. Implementation of P4HB**

*This next set of questions will ask you to describe how P4HB has been implemented.*

1. Describe the process of applying for the P4HB Medicaid family planning waiver.  
*PROBE: How smoothly did the process go?*  
*PROBE: Did the state encounter any barriers in this process?*  
*PROBE: Did the state have to alter its plan in any way to obtain federal approval for the waiver?*
2. Is there an implementation plan for P4HB?  
*PROBE? If so, please describe this plan.*  
*PROBE? Is there something in writing about implementation that you can share with us?*
3. What health care providers were involved in the implementation of P4HB?
4. Who else has been involved in the implementation of P4HB?  
*PROBES? Health care providers, health care organizations, family planning or MCH advocates?*
5. Have there been any challenges or barriers to the implementation of P4HB?  
*PROBE? If so, please describe. If not, what has led to the successful implementation of P4HB?*

## **E. Outreach and Enrollment**

*Next, we would like to better understand the P4HB outreach and enrollment processes. Please describe any differences for women enrolled in the family planning (FP) component or Inter-pregnancy care (IPC) component of the program.*

### **OUTREACH**

1. What kind of outreach did the state conduct to inform residents about the P4HB program?  
*PROBE:* Were there any specific public awareness/media strategies?  
*PROBE:* Did the state rely on its community partners to conduct this outreach?
2. Who specifically was targeted for these outreach efforts?  
*PROBE:* Were there specific populations targeted? (e.g., high risk women, urban or rural residents?)
3. What information about the P4HB program was shared with them?
4. What kind of outreach or training did the state conduct to inform providers about the P4HB program?
5. Which providers were targeted for these outreach efforts?

### **ENROLLMENT**

1. Describe the application process for women served by the P4HB program.  
*PROBES:* Where do applicants enroll? (e.g., doctor's office, welfare office, etc).  
*PROBE:* What type of application forms are used?  
*PROBE:* What type of requirements are there for verification of enrollment information?
2. Since Medicaid managed care is mandatory in the state of Georgia, how do women pick a Care Management Organization (CMO)?  
*PROBE?* If they choose, what information is provided to them to select a CMO? If they do not choose, how does this auto-assignment process work?
3. Please describe the renewal/redetermination process for enrollees of P4HB?  
*PROBE:* What are P4HB clients required to do in order to renew their eligibility?  
*PROBE:* Is there a yearly redetermination process? Or is the timeframe different for the waiver program?
4. How does the enrollment process work for women transitioning between full-scope Medicaid and the P4HB program? In particular, we are interested in women who are in Medicaid due to their pregnancy.  
*PROBE:* How, if at all, does this process differ if the reverse situation exists? So, for instance, what happens when a woman is in the P4HB program and becomes pregnant and wants to apply for full-scope Medicaid. How does this go about doing this?

*PROBE:* Have there been any challenges for women in these situations?

## **F. Service Delivery**

*This next set of questions addresses the delivery of family planning and inter-pregnancy services under the waiver program. This section will also address the provider network and reimbursement.*

1. How many women are currently enrolled in P4HB?  
*PROBES?* How many in the FP component? How many in the IPC component?
2. How many Resource Mothers have been hired for P4HB?  
*PROBE?* Will more be hired? What services typically have they provided so far?
3. What services have enrollees received so far as participants in the P4HB program?  
*PROBE?* List the most common services for FP and IPC component enrollees.
4. What providers are available for women enrolled in the FP component of P4HB?  
*PROBES?* Can women seek P4HB services from Title X (family planning) providers?
5. What providers are available for women enrolled in the IPC component of P4HB?  
*PROBE?* How do women get connected/assigned to a Resource Mother?
6. What are the payment/reimbursement policies for providers participating in the P4HB program?  
*PROBE:* Is there a cap rate? If so, does this differ for family planning services versus IPC-related services?  
*PROBE:* If women seek services from a family planning provider that does not contract directly with a CMO, how does reimbursement work?
7. Have providers voiced any concerns about reimbursement for P4HB-covered services?
8. Since 2001, the Bush Administration added a requirement to states applying for family planning waivers that providers must refer waiver beneficiaries for primary care. Are you aware of the requirement?  
*PROBES:* Do providers participating in your state family planning waiver program refer beneficiaries for primary care? If so, how does this process work?

## **G. Lessons Learned**

**We're almost done. Thank you so much for the information you've provided so far!**

**Now, we would like to ask you about lessons learned.**

1. Overall, how well do you think implementation has gone for the P4HB program?
2. Describe the factors/facilitators that contributed to the implementation of P4HB.
3. What are the biggest challenges so far in the implementation of P4HB?
4. How will the state overcome these barriers?
5. Are there any barriers Georgia has or will be unable to overcome?
6. Are there any particular "lessons" that you have learned thus far with implementing the P4HB?
7. Is there anything else you would like to share from your perspective and experience about the implementation so far with P4HB?

**Thank you so much for your time today. Your answers were very helpful.**

**Do you have any comments or questions?**

*If yes, write notes below.*



**APPENDIX D**  
**DOCUMENT REVIEW FORM**

## P4HB Document Review Summary Form

**Document Name:**

**Document Source/author:**

**Document Category:**  Policy development  Program guideline  
 Marketing/outreach  
 Quarterly report  Provider materials

Summary of Document:

Information on the nature of “the problem”

Information on P4HB goals and objectives

Information on program design

Information on implementation processes

Information on program access and utilization

Information on barriers to implementation

## **APPENDIX E**

### **SUMMARY OF DOCUMENTS REVIEWED**

## Summary of Documents Reviewed

Primary Source	Document
<b>Department of Community Health (DCH)</b>	Planning for Healthy Babies <sup>®</sup> (P4HB <sup>®</sup> ) Concept Paper
	DCH Press Release, December 10, 2010
	P4HB <sup>®</sup> Application (English)
	P4HB <sup>®</sup> post card
	P4HB <sup>®</sup> flyer/poster
	P4HB <sup>®</sup> Physician Statement
	P4HB <sup>®</sup> Physician Statement for Resource Mother
	P4HB <sup>®</sup> Fact Sheet (August 2012)
	P4HB <sup>®</sup> Provider Outreach Plan
	P4HB <sup>®</sup> Communications Plan (November 2010)
	P4HB <sup>®</sup> Marketing Summary
	DCH CMO Contact for P4HB <sup>®</sup>
	P4HB <sup>®</sup> Auto enrollment Letters to Peach Care and RSM members
	2011 P4HB <sup>®</sup> Quarterly Reports
2011 P4HB <sup>®</sup> Annual Report	
<b>Centers for Medicare and Medicaid Services (CMS)</b>	P4HB <sup>®</sup> Approval Letter (October 2010)
	CMS Special Terms and Conditions (STCs) for P4HB <sup>®</sup> (November 2010)
	Final CMS Special Terms and Conditions (STCs) for P4HB <sup>®</sup> (January 2011)
<b>Care Management Organizations (CMOs): Amerigroup, Peach State, Well Care</b>	P4HB <sup>®</sup> CMO Participant Handbooks (November 2011)
	P4HB <sup>®</sup> CMO Member Handbooks (May 2012)
	Amerigroup Memorandum re: 2011 IPC Enrollment (May 2012)
<b>State of Georgia Legislature</b>	2008-2010 State Appropriation Bills
	2008-2010 Amended State Appropriation Bills

## **APPENDIX F**

### **FOCUS GROUP DEMOGRAPHIC FORM**

## Client Demographic Form

We would like to know a little background information about you. All information collected on this form will remain strictly **confidential**. Please answer the questions below. **Do not put your name on this form.**

1. How old are you? \_\_\_\_\_
  
2. What is the highest level of education completed?  
 Less than High School                       High School/GED  
 Some College/Technical School/Community College  
 College graduate or more                       Other \_\_\_\_\_
  
3. Which best describes your race/ethnicity? Select all that apply.  
 Caucasian/White                       Latino/Hispanic  
 African-American/Black                       Other: \_\_\_\_\_  
 Asian
  
4. Which best describes your insurance status?  
 Private Insurance                       Public Insurance (Medicaid/PeachCare)  
 No Insurance                       Other \_\_\_\_\_
  
5. How long have you been coming to this clinic for health care services?  
\_\_\_\_\_
  
6. If you do NOT come to this clinic for family planning services (or other health care services), where do you usually go? \_\_\_\_\_
  
7. Have you ever been told about Planning for Healthy Babies (P4HB), the Medicaid family planning program?  Yes       No
  
8. If you have heard of the P4HB program, how did you learn about it?  
 From someone at this clinic                       From a relative  
 From someone at another clinic or doctor's office                       From a family member  
 From Medicaid (the Department of Community Health)                       Saw advertisement (poster, TV commercial, billboard)  
 From Public Health (the Department of Public Health)                       Other \_\_\_\_\_

9. Are you currently enrolled in Planning for Healthy Babies (P4HB), the Medicaid family planning program?  
 Yes     No
10. If you were told about P4HB but decided NOT to enroll in the program, please explain why?
11. If you are currently in the P4HB program, how long have you been in this program?  
 \_\_\_\_\_
12. If you are in P4HB, did you enroll because you delivered a low-birthweight baby?   
 Yes     No
13. What type of health care services do you typically get at this clinic?
- |  |  |
|--|--|
| <input type="checkbox"/> Birth Control                   | <input type="checkbox"/> Management of chronic health conditions, such as diabetes |
| <input type="checkbox"/> Inter-conceptual counseling     | <input type="checkbox"/> Substance abuse services                                  |
| <input type="checkbox"/> Pregnancy testing               | <input type="checkbox"/> Mental health services                                    |
| <input type="checkbox"/> Annual exams (pap, breast exam) | <input type="checkbox"/> Dental services   |
| <input type="checkbox"/> STD testing                     | <input type="checkbox"/> Case management   |
| <input type="checkbox"/> Primary care services           | <input type="checkbox"/> Other _____   |
14. Have these health care services changes since being enrolled in the P4HB program?  
 Answer only if this applies to you.  Yes     No
15. If you answered "YES" to Question 13, please list the NEW type of health care services you can get at this location through the P4HB program.
16. Please feel free to add any comments or questions here about family planning services at this location or about the P4HB program.

**APPENDIX G**  
**FOCUS GROUP DISCUSSION GUIDE**



## *Planning for Healthy Babies (P4HB) Study*

### Focus Group Facilitator's Guide

#### **DRAFT**

#### **Introduction and Overview of Purpose (5 minutes)**

Hello and welcome to our focus group. I'd like to begin by thanking each of you for taking time out of your day to be here. We appreciate it.

My name is \_\_\_\_\_, and I'm here with \_\_\_\_\_. We work for Emory University, and we have been hired to conduct this discussion group to talk with you about your experiences obtaining services through the Planning for Healthy Babies program.

Each of you has been invited here because you are enrolled in the Planning for Healthy Babies program. Over the next hour and a half or so, we want to talk with you about your experiences getting family planning services through this program and at this health care facility. *[INSERT IF APPROPRIATE; we are also interested in the type of services you receive if you are enrolled in the inter-pregnancy care component of the program]*. Also, we want to know whether or not you have any difficulty getting these services here or elsewhere.

We are conducting a total of six focus groups throughout Georgia with women enrolled in Planning for Healthy Babies. The purpose of these focus groups is to learn what women think about the program, what kind of services they are getting through the program, and to understand if there are any difficulties they are experiencing being in the program. The information we collect from these focus groups will allow us to provide recommendations to Medicaid about how to best improve the program.

#### **Ground Rules**

**(5 - 10 minutes)**

Before we go any further, let me go over a few "ground rules" for today's discussion.

- First, there are no right or wrong answers here today. Please feel free to share your views, even if they are different from what others have said. Please also know that we don't work for Medicaid or for the government, so please tell us your thoughts and opinions, whether they are positive or negative.
- Second, your participation here is entirely voluntary. You are free to leave at any time. Because our discussion may include topics of a personal nature to some participants, I ask that you respect each other and the confidentiality of what is said in the focus group. Please also note that when we summarize the findings from the focus group, we all responses will be "anonymous" and none will be attributed to you by name..
- I would really like to encourage everyone to participate. Each of you does not have to answer each and every question, though, nor do you need to raise your hand to speak. If, however, some of you are shy or I really want to know what you think, I may call on you.
- It is important that only one person speak at a time. Let's show each other the respect we deserve and give everyone their chance to speak. Also, you may have noticed that we are taping today's discussion, so taking turns is important here too—if two people talk at once, we won't be able to understand the tape.
- Now, about the taping. We're taping the session because we don't want to miss anything. Even though we'll be taking notes as fast as we can, I'm certain we won't be able to write everything down! So, the taping is simply a back-up tool to ensure that we get all of your comments. Don't worry, no one will be listening to these tapes besides the research team; your confidentiality will be protected.
- Now, I have a lot that I want to talk about today. So I may be forced, from time to time, to interrupt the discussion and move us along to another topic. But, don't let me cut you off! If there's something important you want to say, let me know before we change subjects.
- Finally, just a word about cell phones and bathrooms. Please either turn off your cell phone or put it on a "silent/pager" mode. If you need to use the bathroom, please do so at any time. You do not need to let me know or ask permission. The bathrooms are located\_\_\_\_\_.
- Any questions? Okay, let's begin.

### **Background Questions**

**(10 – 15 minutes)**

Let's start by going around the table and introducing ourselves. I'd like each of you to tell us your first name. Then, to break the ice, why don't you share with all of us a little bit about yourself, such as how long you have lived in the community and whether you have any children.

Where do you normally go to get family planning services? [IPC: where do you go to get non-family planning services, such as check-ups, or primary care services?]

How long have you going to your provider for family planning services? [IPC: For primary care services?]

How long have you been enrolled/part of the Planning for Healthy Babies program?

*Moderator should feel comfortable with repeating each of these questions for participants (if needed). Also, if there is a blackboard or flipchart, these questions could be written down as well and referred to.*

## **I. Experiences with the Planning for Healthy Babies Program (45 minutes- 1 hour)**

**We'd like to begin talking with you about the Planning for Healthy Babies program. We are interested in learning about your various experiences with the program, ranging from how you heard about it, how you enrolled in it, what kinds of services you receive and from where you receive them. So let's begin!**

### **Outreach Questions**

1. How did you hear about the Planning for Healthy Babies program?

*PROBE:* From a friend or family member? From the clinic/a clinic staff member? From a social worker? From your primary care (or other) MD?

2. What information were you provided about the program? (Did you receive any written materials describing it?)

*PROBE:* What types of services were you told you would be able to get? For how long?

*PROBE:* Were you told this was part of the Medicaid program? Or just a family planning program you qualified for?

### **Enrollment Questions:**

1. What was it like to apply for the Planning for Healthy Babies program? Please describe for us the process you went through to apply for it.

*PROBE:* Was it easy? Or was it difficult?

*PROBE:* Did you face any problems applying for the program?

*PROBE:* Did you apply for it as part of the regular Medicaid application process, or did you apply for the [waiver program] separately?

2. Did you receive any assistance in completing the application?

*PROBE:* If yes, by whom? A social worker/outreach worker? Clinic staff member? Medicaid worker?

3. How long did it take for you to find out if you were eligible for/accepted into the program?

*PROBE:* How did you find out? Were you notified by mail, or through some other means?

4. How long did it take until you could start receiving family planning services, such as exams, or getting your contraceptive supplies? [IPC: How long to get primary care/IPC services?]

*PROBE:* Was this too long to wait? Not long at all?

*PROBE:* Did you have to seek other sources of family planning services while you waited? Pay out of pocket for supplies while you waited?

### **Renewal Questions** *[if applicable]*

1. Next, I would like to talk with you about the renewal process. Have any of you have had to renew your enrollment for the program?

*PROBE:* What was it like to renew?

*PROBE:* Was it easy? Was it difficult?

2. How did you find out that it was time to renew?

*PROBE:* Did you receive a letter in the mail? Did a clinic staff member tell you it was time?

3. Did you receive help from anyone in completing the renewal application?

*PROBE:* If yes, by whom? A social worker/outreach worker? Clinic or other staff member? Medicaid worker?

### **Family Planning Services and Inter-pregnancy Care Services (IPC)**

*[If focus group participants are enrolled in the IPC component of P4HB, they will be asked to also describe the IPC services they seek and the types of providers who provide these services]*

1. Where do you go now to receive family planning services [IPC/primary care services] services?
2. Do you get all of your family planning services [IPC/primary care services] at that location? Or do you obtain family planning services [IPC/primary care services] at other sites/from other providers as well?
3. Are you receiving family planning services [IPC/primary care services] from the same provider/site that you did before you enrolled in the Planning for Healthy Babies program?

*PROBE:* If not, why did you switch locations? Is the current location the only one serving Planning for Healthy Babies clients?

*PROBE:* Where would you go if you were no longer eligible for the Planning for Healthy Babies program?

4. What kind of family planning services [IPC/primary care services] do you typically come in for?

*PROBE:* Family planning: Contraception? Counseling about contraception or other services? Yearly check-ups, such as Pap test and breast exams? Others

*PROBE:* IPC Services: Primary care services, management and follow up of chronic diseases, prescription medication for chronic diseases, dental care, other services?

5. Are you using the family planning services to help plan for your next pregnancy?  
*PROBE:* Or are you using these services to avoid an unintended pregnancy?

6. I'd like you to compare your access to family planning services [IPC/primary care services] now, as an enrollee in the Planning for Healthy Babies program, to before you enrolled in the program.

*PROBE?* Is your access to family planning services [IPC/primary care services] better now than it was before? Worse? How so?

*PROBE:* Can you get the same types of birth control now that you did before being part of the program? If different, how?

*PROBE:* Can you get the same types of family planning services, such as counseling or testing, now that you did before being part of the program? If different, how?

*PROBE:* Can you get the same primary care/IPC services now that you did before being part of the program? IF different, how?

*PROBES:* Do you payless out of pocket? Do you travel fewer miles? Do you have more privacy? Do you “know” your provider?

7. Are you using the Planning for Healthy Babies program to access basic health services, such as Paps, breast exams, STD testing, etc?

*PROBE:* Where do you access these basic health services?

8. Are you able to get any new services now that you were not able to get before enrolling in the Planning for Healthy Babies program? If so, please explain which services.

9. Are you experiencing any difficulties receiving family planning services [IPC/primary care services]? If so, please explain.

10. Did you experience any barriers to these services in the past, before enrolling in the Planning for Healthy Babies program? If so, please explain.

### **III. Lessons Learned**

**(10 minutes)**

We're almost done. Thank you so much for the information you've provided so far! Now, we would like to ask you about any advice you have and perhaps some lessons you may have learned from being part of the Planning for Healthy Babies program.

1. Are you happy with the family planning services [IPC/primary care services] you have been able to get through the Planning for Healthy Babies program?

2. Has the program met your needs in terms of getting family planning services [IPC/primary care services]?

*PROBE:* If so, explain why?

*PROBE:* If no, why not?

3. Are there any services that you have been unhappy with? Has the program not helped you meet certain family planning [IPC/primary care] needs?

*PROBE:* Please explain what services you are unhappy with? If unhappy with providers, please explain.

*PROBE:* Please explain what needs have not been met.

4. What other experiences (good or bad) can you share with us about getting family planning services [IPC/primary care services] through the Planning for Healthy Babies program?

5. Overall, are there any particular benefits or positive things that have come out of your participation in this program?

6. What are the top one or two things that the program has done for you and your family?

7. Is there anything that you think should be done to improve these services?

#### **IV. Thank you**

That's all the questions I have for you today. Is there anything else that anyone would like to add that you think might be helpful for us?

Thank you very much for your time and your thoughts. This information will be very helpful for us to better understand how people in Georgia access family planning services [IPC/primary care services], particularly through the Planning for Healthy Babies program.

**APPENDIX H**  
**PROVIDER SURVEY**





10. Have you received information/materials about P4HB from any of the following? Check all that apply.

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Professional organization                 | <input type="checkbox"/> Colleague   |
| <input type="checkbox"/> Department of Community Health (Medicaid) | <input type="checkbox"/> Patient     |
| <input type="checkbox"/> Department of Public Health               | <input type="checkbox"/> None        |
| <input type="checkbox"/> CMO                                       | <input type="checkbox"/> Other _____ |

11. What kind of information were you provided about P4HB? Check all that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> Client brochures           | <input type="checkbox"/> Provider information via Medicaid website |
| <input type="checkbox"/> P4HB application materials | <input type="checkbox"/> Other                                     |
| <input type="checkbox"/> Provider manual/guidelines | <input type="checkbox"/> None                                      |
| <input type="checkbox"/> P4HB training/meetings     |  |

12. What information about P4HB would you like to receive? Check all that apply.

- |   |   |
|---|---|
| <input type="checkbox"/> Family planning services covered | <input type="checkbox"/> Enrollment process   |
| <input type="checkbox"/> Inter-pregnancy care services    | <input type="checkbox"/> P4HB renewal process |
| <input type="checkbox"/> Resource mother services         | <input type="checkbox"/>                      |
| <input type="checkbox"/> Eligibility                      | Other _____                                   |
| <input type="checkbox"/> How to bill for P4HB services    | _____   |

13. Other comments?

**APPENDIX I**  
**QUALITATIVE CODEBOOKS**

**INFORMANT INTERVIEW**  
**Qualitative Codebook**

<b>LABEL/CODE</b>	<b>Definition</b>	<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
<b>BACKGROUND</b>	Includes information about the informant such as position, length in position, current job responsibilities, and overall role in P4HB program.	Includes personal and professional information	Excludes detailed information about P4HB program knowledge or involvement.
<b>KNOWLEDGE AND AWARENESS OF P4HB</b>	Describes informants' knowledge and awareness of the P4HB program	Includes informant's description of the purpose, design, and scope of P4HB. Also general impressions of the program are included.	Excludes informant's responsibilities for or involvement in the conceptualization, design, or implementation of P4HB.
<i>-Purpose of P4HB</i>	Describes informant's understanding of the purpose of P4HB.	Includes impressions with what the goal or overall purpose is of the program.	
<i>-Design</i>	Describes informant's understanding of the design of P4HB.	Includes description of the eligibility criteria, FP, IPC, and RM components. May also include information related to provider network	
<i>-Enrollment</i>	Describes informant's understanding of the enrollment processes of P4HB.	Includes how women enroll, where they enroll, and what documentation is required	
<i>-Utilization of services</i>	Describes informant's overall impression with the utilization of services by enrollees	May include utilization of either FP, IPC, or RM services	
<b>CONCEPTUALIZATION OF "THE PROBLEM"</b>	Describes informant's understanding of the policy problem and what P4HB was designed to address in terms of health services.	Includes information related to the policy problem and why P4HB was created. May include population of concern, problems of health care access, etc.	
<i>-The Low Birth Weight Problem</i>	Describes the policy problem as one of Georgia's high rates of LBW deliveries	Includes informant's perspective that this is one, if not, the major problem the P4HB program was created to address.	
<i>-The Family Planning problem</i>	Describes the policy problem as inadequate access to family planning among low-income and uninsured women.	Includes informant's perspective that this is one, if not, the major problem the P4HB program was created to address.	

<b>LABEL/CODE</b>	<b>Definition</b>	<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
<b>POLICY PLANNING</b>	Describes the process of creating the P4HB program, from advocacy, legislative support, to financing, to program design.	Includes details about the process of planning the P4HB program and includes the roles that informants had in this planning.	Excludes informant's description of the implementation of the program or barriers to its implementation.
<i>-Low Birth Weight (LBW) work group</i>	Describes the role this workgroup had in discussing and planning the P4HB program	Includes information about the purpose of the workgroup, the discussion involving P4HB, and the role that members had in planning for or designing P4HB.	
<i>-Georgia Legislature</i>	Describes the role that the legislature played in securing funding for P4HB.	Includes information about how informants engaged the legislature about P4HB and any challenges to securing legislators' support for P4HB.	
<i>-Funding</i>	Describes the funding that was required and sought to establish the P4HB program.	Describes how much money was required to finance the program, how and which informants took responsibility for securing this funding through the legislature and budgeting process.	
<i>-1999 Family Planning Waiver</i>	Describes informant's knowledge and involvement with Georgia's 1999 family planning waiver	Includes information about the design of this earlier waiver program, as well as reasons it failed to be implemented.	
<i>-Concept Paper</i>	Describes informant's understanding of this paper that was used as a basis for the CMS waiver application	Includes information about the nature of this document, the author, and elements required to produce this document. May include informant's role in providing support/data for the paper.	
<i>-Medicaid Waiver Application</i>	Describes informant's understanding of the application Georgia's Medicaid program submitted to CMS for approval of the P4HB program	Includes informant's role in preparation of the waiver application, as well as knowledge of this part of the approval process.	
<i>-P4HB Name</i>	Describes informant's impression with the name of the program, how it receives it name, and whether its an adequate reflection of the program's purpose	Includes information about how this name was selected, what impressions people have with the name, and what other names were considered.	

<b>LABEL/CODE</b>	<b>Definition</b>	<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
<i>-Title X family planning clinics</i>	Describes the role that Title X played or did not play in planning P4HB.	Includes perspectives about the role that Title X played, should have played in the policy planning for P4HB.	Excludes Title X family planning clinics role in implementation of P4HB.
<b>PRE-IMPLEMENTATION PROGRAM DEVELOPMENT</b>	Describes activities Medicaid conducted to prepare for the implementation of P4HB	Includes information about marketing and outreach, about systems' development for enrollment of P4HB clients	Excludes any activities that were conducted once P4HB began on January 1, 2011
<i>-Outreach &amp; Marketing</i>	Describes any marketing or outreach that Medicaid conducted toward providers or patients regarding P4HB PRIOR to implementation	Includes informant's perspectives about how or whether P4HB was communicated to providers, patients, and other stakeholders before implementation began. Describes the poster, brochures, application materials, as well as campaigns that were developed prior to implementation	
<i>-Data Systems</i>	Describes data system development that Medicaid required in order to enroll P4HB clients.	Includes information about MMIS, PSI, and Maximum.	
<b>IMPLEMENTATION</b>	Describes informant's perceptions of the implementation of P4HB	Includes information related to outreach and marketing, enrollment, utilization of services	
<i>-Outreach</i>	Describes any P4HB marketing or outreach conducted.	Includes ads, flyers, posters about P4HB that developed for prospective clients. Also includes outreach and marketing for providers. participated.	
<i>-Enrollment</i>	Describes the enrollment process for P4HB.	Includes information about how women enroll in P4HB, either in the FP or IPC component. Includes perceptions of barriers to enrollment.	
<i>-Auto-enrollment</i>	Describes information regarding auto enrollment in FP and IPC.	Includes informant's opinions about how this occurs, whether it is working, and whether it will be good for IPC enrolled clients.	
<i>-Utilization of P4HB services</i>	Describes informant's impressions of whether P4HB clients are utilizing services.	Includes family planning, IPC, and RM services.	

<b>LABEL/CODE</b>	<b>Definition</b>	<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
<b>BARRIERS TO P4HB</b>	Describes informant's perception of the barriers to P4HB.	Includes barriers to enrollment, access to services, or client and provider understanding of the program	
<i>-Lack of Outreach and Marketing</i>	Describes lack of marketing/outreach	Includes the lack of marketing to clients and providers and how this affects their understanding and awareness of the program as well as utilization of services.	
<i>-Lack of Program Guidance</i>	Describes informant's perspectives about the lack of program guidance and/or Medicaid leadership with regard to the program	Includes informant's perspectives that the objectives, aims, and other program related information is not well conveyed to providers and prospective enrollees.	
<i>-Enrollment barriers</i>	Describes problems with the enrollment process	Includes problems that informants have observed with the application procedure, document requirements, and client understanding of the status of their enrollment.	
<i>-Presumptive eligibility</i>	Describes informant's perspectives about presumptive eligibility.	Includes comments that PE should have been part of the enrollment process and a core component of P4HB.	
<i>-CMOs</i>	Describes perspectives that CMOs are an impediment to P4HB services.	Includes perspectives that mandatory managed care enrollment delays enrollment and thus access to all services.	
<i>-Billing and reimbursement problems</i>	Describes problems providers have will billing and/or getting reimbursement for P4HB covered services	Includes information about the lack of billing information/coding for providers to understand about the program. Also includes overall comments about the lack of reimbursement from Medicaid for this program.	
<i>-Coverage issues</i>	Describes problems providers identify with certain services that are not covered in P4HB.	Includes problems with GYN care, IUDs, other non FP services, STD only visits, abnormal paps, pregnancy testing	
<i>-IPC challenges</i>	Describes challenges with this component of program.	Includes challenges with reaching IPC eligible women, enrolling them, and providing the RM services.	



<b>LABEL/CODE</b>	<b>Definition</b>	<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
<b>RECOMMENDATIONS</b>	Describes informants' recommendations for how to improve P4HB.	Includes recommendations about how to improve outreach and understanding about the program and utilization of services.	Does not include recommendations about improving the general Medicaid program
<i>-Improve Marketing/Outreach</i>	Describes ways to improve and increase marketing and outreach of P4HB		
<i>-Improve communication with Medicaid about program</i>	Describes recommendations to improve inter-agency collaboration and communication with Medicaid about P4HB.	Include recommendations about improving communication among providers and others responsible for implementing P4HB.	
<i>-Simplify Enrollment Process</i>	Describes recommendations to simplify the enrollment process.	Includes recommendations to reduce documentation requirements and to allow for easier, faster enrollment in P4HB.	

**FOCUS GROUP  
Qualitative Codebook**

<b>LABEL/CODE</b>	<b>Definition</b>	<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
<b>BACKGROUND</b>	Includes information about the participant, such as age, place of residency, and other personal information shared during the focus group	Includes personal information	Excludes information about P4HB enrollment status or experience with the program
<b>MEDICAID</b>	Describes participant's experience with the Medicaid program, either current or past experience.	Includes information about being in the Medicaid program either currently or in the past. May include information about children's Medicaid status as well.	Excludes information about other types of insurance, such as private insurance experience
<i>-General experience with Medicaid</i>	Describes general experiences or comments about the Medicaid program.	Includes information that participant shared about Medicaid. Can include attitudes about the program or experiences of being on Medicaid	
<i>-P4HB enrollment status</i>	Describes whether or not participant is in P4HB.	Includes comments about participant's knowledge of being in the program. She may not know or only believe she is in program.	Excludes comments or attitudes about the program.
<i>-Peach Care experience</i>	Describes participant's experience with this program.	Includes participant's personal experience enrolled in the program or that of a child.	
<i>-RSM experience</i>	Describes participant's experience with this program.	Includes whether participant was on Medicaid while pregnant.	
<b>KNOWLEDGE AND AWARENESS OF P4HB</b>	Describes participants' knowledge and awareness of the P4HB program	Includes the comments from both current and prospective P4HB clients.	

<b>LABEL/CODE</b>	<b>Definition</b>	<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
<i>-Source of info about P4HB</i>	Describes how participants found out about P4HB.	Includes who informed them about the program or what sources of information they had regarding P4HB.	
<i>-Questions about P4HB</i>	Describes the questions women posed during the focus groups about P4HB.	Includes questions about the nature of the program, how to enroll, what type of services are included, etc.	
<b>OUTREACH</b>	Describes any marketing or advertisement that participants have viewed about P4HB.	Includes ads, flyers, posters about P4HB that participants may have seen or have been given. May also include any trainings, or P4HB campaign in which women participated.	Excludes general information about who informed women about P4HB, such as clinic worker, family member, etc.
<b>ENROLLMENT</b>	Describes the enrollment process for P4HB.		
<i>-CMO selection</i>	Describes the process of selecting a CMO	Includes information about how women selected a CMO, whether they were informed about the CMO selection.	Excludes general comments or problems women experienced with their CMO.
<i>-Auto-enrollment</i>	Describes women's experiences and knowledge of the auto enrollment process	Includes whether women knew they were automatically enrolled in P4HB and how this process worked and general feelings about it.	
<i>-How enroll?</i>	Describes the enrollment process for P4HB.	Includes description of where and how women enrolled in P4HB. Also includes description of documentation requirements and other details about enrollment.	
<i>-Length of enrollment</i>	Describes enrollee's length of P4HB enrollment	Includes information about how long women have been in the program.	

<b>LABEL/CODE</b>	<b>Definition</b>	<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
<i>-Barriers to enrollment</i>	Describes problems with enrollment	Includes information women shared about challenges to the enrollment process. May include details with application procedures or document requirements.	
<i>-Renewal</i>	Describes participants' experiences with the P4HB renewal process.	Includes information about how women were informed about the renewal process and what types of documents are required.	
<b>FAMILY PLANNING UTILIZATION</b>	Describes participants' utilization of family planning	Includes current and past family planning methods, as well as provider sources for family planning	
<i>-General utilization of family planning</i>	Describes participants usual source of family planning.	Includes the usual source of family planning method or service and provider.	Excludes family planning since enrollment in P4HB, when applicable.
<i>-Utilization of family planning since P4HB enrollment</i>	Describes enrollees' family planning utilization since enrollment in P4HB.	Includes information about the types of family planning services the participants have access since enrolling in P4HB. Also includes details about recent changes to type or source of family planning service.	
<i>-Barriers to family planning services</i>	Describes any problems P4HB enrollees have experienced accessing family planning services since enrolling.	Includes barriers to family planning method or provider	
<b>IPC COMPONENT</b>	Describes the experiences of IPC enrolled participants.	Includes information about how the participant enrolled in IPC, what types of services she has accessed, and if there are any barriers to this component of P4HB.	

<b>LABEL/CODE</b>	<b>Definition</b>	<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
<b>CMO Experience</b>	Describes participants' experience with a care management organization (CMO) in P4HB.	Includes what CMO the P4HB enrollee is currently a member of, how and whether the enrollee selected the CMO, and any experience she has with this health plan. May also include information about changing CMOs.	
<b>BARRIERS TO P4HB</b>	Describes any barriers women have experienced with this program	Includes barriers to enrollment, services, or general understanding of program	
<i>-Lack of program information</i>	Describes problems women have with understanding the program.	Includes the lack of program materials and information shared about the program. Also may include why participants do not understand the eligibility or scope of services.	
<i>-Enrollment barriers</i>	Describes problems women had with the enrollment process	Includes problems with the application procedure, document requirements, and overall understanding of the status of their enrollment.	
<i>-Provider availability</i>	Describes problems women had finding a provider who participates in P4HB	Includes problems finding a doctor/provider or one that participates in the Medicaid CMO	
<i>-Financial barriers</i>	Describes women's problems having to pay for family planning or related services.	Includes details about copays or other costs when incurred while seeking family planning services. Includes financial barriers among enrollees and those that are prospective clients.	

<b>LABEL/CODE</b>	<b>Definition</b>	<b>Inclusion Criteria</b>	<b>Exclusion Criteria</b>
<i>-Troubleshooting</i>	Describes whether and how women tried to solve their problems with P4HB.	Includes information about seeking clarification about women's enrollment status and information about program eligibility and service coverage. May include information about calling a CMO or Medicaid, or seeking clarification from their health care provider.	
<b>SATISFACTION WITH P4HB</b>	Describes women's satisfaction with the program	Includes both overall comments about the program, both positive and negative comments.	Does not include recommendations when provided about how to improve P4HB.
<i>-What women liked</i>	Described the specific things women liked about P4HB.	Includes comments from current enrollees and those from women who have thoughts about the positive aspects of the program (prospective clients)	
<i>-What women disliked</i>	Describes the specific thing women disliked about P4HB.	Includes comments from current enrollees and those from women who have thoughts about the negative aspects of the program (prospective clients)	
<b>RECOMMENDATIONS</b>	Describes the recommendations participants had about improving P4HB.	Includes recommendations from both current and prospective clients about the need to improve the program. Also includes specific strategies or changes that are needed.	Does not include recommendations about improving the general Medicaid program or about their health providers' services.

## REFERENCES

- Adams, EK, Kenney, GM, Galactionova, K. (2013). Preventive and Reproductive Health Services for Women: The Role of California's Family Planning Waiver. *Am J Health Promot.* 27(3 Suppl); eS1-eS10.
- Aday, LA and Andersen R.A. (1974). A Framework for the Study of Access to Medical Care. *Health Services Res* 9:208-9.
- Aday, L.A, Andersen, RM, and Fleming, GV. (1980). Health Care in the U.S.: Equitable for Whom? Beverly Hills, Calif.: Sage.
- American Evaluation Association (2011). "About Us." Accessed at <http://www.eval.org/aboutus/organization/aboutus.asp>.
- Andersen RM, McCutcheon A, Aday LA, et al. (1983). Exploring Dimensions of Access to Medical Care. *Health Serv Res.* Spring;18(1):49-74.
- Andersen, I, Aspegren, K., Janzon, L. et al. (1988) Mammographic Screening and Mortality from Breast Cancer: The Charleston TriCounty Experience. *Br Med J.* 297;943-8
- Agyepong, IA, and Adjei, S. (2008). Public Social Policy Development and Implementation: A Case Study of the Ghana National health Insurance Scheme. *Health Policy & Planning.* 23:150-160.
- Allison, G.T. (1972). The Essence of Decision. Boston: Little, Brown
- Andersen, R and Newman, JF. (2005). Societal and Individual Determinants of Medical Care Utilization in the United States. *Milbank Quarterly.* Vol. 83(4):1-28.
- Atkinson, P. A. & Coffey, A. (2004). Analysing Documentary Realities. In D. Silverman (Ed.), Qualitative research: Theory, method and practice (2nd ed.), London: Sage, 56-75.
- Baranoski, T. and G. Stables (2000). "Process Evaluations of the 5-a-Day Projects." Health Education & Behavior 27(2): 157-166.
- Bartholomew, L., G. Parcel, et al. (2001). Intervention Mapping: Designing Theory and Evidence-Based Health Promotion Programs. New York, McGraw-Hill.
- Baum, L. (1981). Comparing the Implementation of Legislative and Judicial Policies. In D. A. Mazmanian & P. A. Sabatier (Eds), Effective Policy Implementation, (p. 39-62). Lexington, MA: Lexington Books.

- Binderman, AB, Grumbach, K, Osmond, D. et al. (1995). Preventable Hospitalizations and Access to Health Care. *JAMA*. 274:4;305-11.
- Bisgaier, J. and Rhodes, KV. (2011). Auditing Access to Specialty Care for Children with Public Insurance. *NEJM*. 364:2324-33.
- Blake, SC, Thorpe, KE, and Howell, KG. (2003). Access to Health Care in the United State. M. Guilford and M. Morgan (eds). Access to Health Care. London: Routledge.
- Bowen, GA. (2009). Document Analysis as a Qualitative Research Method. *Qualitative Research Journal*. Vol. 9(2): 27-40.
- Browning, RP, Marshall, DR, and Tabb, DH. (1981). Implementation and Political Change: Sources of Local Variation in Federal Programs. P. 127-146 in DA Mazmanian and PA Sabatier (eds). Effective Policy Implementation. Lexington: MA: DC Heath.
- Bronstein, JM, Vosel, A, George, SK, Freeman, C, and Payne, LA (2007). Extending Medicaid Coverage for Family Planning Services: Alabama's First Four Years. *Public Health Reports*. 122(2): 190-197.
- Bullock, CS. (1981). Implementation of Equal Education Opportunity Programs: A Comparative Analysis. P. 89-126 in DA Mazmanian and PA Sabatier (eds). Effective Policy Implementation. Lexington: MA: DC Heath.
- Butterfoss, F. and V. Francisco (2004). "Evaluation Community Partnerships and Coalitions with Practitioners in Mind." Health Promot Pract 5(2): 108-114.
- Carcary, M. (2009). The Research Audit Trail-Enhancing Trustworthiness in Qualitative Inquiry. *J Business Research Methods*. 7(1):11-24.
- Carillo, JE, Carillo, V, Perez, HR, Salas-Lopez, D, Natale-Pereira, AN, and Bryon, AT. (2011). Defining and Targeting Health Care Access Barriers. *J Health Care Poor and Underserved*. 22:562-575.
- Carroll, C., M. Patterson, et al. (2007). "A Conceptual Framework for Implementation Fidelity." Implementation Science 2(40): 1-9.
- Centers for Disease Control and Prevention (2008). "Introduction to Process Evaluation in Tobacco Use Prevention and Control." from <http://www.cdc.gov/tobacco/publications/index.htm>.
- Centers for Medicare and Medicaid Services (CMS) (2010). "Family Planning Services Option and New Benefit Rules for Benchmark Plans." from <http://www.cms.gov/smdl/downloads/SMD10013.pdf>.



- Champion, VL. and Scott, CR (1997). Reliability and Validity of Breast Cancer Screening Belief Scales in African American Women. *Nursing Research* 40;331-337.
- Champion, VL. and Menon, U. (1997). Predicting Mammography and Breast Self-Examination in African American Women. *Cancer Nursing*. 20(5):315-322.
- Charmaz, K.(2006). Constructing grounded theory: A practical guide through qualitative analysis. Thousand Oaks, CA: Sage.
- Creswell, J. and V. Plano Clark (2007). Designing and Conducting Mixed Methods Research. Thousand Oaks, CA, Sage Publications.
- Creswell JW, Klassen AC, Plano Clark VL, Smith KC. (2011). *Best practices for mixed methods research in the health sciences*. August 2011. National Institutes of Health. Accessed at [http://obssr.od.nih.gov/mixed\\_methods\\_research](http://obssr.od.nih.gov/mixed_methods_research)
- Creswell, JW. (2012). Qualitative Inquiry & Research Design: Choosing among Five Approaches. Thousand Oaks, Sage.
- Cutcliffe, JR and McKenna, HP. (2004). Expert Qualitative Researchers and the Use of Audit Trails. *J Advanced Nursing*. 45(2): 126-125.
- Dariotis, JK, Bumbarger, BK, Duncan, LG, Greenberg, MT. (2008). How do Implementation Efforts Relate to Program Adherence? Examining the Role of Organizational, Implementer, and Program Factors. *J Comm Psychology*. 36(6):744-760.
- DeCuir-Gunby, JT, Marshall, PL, McCulloch, AW. (2011). Developing and Using a Codebook for the Analysis of Interview Data: An Example from a Professional Development Research Project. *Field Methods*. 23(2): 136-155.
- DeGroff, A. and Cargo, M. (2009). Policy Implementation: Implications for Evaluation. *New Directions for Evaluation*. 124: 47-60.
- DeLeon, P. (1999). The Stages Approach to the Policy Process: What has it Done: Where is it Going? Ed. Paul A Sabatier. Theories of the Policy Process. Westview Press: Colorado.
- DeLeon, P. and DeLeon, L. (2002). Whatever Happened to Policy Implementation? An Alternative Approach. *JPART*. 4(467-492).
- Denzin, NK. (1978). The Research Act. 2<sup>nd</sup> edition. New York: McGraw-Hill.

- Department of Community Health (2009). "Planning for Healthy Babies Concept Paper." from [http://www.georgia.gov/vgn/images/portal/cit\\_1210/33/52/156793595PlanningforHealthyBabiesProgram121709Final.pdf](http://www.georgia.gov/vgn/images/portal/cit_1210/33/52/156793595PlanningforHealthyBabiesProgram121709Final.pdf).
- Department of Community Health (2012). Department of Human Services Online Directives Information System. Medicaid Manual. Revised December 1, 2012. Available at: [http://www.odis.dhr.state.ga.us/3000\\_fam/3480\\_medicaid/MAN3480.doc](http://www.odis.dhr.state.ga.us/3000_fam/3480_medicaid/MAN3480.doc).
- DeVoe JE, Fryer GE, Phillips R, et al.(2003). Receipt of Preventive Care among Adults: Insurance Status and Usual Source of Care. *Am J Public Health*. 93(5):786–91.
- Dibble, MP. (2002). Testing the Statutory Coherence Hypothesis: The Implementation of the Maritime Security Act of 1996. Available at <http://www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA401620>.
- Duffy, MM, Binder, AJ, Skrentny, JD. (2010). Elite Status and Social Change: Using Field Analysis to Explain Policy Formation and Implementation. *Social Problems*. 57(1):49073.
- Eisert S, Gabow P. (2002). Effect of Child Health Insurance Plan enrollment on the utilization of health care services by children using a public safety net system. *Pediatrics*. 110(5):940–5.
- Edwards, J., J. Bronstein, et al. (2003). Evaluation of Medicaid Family Planning Demonstrations. Alexandria, VA, The CNA Corporation.
- Family PACT (2010). "Family PACT Program Report, Fiscal Year 2009-2010." from [http://www.familypact.org/Files/Provider/Research%20Reports/2011-0725\\_FamPACT2011AR\\_508.pdf](http://www.familypact.org/Files/Provider/Research%20Reports/2011-0725_FamPACT2011AR_508.pdf).
- Fanaian, M. (2004). "Evaluation in Logic Model." Primary Health Care Research Network(9).
- Friedman, RM. (1999). A Conceptual Framework for Developing and Implementing Effective Policy in Children's Mental Health. Research and Training Center for Children's Mental Health, Department of Child and Family Studies. University of South Florida.
- Gipsh, K., Sullivan, J., & Dietz, E. [2004, Nov – Dec]. Health Belief Assessment Regarding Screening Colonoscopy. *Gastroenterology Nursing*. Vol. 27/No. 6. pp 262 – 267.

- Gold, R., A. Sonfield, et al. (2009). "Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System." from <http://www.guttmacher.org/pubs/NextSteps.pdf>.
- Googin, ML, Bowman, A, Lester, JP, O'Toole, LJ. (1990). Implementation Theory and Practice: Toward a Third Generation. USA: Harper Collins Publishers.
- Government Accounting Office (GAO). (1990). Case study evaluations. GAO/PEMD-91-10.1.9. Accessed at [http://www.gao.gov/special.pubs/10\\_1\\_9.pdf](http://www.gao.gov/special.pubs/10_1_9.pdf).
- Guadagnolie, E and Cunningham, S. (1989). The effects of non-response and late response on a survey of physician attitudes. *Eval Health Professions*. 12(3):318-328.
- Guba, EG and Lincoln, YS (1981). Effective Evaluation. San Francisco, CA: Jossey-Bass Publishers.
- Grady, MP. (2003). Qualitative and Action Research: A Practitioner's Handbook. Bloomington, IN: Phi Delta Kappa Educational Foundation.
- Guttmacher Institute (2011). "State Facts about Title X and Family Planning: Georgia." from <http://www.guttmacher.org/statecenter/title-X/GA.html>.
- Guttmacher Institute (2013). "State Policies in Brief: Medicaid Family Planning Eligibility Expansions." Accessed at [http://www.guttmacher.org/statecenter/spibs/spib\\_SMFPE.pdf](http://www.guttmacher.org/statecenter/spibs/spib_SMFPE.pdf).
- Hall, AG, Lemak, CH, Steingraber, H, and Schaffer, S. (2008). Expanding the Definition of Access: It Isn't Just about Health Insurance. *J Health Care Poor and Underserved*. 19(20): 625-638.
- Hargraves JL and Hadley J. (2003). The Contribution of Insurance Coverage and Community Resources to Reducing Racial/Ethnic Disparities in Access to Care. *Health Serv Res*. 38(3):809-29.
- Hargrove, E. (1975). The Missing Link: the Study of Implementation of Social Policy. Washington, DC: The Urban Institute.
- Hasson, H. (2010). Systematic Evaluation of Implementation Fidelity of Complex Interventions in Health and Social Care. Implementation Science 5(67).
- Helitzer, DL, Davis, Sm, Gittelsohn, J, Going, SB, Murray, DM, Synder, P, Steckler, AB. (1999). "Process Evaluation in a Multisite, Primary Obesity-Prevention Trial in American Indian School Children." The American Journal of Clinical Nutrition 69(4 Suppl): 816S-824S.

- Helitzer, DL, Yoon, DJ, Wallerstein, N, Dow y Garcia-Verlarde, L. (2000). The Role of Process Evaluation in the Training of Facilitators for an Adolescent Health Education Program. *Journal of School Health*. 70 (4): 141-147.
- Hennick, M., I. Hutter, et al. (2011). Qualitative Research Methods. Thousands Oaks, CA, Sage Publications.
- Hesse-Biber, SN and Levy, P. (2006). The Practice of Qualitative Research. Thousand Oaks, CA: Sage.
- Hoppe, R, van de Graaf, H, and van Dijk, A. (1987). Implementation Research and Policy Design: Problem Tractability, Policy Theory, and Feasibility Testing. *Int Review of Adm Science*. 53(581-604).
- Howlet, M. and Ramesh, M. (2003). Studying Public Policy: Policy Cycles and Policy Subsystems. London, Oxford University Press.
- Hulscher, M., M. Laurant, et al. (2003). Process Evaluation on Quality Improvement Interventions. *Quality and Safety in Health Care* 12: 40-46.
- Institute of Medicine (IOM). (2001). Committee on the Consequences of Uninsurance, Board on Health Care Services. Coverage matters: insurance and health care. Washington, DC: National Academies Press.
- Institute of Medicine (IOM). (2002). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academies Press.
- Isett, KR, Burnam, MA, Coleman-Beattie, B, Hyde, PS, Morrissey, JP, Magnabosco, J, Rapp, CA, Ganju, V, and Goldman, HH. (2007). The State Policy Context of Implementation Issues for Evidence Based Practices in Mental Health. *Psychiatric Services*. 68(7):914-921.
- Jick, TD. (1979). Mixing Qualitative and Quantitative Methods: Triangulation in Action. *Adm Science Q*. 24:602-611.
- Journal of Mixed Methods Research (JMMR). (2012). Accessed at <http://mmr.sagepub.com/>.
- Kaiser Family Foundation (2007). "Medicaid's Role in Family Planning." Retrieved April 14, 2011, from <http://www.kff.org/womenshealth/7064.cfm>.
- Kaiser Family Foundation (2009). "State Medicaid Coverage of Family Planning Services: Summary of State Survey Findings." from <http://www.kff.org/womenshealth/upload/8015.pdf>

- Kaiser Family Foundation (KFF). (2012). *Medicaid's Role for Women across the Lifespan: Current Issues and the Impact of the Affordable Care Act*. Issue Brief. December 2012. Available at <http://www.kff.org/womenshealth/upload/7213-04.pdf>.
- Kellogg, W. (2004). Using Logic Models to Bring Together Planning, Evaluation, and Action Logic Model Development Guide. Battle Creek, Michigan.
- Kempe A, Beaty BL, Crane LA, et al. (2005). Changes in Access, Utilization, and Quality of Care after Enrollment into a State Child Health Insurance Plan. *Pediatrics*. 115(2):364–71.
- Kirby JB, Taliaferro G, and Zuvekas SH. (2006). Explaining Racial and Ethnic Disparities in health care. *Med Care*. 44(5 Suppl):I64–72.
- Kolbe, LJ and Iverson, DC. (1981). Implementing Comprehensive Health Education: Educational Innovations and Social Change. *Health Educ. Q.* 8(1):57-80.
- Krefting, L. (1991). Rigor in Qualitative Research: The Assessment of Trustworthiness. *Am J Occupational Therapy*. 45(1):214-222.
- Lester, J. and M. Goggin (1998). "Back to the Future: The Rediscovery of Implementation Studies." Policy Currents 8(3): 1-8.
- Lincoln, YS, and Guba, EG. (1985). Naturalistic Inquiry. Newbury Park, Sage Publications.
- McFarlane, D. and K. Meier (2001). The Politics of Fertility Control. New York, Seven Bridges Press.
- Litaker, D, Koroukian, SM, Love, TE. (2005). Context and Healthcare Access: Looking Beyond the Individual. *Med Care*. 43(6):531-40.
- Machlup, F. (1993). "Uses, Value, and Benefits of Knowledge." Knowledge: Creation, Diffusion, Utilization 14(4): 448-466
- MAXQDA, software for qualitative data analysis, 1989-2012, VERBI Software – Consult – Sozialforschung GmbH, Berlin, Germany
- Matland, RE (1995). Synthesizing the Implementaiton Literature: The Ambiguity-Conflict Moel of Policy Implementation. *JPART*. 5(2):145-174.
- Mazmanian, DA and Sabatier, PA. (1989). Implementation and Public Policy. Lanham MD: University Press of America.

- McFarlane, DR and Meier, KJ. (2001). The Politics of Fertility Control. Chatham House Publishers: New York.
- McLaughlin, MW. (1976). Implementation of ESEA Title I: A Problem of Compliance. *Teachers College Record*, 77 (3): 397-415.
- Meier, KJ and McFarland, DR. (1996). Statutory Coherence and Policy Implementation: The Case of Family Planning. *Jnl Publ Pol.* 15(3): 281-298.
- Merriam, SB. (1995). What Can You Tell from an N of 1? Issues of Validity and Reliability in Qualitative Research. *PAACE Journal of Lifelong Learning.* 4:51-60.
- Murphy (JT). (1971). Title I of ESEA: The Politics of Implementing Federal Education Reform. *Harvard Educational Review.* 41(1), 35-62.
- National Cancer Institute (NCI). (2005). Theory at a Glance: A Guide for Health Promotion Practice. U.S. Department of Health and Human Services, National Institutes of Health, 2<sup>nd</sup> edition.
- National Center for Mental Health Promotion and Youth Violence Prevention. (2007). Implementation Research: A Synthesis of the Literature. Available at <http://ctndisseminationslibrary.org/PDF/nirnmonograph.pdf>.
- North Carolina Department of Health and Human Services (2010). North Carolina Medicaid Be Smart Family Planning Waiver, Waiver Year Five Interim Annual Report. March 2010, Navigant Consulting.
- Oregon Health (2010). "State of Oregon Family Planning Facts 2010." from [http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Documents/County\\_Data\\_Sheets/Edited%20FINAL%20State%20of%20Oregon%202010\\_03-08-11.pdf](http://public.health.oregon.gov/HealthyPeopleFamilies/ReproductiveSexualHealth/Resources/Documents/County_Data_Sheets/Edited%20FINAL%20State%20of%20Oregon%202010_03-08-11.pdf).
- O'Toole, LJ. (2000). Research on Policy Implementation: Assessment and Prospects. *JPART.* 10(2): 263-288.
- Parsons, W. (1995). Public Policy: An Introduction to the Theory and Practice of Policy Analysis. Northampton, MA: Edward Elgar Publishing, Inc.
- Patton, M. (1987). How to Use Qualitative Methods in Evaluation. Thousand Oaks, CA, Sage Publications.
- Patton, M. (2002). Utilization-Focused Evaluation (U-FE) Checklist. from [www.wmich.edu/evalctr/checklists](http://www.wmich.edu/evalctr/checklists).

- Patton, M. (2008). Utilization-Focused Research, 4th edition. Thousand Oaks, CA, Sage Publications.
- Paudel, NR. (2009). A Critical Account of Policy Implementation Theories: Status and Reconsideration. *Nepalese Journal of Public Policy and Governance*, Vol. xxv, No.2, 36-54.
- Pettigrew, A. (1990). "Longitudinal Field Research on Change: Theory and Practice. *Organizational Science*. 1: 267-292.
- Porter, R. and I. Hicks (1995). "Knowledge Utilization and The Process of Policy Formation: Towards a Framework for Africa." from [http://sara.aed.org/publications/cross\\_cutting/knowledge\\_utilization/html/utilization.htm](http://sara.aed.org/publications/cross_cutting/knowledge_utilization/html/utilization.htm).
- Pressman, JL and Wildavsky, AB. (1973). Implementation. Berkeley, CA: University of California Press.
- Rabin, BA, Brownson, RC, Haire-Joshu, D, Kreuter, M, Weaver, NL. (2008). A Glossary for Dissemination and Implementation Research in Health. *J Public Health Management Practice*. 14(2): 117-123.
- Rebham. DP. (2008). Health Care Utilization: Understanding and Applying Theories and Models of Health Care Seeking Behavior. Case Western Reserve University. Available at <http://www.cwru.edu/med/epidbio/mphp439/healthcareutil.pdf>.
- Rein, M and Rabinovitz, FF. (1977). Implementation: A Theoretical Perspective. Cambridge, MA: Joint Center for Urban Studies of the Massachusetts Institute of Technology and Harvard University
- Richards, L. (2009). Handling Qualitative Data: A Practical Guide. Thousand Oaks, CA, Sage Publications.
- Richardson, LD and Norris, M. (2010). Access to Health and Health Care: How Race and Ethnicity Matter. *Mount Sinai Journal of Medicine*. 77:166–177, 2010
- Rist, RC, and Joyce, MK. (1995). Chapter 2: Qualitative Research and Implementation Evaluation: A Path to Organizational Learning. *Int J Educ Research*.23(2): 127-136.
- Robicuau, RW and Lynn, LE. (2009). The Implementation of Public Policy: Still the Missing Link. *Policy Studies*. 27(1): 21-36.

- Rosenbaum, N. (1981). Statutory Coherence and Policy Implementation: The Case of Wetlands Regulation. Pg. 63-85. In DA Mazmanian and PA Sabatier (eds). Effective Policy Implementation. Lexington, MA: DC Heath.
- Rosenbaum, S, Shin, P, Mauskopf, A, Fund, K, Stern, G, Zuvekas, A. (1995). Beyond the Freedom to Choose. Medicaid, Managed Care, and Family Planning. *The Western Journal of Medicine* 1995;163(3 Suppl):33-8.
- Rosenstock, IM. (1990). The Health Belief Model: Explaining Health Behavior Through Expectancies. In K. Glanz, FM. Lewis, and B.K. Rimers (eds). (1990) *Health Behavior and Health Education: Theory, Research, and Practice*. San Francisco, CA: Oxford Press.
- Ross, JS, Bradley EH, Busch SH. (2006). Use of health care services by lower-income and higher-income uninsured adults. *JAMA*. 3;295(17):2027–36.
- Rossi, P., M. Lipsey, et al. (2004). Evaluation: A Systematic Approach. 7th edition. Thousand Oaks, CA, Sage Publications.
- Sabatier, PA (1986). Top-Down and Bottom-Up Approaches to Implementation Research: A Critical Analysis and Suggested synthesis." *J Public Policy*. 6(1):21-48.
- Sabatier, PA, and Mazmanian, D. (1995). A Conceptual Framework of the Implementation Process. Public Policy: The Essential Readings. Eds. SZ Theodoulou and MA Cahn. Prentice Hall: New Jersey.
- Saunders, R., M. Evans, Joshi, P. (2005). Developing a Process Evaluation Plan for Assessing Health Promotion Program Implementation: A How-To Guide. *Health Promot Pract* 6(2): 134-147.
- Scheirer, M. A., M. C. Shediak, et al. (1995). Measuring the Implementation of Health Promotion Programs: The Case of the Breast and Cervical cancer Program in Maryland. *Health Education Research*. 10(1): 11-25.
- Schneider, M., W. Hall, et al. (2009). Rationale, Design, and Methods for Process Evaluation in the HEALTHY Study. *Int J Obes (Lond)*. 33(Suppl 4): S6-67.
- Schofield, J. (2001). The Old Ways are the Best: The Durability and Usefulness of Bureaucracy in Public Sector Managment. *Organization*. 8(1):77-96.
- Schoen C and DesRoches C. (2000). Uninsured and Unstably Insured: The Importance of Continuous Insurance Coverage. *Health Serv Res*. 35(1 Pt 2):187–206.
- Shadish, W., T. Cook, et al. (1991). Foundations of Program Evaluation: Theories of Practice. Thousand Oaks, CA, Sage Publications.



- Shell, PR. (1986). Local Implementation and Interpretation of Arizona Bilingual Education Statutes and Policies. Dissertation. The University of Arizona.
- Slevin, E. (2000). Enhancing the truthfulness, consistency, and transferability of a qualitative study: utilizing a manifold of approaches. *Nurse Researcher*. 7(2):79-98.
- Sonfield, A, Aldrich, C, and Gold, RB. (2008). State Government Innovation in the Design and Implementation of Medicaid Family Planning Expansions. Guttmacher Institute. March 2008.
- Sonfield, A, and Gold, RB. (2011). Medicaid Family Planning Expansions: Lessons Learned and Implications for the Future. Guttmacher Institute. December 2011.
- Sortet, J.P., & Banks, S.R. (1997). Health Beliefs of Rural Appalachian Women and the Practice of Breast Self-examination. *Cancer Nursing Journal* 20(4), 231-235.
- South Carolina Department of Health and Human Services (2007). Evaluation Design: South Carolina Medicaid Family Planning Waiver. Accessed at <http://www.shepscenter.unc.edu/data/RNDMU/FPMedicaidWaiver/SC%20Waiver%20Renewal%202008%20to%202010.pdf>.
- Stake, RE. (1995). The Art of Case Study Research. Thousand Oaks: Sage.
- Stake, RE. (2006). Multiple Case Study Analysis. New York: Guilford Sage.
- Steckler, A., McLeroy, A, Goodman, RM, Bird, ST, McCormick, L. (1992). Toward Integrating Qualitative and Quantitative Methods: An Introduction. *Health Educ Q*. 19(1): 1-8.
- Steckler, A. and L. Linnan, Eds. (2002). Process Evaluation for Public Health Interventions and Research: An Overview. San Francisco, Jossey Bass.
- Stevens, GD, Seid, M, Halfon, N. (2006). Enrolling Vulnerable, Uninsured but Eligible Children in Public Health Insurance: Association with Health Status and Primary Care Access. *Pediatrics*.117(4):e751-9.
- Sudman, S. (1985). Mail surveys of reluctant professionals. *Evaluation Review*. 9:349-360.
- Tashakkori, T. and C. Teddye (2003). Handbook of Mixed Methods in Social & Behavioral Research. Thousand Oaks, CA, Sage Publications.
- Templeton, L, Deehan, A, Taylor, C, Drummond, C, and Strang, J. (1997). Surveying general practitioners: does a low response rate matter? *British J General Practice*. 27:91-94.

- Thomas, G. (2011). A typology for the case study in social science following a review of definition, discourse and structure. *Qualitative Inquiry*, 17, 6, 511-521
- United States Agency for International Assistance (USAID) (2011). Policy Implementation Assessment Tool: Sample Stakeholder Mapping Form. Accessed at [www.healthpolicyinitiative.com](http://www.healthpolicyinitiative.com).
- VanGeest, JB, Johnson, TP, Welch, VL. (2007). Methodologies for Improving Response Rates in Surveys of Physicians: A Systematic Review. *Eval Health Prof.* 30:303-321.
- Watt, S, Sword, W, Krueger, P. (2005) Implementation of a health care policy: An Analysis of Barriers and Facilitators to Practice Change. *BMC Health Services Research.* 5: 53-59.
- Weiss, CH. (1972). Evaluation Research: Methods of Assessing Program Effectiveness. Upper Saddle River, New Jersey: Prentice Hall.
- Weiss, C.H. (1979). The Many Meanings of Research Utilization.” *Public Administration Review.* September/October, 426- 431.
- Weiss, C.H. (1980). Knowledge Creep and Decision Accretion. *Knowledge: Creation, Diffusion, Utilization*, 1(3): 381-404.
- Werner, A. (2004). A Guide to Implementation Research, The Urban Institute Press.
- Wolf, F. (2010). Enlightened Eclecticism or Hazardous Hotchpotch? Mixed Methods and Triangulation Strategies in Comparative Public Policy Research. *J Mixed Methods Research.* 4:144: 144-167.
- Wolinsky, F.(1988). Seeking and Using Health Services. In Sociology of Health (2<sup>nd</sup> ed., 117-144). Belmont, CA: Wadsworth.
- Yin, RK. (2009). Case study research: Design and methods. 4<sup>th</sup> edition. Thousand Oaks: Sage Publications.