Buncombe County Medical Society Project Access

Expanding Access to Care at the Local Level

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Background

Improving the health of a population requires a multipronged approach to reduce socioeconomic inequality between the rich and poor, improve behaviors associated with the development of chronic illnesses, and expand access to medical services, especially primary care.[1-6] The medically uninsured have difficulty getting needed care. The Center for Studying Health System Change, in a survey of more than 60,000 consumers in 1996-1997, reported that about 31% of uninsured persons did not get needed medical care in the previous year or had to postpone getting it as compared to—at most—15% among insured people.[7]

Medical care for low-income, uninsured people is largely left to the discretion of local communities; where uninsured patients live determines their ability to receive medical care. In those communities in which uninsured patients had less difficulty obtaining medical care, the safety net providers were no better funded or organized than those in communities with more difficult access; however, the private medical community provided more charity care.[7] Nationally, more than one third of uninsured persons identify a private physician as their usual source of care.[7]

The federal role in providing care to the low-income, uninsured population will likely diminish as a result of reductions in Medicare and Medicaid Disproportionate Share Hospital payments due to the Balanced Budget Act of 1997, so that care for this population will be driven by state and local policies and programs. Organized private physician initiatives at the state or local level have the potential to serve a significant portion of the needy population.

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The Charge to the Medical Profession

The medical profession has been called "the finest in the world, presenting the most perfect interchange between science and art, offering the most direct alliance between intellectual conquest and the social good."[8] So how can physicians work toward the social good? One way is to assure that people get good healthcare. What is the medical profession's responsibility in improving access to healthcare?

In 1999 the American College of Physicians Task Force provided a blueprint for local physician activism which includes five recommendations: to (1) convene medical leadership awareness conferences—galvanize and motivate the profession; (2) participate in broad-based coalitions to improve access—engage in building consensus; (3) support physician involvement in local community efforts to provide care for the uninsured—volunteer professional services; (4) encourage public/private partnership solutions to enhance care for underserved Americans—value the opportunity to serve the underserved and uninsured; and (5) overcome cultural and educational barriers to healthcare— collaborate with other organizations and groups.[9]

This article describes one physician community's activities over the past five years that model the American College of Physicians' challenge to our profession. Buncombe County, NC, located in western North Carolina in the heart of the Blue Ridge Mountains, has a population of approximately 190,000 with 8% of the population being black and increasing numbers of Hispanics and Ukrainians. Asheville, the county seat, has 69,000 people and contains one acute care hospital system with 803 beds. The medical community has just over 600 active, non-federal physicians, approximately 30% generalists and 70% specialists. Managed care penetration is primarily manifested by preferred provider organizations comprising approximately 25% of physicians' practices.

The physician community in Buncombe County has been instrumental in significantly enhancing access to care among low-income, uninsured people in the county following the American College of Physicians' blueprint.

1. Convene medical leadership awareness conference—galvanize and motivate the profession. In August 1994, through the financial support of the Robert Wood Johnson Foundation's (RWJF) Reach Out initiative,[10] the Buncombe County Medical Society (BCMS) formed an advocacy planning group comprising private physicians, agencies involved in healthcare delivery to the underserved, agencies providing the underserved with other services (such as food and shelter), representatives of underserved populations, county commissioners, and local business groups, to review the health status of low-income, uninsured people in the county and current ways people access healthcare. Physicians' anecdotal information indicated that uninsured patients presented to the hospitals late in their illnesses, after delays in seeking needed healthcare, and overused the emergency departments for minor medical issues. The county had a long history of incremental attempts by portions of the medical society to improve the underserved's access to care, either through working at the existing free medical clinic started in 1991 or by taking a small number of non-paying patients into their practices. In addition, the county health department ran a primary care clinic providing services through sliding fee scales. While these efforts demonstrated improved access for a small number of patients, a larger, comprehensive, countywide effort was needed to demonstrate the scope of the problem and to engage other community organizations and individuals in the search for solutions.

2. Participate in broad-based coalitions to improve access—engage in building consensus. The planning group described above expanded to become Health Partners, Buncombe County's community health coalition, with a mission to improve health status and access to healthcare of all people in the county, but targeted specifically towards the low-income, uninsured population. Health Partners enhances interaction and communication between groups that deliver healthcare, representatives from underserved populations, health and human service organizations, business leaders, legislators, and county government.

Community Health Assessment. To obtain information about health behaviors, functional status, healthcare utilization, and access/barriers to healthcare, Health Partners used focus group meetings with representatives of vulnerable populations and healthcare providers, town meetings held in medically underserved sections of the county, and a random-digit phone survey of county residents, an adaptation of the Centers for Disease Control's Behaviorial Risk Factor Surveillance System.

Telephone survey data. In 1995 Professional Research Consultants of Omaha, Nebraska contacted 794 adults (in as many households) in the county. Complete age, income, and medical insurance data were available for 583 survey respondents between 18 and 64 years of age. The annual income of 152 households (26%) was less than 200% of federal poverty level and that of 431 (74%) was above. Only 117 (77%) of the 152 families with incomes less than 200% of the federal poverty level had medical insurance, but 407 of the 431 (94%) with higher income had insurance. By extrapolation from these data, it was estimated that 3,700 households in Buncombe County were both uninsured and had low income. Since each household had an average of 3.3 people, it was estimated that more than 12,000 people were uninsured with a household income of less than twice the federal poverty level. This is undoubtedly an underestimate, since 6% of the households had no telephone and could not participate in the survey; most of these were likely to be low income. Based on the numbers of low-income, uninsured clients with no phones served by the local community ministry program, it was estimated that approximately 15,000 people in the county were low income and uninsured.

To test the significance of associations of income and health insurance with healthcare system use and health behaviors, the chi-square test of association was used, except for age, where the one-way analysis of variance (ANOVA) was used. Alpha was set at 0.05. Sociodemographic characteristics of respondents aged 18-64 demonstrate that those classified as uninsured and low income were younger, less educated, less likely to be married and less likely to be employed than people with insurance and higher income (Table 1). People with low income and no insurance were more likely to say they had fair or poor health (17% vs. 6%, $p<0.05$) and more likely to say they had been depressed during the past year (40% vs. 18%, $p<0.05$) as compared to the higher income, insured people. Those with low income and no insurance were less likely to have a designated healthcare provider (57% vs. 79%, $p<0.05$), more likely not to have seen a doctor in the past year because of the cost (51% vs. 7%, $p<0.05$), and more likely to have used the emergency room (28% vs. 12%, $p<0.05$). Regarding health behaviors, those respondents who had lower income and were uninsured were less likely ever to have had a cholesterol test performed (39% vs. 84%, $p<0.05$), more likely to be sedentary (73% vs. 57%, $p<0.05$), and more likely to be a chronic smoker (49% vs. 22%, $p<0.05$), as compared to the higher income, insured respondents (Table 1).

Group input. Health Partners convened 13 focus groups to identify major barriers to care. Input was sought from each of seven groups that often lack ready access to medical care: the elderly, HIV-infected, homeless, gay and lesbian, black men, working uninsured, and Hispanic people. Six focus groups sought providers' perspectives. Four community forums were held in medically underserved areas: three in Asheville and one in a rural area of the county.[11]

The focus groups and community forums identified lack of money as the primary barrier to healthcare, especially for people who were uninsured or had no disposable income to pay medical bills. Other identified barriers included an insufficient number of primary care physicians, long waiting

Table 1. Selected characteristics of Buncombe County, NC respondents aged 18-64 years

Characteristics	Income >200% of poverty		Income ≤200% of poverty	
	Insurance (N = 407)	No insurance (N = 24)	Insurance (N = 117)	No insurance (N = 35)
Average age*	42.3 yrs	35.5 yrs	41.5 yrs	35.9 yrs
High school education or less*	31%	42%	58%	63%
Married*	72%	42%	54%	43%
Working*	84%	79%	65%	54%
Fair/poor health*	6%	8%	24%	17%
Depressed in past year*	18%	44%	30%	40%
Have health care provider*	79%	48%	77%	57%
Did not see doctor last year because of cost*	7%	29%	22%	51%
Used ER in past year*	12%	25%	24%	28%
Ever had cholesterol check*	84%	52%	73%	39%
Sedentary	57%	65%	73%	73%
Chronic smoker*	22%	46%	37%	49%

*Significant ($p < 0.05$) association between this variable and income/insurance status

periods for appointments, lack of office hours in the evening and on the weekend, and inadequate numbers of Spanish-speaking providers. Transportation was a barrier to access for some, since 7% of the respondents did not have a car and the public transportation system operates only until 6:30 pm and within the city of Asheville.

Setting priorities and planning action. At a morning-long retreat in February 1996, more than 50 members of the Health Partners coalition met to review the community health assessment data and prioritize health objectives. Health Partners identified priorities according to their importance (does the problem have serious consequences?) and changeability (will a change make a difference and consume resources efficiently?). The top choice was financial constraints on access to healthcare. The Access Task Force was formed to address this area, to review additional information, set specific objectives, and develop action plans.

3. Support physician involvement in local community efforts to provide care for the uninsured—volunteer professional services. The Access Task Force directed by the Buncombe County Medical Society reviewed several different designs for a countywide system to improve access and focused on the central use of structured physician volunteer services. This core of volunteerism was supported by the medical society and by key physicians in the community. Three lead physicians representing the major specialties spoke at all hospital medical staff meetings over the course of three months to define the problem and consequences of having low income and being uninsured, to review the community health assessment results, and to review local options for expanding access to medical care. These lead physicians identified an additional twenty physicians—based on their medical society leadership roles, previous participation in the physician focus groups, and general enthusiasm for a structured volunteer physician program—to actively recruit physicians to participate in this program.

Prior to the development of the community-wide plan to increase medical care to needy patients, the county's delivery system looked like Figure 1. Care for low-income, uninsured people was limited and was obtained through the Doctors' Free Clinic and the county health department, which had a primary care clinic. Private physicians participated to a small extent by providing some specialty care for these patients in their offices and as part of their unassigned emergency call at the hospitals, but certain specialists were used preferentially and were often overwhelmed by the needed care. The partnership that developed has resulted in a new system of care delivery.[12] Buncombe County Medical Society (BCMS) Project Access, a structured volunteer physician program to match needy patients with free physician services, identified additional partners who could pro-

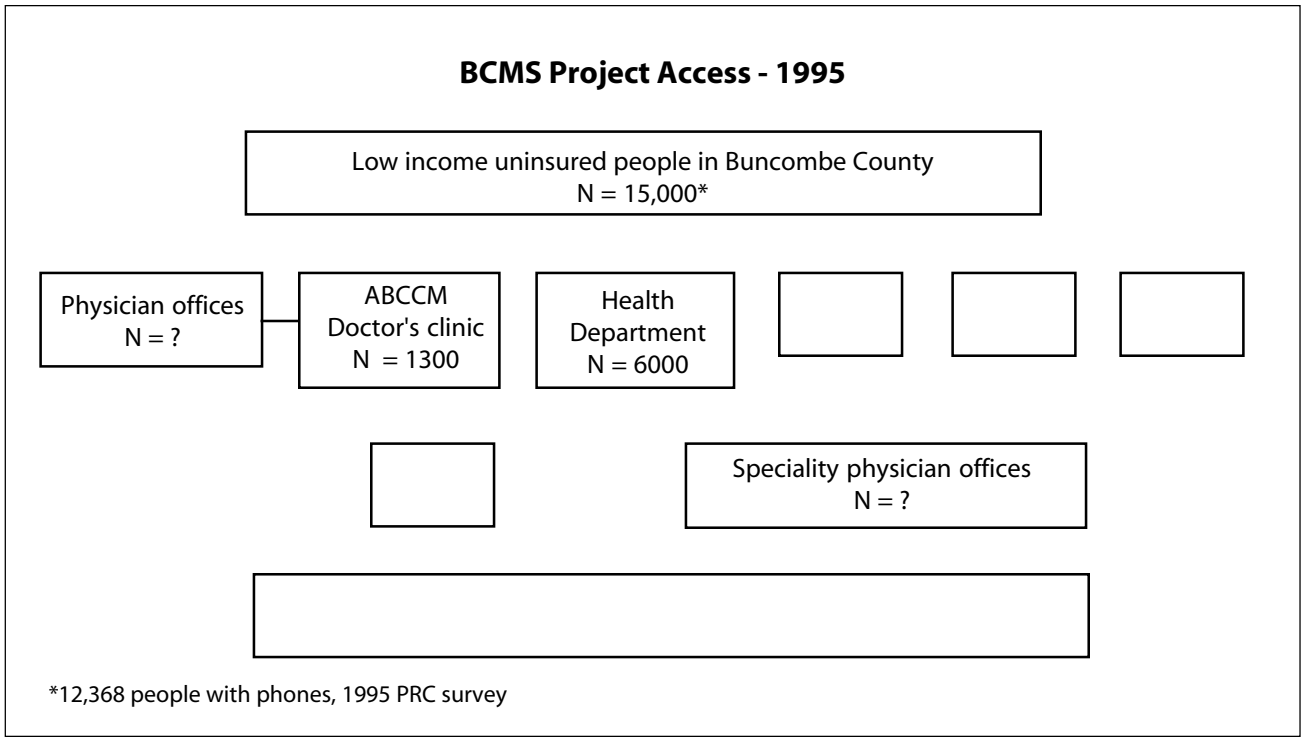

Figure 1. Summary of health care services provided to low-income, uninsured people in Buncombe County in 1995

vide important ancillary services; encouraged the county health department to enhance its efficiency within the primary care clinic; and supported the development of additional neighborhood clinics providing primary care, preventive care, and case management services.

4. Encourage public/private partnership solutions to enhance care for underserved Americans—value the opportunity to serve the underserved and uninsured. Partners' contributions included a variety of free or low-cost care items and care coordination (Table 2). Important in this list are the contributions of the hospital system, the county commissioners, the Department of Social Services, and patients themselves. Patients who are financially eligible (earn less than 200% of federal poverty level) and have no insurance receive free physician visits, both primary care and specialty; free lab and radiology services; free hospitalizations, both inpatient and outpatient; low-cost medications ($4 co-pay per prescription); and patient appointment reminders and assistance with transportation. Patients receive an insurance card for BCMS Project Access and a pharmacy card similar to those which insured patients receive. They are also required to acknowledge and sign a statement of accountability in which they are to follow the treatment plan designed by the patient and physician and are released from the program for failure to show for two appointments. Emergency room visits are not covered, excepting visits that result in hospital admission.

Physicians are asked to pledge a minimum of 20 specialty patients each year, or 10 primary care patients per year, or to work at the free clinic for eight three-hour sessions per year. Ninety percent of eligible physicians participate in the program; 18% of physicians see patients in their offices and also donate time at the free clinic. Pharmacy services are supported by money from the county commissioners and is formulary based; pharmacies submit electronic claims to the Pharmacy Network National Corporation (PNNC) which discounts by 10% the wholesale costs and bills the medical society for the balance. PNNC then reimburses pharmacies. The infrastructure to annually support BCMS Project Access consists of a 0.25 FTE director, in this case the head of the medical society, 1 FTE administrative assistant, and 0.75 FTE clerical support. Financial support for administration (excluding medications) amounts to under $7 per eligible low-income, uninsured patient and is from the county commissioners.

5. Overcome cultural and educational barriers to healthcare—partner and collaborate with other organizations and groups. This experience demonstrates that local communities can design coordinated systems of care to increase access to healthcare. A structured volunteer physician program as described can be developed in communities that have the physician base to develop such a program. This collaborative, but physician-led, program challenges our communi

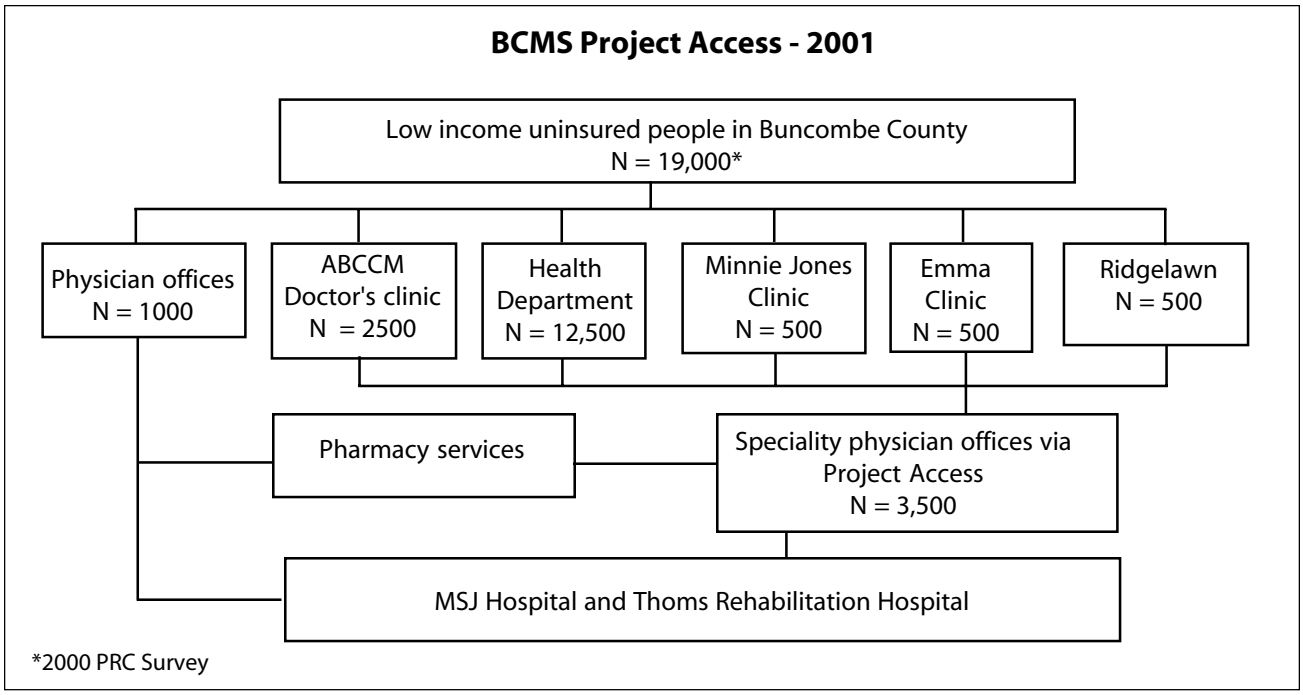

Figure 2. Summary of health care services provided to low-income, uninsured people in Buncombe County in 2001

ties to be creative in requesting support from various partners. All of the partners benefit individually through expansion of services, development of innovative strategies for conducting business, and an enhanced understanding of their community partners' missions and services. For example, the Buncombe County government asked Health Partners to review and advise them on the dispersion of community health funds.

Through local collaborative efforts additional benefits can be gained: partly as a result of this health initiative, Asheville was awarded an All America City designation, which is used to attract new industries and businesses to the area. All those organizations and individuals—physicians and non-physicians alike—who participate in BCMS Project Access are sensitized to the more global issue of caring for the uninsured. Physician participation in such programs supports the American College of Physicians suggestions for activism.

Evaluation of BCMS Project Access

Since the inception of BCMS Project Access in 1996, the participation among physicians has increased from 25% (the percentage who volunteered at the free Doctors' Clinic) to 90%. Three new neighborhood primary care sites have been developed, including a community health center focusing on culturally sensitive healthcare, an important item identified during the focus groups. The health department has increased its efficiency so its capacity to see primary care patients is now nearly double that of 1995. The health department serves more patients without increasing costs; time previously spent on the phone attempting to locate specialty care for patients is now spent caring for patients. Since patients have ready access to needed specialty care, appointments previously consumed seeing patients repeatedly for unresolved specialty care needs are now available for new patients and for proper management of existing patients' chronic primary care conditions.

More than 90% of the estimated 19,000 needy patients received primary care services during 2001 through the county government-sponsored county health center (12,500), free clinic (2,500), private physicians' offices (1,000), and other community clinics (1,500) (Figure 2). Of these patients, 3,500 received free specialty services from the private physicians. The value of the private physician services extended to these patients was nearly $3.6 million for 2001. As time has passed, more medical care has been delivered in doctors' offices rather than the hospital, and the cost of the service per patient served has decreased by 22%, suggesting that more inexpensive and preventive care is being delivered than expensive hospital-based care. Hospital charity care has decreased by 23% from 1997 to 1999.

In 1998 a random sample of BCMS Project Access patients (N=278) was interviewed by phone regarding return to work, insurance coverage, and health status. At enrollment in Project Access 33% were employed for wages, and at interview one year later 44% were employed. In answer to the

Table 2. Buncombe County Medical Society (BCMS) Project Access partners and their contributions

Partners	Contributions
Physicians (BCMS)	• Free patient visits, surgeries • Medical leadership
Hospital system (acute care and rehab)	• Free labs, x-rays, physical therapy, inpatient and outpatient hospitalizations
County health department	• Increased numbers of patients seen • Care coordination
County commissioners	• Funding for medications and administrative costs
Neighborhood clinics	• Culturally sensitive primary care • Care coordination
Pharmacies	• Dispensing/consulting fees
Mountain Health Care (PPO)	• Tracking patient services
Mountain Area Health Education Center	• Evaluation services
Department of Social Services	• Patient eligibility screening • Transportation assistance
Patients	• Enhanced personal accountability
Healthpartners (health coalition)	• Community health assessment data

question "How did the health services you received throughBCMS Project Access affect your ability to work?" 25% stated that the program helped them return to work or do a better job. One quarter of the respondents had health insurance at follow-up and were no longer enrolled in BCMS Project Access. Eighty percent felt their health was better or much better now than when they initially enrolled in BCMS Project Access. Emergency room utilization was 8% during 1998 as compared to the 28% self-reported rate for low-income, uninsured county residents who answered the 1995 phone survey. Patients also completed the Short Form-12 (SF-12) by phone once at the time of the interview.[13] The SF-12 evaluates eight health concepts: physical functioning, role limitations due to physical health problems, bodily pain, general health, vitality (energy/fatigue), social functioning, role limitations due to emotional problems, and mental health (psychological distress and psychological well being). Scoring of the SF-12 is broken down into two scales: the Physical Component Summary and the Mental Component Summary. No significant differences were found in the Physical and Mental Component Summary scores between the BCMS Project Access respondents and age-grouped national norms. Since low-income, uninsured persons reported worse health status in the initial 1995 phone survey as compared to higher income and insured people, the lack of difference found in this evaluation may represent an improvement in health status among BCMS Project Access participants.

Challenges for a Volunteer Effort

Critics may claim that this volunteer effort cannot be sustained with volunteer physician services. However, physicians have provided charity care for years; this program organizes the care so that private physicians in their offices can efficiently see charity patients. The additional services (laboratory, radiology, medication, and hospitalizations) provided to patients enhance the free care provided by physicians. Charity care can be as efficient as insured care. The medical society tracks the care and rewards the physician community through public recognition. Critics may claim that a volunteer effort only works if there are a large number of physicians who will not notice a few needy patients interspersed in their practices. No one knows the upper limit of charitable giving by physicians or other members of the healthcare team if the free care is equitably divided among all physicians, the care can be efficiently delivered in their offices, and the amounts of care that the aggregate physician groups provide to the community is measured and disseminated. Critics may claim that a volunteer program is only a patchwork answer, that it does not really solve the problem

of access to care for uninsured, low-income people. BCMS Project Access leaders acknowledge that the bulk of the patients are not seen for primary care within the private medical community; however, the systematic planning effort identified a need for local neighborhood primary care sites and expanded capabilities of the local health department's primary care clinic. These sites were able to respond to the identified need for more primary care space. The commitment by, and the services of, the physicians catalyzed the development of a more comprehensive system of healthcare delivery for low-income, uninsured people in Buncombe County. In addition, this coordinated effort identified additional local and national resources to support the system of care. The planning process and the resultant BCMS Project Access galvanized the whole community to respond to the challenge of delivering care to low-income uninsured people.

Conclusions

Given the lack of political support for universal health insurance, improvement in access to healthcare will continue to rely heavily on the local safety net and other clinicians.[7] Charity care provided by physicians has generally not been regularly tabulated and is most likely underestimated in many communities.[7] Thus a well-coordinated physician volunteer initiative can be and should be an important component of the healthcare delivery system for the foreseeable future. Physicians are poised, and able, to assume leadership roles in community-wide initiatives to develop healthcare delivery systems for low-income uninsured people.[10] This article has detailed the steps involved and the partnerships required to elevate a structured volunteer physician program from a small undertaking to a more comprehensive and collaborative community-wide healthcare delivery system.

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