

Local Physicians Caring for Their Communities: An Innovative Model to Meeting the Needs of the Uninsured

Gillian K. Baker, MHA, Alan T. McKenzie, and Paul B. Harrison, MPH

"Thank you for saving my feet, and my life." Those words warm the heart of the physicians who care for Joe.

About a year ago, Joe was not feeling well. He felt something was wrong, but he knew he did not have the money to go to the doctor, so he tried not to worry about it. However, as his health began to deteriorate, a friend told him about how physicians in his county will take care of him, even if he cannot pay. A local project coordinates healthcare for folks like Joe, who do not have insurance and cannot afford to go to the doctor.

Joe was very excited about the possibility of being able to get the much-needed healthcare and applied for the project. Joe met the criteria and was accepted into the project and assigned to a primary care provider. On Joe's initial visit to the doctor it was discovered that he has diabetes. Through the project, Joe is able to get the medical care, tests, medications, and supplies he needs to get and keep his diabetes under control. In addition, it was discovered that the disease has caused sores on Joe's feet that, which without the care of a specialist, could result in Joe's feet needing to be amputated. Through Joe's visit to a specialist, his feet have gotten better, and he has been able to avoid an amputation.

In your county a project like this might be called Project Access, or Appalachian Healthcare Project, or maybe Community Care Plan, but it is all the same—physicians donating their time and talents to do what they do best—helping those who are sick.

There are now many counties throughout North Carolina that have volunteer physician care projects, and the number of them continues to grow in North Carolina and throughout the country. For example, Charlotte/Mecklenburg County began officially serving patients through

its Physicians Reach Out initiative in late 2004. But, it all began in Asheville, in 1994, when a grant from the Robert Wood Johnson Foundation started Project Access. The premise of these projects is that local physicians participate in a volunteer medical service program designed to meet the medical needs of residents who have no health insurance and have incomes typically below 150% to 200% of the poverty guidelines. Hospitals also donate care to patients enrolled in such projects. The projects coordinate donated inpatient and outpatient services and pay for limited outpatient medication requirements.

In Buncombe County, the Buncombe County Medical Society administers the first Project Access program, which serves as a model for replications throughout the state. Private physicians can participate in one of two ways in Buncombe County: (1) They can commit to serve patients at one of the safety net clinics, and/or (2) They can agree to see a certain number of patients in their office per year. Eighty percent of the physicians in private practice have agreed to participate in the program. Primary care providers agree to see 10 uninsured

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Gillian K. Baker, MHA, is the Director of the Appalachian Healthcare Project. She can be reached at gillianb@charter.net or 155 Furman Road, Suite 7, Boone, NC 28607. Telephone: 828-263-9493.

Alan T. McKenzie is the CEO of the Buncombe County Medical Society. He can be reached at alan@bcmsonline.org or 304 Summit Street, Asheville, NC 28803. Telephone: 828-274-6989.

Paul B. Harrison, MPH, is the Executive Director of the Wake County Medical Society. He can be reached at pharrison@wakedocs.org or 2500 Blue Ridge Road, Suite 312, Raleigh, NC 27607. Telephone: 919-783-0404 ext. 23.

low-income patients, and specialists agree to see 20 patients per year. Local hospitals donate all lab tests and inpatient and outpatient services. Patients who visit a specialist (or a primary care doctor) in their private office can obtain their medications through a county-funded medication assistance program.

In an effort to document the care being delivered by the project, the County Medical Society processes standard insurance claims forms voluntarily submitted by physicians, hospitals, and pharmacies to document which services were provided and the value (i.e., the usual cost) of the services. Patients referred by private physicians have their eligibility determined through the Medical Society. The average program enrollment period is approximately six months, but this varies based on the patient's needs and length of time that he or she is uninsured.

These projects help address problems associated with donated care including: physicians concern that they would be inundated with requests; patient eligibility, differentiating which patients could afford to pay; and concern that uninsured patients would be able to obtain needed medications or diagnostic services. In addition, the project office eases some of these concerns by verifying patient need and distributing patient referrals equitably among many different providers. This helps spread the burden/risk of caring for the uninsured. In addition, reminder phone calls are made to reduce no-shows and help ensure that patients can obtain specialty and ancillary services and needed medications.

Today people with incomes below the allowed Federal Poverty Level have access to comprehensive care through a network of primary care clinics and private physicians seeing patients in their practices and in the hospital. There is a system of specialty care referral, free pharmacy, and other services. Doctors are routinely donating their time and talent to provide treatment for diabetes and hypertension and perform procedures like heart surgery, knee surgery, and even brain surgery. All of this is done in their private practices and at local hospitals without regard to a patient's ability to pay.

Physician Leadership Role

Project Access initiatives are dependent on physician leadership and the identification of local physician champions. Physician leadership develops and executes all aspects of physician recruitment in an organized volunteer care program. The message of the physician champion is straightforward: the indigent population needs to have better care, and the only way it will be delivered is if the medical community contributes to this care in a way that does not unfairly tax any individual provider. All segments of the healthcare delivery system need to participate, and there needs to be organization, documentation, and controls to ensure the system is treating those in need (both economically and medically) as efficiently and effectively as possible. With a commitment from a significant portion of the medical community, the process can move forward.

Physicians are recruited to participate in the project. By the point of project implementation, 35% to 100% of the physicians in each of the counties where the project is active have joined the effort. Primary care physicians agree to accept 10-12

patients as their responsibility. Specialty physicians agree to accept 20-24 patients per year from the program. Local medical societies, hospitals, health departments, county governments, departments of social services, and area pharmacies have participated in these initiatives to varying degrees based on program location.

Why Physicians Participate

Physicians report great satisfaction from the personal rewards they receive as a result of the service they are providing to the community. They note that the image of their medical community has been enhanced through the positive publicity that the program brings to the profession as a whole, as well as individual participants. This increased awareness of the significant contributions physicians make to the safety net has, in turn, led to increased credibility and political and social influence in their community and at the state and national levels.

There is renewed camaraderie and pride in the medical profession and commitment to the general welfare of their communities. These physicians have discovered that by working together in their communities they can make a difference. They have improved the health of their communities and their profession.

Clearly, physician leadership at the local level produces dramatic results: enhanced healthcare delivery, improved health of communities, and a renewal of the only inexhaustible resource of the healthcare delivery system—the compassion of its caregivers.

Measuring Outcomes

Access to Continuum of Care Increases

In Buncombe County during 2004, of the 210,000 total population, there were approximately 38,000 uninsured. Of the uninsured, approximately 65% (or 25,000 residents) had incomes below 200% of the federal poverty guidelines. Amazingly, over 24,000 of these estimated 25,000 low-income uninsured patients were seen at least once in a safety net clinic or in a private primary care physician's office during that calendar year. Of these, 2,800 were referred for specialty care, hospital services, and/or medications beyond the scope of services available in these free clinics and community clinics. Ninety-three percent of all county residents now report having a medical care home.

Health Status of Uninsured Improves and Charity Costs Decrease

Community-wide health assessments conducted in Buncombe County found that the uninsured were more likely to report being in good or excellent health than the insured. The uninsured were also less likely to report using the emergency room than the insured. Of the patients served through Project Access, 25% reported improved productivity on the job, and 17% reported reduced absenteeism. Per patient charity care costs decreased, perhaps related to improved health status and increased access to primary and preventive care services fostered

through the collaboration of private doctors, hospitals, safety net clinics, and area pharmacies. Area hospitals have documented an average of \$3 million annually in avoided charity care costs.

History of Replication

In late 1998 Buncombe County Medical Society was selected from nearly 1,700 applicants to receive the prestigious Ford Foundation Innovations in American Government Award. With that award came a commitment by the Medical Society to help others replicate its system of care. As a result of the experience gained by the Buncombe County Medical Society, it has now developed a sophisticated approach to helping communities adopt and adapt the Project Access model to their unique circumstances; and thereby, dramatically expand access to care in their communities by better organizing existing resources. Using Project Access as a model, many North Carolina counties have operational systems, including Avery, Watauga, Mitchell, Yancey, Wake, Mecklenburg, Pitt, Cabarrus, Guilford, Forsyth, Caldwell, Vance and Warren Counties, while others have secured necessary funding and are in the process of organizing their systems. Nationally, there are project access systems operating in dozens of communities, such as Wichita, Kansas; Spokane, Washington; Austin, Texas; and Marquette, Michigan. A more comprehensive listing with links to program web sites may be accessed at www.apanonline.org.

Project Access can be replicated in both rural and urban settings such as these projects in Wake and Watauga-Avery Counties.

Appalachian Healthcare Project: A Rural Model

While the Project Access model is easier to establish in communities with large provider bases and existing safety net providers, Project Access models have been established in less resource-rich environments as well. The first rural Project Access program, the Appalachian Healthcare Project, serves Watauga and Avery Counties. Watauga County has a population of 42,857 people with 25 primary care providers and 60 specialists. Avery County has a population of 17,610 with 17 primary care providers and two specialists.

In the spring of 2000, the only place for low-income uninsured patients to receive care was the hospital emergency department. There were no safety net organizations or free clinics providing comprehensive primary care. The Appalachian Healthcare Project was made possible by the commitment of the medical communities in these two counties. Each provider pledged to see anywhere from 12 to 24 patients per year. In addition, the local hospitals offered inpatient, outpatient, and diagnostic services to Appalachian Healthcare Project patients. The commitment of the medical community allows the patient load to be distributed equitably among the physicians. Since the project was implemented in April 2001, approximately 600 people have been served. On average, there are about 200 active patients at any time. In 2004, the medical community provided nearly \$2 million in medical care and medications to Appalachian Healthcare Project patients.

Wake County Project Access: An Urban Model

Urban volunteer service programs, like Project Access, are dependent on community stakeholders working collaboratively for the "common good." In this instance, the presence of six physician champions during the 12-month planning period persuaded leaders of the three hospital corporations and 450 physicians to sign on as participating providers.

The program has allowed the medical community to document the volume of donated care for patients who would not likely be able to pay for services. For this reason, hospital-based physicians and hospital corporations could only gain by their participation in Project Access, which has been strongly supported by local private practice physicians.

The project works collaboratively with an array of primary care safety net clinics, the health department clinics, hospital emergency departments, and private practice physicians. Since its inception in late 2000, Project Access of Wake County has enrolled 5,030 patients and has generated \$20 million in donated care provided by physicians and hospitals. Operating expenses, including the cost of outpatient medications, account for \$1 million, which yields a ratio of cost-to-donated care equal to \$1:\$20.

Current Needs for State Policy Development and Funding

Nationally, over 70% of physicians report providing charity care to the uninsured, yet this remains an often-overlooked component of our state's safety net services to the uninsured. In the absence of more thoughtful policies at the state level, the "specialty care" gap between primary care safety net services and hospital-based services will continue to widen, and many more patients will "fall through the cracks."

While scant state or federal policy has been developed to support continued private physician practice-based charity care, communities are stepping forward and producing dramatic gains in access, improved health, and reduced costs in serving the uninsured. These communities are investing in:

- Creating accountable safety net systems that improve the health of the uninsured and demonstrate significant returns on investment through reduced community costs and improved business productivity from healthier workforces.
- Building and sustaining physician-led administrative support that better organizes and celebrates physician charity care.
- Strategic planning that creates a healthcare safety net providing the full continuum of needed services.
- Systems that assure that uninsured patients receive the medications prescribed by physicians.
- Outcomes measurement systems that document the return on community investment.

State and federal policies are needed to help communities with these needed investments. In addition, the North Carolina Institute of Medicine North Carolina Healthcare Safety Net Task Force Report¹ calls for careful analysis of the

North Carolina's Good Samaritan legislation to assure that it provides appropriate liability protection for doctors donating their care to the uninsured, in particular to assure that this protection extends to cover doctors who are seeing patients for free in their private practices. Current legislation provides protection for patients who are referred by community clinics, but the protective legislation does not clearly extend its coverage to doctors who are participating in organized systems of charity care and seeing patients (for free) in their practices who may not have been referred by a clinic.

Conclusion

While our healthcare finance system cannot be based on charity, care donated by private physicians is a vitally important, yet vastly undervalued, component of our state's healthcare delivery system. Clearly charity care exists and will exist for the foreseeable future. Strategic investment in better organizing and integrating this care has been demonstrated to produce significant return on investment and public policy should be pursued to deliver this care effectively. **NCMJ**

REFERENCES

- 1 North Carolina Healthcare Safety Net Task Force Report: April 2005. North Carolina Institute of Medicine, Durham, NC. 2005.



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309 West Millbrook Road, Suite 121
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mail@naminc.org