

Why are Physicians Signing Up To See Uninsured Patients?

An effective system to provide healthcare to the uninsured population of this country has been the topic of media coverage, political debate and provocative books and movies over the past decade. Despite this attention, few programs with demonstrated success have emerged in response to this problem. While the true hardship of this dilemma falls on the population without coverage, *physicians and their practices* have faced professional and personal frustration, rising costs of doing business and loss of public respect as a result of this issue.

A coordinated, community-based, charity care system for low-income uninsured called [Project Access NOW](#) (Northwest Oregon Washington) has been developed by a collaborative comprised of many community partners. This collaborative serves as a coordinating center for all parties and efforts dedicated to this access initiative. [Clark](#), [Multnomah](#) and [Washington](#) counties each have an operational Project Access program serving patients in their area, and are members of the Project Access NOW Board of Directors. As well as providing a process to reduce duplication of services while maximizing the overall benefit of local resources, Project Access NOW serves local initiatives in the following ways:

Participating Partners	Project Access NOW
<ul style="list-style-type: none"> • Project Access Clackamas County • Project Access Clark County • Project Access Multnomah County • Project Access Washington County • Hospitals • Health Systems • Foundations • Physicians 	<ul style="list-style-type: none"> • Centralized Web-based Database • Coordination of Donated Hospital Services • Evaluation of Program Outcomes • Marketing & Public Relations • Recruitment of Donated Services • Creating Economies of Scale • Enabling regional entities, such as hospitals, to partner more easily

The regional (Northwest Oregon & Washington) effort Project Access NOW and the county initiatives, working in collaboration will achieve remarkable results in the years to come. Their approach involves strong public/private, non-profit/for-profit partnerships among community physicians, county government, hospitals, managed care organizations, community and volunteer clinics and service agencies, pharmacists and residents. This system, initiated by a group of community health leaders, and with the leadership of a group of concerned physicians, is creating open access to the full continuum of quality care in the community for the low-income uninsured population. This will be accomplished without Federal assistance, mandates, regulations, bureaucracy or third party oversight.

Physician Frustration with Healthcare Delivery to the Uninsured

Most physicians feel a sense of obligation to provide services to those who are sick, regardless of ability to pay. Physicians are discouraged by the disjointed approach to providing charity care, causing patients to delay care until there is a health crisis and, subsequently, higher costs for required medical interventions. Given the reduced reimbursement for their services, there is economic pressure on physicians to avoid seeing patients who were unable to pay. The local community and volunteer clinics are at capacity, often seeing patients as many as eight times per year, and with long waiting lists to take new, uninsured, patients.

A major failure of the existing delivery system is the lack of access that uninsured patients have to any semblance of a care continuum. Referrals, needed tests or other ancillary services are not obtained, often because the patients fear incurring the expense of the service. Pharmaceuticals are also too expensive for this group of patients.

Physician practices are incurring avoidable administrative expenses related to treating these patients as well. Financial assessment and development of payment plans are consuming practice staff time as they seek to determine each patient's ability to pay. Uninsured patients often miss their appointments; disrupt schedules and using unnecessary staff time in phone calls and other follow-ups, because they lack the navigation support of an organized system. Collection efforts on the unpaid accounts of uninsured patients take time away from work on potentially collectable accounts, reducing practice cash flow.

Finally, the physicians are hurt and frustrated by the public perception that they do not care about the uninsured and refused to treat them. Justified or not, newspapers, TV news, movies and books depicted private physicians as the cause of the plight of the uninsured, and the image of uncharitability impeded their ability to be patient advocates in the political system. Hospitals are routinely recognized for providing the majority of charity care, and have the documentation to prove their costs. Doctors, on the other hand, have no documentation of the cost of the charitable care they provide. Therefore, being depicted as a significant cause of the problem, when community physicians express frustration or suggested improvements to the system, they are given no credibility.

At the same time, funds are not available to create more access for the patients. Safety net health care is stretched to its maximum and hospitals are suffering economically. All these and other factors lead to an uncoordinated, low quality, high cost delivery system.

Community Physicians Get Involved

Concern over the health status of Multnomah County's 250,000 uninsured residents led the Tri-County Safety Net, the Medical Society of Metropolitan Portland, and the Coalition of Community Health Clinics, under the leadership of several prominent community physicians, to take action. Through this group, which had strong and innovative leadership (both medical and administrative), grants were obtained and other community resources were secured for the effort. The partnership expanded to include representatives from Clark, Clackamas and Washington counties, and evolved into Project Access NOW.

The physicians of Northwest Oregon and Washington are quickly coming to realize that the care of these patients is ultimately unavoidable. Private physicians "on call" are required to treat uninsured patients presenting in emergency rooms. It is clear that the delivery system needs to be revamped so that uninsured patients could receive care in a timely manner. Thus costs could be reduced by treating health problems at an early stage before they became more complex.

Physicians involved in this effort realize that if the medical community as a whole contributed their services in an equal way, the burden on any one practice would be tolerable. Further, improving the efficiency and



effectiveness of the charity clinics would reduce demands on the private physicians. These converts are beginning to spread this message to their colleagues.

Program organizers have discovered, for example, that many of the visits in the community-based clinics are by patients presenting with recurring specialty care problems. These patients need to be referred to specialty physicians so that their conditions can be resolved earlier. This will free up patient appointments in the community clinics to see additional patients.

The message of the physician champions is straightforward. The uninsured population needs access to better care. The only way it can be delivered is if the medical community contributes to this care, with no single provider unduly burdened, and other key segments of the healthcare delivery system participating. Also, organization, documentation and controls need to be in place to insure that the system provides a continuum of care to those in need (both economically and medically) as efficiently and effectively as possible.

With a commitment from the medical community, Project Access is moving forward. The physician champions are conducting an intensive recruitment effort to secure commitments of area physicians and other providers to participate in the system. The goals are outlined in below:

Program Participants and Contribution Goals

Community Physicians – As of April 2008 we had 1,702 physicians enrolled in the program. Our goal is to recruit 70% of area physicians. Primary Care Physicians agree to accept 6 patients as their responsibility or to contribute 6 clinical sessions in a community clinic. Specialty physicians agree to accept 12 patients per year from the program or to contribute 6 specialty clinic sessions in a community clinic.

Local Project Access Initiatives – Responsible for volunteer enrollment, orientation and support, patient financial screening for eligibility certification and enrollment into the program, referral tracking, interpretive services scheduling, support to community clinics and utilization reports.

Project Access NOW – provides public relations and other administrative function, a database to allow patient referrals to participating specialty physicians and to maintain records of patient enrollments, and the Pharmacy Bridge program. The system generates ID cards that act like “insurance cards” for the patients.

Community Safety Net Clinics – will provide medical homes, patient scheduling (including reminder calls and follow-up calls for missed appointments), medication assistance and patient support. Care Oregon - Accepts and processes standard insurance claims (HCFA) submitted by physicians for services rendered to the uninsured population. The practices treat Project Access like an insurance company in their billing systems, submitting claim forms (while writing off costs at time of service) which allow collection of accurate data on the illnesses of patients, procedures provided and dollar value of services being rendered under the program.

Hospitals – will provide hospital services and outpatient ancillary services for the program.

Pharmacy Bridge- provides \$4.00 co-pay prescriptions on a limited formulary, pharmaceutical assistance program application assistance, formulary overrides.

Patients – Accept personal responsibility for keeping appointments, complying with treatment plans and expressing appreciation for the care they receive.

Project Access “insurance cards” eliminate the stigma on these patients of being uninsured when visiting a provider. They also sign Patient Responsibility Agreements and accept increased responsibility for keeping appointments, taking medications as prescribed and complying with treatment plans.

With the access to specialty care readily available, safety net clinics have been able to focus administrative and medical staff on reducing no-shows, arranging for interpretation and other ancillary health services. This improvement, coupled with the participation of the local physicians in community free clinics, effectively increases access to primary care, by reducing repeat visits by patients who are now being treated by the appropriate specialist.

Based on the results of other Project Access models nationwide, the health status of the uninsured population should be raised to within one standard deviation of national physical and mental health norms, while the cost of charity care on a per capita basis should decrease significantly (as much as 50%). Patients seen through this program should report reduced absenteeism from work and report improved productivity. This program will lead to many patients finding permanent employment - with health benefits - and becoming insured patients in the healthcare system.

The best endorsement of Project Access is its replication in other communities.

The Physicians’ Innovation Network <http://www.physiciansinnovation.org/about/about.php> is a national, nonprofit organization serving communities that utilize the Project Access system to coordinate physician charity care for low-income, uninsured people. Project Access provides an effective means to enhance access to care and improve the health of this population.

PIN uses the Buncombe County Medical Society Project Access charity healthcare model developed in Asheville, NC—and others that have been replicated from it—to help guide communities through their own transformational processes. *More than 50 communities*, with populations ranging in size from 22,000 to over 1 million have successfully adopted the Project Access model to their unique circumstances. Dozens more are actively working to implement the coordinated charity care system.

An Award-Winning Model

Since 1996, Asheville’s physicians and hospitals have provided more than \$30 million of documented free care through BCMS Project Access. The Project Access system has received numerous state and national awards, including the Harvard University/Ford Foundation Innovations in American Government Award, the National Association of Counties Caring Award and the American Society of Association Executives Summit Award.

The BCMS Project Access model of care has proven to be effective. After five years of operation, research showed that the uninsured in the community were more likely to report being in good or excellent health than the insured. In addition, the cost of charity care provided by hospitals had declined significantly, and the uninsured were less likely to use the emergency room than the insured.

Benefits to the Practices and Physicians

Project Access-based systems provide considerable benefits to physicians' practices, as outlined below. Participating physicians express improvement in their practice operations and bottom line. With structured and coordinated supports for uninsured patients, the physician and their staff no longer need to negotiate the 'system' on behalf of the patient. With Project Access, physicians have the freedom to focus on healing.

BENEFITS TO PRACTICES

- Collection efforts focus on collectable accounts.
- Practice's accounts receivable more accurately reflect assets.
- Reduced no-show increases patient volume.
- Objective third party patient financial reviews reduce practice staff time spent conducting these assessments.
- Improved patient compliance and accessibility to specialty referrals and ancillary services reduce physician and staff follow-up time.
- Per capita cost of charity care declines.
- Acceptance and documentation of charity care volumes relieves unnecessary time, aggravation and energy in avoiding non-paying patients.
- Physicians see fewer unassigned patients with avoidable conditions while on call for hospital emergency room specialty care.

Physicians in other PA models report great satisfaction from the service they are providing to the community. They note that the image of their medical community has been enhanced through the good publicity generated by a system-wide approach to charity care— for the profession as a whole, as well as individual participants.

Through Project Access systems, physicians are increasingly recognized as patient advocates. Part of this is due to the validation that the data from these systems generate. For example, Buncombe County's program has demonstrated that two thirds of the cost of charity care is borne by the private physicians, a reversal of the perceived ratio of hospital to physician charitable contributions before Project Access. This increased awareness of the significant contributions physicians make to the safety net has in turn led to increased credibility, political and social influence in their community and at the state and national levels.

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

Clearly, physician and health community leadership produce dramatic results: enhanced healthcare delivery, improved health of communities and a renewal of the deepest, perhaps most valuable resource of the healthcare delivery system - the **compassion** of its caregivers.