

Greater Cincinnati Physician Study on Charity and Uncompensated Care

Final Report

Institute for the Study of Health
University of Cincinnati Academic Health Center

July 1, 2008

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Project Overview

Project Aim

The aim of this study was to assess the current level of uncompensated (a.k.a. charity) care provided by physicians in the Greater Cincinnati region, and to determine whether and under what circumstances physicians would be willing to serve additional patients who have limited ability or are unable to pay for care. A particular focus was to identify physician attitudes and concerns relative to specific design characteristics of community-wide models for coordinating care for the uninsured. Additionally, the research team solicited names of area physicians interested in learning about and/or participating in a regional program for the uninsured. This study was performed on behalf of the Academy of Medicine of Cincinnati through a grant from the Health Foundation of Greater Cincinnati. The research was approved by the University of Cincinnati Institutional Review Board (IRB #07-09-05-02E).

Research Objectives

The specific project objectives were to:

1. Determine the current levels of uncompensated care provided by physicians in the community;
2. Identify additional capacity (if any) for expanding care for the uninsured; and,
3. Determine whether and how physicians would be willing to participate in a regional program that would economically qualify and register uninsured patients, schedule and direct patients to the appropriate physician, and allow physicians to determine the number of such patients they would accommodate in their practice.

Background

This project is part of the Access Health 100 initiative launched by the Health Foundation of Greater Cincinnati in response to the growing number of uninsured residents in the Greater Cincinnati region. Among other activities, the initiative involves evaluating for implementation alternative models for ensuring access to care in a coordinated, community-wide fashion. Existing models for the uninsured in other communities share common design characteristics, although no two programs are alike. An important first step in determining the most appropriate model for the region is to establish the current level of uncompensated care provided by physicians, and to elucidate specific barriers to expanding the availability of uncompensated care within the region. Understanding physicians concerns and preferences regarding a coordinated program is essential to tailoring the program to the region. Identification of physicians willing to participate in such an effort is also central to the program design.

Study Design and Methodology

Study Design

To answer the study objectives, a mixed methods study design was employed, including a community-wide survey and an in-depth study of a more limited number of physicians from the community. The design included:

1. **Community-wide Survey.** A self-administered questionnaire was constructed and sent to approximately 4500 providers. Addresses were obtained from a mailing list provided by the Academy of Medicine. An addressed, post-marked return envelop was provided, as was a web address for those who preferred to respond to an online version of the survey.
2. **Focus Groups.** Potential focus group participants were recruited by the Academy of Medicine through its membership fax listing. Selected respondents, chosen to ensure diversity of specialty and geographic location, were organized into two focus groups.

Findings from the survey and focus groups are integrated in the results section of this report. A set of recommendations draws upon all available data to inform study sponsors on potential opportunities, concerns and next steps. Additionally, a list was provided of 73 physicians who self-identified as being interested in learning more about participating in a regional program for the uninsured.

Study Population and Analytic Methods for Survey Data

Three hundred and sixty-four (n=364) physicians responded to the survey. Physician respondents were categorized into one of the three groups detailed below, in an effort to distinguish public from private sector physicians, as well as those in an inpatient setting from those in the outpatient environment. Responses were analyzed based on this categorization scheme.

1. Group 1 (Public Outpatient) - Public health clinic or community health center setting.
2. Group 2 (Private Outpatient) - Private practice / multi-practice / other outpatient setting.
3. Group 3 (Academic /Hospital) - CCHMC / UC / academic / hospital setting.

Of the 364 physician respondents, 18 (4.9%) were categorized as Public Outpatient, 247 (67.8%) were categorized as Private Outpatient and 83 (22.8%) were categorized as Academic /Hospital; there is a small fourth group for whom practice setting was not reported. While analyzing responses categorized by practice setting, descriptive statistics have been reported for all categories (Public Outpatient, Private Outpatient and Academic/Hospital); however, the emphasis is given to the differences between Private Outpatient and the remaining groups of providers because these providers frequently serve uninsured patients as part of their organizational mission.

The data were summarized by percentages and by means and standard deviations. Association between categorical variables was tested using the Fisher's exact test. Difference in mean values of quantitative variables was tested using the two sample t-test.

Descriptive data includes three additional variables; namely, the number of years a physician has been practicing medicine (*Less than 20 years, 20 years or more, Retired*), the physician's specialty (*Family medicine, Internal medicine, Pediatrics, Surgeon (any) and Other*) and the number of physicians in the responding physician's practice setting (*Less than 5, 5 - 15, 16 or more*).

Study Population and Analytic Methods for Focus Group Data

Two focus groups were held in May of 2008, with sixteen physicians participating in total. Eight participants were primary care physicians (e.g., pediatric, internal medicine and family practice) and eight were specialists, including two ophthalmologists, two obstetrician/gynecologists, a radiologist, a radiation oncologist, a psychiatrist and a dermatologist. Of the sixteen participants, one was retired from practice and one recently completed residency.

Focus groups were conducted in accordance with a semi-structured discussion guide developed in consultation with the study sponsor. During the second half of each focus group, participants reviewed a summary of an existing community-wide uncompensated care program in another market, and their feedback was documented (Appendix 2). All responses were audio recorded and documented by the investigator and research associate. Key themes were identified and used to inform the analysis.

Study Limitations

Given that physicians who are concerned about access to care for the uninsured may be more likely to participate in a survey or focus group on the subject, caution is advised regarding the potential for response bias among those participating in this study.

Results

Physician Characteristics and the Patients They Serve

As shown in Table 1, a diverse pool of physicians responded to the survey with nearly all specialties represented. When categorized by practice setting, providers in private outpatient settings had the largest representation with 247 (67.8%) respondents, followed by academic/hospital based providers with 83 (22.8%) respondents. Respondents were nearly equally divided by years of practice into those with more and less than 20 years of practice experience.

Of the 351 respondents who stated their specialty, 196 (55.8%) respondents were from family medicine, internal medicine, pediatrics and surgery (any), with each specialty having between

11.1% and 16.5%; the remaining 155 (44.1%) respondents were categorized as ‘other’ specialty. Regarding practice size, respondents were nearly equally divided into three groups. Of the 348 respondents who stated the number of physicians in their practice group, there was near equal distribution among practice sizes: less than 5, 5-15 and more than 15 providers.

Table 1. Characteristics of Respondents to the Provider Survey.

		Practice setting				Total	
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital		
Overall	N	16	18	247	83	364	
	Row %	4.3%	4.9%	67.8%	22.8%	100.0%	
# Years physician practicing medicine	# Responses		16	18	247	83	364
	Less than 20 years	n	1	11	112	40	164
		Column %	6.2%	61.1%	45.3%	48.1%	45.0%
	20 years or more	n	2	7	128	42	179
		Column %	12.5%	38.8%	51.8%	50.6%	49.1%
	Retired	n	13	0	7	1	21
Column %		81.2%	0.0%	2.8%	1.2%	5.7%	
Physician specialty	# Responses		4	18	246	83	351
	Family Medicine	n	1	5	48	4	58
		Column %	25.0%	27.7%	19.5%	4.8%	16.5%
	Internal Medicine	n	2	4	35	10	51
		Column %	50.0%	22.2%	14.2%	12.0%	14.5%
	Pediatrics	n	0	1	33	14	48
		Column %	0.0%	5.5%	13.4%	16.8%	13.6%
	Surgeon (any)	n	0	0	27	12	39
		Column %	0.0%	0.0%	10.9%	14.4%	11.1%
	Other	n	1	8	103	43	155
		Column %	25.0%	44.4%	41.8%	51.8%	44.1%

		Practice setting				Total	
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital		
# Physicians in practice	# Responses	3	18	246	81	348	
	Less than 5	n	1	8	115	9	133
		Column %	33.3%	44.4%	46.7%	11.1%	38.2%
	5 - 15	n	1	6	78	32	117
		Column %	33.3%	33.3%	31.7%	39.5%	33.6%
	16 or more	n	1	4	53	40	98
		Column %	33.3%	22.2%	21.5%	49.3%	28.1%

Table 2 shows that, overall, the greatest proportion of providers are willing to accept new patients with insurance while the lowest proportion expressed willingness to accept patients on Medicaid. It is of interest to note that a greater proportion of the providers are willing to accept patients who are self-pay than are willing to accept new Medicaid patients. Fisher's exact test indicates a statistically significant difference between Private Outpatient and Academic/Hospital provider groups in the proportion of physicians accepting new patients with Medicaid (65.9% vs. 97.3%, p-value < 0.0001). This may be due to the large proportion of respondents in the Academic /Hospital provider group seeing patients at Cincinnati Children's or University Hospital. There were no statistically significant differences between the Private practitioner and academic groups in the proportion of physicians accepting new patients with Medicare, private insurance and self-pay.

Table 2. Reported Willingness to Accept New Patients Based on Patients' Insurance Coverage

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
Overall	N	16	18	247	83	364
Accept new patients with Medicare?	# Responses	3	17	232	76	328
	# Yes	3	14	182	58	257
	% Yes	100.0%	82.3%	78.4%	76.3%	78.3%
Accept new patients with Medicaid?	# Responses	3	17	232	76	328
	# Yes	2	16	153	74	245
	% Yes	66.6%	94.1%	65.9%	97.3%	74.6%

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
Accept new patients with Private Insurance?	# Responses	3	17	232	76	328
	# Yes	2	16	228	75	321
	% Yes	66.6%	94.1%	98.2%	98.6%	97.8%
Accept new patients with Self-pay?	# Responses	3	17	232	76	328
	# Yes	2	15	206	68	291
	% Yes	66.6%	88.2%	88.7%	89.4%	88.7%

Table 3 shows that, overall, only a small proportion of current patient populations are high income with the majority being of middle or low incomes. Private and academic providers differed significantly in the income distribution of their patient populations with a significantly lower proportion of low income patients among private providers but a significantly greater proportion with middle income or higher. Again, this is likely due to the large proportion of respondents among the academic/hospital-based providers who see patients at Cincinnati Children's or University Hospital.

Table 3. Reported Income Categories of Current Patients

		Practice setting				Total	
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital		
Overall	N	16	18	247	83	364	
Patient income level	# Responses	2	18	246	82	348	
	Low income	n	1	13	15	32	61
		Column %	50.0%	72.2%	6.0%	39.0%	17.5%
	Mid income	n	0	3	126	11	140
		Column %	0.0%	16.6%	51.2%	13.4%	40.2%
	High income	n	0	0	10	0	10
		Column %	0.0%	0.0%	4.0%	0.0%	2.8%
	Mixed income	n	1	2	95	39	137
Column %		50.0%	11.1%	38.6%	47.5%	39.3%	

Table 4 presents the overall mean and median values of the percent of physician’s current patients with Medicaid, Medicare, private insurance and no insurance coverage. Two-sample t-tests indicated statistically significant differences between the private and academic provider groups in the mean percent of patients with Medicaid (p-value = 0.0183), Medicare (p-value < 0.0001), private insurance (p-value < 0.0001) and no insurance coverage (p-value < 0.0001).

Table 4. Reported Medical Coverage of Current Patient Populations

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
Overall	N	16	18	247	83	364
% of patients with Medicare	# Responses	2	14	214	60	290
	Mean	27.5	20.6	27.6	20.9	25.9
	Median	27.5	17.5	30.0	20.0	25.0
% of patients with Medicaid	# Responses	2	16	218	68	304
	Mean	13.5	33.1	12.0	33.8	18.0
	Median	13.5	27.5	10.0	30.0	10.0
% of patients with Private Insurance	# Responses	2	15	223	67	307
	Mean	45.0	18.5	54.9	35.2	48.8
	Median	45.0	10.0	50.0	30.0	49.0
% of patients with no insurance	# Responses	2	15	204	67	288
	Mean	14.0	33.6	7.5	14.6	10.5
	Median	14.0	30.0	5.0	10.0	5.0

Each focus group included a discussion about perceived “gaps in care” for uninsured patients. Most primary care physicians felt they often had to “call in favors” to access specialty care for their uninsured patients. Several reported that these patients were often unable to afford important tests and treatments.

Access to care at Cincinnati Children’s and University Hospital is often problematic for the uninsured, according to focus group participants. Navigating the system can be a challenge, and waiting lists are common. Physicians felt that these existing systems are frequently overwhelmed and that patients suffer as a result.

Several physicians reported difficulty accessing mental health care for all but those with the most severe psychiatric disorders. “People with bipolar and schizophrenia get treatment and those with milder depression suffer,” said one physician. Several felt they become the provider of mental health care for those that are deemed “less in need” of psychiatric services.

Lab tests and radiology services are also difficult to access, according to many participants. One physician stated, “Anything more than a mammogram is a problem.” Another physician said “I choose not to give evidenced based care to some of my diabetics who can’t afford routine testing of their HbA1C. I try to find a middle ground with patients and usually test every 9 months instead of the recommended (semiannual) testing.”

Physicians’ Current Involvement in Charity Care

Table 5 presents the proportion of physicians who see insured, low-income patients who cannot afford any co-payment. Overall, almost 90% of providers report seeing insured, low-income patients who cannot afford co-payments in their practices. However, a significantly lower proportion of providers in private practice vis-à-vis academic practice see such patients (p-value = 0.0251). Differences also existed between physicians based on size of their practice group with a lower proportion of providers in practices with less than 5 physicians than for other size practices who see patients who cannot afford co-payments for their care (p-value = 0.0058).

Overall, there were no statistically significant differences between providers classified by number of years in practice or by physician specialty. However, a significant difference was found based on years in practice for physicians in private practice versus those who practice in academic or hospital settings. This finding is consistent with the discussion among focus group participants who indicated that younger physicians are focused on building their practice and feel pressure from peers to establish a productive track record before pursuing charitable aims.

Table 5. Provision of Uncompensated Care to Insured Low-income Patients Who Cannot Afford Co-Payments

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
Overall	N	16	18	247	83	364
	# Responses	3	17	238	76	334
	N	3	17	238	76	334
	# Yes	3	16	189	69	277
	% Yes	100.0%	94.1%	79.4%	90.7%	82.9%

		Practice setting				Total	
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital		
# Years physician practicing medicine	# Responses		3	17	238	76	334
	Less than 20 years	N	1	11	111	37	160
		# Yes	1	10	81	35	127
		% Yes	100.0%	90.9%	72.9%	94.5%	79.3%
	20 years or more	N	2	6	122	39	169
		# Yes	2	6	104	34	146
		% Yes	100.0%	100.0%	85.2%	87.1%	86.3%
	Retired	N	0	0	5	0	5
		# Yes	0	0	4	0	4
		% Yes	0	0	80.0%	0	80.0%
Physician specialty	# Responses		2	17	237	76	332
	Family Medicine	N	0	5	45	4	54
		# Yes	0	5	38	3	46
		% Yes	0	100.0%	84.4%	75.0%	85.1%
	Internal Medicine	N	1	4	35	10	50
		# Yes	1	3	30	9	43
		% Yes	100.0%	75.0%	85.7%	90.0%	86.0%
	Pediatrics	N	0	1	33	13	47
		# Yes	0	1	24	13	38
		% Yes	0	100.0%	72.7%	100.0%	80.8%
	Surgeon (any)	N	0	0	25	10	35
		# Yes	0	0	20	9	29
		% Yes	0	0	80.0%	90.0%	82.8%
	Other	N	1	7	99	39	146
		# Yes	1	7	76	35	119
		% Yes	100.0%	100.0%	76.7%	89.7%	81.5%

		Practice setting				Total	
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital		
# Physicians in practice	# Responses	3	17	237	75	332	
	Less than 5	N	1	8	112	7	128
		# Yes	1	8	79	7	95
		% Yes	100.0%	100.0%	70.5%	100.0%	74.2%
	5 - 15	N	1	5	75	30	111
		# Yes	1	4	65	28	98
		% Yes	100.0%	80.0%	86.6%	93.3%	88.2%
	16 or more	N	1	4	50	38	93
		# Yes	1	4	44	33	82
		% Yes	100.0%	100.0%	88.0%	86.8%	88.1%

Younger private practice physicians are less likely to see uninsured patients. “I just finished residency and want to do my part and see more uninsured patients but I feel like I first have to get my practice off the ground,” said one focus group participant. Conversely, an established physician that has been in practice for many years reported that he now is at the point where he wants to “give something back” and is considering volunteer opportunities for up to 4 hours per week.

Importantly, those in private practice settings of 5 or fewer physicians are significantly less likely to see uninsured patients who cannot afford a co-payment. Financial pressures associated with operating a small outpatient practice and related factors may account for this finding. Regardless, targeted outreach to physicians in larger groups may yield more increased capacity for charity care.

Table 6 shows that approximately three-quarters of respondents report they are currently providing uncompensated care for uninsured patients. A significantly lower proportion of providers in the private practice group than in the academic and hospital-based provider group are so doing (p-value < 0.0001). A higher proportion of active providers with 20 or more years in practice are providing uncompensated care as compared to providers who have less time in practice or are retired (p-value = 0.0118). Again, a lower proportion of providers in private practice provide uncompensated care than those in other practice settings regardless of years in practice, specialty (p-value = 0.0259) or size of practice (p-value = 0.0025).

Table 6. Current Provision of Uncompensated (Charity) Care to Uninsured Patients

		Practice setting				Total	
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital		
Overall	N	16	18	247	83	364	
	# Responses	3	16	242	78	339	
	N	3	16	242	78	339	
	# Yes	3	15	159	69	246	
	% Yes	100.0%	93.7%	65.7%	88.4%	72.5%	
# Years physician practicing medicine	# Responses		3	16	242	78	339
	Less than 20 years	n	1	11	111	38	161
		# Yes	1	11	59	36	107
		% Yes	100.0%	100.0%	53.1%	94.7%	66.4%
	20 years or more	n	2	5	126	39	172
		# Yes	2	4	97	33	136
		% Yes	100.0%	80.0%	76.9%	84.6%	79.0%
	Retired	n	0	0	5	1	6
		# Yes	0	0	3	0	3
		% Yes	0	0	60.0%	0.0%	50.0%

		Practice setting				Total	
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital		
Physician specialty	# Responses		2	16	241	78	337
	Family Medicine	n	0	5	47	4	56
		# Yes	0	5	31	3	39
		% Yes	0	100.0%	65.9%	75.0%	69.6%
	Internal Medicine	n	1	4	35	10	50
		# Yes	1	4	22	9	36
		% Yes	100.0%	100.0%	62.8%	90.0%	72.0%
	Pediatrics	n	0	0	32	14	46
		# Yes	0	0	12	14	26
		% Yes	0	0	37.5%	100.0%	56.5%
	Surgeon (any)	n	0	0	26	9	35
		# Yes	0	0	23	8	31
		% Yes	0	0	88.4%	88.8%	88.5%
	Other	n	1	7	101	41	150
		# Yes	1	6	70	35	112
% Yes		100.0%	85.7%	69.3%	85.3%	74.6%	
# Physicians in practice	# Responses		3	16	241	77	337
	Less than 5	n	1	8	111	8	128
		# Yes	1	7	70	7	85
		% Yes	100.0%	87.5%	63.0%	87.5%	66.4%
	5 - 15	n	1	4	77	31	113
		# Yes	1	4	46	27	78
		% Yes	100.0%	100.0%	59.7%	87.0%	69.0%
	16 or more	n	1	4	53	38	96
		# Yes	1	4	43	34	82
		% Yes	100.0%	100.0%	81.1%	89.4%	85.4%

The majority of focus group participants routinely saw at least a minimum number of uninsured patients in their office setting. Methods for accommodating these patients varied but included “down coding,” sliding scale fees and writing off bad debt. Specialists were more likely to see uninsured patients in the hospital, and often are not aware of the patient’s insurance status at the time of care. One physician affiliated with a large health system reported that he and his

colleagues are required to provide a specific level of charity care, and estimated his current commitment at approximately six weeks of free care each year.

Several focus group participants described their experience with more formalized programs of care for the uninsured. Two physicians in particular served in a leadership role for two distinct charity care programs. The first is a regional strategy to engage physicians in accommodating additional uninsured patients. This physician described his experience trying to recruit participation among his peers. “It is very challenging to get physicians involved,” he reported. A second physician works with a specific clinic location with the aim of recruiting physicians to volunteer at the facility.

An ophthalmologist shared information about his company’s partnership with a local church to provide vision services for the uninsured. This center recently opened a clinic in Roselawn on Saturday mornings staffed by volunteer physicians. He said, “The culture of his practice includes an expectation that you will volunteer for this service.” He experience was that once the center was in place and the logistics arranged, volunteer physicians were willing to participate.

Table 7 indicates that about one-third of physicians are currently participating in an organized program for uncompensated care. The proportion of providers in a private practice setting who participate in such programs is about half that of those in an academic or hospital setting (p-value < 0.0001). Size of the practice was associated with participation in an organized program for uncompensated care with a lower proportion of providers in the smallest practices being involved (p-value = 0.0182). However, neither the number of years in practice nor specialty was related to participation in such a program.

Table 7. Current Participation in Any Organized Program for Uncompensated Care

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
Overall	N	16	18	247	83	364
	# Responses	3	17	240	77	337
	n	3	17	240	77	337
	# Yes	1	10	55	37	103
	% Yes	33.3%	58.8%	22.9%	48.0%	30.5%

		Practice setting				Total	
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital		
# Years physician practicing medicine	# Responses		3	17	240	77	337
	Less than 20 years	n	1	11	109	38	159
		# Yes	1	7	21	20	49
		% Yes	100.0%	63.6%	19.2%	52.6%	30.8%
	20 years or more	n	1	6	126	38	171
		# Yes	0	3	34	17	54
		% Yes	0.0%	50.0%	26.9%	44.7%	31.5%
	Retired	n	1	0	5	1	7
		# Yes	0	0	0	0	0
		% Yes	0.0%	0	0.0%	0.0%	0.0%
Physician specialty	# Responses		3	17	239	77	336
	Family Medicine	n	0	5	46	4	55
		# Yes	0	4	11	2	17
		% Yes	0	80.0%	23.9%	50.0%	30.9%
	Internal Medicine	n	2	4	35	9	50
		# Yes	1	3	8	7	19
		% Yes	50.0%	75.0%	22.8%	77.7%	38.0%
	Pediatrics	n	0	1	33	13	47
		# Yes	0	0	6	6	12
		% Yes	0	0.0%	18.1%	46.1%	25.5%
	Surgeon (any)	n	0	0	26	11	37
		# Yes	0	0	7	8	15
		% Yes	0	0	26.9%	72.7%	40.5%
	Other	n	1	7	99	40	147
		# Yes	0	3	23	14	40
		% Yes	0.0%	42.8%	23.2%	35.0%	27.2%

		Practice setting				Total	
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital		
# Physicians in practice	# Responses	2	17	239	75	333	
	Less than 5	n	1	8	111	8	128
		# Yes	0	5	18	5	28
		% Yes	0.0%	62.5%	16.2%	62.5%	21.8%
	5 - 15	n	1	5	76	29	111
		# Yes	1	3	18	16	38
		% Yes	100.0%	60.0%	23.6%	55.1%	34.2%
	16 or more	n	0	4	52	38	94
		# Yes	0	2	19	15	36
		% Yes	0	50.0%	36.5%	39.4%	38.2%

Physicians' Future Involvement in Charity Care

Table 8 shows the proportion of physicians willing to provide uncompensated care to additional patients. The proportion of providers in the private practice setting compared to academic providers who were unwilling to see additional charity patients was inversely related to number of additional patients (p-value < 0.0001). Approximately fifty percent of respondents were willing to see additional uninsured patients. Those in the private outpatient setting report a willingness to see 1-5 additional patients, though far fewer were willing to see 6 or more.

Table 8. Number of Additional Charity Care Physicians Are Willing to Serve

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
Overall	N	16	18	247	83	364
# additional charity patients	# Responses	3	16	227	65	311
None	n	0	1	121	15	137
	Column %	0	6.2%	53.3%	23.0%	44.0%
1 - 5	n	1	3	68	13	85
	Column %	33.3%	18.7%	29.9%	20.0%	27.3%

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
6 or more	n	2	12	38	37	89
	Column %	66.6%	75.0%	16.7%	56.9%	28.6%

Table 9 shows that the overall proportions of physicians willing to provide additional uncompensated care for any uninsured, working uninsured, uninsured kids and uninsured adults are 58.1%, 30.0%, 43.9% and 44.3% respectively. Generally, there were no difference between private and academic providers regarding to whom they would provide charity care with the exception of the working uninsured. Here, a greater proportion of private sector providers would see such patients than providers in academic or hospital-based settings (p-value = 0.0013).

Table 9. Patients for Whom Physicians Are Willing to Provide Additional Charity Care

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
Overall	N	16	18	247	83	364
Any uninsured	# Responses	4	16	162	64	246
	# Yes	3	15	88	37	143
	% Yes	75.0%	93.7%	54.3%	57.8%	58.1%
Working uninsured	# Responses	4	16	162	64	246
	# Yes	0	3	61	10	74
	% Yes	0.0%	18.7%	37.6%	15.6%	30.0%
Uninsured kids	# Responses	4	16	162	64	246
	# Yes	0	7	70	31	108
	% Yes	0.0%	43.7%	43.2%	48.4%	43.9%
Uninsured adults	# Responses	4	16	162	64	246
	# Yes	4	10	72	23	109
	% Yes	100.0%	62.5%	44.4%	35.9%	44.3%

Table 10 shows the overall proportions of physicians willing to provide additional uncompensated care in various practice settings. A greater proportion of providers in private practice vis-à-vis those in academic practices were willing to provide additional uncompensated care in office/practice setting (p-value = 0.0114) and in community clinic (p-value < 0.0001) but a smaller proportion were willing to provide charity care in a hospital clinic (p-value = 0.0114).

Table 10. Settings in Which Physicians Are Willing to Provide Additional Charity Care

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
Overall	N	16	18	247	83	364
Office / Practice setting	# Responses	4	16	175	61	256
	# Yes	2	5	94	21	122
	% Yes	50.0%	31.2%	53.7%	34.4%	47.6%
Community clinic	# Responses	4	16	175	61	256
	# Yes	2	7	71	10	90
	% Yes	50.0%	43.7%	40.5%	16.3%	35.1%
Hospital clinic	# Responses	4	16	175	61	256
	# Yes	3	8	75	45	131
	% Yes	75.0%	50.0%	42.8%	73.7%	51.1%

Focus group participants discussed alternative setting in which they would prefer to see uninsured patients. Two distinct approaches emerged, each having its own group of physicians expressing interest. Some physicians are willing to see additional uninsured patients in their office setting, and see this option as introducing the least amount of disruption in their work flow. Others much preferred volunteering at another setting for a specific number of hours or patients.

Numerous physicians expressed concern about seeing uninsured patients in their office, along with their suburban or middle income patients. One physician brought to the group’s attention the fact that he currently provides charity care in his suburban office without difficulty. He reminded the group, “We are essentially talking about the working poor and they really appreciated my services in the office. And I also have less no shows than I might in a clinic setting.”

Participants discussed volunteering at community health centers or other safety-net settings. Several physicians that were familiar with these clinics expressed concern that these existing provider settings were not optimized to efficiently serve a larger proportion of the uninsured.

Patients basically “pack their lunch and stay all day, waiting for their appointments,” said one physician. “This situation will not work well for working class families who have employment commitments.” Similarly, volunteer physicians may not be satisfied working under these circumstances.

Table 11 shows that a high proportion of physicians are currently providing uncompensated diagnostic and treatment services, and are willing to provide other services. Emergency evaluation, anesthesia, co-ordination of care, hospital based care, minor surgery, sports medicine and inpatient care & delivery were listed as the other specialist services currently provided or willing to be provided.

Table 11. Uncompensated Specialist Services Physicians Are Currently Providing or Are Willing to Provide

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
Overall	N	16	18	247	83	364
Diagnostic services	# Responses	2	9	126	60	197
	# Current	2	8	103	52	165
	% Current	100.0%	88.8%	81.7%	86.6%	83.7%
	# Willing	0	1	23	8	32
	% Willing	0.0%	11.1%	18.2%	13.3%	16.2%
Treatment services	# Responses	2	9	126	60	197
	# Current	2	9	119	56	186
	% Current	100.0%	100.0%	94.4%	93.3%	94.4%
	# Willing	0	0	7	4	11
	% Willing	0.0%	0.0%	5.5%	6.6%	5.5%
Other services	# Responses	2	9	126	59	196
	# Current	0	0	7	7	14
	% Current	0.0%	0.0%	5.5%	11.8%	7.1%
	# Willing	2	9	119	52	182
	% Willing	100.0%	100.0%	94.4%	88.1%	92.8%

The focus groups provided additional insight into these topics. Physicians want a system that leverages existing resources while improving efficiency to accommodate more uninsured patients. Participants emphasized the need for flexibility to choose whether to see uninsured patients in their office or at a separate clinic settings. They are concerned about continuity of

care and record keeping at multiple clinic locations. Hospitals and labs would need to be active participants in any community-wide program in order to reduce costs for patients. A variety of specialists would be needed for comprehensive care.

Physicians are uncertain about several legal issues related to volunteering or reducing prices for the uninsured. Malpractice insurance was repeatedly cited as a concern among those interested in volunteering at a clinic site. A retired physician said, “I know of several others willing to volunteer but they also have no malpractice coverage.” Upon further investigation, this physician indicated that retirees may also need help obtaining CME, and keeping their DEA number and active state medical license. One participant stated, “Physicians don’t mind giving up their time but asking to give money (e.g., to obtain license, malpractice, CME, etc.) would be asking too much.” Physicians questioned whether they could legally lower their prices relative to Medicare and private insurance plans. Many felt that legislation would need to be passed in order to protect physicians and other care providers before a windfall of physicians would elect to participate.

Table 12 presents the proportions of physicians who identified various features as desirable for fostering the provision of uncompensated care in the clinic setting. It can be seen that nursing and other support staff provided by clinic is the most desired feature chosen by 71.5% of the overall respondents followed by malpractice insurance coverage desired by 62.6%, all paperwork taken care of by clinic desired by 59.5% and patient scheduling & reminder by clinic desired by 50.6%. Adjustable clinic hours based on physician’s schedule was chosen by only 28.4%.

Table 12. Top 3 Features Desired for Providing Uncompensated Care in a Clinic Setting

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
Overall	N	16	18	247	83	364
Patient scheduling and reminders by clinic	# Responses	4	15	151	55	225
	# Yes	2	11	77	24	114
	% Yes	50.0%	73.3%	50.9%	43.6%	50.6%
All paperwork by clinic	# Responses	4	15	151	55	225
	# Yes	2	8	93	31	134
	% Yes	50.0%	53.3%	61.5%	56.3%	59.5%
Nursing & other support staff by clinic	# Responses	4	15	151	55	225
	# Yes	3	13	106	39	161
	% Yes	75.0%	86.6%	70.1%	70.9%	71.5%

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
Adjustable clinic hours	# Responses	4	15	151	55	225
	# Yes	1	0	44	19	64
	% Yes	25.0%	0.0%	29.1%	34.5%	28.4%
Malpractice insurance coverage as a clinic volunteer	# Responses	4	15	151	55	225
	# Yes	4	11	96	30	141
	% Yes	100.0%	73.3%	63.5%	54.5%	62.6%

Several physicians agreed that coordination, screening and referral for uninsured patients would be beneficial. Many expressed that they did not want to be the person to qualify whether a patient needs care or financial assistance. Most physicians felt that patients should be given a card similar to a health plan, and require a standard \$10-20 co-payment for each visit. Patients should also receive and sign a standard form describing specific expectations, including the expectation that patients would pay for missed visits. Others suggested handing out a fee schedule so patients would understand the value of care they were receiving at a reduced rate.

Physicians at the focus groups felt that peer champions would be important for building interest in a community-wide program. Hospitals could encourage or require their affiliated physicians to perform a minimum amount of charity care by stipulating in their physician contracts. One local health system is reported to have such a system in place currently.

Physicians suggested clearly articulating the expectations of volunteers. For example, volunteers should be asked to contribute a minimum of 4 hours per month or a specific number of events/episodes of specialty care. Designing such a system around 3-month increments might make it more likely that physicians would participate. "It wouldn't seem so overwhelming if I knew I was only committing to see 8 patients per quarter," said one group member.

Table 13 presents the proportions of physicians who ranked various standardized process and resources as most desirable for the provision of uncompensated care. It can be seen that prescription benefit is the most desired standardized process/resource chosen by 65.4% of overall respondents followed by free or low-cost medical tests chosen by 62.4% while standard co-payment was chosen by only 10.4%. The mean value for standard co-payment, recommended by 23 respondents, was \$21.30 and the median value was \$10.00 while the minimum and maximum values were \$10.00 and \$100.00 respectively.

Table 13. Top 3 Standardized Processes and Resources Desired for Uncompensated Care

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
Overall	N	16	18	247	83	364
Standard sliding scale fee	# Responses	2	16	190	61	269
	# Yes	0	5	60	10	75
	% Yes	0.0%	31.2%	31.5%	16.3%	27.8%
Prescription benefit	# Responses	2	16	190	61	269
	# Yes	1	12	119	44	176
	% Yes	50.0%	75.0%	62.6%	72.1%	65.4%
Free or low-cost medical tests	# Responses	2	16	190	61	269
	# Yes	2	10	122	34	168
	% Yes	100.0%	62.5%	64.2%	55.7%	62.4%
Low cost hospital services	# Responses	2	16	190	61	269
	# Yes	1	4	61	22	88
	% Yes	50.0%	25.0%	32.1%	36.0%	32.7%
Case management services	# Responses	2	16	190	61	269
	# Yes	0	4	67	30	101
	% Yes	0.0%	25.0%	35.2%	49.1%	37.5%
Screening and eligibility verification	# Responses	2	16	190	61	269
	# Yes	0	3	44	12	59
	% Yes	0.0%	18.7%	23.1%	19.6%	21.9%
Low-cost specialist services	# Responses	2	16	190	61	269
	# Yes	2	7	51	16	76
	% Yes	100.0%	43.7%	26.8%	26.2%	28.2%

		Practice setting				Total
		Not Reported	Public Outpatient	Private Outpatient	Academic / Hospital	
Standard co-pay	# Responses	2	16	190	61	269
	# Yes	0	2	18	8	28
	% Yes	0.0%	12.5%	9.4%	13.1%	10.4%

Focus group participants reviewed the summary of a community-wide program for the uninsured in Buncombe County, North Carolina (Appendix 2). Physicians were asked to comment on specific design features they would like to see if a similar program were to be established in Greater Cincinnati. They were instructed to discuss the likelihood of such a program being embraced by local physicians.

Most physicians felt this program would work well with some modifications. “I think you would find strong support within the physician community,” said one participant. All felt that numerous provider groups and community organizations needed to be involved in planning a project of this size. The Mental Health Access Point (MHAP) was cited as a potential model for coordinating access to care across the region.

Several expressed concern that a centralized system might not materialize or could become unwieldy given the many different needs across the 20-county region. These physicians suggested that each county be given assistance in identifying their own needs, resources and strategy going forward.

Summary and Recommendations

The views on uncompensated care provided in this study reflect the perspectives of a diverse group of providers. Survey and focus group participants represented varying specialties, years of experience and practice size. There was also diversity in practice settings including public, academic and hospital settings as well as the private sector. Of note, approximately two-thirds of respondents were from the private practice setting, which is likely to hold maximum potential for additional uncompensated care.

Overall, the majority of physicians report that they continue to accept uninsured patients. More physicians were willing to accept new patients with private insurance and self-pay than those with Medicare and Medicaid. Physicians from private practice had a much lower proportion accepting new patients with Medicaid than physicians from the academic / hospital setting. As expected, private practice physicians serve a significantly lower proportion of low income patients and much higher proportion of current middle income patients than those from the public sector or academic / hospital setting.

Private insurance constitutes the medical coverage of nearly half (mean, 48.8%) of current patients followed by Medicare (mean, 25.9%). Physicians from the private practice setting had a much lower proportion of Medicaid patients and patients with no insurance, and much higher proportion of patients with private insurance than physicians from other settings.

Physicians from private practice were less likely to see insured low-income patients who cannot afford co-payments than physicians from the academic / hospital setting. This difference is further highlighted within physicians with less than 20 years of experience. Similarly, physicians from practice groups with less than 5 physicians were less likely to see insured low-income patients who cannot afford co-pay than physicians from practice groups with 5 - 15 physicians or more than 15 physicians. This difference, too, is further highlighted within physicians with less than 20 years of experience.

Current provision of charity care varied by practice setting, experience, specialty and practice group size. Physicians from private practice were less likely to be currently providing charity care than physicians from academic / hospital settings. Physicians with less than 20 years of experience are less likely to be currently providing charity care than those with 20 years or more experience. Only 3 out of 6 retirees are currently providing charity care, although this sample is not large enough to be representative. A much lower proportion of pediatricians and much higher proportion of surgeons were currently providing charity care compared to other specialties. Physicians from practice groups with 16 or more physicians were more likely to be currently providing charity care compared to physicians from smaller practice groups.

Physicians from private practice were less likely to be involved in any organized program for uncompensated care than those from academic / hospital settings. This difference is further highlighted within physicians with less than 20 years of experience. Similarly, physicians from practice groups with less than 5 physicians were less likely to be involved in any organized program for uncompensated care than those from practice groups with 5 - 15 physicians or more than 15 physicians. This difference, too, is further highlighted within physicians with less than 20 years of experience.

A much smaller proportion of physicians from private practice are willing to serve additional charity care patients than those from academic / hospital settings. Physicians did not differentiate, in terms of their willingness to provide charity care, between uninsured children and uninsured adults. The overlapping coverage of the term 'any uninsured' with the term 'working uninsured' might explain the lower proportion of physicians willing to serve 'working uninsured' category than 'any uninsured' category.

A larger proportion of physicians from private practice favored office/practice and community clinic setting for providing additional uncompensated care than physicians from academic / hospital settings.

Among specialist currently providing or willing to provide uncompensated services, 83.7% were already providing uncompensated diagnostic services and 94.4% were already providing uncompensated treatment services, perhaps leaving little room for future expansion.

Physicians chose provision of nursing & other support staff and malpractice insurance coverage as the most desired features while providing uncompensated care in a clinic setting. Physicians

chose prescription benefit & free/low-cost medical testing as the most helpful standardized processes while providing uncompensated care.

Physicians practicing for 20 years or more and in groups of 5 or more physicians appear more likely to serve additional uninsured patients. The largest proportion of private sector outpatient physicians reporting that they would be willing to see additional uninsured patients said that they prefer to see 1 to 5 additional patients.

Physicians need assistance understanding the legal implications of volunteer work. Malpractice insurance, Medicare regulations regarding sliding fee schedules, and related concerns were consistently raised by focus group participants. Few, if any, participants felt they fully understood the law, and most predicted that more physicians would volunteer if these concerns were fully addressed.

At a poignant moment during one focus group, a retired physician said, “This is really about physician culture. In the old days it was expected that you see some patients who weren’t able to pay. We need to say, ‘This is the way we do things around here. As a physician in this community, we expect you to see some portion of the uninsured’.” Participants agreed and suggested approaches to achieving this aim. These include, a) “branding” the provision of care for the uninsured as something important and marketing aggressively to providers; b) recruiting one or more retired physicians to serve as ambassadors to the physician community; and, c) identifying physician thought leaders to inform the approach, guide the messaging and communicate to their peers.

Appendix 1. Survey Instrument

Greater Cincinnati Physician Survey

This survey is commissioned by the Academy of Medicine of Cincinnati to gain a better understanding of the level of uncompensated care (i.e., charity care) by physicians to patients in this region. They also wish to know more about physicians' perceptions of activities related to quality of care and public reporting. Please take a few moments to complete and return this questionnaire. All responses will be anonymous and will be reported in aggregate so that no given individual is identifiable. If you identify yourself to the Academy as willing to provide charity care on the last page of this questionnaire, any identifying information will be removed to ensure the confidentiality of your survey responses.

Please complete and return this survey by April 4th 2008. You may return the completed survey using the enclosed stamped reply envelope. **You may also complete the survey online by going to <https://www.healthnet2.uc.edu/Surveys/GCP>**

Questions About You and Your Practice

First we would like to ask you about yourself and your practice to establish the context of your responses to the questions on charity care and quality of care measurement and reporting.

1. How many years have you been practicing medicine? (Please check all that apply)
 - Less than 10 years
 - 10-19 years
 - 20-29 years
 - 30 years or more
 - I am retired

2. What is the zip code of your primary practice? _____

3. Including yourself, how many physicians are in your practice?
 - Under 5
 - 5-15
 - 16-50
 - Over 50

4. What is your primary practice setting type?
- Public health clinic or community health center
 - Private practice
 - Multi-practice system
 - Other (Please specify_____)
5. What is your specialty?
- Family Medicine
 - Internal Medicine
 - Pediatrics
 - Other (Please specify_____)
6. What patient income level would you say your practice serves mostly? (Please check only one)
- Low income
 - Middle income
 - High income
 - Mixed income
7. Please estimate to the best of your knowledge, what percentage of your patients have each of the following types of medical coverage.
- _____ % Have insurance through Medicare
- _____ % Have insurance through Medicaid
- _____ % Have insurance coverage through private health plans
- _____ % Have no insurance
8. Which of the following types of new patients are you accepting? (Please check all that apply)
- Medicare
 - Medicaid
 - Private insurance
 - Self-pay

Provision of Charity Care

Communities across the US are establishing a more organized program of charity care for the uninsured. The Academy of Medicine and its partners are interested in your feedback on design characteristics of such a program in our community, and in better understanding uncompensated care already provided by area physicians.

9. Are you currently providing charity care for the uninsured?
- Yes No
10. If a low-income patient who has insurance cannot afford a co-payment for care, do you generally see the patient anyway?
- Yes No
11. How many additional charity care patients would you be willing to serve?
- None 1-5 6 or more
12. For whom would you be willing to provide additional uncompensated care?
(Please check all that apply)
- Anyone who is uninsured
- Only the working uninsured
- Children
- Adults
13. Where would you be willing to see additional uncompensated care patients?
(Please check all that apply)
- In my office/practice
- In a community clinic setting
- In a hospital clinic setting
14. If you are currently seeing or are willing to see uncompensated care patients in a clinic setting, which features matter the most to you? Please check the top 3 features that would be most supportive of your volunteer work (Please check only 3 responses)
- The clinic would take care of scheduling and reminders to avoid no-shows
- The clinic would take care of all paperwork
- The clinic would provide nursing and other support staff
- The clinic would adjust hours to meet my schedule

- I would be covered by the clinic's malpractice insurance as a volunteer under state law

15. If you are a specialist, which of the following services do you currently provide or are willing to provide?

- | Currently | Would be willing | |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Diagnostic services |
| <input type="checkbox"/> | <input type="checkbox"/> | Treatment services |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (Please specify _____) |

16. When providing uncompensated care to uninsured patients, it is helpful to have standardized processes and resources in place. Please check the top 3 features most important to you when providing charity care. (Please check only 3 responses)

- A standard sliding scale fee
- Prescription benefit for the uninsured patient
- Access to free or low-cost medical testing
- Low-cost inpatient and outpatient hospital services
- Case management services
- Prior screening and verification of eligibility of services
- Access to low-cost specialist care
- A standard co-pay (What amount would you recommend? \$ _____)

17. Do you currently participate in an organized program of uncompensated care?

- Yes
- No

If yes, please describe:

Charity Care Referral Listing

The Academy of Medicine is interested in compiling contact information of physicians interested in providing charity care and those who are already are doing so. By filling out and signing the information below you are indicating that your contact information can be compiled for these purposes. This section will be detached from your questionnaire upon receipt to ensure anonymity of your responses above.

Are you interested in receiving information about an organized program of charity care in our region?

- Yes
- No

- I am currently providing charity care (Please describe _____)

- I am interested in providing charity care

Name

Specialty

Mailing Address

Phone

Fax

Email

Signature

Appendix 2. Sample Community Program

Focus group participants reviewed the following summary of a community-wide program for the uninsured in Buncombe County, North Carolina. Physicians were asked to comment on specific design features they would like to see if a similar program were to be established in Greater Cincinnati. They were instructed to discuss the likelihood of such a program being embraced by local physicians.

Overview.

Project Access is a partnership formed 8 years ago between county government, county physicians, county service agencies, the hospital, and pharmacists. The Health Department could handle primary care needs but specialty care had always been a problem until Project Access. The community doctors wanted to do their share but not get "slammed." Through Project Access 90% of practicing physicians in Buncombe County (over 600) now see 10-20 individuals referred into their program with no expectation of payment. The County provides seed money, and the Medical Society runs the program, and the hospital absorbs patient costs. Access to primary care services has been raised from 78% in 1995 to an astounding 93% in the year 2000.

Responsiveness and Innovation.

This program responds to the basic human need for access to health care. While access alone will not solve all of the health care ails of the population, until the access problem is solved, most of the problems simply cannot be addressed. A low-income mother with a respiratory infection who has a child whose ear has ached for the last week simply is not interested in learning about the value of exercise and proper nutrition. Project Access and the primary care program of the Buncombe County Health Center fulfills a basic human need that then opens the door to all kinds of other collaboration within the community. It is innovative in that it spreads the indigent care burden across the entire medical community so that no single individual is ever required to see more than 20 clients. That represents less than 1% of the average practice and that burden is happily borne by local physicians.

Agency and Community Roles.

The Buncombe County Health Center is the primary provider of indigent medical care in the community with over 15,000 active clients. Before Project Access, the Department spent an inordinate amount of time trying to locate specialists to take indigent referrals. Specialty care needs were often going unresolved. Through this program the agency was able to almost double its primary care capacity because all local physicians now readily receive referrals on an equitably distributed system freeing the agency to do what it does best, primary care, and spreading specialty indigent care both across over 600 physicians. The County Commissioners contributed almost \$500,000 a year to pay for the drugs dispensed through this program as well as the administrative costs borne by the Medical Society and all safety net providers in the community are given access to refer into the Project Access program for specialty care, pharmaceuticals, and hospitalization.

Costs and Expenditures.

The direct costs of the program are \$390,000. The value of private physician services extended to the patients referred into Project Access was nearly \$3.6 million for 2001. It is clear that the county government sees value in this program and their support has been unwavering since the project

began. The private physicians are happy with the outcomes and delighted that no single individual or practice is being asked to carry more than a fair share.

Lessons Learned.

First and foremost, it was learned that any community who wants to address access to primary care for its indigent population can do so and do so effectively with the resources they already have on hand. For those who are waiting for the solution for access to primary care to come from Washington or even the state capital, the wait may go unrewarded. Buncombe County took the “bull by the horn” and charted its own future. The patients are much better served today, the Health Center much more efficient, the physicians in the community are delighted to participate because no one is being asked to carry more than his or her fair share, and the hospital is happy because their overall indigent care cost has actually decreased. Computer systems have been developed to automate the enrollment of clients in Project Access and to monitor their utilization and the percentage of physicians who volunteer to see patients in the doctor’s free medical clinic has increased.

People in Asheville know that physicians indeed care very deeply about low income individuals and if a proper system is put in place so that no single physician is asked to carry a disproportionate share of the burden, virtually all will volunteer their time and energy. This program is a very strong reinforcement to physicians of why they went to medical school in the first place. They get positive reinforcement for their community service and the patients are getting comprehensive, state-of-the-art treatment, using a Project Access card just as the insured population would use their Blue Cross card.