Access Now:

Improving Access to Specialty Healthcare

for the Low-income Uninsured

By

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A Master's Paper submitted to the faculty of the University of North Carolina at

Chapel Hill. In partial fulfillment of the requirements for the degree of a Master

of Public Health in the Public Health Leadership Program.

Chapel Hill

2009

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Advisor / Date

6-9-09

Second Reader / Date

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Introduction

Seventeen percent of non-elderly Americans were uninsured in 2007.[1] Sixty-five

percent of the uninsured have a family income below 200 percent of the federal poverty

level.[1] The uninsured receive less preventive care, fewer diagnostic services, less

therapeutic care, and are usually more severely ill at presentation.[2] The uninsured have

poorer disease-specific and general mortality and morbidity, which is partially explained

by decreased access to care and medical care use.[2] Thus, the physical and emotional

health of the uninsured suffers due to decreased use of and access to medical services.

Lack of insurance affects also burdens families and communities. Families

without health insurance are twice as likely to spend over five percent of their income on

out-of-pocket health care.[3] In 2005, approximately $43 billion was spent on

uncompensated medical care for the uninsured.[4] An estimated $65 to $130 billion is lost

annually due to the uninsured's poorer health and reduced lifespans.[5] Thus, the health

consequences of uninsurance present a significant burden to patients, family, and

communities.

The burden of care for the uninsured further falls disproportionately on primary

care providers. In minority populations, 45.6 percent of low-income uninsured physician

visits are with family physicians.[6] In comparison, 30.1 percent of insured physician visits

are with family physicians.[6] Since the uninsured present more severely ill and advanced

disease, family physicians are caring for sicker patients that often would be better served

by more specialized care. In a study of children with a chronic condition or disability,

Kuhlthau and colleagues found that 16.9 percent of the uninsured saw a specialist while

28.3 percent of the privately insured saw a specialist.[7] Szilagyi and colleagues found a 5-fold increase in specialty visits after patient enrollment in an insurance program.[8] Uninsured dialysis patients are three times more likely to be referred late to nephrologists than their insured counterparts.[9] The uninsured's decreased access to specialists leads to worse outcomes for patients with hypertension, heart attacks, cancer, trauma, ruptured appendices, liver disease, and patients on ventilator support.[2]

Many communities have safety nets that are intended to provide care for their low-income uninsured. Generally, this includes some combination of emergency departments, health departments, free clinics, and charity care from other private providers. Safety nets are mainly composed of primary care providers and lack specialty care providers.

While the specialty needs of the uninsured are known, few models to address this problem are described in the medical literature. In this program plan and evaluation paper, I first explore what models exist to address the lack of specialty care for the uninsured. I then describe a recently begun program in Richmond, Virginia and outline a plan for its growth and evaluation.

Review

Introduction

What community-wide systems have been developed to address the uninsured's specialty care access issues? Many clinics that cater to the uninsured have relationships with individual specialists and/or hospitals that help meet this need, however, other

clinics and communities do not have such resources.[10] This review looks to explore what community models currently exist in the U.S.

Search Strategy

With the assistance of a public health school librarian and a business school librarian, I searched for model descriptions in the Pub Med, Business Source Premier, and Factiva databases. Search terms included *uninsured, medically uninsured, poverty, indigent, uncompensated, free clinic, homeless, specialist, specialties, referral, consultation,* and *model.* This search strategy yielded only three relevant articles[11-13] that described community-wide initiatives, as opposed to programs designed for one clinic or hospital.

After this literature search, semi-structured phone interviews were conducted with physicians and other health care leaders involved in the routine care of the uninsured. These interviews were conducted between January 12, 2009 and April 20, 2009. Discussion focused on models that they or others use to address specialty care for the uninsured. These interviews also increased awareness of published literature not found in the above literature search, allowed access to unpublished literature, and provided guidance toward relevant internet resources.

Results

Three types of systems emerged from the above search. First, an example of government-mandated health care coverage is seen in the Hillsborough County Health Care Program in Florida. Second, a structured physician referral system seems to be the

most common solution and was first pioneered by Project Access in Buncombe County, North Carolina. Third, Muskegon County, Michigan has developed a model focused on the working uninsured that involves cost sharing between employers, employees, and a third party. Each of these systems required a coordinated restructuring of the community's safety net. In this section, I will describe the implementation of these three examples in more depth, and in the next section, I will discuss some of the merits and shortcomings of each.

Hillsborough County Health Care Program

Background

As of 2004, Hillsborough County, located in Central West Florida, had the fourth largest county population in Florida at 952,548.[14] Of those under the age of 65, 134,309 (14.1 percent) were uninsured and 27.9 percent were under the federal poverty level and uninsured.[14]

In the 1980s, the vast majority of Hillsborough County's medically indigent population received care at Tampa General Hospital.[15] By 1984, in the wake of a growing population and increasing health care costs, Tampa General required a bailout via a ¼ percent sales tax devoted to indigent health care.[16] However by 1989, rising health care costs put Tampa General in the red again.

In 1990, an advisory board determined that cost containment and improved access to care for indigent populations could both be accomplished through better management of patients' health.[16] Shifting the burden of care from emergency departments and hospitals to primary care clinics and neighborhood health centers seemed likely to

improve access, promote prevention and early intervention, and reduce expenses. As of

1996, the average emergency department visit cost was $500 compared to $90 in a

primary care clinic.[17] With the support of various civic and business organizations, an

elected state representative led efforts for approval of a tax for indigent health care to

fund a restructuring of the health care safety net.[16]

The Plan

With these sales tax funds in place, a consulting group assisted in the formation of

a managed care operational plan for those below the federal poverty level.[18] The county

was divided into four geographically-oriented service networks.[19] Each zone would have

its own health centers that provided primary care, pharmacies, and integration with social

services. Primary care providers (PCPs) were the gatekeepers to secondary, tertiary, and

ancillary services, which would be reimbursed at 80 percent of the Medicare rate.[16] To

help contain costs and maximize available services, the county negotiates for durable

medical equipment, pharmaceuticals, home health services, dental care, ambulances,

mental health services, vision care, hospices, and public health services like HIV/AIDS

and TB care.[20] All networks have access to these services.

Buncombe County's Project Access

Background

Buncombe County, North Carolina has approximately 227,000 residents, and 18

percent of them are uninsured.[21] Almost two-thirds of the uninsured are below 200

percent of the federal poverty level.[22] Like many other counties in the U.S., in the 1980s

and early 1990s, Buncombe County had several existing locations for low-income primary care and a fair number of specialists who provided charity care.[23] However, the system was inefficient.

With three hospitals, over 400 private physicians, and a health department that provided services on a sliding fee scale, the county had a good number of uncoordinated resources for providing indigent care.[23] In 1993, Memorial Mission Hospital and St. Joseph's Hospital reported that 35 percent and 40 percent, respectively, of their emergency department visits were for problems that could be addressed in a primary care office.[24] Health department nurses would spend hours of their days calling specialist physicians looking for those would donate care, and when they found willing physicians, lack of access to imaging, hospitals, labs, and medications limited the quality of care.[23] Therefore, the health department, which saw most of the county's outpatient uninsured, was providing inadequate and frequent care to patients who needed chronic specialty follow-up.[23]

In 1991, a church-based free clinic coordinated with a local hospital and volunteer health care providers in order to provide acute, episodic care, but many of their patients had chronic conditions that resulted in frequent visits.[16] Without links between primary care sites and other services such as specialty care, ancillary services, and access to medications, the ability to effectively care for the uninsured was limited.[16]

In 1994, a grant from the Robert Wood Johnson Foundation allowed for the development of a coalition to improve health care access and the health status of the low-income uninsured.[22] In 1995, the coalition examined barriers to care with a community health assessment involving telephone surveys and many focus groups of at-risk

populations and health care providers.[16] Barriers included insufficient funds, limited number of PCPs, long waiting lines at the health department, limited evening and weekend office hours, availability of transportation, and lack of Spanish-speaking providers. Many of these barriers could be better addressed through improved coordination between health care sectors.

The Plan

In 1995, another Robert Wood Johnson Foundation grant led to the development of Project Access, a structured physician volunteer program.[23] Initially, three physicians began to recruit other volunteer physicians, attend hospital department meetings to learn about the consequences of being uninsured, and address the community health assessment results.[25] Soon thereafter, thirty other physicians began to join in recruitment efforts.[25] When a large number of surgeons committed to donating their services if the hospitals would donate their portion of the needed, one physician met with St. Joseph's CFO.[23] They discovered that the hospital rarely recovered their expenses for patients below 150 percent of the federal poverty level, and for those between 151 percent and 200 percent, the recovered costs were equivalent to the cost of collections.[23] Donated hospital services could be designated as charity care instead of bad debt for tax purposes.[23] The hospital also expected that a structured volunteer program would decrease ED utilization.[23] Hence in April 1996, the hospital offered to donate its services for those patients with incomes under 200 percent of the federal poverty level, and the surgeons (and other specialists) followed.[23] When county commissioners saw the evolution of this program and realized that controlling chronic conditions would likely

lead to reduced ED visits and hospitalizations, they provided funding for pharmaceuticals.[26] In June 1996, the program officially started, and physicians began accepting referrals.[25]

Muskegon County's Access Health

Background

In 2000, Muskegon County, Michigan had 20,000 uninsured residents.[27] Twelve thousand were working uninsured, and roughly 3000 worked in small- or medium-sized businesses in the service or retail sectors.[16] In 1996, Muskegon's two hospitals accounted for an estimated 1.78 million preventable hospitalizations.[28] Over the following three years, this number increased by sixteen percent while the population increased by two percent.[28] Although the state offered some basic coverage for the medically indigent population, much of the working uninsured did not receive this coverage.[29] While local leaders recognized that the safety net was inefficient and driven by acute care, they also saw a need for local economic development and were seeking to make local businesses more competitive.[29] In Muskegon, 64 percent of small businesses did not offer health insurance.[16] Employers described difficulty in attracting workers and reported high worker turnover and absenteeism rates; employees described financial stress in cases of medical emergencies.[16]

In 1994, a W.K. Kellogg Foundation grant led to the Muskegon Community Health Project (MCHP), which completed several research projects regarding the county's uninsured.[29] In 1999, 200 businesses were surveyed about barriers that prevented their provision of health care coverage to their employees.[30] While 81 percent

said they would provide coverage if it was affordable, around seventy percent did not

provide coverage because it was not affordable or because of fears of premium increases.

Two-thirds believed that coverage would improve worker retention, and 95 percent

reported they could afford $35-$50 per month per employee. The MCHP also surveyed

the working uninsured[16] and found that 65 percent could afford $35-$60 per month and

70 percent of the working uninsured in small businesses had a negative view of

government entitlement programs.

The Kellogg Foundation grant also allowed for the collaboration between two

very competitive hospitals, two federally qualified health centers (FQHCs), two other

primary care centers, and a wide array of community leaders.[29] Eventually, all

stakeholders agreed that access to care needed to improve and would be the focus of

further work.[29] Given that local leaders wanted to improve the safety net and foster local

economic development, the committee focused on expanding coverage to the working

uninsured.[29]

The Plan

Muskegon County adopted a three-share coverage model and called it Access

Health. Full-time and part-time employees (and their dependents) of small- or medium-

sized businesses with a median hourly wage of less than $12.00 are eligible.[31] Employers

and employees would each pay thirty percent of the cost of the program ($46 per month)

and the community would cover the remaining forty percent ($56 per month).[16]

In Muskegon, this third share was provided via the Disproportionate Share

Hospital (DSH) program.[29] Hospitals that assume care for a disproportionate share of the

low-income Medicaid and uninsured population receive DSH funds to cover their costs.[32] The two hospitals in Muskegon County were not fully utilizing their DSH entitlements, so the county and the hospitals requested for DSH funds to be used toward Access Health.[16] The state agreed to this plan with the provision that the county would also assume responsibility for the indigent uninsured as well. The county agreed.[16]

With this funding model, Access Health covers local physician services, inpatient/outpatient hospitalizations, ambulance, ED, generic formulary prescriptions, labs, x-rays, home health, hospice care, and behavioral health services.[29] Additionally, physicians are paid on the Medicare fee schedule plus twenty percent, and thus, ninety-seven percent of the community's physicians participate.[33] Instead of looking like a charity care model (like Project Access), Access Health is similar to an insurance plan or a "community product" with co-payments and co-insurance, which is thought to be more favorable to the working uninsured population.[16]

Discussion

After an initially limited literature review, a good deal of information became available in verbal and written forms that described the above models. These local communities have developed innovative ways to address the primary and specialty care needs for their uninsured. As discussed below, while each program has provided benefits for their stakeholders, all three have significant limitations.

Hillsborough County Health Care Program

Stakeholders

The Hillsborough County Health Care Program has involved and provided for many stakeholders through their model of care. Participants benefit from greater access to all levels of the health care system. Hospitals have less uninsured patients in their emergency departments, are partially reimbursed for the care they provide, and are encouraged to build clinics as both a steady referral base and an additional location to provide outpatient care for their uninsured and insured patients. Community health centers, Federally Qualified Health Centers, and free clinics receive reimbursement for their care of the uninsured, which offsets their recent losses in Medicaid revenues. The community benefits from reduced costs, shared costs with tourists (about 30 percent of the revenues from the sales tax), additional availability of health care centers, improved integration with social services, and increased access to all levels of health care (including specialty care) through better system integration. Since private providers have no legal obligation to provide care for the uninsured, they benefit the least in this scenario. That being said, most providers were already providing charity care, and this model provides partial reimbursement for their benevolence.

Outcomes

Six years after the program started, it had a reserve fund of $155.5 million that was then allocated to other needed health care programs.[16] In 2002, 70 percent of those eligible were enrolled in the program, which led to 104,123 outpatient visits, 15,268 inpatient visits, and 519,035 prescriptions.[34] As of 2003, the county had saved $11 million in ED costs, reduced inpatient admissions by 45 percent, reduced per member costs by over 50 percent, and decreased hospital length of stay by 50 percent.[35] By

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improving participants' abilities to stay employed, an estimated $15 million is saved every year.[16]

Unique Features/Limitations

The most unique feature of the Hillsborough County Health Care Program is its funding force, which unfortunately, is not a political reality in most communities. By levying a sales tax, the whole community shares the burden of providing health care for the indigent population. Stakeholders are more likely to commit to and believe in this model given that it has a stable funding source. Although it should be noted that in the event of an economic downturn, the program would likely have to rely on some amount of its reserves.

Regrettably, caring for all the uninsured with a ½ percent sales tax is not feasible. Since only one-third of the uninsured population is covered, a significant majority of the uninsured population in Hillsborough County is still dependent on the traditional inefficient safety net. However, all low-income patients can benefit from the increased availability of clinics and health centers because of the creation of this program.

Buncombe County's Project Access

Stakeholders

Physicians, the health department, hospitals, and patients all benefited from Buncombe County's Project Access model. By recruiting a large number of physicians through the county's medical society, the burden of care is shared by the community. No one health care provider is overwhelmed. Physicians can also provide higher quality care

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with the availability of labs, radiographs, inpatient and outpatient resources, durable medical equipment, prescription medicines, and a referral system. Physicians also are acknowledged annually in the newspaper.[23] The health department has become more efficient since patients who need specialty care are less often receiving this care through the health department, and the department's staff can contact the Project Access network for referrals instead of trying to track down individual physicians. In 1995, the health department saw 6000 patients an average of 5.5 times every year, and in 2003, they saw 13,000 patients an average of 2.2 times every year.[16] Visit times have decreased, and the number of clinic staff has actually decreased slightly.[23] In the hospital, total uncompensated care dropped by 15 percent,[36] and reduction in expenses more than offset the losses from providing free services. Patients clearly benefit from improved access to the health care system, and because the program includes incentives to shift care away from the ED and into the clinic setting and provide improved care for patients, the community as a whole benefits.

Outcomes

Project Access was designed to improve low-income uninsured patients' access to health care, to improve their health status, and to aid patients in accessing longer-term solutions. As of 2001, donations included $3.6 million in physician services and $2 million in hospital services.[16] By November of 1996, 70 percent of the county's physicians were volunteering, and in 2004, this number was 96 percent.[16] In a telephone survey of enrollees,[16] 80 percent reported better health, and 25 percent felt that Project Access helped them to return to work and "do a better job". Almost half of patients who

leave the program enroll in insurance programs, and two-thirds of these patients enroll through their employer.

Unique Features/Limitations

The main weakness and strength of Project Access is that its operation is based on volunteers. Cooperation is not guaranteed, and stakeholders can always opt out of the program. This has not been seen with Project Access, but instead initial altruism has developed into a social norm. Additionally, this program is susceptible to changing times. Economic downturns, rising medical malpractice insurance, increased managed care, or participants forgetting the benefit of the model could all lead to a weakened program. Given the minimal funds needed for program implementation, several dozen communities across the country are looking to replicate Project Access.

Muskegon County's Access Health

Stakeholders

Like the previous models, cooperation and coordination benefits all stakeholders. With 97 percent of physicians participating in Access Health, nearly the whole physician community shares the burden of care for the uninsured.[29] With improved reimbursement rates, physicians, hospitals, and FQHCs provide less uncompensated care. With increased access to services, physicians can provide improved and more efficient health care to the working uninsured. Employers have healthier employees, better retention, and a better benefit package for recruiting employees. The county can use more of its DSH funds more efficiently, while fostering improved health and local economic development.

Outcomes

Access Health is intended to provide improved health care access to the working uninsured while fostering local business development. Of the 3000 eligible participants in 2004, 1150 were enrolled from 420 businesses.[29] Of enrolled employers, 78 percent describe improved recruitment,[30] and 58 percent reported reduced absenteeism.[37] Two-thirds of employers state that their employees health has improved.[16] In the coming years, Access Health hopes to enroll another hundred businesses and 1500 employees.[29]

Unique Features/Limitations

The most intriguing aspect of Access Health's model is its similarity to an insurance plan that limits the need for cost shifting to insured patients. Unfortunately, there are several limitations to this model. First, Access Health is limited by DSH funds. These funds only allow the program to cover 3000 residents, so Access Health only covers 10 percent of the county's uninsured population.[29] While continued coverage is likely given the state's high rate of return in Muskegon County ($2 private funds for every $1 spent by the state), no guarantee exists that the DSH funds could be allocated to another location in the state.[29] It is also worthwhile to remember that the state is providing the DSH funds contingent upon the county taking responsibility for the indigent uninsured as well. (Interestingly, a similar three-share plan in Memphis obtains the community's share by using volunteer providers in a manner similar to Buncombe County.[38]) Second, in Muskegon (and in Memphis as well) the model has been a tough sell to business that already have low profit margins.[38] Employers question the wisdom of providing a benefit that may become unaffordable and lead to loss of employees.[16]

Additionally, during economic downturns, low turnover rates can offer little incentive to provide this benefit.

Conclusion

Most U.S. communities have a system of providing specialty care to the uninsured. Most communities have not coordinated resources as efficiently as in the examples above, and many are looking to incorporate aspects of these programs into their health care plans.

In examining the above interventions, a few guiding principles appear. First, developing a health care system that provides specialty care for the uninsured often requires a comprehensive program. Specialty care will be significantly limited without strong primary care, preventive care, access to medications and labs, and the possibility of hospitalization. Access to specialty care is encouraged when a community decides to restructure their safety net so that patients have better primary care and improved access to a larger spectrum of services. Second, providers seem generally willing to provide care for the uninsured if they do not have to deal with a lot of red tape. Once questions about labs, imaging, medications, liability, and hospitalizations are answered, most providers look to participate in the restructured safety net. Third, a wide array of community members is ideal for developing a successful program with community support and resources. Fourth, usually the best balance of expanding coverage and encouraging community cooperation seems to be at the county level.

Lastly, none of these models provide for all of an uninsured community, so new innovations or combinations of current programs are still needed. Interestingly, Project

Access, the least expensive of these models, provides for the largest percentage of the uninsured. Since Project Access is the least expensive and provides for the largest number of uninsured, it has been replicated in several communities. In the remaining pages, we will examine one recently started replication, Access Now in Richmond, Virginia.

Access Now Program Plan

Introduction

Approximately 130,000 uninsured people reside in the Greater Richmond area, and about half of these are low-income residents.[39] This central region of Virginia has the largest uninsured rate in the state, which has led to a good number of philanthropic organizations that comprise Richmond's safety net.[40] However like most communities, the low-income, uninsured residents have until recently had limited access to the community's specialty care providers.[40] Access Now, a Project Access look-a-like, intends to meet the specialty care needs of the low-income, uninsured in Richmond, Virginia.

In the 1990s, despite a reasonably sized safety net, Richmond had a similar set up to most communities in the United States. Richmond's three main hospitals all had indigent care missions and were required by state certificate of public-need obligations to provide a certain amount of indigent care.[40] However, these obligations were often not met.[40] The rest of the safety net consisted of approximately twenty clinics that provided free or low-cost care to the uninsured.[41] Some of these clinics were long running and had

strong relationships with the hospitals and specialist providers that would provide lab work, diagnostic tests, imaging, occasional operating room time, and other specialty care. However, only a few clinics had these strong relationships, and because only a small percentage of the specialists bore the burden of the uninsured, these providers' benevolence was frequently tested.[40]

In 2000, several organizations that focused on caring for the uninsured started to meet together to discuss possible solutions to the fragmented safety net.[42] In 2002, this group became a 501(c)(3) called Richmond Enhancing Access to Community Healthcare (REACH).[42] In 2005, the REACH executive director commented that she received calls at least once a month from medical directors of safety net clinics who could not find a hospital to donate operating room time.[40] The complementary problem of a willing hospital but no willing and able provider was also frequent.[40] REACH, the safety net clinics, the Richmond Academy of Medicine (RAM), and Richmond's hospitals explored solutions to this access problem.[41] After examining several systems across the country, they decided that a model like Project Access would best fit their community, so Access Now was developed and began to serve the Richmond Community in January 2008.[41] The Richmond Academy of Medicine, approximately 800 physicians, and more than a dozen clinics are all working together to make Access Now a hopefully growing success.[43]

Access Now is a structured physician volunteer network aimed at providing access to specialty care for the uninsured who are at or below 200 percent of the federal poverty level and live in the greater Richmond area.[39] Seventy percent of the area's physicians belong to the Richmond Academy of Medicine, which runs Access Now.[39]

The hospitals, safety net clinics, and healthcare providers are attempting to coordinate their resources to more effectively and efficiently meet this community's specialty care needs.

Program Context

The healthcare community in Richmond has seen firsthand the struggles of the low-income uninsured that need specialty care. The strain that this unmet need places on the safety net's primary care providers and the hospitals' emergency departments has also become evident.[40, 41]

Political Context: Our world has experienced an unprecedented level of philanthropy over the past decade. However, the current recession demands that resources are used more efficiently to meet areas of great need. A national or statewide shift to universal health insurance or health coverage is a difficult challenge that may not be possible in the current economic environment. Access Now improves access via a structured and inter-connected charity care model. Hence, the many benefits of the program can be achieved with minimal cost.

National Priorities: The U.S. Department of Health and Human Services developed *Healthy People 2010*, which is a list of national healthcare objectives.[44] *Healthy People 2010* has two overarching goals.[44] The first goal is to increase quality and years of healthy life. By broadening and better coordinating Richmond's safety net, Access Now should increase the uninsured's access to timely and effective care. Increased access has been shown to increase health status.[2] The second goal is to eliminate health disparities. The low-income uninsured have very limited access to specialty care, and the quality of

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the specialty care that they do receive is limited because the lack of coordination of resources.[45, 46] Access Now can help bridge the significant gaps in care between the low-income uninsured and the rest of the population. Additionally, *Healthy People 2010* identified twenty focus areas that must be addressed in order to achieve the overarching goals.[44] Many of these areas cannot be adequately addressed without significant specialty care involvement, and such focus areas include *access to quality health services, cancer, chronic kidney disease, diabetes, heart disease and stroke,* and *HIV.*[44]

State Priorities: According to *Healthy Virginia Communities: Report #2,* two of the state's goals are to protect Virginians from communicable diseases like HIV and to decrease the burden of chronic diseases like heart disease, stroke, cancer, diabetes, breast cancer, and cervical cancer.[47] These disease burdens cannot be effectively addressed without providing access to specialty care services.

Local Priorities: As discussed above, REACH and Access Now were developed out of the greater Richmond community's known need for specialty care and improved safety net collaboration. The region has a large percentage of low-income, uninsured residents that do not have timely access to specialty care outside of the acute care setting.

Acceptability/Stakeholders: REACH has gathered with a diverse array of community organizations to develop Access Now.[41, 42] This coordination of resources should benefit all members of the community. A larger number of specialty physicians are empowered to participate in the program, so the whole medical community can share the burden of care for the uninsured. The availability of resources allows physicians to provide higher quality care. Since less primary care and emergency department time and resources are used for chronic disease, these entities can function more efficiently. Total

uncompensated care in the hospitals is likely to decrease. Last but not least, patients and their communities benefit from the improved access to higher quality care.

Funding: Similar programs obtain funding from a variety of resources, including: city or county governments, local and national foundations, federal or state grants, and the local medical society.[25] Area hospitals or managed care organizations are also often supportive.[25] The state provides medical malpractice insurance for Access Now.[43] The Richmond Academy of Medicine has decided that they will fund the program via grants and a smaller contribution from the RAM itself.[39]

Challenges: Access Now will face many challenges as it develops. First, the program is based on the idea that physicians are willing to volunteer. This belief has proven true in dozens of other communities that have implemented similar programs.[48] However, continuing declines in reimbursement in a managed care environment may require physicians to see a greater number of insured patients and limit their abilities to care for the uninsured. Second, Access Now will need a stable funding source to cover its operating costs of at least $200,000 per year.[39] Third, specialists will be limited in this program by lack of access to sometimes essential medications. The need for higher quality care will require improved access to medications necessary for care. Fourth, the low-income, uninsured population in Richmond is growing in diversity and will require bilingual staff and cultural sensitivity.[43] Fifth, the number of uninsured is rising, so Access Now (and the health system as a whole) will need to meet this increasing demand.

Goals and Objectives

Access Now intends "to develop seamless access to specialty care for patients of area safety net clinics who are between the ages of 18 and 64, do not have health insurance, are at or below 200 percent of poverty and live in the greater Richmond community".

Short-term Objectives: 1-3 years

- By year one, Access Now will develop an interpreters program for Spanish-speaking patients.

- By year one, recruit at least fifteen physicians, who will be trained to recruit their peers.

- By year two, 50 percent of physician members of the Richmond Academy of Medicine will volunteer with Access Now.

- By year two, the number of physician volunteers in the areas of gastroenterology, general surgery, orthopedics, obstetrics and gynecology, ophthalmology, and urology will increase by 25 percent.

- By year three, Access Now will secure stable funding of $250,000 per year.

- By year three, Access Now will coordinate 2000 patient visits per year.

Long-term Objectives: 4-6 years

- By year five, 75 percent of physician members of the Richmond Academy of Medicine will volunteer with Access Now.

- By year five, Access Now will coordinate 2500 patient visits per year.

- By year five, Access Now will expand services to include increased access to free or very low-cost pharmaceuticals.

Logic Model

Resources/Inputs	Activities	Outputs	Short- & Long-Term Outcomes	Impact
In order to accomplish our set of activities, we will need the following:	In order to address our problems, we will conduct the following activities:	We expect that once completed or under way these activities will produce the following evidence of service delivery:	We expect that if completed or ongoing, these activities will lead to the following changes in 1-3 then 4-6 years:	We expect that if completed, these activities will lead to the following changes in 7-10 years:
-Staff to recruit and coordinate Spanish-speaking volunteers -Brochure to explain the need and requirements for Spanish-speaking volunteers -Staff to train physician recruiters and coordinate other	-Give brochures to participating clinics -Give brochures to organizations with large numbers of Spanish-speaking members -Email to participating physicians requesting recruiters	-Spanish-speaking volunteers will be recruited and start to help with interpretation -At least 15 physicians will train to recruit other physicians -Increased physician participation in response to peer recruitment,	*Short*: -Development of a more formal interpreters program -25 percent more physician volunteers, especially in the most critically needed areas -Secure stable funding for Access Now's current operations	-Improved health for Spanish-speaking patients -Improved health for the uninsured -More specialties available to patients -Larger physician network providing charity specialty care

recruiting efforts -Staff with focus on fundraising for both sustaining the program and for expansion -Access to news media (radio, newspaper, television)	-Develop a brief training program to train physicians to recruit others -Include information about Access Now's need for volunteers in RAM's mailings to physicians -List participating physicians in the local newspaper on a monthly basis -Apply for any local, state, or federal healthcare-related grants -Target fundraising around local foundations dedicated to healthcare	mailings, and newspaper promotions -Increased funds available for Access Now programming and development -Increased community awareness of Access Now	-2000 patient visits per year -Improved communication between Spanish-speaking patients and healthcare providers -Improved access and well-being for Spanish-speaking patients *Long*: -Secure funding for expansion of Access Now to include increased access to free or very low-cost pharmaceuticals -2500 patient visits per year	-Improved medication availability for the uninsured

	-Given evidence of positive rate of return, lobby state and local government for funding for pharmaceuticals -Investigate avenues for finding financial support from individuals -Place advertisements in the media -Contact media personnel that might be interested in doing a piece on Access Now -Flyers to be given to employers that employ minimum wage workers		-75 percent of RAM physicians volunteer with Access Now	

Application of Program Theory

As a relatively new program, Access Now is looking to establish itself in the greater Richmond healthcare community and grow in resources and scope.[43, 49] This will require increased involvement of physicians, patients, the community, and funders. The Innovation Decision Process is particularly insightful in this context and is helpful in evaluating the adoption of Access Now by physicians, patients, and funders.

Innovation Decision Process

For a program or innovation to diffuse throughout a community, people's attitudes toward it tend to proceed through five stages: knowledge, persuasion, decision, implementation, and confirmation.[50] First, people must know about Access Now.[51] Given that referring physicians in participating clinics are the gatekeepers to this service, most referring physicians already know about the program. Seventy percent of Richmond's physicians are members of the Richmond Academy of Medicine, so most of Richmond's physicians are probably aware of the program. Low-income, uninsured patients may not be as aware of Access Now. Targeting these patients would involve targeting patients at their workplaces, in the media, and other venues that cater to low-income residents. News media could also increase the awareness of possible local funders.

Second, as people's knowledge grows, they will form an attitude toward Access Now.[51] Non-participating physicians attitudes toward Access Now are most likely to be

influenced by the experiences of participating physicians, who for this reason at least, must be accommodated as much as possible.[38, 41] This accommodation would mean not overloading those that volunteer with patients or paperwork, expressing appreciation as frequently as possible, and easing the burden on their office staff as well. Patients' attitudes toward the program will depend on how they are treated. Are they treated like charity cases or like other patients? Do they receive quality and timely care? Patients do receive an ID card, which is very similar to an insurance card, in order to avoid the stigma associated with receiving charity care. Quality and timely care should improve if the program continues to grow. Funders' attitudes towards access health will depend at least on whether it's a good investment. News media, internet resources, and brochures should all include stories of patients that have been helped as well as numbers that describe the amount of medical care donated compared to the cost of running the program.

Third, people's attitudes toward Access Now will decide whether they accept or reject participation.[51] If physicians see Access Now as a growing organization that allows them to care for patients well and spread the burden of care for the uninsured over the entire provider community, then they are likely to accept the program. If instead they hear that participating office staffs are unhappy, patients are unhappy, and the workload is excessive, physicians will continue practicing as they always have. If patients believe and experience that this is a beneficial program that delivers what it offers, they will embrace the program. However, some patients may reject the program if they feel like they are simply receiving a welfare handout. If funding Access Now seems like a financially and socially wise investment, Access Now should continue to secure its

current funds and other funds. On the other hand, if the program is seen as only marginally useful or inefficient, the program will suffer financially.

Fourth, if people decide to participate in Access Now, the resulting implementation of the program must be as seamless as possible.[38, 41, 51] Physicians will withdraw from the program if their office staff is unhappy, patients consistently do not show for appointments, or patients are inappropriately referred. Access Now currently screens the vast majority of referrals to ensure that they are appropriate. Paperwork is also minimized. If patients miss more than one appointment in a given period of time, they are withdrawn from the program. Additionally, the addition of Spanish interpreters to the program will ensure that any specialist can take care of any Spanish-speaking patient. Patients are likely to adopt Access Now quickly because it provides services that are otherwise unavailable, but Access Now must continue to provide quality service to maintain both their patients and their funders.

Fifth, positive experiences with Access Now reinforce people's decisions to participate.[51] Physicians, patients, and funders will all continue their support and others' support of the program if Access Now meets or exceeds their expectations.

Implementation

Further growth of the Access Now program plan will first require the development of a translation program.[43] Currently, two of the program plan's staff spend at least ten hours per week providing in-person translation services for Access Now patients.[43] With the significant Spanish-speaking population in the Richmond area, this intervention should not be overly difficult to develop and would quickly free up staff time

to focus on sustaining and growing the other aspects of the program. Staff will need to create a brochure describing the need for Spanish-speaking volunteers and what would be required of them. These brochures would be sent to participating clinics as well as various Hispanic and Latino community organizations. The program would ask volunteers to donate two hours of their time per week with a goal of recruiting a minimum of fifteen volunteers.

Second, the staff will need to recruit fifteen physicians to undergo a brief training to enable them to more effectively educate and recruit their peers to Access Now.[25] Other Project Access look-a-like programs have found that the most effective recruiters of physicians are other physicians.[23, 41] Project Access already has developed several resources about recruiting physicians, so this training curriculum would be relatively easy to develop. With around eight hundred physicians already volunteering, at least fifteen physicians are likely to respond to a simple email requesting thirty minutes in their office to learn more about the program and to learn about recruiting other physicians.[49]

Third, the development of the translation program and the training of physician recruiters within the next year should allow Access Now's staff to use more of their time focusing on publicity and securing necessary funding. Setting up meetings with various media outlets in the first two months of the second year would allow Access Now to gain needed insight into the most desired and effective forms of communication. The media may be particularly interested in certain aspects of the program that might allow more publicity for Access Now. Advertisements in these venues would also prove useful. With increased publicity, more funding opportunities may become available, and while

attempting to increase publicity, staff will need to use their time to contact individual, private, local, state, and federal funding sources.

Fourth, increased funding will allow the program to expand its size and breadth. If funding goals are met three years from now, the program can consider meeting with other Project Access look-a-likes, government organizations, and pharmaceutical organizations to explore options for improved medication access.

Conclusion

Access Now is a structured physician volunteer program that serves the low-income, uninsured residents of the greater Richmond area and that has had reasonable success during its first year of service. However, thousands of eligible patients have not yet obtained access to its services. To meet the needs of these patients, the program must continue to grow significantly over the next several years. The growth of its physician base and the availability of volunteer translation services will be necessary as the staff also seeks to expand its financial resources.

Program Evaluation

Introduction and Approach to Evaluation

Access Now intends to provide specialty care services to patients in the Greater Richmond area with household incomes below 200 percent of the federal poverty level. We have outlined above several short and long-term objectives for Access Now. These objectives serve as markers of the impact that Access now is having in the Richmond

community. Over the next five years, the evaluation plan outlined below aims to assess Access Now's progress toward these goals.

Evaluator Role

Access Now is a growing community-based initiative with many stakeholders. Its evaluator will need knowledge of the Richmond medical provider community, its healthcare safety net, and its medically indigent patient population. If the evaluator is particularly familiar with the Hispanic community, that would be helpful as well.

Although a combination of internal and external evaluators would be ideal, Access Now currently has limited funds. An external evaluator would likely be more expensive, require more time to perform the evaluation, and be potentially disruptive to the ongoing progress of the program. While an internal evaluator is unlikely to possess the objectivity and possibly the same level of evaluation skills as an external evaluator, an internal evaluator would already understand the program and its context. Thus, an internal evaluator is likely to provide a less costly and more efficient evaluation.

Stakeholder Input

The many stakeholders involved in the program include project staff, patients, providers and their clinics, hospitals, funding agencies, and community leaders in lower socioeconomic status and Hispanic communities. Patients will probably be most concerned about access to quality specialty care in a timely manner.[23] Hospitals and providers want to deliver their charity care in a financially viable manner without lots of red tape.[38] Funding agencies want to see a significant return on their investment, which

can most easily be seen by the numbers of patients served and the services they received. Community leaders are hoping for a well-run and growing program that more effectively meets their constituents needs.

If the program's objectives are met, all stakeholders are likely to be encouraged by the results and desire continued participation. The answers to most of the stakeholders' questions can be and will be answered by interviews with project staff, surveys of physicians, and surveys of patients.

Evaluation Study Design and Methods

Evaluation Design

In setting objectives for Access Now over the next five years, we have created a framework for the observational evaluation of the program's success and impact. This measure must assess how well Access Now has met these goals. The evaluation should bring to light the reasons why each objective has or has not been met.

Since Access Now has been running for over one year now, baseline data from before Access Now began cannot be prospectively collected. However, baseline data regarding services donated, financial accounting, number of patients served, and number and type of physicians volunteering is already available. Beyond this, most data will be prospectively collected over the next 5 years.

This type of evaluation has several strengths and weaknesses. An internal evaluation that involves a limited number of stakeholders is relatively inexpensive and efficient. However, lack of prospective baseline data from before Access Now and the lack of a control group limit some applications of the evaluation results since not all

results could be attributed to Access Now's success or failure. Additionally, the results of interviews and surveys are highly subject to bias, measurement error, and response rates.

Evaluation Methods

Our data will come from four sources: open-ended interviews with project staff, physician surveys, patient surveys, and document reviews. The open-ended interviews and document reviews will be used to collect quantitative data, while interviews and surveys will be used for qualitative data collection.

Since our objectives are scheduled for one, two, three, and five years, our evaluations will also correspond with this timeline. After one year, open-ended interviews with the project staff, document reviews, surveys to Spanish-speaking patients using the interpreter service, and surveys to physicians will be used to assess the first two short-term objectives. At the end of the second and third years, the next four short-term objectives will be evaluated via open-ended interviews with project staff, document reviews, and surveys to physicians. After five years, project staff interviews, surveys to physicians and patients, and document reviews will be used to assess the long-term objectives.

Dissemination Plan

Access Now is a community-based program that requires the investment of many different stakeholders for its success. Therefore, giving these stakeholders access to the evaluation data will be necessary for the growth, improvement, and continuation of the

program. After each evaluation time interval, program staff will meet with key

stakeholders to discuss the results and make plans for continued improvement. These

results will be summarized and made available to all stakeholders. This may take the

form of emails, presentations, and dissemination to the media.

Evaluation Planning Tables

Short-term Objective #1: By year one, Access Now will develop an interpreters program

for Spanish-speaking patients.

Evaluation question	Participant	Evaluation method (year one)
Was a brochure created to describe the need and requirements for Spanish-speaking volunteers?	Program director and coordinators	Open-ended interviews
Has the interpreters program been developed? If no, why not?	Program director and coordinators	Open-ended interviews
Are there enough volunteer interpreters to provide services to all patients that need/request them?	Program director and coordinators	Document review

How many hours per month does the average volunteer serve?	Program director and coordinators	Document review
Are patients satisfied with this program?	Program director and coordinators Spanish-speaking patients	Open-ended interviews Survey
Are physicians satisfied with this program?	Program director and coordinators Physicians	Open-ended interviews Survey
Does this program effectively free up time for Access Now's staff?	Program director and coordinators	Open-ended interviews
Which locations and types of advertisements were most effective?	Program director and coordinators	Open-ended interviews
How could this program be improved?	Program director and coordinators Spanish-speaking patients Physicians	Open-ended interviews Surveys

Short-term Objective #2:   By year one, recruit at least fifteen physicians, who will be trained to recruit their peers.

Evaluation question	Participant	Evaluation method (year one)
Was an email sent to participating physicians looking for physician recruiters?	Program director and coordinators	Open-ended interviews Document review
Was a training program developed for these physician recruiters?	Program director and coordinators	Open-ended interview
How much time does the training program require?	Program director and coordinators Physician recruiters	Open-ended interviews Survey
How many physicians are volunteering to help recruit their peers?	Program director and coordinators	Document review
How many physicians have physician recruiters recruited?	Program director and coordinators Physician recruiters	Open-ended interviews Document review Survey
How could the training program be improved?	Program director and coordinators Physician recruiters	Open-ended interviews Survey
Are more physician	Program director and	Open-ended interviews

recruiters needed?	coordinators	

Short-term objective #3: By year two, 50 percent of physician members of the Richmond Academy of Medicine (RAM) will volunteer with Access Now.

Evaluation question	Participant	Evaluation Method (year two)
What percentage of physician members of RAM volunteer with Access Now?	Program director and coordinators	Document review
What kind of information is provided in RAM's newsletters about Access Now?	Program director and coordinators	Open-ended interviews
How do most physicians hear about Access Now?	Program director and coordinators Physicians	Open-ended interviews Survey
Are there specific aspects of the program that encourage or discourage physician	Program director and coordinators Physicians	Open-ended interviews Survey

participation?		

Short-term objective #4: By year two, the number of physician volunteers in the areas of gastroenterology, general surgery, orthopedics, obstetrics and gynecology, ophthalmology, and urology will increase by 25 percent.

Evaluation question	Participant	Evaluation Method (year two)
Has the number of physician volunteers in these areas increased? If so, by what percentage?	Program director and coordinators	Open-ended interviews
How many non-participating physicians in these areas have program staff or recruiters directly approached?	Program director and coordinators	Open-ended interviews Document review
Of those approached, how many decided to participate?	Program director and coordinators	Open-ended interviews Document review
Of those who decided to participate, what reasons	Program director and coordinators	Open-ended interviews

did they give for participation?		
Of those who decided not to participate, what reasons did they give not to participate?	Program director and coordinators	Open-ended interviews

Short-term objective #5: By year three, Access Now will secure stable funding of $250,000 per year.

Evaluation question	Participant	Evaluation method (year three)
What are Access Now's funding sources?	Program director and coordinators	Open-ended interviews Document review
How much guaranteed funding does Access Now have for the next three years?	Program director and coordinators	Open-ended interviews Document review
What methods of fundraising and advertising have been used?	Program director and coordinators	Open-ended interviews Document review
Describe your future	Program director and	Open-ended interviews

fundraising plans.	coordinators	

Short-term objective #6: By year three, Access Now will coordinate 2000 patient visits per year.

Evaluation question	Participant	Evaluation method (year three)
How many patient visits does Access Now coordinate per year?	Program director and coordinators	Open-ended interviews Document review
What percentage of eligible patients in the community use Access Now?	Program director and coordinators	Open-ended interviews Document review
What are the main factors that limit more participation?	Program director and coordinators Physicians	Open-ended interviews Survey

Long-term objective #1: By year five, 75 percent of physician members of the Richmond Academy of Medicine will volunteer with Access Now.

Evaluation question	Participant	Evaluation Method (year five)

What percentage of physician members of RAM volunteer with Access Now?	Program director and coordinators	Document review
What kind of information is provided in RAM's newsletters about Access Now?	Program director and coordinators	Open-ended interviews
How do most physicians hear about Access Now?	Program director and coordinators Physicians	Open-ended interviews Survey
Are there specific aspects of the program that encourage or discourage physician participation?	Program director and coordinators Physicians	Open-ended interviews Survey

Long-term objective #2: By year five, Access Now will coordinate 2500 patient visits per year.

Evaluation question	Participant	Evaluation method (year five)
How many patient visits	Program director and	Open-ended interviews

does Access Now coordinate per year?	coordinators	Document review
What percentage of eligible patients in the community use Access Now?	Program director and coordinators	Open-ended interviews Document review
What are the main factors that limit more participation?	Program director and coordinators Physicians	Open-ended interviews Survey
Are patients satisfied with the program?	Patients	Survey

Long-term objective #3: By year five, Access Now will expand services to include increased access to free or very low-cost pharmaceuticals.

Evaluation question	Participant	Evaluation method (year 5)
Do patients in Access Now have increased access to free or very low-cost pharmaceuticals? If no, why not?	Program director and coordinators	Open-ended interviews
What are the funding sources for this program?	Program director and coordinators	Open-ended questions Document review

Is this program sustainable?	Program director and coordinators	Open-ended questions
Has this program improved physician recruitment/retention?	Physicians	Survey

Conclusion

Without universal healthcare coverage, many of our nation's low-income uninsured suffer from the effects of limited healthcare access, especially to specialist services. Many communities' safety nets are not currently organized to address this problem, so some have explored models of providing improved access to specialists. Unfortunately, few of these models are described in the medical literature. In this paper, we have seen that Project Access seems to be the most affordable and easily reproducible model currently available. This structured charity care network allows the medical community to share the burden of providing quality care for the low-income uninsured in a cost-efficient manner. Access Now is one example of a community that has recently adopted the Project Access model and is looking to continue to grow. So far this year, they have seen a forty percent increase in patient volume, and these numbers are expected to continue to increase. In the next several years, Access Now hopes to continue to grow in its number of patient visits, number of physician volunteers, and scope of services it provides.

As programs like Access Now continue to develop, we will likely see new ideas and methods of addressing the specialist needs of the low-income uninsured. As we look to develop more sophisticated models, many questions arise. Which models provide the most timely and highest quality care? Will programs arise that combine several of the above models? Will managed care affect providers' and hospitals' abilities to provide charity care? Will there be a nationwide restructuring of the healthcare safety net? As our nations and its many communities seek answers, the needs of the low-income uninsured remain.

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