Summit County's

ACCESS TO CARE PROGRAM

A Report To The Community

NOVEMBER, 2007

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SUMMIT COUNTY'S **ACCESS TO CARE** PROGRAM: A REPORT TO THE COMMUNITY

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What Does ACCESS TO CARE Mean to Summit County?

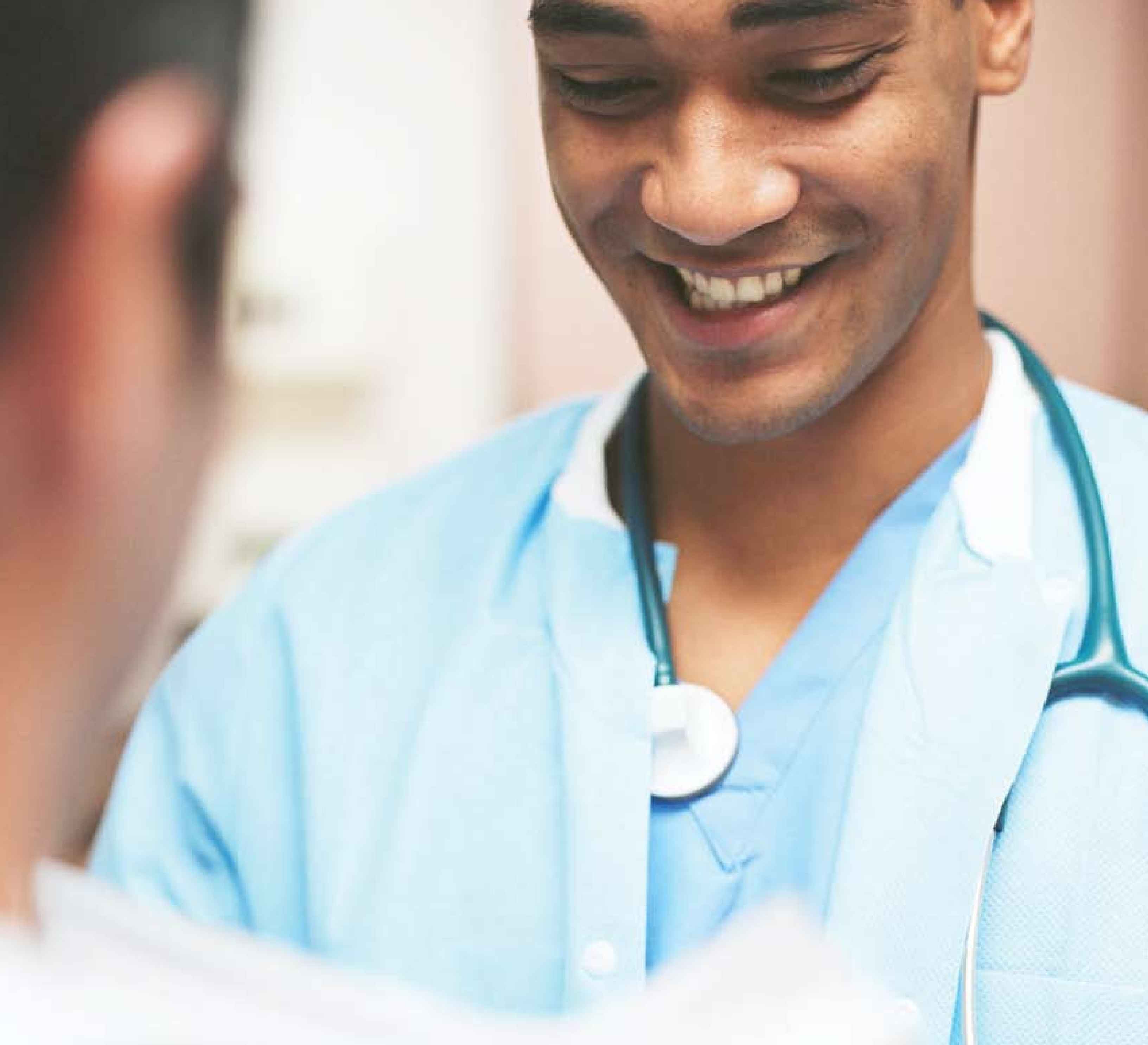
The Access To Care program is a valuable community resource. The program's value arises not only from the vital services it provides to its participants, but also from the fact that it is a community-based program. Northeast Ohio has a national reputation for philanthropy and charitable giving. Nowhere is this more clearly demonstrated than in the commitment of the medical institutions who participate in the program, and in the willingness of the more than 200 volunteer physicians who donate their time and talent to serving their less-fortunate neighbors.

In an era where even basic health care benefits are growing ever more expensive and ever harder to afford, the Access To Care project provides a critical safety net for low-income adults who do not qualify for either federally subsidized health care or employer-based health insurance, as well as those who do qualify for, but cannot afford, private health insurance. How many people fall into this safety net? To date, more than 2,000 uninsured adults have been served by the Access To Care program. Nearly $1,000,000 worth of pharmaceuticals have been leveraged since the program's inception, as has nearly $14 million worth of donated care.

These important investments have had a major impact on the people receiving care. Consider the severity of some of the conditions with which these 2,000 participants have been diagnosed. Forty percent have been diagnosed with hypertension. Another 20 percent were diagnosed with diabetes or a related condition, while an additional 15 percent were diagnosed with chronic obstructive pulmonary disease (COPD). Left untreated, these conditions nearly always lead to far more serious consequences – consequences which often prove catastrophic for participants and expensive for hospitals, whose emergency departments have long been the health care provider of last resort. Access To Care helps doctors treat illnesses before they become life- and health-threatening, keeping people healthier and reducing the number of people who rely on hospital emergency departments for their primary care.

Unfortunately, the 2,000 people currently being served by the Access To Care program account for only a small percentage of the estimated 62,000 uninsured adults in Summit County who need help. Because Access To Care is a model that works, maintaining the program to keep serving the people who currently rely on it and developing the program so it can become a more comprehensive solution should be a high priority for both citizens and community leaders in Summit County.

Health care has long been, and is liable to remain, an unsolved crisis for the millions of Americans shut out of both the private and public health insurance systems. Waiting for solutions from Columbus or Washington is not an option; viable solutions are rarely proposed and fail to win the necessary support when they are. Too many people endure the destruction of health and quality of life that lack of access to health care inevitably causes. Too many businesses cope with the excessive sick days and lost productivity that plague workers without health insurance. If the health care crisis is to be solved in Summit County, it will have to be the Summit County community that solves it. The Access To Care program is an integral part of that long-term, community-based solution.



“I am very thankful for such a program. I had been going without my meds because I couldn’t afford them and my health was really getting bad. I can only say thank you to everyone who runs this program and to the people donating money to it.”

“As a physician, volunteering for Access To Care is better than seeing uninsured patients on my own because it provides a coordinated system to help my patients get access to medications, specialists, hospitals, laboratory and diagnostic services they need.”

EXECUTIVE **SUMMARY**

In 2004, the Access To Care program was created as a pilot project by Healthy Connections Network. Access To Care is a first step in addressing the problem of the uninsured in Summit County. The program was designed to connect uninsured, low-income adults living in the county with a network of volunteer health care services with the goals of:

- Connecting participants with a primary source of health care
- Providing pharmaceutical assistance
- Ensuring appropriate use of the health care system
- Mobilizing and expanding volunteer provider resources
- Coordinating cost-effective health care
- Referring eligible persons for Medicaid and Healthy Start

The program has completed an evaluation of its first 18 months of operations to analyze the demographics of the population served and to determine the return to the community on its investment. Provider and participant satisfaction was also assessed.

Key Findings:

- Together, direct and indirect cost savings of the Access To Care program, drug donations, additional Medicaid funding, and increased personal income due to increased productivity and reduced rates of illness and mortality total between $4.0 million and $4.2 million.
- The benefits of the Access To Care program are between 4.9 and 5.2 times greater than its cost.
- Emergency department usage by Access to Care participants was reduced by 7.8 visits per 100 people as compared to a national comparison group.
- The network of volunteer health care providers donated a total of $4.5 million in care to 1,171 individuals.
- 73 percent of Access To Care participants live in the city of Akron versus suburban Summit County.
- 62 percent of participants are age 45 or older (23 percent age 30-44; 15 percent age 29 or younger).
- 64 percent of participants are White, non-Hispanic (32 percent African-American, non-Hispanic; 4 percent other).
- 65 percent of participants are female.
- 49 percent of participants are single (24 percent married; 28 percent divorced, separated, widowed).
- 34 percent of participants work part-time and 42 percent are unemployed .
- 60 percent of participants earn less than $12,000 per year.
- The majority of providers responding to the survey were either very or somewhat satisfied with the program.
- The vast majority of respondents (89 percent) said they are more likely to go to the doctor than before enrolling in the program.
- More than 2/3 of respondents said that their health has improved since enrolling in Access To Care.
- 98 percent of participants said they would refer friends to the program.

Overall, the Access To Care program has resulted in many benefits to the participants, volunteer providers, and the Summit County community as a whole. Access To Care is a model for how a community can coordinate its resources, join together to make better use of existing community resources, and take local ownership of the problem of the uninsured.

INTRODUCTION:

What is ACCESS TO CARE?

The Access To Care (ATC) project is a program of the Healthy Connections Network (HCN). HCN, formed in 1999, is a 501 (c) (3) non-profit collaborative group representing public and private health and social service providers in Summit County. HCN has received funding from the following organizations to support Access To Care: U.S. Department of Health and Human Services, Health Resources and Services Administration, Knight Foundation, GAR Foundation, Akron Community Foundation, United Way of Summit County, Kaiser Permanente of Ohio, Tuscora Park Health and Wellness Foundation, OMNOVA Solutions Foundation, Akron General Medical Center, Sisler McFawn Foundation, Brennan Family Foundation, Summa Health System, and Akron Children's Hospital.

The Access To Care Program coordinates donated physician services to eligible uninsured low-income adults. The program serves uninsured adults age 18-64 who are below 200 percent of the federal poverty level and not eligible for health insurance through other means (Medicaid, Medicare, employer-sponsored benefits, VA benefits, or student health benefits). To achieve this goal, the ATC program engages in a number of activities, such as:

- Connecting lower income uninsured persons to a regular source of health care
- Coordinating pharmaceutical assistance for participants
- Connecting uninsured persons with necessary social supports
- Referring eligible persons for Medicaid and Healthy Start
- Mobilizing and expanding volunteer provider resources
- Ensuring appropriate use of the health care system
- Coordinating cost-effective health care

In order to provide these services to the community, Access To Care utilizes a network of over 200 volunteer health care providers, including:

- Private practice physicians (primary and specialty care)
- Safety-net providers
- Hospital systems

METHODOLOGY:

How This Analysis Was Conducted

The analysis contained in this report was produced by two outside organizations. The Center for Community Solutions utilized anonymous participant and service provision data gathered for the first 18 months of the operation of the program (March 2005 through August 2006). These data, provided by Access To Care staff, were used to build the demographic profiles contained in Parts I, II, and III of the following report. The same data was used to create Maps 1 through 4.

In order to provide the geographic analysis contained in the four maps, ATC staff broke out the participant and service provision data into 20 clusters of census tracts, then provided the data to The Center for Community Solutions for further analysis. This method of breaking Summit County into these 20 clusters was originally used in the Summit 2010: A Quality of Life Project.

By breaking down the data in this manner, progress on Access To Care can be integrated with the improvement plans now being implemented by the Summit 2010 project.

Data for Part V of the report, regarding participant and provider satisfaction, came from the results of two mail surveys conducted by ATC staff in the summer of 2007. Survey data and a preliminary analysis conducted by ATC staff was provided to The Center for Community Solutions, which utilized each in preparation of the analysis contained in Part V of this report.

The return on community investment analysis presented in Part IV was conducted by Elizabeth Erickson, Associate Professor at the Department of Economics, University of Akron, and Richard Steiner, Professor, Department of Statistics at the University of Akron. Erickson and Steiner utilized the same anonymous participant and service provision data from the same time period as the demographic analysis, combined with data and information from several other sources identified below. The analysis was prepared utilizing a well-established format for evaluating the return on a community's investment for providing access to health care published by David Rogoff, *Measuring the Return on Community's Investment Resulting from Providing Access to Affordable Health Coverage*, July 2003.

References for Return on Community Investment Analysis

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- Vigdor, E., *Insuring Health: the Six Reports and Summaries of the Committee on the Consequences of Un-insurance* (2001-2004), Institutes of Medicine 2001-2004
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PART I: DEMOGRAPHIC PROFILE

What Do Access To Care Participants Look Like?

In this section, we will take a look at the demographic makeup of Access To Care participants, including where they live; how old they are; and their race, gender, marital status, employment status, and income.

Fig. 1: Where Do *Access To Care* Participants Live?

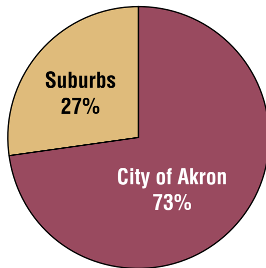


Fig. 2: How Old Are *Access To Care* Participants?

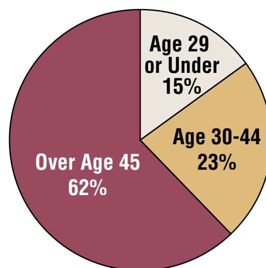


Fig. 3: Racial Makeup of *Access To Care* Participants

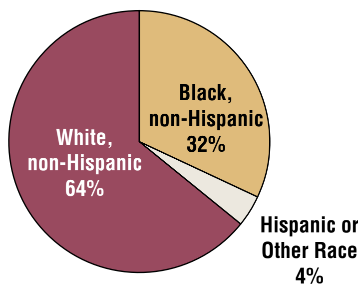
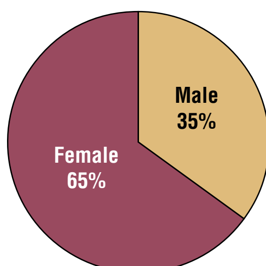


Fig. 4: Gender of *Access To Care* Participants



Place of Residence

Nearly three-quarters of ATC participants reside in the city of Akron (nearly 850 participants, or 73 percent of the total), while the remainder reside in suburban Summit County (nearly 320 participants, or 27 percent of the total).

Within the city of Akron, nearly half of participants, 46 percent, reside in either the Southeast Akron or Southwest Akron clusters (23 percent each). Just over one-quarter of suburban participants (27 percent) reside in Cuyahoga Falls, with additional concentrations of participants in the Barberton, Coventry / Green, and Stow / Silver Lake clusters (18 percent, 15 percent, and 12 percent, respectively). Together, these four clusters account for nearly three-quarters of all suburban ATC participants.

Age

The median age of all ATC participants is 48 years old – well above the median age of the population as a whole, which, according to the U. S. Census Bureau's 2005 American Community Survey (ACS) was 38.6 years of age. The median age for participants in the city of Akron (47.0) was somewhat lower than the median age for suburban participants (50.0).

Most ATC participants, nearly two-thirds, are older than age 45 (62 percent). Another one-quarter are between the ages of 30 and 44, while an additional 15 percent are under age 30, as Figure 2 shows.

Race

Countywide, nearly two-thirds of all ATC participants were White, non-Hispanic (64 percent), while nearly all of the remainder were African-American, non-Hispanic (32 percent). Only 4 percent of participants were of another race.

That picture changes noticeably when looking at Akron and its suburbs separately. In the suburbs, nearly all of the ATC participants were White, non-Hispanic (90 percent). Within the city of Akron, the racial makeup of ATC participants was much more balanced, with 54 percent being White, non-Hispanic and the remaining 46 percent being either African-American, non-Hispanic (42 percent) or of another race (4 percent).

Gender

All told, just over two-thirds of ATC participants were female (65 percent). Unlike the racial makeup of ATC participants, there are few meaningful differences between genders for Akron and its suburbs, with Akron having a slightly lower female percentage than the suburbs (63 percent and 69 percent, respectively).

Marital Status

Almost half of ATC participants (49 percent) are single. Another 28 percent are either divorced, separated, or widowed. Only 23 percent are married.

There were some differences between Akron and its suburbs.

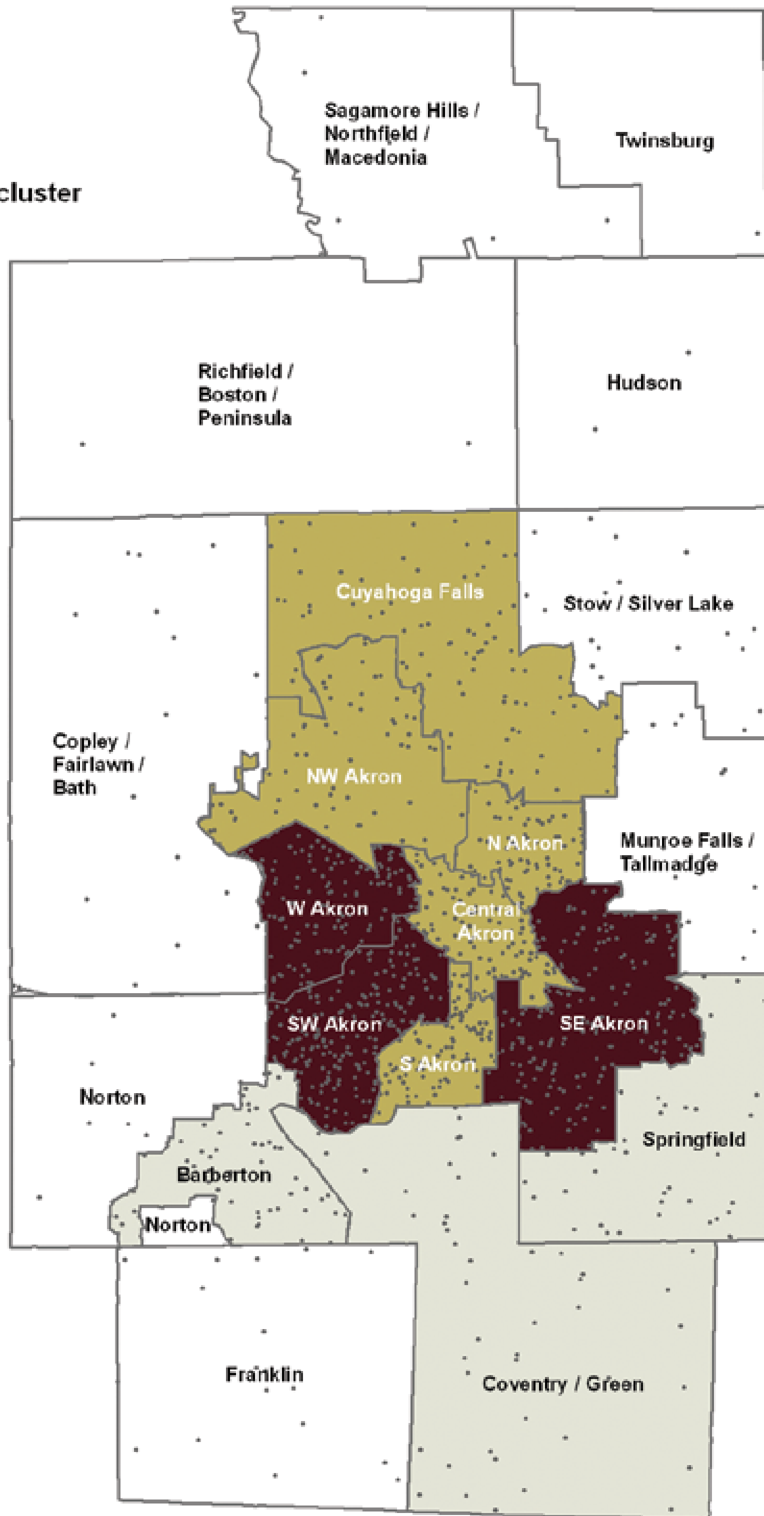
Map 1: Access To Care (ATC) Participants By Cluster As A Percent of Total, Summit County, 2006

All Clients

1 Dot = 1 Participant

Percent of all participants in each cluster

- More than 10.1%
- 5.1% to 10.0%
- 2.6% to 5.0%
- Less than 2.5%



All told, just over two-thirds of ATC participants were female (65 percent).

Akron has a higher percentage of single participants than the suburbs (52 percent and 40 percent, respectively), and a correspondingly lower percentage of married and divorced / separated / widowed participants than in the suburbs.

Employment Status

Half of all ATC participants are employed either full-time (16 percent) or part-time (34 percent), while nearly half (42 percent) are unemployed.

Little difference was seen between the city of Akron and the suburbs. Slightly higher percentages of Akron ATC participants said they were either employed full- or part-time (52 percent in Akron versus 45 percent in the suburbs), while unemployment was slightly more prevalent in the suburbs than in Akron (44 percent and 41 percent, respectively).

Monthly Household Income

By any account, ATC participants are an economically marginalized group. The median monthly income for a household with an ATC participant in it was $792, or about $9,500 per year. Nearly two-thirds of ATC participants report earning less than $1,000 in household income per month; a maximum of $12,000 per year. An additional 21 percent report monthly household incomes of between $1,000 and $1,500 (a maximum of $18,000 per year). A small minority of 8 percent make more than $2,000 per month, or a maximum of $24,000 per year.

Even if most participants lived alone, the vast majority would still be living below poverty. However, it is likely that many ATC participants do not live alone; as we saw earlier, nearly a quarter are married.

Fig. 5: Marital Status of *Access To Care* Participants

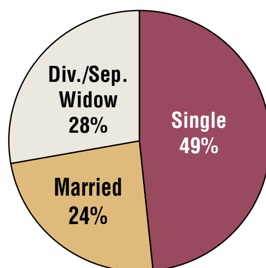
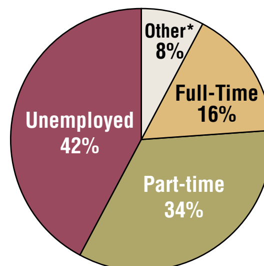
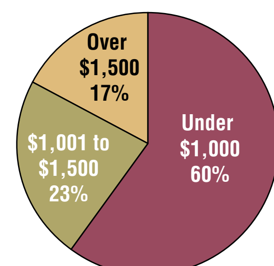


Fig. 6: Employment Status of *Access To Care* Participants



** Includes the categories of "full-time student," "household member employed," "self-employed," and "retired / pension."*

Fig. 7: Monthly Income of *Access To Care* Participants



PART II: UTILIZATION PROFILE

What Medical Conditions Do Access To Care Participants Have and What Services Do They Utilize?

In this section, we will look at the number and types of diagnoses reported by ATC participants, and which services ATC participants utilized.

Most Frequent Diagnoses

The most frequent diagnoses were found in the Endocrine / Nutritional / Metabolic / Immunity category, which accounted for 17 percent of all ATC services. This category includes such diseases as diabetes, thyroid gland disorders, various nutritional deficiencies, as well as obesity, metabolic and immune system disorders. Diagnoses related to the circulatory system were the next most frequent, accounting for 15 percent of all ATC services. This category includes things such as hypertension, heart disease, and other cardiovascular issues. Musculoskeletal / Connective problems were the third most frequent category, accounting for 13 percent of all services. These problems include such things as arthritis, knee and other joint problems, rheumatism, and other muscle and bone-related issues.

In addition to the major diagnosis categories discussed above, Access To Care also pays particular attention to three common target conditions for which early intervention has been shown to be effective in reducing long-term complications: Diabetes Mellitus, Hypertension, and Chronic Obstructive Pulmonary Disease (COPD). The reason for this increased attention is that these three conditions can be effectively treated if diagnosed early, but will cause serious problems if they remain undiagnosed or are not treated effectively.

Of the three, hypertension was the most frequent diagnosis, accounting for 20 percent of all services. Diabetes was the second most frequent, accounting for 16 percent of all services, while COPD was the least prevalent of the three, accounting for 6 percent of all services. Little difference exists between city and suburb in these three diagnoses, though there are some interesting differences between clusters (See Maps 2, 3, and 4).

Most Frequent Services Utilized

The most frequently utilized service codes were in the Pathology / Lab category, accounting for more than a quarter (27 percent) of all services provided. These services include such things as basic metabolic panels, urinalysis, or drug testing. Evaluation / Management was the next most frequently occurring code grouping, accounting for 26 percent of all services provided. These services include things such as office visits for new and established patients, initial and subsequent hospital visits, and consultations to establish family history and patient health history. Medicine was the third most frequent category, accounting for 15 percent of all services provided. This category includes services such as ophthalmology, hearing tests, and echocardiography. Anesthesia was the least frequently occurring service category, accounting for one percent of all services.

Fig. 8a: Major *Access To Care* Diagnosis Categories (as a percent of all services provided)

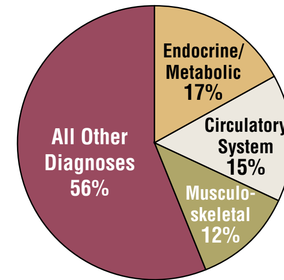


Fig. 8b: ATC Claims Citing Serious Health Conditions (as a percent of all services provided)

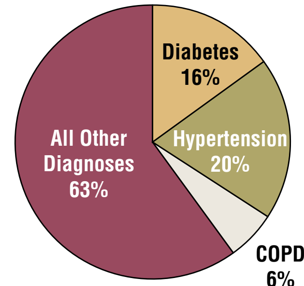
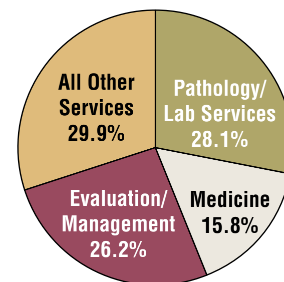


Fig. 9: Service Categories of *Access To Care* Participants



No meaningful differences in services received were apparent between the city of Akron and the suburbs, though all three categories discussed above were slightly more likely to occur in the city of Akron than in the suburbs.

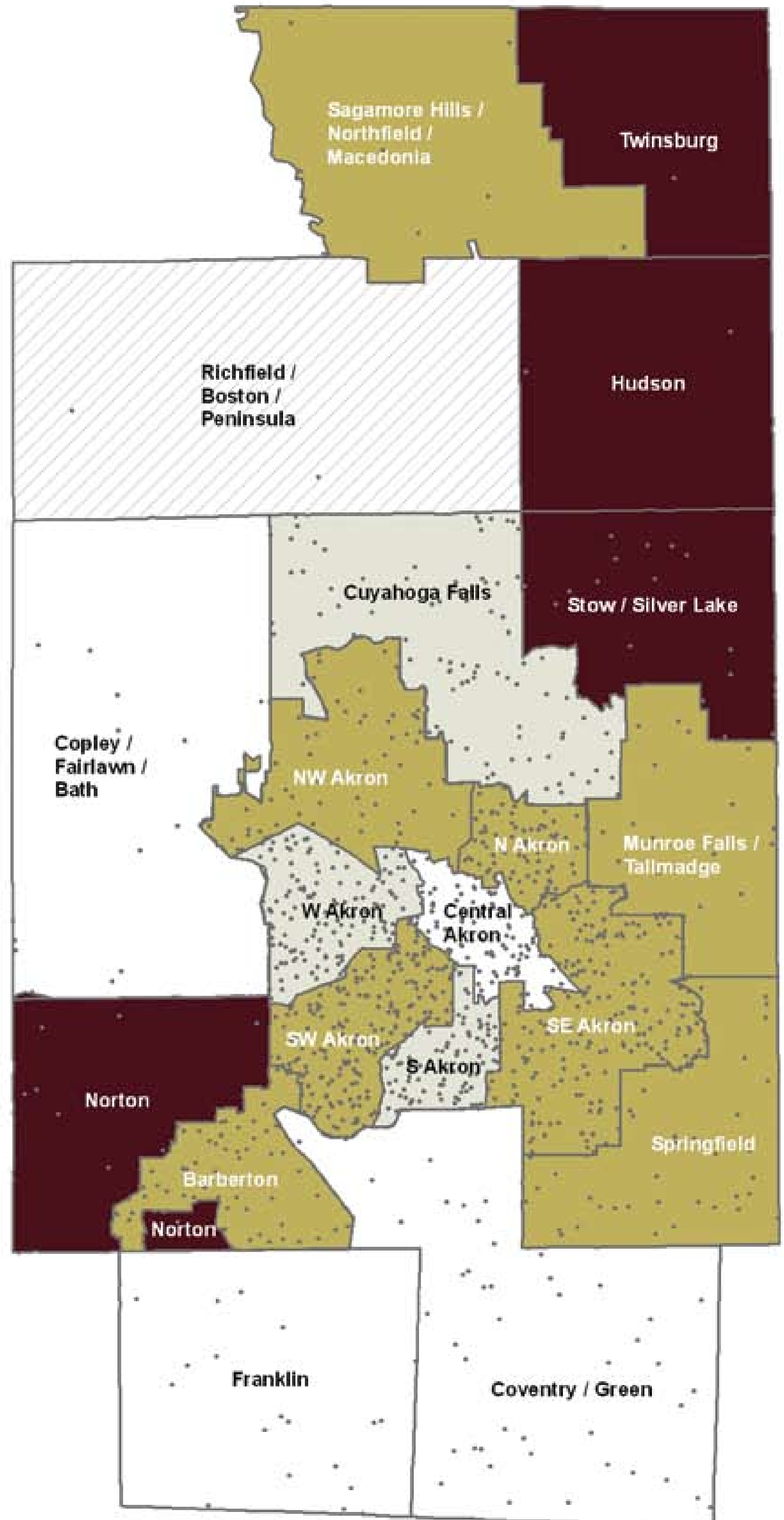
Map 2: Diabetes As A Percentage of All Diagnoses Summit County by Cluster, 2006

All Clients

1 Dot = 1 Diagnosis

Cluster

- 25.1% or higher
- 15.1% to 25.0%
- 10.1% to 15.0%
- 10.0% or lower
- No diagnoses of diabetes



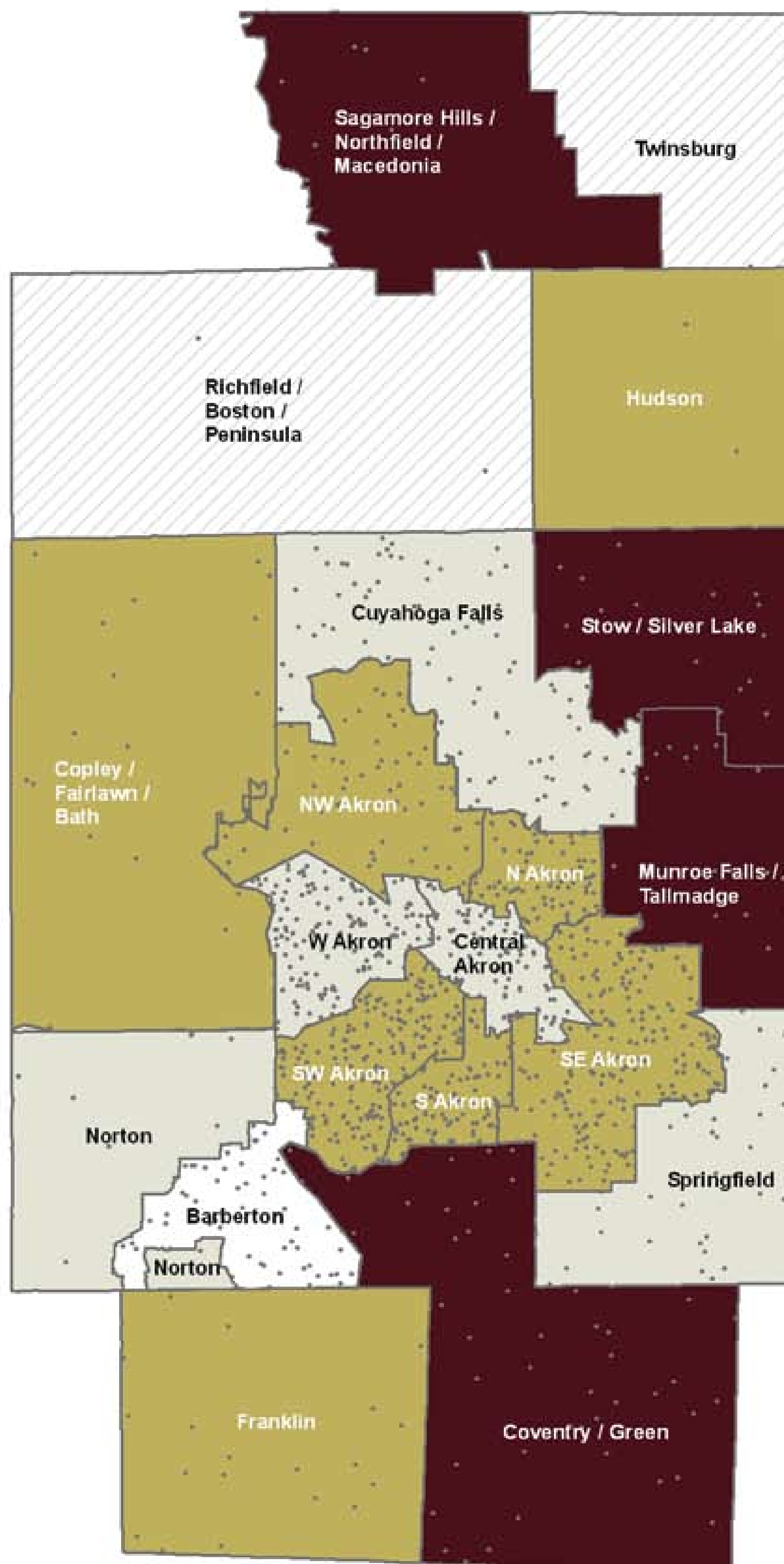
Map 3: Hypertension As A Percentage of All Diagnoses Summit County by Cluster, 2006

All Clients

1 Dot = 1 Diagnosis

Cluster

- 25.1% or higher
- 20.1% to 25.0%
- 15.1% to 20.0%
- 15.0% or lower
- No hypertension diagnoses



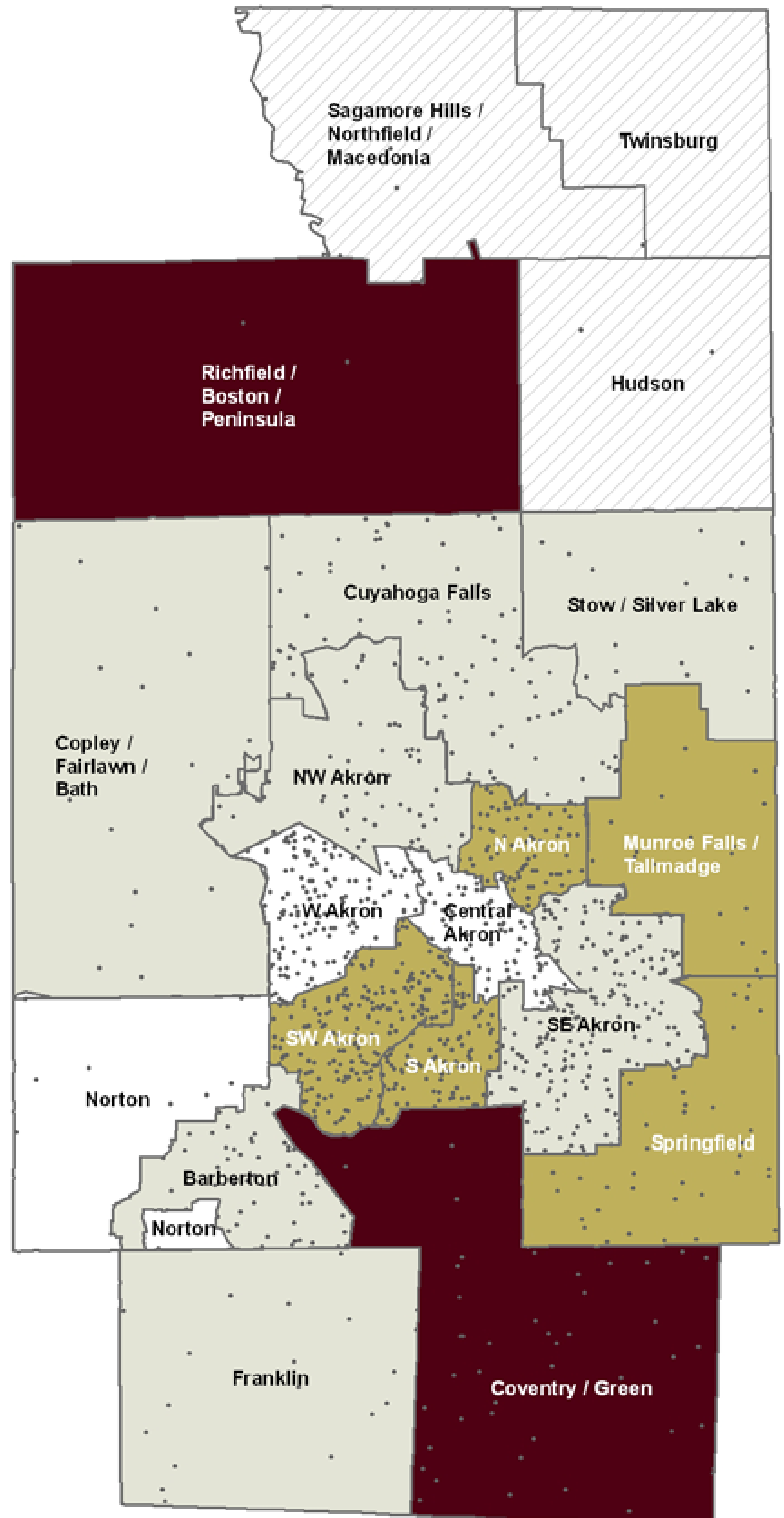
Map 4: COPD As A Percentage of All Diagnoses Summit County by Cluster, 2006

All Clients

1 Dot = 1 Diagnosis

Cluster

- 10.1% or higher
- 7.6% to 10.0%
- 5.1% to 7.5%
- 0.0% to 5.0%
- No diagnoses of COPD



PART III: DONATED CARE ANALYSIS

In this section, we take a look at the value of donated care. And, as in earlier sections, we'll examine how donated care was geographically distributed across Summit County.

Donated Care

All told, the Access To Care program provided just under 6,700 medical services to its 1,171 participants during the period examined by this study for an estimated $4.5 million worth of donated care (an average of $667 per service provided).

A large majority, 4,700, or about 70 percent of total services, were provided in the city of Akron, while just under 2,000 were generated in the suburbs (see Figure 10a). Nearly three-quarters of all donated services delivered were provided by one of the hospital systems participating in Access To Care (72 percent), while the remainder were provided by one of the volunteer private physicians (see Figure 10b).[1]

Fig. 10a: Geographic Location of Donated Care Services

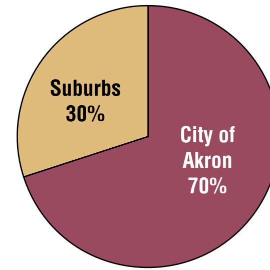
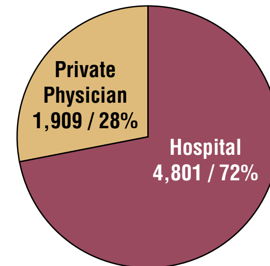


Fig. 10b: Number and Percent of *Access To Care* Donated Services by Provider



PART IV: RETURN ON COMMUNITY INVESTMENT

How Does The Access To Care Program Benefit Summit County?

The purpose of this analysis is to estimate what is called the Return on Community Investment or ROCI. In other words, did the ATC program produce more benefits than the community spent to set up and operate the program? This study examines the costs versus benefits of providing medical coverage to the 1,171 persons who were enrolled in the program between March 1, 2005, and August 31, 2006.

The general format used to estimate Summit County's ROCI for programs providing access to health care is set out in David Rogoff's *Measuring the Return on Community's Investment Resulting from Providing Access to Affordable Health Coverage*, July 2003. As noted above, estimating ROCI involves determining the benefits of the ATC program to Summit County and comparing it to the costs of the program to Summit County. The difference between the benefits and the costs is the ROCI.

There are four categories to consider in determining the benefits of providing access to health care (Rogoff, p.11):

1. Direct cost savings of providing timely primary care, rather than later and more expensive emergency department care;
2. Indirect cost savings, including such administrative savings as lower costs due to centralization of an activity;
3. Inflow of resources into the community; and
4. Changes in people's quality of life, such as improved productivity, reduced rates of illnesses and disease, and reduced mortality.

Two estimates of the dollar value of each benefit were obtained. One estimate was based on a conservative scenario, while the second was based on a more realistic, less conservative scenario.

1. Direct cost savings come from two sources: 1) a reduced number of emergency department (ED) visits, which is achieved by shifting uninsured participant primary care visits to ATC participating primary care providers, and 2) a reduced number of in-patient (IP) visits, which is achieved by providing early treatment and management of possible non-emergency conditions by ATC participating primary care providers. The cost savings from reducing the

Table 1: Calculation of Return on Community Investment (Net Benefit)

TYPE OF SAVINGS:	LOW ESTIMATE	HIGH ESTIMATE
1,2 Direct and Indirect Cost Savings	**$74,802**	**$312,147**
3. Inflow of Resources		
a. Patient Assistance Programs - drug donations	$726,861	$726,861
b. Additional Medicaid Funding	$0	$28,422
4. Changes in Quality of Life		
a. Increased income due to increased productivity and reduced rates of illness and mortality	$3,179,265	$3,179,265
Estimated Total Benefit of the ATC Program	**$3,980,928**	**$4,246,695**
Total Cost of the ATC Program	**$811,944**	**$811,944**
Estimated Benefit-to-Cost Ratio	**4.9**	**5.2**

number of ED and IP visits were obtained by comparing ED and IP use and cost per visit by ATC participants with national data from the Medical Expenditure Panel Survey (AHRQ-MEPS). It is estimated that Emergency Department cost savings due to ATC are estimated to be between $74,802 and $174,127, based on an estimated reduction of 7.8 visits per 100 persons (a reduction of 137 visits over the 18-month period of this study).[2] In-patient cost savings are estimated to be $138,020. This figure is the less conservative estimate discussed earlier. Because the data necessary to calculate the more conservative estimate are unavailable, we show the more conservative estimate to be $0.

2. Indirect cost savings come from centralizing functions which were once carried out by separate agencies before the establishment of the ATC program. One cost reduction objective was to make it easier and more economical for physicians to volunteer their time by organizing appointments and referrals to specialists. These savings were incorporated in the per visit cost estimate used in computing the direct cost savings, above. The combined direct and indirect cost savings realized by ATC are estimated to be between $74,802 and $312,147.

3. Inflow of resources into Summit County is primarily due to donations of drugs by various pharmaceutical companies through their patient assistance programs. The value of these donations was $726,861. It is also likely that an additional $28,422 in Medicaid funding was brought in through ATC by providing participants with data indicating that they were eligible for Medicaid.[3] Thus, the inflow of resources into the community as a result of ATC is estimated to be between $726,861 and $755,283.

4. Changes in quality of life in terms of improved productivity were estimated using a 10 percent increase in income (Rogoff, 2003), work experiences of ATC participants, and the estimated effect of this increased income on the local economy. The value of the increased productivity of ATC participants is estimated to be between $1,737,963 and $2,896,605. Improved quality of life through increased productivity and reduced rates of illnesses and mortality were estimated to be $3,179,265, based on an Ohio study by Meyer, Hadley, & Smith entitled *Mapping Health Spending & Insurance Coverage in Ohio* (Health Policy Institute of Ohio, 2007).[4]

Combining the benefits from direct cost savings, indirect cost savings, inflow of resources, and increased quality of life, yields an estimated total value of the benefits of the Access To Care program from March 1, 2005, to August 31, 2006 of between $3,980,928 and $4,246,695.

The total cost of the ATC program from March 1, 2005, to August 31, 2006 was $811,944. Therefore, the return on community investment for ATC between March 1, 2005, and August 31, 2006 is estimated to be between $3,168,984 and $3,434,751. In other words, when comparing the benefits of ATC to its costs, the benefits are somewhere between 4.9 and 5.2 times higher than the costs of providing the program.

PART V: PARTICIPANT AND PROVIDER SATISFACTION

In order to offer a complete review, we also examined how satisfied participants and volunteer providers were with the Access To Care program.

Patient Satisfaction

All told, 334 participants responded to the participant satisfaction survey. Their responses are summarized below:

Change in health status – More than two-thirds of respondents say that their health has either improved a great deal (37 percent) or somewhat (32 percent) since enrolling in ATC. Nearly all of the rest report that their health status is unchanged.

Likelihood of visiting a physician – The vast majority of respondents, 89 percent, said they are more likely to go to the doctor than before enrolling in the program.

Willingness to refer others to the ATC program – Almost all participants, 98 percent, say they would refer friends to the ATC program.

Services received – Nearly all respondents say they have visited a doctor since enrolling in the program (91 percent), while another 75 percent received lab tests and an additional 67 percent received medications. Other services received can be found in Figure 12 below.

Fig. 11: Since Enrolling in the *Access To Care* Program, Has Your Health...

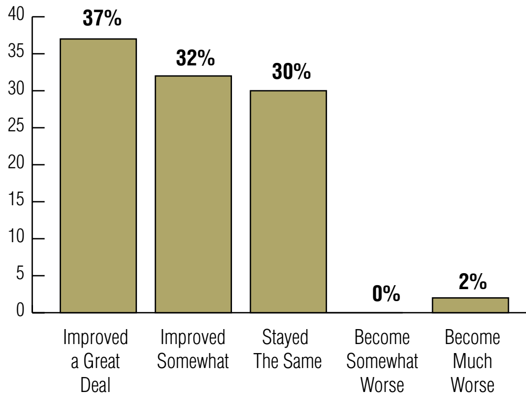


Fig. 12: Since Enrolling in the *Access To Care* Program, are You More or Less Likely to Go to the Doctor?

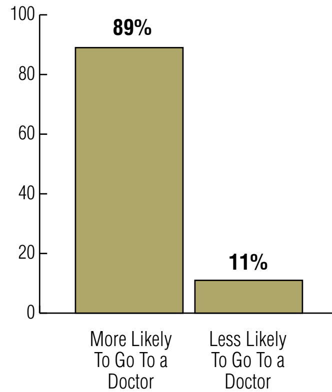


Fig. 13: Would You Refer Your Friends to the *Access To Care* Program?

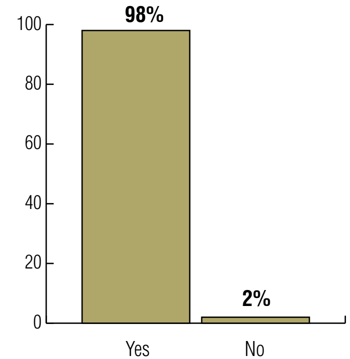


Fig. 14: Which of These Services Have You Received Since Becoming Enrolled in the *Access To Care* Program?
(more than one response can be chosen)

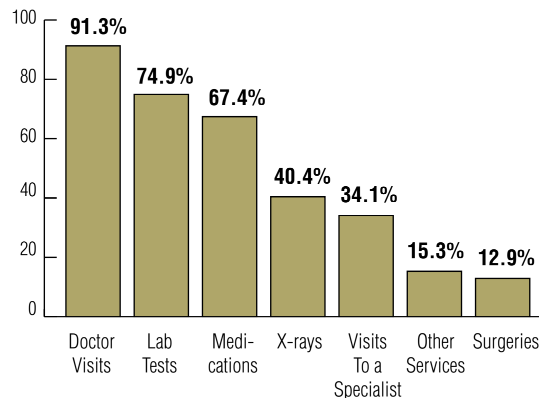


Fig. 15: How Satisfied Are You With...?
(percent completely satisfied)

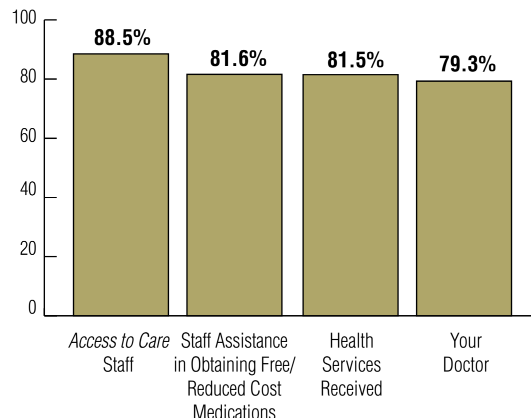


Fig. 16: How Long Did You Wait to See the Doctor After Contacting the *Access To Care* Program?

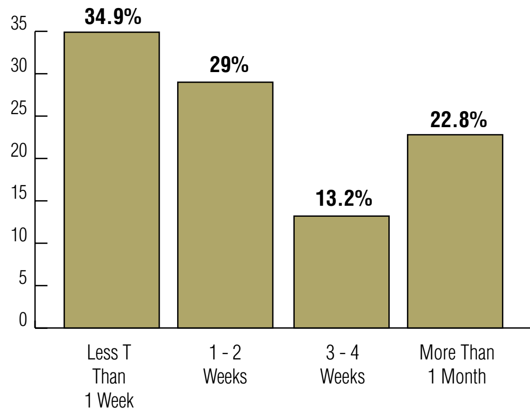


Fig. 17: How Many Times in the Past Two Years Did You Use the Emergency Room?

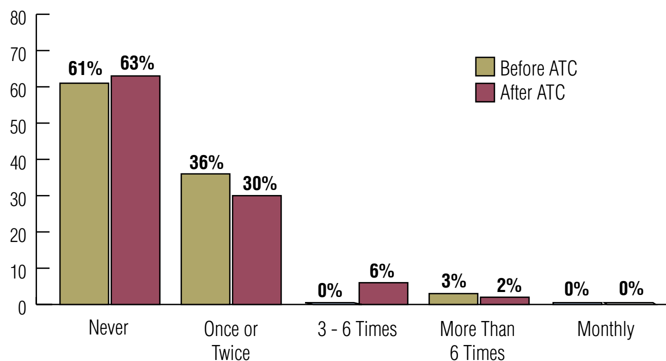
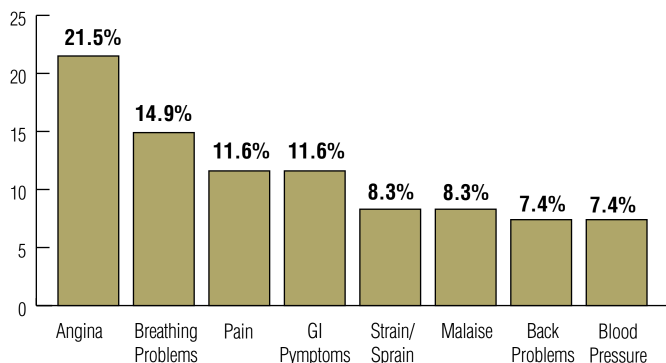


Fig. 18: What Were Your Symptoms?

(open-ended quesion asked of those reporting an ER visit – more than one can be chosen)



Satisfaction with specific ATC services – Large majorities of respondents are completely satisfied with various aspects of the ATC program. Even the part of the program which received the lowest "completely satisfied" rating – the doctors themselves – still completely satisfied nearly 80 percent of all participants. Complete satisfaction with the ATC staff received the highest rating of all, nearly 89 percent.

Waiting period for medical services – Nearly two-thirds of respondents say that they waited two weeks or less to see a doctor once enrolled in ATC (64 percent). Nearly one-quarter (23 percent) said they waited a month or more.

Emergency Room (ER) use – Just over one-third of participants say they have used the ER during the past two years. The percentage of those who say they never use the ER rose slightly after enrollment in ATC, from 61 percent to 63 percent. Most of those who say they have used the ER do so only once or twice; a figure which drops from 36 percent to 30 percent after enrolling in ATC. However, the percentage of participants who use the ER three to six times per year rose from zero to 6 percent after enrolling in ATC (see Figure 17).

Symptoms which brought respondents to the ER – Angina was the most common symptom which prompted an ER visit, cited by 22 percent of respondents. Breathing problems, general pain, and gastrointestinal symptoms were reported by another 38 percent. Other causes can be found in Figure 18.

1 Note: The term "hospital system" includes more than just a particular hospital. It includes all hospitals, clinics, lab/diagnostic services, emergency departments, and employed physicians associated with a particular system. Any provider which does not get defined as a member of a hospital system is considered to be a private physician.

2 The cost savings data were calculated utilizing a locally derived estimate of the cost of ED services (for the low end of the estimate), and national estimates from the Medical Expenditure Panel Survey (for the high end of the estimate).

3 Estimated Medicaid funding was calculated utilizing a study of Medicaid conducted by Desai, Kim and Greenbaum of the Health Policy Institute of Ohio (2005), as well as on actual data from 21 ATC clients who left the program after qualifying for Medicaid benefits. Erickson and Steiner based their calculations on the Health Policy Institute's Summit County-specific estimated cost of $3,867 per Medicaid client. Because the higher estimate included nursing home costs (irrelevant to ATC participants), the estimate was reduced by 27 percent to yield an estimate of $2,811 per additional Medicaid client because of ATC.

4 Reduced rates of illness and mortality were estimated using the Health Policy Institute study's conservative estimated cost savings of $1,600 per year per person. Multiplying that figure by the total number of 1,171 ATC participants would have generated $3,179,265 over the 18-month period of this study.

11 out of 13 doctors said that they felt it was their responsibility as a physician to volunteer for ATC.

Physician Satisfaction

Participation in ATC – All together, there were 16 responses to the physician satisfaction survey out of a total of 77 mailed. Nearly all of the respondents were participants in the program for at least six months, with the bulk of respondents (nine of the 16) saying they have been participating for more than one year.

Reasons for volunteering for ATC – Nearly all of the responses, 11 of the 13 who answered this question, said that they felt it was their responsibility as a physician.

Helpfulness of orientation – Nearly all of those who answered this question (six of eight), said that the orientation process conducted by ATC staff was extremely helpful, while the remaining two said it was not at all helpful.

Program expansion – Ten of 13 respondents said that their practice recommended enrollment in the ATC program to existing patients. Only two did not.

Participation in program expansion efforts – Only two of the 13 physicians responding to this question said they would be willing to assist in recruiting other physicians to help ATC expand its network.

Problems with the ATC program – The most frequent problem cited by responding physicians was participants not showing up for their appointment (three mentions). Five physicians said there were no problems.

Satisfaction with various aspects of the ATC program – Participating physicians were asked to rate their satisfaction with four different aspects of the ATC program:

- **Lab work for patients** – All 10 responding physicians were either very or somewhat satisfied.
- **Specialty care / ancillary services** – Twelve of the 13 physicians who responded were either very or somewhat satisfied, while one was dissatisfied.
- **Pharmaceuticals** – Eight respondents were either very or somewhat satisfied, while an additional four were dissatisfied.
- **Recognition of your donated time and skills by ATC** – Most physicians, 11 of the 13, were either very or somewhat satisfied with the recognition they received, while two were dissatisfied.
- **Overall satisfaction** – All 14 physicians who responded to this question said they were either very or somewhat satisfied with the ATC program. None were dissatisfied.

Healthy Connections Network
P.O. Box 2734
Akron, OH 44309-2734
330-972-7894

www.healthysummit.org/hcn