Project Access: Giving back at home

by Joseph B. Cofer, MD, FACS

As I read the plea for a surgeon to accompany a medical mission to Honduras in the August 10, 2007, edition of the *ACS NewsScope*, I was reminded of a surgical mission trip I made to Haiti where I performed many inguinal hernia operations on several young men, most of whom probably had had hernias since infancy. The trip was significant to me in many important ways and I honor the work of selfless physicians who perform medical mission work overseas. At the same time, I was struck by the large amount of resources expended to provide a relatively small amount of medical care. This trip was a significant financial expense to me, including the direct costs of airplane tickets, lodging, and meals, and the indirect costs of being away from my practice. In fact, there are many opportunities for surgeons to perform meaningful charity work right here at home in programs that are vastly more cost-effective (cost/relative value unit) than overseas medical efforts. For example, we have a program in Chattanooga, TN, that might serve as a model for other surgeons around the country who are interested in providing domestic charity care.

Creation of Project Access

The Project Access model was initially developed in 1995 by the Buncombe County (North Carolina) Medical Society under the leadership of Suzanne E. Landis, MD, MPH, professor of family medicine at University of North Carolina School of Medicine in Chapel Hill, a founder of the Physicians Innovation Network, and a chief architect of Project Access. In 2002, the leadership of the Chattanooga-Hamilton County Medical Society (CHCMS) decided to create a similar program to serve Hamilton County residents. By October 2002, the CHCMS had brokered a meeting that included CHCMS leadership and the chief executive officers of the three major hospitals in Chattanooga. At that meeting, we decided to create our own version of the Project Access model in Chattanooga. The hospitals were convinced to come on board because we could clearly make the case that it is easier and less costly to provide free care to perform an elective same-day cholecystectomy or outpatient treatment of hypertension or outpatient treatment of diabetes than to treat their respective complications such as gangrenous cholecystitis/biliary pancreatitis, hypertensive stroke, or diabetic ketoacidosis. If treatable medical conditions are allowed to progress, the patients will end up in the emergency room and hospitals will eventually be forced to provide the care anyway. The plan was to construct a county-wide network of primary care physicians and specialists together with the hospitals to provide free care to a segment of the uninsured residents of Hamilton County. Once the agreement was reached to move forward, seed money was raised; $50,000 donated by the CHCMS and another $150,000 donated by the three hospitals and the local dialysis clinic. With this seed money, we were able to hire an experienced director, Rae Bond, to head up this initiative (see photo, page 15). She began work in February 2003.

At that point, the Project Access team began to seek longer-term funding and to recruit other partners to participate in the program, including health centers operated by several entities (that is, the county health department, a nonprofit hospital system, and federally qualified health centers), and to launch a major physician recruitment effort.

Physician leaders and representatives from partner agencies formed the Project Access Operations Council, which developed eligibility criteria, operational strategies, and policies and procedures for the initiative. This effort received significant assistance from Project Access initiatives in other communities, most notably Sedgwick County (Wichita, KS) Project Access, which allowed us to use their policies and procedures as a starting point. Eventually, the Hamilton County program also purchased Wichita's Charisma Salus software to coordinate care. Ms. Bond also wrote a successful proposal that brought us a three-year, $1.9 million federal Healthy Communities Access Program grant in September 2003. With the grant money, we were able to purchase computer hardware and software, add phone lines, and hire a few employees. The Project Access staff screens potential patients, coordinates care, manages patient allocation, recruits physicians, enters and manages data, and helps our patients navigate the numerous and confusing pharmacy industry-sponsored drug programs.

Project Access staff at work. Counter-clockwise from upper left: J. Patrick Dilworth, MD, with a patient; program manager Tonya Williams; Ms. Bond; Ms. Williams and Holly Lyons review files.

Table

Category	2004	2005	2006	January–June 2007	Total
Patients screened	511	1,370	1,459	697	4,037
New patients enrolled	136	651	841	607	2,235
Total patients currently enrolled					387
Patient care completed (disenrolled)	179	549	808	531	2,067
Patients disenrolled due to noncompliance	10	9	9	11	39
Not eligible; directed to other resources	183	466	667	317	1,633
Physician care claims received	717	3,848	5,103	2,413	12,081
Hospital claims received	162	1,328	2,415	1,086	4,991
Physician care delivered	$152,886	$939,474	$1,569,496	$745,309	$3,407,165
Hospital care delivered	$588,752	$3,977,382	$8,085,759	$4,769,577	$17,421,470
Total care for all claims					**$20,828,635**

Project Access opens its doors

By April 2004, we were ready to admit our first patient. To qualify for the program, a person must be a resident of Hamilton County for at least 90 days, have income lower than 150 percent of the federal poverty level ($25,755 for a family of three), and have no other access to health insurance (such as employer provided, Medicare, Medicaid, and so on). Potential patients are referred to the program by partner health centers, hospitals, and physicians; they can also apply directly. Project Access is housed at the Medical Society. Patients are evaluated and those who qualify are enrolled and issued a Project Access enrollment card that allows them to receive care at partner facilities. Each new patient is connected to a primary care home, typically at one of the various health centers in the community. Patients' primary care physician can, in turn, contact Project Access to coordinate specialty care needed by the patients. Patients are strongly encouraged to use the emergency room (ER) only for true emergencies and inappropriate use of the ER can result in disenrollment from Project Access.

When Project Access began in 2004, we quickly had more than 350 physicians volunteer their services. By June 2007, more than 580 physicians in Hamilton County have agreed to see Project Access patients free of charge.

Typically we ask the specialists (general surgeons, cardiologists, urologists, and so on) to agree to see 10 to 20 patients a year, and we ask the primary care physicians to see five to 10 patients a year. The physicians provide this care completely voluntarily. Essentially all specialties are represented. All hospitals provide free surgical and other imaging and laboratory services as necessary, and the allocation of patients to physicians is coordinated with the help of the Project Access software program that tracks physician commitments and availability. Each partner facility and physician creates a Project Access identifier in their billing system, as though it was an insurance company, to generate a HCFA-1500 form for all care that is provided. The system is then programmed to write off the care as charity. This process enables Project Access to document the date, treatment, care provided, and the value of the care. As there are currently more than 580 physicians involved, the individual workload of each physician is really quite small. For example,

I myself might see one surgical consult every other month as almost all the general surgeons in town have agreed to see these patients.

Since the program's inception in April 2004 through June 2007, we have screened more than 4,037 patients. Of these patients, 2,235 were enrolled. The value of total physician care delivered to date is $3.4 million. The value of total hospital care delivered is $17.4 million (see Table, page 16).

Project Access' benefits

One of the beauties of this program is that if a person has a medical condition that makes him or her unemployable, that person can join Project Access, have the condition (such as an inguinal hernia) treated, and then six weeks later return to the workforce where health insurance often can be obtained. At this point, the person drops out of Project Access. Of the 2,235 patients we have enrolled over the last three years, 2,067 participants have now had their care completed and they have been disenrolled. Approximately 20 percent of these individuals now have health insurance. We currently have 387 patients enrolled in the program.

Another significant benefit of this program is that many of the patients initially screened do not truly need help from Project Access but need referral to some other agency that can solve their problem. Over the last three years, of the 4,037 patients we screened, 1,633 were not eligible for our program but were directed to other resources to receive help. In essence, Project Access serves as an umbrella organization to provide resources to the uninsured people in our community who need medical care or some other type of resource to sustain them.

Finally, we provide assistance to other communities who wish to do the same thing. We have helped communities from as far away as Michigan, and recently helped our "sister city," Knoxville, TN, get its program up and running.

Our program has truly made an impact in our community. It has been widely accepted by the physicians because it is our program, run by us, and not the result of some government mandate. Although this program is not as dramatic as going to a foreign country and providing medical care under adverse circumstances, I believe it performs a vital function in providing medical care for a segment of the uninsured in our community. Although traveling to other countries to care for those in need is important, as surgeons we should not lose sight of the fact that we can care for those individuals in need in our backyards as well. Ω

Dr. Cofer *is a professor of surgery and the surgery residency program director, department of surgery, for the University of Tennessee College of Medicine, Chattanooga Unit.*