Notes From the Field

Reaching Out to the Underserved: A Successful Volunteer Program

Since the mid-1960s, there have been more than 75 major federal programs and countless state initiatives aimed at increasing access to health care and improving health. By many measures, however, the problems in our communities have gotten worse. Providers, educators, and policymakers alike are recognizing that the health problems our society faces require innovative approaches. In this report, we describe the development of a community–academic partnership that implemented a volunteer program to meet some of the health care needs of the underserved and uninsured. In addition to describing the program, we explain the major barriers encountered, the strategies for meeting them, and the outcomes of the program.

Partnership and Program Objectives

In December 1993, the Robert Wood Johnson Foundation issued a request for proposals for Reach Out: Physicians' Initiative to Expand Care to Underserved Americans, a program that challenged private physicians to expand their role in caring for medically underserved people. In response to this opportunity, a community–academic partnership was formed in Montgomery County, Ohio (population approximately 570 000 in 1995) to develop an innovative approach to address the lack of access to health care for the uninsured in the community. The partners consisted of the Montgomery County Medical Society, the Combined Health District of Montgomery County, and the Wright State University School of Medicine. The Combined Health District of Montgomery County, the local public health agency, has extensive experience in working with the underserved. This agency worked with academia very closely from the outset of this idea and has stayed involved in every aspect through its membership on the board of Reach Out.

This program thus highlights a positive outcome of public health–medicine collaboration. These and other partners developed and implemented a method of health care delivery that brings voluntary practicing physicians and other health care providers into settings where they provide direct health care to the underserved in the communities. The program identifies and uses the "untapped benevolence" of physicians in the community and provides a structure with minimal constraints. The program has 4 major objectives: (1) assessment of needs, (2) identification of resources, (3) development of a delivery system, and (4) long-term program stability.

Strategies

Several strategies were developed to address critical barriers: financial, educational, physical, and legal.

Financial barriers. Free care for the underserved and working poor was provided. In addition, the possibilities of reimbursement from a sliding scale, Medicare, and Medicaid were explored.

Educational barriers. Community health advocates, churches, schools, social services, and other community organizations addressed the concerns related to the lack of knowledge of resources and ways to gain access to them. An effort to decrease the use of emergency rooms was important and was addressed by better informing clients about existing resources and how to gain access to them. The emphasis was on prevention and wellness. Information was provided to physicians on available resources and their expanded involvement in the program so that they could make better referrals to their patients.

Physical barriers. Two neighborhood health centers were selected as the first model sites. These centers, located in the underserved areas of Dayton, are on public bus routes.

Legal barriers. Legislators at the local and state levels were educated to help make volunteer care more risk free. In addition, it was important that providers knew of existing limitations and proactive efforts to eliminate them (i.e., extension of Good Samaritan statutes and working with malpractice carriers).

Outcomes

During the course of the program, we met all 4 objectives. To help develop a system of ongoing assessment of the underserved population's needs and barriers to health care, the Community Health Advocate program was established. Community health advocates were selected from the community and trained to help make referrals and gather information from clients. This program helped gather data quickly and develop an assessment system to identify the barriers to health care in the community. In a door-to-door survey, 1890 persons were interviewed and 413 surveys were completed. The data collected indicated that the working poor are more likely to be without health insurance than the nonworking poor (44% vs 18%). Ninety percent of the people surveyed were unaware of special medical services with reduced or waived costs for the poor. Sixty-three percent of the people who had insurance still found it difficult to pay for medical care.

Several activities helped in developing a system of available resources. A medical society survey of member physicians was conducted to assist in identifying those interested

in the program. This process of assessment, identification, and involvement of physicians was nonjudgmental and without pressure. Focus group discussions similar to the initial partnership discussions were held to obtain more in-depth information. The partnership expanded to other organizations to identify and involve practicing physicians. Many physicians were recruited for the program by capitalizing on personal relationships. Finally, a database of available resources was developed that could be used to improve access to health care for the underserved. Medical students (n=38) benefited by working alongside faculty physicians who volunteered for the project or by assisting with patient intake and medical histories. Our survey of these students showed that they value highly the experience of working with the underserved. It has sometimes been difficult to accommodate all of the students who show an interest in volunteering at the Reach Out clinic.

To develop and implement a model of service delivery for providing care to the underserved that focused specifically on voluntary care by physicians, the partnership focused on the outcomes from the first 2 objectives, assessment of needs and identification of resources. To shift from a system in which many individuals in underserved communities could not gain access to health care to a new system in which these same individuals would receive health care at no cost took a great deal of commitment on the part of private physicians and others in the health professions to volunteer their services. In addition, the commitment of time and resources from the community, as well as the breaking down of barriers to health care, was necessary in making this change in the system.

Two model sites were established that used neighborhood health centers in east and west Dayton to meet the health needs of the African American and Appalachian citizens of those communities. A multiprofessional approach to health care was used, and a support system was established for the provision of volunteer care that included a coordinator, nurses, medical assistance, and social workers. Two area hospitals, Good Samaritan Hospital and Miami Valley Hospital, also provided strong support that included cost sharing, space, and supplies for the program. From March 1, 1995, through July 31, 1998, Reach Out took care of about 2500 patients, with a total of about 3500 visits. Two hundred fifty-six volunteers, including 136 physicians (both primary care and subspecialty), and 20 agencies contributed to the success of Reach Out during this time. A summary of the patient population served is as follows: 27% of patients were from birth to 18 years of age, 56% were aged 19 to 45 years, 16% were aged 46 to 64 years, and 1% were 65 years and older; the ethnic composition was primarily White (41.2%) and African American (41.1%); and 40% were male and 60% female.

We used a simple formula to show the hospitals how much money Reach Out clinics might have saved for these institutions. Our patient survey showed that 62% of the patients would have gone to local emergency rooms if there had been no Reach Out clinic. The average cost of a nonemergency visit to an emergency room was $297. The number of potential patient visits to local emergency rooms was therefore 62% of 3500 visits, or 2170 visits. The total cost to local emergency rooms would have been 2170×$297, or $644 490. This was a crude estimate, but it did bring a message to the hospitals about the potential savings. We also know that we significantly underestimated the value of the care we provided, as this dollar value does not include the value of services provided by subspecialty care, laboratories, x-rays, and procedures. We also did not calculate the value of all volunteer work. It does show that with a budget of approximately $75 000 a year (the Robert Wood Johnson Foundation grant was $300 000 for 4 years), Reach Out provided significant services to the community and reduced emergency room visits. Incidentally, the Robert Wood Johnson Foundation found this estimate of cost savings very helpful.

We gave high priority to the efforts to sustain the program beyond the grant period by forming committees focused on fund development. We raised funds via a letter-writing campaign geared toward physicians and by having a yearly basketball game between physicians and lawyers. We also received other grants over the years to sustain this program. Now, with the significant financial commitment of a local hospital (Miami Valley Hospital) and a university (Wright State University), the longevity of this project seems assured. Our success in securing these funds results from the community's interest in the survival of this worthwhile initiative.

In summary, the Reach Out program provides a model that other communities can adopt to meet the needs of the uninsured. By bringing together diverse partners and capitalizing on the strengths and "untapped benevolence" of providers, the program makes a difference. □

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