Reach Out: Physicians' Initiative to Expand Care to Underserved Americans

An RWJF national program

**SUMMARY**

The Robert Wood Johnson Foundation (RWJF) launched *Reach Out: Physicians' Initiative to Expand Care to Underserved Americans* in 1992. The program's aim was to:

- Complement publicly funded safety net providers, such as community health centers.
- Expand the private sector's capacity to care for the medically underserved.
- Promote the creation of physician-led systems of indigent care supported by partnerships with local providers and other community-based organizations working with the poor.

RWJF authorized $15 million in funding for the program, to begin in March 1993, later (1995) reducing the amount to $12 million.

**The Program**

During 1993–1994 *Reach Out* received over 400 project proposals from doctors' groups. Of these, the national program office selected 40, representing a variety of proposed site models. All sites selected had a commitment to increasing access to care, leadership by practicing physicians and evidence of community support. *Reach Out* placed particular emphasis on selecting sites that relied on voluntarism. Sites were variously located: from large metropolitan areas to remote locations in Maine and Montana, and five projects were statewide.

The selected projects received funding in two stages. In a planning stage, RWJF provided each project site a one-year development grant of up to $100,000. At the end of this development period, grantees were eligible for three-year implementation grants of $200,000. One site dropped out after 12 months.

Each of the 39 implementation grantees established partnerships with primary care providers, hospitals, health departments, state agencies and others. Under the direction of H. Denman Scott, M.D., M.P.H., the national program office at Memorial Hospital in
Pawtucket, R.I., provided ongoing administrative direction and technical assistance to these projects.

The 39 implemented projects fell into seven model categories. The two most common models, the free clinic (10) and the referral network (16), accounted for two-thirds of the total number of projects. Other projects were modeled as combined clinic/referral networks, rural primary care networks, public health private partnerships, managed care look-alikes, and insurance look-alikes. Many projects had elements of two or more models.

**Key Results**

As cited in the *Journal of the American Medical Society (JAMA)* in January 2000, 11,252 physicians participated in *Reach Out*, providing care to the underserved via their community's site. Some 199,584 people received medical care through *Reach Out*. Not all patients were uninsured; some were enrolled in Medicaid and the care provided was not on a volunteer basis.

Put differently, approximately 2 percent of U.S. physicians volunteered to treat 0.5 percent of the nation's uninsured, under *Reach Out*. Service to these nearly 200,000 patients cost about $60 per patient (based on the total $12 million RWJF program cost). A significant number of these patients were provided ongoing medical homes throughout the three-year implementation phase of the program, while others received specialized care such as surgery or costly tests.

In the view of the national program office, perhaps the single most important accomplishment of *Reach Out* was its documentation of physicians' capacity and willingness to lead community-wide efforts for the medically underserved.

The program also demonstrated the capacity of communities to develop and run programs for the medically underserved that suit their local needs and resources.

According to the national program office, there were two unexpected discoveries:

- The universal difficulty, among the underserved in *Reach Out* projects, of maintaining oral health.
- The difficulties, mainly financial, of these underserved in securing needed pharmaceuticals.

At the conclusion of *Reach Out* in the fall of 1999, the national program office judged that 21 of 39 implemented projects were "stable," that is, expected to exist for at least two years beyond RWJF funding. Another 14 were classified as semi-stable, or coping with problems but with some chance of continuation beyond RWJF funding.
In a 1999 analysis, the national program office concluded that collaboration with safety net agencies was a key ingredient of project sustainability.

This report provides more comprehensive details about 10 sites (see the Project List). These 10 sites were selected by RWJF, the project evaluator and the national program office to highlight the variety of operating structures by which community based care models can be made to work.

**Evaluation**

Irene M. Wielawski, a former investigative reporter for the *Los Angeles Times*, conducted an evaluation of the *Reach Out* program for RWJF. Her conclusions, listed in more detail in the body of this report (see Program Evaluation as well as Lessons Learned), included the following:

- The willingness of health care professionals to help people regardless of their ability to pay is alive and well, particularly with community backing—for example administrative or case management support.
- Health care systems and health care improvements for the medically underserved must have strong local input.
- In providing community based care for the medically underserved, there is no one-size-fits-all model.
- Not only local leadership and local chemistry, but also local history appears far more predictive of success of a community health care effort than the actual architecture of the model being used.
- The quality of the project manager is critical to the success of any volunteer program to aid the medically underserved.

Writing in the January 2000 article in the *Journal of the American Medical Association* (JAMA) cited above, *Reach Out’s* national program director, Scott, concluded that:

- "The *Reach Out* experience illustrates a variety of approaches to care for the underserved. All of these models can work. Success has been most difficult in urban centers, where the numbers of underserved were vast."
- "Which model a community might choose to pursue depends on local circumstances, including the background and inclination of local physician leadership and the availability of other services in the community."
- "Programs need a funded administrative structure. The tasks of recruitment, scheduling, marketing, information management and case management require paid staff. The staff need not be large to be effective."
For a more comprehensive summary of findings about Reach Out, from JAMA and other sources, see Lessons Learned.

Communications

Media coverage of Reach Out included, an extended commentary appearing in the Los Angeles Times, the Houston Chronicle and Newsday, in 1994, and a feature article in the Boston Globe Magazine, in 1995. (See the Bibliography for further details.)

Afterward

Upon the close of Reach Out, RWJF established Volunteers in Health Care, a national, nonprofit resource center to make use of the lessons learned under Reach Out, and thus aimed at assisting volunteer-led health care initiatives serving the uninsured. Volunteers in Health Care makes available specialized products such as patient tracking software, as well as "field reports," short compendiums of advice, some written by former Reach Out site volunteers and many others written by non-Reach Out sites, outlining the "how to's" critical to starting or expanding programs for the uninsured. A valuable tool developed under Reach Out and available through Volunteers in Health Care is "RxAssist", a continually updated, searchable database detailing more than 100 pharmaceutical companies' patient assistance programs. Available at www.rxassist.org, it is already in wide use helping address the difficulty of obtaining affordable drugs for patients who cannot afford them. RxAssist has grown from 150,000 hits per month in 2000 to 2.6 million hits per month in 2005. RWJF has continued support for RxAssist through December 2005 (ID# 053639). The project has established a business plan and program generated income is expected to support approximately 50 percent of continuing operations in 2006.

THE PROBLEM

According to the January 5, 2000 article in the Journal of the American Medical Association, "Physicians Helping the Underserved: The Reach Out Program," "studies have demonstrated that the uninsured have difficulty getting medical care, that when they are hospitalized their illnesses and injuries are far more acute and advanced than those of people with insurance and that the mortality rate is higher for uninsured than for insured persons." In the early 1990s, the number of medically uninsured individuals in the United States approached 37 million and was growing fast (it was to exceed 44 million, according to some estimates, by 2000); according to an RWJF-funded study by the Institute of Medicine, 75 million Americans went without coverage in 2001–2002.

Studies also have shown that both a higher risk of being sick and a greater probability of being among the uninsured fall on people with low income. Ironically, those with low income face at least two other burdens. Programs such as the federal State Children's
Health Insurance Program (SCHIP) and state Medicaid programs—which are voluntary and means-tested—demand that people accomplish considerable, and detailed, paperwork to qualify. In contrast, people with access to health insurance offered by employers or Medicare are unfettered by the extensive enrollment paperwork required by the means-tested programs, including proof of work status, income level, marital status and level of family in-kind support, all of which have to be proved again during periodic recertifications often required of recipients.

Available health care is not a universal panacea, and lack of insurance is not the only barrier to access to health care. Some families, however, can be so overwhelmed by medical bills that they simply stop seeking needed medical care. Others may have enrolled in Medicaid but find that providers in their community will not accept their insurance cards. In addition, some may be Medicaid beneficiaries who can locate a provider but do not have access to transportation, cash for medications or other resources they need to obtain proper care. These circumstances often result in discontinuous and uncoordinated medical care for significant numbers of patients.

Other factors are also related to care, or lack of care, for the uninsured:

- **Many physicians are disinclined to treat the uninsured.** Despite some evidence of unused physician capacity nationally, and a long-standing tradition in which physicians provided "charity care," by the early 1990s a majority of physicians appeared unable to or dissuaded from helping the medically underserved. A number of factors appeared to influence their choice, including: the escalating cost to physicians of providing such care, limitations placed on physicians' time by the demands of managed care systems, the location of the uninsured and a reluctance on the part of most physicians to commit to serious voluntary efforts for fear of being swamped by charity cases.

- **A counterpoint of care for the underserved.** As if in counterpoint to physicians' lack of effort, in recent decades a number of community institutional forums were developed to serve the uninsured of this country. They include community clinics specifically for the uninsured, Federally Qualified Health Centers (which are local clinics serving low-income individuals and families that meet federally defined standards of service), systems of indigent care integrated into hospital-based outpatient services, community health departments that operate free or low-cost clinical care through public health clinics and, more recently, county or municipally-based HMOs designed to provide services to the uninsured.

- **Universal health care...any minute.** By 1992, the nation appeared to look optimistically toward legislative proposals introduced by the Clinton administration to create comprehensive health care reform and universal coverage. At the same time, many within the health care community still felt it would be necessary to bridge gaps in access while the country awaited federal and state solutions to the lack of health care for the uninsured and the underserved—that is, to serve people with newly-
minted public insurance who nevertheless lacked access to a full continuum of care. In 1994, however, comprehensive reform in the form of the Clinton administration's Health Security Act was defeated. From that point on, there was no foreseeable national health care reform. Instead, there were private sector developments—the explosive overhaul of health care financing and delivery, which was much documented and known as "the managed care revolution."

- **The ethical dilemma of physicians.** Thus, as the 1990s unfolded, government and the health care and insurance industries looked to competitive market forces as a solution for many problems that beset U.S. health care. This growth in managed care, however, led to little or no competition among health plans and HMOs to enroll the uninsured. The voices of physician advocates for the uninsured, among others, were largely ignored. The situation flew in the face of—according to the *JAMA* article cited above—"the ethical principle to care for people in need regardless of station or income, [which] has informed the medical profession for centuries."

- **Overcharging the uninsured.** This overhaul, and the discounts in care pricing achieved by health management organizations, did not, on the whole, apply to the uninsured, who were most often quoted a full (and inflated) price for medical services—doctors, hospitals, equipment, drugs and recovery therapies. The result, during the 1990s, was predictable. Writing in *Health Affairs* in October 2000, Reach Out evaluator Wielawski commented: "a joint survey in 1997 by the Henry J. Kaiser Family Foundation and the Commonwealth Fund found that prohibitive cost led 55 percent of the uninsured to postpone care…30 percent to skip treatment entirely, and 24 percent to not fill prescriptions—all of which can lead to far more complicated and costly illness. The gap in drug prices alone for people with and without health insurance nearly doubled between 1996 and 1999, according to a government study." Overcharging, in fact, had become one of the many unintended and largely overlooked results of a decade-long obsession with curbing health care costs. Interest groups—representing government, employers, insurers, hospitals, medical equipment vendors and health care professionals—had fought vigorously to protect their interests. As Wielawski put it, "the uninsured, with no organized voice, emerge as losers."

- **A trend: a collaboration of medicine and public health.** Looking back from the vantage point of 1997, the Center for the Advancement of Collaborative Strategies in Health, part of the New York Academy of Medicine, noted in a published study that medicine and public health professionals were beginning to turn to each other as partners in order to influence the shape of the changing national health care system. These collaborations often involved providing care for the uninsured and underserved. Their interest in collaboration could be seen as a consequence of several factors affecting the decade of the 1990s in this country:
  
  — Market forces ("the managed care revolution") were reducing excess system capacity, for example by imposing substantial payment discounts (to those...
treating the insured), or by a variety of mechanisms shifting the risk of such treatment to providers.

— Government was privatizing health care by moving publicly insured patients into private health plans.

— Federal health care authority was increasingly devolving to the states.

PROGRAM STRATEGY AND DESIGN

RWJF entered these troubled waters with a $12 million, five-year program called *Reach Out: Physicians' Initiative to Expand Care to Underserved Americans*. Launched in September 1993, this relatively small program encountered rough going in its six-year life, tossed like other players in health care by the political and economic turbulence of the 1990s: the failure of national health care reform, the bruising marketplace free-for-all that followed, the rise of managed care and, during the late 1990s, uncertain signals from Washington about the future of Medicare and Medicaid. Nonetheless, 39 of the 40 Reach Out projects survived to implementation, and some proved nimble at using their small size and relatively loose structures to take advantage of opportunities presented by change.

Program Objectives

The *Reach Out* program had a twofold goal: (1) to foster local experiments on how best to deliver health care to the underserved, particularly trials of models that would not pay for physicians' time; and (2) to complement publicly funded safety net providers, such as community health centers, and expand capacity in the private sector to care for the underserved, in however modest a way. Although private physicians historically have delivered charity care in their offices, this traditional case-by-case provision of care has been largely invisible to the public. *Reach Out* promoted the creation of physician-led, organized systems of indigent care supported by partnerships with providers and other community-based organizations working with the poor.

*Reach Out* had four key objectives:

- Increase the number of private physicians who provide care to the medically underserved.
- Substantially increase the number of underserved people receiving timely and appropriate care from their community's private physicians.
- Establish partnerships between projects and local primary care providers, hospitals, health departments, state agencies, and others to:
  - Collaborate in the provision of health and social services.
— Reduce the financial, administrative and policy constraints on private physician care for underserved people.

- Take actions to sustain project operations after the conclusion of RWJF funding.

Acknowledging the realities addressed—roughly 37 million medically uninsured in 1993 as Reach Out began and 41.2 million in 2001—the program was designed only to point the way to possible solutions, and could at best make only a modest dent in this problem. As Reach Out's Director Scott said: "a major expansion of Reach Out would not solve the growing problem of access to health care. One thousand organized programs, performing as the Reach Out projects have on average, would provide care to about 5 million uninsured and underserved persons, [only] a small fraction of the large national problem."

**THE PROGRAM**

**Two Program Stages**

*Reach Out* unfolded in two stages. In the first, RWJF awarded one-year planning and development grants of up to $100,000 apiece to 40 groups from a pool of over 400 applicants. At the conclusion of their planning grants, grantees applied for the second round of funding, a $200,000 implementation grant. Planning and implementation money was to be used in building projects, not for the direct treatment of underserved patients.

- **Planning:** In this step the national program office (under grant ID#s 021235, 022198 and 024002) developed guidelines for prospective sites, conducted site visits, evaluated proposals for funding and conducted other preparatory activities. The national program office issued calls for proposals for planning grants in two rounds: round one resulted in 244 proposals, from which 22 sites were selected to receive planning funds in June 1994; an additional 18 round-two sites were selected out of 144 proposals in July 1995.

- **Implementation:** During implementation, 39 grants were awarded for sites following a successful year of planning: 22 grantees in August 1995, and 17 (all round-one grantees and all but one of round-two grantees) between July and November 1996.

Twenty sites concluded their implementation funding in July 1998; 19 more in 1999.

**Site Selection and the National Advisory Committee**

RWJF appointed a National Advisory Committee to choose *Reach Out* grantees. Chaired by James G. Nuckolls, M.D., a physician from rural Galax, Va., the 14-member National Advisory Committee was composed of physicians and administrators experienced in the design and implementation of innovative models of care for the underserved. Members of the National Advisory Committee continued their involvement in *Reach Out* throughout
the life of the program, offering advice when requested, participating in site visits and attending conferences for project leaders. For a list of National Advisory Committee members at the close of the program in 1999, see Appendix 1.

**Key Elements of Reach Out**

- **Limited formal restraints on project design.** According to the chapter on the program in the 1997 *To Improve Health and Health Care for All Americans*, since Reach Out was meant to foster local experiments for delivering health care to the underserved, the National Advisory Committee did not require a specific model, thus allowing applicants to design projects that made sense and were feasible within local health care systems. Applicants could select one or a combination of populations to serve, including the uninsured, those on public insurance (e.g., Medicare or Medicaid) or a special population such as the homeless. Selection strongly favored applications based in volunteerism. One restriction placed on applicant—that no grant money could be used to pay for the treatment of underserved patients—encouraged grantees to reorganize their communities' existing resources into a system from which greater numbers could benefit. Finally, Reach Out expected grantees to find permanent, local funding after four years of RWJF support (one for planning, three for implementation).

- **Medical organizations in the lead role.** RWJF, through the National Advisory Committee, required that medical organizations representing physicians in private practice take the lead in directing the projects. Applicants could be local or state medical societies, primary care associations, large group practices, hospitals that included office-based attending physicians or other medical groups, including nonprofit or religious organizations. Federally funded community health centers were not candidates for funds as Reach Out sought to supplement, rather than directly support, publicly funded entities. Projects were concentrated in the northeast, southeast and western United States. See Appendix 2 for a complete list of funded projects. See the Project List for the 10 projects on which Program Results reports have been written.

**Common Challenges Faced**

These projects faced a common set of challenges. They had to recruit and schedule physicians to provide care and arrange for the laboratory, diagnostic and pharmacy services that enable physicians to practice effectively. For all projects, addressing patients' oral health and obtaining pharmaceuticals turned out to be special problems. Each project's staff had to know the prospective patient base and make the project known to those patients. Language competencies, transportation of patients and the complex social and financial problems of patients emerged as frequent challenges. Staff had to determine eligibility requirements and decide how extensively and how often to verify eligibility. Tracking both patients and providers required several of the projects to
computerize data. Skill in working with community groups and finding local sources of support in dollars, or in-kind, was also essential. Dealing with such issues required extensive knowledge of administrative and other nonmedical services.

Practicing physicians who assumed leadership roles in these projects typically did not have the time to undertake nonclinical tasks. In developing its strategy to deal with these challenges, the national program office asked physicians to provide project direction and to use the grant funds to recruit the extra, unpaid participants required to develop an effective program. Staff also used grant funds to hire some full-time staff, purchase computers, develop or adapt software and so forth. The result was a variety of community-based models. Roughly grouped into seven categories, these models—or types of project—are sketched in some detail under Models of Care in the Results section. Ten are described in Program Results reports. (See links in the Project List.)

National Program Office

The national program office, which administered the Reach Out program, was housed initially at the American College of Physicians, Philadelphia (March 1993 to July 1994); then at Brown University's Center for Gerontology and Health Care Research in Providence, R.I. (August 1994 to July 1995); and finally at Memorial Hospital, Pawtucket, R.I. (August 1995 to October 1999). H. Denman Scott, M.D., M.P.H., an internist who is Associate Dean at Brown University School of Medicine, headed the program. Its initial deputy director was Melinda L. Thomas, M.S. Beginning in 1997, Johanna Bell, M.P.H., moved up to deputy from a position as Reach Out's communications director. The national program office had a variety of responsibilities:

- To conduct oversight of all projects, including performance monitoring and communication of recommendations to address problems identified through site visits and telephone contacts.
- To create a management information system to aggregate data reports flowing from each project.
- To promote networking and collaborative problem solving among project leadership in the field, including the promotion of regional meetings for site leaders to share experiences and ideas.
- To disseminate information to a wider public about Reach Out projects.

During Reach Out, the national program office made a number of collaborative gestures toward the American Medical Association (AMA), intended to foster joint ventures. According to the office, these did not prove fruitful. The national program office concluded, "This may be more due to the bureaucratic nature of the AMA than to any basic philosophical difference [between Reach Out and the AMA]."
Technical Assistance

The national program office provided technical assistance to sites primarily in five ways:

- **Annual conferences.** These were designed around the issues and questions most frequently encountered in the field each year. At the annual meetings, national program office staff encouraged networking—the opportunity for site staff to meet and share experiences—which the site staff found to be most valuable. (For details of the six annual conferences held from 1995 to 1999, see the National Program Office Bibliography.)

- **Site visits.** One or more national program office representatives participated in each of these approximately annual visits, ensuring ample opportunity for project staff to meet with the national program office and for the national program office to share requested information.

- **The Reach Out website.** Through the Reach Out website established in 1997 (and no longer operational), the national program office was able to convey administrative information and technical assistance to the sites, to facilitate networking among project sites and to draw their attention to the relevant work of other organizations.

- **Site reporting and review.** The national program office required all sites to submit quarterly and annual performance reports. The deputy director and a project liaison serving on the National Advisory Committee contacted sites after receipt of these reports to ask questions, review progress and assist projects with any concerns.

- **"Mini-grants."** The national program office awarded enhanced technical assistance grants ($2,500 each) to five projects, and travel stipends ($1,200 each) to six projects. The technical assistance grants advanced research efforts by the sites, such as market research to focus outreach to potential patients, or the development of a valuation model of a site's no-cost services, as was the case at the San Francisco site. The travel stipends were used for project-to-project visits.

As projects sought advice on how to build local coalitions, the national program office focused much of its technical assistance on helping projects establish partnerships with primary care providers, hospitals, health departments, state agencies and others. Over the five years of program implementation, the national program office found that the most helpful form of technical assistance involved the facilitation of networking; i.e. allowing grantees to learn from each other, particularly at annual meetings (and through site-to-site travel). Technical assistance, based specifically in the Reach Out sites' experience as well as the experience of thousands of organizations in the clinical volunteer community, is currently available to the public through RWJF's national resource program, Volunteers in Health Care, in the form of "field reports," surveys, forms and how-to manuals. See more about this resource program under **Afterward.**
Encouragement of Collaborations

The national program office encouraged project grantees to work with local chapters of medical societies. According to the national program office, 28 of the *Reach Out* projects had some kind of connection with a medical society, either local, state or specialty. Medical society linkages proved especially important for projects established as referral networks, since specialty physicians were more likely to be members of local medical societies and proved highly receptive to requests for volunteers. Grantees were also encouraged to form relationships with government, from state departments of human services to city and county health departments. Generally, these collaborations were less successful than the medical society connections, with some notable exceptions, according to the national program office. These exceptions are described under Public-Private Partnerships.

Site Visits

National program office staff and National Advisory Committee members participated in local site visits. During these visits, national program office staff conducted key informant interviews with the project director, project administrator and a third key informant, such as a local board member or physician volunteer. The national program office chose, during these visits, to act primarily as a sounding board. This approach appeared to encourage site staff to develop appropriate local solutions. National program office staff members were sometimes able to answer questions by sharing the techniques, processes and findings of a fellow project director or staff. One of the questions most frequently asked of national program office site visitors was, "Can you give us a national perspective on what other communities are doing, especially other *Reach Out* projects?"

Project Data-Gathering

Besides personal contact with projects via e-mail, phone, at annual conferences and at site visits, the national program office employed a number of formal techniques to keep abreast of, and assess, project development. These techniques included review of quarterly performance reports submitted by each project (which consisted primarily of qualitative information), and the semi-annual review of projects’ budget reports. In addition, three survey or questionnaire instruments were used; these were a minimum data set, a resource survey and a key informant interview. All are described in Appendix 3.

Impact of External Factors on *Reach Out*

At the inception of the program, in 1992–93, both RWJF and many of those who went on to start projects believed that universal health care coverage was imminent. As such, some of the projects were designed and perceived as stopgap measures until universal
health care came about. When this didn't happen, project staff members found themselves in the position of serving growing, rather than dwindling, populations in their communities. A number of external factors being played out nationally influenced, to varying degrees at the sites, the success and evolution of projects:

- **The "Managed Care Revolution."** In the mid-90s the development and proliferation of managed care impacted most projects. First projects in northern California and New England felt the effects of managed care, followed by projects in the rest of the country, with those in the southern states experiencing the last wave of change. While these effects cannot be explicated in detail here, at most sites, in varying ways, the rise in managed care had an impact on:
  - Volunteer generalist physician recruitment and retention, which became more difficult.
  - The amount of cost-shifting as well as the availability of health care resources at the local, state and federal level.
  - The size and diversity of the uninsured population.
  - The work pressure on primary care physicians (and—paradoxically—the ease of recruiting specialist physicians as project volunteers. National program office staff note that in some cases physicians were more interested in volunteering as a way to escape the pressures and paperwork of managed care.)
  - Competition for Medicaid eligible patients in states in which such populations as the homeless, young families and children on Medicaid were being directed into managed care plans.

- **For-Profit Conversion.** The conversion of community hospitals from nonprofit to for-profit entities was a dramatic and important environmental factor for many projects. In some instances such hospitals were local Reach Out partners but their commitment to the uninsured and the community, following conversion to for-profit status, became questionable. However, many projects found that nonprofits faced increasing pressure to quantify the free care given to the community, and this actually increased services and health care professionals directed toward Reach Out sites.

- **Erosion of Public Health Infrastructure.** Los Angeles was perhaps the most visible instance of such erosion, during the period of these grants. But it was not the only big city or region of the country where public health clinics began closing, services were cut and Reach Out projects lost collaborators and providers while struggling to cope with massive numbers of underserved patients.

- **Welfare Reform.** Welfare reform was a source of anxiety at many Reach Out project sites, as project staff anticipated large increases in the number of uninsured, low-income workers who would now be seeking care. Although none of the projects were able, according to the national program office, to document the increases in need for
health care as a direct result of welfare reform, media reports of increased demand on food banks and the rise of the uninsured by one million in the last year of the program, appeared to be strong indicators of an expanding population in need.

- **Voluntarism and the Uninsured.** The program, according to the national program office, benefited from the nation's growing interest in voluntarism as well as, paradoxically, its inability to reconcile the growing problem of the uninsured with governmental pressure to reduce and de-centralize social welfare and health care programs. These two factors helped the many projects gain media interest and widespread support from local governmental and private entities. For the national program office it created an opportunity to reach out to organizations interested in changing the status quo by increasing access to health care. Organizations seeking this kind of change may not have taken to local, volunteer-led initiatives if the political climate had offered a more "global" alternative through policy changes.

**Consultants**

During the five years of *Reach Out*, the national program office employed consultants in two areas: for tasks involving publicity, and for the establishment of an effective management information system. To assist with the communication tasks involved in (a) handling calls for proposals, and (b) disseminating information about the program through press releases and other forms of publicity, the national program office contracted with Burness Communications, a Bethesda, Md., firm specializing in publicity and other forms of information dissemination and Diana Creed, a communications consultant from Plainville, Mass.

To create an effective information system, the national program office employed Nancy Carpenter of Boston, staff at the University of Maryland, and Bob Goodman of New Orleans, La. In fiscal years 1998 and 1999, the national program office also employed a Brown University Medical School student in transcribing its key informant interviews and fact-checking its Minimum Data Set.

**RESULTS**

- **Physicians have the capacity and willingness to lead community-wide efforts for the underserved.** In the national program office's view, perhaps the single most important accomplishment of *Reach Out* was its documentation of physicians' capacity and willingness to lead community-wide efforts for the underserved, including, but not limited to, their enthusiasm for providing their time free of charge to care for patients who lacked the ability to pay for their services. According to program director Scott, "...the program also demonstrated the creativity and capacity of communities to develop and run programs for the underserved which suited their needs and resources. All 39 projects, whether or not they were ultimately successful or sustained, demonstrated resourcefulness in getting projects off the ground with
very little money; in procuring laboratory services, inpatient care and pharmaceuticals; in developing case management and tracking programs; and in navigating the complex issues of eligibility screening, physician recruitment, malpractice immunity and dozens of other issues. These many accomplishments could only occur through the development of innovative partnerships, methods and programs by the grantees themselves.” The January 2000 JAMA article, previously cited, concurred, but with a caveat concerning the sheer size of the problem addressed: "with strong physician leadership and a funded administrative core, organized community efforts can develop and sustain an effective program. Programs such as Reach Out cannot solve the national problem of access to health care, but they can make a small but important impact on the number of uninsured and underserved persons without access to health care."

- **Two findings of the Reach Out program were about problems that proved larger than expected, according to national program office staff:** (1) the universal difficulty, among the projects' underserved patients of maintaining oral health care; and (2) the difficulties, mainly financial, of these underserved patients in securing needed pharmaceuticals. These results may not have been discernable to national program office staff taking a project-by-project view, but emerged within the aggregate view of over three dozen projects.

- **There was relative success, at some sites, of efforts to encourage patients to adopt more healthful lifestyle practices.** Reach Out appears to demonstrate that giving patients support in a recommended lifestyle change after a doctor's appointment—usually by linking the patient to a community organization concerned with facilitating such change—can be very effective. According to the evaluator, a key element in this process, where it was effective, appeared to be follow-up calls in which the caller—not the doctor but rather a nurse or social service coordinator—guided the patient after the visit, or simply checked up on him or her.

- **On the national level, the national program office experienced difficulty with systems intended to collect data, to develop outcome measures, and to evaluate their program.** Sites were fully engaged enrolling physicians, caring for patients and seeing to all aspects of organizational survival. They tended to give short shrift to the collection of data, especially at the beginning of their projects. This difficulty diminished somewhat over the life of the program, but it undermined the national program office's ability to speak about the program's global success. On the local level, in some instances it also lessened the grantee's ability to present the results of their work as they sought funding to assure future sustainability.

- **As cited in the Journal of the American Medical Society (JAMA), 11,252 physicians participated in Reach Out projects in their local communities, providing care to the underserved and 199,584 people received medical care through Reach Out.** This meant a demonstrable cost of about $60 per patient over the life of the program (based on $12 million in RWJF funding). This cost per patient was not for a single office visit in many cases: a significant proportion of these
patients were provided ongoing medical homes throughout the program, while others received services such as surgery and costly tests. Overall, approximately 2 percent of U.S. physicians volunteered care (along with others) to provide care to approximately .5 percent of the nation's uninsured. Not all of the patients were uninsured; some physicians were caring for Medicaid patients through Reach Out and receiving a fee for doing so.

- At the conclusion of Reach Out, in the fall of 1999, the national program office judged that 21 of 39 projects were "stable," that is expected to exist for at least two years beyond RWJF funding. Another 14 were classified as semi-stable: coping with problems but with some chance of continuation. Because sustainability of projects was a primary goal for the program, it made sense to try to distinguish those characteristics of a sustainable project from those that would fail without foundation support. In 1999, the national program office conducted an analysis of nine project characteristics for their impact on project sustainability. The national program office concluded that collaboration with safety net agencies (such as child health care clinics, free clinics or community health departments), while not always easy to establish or sustain, was a key ingredient of project sustainability. For more details of this analysis, see What do Sustainable Systems for Indigent Care Look Like?

- Each of the 39 grantees established partnerships with primary care providers, hospitals, health departments, state agencies and others. Most had a connection with a medical society, local, state or specialty. About 40 percent of projects received federal, state or local funding. (For more information, see Public-Private Partnerships.)

Selected Community Characteristics

Project analyses in the rest of this section on overall results are drawn from an unpublished report, Innovations in Health Care Delivery for the Medically Underserved: Analysis of 39 Projects, by national program office staff and consultants A. Hornsby, S. Hanson and J. Walton.

One of the founding principles of the Reach Out program was that communities could create their own models for expanding access to care. Consequently, the design and activities of projects derived in large part from the license each project director was given in designing community-tailored service delivery systems that could both meet the needs of underserved populations and secure the support of providers.

The Reach Out projects were located in a broad cross-section of American communities. Most (23) served urban areas solely, with 16 located in areas with more than one million inhabitants. Five projects served exclusively rural populations. Projects were located throughout the country. The largest number of projects was in the South (15), followed closely by the West with 13 of the projects. Only 11 were located in the Midwest or Northeast.
States with Reach Out projects showed great variation in the percentage of their populations that was uninsured—with rates ranging from a low of 9.1 percent (Minnesota) to a high of 24.4 percent (Texas), and an average rate of 15.6 percent.

- Of the projects, 31 percent were located in states where the percentage of uninsured (averaged over a three year period, 1995 to 1997) was greater than 18 percent.
- 41 percent were in states where the percentage of uninsured was 13 to 17 percent.
- 29 percent were in states with fewer than 12 percent of the population uninsured.
- Projects in states with levels of uninsurance of 15 percent or more fared relatively poorly on socioeconomic and health status indicators—e.g., income levels and rates of child poverty and infant mortality.
- Project states with higher uninsurance rates also had lower levels of HMO penetration (the percentage of the population enrolled in health maintenance organizations), with the exception of California.
- The degree of managed care penetration also varied widely by project state from 1.9 percent of the population covered by managed care in West Virginia to 42 percent in Oregon. Average HMO penetration among Reach Out projects states was 23 percent.

All but one Reach Out project were located in counties with at least one-fifth of their territory designated as a medically underserved area by the federal Health Resources and Services Administration, although there was significant variation in the percentage of medically underserved areas in counties served by the projects.

- One county service area (Montgomery County, Md.) had no medically underserved area census tracts.
- Two projects served four counties with 100 percent medically underserved area designation (Gadsen, Jefferson and Wakula Counties in Florida and Cleveland County, North Carolina). Projects located in the South had the highest proportion of medically underserved area designations.

**Project Characteristics**

As the Reach Out initiative developed, it became apparent to the national program office that the 39 projects had operational similarities as well as differences. Differences could be extreme. For example, the number of physicians participating in a Reach Out project (as reported by each project) ranged from 3 to 3,366 in a project organized by the Colorado chapter of the American Academy of Pediatrics in Denver, Colo. Numbers of patients enrolled ranged from 13 to 19,207 in the "Commun-I-Care" project based in Columbia, S.C. Three more broad characterizations of Reach Out projects follow, derived from a study the national program office conducted in 1999.
Selected Project Organizational Characteristics

- 38 had at least one working relationship with a safety net institution; 23 had relationships with three or four types of safety net institutions.
- 28 had ties to local or state medical societies.
- 30 ensured access to comprehensive care.
- 23 always used means testing to determine patient eligibility.
- 21 offered services for free.
- 18 developed models in which physicians were not compensated for services.
- 17 were expansions of existing programs, while 22 were start-ups.
- 7 were faith-based.

Whom the Projects Targeted

- Age criteria:
  - All ages (23 projects).
  - Adults ages 18 to 64 (10 projects).
  - Children from birth to 19 years of age (six projects).
- Insurance status:
  - Uninsured only (18 projects).
  - Underserved (21 projects).
- Only special populations served:
  - Homeless adults (three projects).
  - Foster children (one project).
  - Families at risk for child abuse (one project).

Services Offered

- 37 projects offered access to primary care.
- 34 projects included ancillary services as part of their care.
- 31 projects offered patients a medical home, that is, they designated a health care professional, or health care office, as a patient's ongoing medical contact.
- 27 projects assisted patients in obtaining medications.
• 24 projects offered access to specialist care.
• 15 projects offered mental health therapy.
• 13 projects recruited more than 10 types of specialists.
• 11 projects recruited 1 to 10 types of specialists.
• 10 projects offered dental care.

Models of Care

Based on an analysis of its 39 sites that implemented a Reach Out project, the national program office distinguished seven structural models for care delivery. Not all projects fit neatly into one or another category; some had elements of more than one model; others evolved, starting in one model category and moving to another. The descriptions below are illustrated, in some cases, by operating sites.

• **Referral network.** By far, the most frequently identified delivery model among projects was a referral network coordinated by a central administrative entity (usually a hired manager and one or two assistants), in which physicians agreed to see project patients in their offices for free or for a reduced fee. Physicians either indicated the number of patients they would see (e.g., 10 patients a month) or agreed to a number established by the local project. Many projects offered both primary and specialty care through the referral network mechanism. An administrative component allowed for case management and the reduction of no-shows, and distributed patients evenly among physician volunteers. Sixteen projects fell into this category.

• **Freestanding clinics and combined clinic/referral networks** were the next most common models. Ten projects were freestanding clinics, and two more were combined clinic-referral networks. In clinic models, patients were seen by a combination of paid staff and volunteer physicians, nurses and other health care workers in a setting resembling that of any other health care center. In a combined clinic/referral network arrangement the network could include private practice physicians, public health clinics and hospitals. Some care (usually primary care) was delivered in a clinic setting, some in private practice physicians’ offices (usually care requiring a specialist) and some in hospitals. The arrangement offered patient services ranging from primary care to inpatient surgery. Many of the projects evolved into this model after having started with a narrower scope of services and list of collaborators.

• A small number of projects operated as public health/private partnerships or managed care lookalikes (six), insurance lookalikes (two) or rural integrated primary care networks (two). In addition, a single project stood alone as a model providing elective ambulatory surgery. Examples of each are described below.

  — **Public health/private partnerships** or managed care lookalikes. Ramsey County Physicians, the project in St. Paul, Minn. was a collaboration between the Ramsey
County Medical Society and the MetroEast Program for Health (a community based, nonprofit health care and outreach organization serving the eastern portion of the Twin Cities), to provide access to comprehensive health services for medically underserved residents of the east metro area of St. Paul. The project had two components. The medical society developed a specialty physician network, while MetroEast provided community-based access to the full continuum of primary health care services, including case management, for residents of low-income neighborhoods in Ramsey County. Patients were enrolled in the health plan and received care in the manner of a managed care operation. All such public health/private practice partnerships within Reach Out strengthened and/or expanded existing programs for the underserved, such as Medicaid, by adding public health nurses, case management/care coordination services and private practice physician services.

— **Insurance lookalike.** The Church Health Center of Memphis, Tenn., in partnership with the Memphis and Shelby County Medical Society, developed a low-cost health coverage plan ("The Memphis Plan") for employees of small businesses. Reach Out funding was used to expand all aspects of that plan. The program encouraged local employers to insure their minimum-wage workers by offering an affordable health plan that used local volunteer physicians to deliver care. Proceeds from the plan funded the administrative component of the project and helped assure its sustainability. (See Program Results Report on ID#s 027630 and 029993 for more project details.)

— **Rural integrated primary care network.** The Peninsula Primary Care Associates in Blue Hill, Maine, represented a hospital-based physician group practice created among Blue Hill Memorial Hospital and four private practices located in an eleven-town area of rural, coastal Maine (population 18,000). The physicians saw all patients regardless of ability to pay. The project established an organized delivery system that supported physicians and served to increase physician retention in the area. (See Program Results Report on ID#s 024546 and 027436 for more project details.) Rural integrated primary care networks attempted to assure medical homes for all area residents as well as reduce emergency room use by creating a not-for-profit corporation supported by private practicing physicians, hospitals and health centers in the rural area.

— One project provided **elective surgical care** for people who would otherwise go without it because of lack of insurance or financial resources. Surgeons of the Ambulatory Surgery Access Coalition of San Francisco provided such procedures as hernia repair, varicose vein removal and biopsy or removal of soft tissue lesions. All services and supplies were donated. This required enlisting the entire surgical team, as well as operating room time. (See Program Results Report on ID#s 024544 and 027434.)
**Reach Out to Just the Uninsured or Also Serve the Insured**

Twenty-five projects (64 percent) created or partnered with systems that only provided care to the underserved. These included five of seven Reach Out clinics providing free services, 12 of 18 referral networks, all seven combined clinic/referral projects and one of the five managed care lookalike projects. In contrast, 14 Reach Out projects (36 percent) chose to embed their care systems in organizations that also served the privately insured. These included two of the seven free clinics, six of 18 referral networks, four of the five managed care and insurance lookalikes and both rural integrated primary care network projects.

Table 1 examines how Reach Out’s projects—divided between these 25 projects helping the underserved only, and the 14 embedded in organizations serving the privately insured—differed in terms of project management, available services, financing and partnerships.

**Table 1**

<table>
<thead>
<tr>
<th>Project characteristics</th>
<th>Project created or partnered with a delivery system serving only the medically underserved (25 projects)</th>
<th>Project embedded in a delivery system also serving the privately insured (14 projects)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County medical society helps with recruitment</td>
<td>38%</td>
<td>23%</td>
</tr>
<tr>
<td>Uses innovative recruitment (e.g., fulfills community service requirement)</td>
<td>32%</td>
<td>7%</td>
</tr>
<tr>
<td>Physicians compensated for service</td>
<td>40%</td>
<td>78%</td>
</tr>
<tr>
<td>Physicians agree to accept a certain number of patients</td>
<td>72%</td>
<td>43%</td>
</tr>
<tr>
<td>Case management used</td>
<td>64%</td>
<td>86%</td>
</tr>
<tr>
<td>Large board (10–36 members)</td>
<td>72%</td>
<td>50%</td>
</tr>
<tr>
<td>Frequent board meetings (monthly or more often)</td>
<td>40%</td>
<td>21%</td>
</tr>
<tr>
<td><strong>Services Available</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty care</td>
<td>64%</td>
<td>50%</td>
</tr>
<tr>
<td>Mental health</td>
<td>36%</td>
<td>43%</td>
</tr>
<tr>
<td>Dental</td>
<td>36%</td>
<td>7%</td>
</tr>
<tr>
<td>Assistance filling prescriptions</td>
<td>32%</td>
<td>36%</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third party payers</td>
<td>16%</td>
<td>57%</td>
</tr>
<tr>
<td>Patients pay something for services</td>
<td>44%</td>
<td>50%</td>
</tr>
</tbody>
</table>
This table reveals marked differences in governance patterns between the two types of projects.

- Much higher proportions of the underserved-only projects had larger, working boards that were involved in project fund-raising. The national program office speculates that this was perhaps indicative of an emphasis placed on mobilizing broader community interest.

- Underserved-only projects also seemed to place more emphasis on recruitment: a higher percentage had medical society support and used innovative techniques such as arranging for Reach Out service to fulfill community service requirements established by the physicians' employers, or using a broadcast fax technique combined with videos and outreach via professional and community meetings. In fact, all six of the projects that established official recruitment committees were underserved-only projects (not indicated in table).

Patterns of financing Reach Out projects varied dramatically between the two approaches.

- The projects embedded in a delivery system also serving the privately insured were distinguished by the high proportion of third party payer arrangements, supplemented by patient payment in half of these projects.

- In contrast, underserved-only projects relied much more heavily on their communities' financial support.

- In addition, a higher proportion of underserved-only projects receive financial support from individual sources (for example, government, nonprofit and/or foundations), and more of these projects successfully established a portfolio with multiple types of donor organizations (four to seven types), unlike most embedded projects.

Finally, in terms of public-private partnerships, the underserved-only projects had a far higher proportion of working relationships with safety net organizations, which have decades of experience with giving health care to the poor.
Engaging the Physician Community

The Reach Out initiatives recruited, in sum, 11,252 physicians to provide care to their communities' uninsured. Given the restraints on physician volunteerism, projects needed to be creative and persistent in their efforts at physician recruitment. The projects used three strategies to engage the physician community in providing care to the underserved.

1. **Develop effective physician outreach by cultivating relationships with medical societies and using multiple marketing techniques.** Active involvement in a project by a medical society or specialty medical association was one of the most significant aids to physician recruitment. In fact, medical societies were the applicant institutions for 12 projects and housed nine. Recruitment efforts for 72 percent of the projects were supported by city, county or state medical societies or other organizations.

Several marketing techniques were used to recruit physicians, including recruitment committees, group presentations, one-on-one solicitations, "advertising" in professional publications, newspaper articles, videos, broadcast faxes and direct mail appeals. Although there was considerable variation across projects in the style and intensity of efforts to recruit physicians, the projects that recruited the most physicians employed three or more of these techniques. Almost 40 percent of the projects used four or more recruitment techniques to reach physicians in their communities. For example, the Reach Out project in Denver fielded a recruitment effort that combined phone contact, one-on-one meetings, direct mail and the provision of speakers for a wide range of professional meetings. The Reach Out Florida City/Good News Clinic arranged for physicians' services to the clinic to fulfill the community service requirement of the Baptist Health System.

2. **Identify and eliminate barriers to physician participation.** Potential physician volunteers for Reach Out seemed to be concerned about four issues: (1) unequal volunteer burden among physicians; (2) inconvenient treatment locations; (3) additional administrative burden; and (4) malpractice liability. Reach Out projects addressed these issues in a variety of ways:

   - **Creating a shared burden.** Some project directors remarked informally that in many situations the recruitment of physicians was more successful if the project made clear that all physician volunteers were asked to make a specific level of commitment to the project. This was especially important in recruiting specialists from fields for which there was a very large demand, such as gynecology, surgery and cardiology. Typically, project staff asked physicians to commit to see a specified number of Reach Out patients or to serve a set number of hours per month. This not only established clear limits to what the project would ask of each physician, but also communicated that the project was sensitive to the issue of burnout and the importance of equalizing the burden among all physicians. Twenty-four of the projects (62 percent) asked the physician recruits to agree to accept a certain number
of patients. Of the remaining projects one-half were either free clinics where doctors saw patients on a walk-in basis for a limited number of hours, or projects that were managed care lookalikes and rural primary care practices that handled the issue of workload distribution in other ways.

- **Offering choice and convenience of treatment sites.** Another issue for project design was whether to make it possible for physicians to accept *Reach Out* patients in their usual place of practice or whether to offer them a choice of where to see patients. Almost 60 percent of projects (23) arranged for physicians to see *Reach Out* patients in their usual places of practice. An additional nine projects gave physicians the choice of seeing patients in their offices or traveling to a setting outside of their place of practice. Seven projects recruited doctors to see patients in clinics away from their usual place of practice.

- **Ensuring minimal administrative demands on physicians.** *Reach Out* projects were aware of the need for regular staffing, in part because of physician concern about additional administrative burden from working with indigent patients through a program external to their practices. All but four of the 39 projects hired staff to provide administrative support. Two of the four projects that did not hire support staff had closed their doors by the conclusion of RWJF funding.

- **Addressing the issue of liability protection.** According to responses to a questionnaire administered by the national program office in late 1997, a variety of mechanisms provided malpractice liability coverage for physicians participating in *Reach Out* projects:
  - State legislation extended charitable immunity protection to volunteer doctors.
  - Physicians either fell under the liability insurance of another entity (i.e., county clinic, health department), or relied upon their own insurance.
  - Combination of A and B: many *Reach Out* physicians chose to self-insure despite the existence of state charitable immunity legislation.
  - The project's host organization paid for the physicians' malpractice liability insurance.
  - Combination of B and D: the project paid for those physicians whose personal insurance did not adequately protect them from malpractice liability for their volunteer service.

Several projects that purchased coverage for their physicians or reported that their physicians were self-insured or covered by another entity were, in fact, located in states with charitable immunity laws. National program office staff found that physicians tended to be wary of the protection offered by charitable immunity legislation, largely because the legislation had not yet been tested in the courts.
3. **Socialize future practitioners by involving students in care delivery.** A majority of projects used either residents or medical students as supervised volunteers for clinical services. Nursing students and social work students assisted in a number of projects. These projects either served as sites for student rotations or enabled students to work as volunteers in clinics (under clinical supervision):

- 22 projects used medical residents.
- 9 projects used medical students.
- 9 projects used nursing students (7 of these used both medical and nursing students).
- 7 projects used social work students (5 of these did not use any other type of student).

In particular, two projects—both homeless shelters that used *Reach Out* funding to enhance existing services—drew substantially upon academic partnerships. Both the *Reach Out* project of St. Vincent de Paul Village in San Diego (described more fully in the Program Results on ID#s 024562 and 027452), and the Louisville, Ky. project called the Healing Place, used residents as well as medical, nursing and dental students to provide volunteer services. St. Vincent's also included social work students and the Healing Place included podiatry students. The Healing Place further extended its involvement with students by creating a chemical dependency training module that became a required rotation for third year medical students at the School of Medicine-University of Louisville.

**Public-Private Partnerships**

According to the Access Project of the privately financed Center for Community Health Resources and Action, a majority of efforts to increase access to health care in the United States in 1999 were (and probably continue to be) organized as coalitions. The *Reach Out* projects, for the most part, fell into this category. In several locales, projects generated a particular kind of coalition: public-private partnerships between private physicians and public sector agencies and providers, including hospitals; state, county, or city health departments; and community health centers.

While 36 projects developed a relationship with a government entity—from state departments of human services to city and county health departments—generally these collaborations were less successful than those with medical societies (reported for 28 projects). There were, however, some notable exceptions. A North Carolina project sponsored by the Buncombe County Medical Society received funds from the county to purchase prescription drugs for its patients. Cleveland County, another North Carolina *Reach Out* project, was a collaboration among the local health department, hospital and county government, and is still in operation. Overall, 15 of 36 projects received federal, state, county or municipal funding. *Reach Out* projects located in major metropolitan areas...
areas, such as Los Angeles, Washington and Dallas, faced the greatest challenges in finding partners. Shortages of funds and services in these areas are so profound that it was difficult to engage collaborators for the relatively modest efforts of local *Reach Out* projects.

**Relations with Safety Net Providers.** Thirty-seven of the 39 projects had working relationships with at least one type of public safety net provider: city/county health departments, state health departments, federally qualified health centers (clinics serving low-income individuals and families that meet federally defined standards of service) and public health clinics. Twenty-eight of these had relationships with state agencies. See Table 2, below, which describes how projects ranged in their ties to safety net providers.

**Table 2**

<table>
<thead>
<tr>
<th>Projects in Relationships with Safety Net Providers</th>
<th>Number of Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>No safety net provider relationships</td>
<td>4</td>
</tr>
<tr>
<td>Relationship with one type of safety net provider</td>
<td>12</td>
</tr>
<tr>
<td>Relationship with two types of safety net providers</td>
<td>13</td>
</tr>
<tr>
<td>Relationship with 3 or 4 types of safety net providers</td>
<td>12</td>
</tr>
<tr>
<td>Relationship with 5 types of safety net providers (<em>Reach Out</em> West Virginia)</td>
<td>1</td>
</tr>
</tbody>
</table>

**Expanding Public Health Care Capacity.** The most common approach to expanding health care access among *Reach Out* projects was to expand the capacity of a public delivery system by increasing the number of providers and/or by linking public health nursing functions to clinical care in private settings. This augmentation worked both ways:

- **The private sector supplemented public sector capacity to deliver care.** *Reach Out* placed private-practice physicians into public sector clinics as volunteers (e.g., projects in Sacramento, Calif., Montgomery County, Ohio and Asheville, N.C.) and created networks of private physicians who would receive referrals from public clinics.

- **Public sector agencies supplemented private practice care capacity.** *Reach Out* helped link public sector employees to private practices (e.g., projects in Columbia, S.C., where public health nurses were assigned to physician offices and Montgomery, Ala., where care coordinators followed new mothers to ensure ongoing care with their volunteer private physicians).

**Relations with City and County Health Departments.** Commonly, projects developed relationships with city and county health departments. Typically, the relationships fell into one or more of the following categories:

- **Physician recruitment.** The *Reach Out* project in Asheville, N.C., "Project Access," recruited physicians to work in county-run clinics.
• Reciprocal service arrangements. The project in Baltimore, the New Song Health Center, had an agreement with the Baltimore City Health Department in which the health center provided primary care services for individuals referred from the city Sexually Transmitted Disease (STD) clinic and in return the city provided free HIV and STD lab services to New Song.

• **Shared service delivery.** The Shelby, N.C. project, CLECO Primary Care Network, collaborated with the county health department on several initiatives: linking public health promotion and epidemiological surveillance with clinical and case management services for patients with hypertension and diabetes; nutritional counseling; family planning services in physicians' offices; and a program in junior and senior public high schools. CLECO physicians provided back up and supervision of mid-level providers, served as a referral source and provided call coverage after hours and on weekends for the public school students.

• **Facilities use.** The Dayton, Ohio, project, Reach Out of Montgomery County, had an arrangement with the combined city/county health department to use two health clinics after hours to run free clinics. Volunteer physicians offered primary care in the clinics and could refer patients back to the public health clinics.

• **Service referrals and screenings.** Both San Francisco (Ambulatory Surgery Access Coalition) and Tallahassee, Fla. (Physicians' Outreach Project) received patients via service referrals and screenings from public health clinics. The San Francisco city clinics performed pre-surgery work-ups for ambulatory surgery patients, and clinics in rural counties outside of Tallahassee worked with the Reach Out project to conduct intake interviews and channel uninsured patients to the project.

• **Project enrollment.** The county health department assisted staff at Rockville, Md.'s Project Access in determining patient eligibility at a variety of satellite locations, and added data on Project Access patients to the county system. When patients were not eligible for public programs, they were enrolled in Project Access and billed according to a sliding fee scale. Once enrolled, patients received a county identification card and were assigned a physician. Project Access also helped patients maintain continuity of care by freeing up bottlenecks patients encountered in moving between levels and services in the county system and the Reach Out network. Five hospitals became part of the network by providing free or discounted services, and a Project Access billing code was established by the hospitals to signal cost write-offs.

**Two Innovative Examples.** These examples describe innovative public-private partnerships in two Reach Out projects.

• Sacramento, Calif.'s project, called SPIRIT: Sacramento Physicians' Initiative to Reach Out, Innovate and Teach, supported a partnership between county clinics and volunteer private physicians. The project both supplemented the primary care capacity of the county system by placing volunteer physicians in county clinics, and provided access to volunteer physician specialists. The primary care clinics referred
patients who needed specialist care to the project, which then screened for financial eligibility to determine which patients would receive appointments with specialists. Specialists then treated Spirit patients in their offices.

- Columbia, S.C.'s project, South Carolina Institute for Medical Education and Research, made its goal to support physicians caring for Medicaid pediatric patients. The project worked to create a model for a statewide program of public-private partnerships between local public health departments and private physicians. The partnership entailed assigning a public health nurse to the physicians' offices, with each physician having latitude in how to use the services of this nurse. Typical activities for assigned nurses were care coordination, home visiting, delivery of preventive services and health education. The state public health agency provided incentives to the local public health districts to set up these partnerships by offering them small grants. By 1999 there were 40 such partnerships in 23 counties. Toward the end of the Reach Out project, South Carolina created a program called the Healthy Options Program to give physicians an incentive to offer a medical home to greater numbers of Medicaid children: payments were increased by 40 percent. As physicians signed up for the Healthy Options Program, the state public health department distributed their names to directors of South Carolina's 13 public health districts. Each district was encouraged to contact these physicians and propose the idea of establishing a partnership.

**Case Management**

The Reach Out projects demonstrated that the underserved could benefit from organized systems of case management to address the health problems afflicting low-income people in the United States. As mentioned already, these problems included discouragement in seeking care despite health insurance because of the pile up of medical bills, discouragement in seeking subsidized medical care due to extensive paperwork requirements (for example, in qualifying for the federal State Children's Health Insurance Program, SCHIP), a shortage of providers accepting Medicaid payment, transportation issues and shortage of cash for medications.

To address these issues, Reach Out made case management a centerpiece of the initiative: 33 of the 39 projects (85 percent) incorporated some element of it, and 14 projects (36 percent) identified case management as a central feature of their project design. Anecdotal reports suggest that in many projects, case management was a significant, or the significant factor in physician recruitment and retention. A physician backed by an effective case management system could derive some assurance that patients would seek to obtain prescribed drugs, make and keep needed appointments, maintain contact with the health care system over time, even follow through on suggested changes in lifestyle, etc. Projects frequently found that uninsured patients—though unaware of this themselves—were eligible for publicly supported programs such as Medicaid or, because of disability, Medicare.
Projects' Case Management Goals. Two case management models are medical/clinical and community/social services. Elements of both proved important as Reach Out projects developed and refined their methods. Two general goals for case management across the range of Reach Out project designs emerged:

- **Goal 1: Coordinate service delivery and ensure continuity of care.** Projects achieved this goal largely by hiring case management staff. Nineteen projects (49 percent) had case managers (social workers, RNs, community health advocates and/or family support workers) who coordinated patient care across one or both of the following:
  - **Sites or care settings,** for example, physician offices, hospitals, county public health units, state health and human services agencies, community health centers or nontraditional delivery sites such as school health clinics or churches.
  - **Types of service,** for example, accessing not only medical care (primary and/or specialist care) but also other services including dentistry, nutritional counseling, mental health care, social services and/or community services (e.g. financial counseling, housing assistance or food banks).

- **Goal 2: Ensure appropriate care and appropriate use of health care resources.** This goal largely focused on the resources many patients served by Reach Out projects were (or were not) already using, for example, over reliance on the use of emergency rooms for primary care, or the lack of a referring physician in order to see a specialist. Projects achieved this goal largely by: (1) establishing a gatekeeper function (33 of 39 projects required that a patient see a primary care physician before being referred to a specialist; (2) performing utilization reviews (11 projects); or (3) delivering patient education (8 projects taught patients appropriate use of medical resources).

Several projects that developed innovative ways to attain these case management goals are described below:

- **The Child Health Access Project in Montgomery, Ala.** The project goal was to increase the number of Medicaid-eligible newborns receiving neo-natal care. Montgomery, at the time, had high rates of infant mortality and low-birthweight babies, and many walk-in deliveries, with little or no systematic neo-natal care. The project recruited pediatricians to accept the infants into their practices and hired care coordinators and a social work manager. New mothers were contacted in the hospital by the social work manager, who explained that they had care options in addition to the public health clinics, including seeing a Reach Out physician. In a departure from existing practices, care coordinators then made home visits and conducted risk assessments, which were used in part to determine the frequency of follow-up visits. Care coordinators also made appointments for the infants, provided families with transportation to the doctor's office and maintained communication with the physicians. One Reach Out care coordinator was situated at the public health clinic,
as some mothers preferred to continue seeing public health providers. (For a more detailed description of this site, see Program Results Report on ID#s 024551 and 027441.)

- **The Community Caring Project, in Dillon, Mont.** In a county of 5,542 square miles, project staff recruited all 14 physicians in the area and negotiated reduced fees for uninsured individuals they had identified. Project staff conducted outreach to families and screened and enrolled eligible patients in federal and state benefits programs (Medicaid, SSI, Montana BlueCross/BlueShield for children). Families ineligible for these programs were enrolled in the Reach Out project and provided with health care and case management. A social worker identified families at risk for treatable problems and worked intensively with them, including enrolling them where possible with social service agencies, filling out indigent drug program applications and providing financial counseling. The project had a special focus on chronic health problems, addressing a situation previously largely neglected in the area.

- **The Community Access to Health Care project in Lincoln, Neb.** One project goal was to reduce inappropriate use of emergency rooms (ERs)—transferring patients to Reach Out primary care where possible—by linking them to a public health nurse. Rural counties were grouped into three sectors and each was given a public health nurse liaison. Information on patients seen in hospital emergency rooms was faxed to the area's public health nurse within 24 hours. Using a scale developed by project physicians, the nurse assessed whether the ER visit was appropriate. The nurse then contacted each patient, discussing the care received in ER, reinforced any instructions given at the ER to motivate compliance and discussed discontinuing use of the emergency room for non-emergency care, if appropriate. People without a usual source of care were referred to a primary care physician in the network created by the project. The nurse also delivered health education and referred individuals to federal benefits programs such as the federal Women, Infants and Children program (WIC).

**What Do Sustainable Systems for Indigent Care Look Like?**

In the fall of 1999, the national program office staff classified the projects into three levels of stability, drawing on four years of knowledge about each project, site visits and the projects' annual and quarterly reports:

- 21 projects were classified as "stable"—that is, expected to exist for at least two years beyond RWJF funding;
- 14 projects were classified as "semi-stable"—these projects had problems but had some chance for continuation;
- 4 projects were "discontinued"—operations ceased before the end of the Reach Out initiative.

Table 3 ranks a number of characteristics of 21 "stable" projects.
Table 3

<table>
<thead>
<tr>
<th>Project Characteristics</th>
<th>Percent of 21 &quot;Stable&quot; Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had working relations with local public health unit</td>
<td>86%</td>
</tr>
<tr>
<td>Had support from more than one type of donor</td>
<td>71%</td>
</tr>
<tr>
<td>Targeted underserved only</td>
<td>67%</td>
</tr>
<tr>
<td>Project pre-existed Reach Out funding</td>
<td>62%</td>
</tr>
<tr>
<td>Received government funding</td>
<td>43%</td>
</tr>
<tr>
<td>Medical society assisted with physician recruitment</td>
<td>43%</td>
</tr>
<tr>
<td>Board met monthly or more often</td>
<td>43%</td>
</tr>
<tr>
<td>Used strategic planning</td>
<td>24%</td>
</tr>
<tr>
<td>Faith-based</td>
<td>19%</td>
</tr>
</tbody>
</table>

None of the four discontinued projects had any of the above characteristics. High proportions of the stable projects targeted only the underserved. They also had developed relationships with local public health units and had greater breadth of financial support.

Analysis cannot explain the disadvantages or advantages, vis-à-vis long-term sustainability, of a project's embeddedness within a delivery system also serving the privately insured. Informal reports received by the national program office indicated, however, that several projects that were embedded within a system serving the privately insured had difficulty locating enough people needing health care to make use of the physician services that the projects had recruited. These same projects also had no partnerships with safety net organizations, or were more likely to have weak connections.

Thus, it appears that collaboration with safety net organizations, which have had years of experience serving the poor, was a key ingredient for successful project design, recruitment of physicians and identification and enrollment of clients. In the case of 86 percent of stable projects, this collaboration was with a local public health unit.

The Impact of Projects on Their Communities and on Physicians

In the fall of 1998, the national program office asked project leaders about the impact of the Reach Out initiative in their communities. Although many acknowledged that Reach Out projects were just beginning to address a significant national problem, all concurred that projects raised awareness of the problem of the uninsured, or under-insured, within their community and tapped into physician eagerness to help the underserved.

One project director—a physician—remarked that Reach Out, which offered his first experience in working with the poor in his community, had transformed him: "A lot of people don't have the personal or emotional resources to deal with overwhelming health problems. Major barriers to access are patients' unawareness of what resources are
available to them or their inability to use the resources they do have. The social work support [under Reach Out] helps them get more appropriate care at a more appropriate time in a less expensive setting."

Project leaders noted that the initiative was often a catalyst for local action that provided a framework for thinking about and creating local systems of indigent care. As one manager put it, "without that [project] structure in place, we couldn't have done it."

The manager of another project remarked: "The grant allowed us to actually have personnel available to do the jobs that were not getting done. It allowed for planning and implementation of new concepts. Some of those concepts proved flawed, but the learning experience proved invaluable."

Another noted: "In holding meetings, we were shocked to realize that outside of physicians, there is a major lack of communication between people in local health care fields. Our meeting provided the first time that the CEOs of the two local hospitals sat down at the same table. Similar experiences occurred with meetings between dentists, social service agencies and insurance providers."

**Health Care as Civic Practice**

In an article entitled "Health as a Civic Question," published in 1994 (available at the website of the nonprofit Civic Practices Network), the authors suggest that health care should be thought of as one type of civic practice, by which they mean cooperative and participatory efforts—in this case, by health care professionals—to produce something of local value through public deliberation and collaborative problem solving. The Reach Out projects appeared to exemplify the practice of health care as public work or civic practice. If that is the case, then central to project successes, large and small, was the scaffolding of partnerships—between corporations and nonprofit agencies, between medicine and public health.

If one thinks of community as "a fabric of relationships created by public work"—as cited in another article from a bioethics forum on that same website, then it may be fair to say that involving private physicians for the first time in creating local, organized systems of care for the medically underserved resulted in the creation of new kinds of communities. In an unpublished report, the national program office speculates: "perhaps these new mini-publics of the uninsured and their caregivers will form groundswells of support for better state and national solutions to the problem of inadequate access to health care in the United States."
PROGRAM EVALUATION

Journalist Irene M. Wielawski conducted an evaluation on Reach Out over the period May 1994 through January 2001 (under RWJF grant ID#s 023910, 024341, 034807, 034942 and 038592). Prior to this evaluation, she was an investigative reporter for the Los Angeles Times. RWJF program staff chose a journalist as program evaluator after consideration, with national program office staff, of a suggestion put forward by the program director Scott not to employ traditional social science evaluation methods in this task. He believed that a journalist could best capture the defining stories of this program's community projects—including the plight of the uninsured—as well as lessons from the field about how to encourage physician volunteerism, and that this material might reach a much wider public. In order to fulfill this latter purpose, RWJF asked Wielawski to document her experience in the field as a book for the general reader.

In a parallel but more quantitative evaluative effort already cited, the national program office collected extensive site data on access to care and other aspects of Reach Out projects over the course of the program (see Results). Wielawski structured her more journalistic findings—based on interviews with site staff, community leaders and patients—as a number of articles appearing in national magazines and newspapers. (The Evaluation Bibliography lists these.) She has outlined a proposal for a book embodying her site research and is currently seeking a publisher.

Evaluation Findings

Her principal findings and opinions follow:

- **Benevolence, the willingness of health care professionals to help, is alive and well.** Many in the health care field believed, at the time Reach Out was launched, that those who went to medical school had some motivation beyond "I'm going to be rich and powerful." Benevolence, it was felt, doesn't exist only among physicians, but in health administrators, hospital administrators, nurses, etc. According to Wielawski, "I went into this evaluation believing that this sentiment is obvious"… (that those who select the serving professions are generally people who get some psychic feedback from helping, and from interactions with human beings). "My beliefs were amply confirmed."

- **Health care is very much a local issue, in terms of its political constituency, and national health care reform will have to come to grips with this fact.** The sheer multiplicity of forms local projects assumed under Reach Out, not to mention the differences among those served and differences in projects' communities—their social and demographic factors and geography—attest to this fact. Health care is very much a function of its locale. Wielawski: "Reach Out was an excellent laboratory for understanding why top down health reform doesn't have a strong constituency, and thus that it's a very hard thing to sell."
• Health care systems and health care improvements must have strong local input. Whatever health care reform is designed at the federal level, it must allow tremendous latitude at the local level to make it work. Wielawski: "Coming out of this evaluation, I felt that the people who stepped up to be Reach Out leaders were very frustrated with the 1992–93 national debate [on national health care reform], and felt the point had been, and was being, missed. They thought that in their community they could do a better job; and they knew which people needed to be on board in order for something to work. Reach Out was a program that identified and empowered natural leaders in the health care community."

• In voluntarism, there is no one-size-fits-all model. Wielawski: "As an evaluator, I was charged to be on the lookout for models [of voluntarism in care] that would fit other communities. It's true you could find some models where the gross outlines could be transferred to a comparable community, but there would still have to be tremendous fine-tuning in order for that model to work. Suppose there were no fine-tuning, but a model were simply exported from a community to another, demographically. I'm convinced there could be a logical explanation for why a model is wildly successful in one community, and a colossal failure in the next. And the explanation would not be a failure of the will on the part of individuals."

• Not only local leadership and local chemistry, but also local history is far more predictive of success than the actual architecture of the model being used. Wielawski: "In addition to the health care model being used locally, I saw another thing operating, which remains much more difficult to define: that is, the 'alchemy' of leadership, the relationships within the health care community—whether they were respectful and mutually supportive, or antagonistic—and then behind that the history of health care within that community, going in many instances back to the 19th century. Was there a ghetto of immigrants that the health care community had always cut off and shunned? If so, you have a terribly uphill battle."

• Not everything works by a grant cycle. Wielawski: "Reach Out implementation lasted 3–4 years. A lot of what these sites were trying to do was turn a supertanker in their community; to bring in a whole new constituency. Three to four years wasn't enough time. I think all of them could have used a longer period of funding to accomplish a very ambitious goal."

• The quality of the project manager is critical to the success of the site. Wielawski: "A significant number of sites hired the cheapest, youngest person for project manager they could find. And usually made the job part time. This was often someone right out of college who was deciding whether or not to go to graduate school, a social service intern…. It was such a mistake. The projects that were shrewder—and I have to think that the project leaders in these had some management experience—knew that the front person for this project—it was never the physician, it was always the project manager—had to be a confident, articulate, fairly seasoned adult. That person had to stand up before the local medical society physicians and say, 'Look, we need you. It's not going to take that much time. The success of this
project depends on every one of you participating to some level. This is what we can guarantee in return,' etc. You can't do that if you're 22 and just out of high school…. I think for one of these Reach Out projects, you need somebody who had been an executive director of United Way or March of Dimes or the Heart Association. Let them come from that milieu, but don't make their salary a quarter of what they can get in those positions. Because, particularly in a small community if they're any good at what they're doing, they're going to get a million job offers."

**Communications**

Evaluator Wielawski wrote feature articles about Reach Out's efforts and the situation facing the underserved in the United States, which appeared in the Los Angeles Times in 1994 ("Managed Care Eludes Only Congress: Washington Should Pay Attention to Reforms Occurring at the Grass-Roots Level"), and in the Boston Globe Magazine in 1995 ("The Blue Hill Cure: While the Nation Struggles to Fix its Ailing Health-Care System, the Doctors and Patients of this Remote Maine Region are Taking Care of Business by Taking Care of Each Other"). Other articles by Wielawski concerning Reach Out's efforts appeared in Modern Healthcare and Health Affairs in the period 1997 to 2000.

Wielawski spoke about Reach Out and the plight of the medically underserved on eight occasions between 1997 and 2001, four of them at national conferences. These included talks before the Inaugural Conference of the Association of Health Care Journalists (Webcast by the Kaiser Family Foundation), the Interdisciplinary Community Health Fellowship Program of the American Medical Student Association and the governing board of the privately funded Center for Health and Social Policy. Her articles in Health Affairs and the Los Angeles Times have been reprinted, or reproduced on websites, for distribution through a number of outlets including Newsday and the Houston Chronicle, the organization Families USA (a national nonprofit organization dedicated to achieving affordable health and long-term care for Americans), the website of the Association of Health Care Journalists and American Health Line (a Web publication). See the Evaluation Bibliography for details concerning Ms. Wielawski's communications work described here.

In January 2000, national program office staff published the previously cited article about Reach Out in JAMA. Entitled, "The Reach Out Program: Caring for the Uninsured and Underinsured", the article concluded that communities can mount and sustain an effective program enlarging access to health care, however modest their impact nationally on the number of medically uninsured and underserved persons.

Ten articles by national program office staff concerning Reach Out have appeared over the years. "Quick Uptakes: Caring for the Underserved," appeared JAMA October 1994. Other articles appeared in American Medical News, ADVANCES (the quarterly newsletter
of the Robert Wood Johnson Foundation), *Health Care Professional Magazine, Clinician and Community* and *George Street Journal* (a publication of Brown University), among others. A report written by national program office staff, *The Reach Out Program: Innovations in Health Care Delivery for the Underserved: Analysis of 39 Projects*, as well as three shorter articles describing aspects the program also by national program office staff, are unpublished at this writing.

From 1997 to 1999, the national program office ran a website, which conveyed information about the program and its sites to interested parties. Run primarily as a site for the "closed community" of project site staffs, its main purposes were to deliver technical assistance to its users, to share information, to facilitate networking and to inform sites about the relevant work of organizations. Information from *Reach Out*'s experience creating and supporting local sites is currently available to the public on the website of the RWJF resource program (and successor to *Reach Out*), *Volunteers in Health Care*. See the National Program Office Bibliography for complete details.

**LESSONS LEARNED**

1. **Most physicians are willing, and often eager, to become engaged at the local level in helping address the issues of the underserved.** However, a project relying on physicians' voluntarism must be aware of, and from the beginning answer to, physicians' concerns about a number of issues: limits on their contributions, liability coverage, a place at which to volunteer, administrative and case management backup and pharmaceuticals for prescriptions, among others. (National program office staff)

2. **In volunteer physician-based projects to increase access to health care, there are no "cookie cutter" solutions or sets of project models that will work for all communities—not even models for communities similar in size, socio-demographics, etc.** Successful efforts require shaping by, and tailoring to, the communities in which they will be implemented. (National program office staff)

3. **Skills in working with community groups and tapping into local sources of support in dollars and in kind contributions are essential to projects of the type Reach Out exemplified.** In the view of the national program office, sites must also demonstrate their effectiveness to local foundations and public agencies in order to earn support. Sources of such support came forward for more than two thirds of *Reach Out* projects. (National program office staff)

4. **Adequate infrastructure support is critical to any systematic effort to deliver care to the uninsured.** It is vital that a number of services be in place for a project to succeed. These support services include: pharmacy, lab work, x-rays and specialty medical services. It is necessary for project leadership and management to negotiate with hospitals, imaging centers and others to donate their services. (National program office staff)
5. **Successful Reach Out projects had a local "champion."** This person typically functions as an advocate at least through the planning and well on into the implementation phases. (National program office staff)

6. **A small but successful volunteer project can often serve as a local catalyst for further action to increase access to health care.** However, to do so, it must capture the attention and energies of local advocates, and in particular the surrounding health care communities. This is most often achieved "naturally" via word of mouth, augmented with some level of public relations efforts. (National program office staff)

7. **Carrying out these projects proved to be more complex than expected.** As pointed out in a *Journal of the American Medical Association (JAMA)* article in January 2000, "Significant progress [in building a sustainable project] often did not appear until late in the third or fourth year of grant funding. Projects had to recruit and schedule physicians to provide care; arrange for the laboratory, diagnostic and pharmacy services; know their prospective patient base and make the project known to those patients; and determine eligibility requirements. Language competencies, transportation of patients and the complex social and financial problems of patients emerged as challenges." (*JAMA* article)

8. **Physician leadership is an indispensable ingredient for individual project success.** Physician leadership adds to the credibility of a project; it also facilitates needed partnerships, in particular with other medically oriented organizations. In addition, only physicians appear able to guide the development of clinical services in an adequate way. Physician leadership also helps in recruiting other physicians. Most physician volunteers were recruited physician to physician. (National program office, "News" and *JAMA* article)

9. **Successful projects were careful not to overburden volunteer physicians.** As pointed out in the *JAMA* article cited above, "typically physicians in volunteer clinics spent between one and four half-day or evening sessions per months; the [project volunteer] physicians in private offices saw only a few patients per month." (National program office staff)

10. **Physicians in a community should be approached to act as volunteers together, or there may be resistance among individual physicians to act at all.** According to RWJF Program Officer Susan Hassmiller, "Doctors are willing to volunteer as long as they know that others in the community will share the burden. They don't want to be the only practice that opens up for free visits; they don't want to be the only one in the community that keeps getting all the Medicaid or all the "frees"; they don't want to be the only one who goes over to the free clinic on Thursday night….." (RWJF Program Officer)

11. **Pharmaceutical support is an essential element in encouraging physician involvement.** According to RWJF Program Officer Susan Hassmiller, "doctors can't do their job unless they can write prescriptions. They don't really want to deal with
the situation where someone could not afford to pay for a needed prescription."
(RWJF Program Officer)

12. **Physicians appear to be more willing to volunteer to take uninsured and Medicaid patients when the case management of patients is provided.** Because uninsured patients frequently have other needs related to their medical care, successful *Reach Out* projects often partnered with another entity providing this support, for example a public health department. Here public health nurses partnering with a clinic or doctor's office saw to patients' social needs and saw that they got to their appointments dealing with these social needs. (*JAMA* article)

13. **It is advisable to collaborate with one or more safety net agencies.** These can yield instant access to potential patients. A number of *Reach Out* projects, which were "embedded" within a health care organization also caring for the insured, had difficulty locating enough patients to make use of the physician services the projects had recruited. Eighty-six percent of "stable" projects had a collaboration with a local public health unit. (National program office staff)

14. **A volunteer physician project cannot cover all health needs in a community.** As noted in the January 2000 *JAMA* article, "from time to time, patients [at *Reach Out* projects] presented with complex problems for which projects did not have the resources or referral base to meet contemporary standards of care." These instances present potentially insurmountable challenges, but do not constitute a project failure where the aim is to complement publicly funded safety net providers or expand capacity in the private sector to care for the underserved. (*JAMA* article)

15. **The exposure of volunteer physicians to malpractice liability proved to be solvable in the *Reach Out* projects.** *JAMA* (January 2000): "Physician concern about malpractice regularly surfaced. This issue was solved in a variety of ways. Physician recruitment did not suffer, and no malpractice suits [were] filed. The impression that the underserved might be more litigious than insured individuals has not been borne out." (*JAMA* article)

16. **A minimum of one funded administrative staff person is crucial to help recruit physicians and schedule both physicians and patients.** Experience with *Reach Out* projects has found that volunteer physicians or others cannot adequately handle the following needed tasks: arrange for lab, diagnostic and pharmacy services; reach out to patients; and cope with the social, transportation and financial difficulties these patients often face. According to the RWJF Project Officer, Susan Hassmiller: "Participating physicians all agreed to see patients as long as there was an understanding that other people would get patients there, support them." (RWJF Program Officer)

17. **It's important to hire a qualified project manager, and pay this person enough to keep him or her on staff.** RWJF's program evaluator, who visited project sites, suggests where to find these qualified people: "you need somebody who had been an executive director of United Way or March of Dimes or the Heart Association. Let
them come from that milieu, but don't make their salary a quarter of what they can get in those positions. Because, particularly in a small community if they're any good at what they're doing, they're going to get a million job offers." (Evaluator)

18. **In the experience of the Reach Out program, statewide efforts to enlist volunteer physicians in providing care are not as likely to succeed as community efforts.** As Reach Out's Director Scott put it, "this is biting off too much for a volunteer-led project. A project's focus must be on the community problems and resources." (National Program Director)

19. **The success of projects' efforts to have their underserved patients adopt healthy practices will depend heavily on linkages to community organizations.** Reach Out demonstrated that giving patients support in this after a doctor's appointment—through a linkage to an entity in the community that will help the patient with a recommended lifestyle change—can be very effective. For example, an elderly and overweight patient counseled to be more active is then, though an administrative link, picked up by a senior center that offers exercise classes. Reach Out sites demonstrated the efficacy of follow-up calls in which the caller, a project staff person (not the doctor), a nurse or social service coordinator guided the patient after the visit or simply checked up on him or her. (Evaluator)

20. **Bringing project leaders together can be an antidote to individual "burnout," while allowing them to exchange ideas and best practices.** As the article in JAMA put it: "Many Reach Out leaders have worked on the problems of the uninsured against great odds. Many have expressed a sense of frustration and fear of burnout. Coming to know colleagues from around the country has been an immense source of support and has provided the opportunity to exchange ideas and best practices." (JAMA article)

21. **Case management of patients helps the bottom line of a Reach Out type volunteer organization, and pays dividends in patients' lives.** Projects frequently found that uninsured patients—though unaware of this themselves—were eligible for publicly supported programs such as Medicaid or, because of disability, Medicare, and could be promptly enrolled. (National program office staff)

22. **Project sites will be well served to establish, early on, systems to collect data, develop outcome measures, and evaluate their programs.** In Reach Out, sites' general failure to do so hampered the national program office's ability to speak about the program's global success and diminished the grantee's ability to seek alternative funding for their future sustainability. (National program office staff)

23. **Linkages between doctors and community programs that support healthy behavior appear to play a key role in enhancing the population's health through lifestyle changes.** Reach Out's most successful sites developed linkages of this sort. Program officer Susan Hassmiller: "Let's say a doctor's office wants to counsel its patients on how to be more active. Doctors get frustrated: they don't have a lot of time, don't get reimbursed for this and don't know how to do it, exactly. And they
always used to say, 'Why do it anyway, the patients go home, they don't do any better.' However, we've found from Reach Out and a number of other programs—for example, Turning Point: Collaborating for a New Century of Public Health—that if there are strong, coordinated linkages between the medical offices and the community, it will help achieve the desired result." (RWJF Program Officer)

24. In some instances, a political debate may be affected through the mounting of demonstration projects, which have no overt political purpose at all. Sensitizing a cadre of physicians to the problems of underserved persons can draw respected voices, that otherwise might be silent, into the political debate over access to medical care. Reach Out's Director, Scott, adds: "It might be possible to build the political will for change in the health care system through the daily care of those outside the system—looking in." (National Program Director)

AFTERWARD

Under RWJF grant ID#s 030114, 035301 and 040746, the national program office is continuing to share the lessons and findings of Reach Out through RWJF's Volunteers in Health Care, a national nonprofit resource center. Led by Reach Out former director H. Denman Scott, Volunteers in Health Care assists volunteer-led health care initiatives serving the uninsured.

Among Volunteers in Health Care's available tools are its field reports—short compendiums of advice written by practitioners, both those who participated in or led Reach Out projects and those who were involved in other similar efforts, outlining the "how to's" critical to starting or expanding programs for the uninsured. Each report includes a brief description of the organization writing it and a contact person for further information. Topics of help include:

- Physician volunteerism.
- Operational issues associated with starting free clinics or referral networks.
- Patients' need for access to ancillary services.
- The difficulties with access to prescription drugs and access to oral health care.
- Counting the uninsured.
- Creating partnerships locally.
- Engaging medical societies and hospital systems.
- Creating data collection systems.

Additionally, Volunteers in Health Care offers a product called "RxAssist." Conceived under Reach Out and set up by Volunteers in Health Care in 1999, RxAssist is a
continually updated, searchable database on more than 100 pharmaceutical companies' patient assistance programs. It may be accessed at www.rxassist.org. RxAssist has grown from 150,000 hits per month in 2000 to 2.6 million hits per month in 2005. RWJF has continued support for RxAssist through December 2005 (ID# 053639). The project has established a business plan and Scott, the director, expects to receive funding through other funders, partnership, and program generated income, which is expected to support approximately 50 percent of continuing operations in 2006.

Furthermore, Volunteers in Health Care has developed specialized products, such as patient tracking software and a state-by-state charitable immunity manual. It shares successful tools—for example, surveys, forms and how-to manuals—developed by Reach Out projects and others. Many services and products of Volunteers in Health Care are free of charge; others have a fee.

Prepared by: James Wood
Reviewed by: Janet Heroux, Marian Bass and Molly McKaughan
Program Officer: Susan Hassmiller
APPENDIX 1

National Advisory Committee, as of December 1999

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

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Pediatrician
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California Department of Health Services
Sacramento, Calif.

M. Roy Schwarz, M.D.
American Medical Association
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Robert H. Thompson
PrimeCare New York
Managed Care Administrators
New York, N.Y.

APPENDIX 2

All Reach Out Projects Sites (Listed by state, alphabetically)

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Montgomery, Ala.

Gift of Life Foundation
Project Directors: Robert Beshear, M.D., Albert Z. Holloway, M.D.
(205) 272-1820
Planning: August 1994 to July 1995
Implementation: August 1995 to July 1998
— 15 participating physicians served 2,552 patients.
Phoenix, Ariz.

Arizona Chapter of the American Academy of Pediatrics
Project Director: Rickey L. Williams, M.D., M.P.H.
(602) 722-2585
Planning: August 1995 to July 1996
Implementation: August 1996 to July 1999
— 165 participating physicians served 1,613 patients.

Los Angeles, Calif.

Cedars-Sinai Medical Center
Project Director: Neal D. Kaufman, M.D., M.P.H.
(310) 855-6386
Planning: August 1995 to November 1996
Implementation: August 1996 to December 1999
— 68 participating physicians served 497 patients.

Charles R. Drew University of Medicine and Science
Project Director, Planning: Richard Williams, M.D.
(213) 931-2247
Project Director, Implementation: Jeffrie D. Miller, M.D., M.H.A.
(213) 563-4928
Planning: August 1994 to September 1995
Implementation: August 1995 to July 1998
— 23 participating physicians served 48,290 patients.

Sacramento, Calif.

Sacramento-El Dorado Medical Society
Project Director: Glennah Trochet, M.D.
(916) 366-2601
Planning: August 1994 to July 1995
Implementation: August 1995 to July 1998
— 77 participating physicians served an unreported number of patients.

San Diego, Calif.

MultiCultural Primary Care Medical Group
Project Director, Planning: Lantz Arnell, M.D.
Project Director, Implementation: Richard O. Butcher, M.D.
(619) 299-3122
Planning: August 1994 to August 1995
Implementation: September 1995 to August 1998
— 170 participating physicians served 3,696 patients.

**St. Vincent de Paul Village**
Project Director: Christopher Abbott, M.D.
(619) 233-8500
Planning: August 1994 to July 1995
Implementation: August 1995 to July 1998
— 255 participating physicians served 7,925 patients.

**San Francisco, Calif.**
Ambulatory Surgery Access Coalition
Project Director: William Schecter, M.D.
(415) 206-8814
Planning: August 1994 to January 1996
Implementation: August 1995 to July 1998
— 74 participating surgeons served 397 patients.

**San Jose/Morgan Hill, Calif.**

**Rotacare South Bay**
Project Director, Planning: Mark Campbell, M.D.
(408) 866-8200
Planning: August 1995 to July 1996

**Rotacare International**
Project Director, Implementation: Duncan Govan, M.D.
(408) 782-0048
Implementation: August 1996 to July 1999
— 120 participating physicians served 6,495 patients.

**Englewood, Colo.**

**Colorado Chapter of the Academy of Pediatrics**
Project Director: Steve Berman, M.D.
(303) 837-2744
Planning: August 1994 to August 1995
Implementation: August 1995 to July 1998
— 3,366 participating physicians served 10,881 patients.

**Washington, D.C.**

**Howard University Hospital**
Project Directors: Floyd J. Malveaux, M.D., Ph.D. and Henry W. Williams M.D.
(202) 806-6270
Planning: August 1994 to August 1995
Implementation: September 1995 to August 1998
— 46 participating physicians served 449 patients.

**Miami, Fla.**

**Miami Baptist Association**
Project Director: Nilda Soto, M.D.
(305) 246-2400
Planning: August 1995 to December 1996
Implementation: August 1996 to July 1999
— 145 participating physicians served 2,798 patients.

**SSJ Mercy Health System**
Project Director: Pedro Jose Greer Jr., M.D.
(305) 856-7333
Project Director: Maureen G. Mann
(305) 285-2118
Planning: August 1995 to September 1996
Implementation: August 1996 to July 1999
— 124 participating physicians served 4,371 patients.

**Tallahassee, Fla.**

**Capital Medical Society Foundation**
Project Director: James Stockwell, M.D.
(904) 877-2105
Planning: August 1994 to July 1995
Implementation: August 1995 to July 1998
— 313 participating physicians served 530 patients.

**Des Moines, Iowa**

**Health Care Access Network**
Project Director: James L. Blessman, M.D.
(515) 247-4430
Planning: August 1995 to July 1996
Implementation: August 1996 to July 1999
— 140 participating physicians served 7,625 patients.

**Louisville, Ky.**

**Jefferson County Medical Society Outreach Program**
Project Director: Mary Ann C. Henry, M.D.
(502) 629-8625
Planning: August 1994 to December 1995
Implementation: August 1995 to July 1999
— 82 participating physicians served 3,136 patients.

**Blue Hill, Maine**

**Blue Hill Memorial Hospital**
Project Director: Daniel Rissi, M.D.
(207) 374-2836
Planning: August 1994 to July 1995
Implementation: August 1995 to July 1998
— Participating physicians served an unreported number of patients.

**Baltimore, Md.**

**New Song Urban Ministries**
Project Director: Belinda Y. Chen, M.D.
Planning: August 1995 to July 1996
Implementation: August 1996 to May 2000
— 32 participating physicians served 1,691 patients.

**Rockville, Md.**

**Primary Care Coalition of Montgomery County, Md.**
Project Director: Mona Sarfaty, M.D.
(301) 738-3311
Planning: August 1995 to March 1997
Implementation: August 1996 to November 1999
— 310 participating physicians served 609 patients.

Fall River, Mass.

Stanley Street Treatment and Resources
Project Director, Planning: David S. Greer, M.D.
(401) 729-3100
Project Director, Implementation: Ronald Schwartz, M.D.
(508) 679-5222
Planning: August 1995 to July 1996
Implementation: August 1996 to July 1999
— 279 participating physicians served 747 patients.


Worcester District Medical Society
Project Director: Randy E. Wertheimer, M.D.
(508) 793-6156
Planning August 1995 to July 1996
Implementation August 1996 to July 1999
— 818 participating physicians served 5,833 patients.

Portage, Mich.

Kalamazoo Academy of Medicine
Project Director: Donna L. Ritter, M.D.
Planning: August 1994 to October 1995
Implementation: August 1995 to December 1999
— 178 participating physicians served 404 patients.

South Saint Paul, Minn.

MetroEast Program for Health
Project Director: Thomas B. Dunkel, M.D.
Planning: August 1995 to October 1996
Implementation: August 1996 to October 1999
— 183 participating physicians served 1,404 patients.

Dillon, Mont.

County of Beaverhead, Barrett Memorial Hospital
(406) 683-6164
Planning: August 1995 to November 1996
Implementation: January 1997 to December 1999
— 14 participating physicians served 335 patients.

Lincoln, Neb.

Lancaster County Medical Society
Project Director: Darroll J. Loschen, M.D.
(402) 362-5675
Planning: August 1994 to September 1995
Implementation: August 1995 to July 1998
— 93 participating physicians served 5,229 patients.

Exeter, N.H.

Seacoast HealthNet
Project Director: Gwendolyn Gladstone, M.D.
(603) 772-8119
Planning: September 1994 to August 1995
Implementation: August 1995 to July 1998
— 259 participating physicians served 1,450 patients.

Asheville, N.C.

Buncombe County Medical Society
Project Co-Directors: Phillip Davis, M.D. and Suzanne Landis, M.D.
(828) 274-2267
Planning: August 1994 to July 1995
Implementation: August 1995 to July 1998
— 458 participating physicians served 7,132 patients.
Shelby, N.C.

**CLECO Primary Care Network**
Project Director, Planning: Thomas R. Harris, M.D.  
(704) 484-5200  
Project Directors, Implementation: Denis R. Seagle, Denese Stallings  
(704) 484-9077  
Planning: August 1995 to July 1996  
Implementation: August 1996 to July 1999

— 64 participating physicians served 6,920 patients.

Dayton, Ohio

**Montgomery County Medical Society**
Project Director: Syed M. Ahmed, M.D., M.P.H.  
(414) 456-8291  
Planning: August 1994 to September 1995

*Reach Out of Montgomery County*
Implementation: August 1995 to July 1998

— 105 participating physicians served 2,121 patients.

Toledo, Ohio

**The Academy of Medicine of Toledo and Lucas County**
Project Director: David L. Grossman, M.D.  
Planning: August 1994 to August 1995  
Implementation: August 1995 to December 1997

Eugene, Ore.

**Lane County Medical Society**
Project Director: Michael Weinstein, M.D.  
(503) 342-8255  
Planning: August 1994 to July 1995  
Implementation: August 1995 to July 1998

— 74 participating physicians served 1,888 patients.
Klamath Falls, Ore.

Klamath Comprehensive Care
Project Director: Wendy Ann Warren, M.D., M.S.W.
(541) 882-4698
Planning: September 1994 to August 1995
Implementation: August 1995 to July 1998
— 27 participating physicians served 258 patients.

Pittsburgh, Pa.

Children’s Hospital of Pittsburgh
Project Director, Planning: Mary Carrasco, M.D.
(412) 692-8664
Project Director, Implementation: Heidi M. Feldman, M.D., Ph.D.
Planning: August 1995 to December 1996
Implementation: August 1996 to July 1999
— 309 participating physicians served 757 patients.

Charleston, S.C.

Palmetto Project
Project Director: Bartolo M. Barone, M.D.
(803) 933-9183
Planning: August 1994 to July 1995
Implementation: August 1995 to July 1998
— 1,150 participating physicians served 19,207 patients.

Columbia, S.C.

South Carolina Institute for Medical Education and Research
Project Director: Dexter Cook, M.D.
(803) 798-6207
Planning: August 1994 to November 1995
— 42 participating physicians served 3,698 patients.

Memphis, Tenn.

Church Health Center of Memphis
Project Director: G. Scott Morris, M.D., M.Div.
Dallas, Texas

**The C. V. Roman Foundation**
Project Director: James E. Race, M.D.
(213) 943-3136
Planning: August 1994 to October 1995
Implementation: November 1995 to July 1997
— 16 participating physicians served 1,591 patients.

Seattle, Wash.

**Medalia HealthCare**
Project Director, Planning: Samuel W. Cullison, M.D.
(206) 320-2913
Project Director, Implementation: Nancy Heisel, M.D.
(206) 320-2582
Planning: August 1995 to December 1996
Implementation: January 1997 to December 1999
— 35 participating physicians served 1,322 patients.

Morgantown, W.Va.

**West Virginia University Foundation**
Project Director, Planning: Raymond A. Smego Jr., M.D., M.P.H., F.A.C.P.
Project Director, Implementation: Louis Teba, M.D.
Planning: August 1995 to September 1996
Implementation: August 1996 to July 1999
— 484 participating physicians served 36,564 patients.

Janesville, Wis.

**Rock County Medical Society**
Project Director: David C. Murdy, M.D., M.B.A.
Planning: August 1995 to July 1996
No implementation
APPENDIX 3

Reach Out Project Data-Gathering

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Besides personal contact with project staffs via e-mail, phone, at annual conferences and at site visits, the national program office employed a number of formal techniques to keep abreast of, and assess, project development. These techniques included review of quarterly performance reports submitted by each project (consisting primarily of qualitative information) and the semi-annual review of projects' budget reports. In addition, three survey or questionnaire instruments were used:

- **The Minimum Data Set.** The national program office used a data collection tool it termed "the minimum data set" to gather basic statistics intended to reflect each project's progress in meeting its own goals. It collected information from project staffs for six-month periods throughout the life of the program, asking project staffs to provide data on the physicians participating in the program and on the patients receiving care. The tool was revised midway through the program's life because project staffs were having difficulty collecting the data and because it was not clear that projects were reporting data consistently over time or that project sites were reporting data in the same way as their peer projects. For example, because of the wide range of project models, one project's definition of an "enrolled patient" was often different from others'. Similar disparities existed in how projects defined physicians participating—some included only those providing direct care, while others included individuals such as radiologists and pathologists who provided their services, but did not actually see the patients. The Minimum Data Set was nonetheless a useful tool for tracking an individual project's progress. It was less useful in comparing projects to one another.

- **The Resource Survey.** During the period May 29 to September 10, 1998, the national program office conducted one-hour interviews with staff at all project sites. The information gained from these interviews comprised the Resource Survey, which centralized, codified and quantified the Reach Out experience, and clarified the nature of technical assistance offered under Reach Out's successor program, Volunteers in Health Care (see Afterward). Alongside this instrument, the national program office began to collect administrative tools from sites, such as patient satisfaction surveys, volunteer recruitment letters and patient tracking systems. Resource Survey data formed the basis for an unpublished report written by national program office staff, Innovations in Health Care Delivery for the Medically Underserved: Analysis of 39 Projects. Results draws on information in this report.

- **The Key Informant Interview.** This instrument, administered during site visits, allowed the national program office to form an idea of each project in terms of a number of variables: its physician recruitment techniques, project leaders' and
volunteers' motivations, the spectrum and continuing nature of patient care, site policies and organizational structure and its local coalition-building, among others. Volunteers in Health Care, *Reach Out*'s successor program, makes available selected data based on these interviews.

- **Short surveys.** On two occasions, the national program office conducted additional short surveys of sites to gain specific information related to technical assistance needed or information of interest to RWJF. An example of the latter was a September 1998 survey asking all sites one question: "Some people worry that programs like *Reach Out* are a band-aid on the problems of the uninsured, but have you ever heard from members of your medical community or the community at large that there's no need for further action on the uninsured because *Reach Out* is taking care of the problem?" (Thirty-seven sites responded. Thirty-two projects answered no; five said yes.)
BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

National Program Office Bibliography

Articles


Reports


Survey Instruments


Grantee Websites

www.reachoutweb.org provided information on the history of Reach Out and technical assistance for Reach Out grantees. It included profiles of several Reach Out sites, a project directory with contact information for each Reach Out site and news and announcements. Pawtucket, RI: Reach Out National Program Office. Closed 1999. Estimated 7,318 visits per month. The website is no longer available.
Sponsored Conferences


"Reach Out Annual Meeting," 1996, St. Petersburg, FL. Attended by 110 Reach Out participants.


"Reach Out Annual meeting," 1999, Isle of Palms, SC. 106 participants, representing all 39 Reach Out sites. Twenty-six presentations.

Evaluation Bibliography

Book Chapters


Articles


Wielawski I. "The Blue Hill Cure: While the Nation Struggles to Fix Its Ailing Health Care System, the Doctors and Patients of this Remote Maine Region are Taking Care of Business by Taking Care of Each Other." Boston Globe Magazine, October 15, 1995.


Presentations and Testimony


PROJECT LIST

Reports on the projects managed under this National Program are listed below. Click on a project's title to see the complete report, which typically includes a summary, description of the project's objectives, its results or findings, post grant activities and a list of key products.

- "Reach Out: Memphis" Expands Health Care Coverage for Uninsured (Grant ID# 29993, etc., January 2004)
- A Network of Medical Volunteers Expands in South Carolina (Grant ID# 27450, etc., January 2004)
- Maine Hospital Forms Rural Integrated Primary Care System to Attract Physicians and Broaden Access to Care (Grant ID# 27436, etc., January 2004)
- Ohio Volunteers Provide Health Care for Low-Income Patients (Grant ID# 27448, etc., January 2004)
- Operation Access in San Francisco Coordinates Free Surgeries for Low-Income and Uninsured People (Grant ID# 27434, etc., January 2004)
- Physicians' Outreach Project Expands Access to Specialty Care for Low-Income Patients in Tallahassee (Grant ID# 27438, etc., January 2004)
- Project Expands Well-Baby Care for Infants Born to Low-Income Women (Grant ID# 27441, etc., January 2004)
- Reach Out Projects Extend Outreach of Medical Care to West Virginians (Grant ID# 30002, etc., January 2004)
- San Diego Shelter Recruits Volunteers to Expand Health Services (Grant ID# 27452, etc., January 2004)
- Volunteer Physicians Linked to Needy Patients in Asheville, N.C. (Grant ID# 27437, etc., July 2008)