

Institute for Public Policy
and Economic Analysis

Project Access
Spokane: Year One
Program Assessment
and Operations
Analysis, October
2003 to September
2004

Spokane County WA



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Year One Program Assessment and Operations Analysis,
October 2003 to September 2004.**

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PREFACE

This assessment was conducted by David Bunting, PhD, Professor of Economics at Eastern Washington University, Cheney, WA, under contract between Spokane County Medical Society, the sponsor of Project Access, and the EWU Institute for Public Policy & Economic Analysis, Patrick Jones, PhD, Executive Director.

Data regarding patient demographics and provider claims were compiled, verified and summarized by Michael Brown, Applied Health Data Analysis, LLC, Liberty Lake, WA.

John Driscoll, Project Access Director, Jan Monaco, Executive Director of the Spokane County Medical Society, and Dr. Samuel Selinger, founder of Project Access Spokane, reviewed various drafts of the assessment and offered many useful comments and suggestions.

Liz Burris, Project Access administrative assistant, provided important incidental information as the report was written.

EXECUTIVE SUMMARY

The problem of inadequate access to health care in the United States is well-known. An “estimated 15.6 percent of the population, or 45.0 million people, were without health insurance coverage in 2003.” For people in households with annual incomes of less than \$25,000, 24.2 percent had no health insurance coverage while only 8.2 percent with incomes of \$75,000 or more were uncovered.

Physicians have a conflicted role in resolving the problem of inadequate access. A recent study found many are reluctant to treat the uninsured, primarily because of escalating practice costs, time constraints, patient access and a fear of being swamped by charity cases. However, this reluctance can be overcome through appropriately designed programs. A review of physician led initiatives found that “physicians have the capacity and willingness to lead community-wide efforts for the underserved,” including donation of care for those unable to pay. Successful initiatives depended on the development of innovative partnerships, methods and programs by the physicians themselves.

Project Access Spokane is a community-based, physician-led initiative to expand access to health care for medically underserved citizens of Spokane County, Washington by providing on-demand health care to low income county residents without health insurance. Formed late in 2001 and launched in September, 2003, in partnership with hospitals, business, and community organizations and funded by financial and in-kind support from community groups and national organizations, the initiative is sponsored and administered by the Spokane County Medical Society Foundation. Participating primary care physicians are asked to accept ten patients per year while specialists are asked to accept twenty patients per year or to donate eight sessions at a neighborhood free clinic. Hospitals donate inpatient care, lab and radiology services, as well as outpatient services. Pharmacists provide wholesale pharmaceuticals, partially paid by a \$4 co-payment, while waiving all other charges, including counseling and dispensing fees. Enrollment is limited to low income Spokane County residents without medical insurance and not currently receiving state or federal medical benefits. Patients are enrolled for six months for primary care or three months for specialty care and assigned to a primary care or specialist physician depending on medical need. Medical

services provided to patients are reported by physicians and hospitals through industry standard insurance claim submission processes to document utilization rates, disease categories and donated charge information.

During its first year, 706 patients were enrolled in Project Access. Their racial profile approximated that of Spokane County, with 86 percent indicating they were white. About 75 percent resided in the cities of Spokane or Spokane Valley, and the fraction married was significantly fewer than for the county. Although the distribution of patients by sex was significantly different than for the county, the distribution by age was similar. The percent of patients aged 25 or less and between 56 and 65 was much larger than for the county while the fraction 65 or older was much less. Nearly 48 percent of the patients had household incomes less than \$10,000 while another 29 percent had incomes between \$10,000 and \$15,000. Comparable percentages for the county were 10 and 7 percent, respectively. About 52 percent of patients were directly enrolled at the Project Access site and 30 percent at two Community Health Association of Spokane [CHAS] clinics.

Insurance claims submitted by providers are used to measure the volume and value of Project Access medical services. Claims were submitted by 380 professionals, primarily physicians but including physical therapists, chiropractors, nurses and similar practitioners, 18 clinics and 4 medical centers. However, this data substantially understated the actual value of services donated because claims were submitted for only 417 of 706 patients. The apparent reason for this low submission rate is that some participating physicians did not submit insurance claims for all their services, most likely because completion of the claim form simply added to work already donated. Incomplete claims from other types of providers appear less important.

Medical professionals accounted for 28 percent of all claims and 84 percent of all visits while medical centers as providers of complicated hospital services accounted for 69 percent of all claims and 12 percent of all visits. Average provider claims ranged from \$1,900 for each clinic to \$481,000 for each medical center. Claims per visit clustered around \$350 for individuals and clinics, rising to \$6,800 for medical centers.

Individual providers did not participate equally in Project Access. Those in the lowest claims quintile accounted for 1.4 and 5.5 percent of all claims and visits,

respectively, while those in the highest quintile accounted for 65 and 45 percent of all claims and visits. The lowest claims quintile averaged 1.3 visits each while the highest had 10.6 each. Claims per provider in the lowest group were \$140 while in the highest they were nearly \$6,800.

Patients also did not utilize providers equally. On average, each saw 3.4 different providers but those in lowest claim quintile accessed exactly one provider each while those in the highest quintile, accounting for nearly half of all the providers accessed, averaged 8.4 different providers each. Patients were organized into deciles based on their claims. The average claim for the eighth decile was greater than the total claims for first. About 80 percent of the claims were accounted for by the highest two deciles while the ten largest claims alone accounted for 43 percent of all claims.

The most common medical problems involved perinatal conditions and genitourinary diseases with 18.7 and 10.5 percent of all diagnoses. The most common place for diagnoses was the office of the provider, followed by hospital outpatient facilities. About 78 percent of all claims were accounted for by hospital inpatient or outpatient care. Hospital inpatient treatments for neoplasms and congenital anomalies represented the largest amount of claims, accounting for 31 percent of all claims. Claims for congenital anomalies of \$161,000 per patient for hospital care and \$32,000 per patient regardless of place of service were more than five times larger than average claims for neoplasms, \$26,000 and \$6,400, respectively, the next largest diagnostic group.

Patients most commonly visited the office of a physician or other medical professional once. Heavy utilization of the same place of service was relatively infrequent with patients with six or more visits accounting for only about 5 percent of all visits. However, these patients accounted for more than 60 percent of all claims. Average inpatient claims were of \$14,100 nearly seven times larger than outpatient ones at \$2,900.

During its first operational year Project Access had total income of \$366,002 and total expenses of \$320,915, leaving a carryover for year two operations of \$45,087 as a consequence of multiyear grants for operations and administrative costs. The estimated value of donated services is \$3,104,210, representing 3,198 visits and 7,580

procedures. In terms of a benefit-cost ratio, for every dollar of expense, Project Access generated \$9.67 in medical services to the medically underserved citizens of Spokane County at an average cost of \$499 each. Individually patients received an average of \$4,395 in medical services, averaged 4.5 visits to a variety of medical providers and received an average of 10.7 medical procedures or services.

The problem of insurance claim under-reporting should be a matter of concern because the value and volume of services provided by Project Access can not be accurately determined. Surveys should be undertaken to determine patient and provider satisfaction, program strengths and weakness, and to identify unmet needs. A post treatment survey could be used to determine the effectiveness of Project Access care and its impact on other community low income health programs and emergency services. This survey also would permit a determination of the influence of Project Access on the labor force participation rate of patients as well as providing a basis to estimate its overall economic and social benefits to Spokane County. Participating physicians and medical professionals average fewer patients than they agreed to accept. Reasons for this relatively low enrollment should be examined. Perhaps, as a new program, Project Access is undergoing startup problems in establishing eligibility procedures and identifying and informing prospective patients.

**PROJECT ACCESS SPOKANE:
YEAR ONE PROGRAM ASSESSMENT AND OPERATIONS ANALYSIS,
OCTOBER 2003 TO SEPTEMBER 2004.**

1. INTRODUCTION

The problem of inadequate access to health care in the United States is well-known. According to a recent U.S. Census Bureau survey an “estimated 15.6 percent of the population, or 45.0 million people, were without health insurance coverage in 2003, up from 15.2 percent and 43.6 million people in 2002 [US Census Bureau, 2004].” As might be expected, health insurance coverage is related to income. For people in households with annual incomes of less than \$25,000 in 2003, 24.2 percent had no health insurance while for those with incomes of \$75,000 or more, only 8.2 percent were uncovered [US Census Bureau, 2004].

As providers of health care, physicians have a conflicted role in resolving this problem of inadequate access. In a recent study, “Reach Out: Physicians' Initiative to Expand Care to Underserved Americans,” funded by the Robert Wood Johnson Foundation, Irene M. Wielawski [2004] found that many physicians are reluctant to treat the uninsured. “Despite some evidence of unused physician capacity nationally, and a long-standing tradition to provide ‘charity care,’ by the early 1990s the majority of physicians appeared reluctant to help the medically underserved” because of escalating practice costs, time constraints, patient access and a general unwillingness to commit to serious voluntary efforts for fear of being swamped by charity cases.

However, Wielawski found that this reluctance can be overcome through appropriately designed programs. In a review of physician led initiatives to confront the problem of inadequate health care access, she found that “physicians have the 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 [Wielawski, 2004].” All the initiatives “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,”

accomplishments that could only occur through the development of innovative partnerships, methods and programs by the physicians themselves.

Voluntary physician initiatives were found to face a common set of challenges [Wielawski, 2004.]. They had to recruit and schedule physicians and arrange for the laboratory, diagnostic and pharmacy services. Administrative staff had to develop procedures to identify and inform prospective patients and to determine eligibility requirements. Both patients and providers have to be monitored, usually through some computerized scheduling and patient care system. Skill in working with community groups and finding local sources of support in dollars, or in-kind contributions, was also essential. Dealing with such issues required extensive knowledge of administrative and other non-medical services. Finally, practicing physicians who assumed leadership roles in these projects typically did not have the time to undertake these non-clinical tasks.

2. ORIGINS OF PROJECT ACCESS

Project Access Spokane is modeled after the original Project Access, formed in Buncombe County, North Carolina in response to the frustrations of physicians over the fragmented approach to providing health care to uninsured, low-income county residents. As described in a report summarizing its early operations, beginning in 1995 the Buncombe County Medical Society, in conjunction with community partners and with grant funding from the Robert Wood Johnson Foundation, initiated efforts to develop a health care delivery program [Buncombe Report, 1998].

Over 500 Buncombe County physicians agreed to provide donated care to patients through a program that eventually became Project Access. County government officials agreed to allocate county indigent care funds to the project. The County Health Center, a major source of primary care for indigent patients, and the Department of Social Services screened and enrolled patients while hospitals agreed to accept and provide a full range of services for Project Access patients.

Community-based indigent care clinics provided another access point to Project Access. Some physician volunteers chose to see patients in those settings. County pharmacists agreed to waive part of their regular charges and filled prescriptions offered

through the Project Access formulary while local agencies donated evaluation and insurance claims tracking services.

Project Access enjoyed great success in Buncombe County, enrolling 1,668 patients, of which 719 received documented donated care during its first two years [Buncombe Report, 1998]. The project attracted considerable state, national, and international attention and has received numerous awards, honors and commendations.

The initial impetus to establish Project Access in Spokane County came from Dr. Samuel Selinger, a local [now semi-retired] cardiac/thoracic surgeon in late 2001 and early 2002. By February 2002 the project was endorsed by the Board of the Spokane County Medical Society and by the end of the year a Director was hired and agreements to participate by more than a hundred physicians and both Spokane hospital systems were reached. Providence Services of Eastern Washington and Group Health Cooperative provided startup grants while the City of Spokane agreed to fund pharmacy services. In early 2003 concept presentations were made to various city and county economic development and policy groups as well as to the Spokane County Commissioners, Chamber of Commerce and neighboring communities. In July of 2003 a Robert Wood Johnson Foundation grant was received allowing Project Access Spokane to be launched during September, 2003 under the direction of the Spokane County Medical Society Foundation.

The key to the early success of Project Access in Spokane County was the initiative and commitment of the physician community, ultimately involving over 600 physicians. This participation and the willingness to donate care provided a basis to procure additional donations and to engage other partners in the community.

3. OPERATION OF PROJECT ACCESS

Project Access is a community-based, physician-led initiative to expand access to health care for medically underserved citizens of Spokane County, Washington by providing on-demand health care to low income county residents without health insurance. In partnership with hospitals, business, and community organizations and funded by financial and in-kind support from community groups and national

organizations, the initiative is sponsored and administered by the Spokane County Medical Society Foundation.

Currently Project Access employs a director, an enrollment specialist, two patient care coordinators, and an executive assistant. This staff determines eligibility, enrolls patients and coordinates the delivery of health care services. They administer centralized applications, referrals, and enrollment processes; maintain a database of patients, physicians, and appointments; determine the drug formulary; develop and administer a medication assistance program; conduct provider recruitment, promotion and communications; and undertake ongoing resource development. Finally, they remind patients of appointments 24 to 48 hours before each appointment.

Participating primary care physicians are asked to accept ten Project Access patients per year while specialists are asked to accept twenty patients per year or to donate eight sessions at a neighborhood free clinic. Hospitals donate inpatient care, lab and radiology services, as well as outpatient services. Pharmacists provide wholesale pharmaceuticals, partially paid by a \$4 co-payment, while waiving all other charges, including counseling and dispensing fees.

Spokane County residents can enroll in Project Access if they have no medical insurance and are not currently receiving state or federal medical benefits such as Medicare or Medicaid. Their family income must be less than two hundred percent of the Federal Poverty Level, currently at \$36,200 annually for a family of four. Patients must sign a responsibility agreement, agreeing both not to miss physician or hospital appointments and to pay a \$4 co-payment for each medication received. Thereafter, they are eligible for, at no cost, physician office visits and office related services, hospital inpatient and outpatient services, surgeries and treatments, laboratory and radiology tests and procedures, and prescription medications to a maximum of \$750 per year in value. Patients are accepted by all local hospitals. Transportation and interpreter services are provided as needed. Ambulance and emergency room services and vision hardware are not provided by Project Access.

Patients are enrolled into Project Access three different ways. Those in need of specialty and hospital care are referred to Project Access through one of several Federally Qualified Community Clinics in Spokane, including the Community Health

Association of Spokane, The NATIVE Project, or the Spokane Falls Family Clinic as well as through non-federally qualified clinics. Participating private physicians can refer patients under their care. Finally, patients can self refer themselves to Project Access. Upon referral, eligibility specialists gather income information, assess eligibility for state or federal programs, and enroll qualified applicants.

Patients are enrolled in Project Access for six months for primary care or three months for specialty care. They are assigned to a primary care physician or specialist physician depending on their medical needs. Appointments with volunteer physicians and providers are scheduled by Project Access staff. If requested by their physician, enrollment may be extended for those patients continuing to meet income and residency eligibility requirements.

Medical services provided to Project Access patients are reported by physicians and hospitals through industry standard insurance claim submission processes. Claims processing is provided at no charge by the Spokane Physician Hospital Community Organization (SPHCO), a third party administrator. Physician and hospitals submit claims to Project Access indicating the standard procedure coding, diagnosis, and charge for services provided. Claims data made available by SPHCO is used to document utilization rates, disease categories and charge information. At the end of the year, reports summarizing this information are developed and shared with volunteer providers, funding agencies, business and governmental entities.

Project Access has developed care coordination plans, including language and transportation assistance, to enable patients to navigate the medical care system to gain access to needed medical services and to help them to obtain health insurance.

Pharmaceutical funding for Project Access is provided by Spokane County and the cities of Spokane, Spokane Valley, Airway Heights, Cheney, Deer Park, Liberty Lake, Medical Lake and Millwood. Numerous private and public organizations, separately listed in an appendix, also provided financial and in-kind support. Funding covers administrative expenses and the actual cost of providing prescription medication and does not reimburse any providers for services provided.

4. PATIENT CHARACTERISTICS

During its first year 706 patients were enrolled in Project Access. Table 4.1 shows their self assigned race, alone or in combination with some other race. As compared to a “Profile of Selected Economic Characteristics: 2000” prepared by the U.S. Census Bureau [WA OFM, 2005a], the racial profile of patients approximated that of the county with 86 percent indicating they were white as compared to 94 percent for the county as a whole. The fraction indicating American Indian or Alaskan Native origins was 4.5 percent, almost twice that of the county. While not recognized as a race by the Census, 3 percent of the patients designated themselves as Hispanic or Latino. Other racial categories of lesser frequency included Black or African American and Asian.

Table 4.1
Race [Alone or in combination other races]

Race	Number	Percent	County
White	608	86.1	93.9
American Indian or Alaskan Native	32	4.5	2.4
Hispanic or Latino	23	3.3	--
Black or African American	13	1.8	2.2
Asian	12	1.7	2.6
Some Other Race, No Response	18	2.6	1.4
Total	706	100.0	100.0

Table 4.2
Spokane County Residence

Residence	Number	Percent	County
City of Spokane	377	53.4	46.1
City of Spokane Valley	175	24.8	19.1
Other Cities	43	6.1	6.8
Unincorporated Areas	98	13.9	28.0
Other, Not Reported	13	1.8	--
Total	706	100.0	100.0

As Table 4.2 discloses, 75 percent of the patients resided in the cities of Spokane or Spokane Valley, another 6 percent lived in adjacent cities, and the remainder was scattered in unincorporated areas throughout the county. With the exception of those living in unincorporated areas, these percents are similar for those for Spokane County generally, based on residence statistics compiled by the Washington Office of Financial Management [WA OFM, 2005b].

The fraction of patients indicating they were married was significantly smaller than for Spokane County. In the county 55 percent of those 15 or older indicated they were married while, as Table 4.3 shows, only 31 percent of patients were currently married, although the single category most likely includes some who were previously married. The high fraction of single patients does not necessarily imply single person households. As found in Table 4.4, only 41 percent of the patients live alone; the other 59 percent are in multi-person households that could involve other adults, related by blood or marriage, children and diverse other people.

**Table 4.3
Marital Status**

Status	Number	Percent
Single	422	59.8
Married	217	30.7
Parent - Head of Household	55	7.8
Other	6	.8
No Response	6	.8
Total	706	100.0

**Table 4.4
Family Size**

Family Size	Number	Percent
1	292	41.4
2	191	27.1
3	91	12.9
4	66	9.3
5	36	5.1
6+	22	3.1
No Response	8	1.1
Total	706	100.0

Although the distribution of patients by sex was significantly different than for Spokane County, the distribution by age was similar. Table 4.5 shows patient age distribution by sex while Table 4.6 compares the age distribution to that of the county. Project Access patients were disproportionately female with 63 percent female as compared to 51 percent for the county.

Since nearly all patients are adults, their age distribution is compared to the county distribution of people 18 or older as found in Table 4.6. The percent of patients aged 25 or less and between 56 and 65 is much larger while the fraction 65 or older is much less because nearly all people in this age category are eligible for Medicare assistance.

**Table 4.5
Age Distribution**

Age	Male	Female	Total
<20	5	4	9
21-25	32	44	76
26-35	51	76	127
36-45	67	105	173
46-55	59	127	186
56-60	27	47	74
61-65	15	32	47
65+	3	7	10
Total	259	442	701
NR	2	3	5

**Table 4.6
Relative Age Distribution**

Age	Project Access		County
	Number	Percent	Percent
21-25	76	11.0	6.1
26-35	127	18.3	19.8
36-45	173	25.0	28.9
46-55	186	26.8	23.4
56-60	74	10.7	2.5
61-65	47	6.8	1.4
65+	10	1.4	17.8
Total	693	100.0	100.0

Project Access is intended to provide health care assistance to low income people unable to secure care by other means. Table 4.7 compares the annualized monthly incomes of patients with the distribution of county household incomes in 1999.

**Table 4.7
Income Distribution**

Range	Project Access		County
	Number	Percent	Percent
<\$10,000	337	47.9	10.0
\$10-\$15,000	201	28.6	7.2
\$15-\$25,000	104	14.8	15.0
\$25-\$35,000	50	7.1	14.6
\$35,000+	12	1.7	53.2
Total	704	100.0	100.0

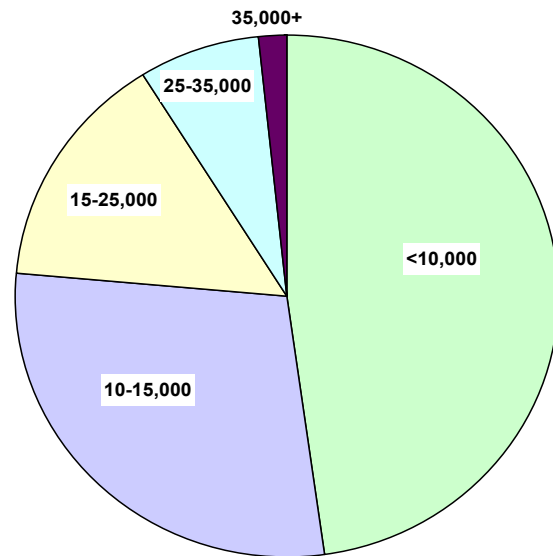


Chart 4.1 Patient Income [\$\$\$]

Nearly half, 48 percent, of the patients had household incomes less than \$10,000 while another 29 percent had incomes between \$10,000 and \$15,000. For the county as a whole, the percentages for these two categories were 10 and 7 percent, respectively. Combining these two income categories, 77 percent of the patients as compared to 17

percent of all county households, had incomes less than \$15,000. This income distribution is also illustrated in Chart 4.1. Although 23 percent of the patients had incomes greater than \$15,000, this figure is misleading because their incomes are based on annualized monthly incomes. That is, a person reporting a monthly income of \$2,000 is assumed to have an annual income of \$24,000, a situation that does not reflect the seasonal and part-time employment of many of the patients.

Finally, while patients were referred from a variety of sites, Table 4.8 shows more than half were directly enrolled at the Project Access site and an additional 24 percent were referred by the Community Health Association of Spokane [CHAS] Maple Street clinic, followed by 7 percent at both the CHAS Valley clinic and Columbia Primary Care [previously, Columbia IPA [Columbia Independent Practice Association]]. Other important referral sites include the Spokane Falls Family Clinic, CHAS Downtown and NE, People’s and Christ Clinic, East Central Community Organization [ECCO] and NATIVE Health of Spokane.

**Table 4.8
Referral Sites**

Site	Number	Percent
Project Access	364	51.6
CHAS [Maple]	169	23.9
CHAS [Valley]	49	6.9
Columbia IPA	49	6.9
Spokane Falls Family Clinic	26	3.7
CHAS [Downtown]	18	2.5
CHAS [NE]	15	2.1
People's Clinic	6	.8
Christ Clinic	4	.6
ECCO	4	.6
NATIVE Health of Spokane	2	.3
Total	706	100.0

5. PROVIDER CHARACTERISTICS

Over 600 Spokane County physicians pledged to donate services to Project Access. In addition to this group, other providers include physical therapists, chiropractors, nurses and similar professionals. Additionally, health care services were donated by various clinics and medical centers. Of these diverse providers, 380

professionals, 18 clinics and 4 medical centers submitted medical claims in the fiscal year under consideration. Claims were also submitted by various billing offices as anonymous "professional services," usually representing individual professional services provided in medical centers.

However, this claims data substantially understates the actual value of services donated by Project Access providers. Some participating physicians did not submit insurance claims for all their services, most likely because completion of the claim form would simply add to work already donated. The extent of this problem is potentially significant because insurance claims were submitted for only 417 of 706 patients. The problem of incomplete claims seems less important for other types of providers. Since hospitals historically have attempted to account for all their expenses, regardless of payer, their insurance claims most likely will closely reflect the value of services donated. Although their participation in Project Access is relatively small, the extent of under-reporting by other types of providers is unknown.

Perhaps the differences between physician and hospital vigilance in submitting claims for Project Access services is best illustrated by the common occurrence of admission to a hospital. After admission, the hospital, following its standard procedures, submits an insurance claim for its services, thereby also indicating a patient visit. However, the admitting physician, usually consumed with a hectic practice schedule, does not submit a claim for services since it simply represents additional donated time as well as added administrative expenses.

The under-reporting of claims seems to be a common problem for Project Access programs. For example, the Buncombe County Project Access enrolled 1,668 patients during its first two years. "Of these, 860 had more than one 1997 outpatient visit under the PA program, and 719 could be matched by name and birth date to HCFAs [standard insurance claim forms] returned to the PA office. [Buncombe Report, 1998]." Based on total enrollment, this led to a claims submission rate of 43 percent. The submission rate for Project Access Spokane was much larger with claims for 59 percent of its patients submitted to the Spokane Physician Community Organization for processing.

While the value of claims data indicates the value of donated services, it does not reflect the utilization of different health care services received by patients. Patient

utilization, or volume of donated services received, will be measured by the number of patient “visits” to providers to access to different health care services. Unlike value of claims, visits do not reflect the complexity of care received nor are they distorted by relatively expensive care for a few patients. For example, an office visit for a simple blister and a hospital stay for a heart transplant are both single visits. As will be shown below, visits are an important access measure because about 85 percent of all visits were to individual providers while about 70 percent of all claims were from hospitals and clinics. However, because they are derived from insurance submissions, visits are probably also under-reported.

Table 5.1 summarizes the activities of different providers while Table 5.2 shows the relative distribution of number, claims and visits by type of provider. When professional services are added, individual providers accounted for 28 percent of all claims and 84 percent of all visits while medical centers as providers of complicated and hospital services accounted for 69 percent of all claims and 12 percent of all visits. Average claims from providers ranged from \$1,900 for each clinic to \$481,000 for each medical center. Claims per patient visit clustered around \$350 for individuals and clinics and, again representing the type of care provided, jumped to \$6,800 for medical centers.

Table 5.1
Claims and Visits: All Providers

Provider	Num	Claims	Visits	Claim per Provider	Ave Visits	Claim Per Visit
Professional	380	\$796,170	1,802	\$2,095	4.7	\$442
Professional Services	8	42,019	164	5,252	20.5	256
Clinics	18	34,631	93	1,924	5.2	372
Medical Centers	4	1,925,862	284	481,465	71.0	6,781
Total	410	\$2,798,682	2,343	\$6,826	5.7	\$1,194

Table 5.2
Distribution of Claims and Visits: All Providers

Provider	Num	Claims	Visits
Professional	92.7	28.4	76.9
Professional Services	2.0	1.5	7.0
Clinics	4.4	1.2	4.0
Medical Centers	1.0	68.8	12.1
Total	100.0	100.0	100.0

Throughout this report questions arise concerning the extent of participation or claims that are accounted for by a fraction of patients or providers. A common method to illustrate this extent is to sort patients or providers by their participation or claims from smallest to largest and then form groups on the basis of equal fifths [quintiles] or tens [deciles]. Differences in quintile or decile numbers will then reflect differences in participation or claims. For example, Table 5.3 shows that individual providers did not participate equally in Project Access. Total claims submitted by each provider were sorted from lowest to highest and then divided into five each groups or quintiles. The 76 providers with the lowest claims accounted for 1.4 and 5.5 percent of all claims and visits, respectively, while the 76 with the highest claims accounted for 65 and 45 percent of all claims and visits. The table illustrates the variable participation of individual professionals in Project Access. The lowest quintile averaged 1.3 visits each while the highest had 10.6 each. Claims per provider in the lowest group were \$140 while in the highest they were nearly \$6,800.

Table 5.3
Claims and Visits: Professional Providers

Quintile	Num	Claims	Visits	Claim per Provider	Ave Visits	Claim Per Visit	Distribution	
							Claims	Visits
1	76	\$10,890	100	\$143	1.3	\$109	1.4	5.5
2	76	30,299	175	399	2.3	173	3.8	9.7
3	76	69,897	289	920	3.8	242	8.8	16.0
4	76	168,547	433	2,218	5.7	389	21.2	24.0
5	76	516,537	805	6,797	10.6	642	64.9	44.7
Total	380	\$796,170	1,802	\$2,095	4.7	\$442	100.0	100.0

On the other hand, patients did not utilize providers equally. Table 5.4 shows that on average, each patient saw 3.4 different providers. When patients for which claims data exist are organized into quintiles based on the number of separate providers accessed, provider utilization is highly skewed towards a relatively small number of patients. Patients in first quintile accessed exactly one provider each, those in the second quintile averaged 1.3 providers each, those in the third 2.4 providers while those in the last quintile, accounting for nearly half of all the providers accessed, averaged 8.4 different providers each.

**Table 5.4
Patients and Provider Utilization**

Quintile	Patients	Share		Providers Per Patient
		Providers	Providers	
1	84	84	5.9	1.0
2	84	109	7.7	1.3
3	83	199	14.1	2.4
4	83	334	23.6	4.0
5	83	687	48.6	8.3
Total	417	1,413	100.0	3.4

6. CLAIMS CHARACTERISTICS

Between October 2003 and September 2004 insurance claims forms were submitted for 417 patients. This group was sorted on the basis of total individual claims and organized into deciles with the first decile containing the claims 42 patients with the lowest claims and so on to the highest decile which contains the claims of the 41 patients with the highest claims. Table 6.1 shows the amount of claims and the number of visits for each decile as well as average claims, average visits, average claims per visit and the percentage decile distribution of claims and visits.

**Table 6.1
Claims and Visits by Claim Decile**

Decile	Num	Claims	Visits	Ave Claim	Ave Visits	Claim per Visit	Distribution	
							Claims	Visits
1	42	\$4,691	48	\$112	1.1	\$98	.2	2.0
2	42	8,813	57	210	1.4	155	.3	2.4
3	42	13,498	91	321	2.2	148	.5	3.8
4	42	26,982	118	642	2.8	229	1.0	4.9
5	42	49,502	111	1,179	2.6	446	1.8	4.6
6	42	70,025	201	1,667	4.8	348	2.5	8.3
7	42	126,835	217	3,020	5.2	584	4.5	9.0
8	41	219,471	298	5,353	7.3	736	7.8	12.4
9	41	408,605	390	9,966	9.5	1,048	14.6	16.2
10	41	1,870,261	877	45,616	21.4	2,133	66.8	36.4
Total	417	\$2,798,682	2,408	\$6,711	5.8	\$1,162	100.0	100.0

Differences between decile claims are staggering. The average claim for the eighth decile was greater than the total claims for first. The total value of claims for the lower five deciles was less than that for the seventh decile. The distributions found in Table 6.1 indicate that about 80 percent of the claims were accounted for by the highest

two deciles. To illustrate the magnitude of large claims, Table 6.2 contains the claims of ten patients with the largest claims, a group alone accounted for 43 percent of all claims. This disproportionate distribution of claims is also clearly illustrated by Figure 6.1.

**Table 6.2
Largest Ten Claims**

Patient	Claims	Visits
Patient 1	\$533,058	104
Patient 2	178,937	39
Patient 3	78,007	10
Patient 4	73,549	37
Patient 5	72,965	15
Patient 6	57,314	32
Patient 7	57,283	24
Patient 8	52,459	7
Patient 9	43,973	12
Patient 10	40,716	34
Total	\$1,188,261	314
Share	42.5	13.2

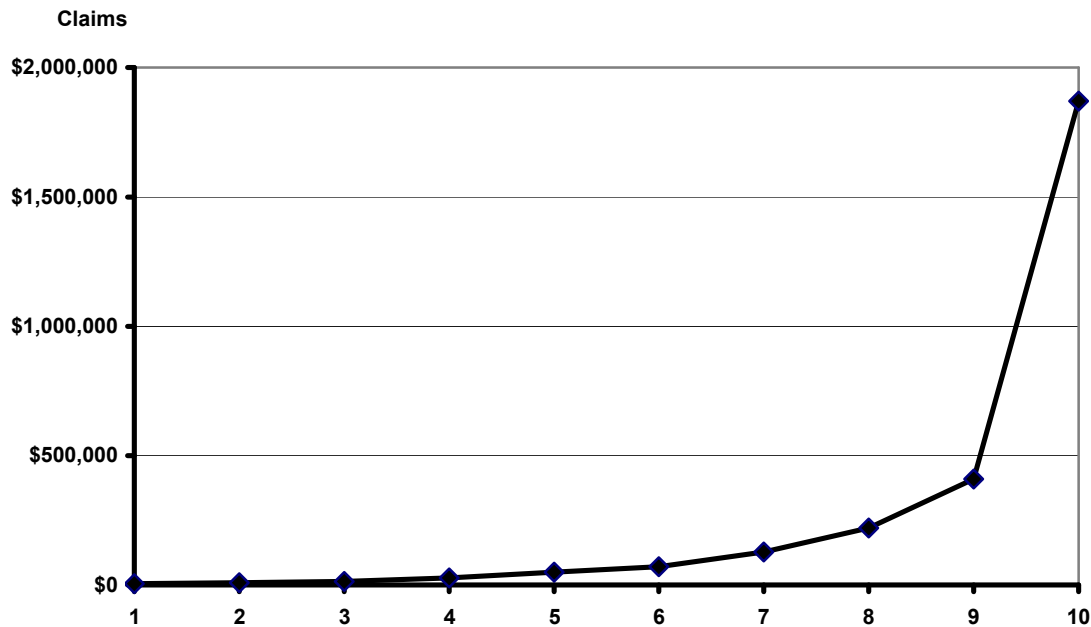


Figure 6.1. Claims by Claim Decile

7. DIAGNOSES AND UTILIZATION

Insurance claims for Project Access patients include an ICD-9 code indicating the specific disease or injury for which treatment was provided. According to the National Center for Health Statistics, “the International Classification of Diseases, Clinical

Modification [ICD-9-CM] is used to code the diagnoses associated with inpatient, outpatient, and physician office utilization in the U.S [NCHS, 2005].” These codes represent a statistical classification system that arranges diseases and injuries into groups according to established criteria. For example, an ICD-9 code for a broken arm is fractured radius, 813.81 [Ohio, 2005].

**Table 7.1
IDC-9 Groups**

Brief Group Name	IDC-9 Group (code range)
Neoplasms	Neoplasms (140-239)
Congenital Anomalies	Congenital Anomalies (740-759)
Musculoskeletal System	Diseases of the Musculoskeletal System and Connective Tissue (710-739)
Circulatory System	Diseases of the Circulatory System (390-459)
Genitourinary System	Diseases of the Genitourinary System (580-629)
Digestive System	Diseases of the Digestive System (520-579)
Perinatal Conditions	Certain Conditions Originating in the Perinatal Period (760-779)
Unknown	Not Classified
S/S & Ill-Defined Conditions	Symptoms, Signs, and Ill-Defined Conditions (780- 799)
Endocrine/ Metabolic & Immunity	Endocrine, Nutritional and Metabolic Diseases, and Immunity Disorders (240-279)
Respiratory System	Diseases of the Respiratory System (460-519)
Nervous System/Sense Organs	Diseases of the Nervous System and Sense Organs (320-389)
Other	Infectious and Parasitic Diseases (001-139) Diseases of the Blood and Blood-Forming Organs (280-289) Mental Disorders (290-319) Complications of Pregnancy, Childbirth, and the Puerperium (630-677) Diseases of the Skin And Subcutaneous Tissue (680- 709) Injury and Poisoning (800-999)

In Table 7.1 ICD-9 codes are collected into summary groups following a tabular index compiled by the Practice Management Information Corporation [PMIC, 2005]. Each IDC-9 group is matched up with a shorter, “Brief Group Name” to facilitate tabular presentation of the frequency and costs of diseases and injuries encountered by Project Access patients. The table, as well as the ones following, is organized on the basis of total Project Access claims with “neoplasm,” the group accounting for the greatest claims listed first, followed by “congenital anomalies,” the second largest claim group,

and so on to “other,” the smallest claim group. This last group combines several code groups that involved only a few patients with relatively small total claims.

Table 7.2 shows the relative frequency of patient diagnoses by ICD-9 group and place of service. The most common medical problems were those involving perinatal conditions and genitourinary diseases with 18.7 and 10.5 percent of all diagnoses. The most common place for diagnoses was the office of the provider, followed by hospital outpatient facilities.

Table 7.2
Relative Frequency of Patients by Diagnoses and Place of Service

ICD-9 Group	Inpatient	Outpatient	Office	A-E-L	Total
Neoplasm	1.4	2.7	4.0	1.1	9.2
Congenital Anomalies	.3	.5	.7	.1	1.5
Musculoskeletal System	.7	1.5	7.0	.9	10.0
Circulatory System	1.2	2.2	3.9	.6	7.9
Genitourinary System	1.5	2.5	7.9	2.2	14.1
Digestive System	.6	2.0	2.9	2.2	7.6
Perinatal Conditions	1.8	3.3	11.3	2.2	18.7
Unknown	1.1	3.0	3.5	2.9	10.5
S/S & Ill-Defined Conditions	.4	1.0	2.5	1.3	5.1
Endocrine/Metabolic & Immunity	.3	.8	3.0	1.0	5.0
Respiratory System	.8	.5	1.6	.1	3.0
Nervous System/Sense Organs	.1	.1	3.4	.3	3.9
Other	.4	.3	2.3	.5	3.4
Total	10.6	20.2	54.0	15.3	100.0
Number	111	212	566	160	1,049

Table 7.3 shows the share of claims by diagnoses and place of service. About 78 percent of all claims were accounted for by hospital care, either as inpatient or outpatient care. Hospital inpatient treatments for neoplasms and congenital anomalies represented the largest amount of claims, accounting for 31 percent of all claims. These two diagnoses as well those for the musculoskeletal and circulatory systems accounted for 60 percent of all claims.

Table 7.4 shows average patient claim by diagnoses and place of service. Both inpatient and total claims for congenital anomalies of \$161,000 per patient for hospital care and \$32,000 per patient regardless of place of service were more than five times

larger than average claims for neoplasms, \$26,000 and \$6,400, respectively, the next largest diagnostic group.

Table 7.3
Share of Total Claims by Diagnoses and Place of Service

ICD-9 Group	Inpatient	Outpatient	Office	A-E-L	Total
Neoplasm	14.2	5.0	2.4	.8	22.4
Congenital Anomalies	17.3	.8	.1	.1	18.3
Musculoskeletal System	5.3	1.5	2.9	.9	10.7
Circulatory System	6.7	2.4	.9	.5	10.5
Genitourinary System	3.8	2.7	1.4	1.2	9.1
Digestive System	3.9	3.3	.3	1.2	8.7
Perinatal Conditions	2.2	1.9	3.5	.6	8.2
Unknown	.4	2.5	.3	1.3	4.6
S/S & Ill-Defined Conditions	.7	.7	.5	.6	2.5
Endocrine/Metabolic & Immunity	.9	.4	.3	.1	1.7
Respiratory System	.8	.4	.2	.0	1.3
Nervous System/Sense Organs	.0	.5	.5	.3	1.3
Other	.0	.1	.2	.3	.7
Total	56.1	22.2	13.6	8.0	100.0
Amount	\$1,568,626	\$621,899	\$381,345	\$225,023	\$2,796,893

Table 7.4
Average Patient Claim by Diagnoses and Place of Service

ICD-9 Group	Inpatient	Outpatient	Office	A-E-L	Total
Neoplasm	\$26,400	\$5,016	\$1,610	\$1,899	\$6,463
Congenital Anomalies	161,296	4,348	587	3,390	32,070
Musculoskeletal System	21,304	2,589	1,117	2,862	2,837
Circulatory System	14,477	2,977	592	2,288	3,550
Genitourinary System	6,629	2,887	479	1,476	1,722
Digestive System	18,083	4,371	314	1,483	3,048
Perinatal Conditions	3,167	1,549	833	744	1,177
Unknown	882	2,281	249	1,253	1,164
S/S & Ill-Defined Conditions	4,706	1,985	523	1,244	1,291
Endocrine/Metabolic & Immunity	8,103	1,363	312	152	892
Respiratory System	2,630	2,072	276	400	1,177
Nervous System/Sense Organs	964	13,004	358	2,875	865
Other	239	1,314	222	1,733	525
Average	\$14,132	\$2,933	\$674	\$1,406	\$2,666

Patient utilization of health care facilities is shown in Tables 7.5 and 7.6. In terms of visits, patients most commonly visited the office of a physician or other medical professional once followed by single A-E-L [ambulatory surgery center, emergency room or laboratory] visits. Offices were the most common place visited followed by out patient and A-E-L visits. Heavy utilization of the same place of service was relatively infrequent with patients with six or more visits accounting for only about 5 percent of all visits.

On the other hand, as might be expected, patients who heavily utilized medical services accounted for a disproportionate share of all claims. As Table 7.6 shows, patients with 4 or 5 visits accounted for 28 percent of all claims while those with 6 to 10 visits accounted for 13 percent and those with 11 or more accounting for 20 percent. As a group, patients with 4 or more visits accounted for more than 60 percent of all claims. Average inpatient claims of \$14,100 were nearly seven times larger than outpatient ones of \$2,900. As might be expected, average claims increased with the frequency of visits with average claims for patients with eleven or more visits 10 times larger for inpatients and 25 times larger for office visits.

Table 7.5
Patients by Number of Visits and Place of Service

Place of Service	Number of Visits						Total
	1	2	3	4-5	6-10	11+	
Patients							
Inpatient	41	18	12	21	13	6	111
Outpatient	89	51	34	27	7	4	212
Office	336	119	52	37	17	5	566
A-E-L	111	32	11	4	2	0	160
Total	577	220	109	89	39	15	1,049
Relative Frequency							
Inpatient	3.9	1.7	1.1	2.0	1.2	.6	10.6
Outpatient	8.5	4.9	3.2	2.6	.7	.4	20.2
Office	32.0	11.3	5.0	3.5	1.6	.5	54.0
A-E-L	10.6	3.1	1.0	.4	.2	.0	15.3
Total	55.0	21.0	10.4	8.5	3.7	1.4	100.0

**Table 7.6
Claims by Visits and Place of Service**

Place of Service	Number of Visits						Total
	1	2	3	4-5	6-10	11+	
Claim							
Inpatient	\$70,856	\$72,812	\$142,453	\$517,966	\$261,594	\$502,944	\$1,568,626
Outpatient	87,003	138,823	125,340	198,793	64,402	7,539	621,899
Office	117,580	82,083	60,876	55,929	22,580	42,298	381,345
A-E-L	149,384	46,769	23,447	1,905	3,518	0	225,023
Total	\$424,824	\$340,486	\$352,116	\$774,593	\$352,094	\$552,781	\$2,796,893
Average Claim							
Inpatient	\$1,728	\$4,045	\$11,871	\$48,377	\$91,157	\$83,824	\$14,132
Outpatient	978	2,722	3,686	15,137	17,487	1,885	2,933
Office	350	690	1,171	3,117	5,227	8,460	674
A-E-L	1,346	1,462	2,132	760	3,518	0	1,406
Total	\$736	\$1,548	\$3,230	\$18,766	\$30,165	\$36,852	\$2,666
Relative Frequency							
Inpatient	2.5	2.6	5.1	18.5	9.4	18.0	56.1
Outpatient	3.1	5.0	4.5	7.1	2.3	0.3	22.2
Office	4.2	2.9	2.2	2.0	0.8	1.5	13.6
A-E-L	5.3	1.7	0.8	0.1	0.1	0.0	8.0
Total	15.2	12.2	12.6	27.7	12.6	19.8	100.0

8. BENEFITS AND COSTS

As shown in Table 8.1, during its first operational year, from October 2003 to September 2004, Project Access had total income of \$366,002 and total expenses of \$320,915, leaving a carryover for year two operations of \$45,087. Major sources of income and the cause of the carryover are multiyear grants for operations and administrative costs by the Robert Wood Johnson Foundation, with matching funds from Sacred Heart Medical Center, Empire Health Services, Group Health, the Yakima Valley Farm Workers Clinic, the Washington Health Foundation, the Community Health Plan, Health Improvement Partnership - Health Resources and Services Administration, Foundation Northwest and Washington Trust Bank. Drugs and pharmaceutical services were funded by grants from Spokane County and the Cities of Spokane, Airway Heights, Cheney, Deer Park, Liberty Lake, Medical Lake, Millwood and Spokane Valley. Major expenses were personnel costs followed by operations and administration.

Table 8.1
2003 - 2004 Income and Expenses

Income	Amount	Percent	Expenses	Amount	Percent
Health Care Organizations	\$166,409	45.5	Personnel	\$232,181	72.3
Robert W. Johnson Foundation	141,666	38.7	Operations	50,400	15.7
Regional Grants	51,000	13.9	Administration	38,334	12.0
Community Businesses	6,525	1.8			
Other	402	.1			
Subtotal	\$366,002	100.0	Subtotal	\$320,915	100.0
Carry Forward	\$45,087				

Project Access produces both measurable and unmeasurable benefits. Health care services are provided to patients who might otherwise utilize emergency room or other medical services, thereby relieving the community of the costs of health care services that it might have been provided to Project Access patients. Individuals receiving Project Access care presumably are healthier and now more able to make a greater contribution to the local economy. Community welfare is increased because the health of some of its members has increased. Unfortunately, benefits bearing on individual or community well-being or avoided public expenditures are very difficult to measure and, while important, must be ignored for purposes of this assessment.

Measurable benefits from Project Access are of two types. One involves the utilization or volume of health care services without consideration to the complexity or cost of care as indicated by the number of patient visits recorded in insurance claims submitted by physicians and hospitals showing the procedure, diagnosis, and charge for services provided. A second measure of benefits is the dollar amount of insurance claims submitted by providers which indicates the quality and intensity of health care delivered. However, as previously discussed, these measures substantially understate the actual volume and value of services donated because insurance claims were not submitted for about 40 percent of all Project Access patients.

Table 8.2 shows patients, medical claims, visits and procedures by place of service, based on insurance claims for 417 patients. Of this group, 380 visited a physician or medical professional while 148 utilized hospital outpatient services, 60 inpatient or laboratory services and so on. Since the same patient could visit an office, become an inpatient and then outpatient, patients by place of service does not provide a unique patient count. Although office visits accounted for nearly half of all visits and a

third of procedures as indicated by specific codes found on insurance claims, hospital services accounted for 78 percent of all claims.

Table 8.3 shows the percent distribution of claims, visits and procedures by place of service. Activities involving hospital inpatient and services predominate, representing 78 percent of the claims, 43 percent of the visits and 51 percent of all procedures. While nearly half of all visits were to offices and a third of procedures were in offices, this place of service accounted for only 14 percent of all claims, probably a reflection of under-reporting. Finally, the distribution of visits and claims by place of service is also illustrated in Charts 8.1 and 8.2.

Table 8.2
Medical Claims by Place of Service

Place of Service	Patients	Claims	Visits	Procedures
Hospital Inpatient	60	\$1,568,626	522	1,355
Hospital Outpatient	148	621,899	514	1,729
Office	380	381,345	1,105	1,958
Ambul. Surgery Cent	46	183,714	74	425
Emergency Room	32	25,458	52	175
Laboratory	60	15,850	113	390
Ambulance	1	1,276	2	4
Home	4	513	5	5
Total	417*	\$2,798,682	2,387	6,041

* Unique patients

Table 8.3
Distribution of Medical Claims
by Place of Service

Place of Service	Claims	Visits	Procedures
Hospital Inpatient	56.0	21.9	22.4
Hospital Outpatient	22.2	21.5	28.6
Office	13.6	46.3	32.4
Ambul. Surgery Cent	6.6	3.1	7.0
Emergency Room	0.9	2.2	2.9
Laboratory	0.6	4.7	6.5
Ambulance	0.0	0.1	0.1
Home	0.0	0.2	0.1
Total	100.0	100.0	100.0

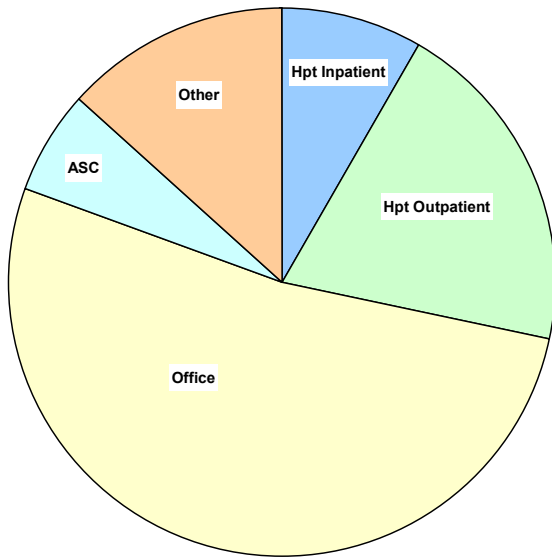


Chart 8.1 Patient Visits

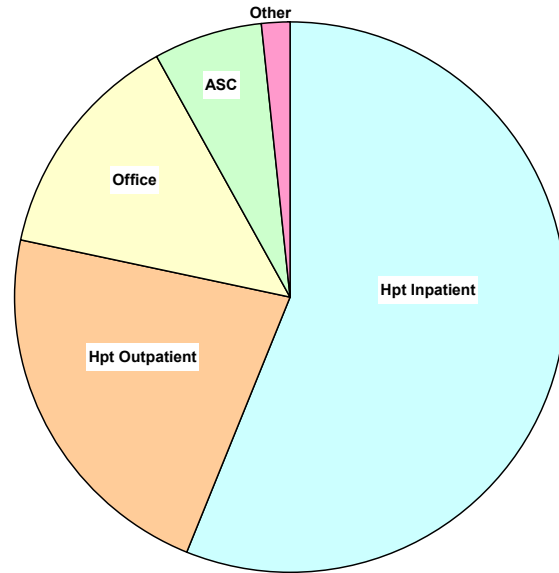


Chart 8.2 Patient Claims

Because insurance claims are lacking for nearly 40 percent of the patients, the claims data found above in Table 8.2 significantly understates both the value and volume of medical services donated by Project Access participants. The magnitude of this understatement is estimated as follows. Of 417 patients for which claims data exists, 380 or 91.13 percent had an office visit. This same behavior is assumed for 263 of the 289 patients for which no claims data exists. These patients are further assumed to have generated “average” office claims, visits and procedures; the totals of which are shown in Table 4.3 as “Office Estimate.” The remaining 26 patients are assumed represent “average” claims, visits and procedures of “other” places of services which includes, ambulatory surgery centers, emergency room, laboratory, ambulance and home care. This estimate is found in Table 4.3 as “Other Estimate.”

Together, with the known claims data, Table 8.3 shows the estimated value and volume of donated Project Access services during its first year of operation. These figures indicate \$3,104,210 in medical services representing 3,198 visits and 7,580 procedures were donated by the Spokane County medical community to Project Access.

Table 8.3
Estimated Project Access Medical Services,
October 2003 to September 2004

Source	Patients	Claims	Visits	Procedures
Medical Claims	417	\$2,798,682	2,387	6,041
Office Estimate	263	264,289	766	1,357
Other Estimate	26	41,238	45	182
Total	706	\$3,104,210	3,198	7,580

The data in Table 8.3 allow the calculation of a benefit-cost ratio for Project Access. An estimated total of \$3,104,210 in medical services was donated to Project Access to provide care for 706 patients at an expense of \$320,915. Thus, for every dollar of expense, Project Access generated \$9.67 in medical services to the medically underserved citizens of Spokane County. Individual Project Access patients received an average of \$4,395 in medical services, averaged 4.5 visits to a variety of medical providers and received an average of 10.7 medical procedures or services.

9. RECOMMEDATIONS

During its first operational year, from October 2003 to September 2004, Project Access provided an estimated total of \$3,104,210 in medical services to 706 low income, uninsured, Spokane County residents at an average cost of \$499 each. This average should be compared against the experiences of similar voluntary initiatives to determine the relative cost-effectiveness of Project Access and to develop cost benchmarks.

Insurance claims were not submitted for nearly 40 percent of the patients. Reasons for this low submission rate should be a matter of concern because it makes it difficult to accurately determine the value and volume of services provided by Project Access. Reasons for the low submission rate might be lack of awareness by participating providers regarding the importance of claims submissions, inadequate record-keeping or inconsistent claims procedures. A potential stop-gap until the problem is resolved is to for the Project Access administrative staff to maintain elaborate appointment data including provider and referral specifics. Activity estimates could be developed from this administrative data.

Both patient and provider views regarding Project Access should be surveyed to determine participant satisfaction, program strengths and weakness, and identify unmet needs. The importance and usefulness of these surveys can not be understated:

“...satisfaction is a key indicator of the success or failure of a program, ... critical in guiding changes in program planning. Patient satisfaction provides feedback to Project Access leadership and staff about opportunities to improve their processes. To retain physician support to continue providing donated medical services, physician satisfaction and dissatisfaction [should be] monitored [Ablah, Wetta-Hall and Burdsal, 2004].”

A post-treatment follow up survey would allow determination of the effectiveness of Project Access care and its impact on other community low income health programs and emergency services. The survey would permit a determination of the influence of Project Access on the labor force participation rate of patients and also provide a basis to estimate the overall economic and social benefits of the program to Spokane County.

Participating physicians and medical professionals agreed to accept ten patients per year while specialists would accept twenty patients. This standard has not been approached. A least one claim was submitted by 380 providers indicating a potential client base of 3,800 patients as opposed to the current actual number of 706. Reasons for this relatively low enrollment of Project Access should be examined. As a new program, perhaps it is undergoing startup problems in establishing eligibility procedures and identifying and informing prospective patients.

While some of these recommendations are procedural, others imply the need to develop, implement and analyze relatively complicated survey instruments, an undertaking that would be difficult to accomplish with current levels of information technology and funding.

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**MUNICIPALITIES, ORGANIZATIONS, FOUNDATIONS, GROUPS,
AND INDIVIDUALS PROVIDING FINANCIAL OR IN-KIND SUPPORT
TO PROJECT ACCESS**

City of Airway Heights	Intercollegiate College of Nursing
City of Cheney	Itronix Corporation
City of Deer Park	Martin Investment Group
City of Liberty Lake	Mike and Muffy Murphy Fund
City of Medical Lake	Molina Health Care of Washington
City of Millwood	Spokane Physician Hospital Community Organization
City of Spokane	Premera Blue Cross
City of Spokane Valley	Providence Health Services [Sacred Heart, Holy Family & Deer Park Hospitals]
Community Foundation of South Puget Sound	Robert Wood Johnson Foundation
Community Health Association of Spokane [CHAS Clinics]	Spokane County
Community Health Plan of Washington	Spokane County Department of Health
Downtown Kiwanis	Spokane County Medical Society Foundation
Spokane Downtown Rotary Club #21	Washington Health Foundation
Empire Health Services [Deaconess & Valley Hospitals]	Washington Trust Bank
Family Home Care Corporation	Yakima Valley Farm Workers Clinic [Spokane Falls Family Clinic]
Foundation Northwest	
Group Health Community Foundation	
Health Improvement Partnership	

ORGANIZATIONS DONATING MEDICAL SERVICES TO PROJECT ACCESS

American Medical Response	Inland Neurosurgery & Spine
Choice Medical Supplies	PAML
Deaconess Medical Center	Sacred Heart Medical Center
Family Home Care	Spokane Eye Surgery Center Associates
Gentiva Health Services	St Luke's Rehabilitation Institute
Holy Family Hospital	Valley Hospital & Medical Center
Inland Imaging	

INDIVIDUALS DONATING MEDICAL SERVICES TO PROJECT ACCESS

Daniel Abbott
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Karen Ahlstrom
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