Affordable health care practiced here

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We present our experience in providing affordable primary care to the uninsured population of a rural Wisconsin county in the hope that it may be of interest to physicians in other parts of the state with similar needs.

Door County has been aware of a crisis in providing access to primary health care for several years and "access to affordable health care" has been identified as one of the top concerns by civic organizations. It is estimated that more than 35% of the county's working people are inadequately covered by medical insurance and 7.8% were uninsured in 2000. According to census data, 6.4% of residents had an income lower than the federal poverty level. Door County is an officially designated medically underserved area. A free clinic, based at the county's only hospital, was open from June 2000 to July 2003. It met some of the needs, but failed to attract individuals reluctant to be recipients of charity. Financial and space problems led to the free clinic's closing.

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Seven months later, a primary care clinic for the uninsured was opened by a local nonprofit organization and later was incorporated as the Community Clinic of Door County (CCDC) with the goal of making primary health care affordable to the uninsured and medically indigent population of our county and the adjacent area. In the 20 months of the program's operation, we have served 408 individual patients with a total of 1125 encounters. Currently we see about 100 patients a month.

The core clinical staff consists of three retired physicians (two internists and one neurologist) working no more than one half day per week, supplemented episodically, as needed, by active family physicians and internists from local practices. A paid nurse practitioner has her own patient panel and provides schedule back up for the physicians. All patients are seen by appointment during three scheduled sessions per week. The receptionist works Monday through Thursday and refers emergencies to the hospital unless appropriate clinical staff are available. Volunteer registered nurses, most of whom are retired, participate in assessment, teaching, and counseling during all clinic sessions.

Our patient population reflects the entire spectrum of the uninsured. All age groups, from the late teens to the early sixties, are almost equally represented. Most patients are employed, many in part-time or seasonal jobs. The typical patient lives on less income than identified in federal poverty guidelines and has not seen a physician in more than four years. About 60% of the patients are women. Of the initial appointments, 65% are made for acute problems, but many of these patients also have significant chronic diseases. Forty-five percent of all registered patients receive ongoing care for significant chronic health problems. One third of the chronic diseases had been diagnosed but care had been interrupted or neglected prior to the patient's first visit.

A key condition for the successful practice of affordable care is limitation of practice overhead. The expenses of the CCDC are limited to payment for supplies, utilities, and the full-time salary of a secretary/receptionist and partial salary support for an administrator and a nurse practitioner. Physicians and nurses, including the clinic manager, are unpaid volunteers. Liability protection is provided by the State Risk Management Program for Volunteer Health Care Providers (Act 206). The facility is provided rent-free. The clinic does no billing and does not deal with any insurance companies.

As its name implies, the clinic is provided by and for the community. The United Way provides rec-

ognition, credibility, and financial support. The local clinics and the hospital contribute referrals, volunteers, and a limited budget for basic laboratory tests. United Way funding and individual donors help pay for special needs, but payment by patients covers more than 25% of income. The charge schedule differentiates new and return visits by intensity. Fees slide on a scale based on family size and income. Currently the average charge for all visits is $20. The charge for a Level 1 follow-up visit is $5. At the other end of the scale, the charge for a comprehensive examination of a Level 5 patient is $50. Limited laboratory tests for Level 1 and Level 2 patients are provided free of charge by the cooperating clinics. Other tests are done by a regional referral laboratory and provided at cost.

Practicing Cost Savings

The clinic has been able to stay within its limited budget by practicing in a cost-saving manner. As opposed to usual practice, our physician time is a "free" resource. Consequently, we can be generous with that commodity. Physicians spend ample time on the medical history, if necessary on a second visit, since history contributes the majority of important data necessary for diagnosis. Significant effort is spent on patient education. Laboratory studies are limited to the necessary essentials. Panels of laboratory tests, other than lipids, are not used. Close follow-up and return visits are used instead of expensive testing to obtain reasonable diagnostic certainty. Brief therapeutic trials are employed when appropriate to confirm diagnosis with certainty. Instead of using mostly disposables, we launder and sterilize equipment on site. Basic point-of-care diagnostics are employed in the clinic. Additional procedures will be added if they prove "affordable."

Medications

Because the expense of medications limits patients' compliance with good health care, we use several methods to provide necessary drugs to our patients. Drug samples are often used for initial and short-term use. Most of our patients qualify for manufacturer's assistance programs, and we have referred 40 patients to date. More recently we have found the "Rx Outreach" program helpful for patients with low incomes. When a branded drug is not necessary, we provide medications from a purchased supply of generic medications, asking the patient for a voluntary contribution (suggested amount for a one-month supply is $5). The contributions are used to replenish stock. This revolving drug supply was initially funded externally, but is now self-sustaining. And since the cost of home monitoring of blood glucose is not affordable for many diabetics, the clinic uses charity resources to cover that and similar needs.

Referrals

Referrals for consultations and procedures have been necessary only rarely, averaging three per month. We are able to reassure the hospital and group practices of the indigent status of referred patients who are not expected to be able to pay. As a result, these patients have been accepted for charity care. Some of our patients are obviously disabled long-term or qualify for Medicaid but have not been able to receive recognition of their eligibility. Preparing a progress note that summarizes the medical history and that quantitatively describes the patient's disability has been effective in getting public insurance approved for several patients. In those cases, and whenever patients receive health insurance, they are referred or returned to the local clinics for care, consistent with our mission not to compete with the established clinics.

Rewards

The practice proves to be a rewarding experience to physicians, especially those recently retired from practice. Patients are grateful. Positive consequences in health can be observed weekly. There is no outside interference in the practice, especially no calls to or from insurance companies. Documentation serves only the process of care. We are able to comply with established practice guidelines by choosing the most economical listed alternatives and are able to maintain quality care while striving for affordability.

The existence of discretionary options in the management of many health conditions presents one of the keys to offering affordable care. In choosing affordability, the physician and patient forgo the more expensive options. Many of these options have no significant impact on eventual outcome, but serve to enhance short-term diagnostic certainty or the efficient functioning of a practice. The fact that practice routines are different from the usual fee-for-service setting calls for analysis of effectiveness. This may be helpful in the eventual redesign of the health care system. In the meantime we will continue to provide affordable care for uninsured people.

The ability to replicate our approach elsewhere will depend on a community's willingness to provide space and basic support and on the availability of volunteers. We encourage these efforts, and feel that they do indeed make a difference.

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