

BUSINESS PLAN
CUMBERLAND ACCESS PROJECT

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EXECUTIVE SUMMARY

An estimated 25,750 low-income workers in the Lenowisco, Cumberland Plateau, and Mt. Rogers Health District in southwest Virginia have no medical insurance. As a result uninsured workers forego needed medical attention, especially preventive care and early episodic treatment. Many work in spite of undetected problems that signal the onset of serious chronic disease. Postponing medical care due to a lack of insurance helps explain some disturbing disparities between the far southwest Virginia population and the population of Virginia as a whole. Compared to all Virginian, residents of the far southwest are more likely to suffer from chronic illnesses which have contributed to a 29% permanent disability rate compared to the Virginia rate of 17%.

Because of these disturbing facts we plan to develop the Cumberland Access Project (CAP) which will create a region-wide network of physicians and hospitals willing to provide free medical care and ancillary (x-ray, lab) services to a set number of uninsured workers. In our innovative model a public entity will employ staff to recruit private physicians and hospitals into a health care network that creates access by providing free medical care to uninsured workers. These workers and their employers will be asked to participate in their care by providing a fee to register for this program and to keep this service in progress. We intend to serve workers under 300% of the poverty level with the goal of having 40% under 100% of the poverty level, 32% under 200% of the poverty level, and 28% under 300% of the poverty level.

Case managers will be hired to recruit network providers, register and enroll patients, monitor patient compliance, and measure program progress. This project will track services through a software program designed to establish income guidelines for uninsured workers, determine registration fees in accordance to their income, distribute a fair number of patients to each volunteering physician, track compliance of patients, report the dollar value of services, and evaluate satisfaction of physicians and clients. We anticipate that start-up money will come from a Virginia Health Care Foundation grant and continuation of the program will be possible through fees from clients and their employers who register for the program.

CAP will be a total community effort, as it will require charitable public and private partnerships. The advantage to the community will be great. As health care is made available to working uninsured families we anticipate fewer chronic health problem, the work force will be stronger and healthier, the emergency room will see better utilized services, and physicians will be sharing the burden of non-paying patients in a coordinated manner. This project will also allow us to monitor the health care needs of the area and use of this information will help steer us to further meet the health needs of our community.

PROJECT DESCRIPTION

All people need access to essential healthcare. The medical community has a long tradition of compassionately providing charitable care in a variety of forms and fashions. Less commonly, mechanisms have emerged to create a framework around which those compassionate impulses can be harnessed, coordinated and systematically expanded to provide for those in need. That is the object of the **Cumberland Access Project (CAP)**.

The CAP is structured in phases. Phase I begins in Russell County Virginia, a portion of the planned 13 county service area. This model of coordinated charity care has been successfully implemented elsewhere but unique to the CAP is its regional scope and inclusiveness. In Phase I, uninsured working adults in Russell County will be enrolled in this no-cost, timely and coordinated care network established through alliance and integration of existing free clinical resources coupled with the generous participation of Physicians, and other licensed and institutional health care providers in Southwest Virginia.

After completion of Phase I, the CAP will be expanded to the surrounding twelve county area chosen for its similar demographics, economic base, geography and Medical referral patterns. The Buncombe County Medical Society's Project Access was the contemporary pioneer of this model and Project Access of Danville was the first to initiate a similar project in Virginia, the Cumberland Access Project is the first of its kind to plan to offer such a program over such a large geographic area. Additionally, the CAP places its emphasis on the "working uninsured" and employs a nominal registration fee to enable both some program maintenance funds and a measure of commitment for its clients. The CAP also calls for the support of area employers who are unable to offer insurance to their employees or those that do and wish to improve the health of the employable workforce.

Phase I will serve as a pilot and demonstration project for the larger area that we intend to serve. An office will be set up using in-kind building space, furniture, and computer access within the local health department or the community action agency. A case coordinator will be hired to screen patients, provide a medical access card at enrollment (much like an insurance card) and make appropriate referrals to participating physicians.

Primary care physicians in the region area will be asked to provide 10 clients with a medical home for a year. Specialists will be asked to provide 20 consultations in their specialty per year. Inducements, in addition to personal and professional satisfaction, include no malpractice liability. This is triggered under Virginia's "Good Samaritan" legislation VA 54.1-106 when there is no payment/expectation of payment. There is also a state tax incentive through the Neighborhood Assistance Program. CAP will actively work to assure these physicians receive community recognition for their contributions through various media, including news paper advertising,

Participating physicians will find it markedly easier to care for these patients as the CAP will assist with case management and tracking and referral for tests and specialty consultation. A software enabled donation and care value tracking system keeps up with these important metrics. Physicians with existing charitable care relationships will be able to refer their eligible patients to

the CAP to take advantage of the benefits of the program. Often physicians feel alone and overwhelmed when caring for low-income sick people. This model provides those who are already providing free services a satisfying involvement in a recognized charitable partnership while being able to set limits. It also encourages those who do not regularly provide free care to do so, thus spreading out the burden and expanding the resource base. Central to the CAP's intent is to form mutually beneficial alliances with existing regional free clinics and Rural Health Clinics as mutual referral and care resources under this program.

Hospitals are also critical allies. As participants, they will be asked to provide free lab services, x-ray, and diagnostic services. This will help providers have resources for consultation and diagnosis outside their office. From the hospital's standpoint this program both provides them with an opportunity to meet their charitable care missions while often resulting in a net cost savings through a reduction in unnecessary emergency room visits as well as in duplication of services by those who have no ability to pay. This model has demonstrated reductions in non-emergent ED utilization rates. Similarly, unreimbursed hospitalization rates decline due to earlier intervention and better chronic disease management. The tracking component of Cumberland Access Project will also provide retrievable medical information thereby avoiding the expense of repeated tests.

An existing pharmacy access program, Pharmacy Connect, will be utilized to provide prescribed medications whenever possible and specific grant monies will be set aside to help cover the cost of medicine. CAP clients will also be asked to pay a \$5 co-pay to help toward the cost of their prescriptions. The ability of patients to have access to medicines prescribed is another vital part of this program and another advantage to the physicians and patients.

CAP intends to enroll 100 clients during the first year. Patients must meet income guidelines. Forty will be under 100% of the poverty level and will be assessed a \$100 registration fee to defray enrollment expenses and keep the program in place for the next year. This charge will go toward the referral and tracking of each client and assist with metrics. This is not a fee for any medical service rendered. Physicians will be asked to submit a HCFA 1500 form to track services but will not have to deal with frustrating and obligatory billing to the patient often required outside such a program.

Faith-based partners will be encouraged to consider sponsoring all or part of these fees for those unable to pay. Employers will also be asked to contribute to this fee based upon the number of employees they hire. Thirty two participants will be under 200% of the poverty level and will be asked to pay \$200 per year with the same formula for employer contribution and 28 participants will be under 300% of the poverty level and will be asked to contribute \$400 per year with help from their employer.

Phase II (year 2) will include expansion throughout the Cumberland Plateau Health District (counties of Dickenson, Buchanan, and Tazewell in addition to Russell). Phase III will encompass expansion into the Lenowisco and Mt. Rogers Health Districts which will include an additional nine counties and 3 cities.

Each individual will be expected to follow through with all appointments and after care. This will also be monitored. Policies will be in place to address those who do not comply with the program expectations for thoughtful stewardship of the care resources. These participants will face discharge and replacement. Several software products are under consideration to assist with data tracking and measurement.

PERFORMANCE OBJECTIVES/MEASURES

Objective #1: Secure adequate financing for the Cumberland Access Project.

By 01/31/03. Submit a concept letter about the Cumberland Access Project to the Virginia Health Care Foundation (VHCF). The Cumberland Plateau Health District will act as service agent for the new project. **(MAPH Team.)**

By 03/28/03. If encouraged by VHCF, submit a formal proposal for funds to establish and operate the CAP for one year. Customize the CAP business plan as needed to meet VHCF grant guidelines. **(MAPH Team)**

By 06/01/03. Prepare and submit an application for Healthy Communities Access Program (HCAP) funds to the Health Resources and Services Administration (HRSA). **(MAPH Team)**

By 07/01/03. Receive operating funds from the VHCF. **(VHCF)**

By 11/01/03. Learn whether the application for HCAP grant funds is approved or rejected. If approved, modify program plans accordingly. If not approved, revise application for re-submission in 2004. **(CAP Advisory Board)**

By 05/01/04. Re-submit application to HRSA for HCAP grant funds. **(CAP Advisory Board)**

By 05/01/05. Re-submit application to HRSA for HCAP grant funds. **(CAP Advisory Board)**

Objective #2: Staff and equip the Cumberland Access Project.

By 08/01/03. Occupy donated space on the premises of the Russell County Health Department in Lebanon, Virginia. Solicit donated office furniture and equipment from area businesses and/or surplus equipment from the Commonwealth of Virginia. **(Medical Director)**

By 08/01/03. Receive and set up computer equipment to be donated by the Cumberland Plateau Health District and the Southwest Virginia Graduate Medical Education Consortium. Purchase customized computer software. **(Medical Director)**

By 09/01/03. Employ an experienced registered nurse or social worker as Case Manager #1. Employ a Clerk. Install the new employees on the premises of the Russell County Health Department. **(Medical Director)**

By 10/01/03. Orient staff to their duties and arrange for on-site computer training with software vendor and colleagues in similar programs. **(Medical Director)**

By 12/31/04. Employ Case Manager #2. Orient staff to their duties. **(CAP Director/Case Manager)** Purchase computer hardware for new staff. **(Medical Director)**

By 12/31/05. Employ Case Managers #3 and #4. Orient staff to duties. Purchase computer equipment for new staff. **(CAP Director/Case Manager)**

Objective #3: Provide for effective governance of the program.

By 04/01/03. Create a CAP Advisory Board with individuals representing public and private health care providers, potential CAP clients, hospitals and local employers. **(MAPH Team)**

By 12/31/03. Establish policies and procedures to guide administration of the program using models available from similar projects in Virginia or other states. **(CAP Advisory Board, Legal Counsel)**

By 12/31/03. Upon demonstration of leadership ability and work capacity, appoint Case Manager #1 to the position of CAP Director/Case Manager. **(CAP Advisory Board)**

Objective #4: Recruit physicians and facilities as CAP service providers.

By 12/31/03. Market the program in Russell County. Place advertisements announcing the program in the local and regional newspapers and on the local radio station. Issue press releases to the media and solicit invitations to appear on local radio and television talk shows. Promote the program at meetings of the local chamber of commerce, other civic organizations, and the local ministerial association. **(CAP Director/Case Manager, Medical Director, CAP Advisory Board)**

By 12/31/03. Draft a set of contracts for use with primary care physicians, specialists, acute care hospitals, and tertiary care facilities. **(CAP Director/Case Manager)**

By 02/01/04. Secure written contracts with an initial set of 7-8 primary care physicians, all local specialists willing to commit, the UVA Office of Telemedicine, and the Russell County Medical Center. **(CAP Director/Case Manager, Clerk)**

By 02/01/04. Design an identification card for CAP clientele. **(CAP Director/Case Manager)**

By 02/01/04. Establish a new primary care service at the Russell County Health Department capable of enrolling 15 CAP clients. **(Medical Director)**

12/31/04 – 02/28/05. Renew marketing efforts in Russell County and market the program as above to residents of Tazewell, Buchanan, and Dickenson Counties. **(Case Managers)**

By 03/01/05. Expand the Cumberland Access Project to include the entire Cumberland Plateau Health District (Buchanan, Dickenson, Russell, and Tazewell Counties). Secure written contracts with at least 25 primary care physicians in the Health District, with as many local specialists as are willing to commit, and with Buchanan General Hospital, Tazewell Community Hospital, and the Clinch Valley Medical Center. **(Case Managers, Clerk)**

By 07/01/06. Expand CAP to include the Lenowisco and Mt. Rogers Health Districts (counties and cities of Lee, Norton, Scott, Wise, Washington, Bristol, Grayson, Carroll, Galax, Bland, Smyth, and Wythe). Secure written contracts with 80 primary care physicians, all specialists willing to commit, and the following hospitals: Johnston Memorial, Smyth County Community, Wythe County Community, Norton Community, Bon Secours St. Mary's, Lee Regional Medical Center, and Twin County Regional Healthcare. **(Case Managers, Clerk)**

Objective #5: Enroll uninsured workers as CAP clients.

By 12/31/03. Set a date to begin accepting applications from uninsured workers to participate in the Cumberland Access Project. **(CAP Advisory Board)**

By 12/31/03. Seek financial commitments from Russell County businesses to cover all or part of CAP registration fees on behalf of their employees. Seek donations from faith-based organizations to sponsor clients whose employers are unable or unwilling to sponsor them. **(CAP Director/Case Manager, Clerk)**

By 03/01/04. Enroll 100 uninsured workers from Russell County as clients in the CAP program. Forty of these workers should have incomes under 100% of poverty, 32 should have incomes between 101 and 200% of poverty, and 28 should have incomes between 201 and 300% of poverty. **(Case Managers)**

By 03/01/04. Assign clients to participating primary care providers. Refer clients as needed to participating providers of ancillary services (lab, x-ray, pharmacy, etc.) and sub-specialty physicians. **(Case Managers)**

By 03/01/04. Monitor the provision of services to CAP clientele and client compliance in keeping appointments and following through with provider treatment plans. **(Case Managers)**

By 06/01/04. Increase enrollment to 250 uninsured workers from Russell County. 100 workers should have incomes <100% poverty, 80 should have incomes between 101 and 200% of poverty, and 70 should have incomes between 201 and 300% of poverty. **(Case Managers)**

By 03/01/05. Expand enrollment to 375 uninsured workers from the Cumberland Plateau Health District. 150 clients should have incomes <100% poverty, 120 should have incomes between 101 and 200% of poverty, and 105 should have incomes between 201 and 300% of poverty. **(Case Managers)**

By 07/01/06. Increase enrollment to 1,000 uninsured workers from the Cumberland Plateau, Lenowisco, and Mount Rogers Health Districts. Each Case Manager will handle 250 clients.

400 clients should have incomes <100% poverty, 320 should have incomes between 101 and 200% poverty, and 280 should have incomes between 201 and 300% poverty. **(Case Managers)**

By 07/01/07. Increase enrollment to 1,200 uninsured workers from the tree health districts. Each Case Manager will have 300 clients. 500 clients should have incomes <100% poverty, 400 should have incomes between 101 and 200% poverty, and 300 should have incomes between 201 and 300% poverty. **(Case Managers)**

INDUSTRY ANALYSIS

Nationwide, care provision for the uninsured is a very loosely structured conglomeration of governmental and nongovernmental programs funded primarily through grants and write-offs. Write offs, often result from legal requirements to provide care in emergency circumstances or beneficial action on the part of a variety of individuals and organizations. Given the lack of a national solution to the well documented problem of the uninsured, the trend has been for local action on the part of various, mostly nongovernmental organizations to utilize a variety of charitable and reduced cost care coupled with a modicum of governmental grant funding or redirection of existing funding.

These mostly partial or ‘stop-gap’ solutions cobble together local care access in various forms to include sliding scale or free clinics, insurance-like programs or managed charitable care. In most communities however these resources simply don’t exist and often care is forgone until the situation becomes dire enough to qualify for governmental entitlements or emergency care is required. Often patients are left with few options other than bankruptcy to clear their accounts following significant medical episodes.

In the CAP Phase I target area, various health care providers currently offer disparate elements of care to the medically needy and underserved, but lack the capacity to offer the totality of care needed. Russell County has one community health center that offers primary care according to a sliding fee scale and there is a free health clinic in a neighboring county that accommodates many residents of Russell County. Very similar circumstances exist in the Phase II and III markets.

Not surprisingly, the single largest barrier to this caring for the uninsured has proven to be funding necessary to provide the coordination and management of donated care. We plan to obtain the funding we need through a combination of registration fees charged to clients, in-kind support, and contributions from local public and private sources. This endeavor may be perceived as a threat by our local free clinic organization and possible to some extent by federally supported community clinics.

We will counter this perception and concern by actively allying with these organizations to include offering their key leaders board membership and actively working to collaborate, support and deconflict our model with the existing resources. This has been successfully accomplished by more than 10 other communities nationwide who have embarked on this model. The ultimate keys to success in this endeavor will be the securing and maintenance of adequate

funding opportunities to create the infrastructure to unify and manage the provision of donated care.

TARGET MARKET AND DEMONSTRATION OF NEED

- **Low income (under 300% of federal poverty level) uninsured working adults**

The Cumberland Access Project will be developed in three phases. Phase I will involve Russell County, Virginia. Phase II will involve the Cumberland Plateau Health District, comprised of Russell, Tazewell, Buchanan, and Dickenson Counties. Phase III will involve the Cumberland Plateau Health District, the Lenowisco Health District, and the Mount Rogers Health Districts. These three health districts include the 16 westernmost counties and cities in Virginia’s mountainous and economically challenged Far Southwest region. The directors of all three health districts have agreed to promote CAP.

The success of CAP depends upon the enrollment of uninsured workers who are willing to pay a modest fee in support of the program’s administrative costs. Market research shows that CAP will need to enroll only a small fraction of the region’s uninsured workers in order to generate enough revenue to run the program after the start-up year.

We estimated the number of uninsured workers for each phase of our project by looking at U.S. Census 2000 figures on employment by industry. The following chart estimates how many uninsured workers there are in Russell County, the Cumberland Plateau Health District, and the Southwest Virginia region.

	Phase I: Russell County			Phase II: Cumberland Plateau			Phase III: Southwest Virginia		
	Uninsured			Uninsured			Uninsured		
<i>Industry</i>	#Wkrs	%	#	#Wkrs	%	#	#Wkrs	%	#
Farm/Mine/Forest	1028	20%	205	4365	20%	873	9999	20%	1999
Construction	898	30%	269	3195	30%	958	11906	30%	3571
Manufacturing	1939	20%	388	4764	20%	952	32763	20%	6553
Retail/Wholesale Trade	1498	25%	374	6855	25%	1713	25977	25%	6474
Trans/Warehouse/Utilities	816	10%	81	2987	10%	298	8614	10%	861
Information	125	0%	0	760	0%	0	2978	0%	0
Finance/Insurance/Realty	337	5%	17	1452	5%	73	5432	5%	272
Admin/Science/Manage	558	0%	0	1958	0%	0	7357	0%	0
Education/Health/Social	2179	5%	108	8945	5%	447	32067	5%	1603
Food/Accom/Recreation	427	30%	128	1885	30%	565	9750	30%	2925
Public Administration	555	0%	0	2295	0%	0	7708	0%	0
Other Services	509	20%	102	2163	20%	432	7499	20%	1499
Totals	10869	15.3%	1672	41624	15.1%	6311	162050	15.8%	25757

Estimated percentages of uninsured workers in each industry are based on our experience in providing health care to patients employed in these industries. Our estimate is that 20-30% of workers in lower paying occupations such as farming, logging, construction, manufacturing, and retail trade or in lower paying services such as food, recreation, and accommodations are likely to be uninsured. We estimate that 0-10% of workers in higher paying fields such as finance, insurance, utilities, and public administration or in higher paying services such as health, education, and information are uninsured. Our estimates are conservative but consistent with findings reported in *The Virginia Health Access Survey 2001* by the Virginia Health Care Foundation, which estimates that 20.4% of the overall Southwest Virginia population is uninsured.

CAP needs to enroll less than 6% (100 individuals) of an estimated 1,672 uninsured workers in Russell County in order to generate projected revenue from enrollment fees in year one (Phase I). We need to enroll 22% (375 individuals) of all uninsured workers in Russell County in year two. Starting in the last quarter of year two, CAP will implement Phase II, expanding operations into the Cumberland Plateau Health District. We need to enroll 12% of the Cumberland Plateau's uninsured workers in year three and 16% in year four to generate enough revenue for operations. Phase III of our project, which involves expansion into the Lenowisco and Mount Rogers Health Districts, will be implemented only if we are successful in obtaining federal funds to capitalize the project.

People who live in our target area are at greater risk of poor health status than the people of Virginia as a whole. According to averaged, age-adjusted death rates for the five-year period 1996-2000 in *Virginia Health Statistics Annual Reports*, adults aged 35-64 in the southwest die at a rate that is 30% faster than the same age group in Virginia. Moreover, residents of southwest Virginia are:

- 50% more likely to die from heart disease
- 51% more likely to die from COPD
- 52% more likely to die from pneumonia/influenza
- 29% more likely to die from diabetes mellitus
- 54% more likely to die from chronic liver disease,
- 49% more likely to die from unintentional injuries, and
- 69% more likely to commit suicide.

Not only is the population of southwest Virginia sicker than the overall population of Virginia, it is also poorer. Twenty-nine percent (29%) of our population between the ages of 21 and 64 is disabled; only 17% of the same set in Virginia is disabled. The poverty rate in our target area is 75% higher than the Virginia rate (16.8% compared to 9.6%) and per capita income in the southwest (\$15,787) is only 65% of the capita income in Virginia (\$23,975). (Data source: U.S. Census 2000.) Poverty makes people sick. Low income uninsured workers should be amply motivated to enroll in the CAP program so that they can access on-going medical services at minimal cost.

According to *Health Care Access in Southwest Virginia (2001)*, one of the major barriers to health care in Southwest Virginia is a “lack of coordination for resources and services.” The consensus is that additional resources are needed to create access to timely, appropriate medical care that includes basic patient education, preventive services, and on-going management of chronic illnesses. Medical literature shows that early and episodic intervention prevents more costly or injurious disease progression.

In addition to a target population, we are addressing several perceived needs of stakeholder groups within the community.

- **For enrollees/clients:** CAP will bring timelier access to episodic, primary and specialty care in an office setting without embarrassment or financial hardship. CAP should also enhance access to preventive services and early episodic intervention, thereby preventing disease progression while reducing overall costs.
- **For the community:** We believe there will be increased pride and satisfaction among uninsured workers and employers alike, along with a more progressive and attractive business environment. Over time, CAP should reduce the number of disabled workers in the region due to the early treatment of episodic problems and the slower advance of chronic illnesses.
- **For regional employers:** CAP should make a small but positive impact in the areas of improved worker health, reduced absenteeism, and fewer Workers’ Compensation claims. We recognize that it may not be possible to measure such an impact other than by anecdotal information.

THE COMPETITION

Partners and resources in the community include the following: Physicians, other clinicians, hospitals, free clinics, pharmacists, local governments, public health workers, employers, faith-based and charitable organizations, community and volunteer organizations, industrial development authorities, local social services departments, disaster and emergency task forces, home health care providers, and EMS providers.

Although federally supported clinics with their ability to provide sliding scale or even free care represent a potential ‘competitor’, successful alliances between similar models and these federally supported entities exist. The physicians in this type of clinic can enjoy the case management and ancillary care access benefits of participation, while providing a medical home for CAP clients. Physicians will also have the benefit of no malpractice liability. The clinic, in turn, is often able to increase its patient base while decreasing its costs in caring for these clients. Free clinics may decrease their patient overflow. Employers may see less absenteeism from employees. Hospitals will have less unnecessary hospitalizations and ER visits. Locally, we should experience a healthier community and workforce. Differences in poverty level based eligibility will be deconflicted. It is evident that collaboration, rather competition is the best way to assist the uninsured citizens of our area. Should another organization arise with this or similar model, we would certainly anticipate forming a mutually beneficial strategic alliance or merging our operations if more advantageous.

MARKETING STRATEGY

Our goal is to market CAP to identified customers and service providers to insure support for and sustainability of a strong, viable program for our region. The first step is to develop a coalition of potential partners and strategic alliances within the community. Beginning in October 2002, we began to target and contact interested primary and specialty-care physicians, speak with hospitals to coordinate services, arrange coordination for prescription medication through Pharmacy Connect, and talk with local health care clinics for support and cooperation. These recruitment efforts are just beginning and will enable CAP to provide a full range of health care services.

One important inducement for professional recruitment will be the use of the Neighborhood Assistance Program (NAP). The NAP was created in 1981 by Virginia's General Assembly to provide a state tax incentive to businesses and individuals to encourage their participation in helping alleviate poverty. Eligible 501c3 and c4 organizations are awarded allocations on a basis of proven operational success and their capacity to serve impoverished people. Each organization is approved on a twelve-month period and must re-apply each year to participate. Individuals and businesses may be eligible for a state tax credit equal to 45% of the donation value. Professional services are limited to accounting, actuarial services, law dentistry, medicine, optometry, pharmacy and professional engineers, providing services at specific locations. Clinch Valley Community Action, Inc., a cooperative partner in the CAP has a trained NAP representative that is available to present the NAP program to businesses and physicians for this recruitment.

CAP plans to incorporate the use of a professional design consultant and the CAP Board for the production of a logo for the program. The board will also decide advertising media, as well. Media resources include reaching employees through newspapers, flyers in pay envelopes, and "town" meetings for large groups; reaching service providers through direct contact, association meetings, Chamber of Commerce meetings and mailings, and newspaper articles and interviews. Quarterly newsletters will be sent to all participating employees, physicians, service providers, and businesses.

Marketing Plan

Customers: Patients, business owners, physicians, office managers, professional staff of service agencies, vendors, staff of Russell County Medical center, and staff of Stone Mountain Health.

I. Physician Recruitment and Retention

Recruitment Campaign

- Kick off medial campaign including advertising and interviews with CAP Director in two local papers – reaching all of Southwest Virginia
- Cooperation with Medical Association for group presentations of CAP program

- Letters to approximately 50 physicians/office managers or other service providers with recruitment literature about CAP
- Commitment forms mailed to all of above contacts
- Follow-up office visits to participating providers, reaching approximately 150 individuals
- Thank you letters to all participants
- Recognition of participants in the two local newspapers, reaching all of Russell County and Southwest Virginia

Recognition

- Monthly advertisement recognizing participants in local papers
- Annual Certificates of Appreciation to all participating parties
- Thank you letters when commitment has been reached
- Quarterly newsletters reaching approximately 500 participants, physicians, and businesses
- Annual recognition event/fundraiser (dinner, etc.)

II. Local Support

Service Organizations

- Letters to 35 local clubs and organizations requesting support
- Presentations to clubs, reaching approximately 500 individuals

Churches

- Mail brochures and referral information to churches
- Presentations approximately 500 individuals/church members
- Seek financial support for prescriptions and other needs

County and City Government

- Mail brochures and literature on CAP program
- Request presentation time at city and county meetings

Private Sector/Businesses

- Educate the business community about the value of CAP to the workforce
- Attach brochures with payroll checks in local businesses, reaching approximately 1000
- Approach businesses with participating employees for financial support

III. State Support

- Maintain contact with state and local representatives through quarterly newsletters
- Virginia Health Care Foundation Grants

IV. Federal Support

- Community Access Project Grant - if refunded

- Continue to seek federal funding
- Support the Health Communities Coalition

V. Private Support

- Seek private donations
- Promote NAP to private sector

PROJECT OPERATIONS AND MANAGEMENT

Partner Roles

The Cumberland Access Project (CAP) is a physician driven concept supported and strengthened by collaborative partners. Partners include:

- Russell County Health Department (RCHD)
- Russell County Department of Social Services (RCDSS)
- Russell County Medical Center (RCMC)
- Tri-County Health (free) Clinic
- Chamber of Commerce,
- Town Councils
- County Board of Supervisors
- Pharmacy Connect, and
- Federally Qualified Health Centers.

Cumberland Access Project expects referrals from RCDSS, RCHD, RCMC Emergency Department, private physicians, free clinics as well as self-referrals from “word of mouth”. Patients will meet income guidelines which will cover 40% of people under 100% of the Federal Poverty Level (FPL), 32% under 200% of FPL, and 28% under 300% of FPL (See CAP Income Guidelines Table). Cumberland Access Project’s day-to-day operations will be managed by a Director under the guidance of a Board of Directors made up of representatives from the community partners. Cumberland Access Project is a non-profit, community-based program supported by in-kind contributions and registration fees charged to clients, their employers or faith-based sponsors.

Daily Operations

Physician Pool. The physicians’ commitment to the CAP is acceptance of a specific number of referrals each year. Once a physician has reached his/her pledged limit, he/she is no longer listed on the “Available Physician” report.

Eligibility Criteria. To be enrolled in CAP, applicants must be employed residents of Russell County with incomes less than 300% of the FPL and with no form of health insurance coverage, including Medicaid, Medicare, or VA benefits.

Enrollment Process and Service Provision

- A phone screening will be taken on each referral to determine eligibility. If client qualifies, an appointment will be scheduled with a CAP case manager for a face-to-face interview.
- When clients arrive for first interview, they will be given a health history questionnaire. The case manager will go over this information with the client.
- At face-to-face interview, client must provide proof of income, previous year's income tax return, and picture ID.
- Case manager takes client's picture and makes ID card; schedules first appointment with primary care provider, and assists client with paperwork for medication assistance.
- Client's enrollment is created in the CAP database (This database will provide the client's enrollment dates, physician appointments, client demographics and income verification. Also, the database will track the number of referrals physicians have pledged and accepted, eliminating the need for the physician's practice to maintain these records).
- After a client is established in the database, the client is mailed a letter outlining the CAP program and its policies along with a resource list of contacts.
- Client will also be mailed a CAP Card. Clients must use their CAP Cards each time they are seen. The CAP Card provides the client's enrollment site and effective date.
- If client's primary care provider sends a specialist referral, the case manager schedules an appointment with the designated specialist.
- Once a client has seen a primary care provider, if prescriptions are written, they will be referred to the Pharmacy Connect program for enrollment. If found eligible, clients can receive donated medicines from pharmaceutical manufacturing companies. CAP will seek additional funds to subsidize medicines for patients ineligible for Pharmacy Connect.
- Clients will be responsible for making any follow-up appointments.
- Clients will be enrolled for one year; at this time they are to be re-evaluated for eligibility.

Value of Services Tracking. Physicians will submit to CAP a completed HCFA 1500 form for each patient visit, thereby enabling the program to track the dollar value of donated services. Cumberland Access Project will be registered with the Neighborhood Assistance Program (NAP), which can provide state tax breaks for providers who donate services.

The CAP enrollees will receive all laboratory, x-ray, diagnostic services and rehabilitation services free of charge due to the collaboration between CAP and RCMC. The hospital will submit to CAP completed HCFA forms listing the value of donated services.

Changes in Client Status. After enrollment, clients must contact CAP in the following instances:

- If they become covered by Medicaid or other health insurance.
- If their income changes.
- When the provider notifies them (clients) that they have completed his/her care.
- If they have a new medical problem that requires specialty care.

Appointment Cancellation. Clients must contact providers at least 24 hours ahead of time if they are unable to keep appointments. Clients must also notify the CAP case manager when appointments are cancelled.

Pharmacy Connect. By linking clients with the Pharmacy Connect program, enrollees will have access to prescription medication on a specified formulary. Cumberland Access Project will continue to seek funding for medications not obtained through Pharmacy Connect.

Malpractice Protection. As long as physicians provide charity care in the office without charging or billing for services they are protected from malpractice under Statute 32.1 – 127.3 *Immunity from Liability Act*.

Information Systems. Cumberland Access Project will implement a state-of-the-art referral, enrollment and client application system to streamline the process of referring the uninsured to needed health services. The system will assist with client enrollment and program eligibility, as well as tracking client appointments and events.

Community Recognition. An ad will be run quarterly in the local newspaper, thanking participating physicians for their commitment to the CAP. A yearly recognition dinner is also planned to show appreciation to the participating providers

Client Courtesy. Upon a client's successful enrollment into the CAP, they will be advised both verbally and in writing of all of the following:

“Many clients will ask who provides all the free health care. Simply put, the health care you receive comes from the hearts of physicians and other health care providers, including the Russell County Medical Center. Cumberland Access Project physicians and providers are not paid by anyone for the care you receive. We encourage clients to say ‘thank you’ to the physicians, nurses, hospital staff, volunteers and others who are providing your care. If you would like to do more to say thank you, please send the provider a card or note of thanks.”

Department/Agency Culture. The goal of the Cumberland Access Project is to give uninsured working adults a “medical home” with a primary physician. The purposes of the Cumberland Access Project shall be non-profit, and exclusively to implement a coordinated, regional and charitable network of physicians and other clinical service providers that will provide office based access to free episodic, primary and specialty medical care for uninsured working people. No part of the corporation's net earnings shall inure to the benefit of any member or individual.

Time Line

January 31, 2003. Submit concept letter to Virginia Health Care Foundation (VHCF).

March 28, 2003. Submit formal proposal to VHCF for CAP start-up funds. Create CAP Advisory Board.

June 1, 2003. Submit application to Health Resources Services Administration for Healthy Communities Access Program (HCAP) funds.

August 1, 2003. Occupy office space, set up donated computers, and purchase software.

September 1, 2003. Employ Case Manager #1 and Clerk.

October 1, 2003. Complete orientation and training of initial staff.

November 1, 2003. Learn whether HCAP application is approved. If approved, modify business plan. If not approved revise application for resubmission next year.

December 30, 2003. Market the program in Russell County. Draft contracts for participating physicians and facilities. Secure commitments from employers to pay enrollment fees on behalf of employees. Establish program policies and procedures. Upon positive evaluation, promote Case Manager #1 to CAP Director/Case Manager.

February 1, 2004. Secure written contracts with initial set of participating physicians and facilities. Design ID card for clientele. Establish primary care service at Russell County Health Department.

March 1, 2004. Enroll 100 clients. Assign and refer clientele to participating providers. Begin monitoring the provision of services and client compliance with treatment plans.

May 1, 2004. Submit follow-up application to HRSA for HCAP funding.

June 1, 2004. Expand enrollment to 250 clients.

December 31, 2004. Employ and equip Case Manager #2. Begin marketing in Tazewell, Buchanan, and Dickenson Counties.

March 1, 2005. Begin Phase II. Expand program to include the entire Cumberland Plateau Health District. Market the program in new territories. Secure written contracts with participating physicians and facilities in the expanded territory. Expand enrollment to 375 clients.

May 1, 2005. Submit follow-up application to HRSA for HCAP funding.

July 1, 2005. Begin reimbursing Cumberland Plateau Health District for a portion of the Health Director's time. Increase enrollment to 500 clients.

December 31, 2005. Employ and equip Case Managers #3 and #4. Renew marketing efforts throughout the Cumberland Plateau Health District.

July 1, 2006. Increase enrollment to 1,000 clients.

July 1, 2007. Increase enrollment to 1,200 clients.

Note: Phase III will be implemented only if CAP receives community access program grant funds from the Health Resources and Services Administration.

RISKS AND EXIT PLAN

Potential Risks

The single largest barrier to this endeavor has proven to be funding necessary to provide the coordination and management of donated care. We plan to obtain the funding we need through a combination of registration fees charged to clients, in-kind support, and contributions from public and private sources. By mobilizing community leaders to serve on planning committees, having a detailed plan for improving access for the medically needy, and making the medical community aware of the extent and nature of access problems faced by uninsured citizens, we will acquire the resources we need.

Due to limited financial resources available to our County Board of supervisors, little can be expected in the way of financial help from local government. However, informing the board of our intentions and having them serve on our planning committees will be a way to secure political support, as the Board wants what is best for the community. Keys to success in this endeavor will be adequate funding and opportunities to unify the provision of donated care.

Long-Term Development Plan

Cumberland Access Project (CAP) is being modeled upon an initiative pioneered in Buncombe County, North Carolina in 1994. The Access Project has been successfully replicated in at least 9 other localities. To our knowledge, however, it has not been attempted on the broad regional scale we envision. In our largely rural region, resources are limited and referral and medical access patterns do not stay within governmental or political subdivisions. This adds to the challenge but we believe also necessitates a broader regional approach.

We envision this most practically occurring in phases with participation targets. These phases may be circumvented or very rapidly advanced depending upon funds and the rapidity of provider interest in participation. Phase I is anticipated to involve initiating the program in Russell County where we will target 100 uninsured working adults the first year. In phase II, the program will be extended into the Cumberland Plateau Health District (counties of Dickenson, Buchanan, and Tazewell in addition to Russell) to target 375 working adults, and Phase III will include two surrounding health districts (Lenowisco and Mount Rogers with an additional 9 counties and 3 cities) to include at least 1200 working adults.

We believe the initial CAP effort will serve as a pilot and demonstration project for the larger area that we wish to serve. An office will be set up using in-kind building space, furniture, and computer access within the local health department or the community action agency. A case coordinator will be engaged to screen patients, provide a medical access card at enrollment (much like an insurance card) and make appropriate referrals to participating physicians.

Regulations

Cumberland Access Project, Inc. will be a Non-Stock Corporation. The purposes of the corporation shall be non-profit, and exclusively to implement a coordinated, regional and charitable network of physicians and other clinical service providers that will provide office based access to free episodic, primary and specialty medical care for uninsured working adults. No part of the corporation's net earnings shall inure to the benefit of any member or individual. Further, the corporation is not organized for profit or organized to engage in activity ordinarily carried on for profit (even if the business is operated on a cooperative basis or produces only sufficient income to be self-sustaining).

Exit Plan

Upon dissolution of the corporation, any funds remaining after payment of all debts shall be distributed to such organizations that in the opinion of the Board of Directors of the corporation, enhances the delivery of health care services without charge to low-income, uninsured working adults in Southwest Virginia.

Five-Year Profit Projection

	2003		2004		2005		2006		2007	
Revenues	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Fees	\$21,600	11	\$81,000	84	\$164,000	88	\$220,000	92	\$250,000	96
Grant	\$150,000	79	\$0	0	\$0	0	\$0	0	\$0	0
In Kind	\$18,460	10	\$15,190	16	\$21,330	12	\$19,070	8	\$10,800	4
Total Revenues	\$190,060	100	\$96,190	100	\$185,330	100	\$239,070	100	\$260,800	100
Expenses	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
Case Mgr. #1	\$30,000	20	\$37,080	32	\$38,190	20	\$39,340	16	\$40,520	16
Case Mgr. #2	\$0	0	\$15,000	13	\$30,900	16	\$31,830	13	\$32,780	13
Case Mgr. #3	\$0	0	\$0	0	\$15,000	8	\$30,900	13	\$31,830	113
Case Mgr. #4	\$0	0	\$0	0	\$15,000	8	\$30,900	13	\$31,830	13
Clerk	\$15,000	10	\$18,540	16	\$19,100	10	\$19,670	8	\$20,260	8
Fringe Benefits	\$11,700	8	\$18,360	16	\$30,730	16	\$39,690	16	\$40,880	17
Contract –MD	\$7,560*	5	\$7,790*	7	\$8,030*	4	\$8,270*	3	\$8,530	3
Travel/Mileage	\$2,925	2	\$4,290	3	\$7,800	4	\$11,700	5	\$11,700	5
Telephone	\$2,500	2	\$2,500	2	\$2,800	1	\$3,200	1	\$3,500	1
Supplies	\$1,750	1	\$1,550	1	\$2,640	1	\$3,330	1	\$3,500	1
Space	\$5,400*	4	\$5,400*	5	\$10,800*	6	\$10,800*	5	\$10,800*	5
Marketing/Post	\$2,400	2	\$3,500	3	\$5,500	3	\$4,500	2	\$4,500	2
Computer Sw	\$62,000	42	\$0	0	\$0	0	\$0	0	\$0	0
Computer Hw	\$2,000*	1	\$2,000*	1	\$2,000	1	\$6,000	3	\$4,000	2
Print/Copy	\$1,000*	1	\$1,000	1	\$1,500	1	\$1,500	1	\$2,000	1
Furniture	\$2,500*	2	\$0	0	\$2,500*	1	\$0	0	\$0	
Total Expenses	\$146,735	100	\$117,010	100	\$192,490	100	\$241,630	100	\$246,630	100
Net Profit (Loss)	\$43,325		(20,820)		(7,160)		(\$2,560)		\$14,170	

*In Kind

Notes on Five-Year Profit Projection

Revenue. Tables appearing below show revenue generated by registration fees per operating year. We have applied to the Virginia Health Care Foundation for a start-up grant of \$150,000. Carry-forward funds from the start-up grant will cover losses in years 2004, 2005, and 2006.

In-kind revenue includes:

- services of the Medical Director from 2003 to 2006. The CAP Medical Director is Director of the Cumberland Plateau Health District.
- space donated by the Russell County Health Department from 2003 to 2007 and Clinch Valley Community Action from 2005 to 2007
- computer hardware donated by the Southwest Virginia GMEC in 2003 and the Cumberland Plateau Health District in 2004
- printing/copying donated by the Russell County Health Department in 2003, and

- furniture donated by local businesses in 2003 and 2005.

Expenses. CAP will employ 0.83 FTE case managers in 2003, 1.5 FTE case managers in 2004, 3.0 FTE case managers in 2005, and 4.0 FTE case managers in 2006 through 2007. We will employ 0.83 clerks in 2003 and 1.0 FTE clerks thereafter. Cumberland Plateau Health District will donate Medical Director services to CAP from 2003 through 2006. CAP will reimburse Cumberland Plateau for Medical Director services in 2007 and thereafter. Space costs, computer hardware, printing/copying services, and furniture will be donated as indicated in the revenue notes above. These are in-kind expenses. We will contract with a software firm to design a system that meets program requirements. The software expense listed above is the amount actually paid for customized software by an organization similar to CAP.

Sliding Scale, Projected Enrollment, and Breakdown of Revenue from Registration Fees

The sliding scale that appears in the following table will be used to determine how much each client will be charged for registration. The sliding scale is based on the federal poverty guidelines published annually by the U.S. Department of Health and Human Services.

Sliding Fee Scale – 2003	Size of Family Unit	Annual Limit
<i>Under 100% of the Poverty Level</i>	1	\$8,980
	2	\$12,120
	3	\$15,260
For each additional person, add \$3,140.		
<i>Between 101% and 200% of the Poverty Level</i>	1	\$17,960
	2	\$24,240
	3	\$30,520
For each additional person, add \$6,280.		
<i>Between 201% and 300 % of the Poverty Level</i>	1	\$26,940
	2	\$36,360
	3	\$45,780
For each additional person, add \$9,420.		

In order to generate enough revenue from registration fees, CAP must enroll clients as shown in the following table.

Enrollment By Poverty Status	Year 1	Year 2	Year 3	Year 4	Year 5
<100% Poverty – Pay \$100	40	150	300	400	500
101% - 200% Poverty – Pay \$200	32	120	230	300	400
201% - 300% Poverty – Pay \$400	28	105	220	300	300
Total Enrollment	100	375	750	1,000	1,200

The five tables below break out the amount of revenue from registration fees projected for the first five years of operation.

Registration Fee Revenue Breakdown – Year One					
Poverty Status	Annual Fee	X	Clients	=	Revenue
Under 100%	\$100	X	40	=	\$ 4,000
101% - 200%	\$200	X	32	=	\$ 6,000
201% - 300%	\$400	X	28	=	\$11,200
Totals			100		\$21,600

Registration Fee Revenue Breakdown – Year Two					
Poverty Status	Annual Fee	X	Clients	=	Revenue
Under 100%	\$100	X	150	=	\$15,000
101% - 200%	\$200	X	120	=	\$24,000
201% - 300%	\$400	X	105	=	\$42,000
Totals			375		\$81,000

Registration Fee Revenue Breakdown – Year Three					
Poverty Status	Annual Fee	X	Clients	=	Revenue
Under 100%	\$100	X	300	=	\$30,000
101% - 200%	\$200	X	230	=	\$46,000
201% - 300%	\$400	X	220	=	\$88,000
Totals			750		\$164,000

Registration Fee Revenue Breakdown – Year Four					
Poverty Status	Annual Fee	X	Clients	=	Revenue
Under 100%	\$100	X	400	=	\$40,000
101% - 200%	\$200	X	300	=	\$60,000
201% - 300%	\$400	X	300	=	\$120,000
Totals			1,000		\$220,000

Registration Fee Revenue Breakdown – Year Five					
Poverty Status	Annual Fee	X	Clients	=	Revenue
Under 100%	\$100	X	500	=	\$50,000
101% - 200%	\$200	X	400	=	\$80,000
201% - 300%	\$400	X	300	=	\$120,000
Totals			1,200		\$250,000

Twelve-Month Cash Flow
 Fiscal Year Begins: July 1, 2003

	7/03	8/03	9/03	10/03	11/03	12/03	1/04	2/04	3-04	4/04	5/04	6/04	Total
Cash on Hand		\$150,000	\$88,000	\$80,308	\$73,065	\$65,823	\$59,180	\$52,938	\$46,695	\$47,653	\$48,610	\$49,568	
Grant	\$150,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$150,000
Fee Collection	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$7,200	\$7,200	\$7,200	\$0	\$21,600
In Kind	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total Cash	\$150,000	\$150,000	\$88,000	\$80,308	\$73,065	\$65,823	\$59,180	\$52,938	\$53,895	\$54,853	\$55,810	\$49,468	\$171,600
Cash Paid Out													
Salaries	\$0	\$0	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$4,500	\$45,000
Fringe Benefits	\$0	\$0	\$1,170	\$1,170	\$1,170	\$1,170	\$1,170	\$1,170	\$1,170	\$1,170	\$1,170	\$1,170	\$11,700
Contract-MD	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Travel/Mileage	\$0	\$0	\$292	\$293	\$292	\$293	\$292	\$293	\$292	\$293	\$292	\$293	\$2,925
Telephone	\$0	\$0	\$1,150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$150	\$2,500
Supplies	\$0	\$0	\$580	\$130	\$130	\$130	\$130	\$130	\$130	\$130	\$130	\$130	\$1,750
Space	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Marketing	\$0	\$0	\$0	\$1,000	\$1,000	\$400	\$0	\$0	\$0	\$0	\$0	\$0	\$2,400
Computer Sfw	\$0	\$62,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$62,000
Computer Hdw	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Printing/Copying	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Furniture	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total Cash Out	\$0	\$62,000	\$7,692	\$7,243	\$7,242	\$6,643	\$6,242	\$6,243	\$6,242	\$6,243	\$6,242	\$6,243	\$128,275
Cash Position	\$150,000	\$88,000	\$80,308	\$73,065	\$65,823	\$59,180	\$52,938	\$46,695	\$47,653	\$48,610	\$49,568	\$43,325	\$43,325

Breakeven Analysis

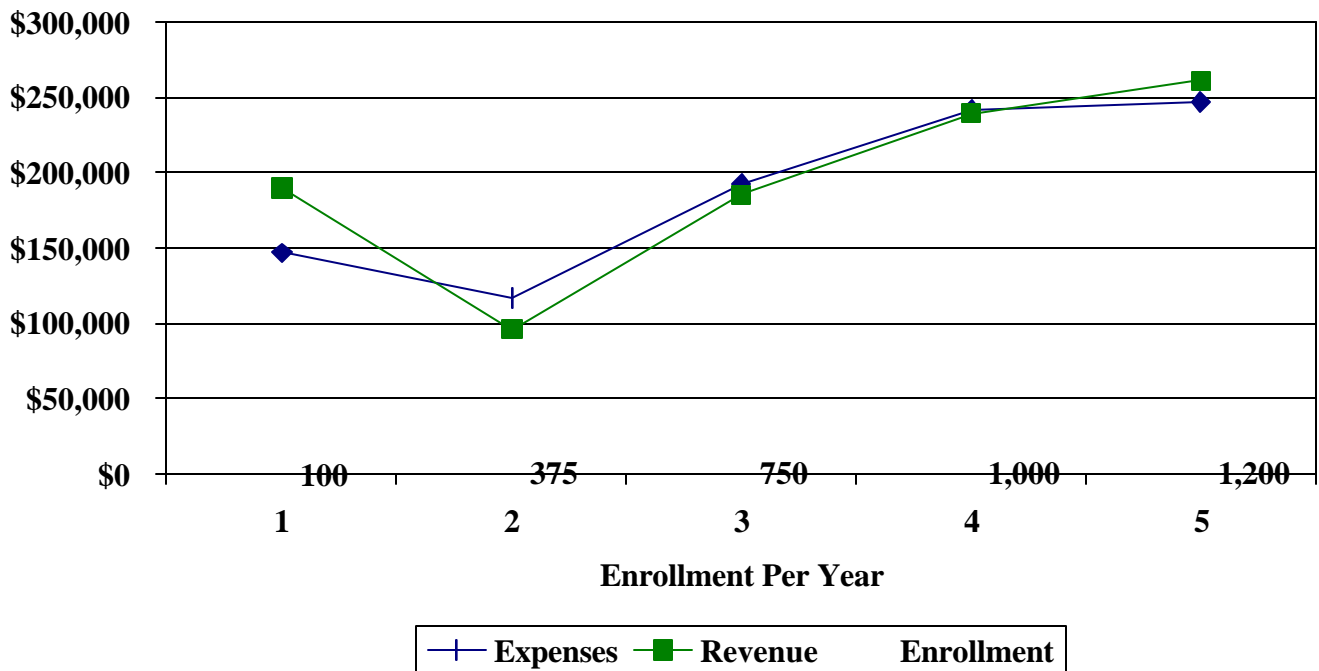
CAP has applied for a grant of \$150,000, receivable in the first year of operations. With the grant, the project will not lose money in its first operating year and unspent grant funds will be carried forward to offset losses in years 2-4. CAP should become self-sustaining in its fifth year of operations. See the table and chart below.

Including a look at fixed vs. variable costs in the breakeven analysis did not prove useful. Most of the fixed costs for CAP are in salaried personnel and since the number of salaried employees changes each year in the project, our fixed costs proved highly variable!

Comparison of CAP Expenses and Revenue

	Year One	Year Two	Year Three	Year Four	Year Five
Expenses	\$146,735	\$117,010	\$192,490	\$241,630	\$246,630
Revenue	\$190,060	\$96,190	\$185,330	\$239,070	\$260,800
Enrollment	100	375	750	1,000	1,200

Cumberland Access Project: Breakeven Analysis



Projected Balance Sheet

	06/30/04	06/30/05	06/30/06	06/30/07	06/30/08
Assets					
Cash in Bank	\$43,325	\$22,505	\$15,345	\$12,785	\$26,955
Accounts Receivable	\$0	\$0	\$0	\$0	\$0
Computer Software	\$41,335	\$24,806	\$12,406	\$4,141	\$0
Total Assets	\$84,660	\$47,311	\$27,751	\$16,926	\$26,955
Liabilities and Equity					
Retained Grant and Fees	\$43,325	\$0	\$0	\$0	\$0
Retained Fees	\$0	\$22,505	\$15,345	\$12,785	\$26,955
Accounts Payable	\$0	\$0	\$0	\$0	\$0
Equity in Software	\$41,335	\$24,806	\$12,406	\$4,141	\$0
Total Liabilities and Equity	\$84,660	\$47,311	\$27,751	\$16,926	\$26,955