



Replication Manual

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OPERATION ACCESS

Replication Manual

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I. INTRODUCTION

OPERATION ACCESS (OA) was started in 1993 by two prominent Bay area surgeons, Dr. Douglas Grey of Kaiser Permanente-San Francisco and Dr. William Schecter of San Francisco General Hospital. The purpose was to help low-income, uninsured people in the community gain access to necessary surgical care. They observed that these individuals were likely to postpone treatment and experience worsening symptoms until an emergency developed.

Paul Hofmann, Dr.P.H, a leading national expert in the field of clinical and organizational ethics, EVP and COO of Alta Bates Corporation in Northern California and former Director of Stanford University Hospital and Clinics was approached to lend his assistance. Dr. Hofmann initiated efforts to obtain tax exemption for **OPERATION ACCESS**, develop articles of incorporation and bylaws, and prepare the initial business plan. He also helped to secure some start-up funding from the Robert Wood Johnson Foundation, through a national initiative called “Reach Out,” designed to encourage medical professionals to volunteer in their local communities.

OA’s initial partnership/network consisted of 15 medical volunteers, one hospital, and 7 clinics in San Francisco County. Today, the OA network has grown to include 80 community clinics that refer patients to OA, 850 medical volunteers, 18 medical groups and 31 hospitals and medical centers serving 6 Bay Area counties: Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Sonoma.

In 2009, 1,175 people received donated surgical services, specialty procedures and screenings through OA. Over 6,000 donated services have now been provided to vulnerable, uninsured people in the Bay Area since OA provided its first surgery in 1994. The total charity care provided through OA now exceeds \$35 million, and for every \$1 donated, OA is able to deliver \$9 of much needed medical care.

Mission: **OPERATION ACCESS** mobilizes a network of medical volunteers, hospitals, and community clinics to provide low-income, uninsured people access to donated outpatient surgeries and procedures that improve their health, ability to work, and quality of life.

This mission has led OA to address three important community health goals:

Goal 1. Improve Access to Care

There is a growing need to improve access to healthcare services for the underserved. Over the past 17 years, OA has developed a collaborative network of clinics, hospitals and medical volunteers so that an increasing number of low-income and uninsured people in the Bay Area can receive the outpatient surgical care they need but cannot afford.

Goal 2. Promote Local Medical Volunteerism

The long tradition of volunteer missions abroad demonstrates the desire among medical professionals to donate care to those in need. Yet, one does not have to travel overseas to find people in need. They also live in our own community. OA provides a meaningful and effective way for medical professionals to volunteer locally and give back to their communities.

Goal 3. Reduce Health Disparities and Barriers to Care

Cultural and linguistic differences often result in an inability to obtain quality care or any care at all, especially when trying to navigate the complexities of healthcare in the United States. OA reduces health disparities and barriers to care by providing medical interpreters for our non-English speaking patients, as well as translated materials.

OPERATION ACCESS is an independent 501 (c)(3) organization, and has established a volunteer network of health-care providers (clinics, hospitals, medical professionals) organized to provide low-risk, outpatient surgery services, free of charge, to uninsured, eligible patients.

This provision of charity care is certainly not new. Physicians and hospitals have been caring for medically indigent patients as part of their practices throughout modern medical history. OA honors and promotes that tradition, and provides an easy and effective way for health providers to volunteer locally to help people in need.

With the rise of managed care practices and an increasingly competitive healthcare environment, this type of charity care is more difficult than ever to deliver. Providers often lack the time and resources to care for an increasing contingent of uninsured patients. A physician in a staff model HMO, for instance, could hardly decide on his or her own to treat non-paying patient using staff, facilities, technology, and supplies that are not entirely at their discretion.

Physicians in independent practices readily acknowledge that they do not have the resources to manage special needs of the uninsured. All providers are concerned about patient payer mix and maintaining optimal levels of reimbursements.

Health plans with fiduciary duties to employer groups and members are not always willing to make unilateral decisions to absorb the cost of care for non-members. Automated billing systems now reveal actual costs of providing indigent care, costs that were formerly invisible. Some hospitals have become very savvy at reducing access points to uninsured patients, directing care elsewhere, implementing co-pays, and establishing other strategies to offset what is now regarded as a controllable cost center. What is regarded in the industry as sound, provider-side business practices and operating efficiencies translate into access barriers to patients in need of care.

As public and private charity hospitals absorb a higher proportion of this care, they are increasingly unable to meet burgeoning needs. Institutions nationally acclaimed for emergency care, trauma, specialty AIDS treatment, and transplantation are also expected to provide very basic, low-risk procedures to medically indigent patients. Other hospitals, by virtue of their

private status or membership structure, do very little in the way of uncompensated care. The result is an inequitable and inefficient indigent care delivery system.

OPERATION ACCESS has responded to these formidable access barriers and is addressing the uneven distribution of indigent surgical care. The basic assumption is that providers are willing, as well as morally obligated, to provide for the uninsured if given the chance to do so. **OPERATION ACCESS** is an efficient mechanism for them to do this.

Medical professionals often lament that while they are aware of the needs of their community, they have no capacity to provide charity care in their own practices. They are also aware of opportunities to travel to remote third world countries to deliver sorely needed care, but are unable to because of family and work obligations. **OPERATION ACCESS** gives them the opportunity to donate their most valuable asset, their professional skills, in their own community.

What is unique about **OPERATION ACCESS** is the level of collaboration and the volunteer delivery model. The opportunity to care for needy patients is distributed equitably at minimal cost to participating hospitals. There are no subsidized charges or cost shifts. This is truly free care and the service is direct from volunteer provider to patient.

Though the cost is “free”, the value of the service is tremendous. In monetary terms, a single surgery valued at \$5,000 or more is delivered at the cost of the surgical supplies: less than \$100. More important, there is an improvement in overall quality of life for patients through the relief of pain, increased mobility, and improved capacity to work. The value to patients, health providers, and society as a whole of providing early access, low risk care to prevent more serious and complicated medical problems later, can not be understated.

The information provided in this manual is a description of the planning and implementation process undertaken to establish **OPERATION ACCESS**. This document encapsulates the organizational structure and elements of delivering operations that has worked for **OPERATION ACCESS**.

Implicit in this manual is the acknowledgment that it may prove to be a unique model that would look different had it evolved in another community. Each section of the manual represents a significant step or aspect of **OPERATION ACCESS**' developmental process. We attempt to comment on alternatives we considered in the development process and on specific factors which affected our decision-making.

The overriding purpose of this manual is to inform others about **OPERATION ACCESS**, and to provide guidelines for other communities who would like to deliver services using this template. We anticipate that others will carve out pieces of what we have done that are relevant to their needs and resources. We fully expect that users may change and improve upon the tools and structure we have devised.

To supplement this manual, an extranet has been created on the OA website which contains over 100 documents developed over the years to implement and grow and evaluate the program. On the extranet are folders labeled hospitals, clinics, patient care, fund-raising,

planning, volunteers, reporting, database, presentations, internal operations and fact sheets. Within each folder are contained useful documents to supplement the narrative contained in this manual and help others replicate the OA program.

To the extent that the human needs and marketplace trends witnessed here in the Bay area occur in other areas, the opportunity to provide donated surgical care to vulnerable populations through a volunteer network will become apparent. Thus, when other communities recognize a similar need, perhaps our experience will be of some value in developing an appropriate response.

Your feedback on our program and on the usefulness of this document is welcome. We would like this to be the beginning of an evolving collaboration. Over time, we hope to engage other volunteer healthcare programs into a larger network for the exchange of ideas. We envision there will be opportunities to share best practices, to stimulate new approaches, to work together for systemic change, to engage in valuable research, and even to obtain joint funding.

II. GETTING STARTED

The importance of each and every stakeholder in the OA chain of service (outlined below) cannot be emphasized enough. Without a full complement of providers, the OA program cannot work. The community clinics must be partners and refer patients, the hospitals must be partners and provide the operating rooms and supplies, and the surgeons, nurses and anesthesiologists must be partners to provide the donated surgical care. There must be a dedicated staff and engaged Board.

- *Physician Leadership*

While no single constituency has greater significance than any other on ongoing operations, at the outset of the establishment of this program, physician leadership is critical to securing collaboration of the other professionals and institutions.

The two surgeon founders of **OPERATION ACCESS** generated the idea and created the momentum that made the program possible. Continued leadership by surgeons in presenting the idea to others, rallying the volunteers, and acting as medical directors of clinical operations was instrumental to the initial success of the program and the subsequent growth.

For this reason, identifying physician leadership is seen as a critical first step in developing a similar program elsewhere. Ideally, a surgical leader would take the initiative, be willing to assume responsibility, and become a champion for all facets of the program including the mission, objectives, process, and outcomes.

- *Alternatives to Physician Leadership*

OPERATION ACCESS' experience has been that the surgeons were instrumental to start-up and implementation. However, leaders in other disciplines or of participating institutions might well perform a similar role. Engaging medical center executives in start-up activities was considered. One potential problem with hospital administration acting as the starting force could be perceived coercion in recruiting staff volunteers.

The hospital administration might also have concerns about soliciting volunteers in light of ongoing union negotiations. One last downside with hospital initiation is in getting new facilities to participate. Once the program was piloted and implemented at one facility, there may be a tendency for new hospitals to identify it as the pilot facility's program. A need to consistently emphasize the collaborative nature of the venture is necessary.

- *Planning Team Formation*

The next step in forming OA was bringing in a multi-disciplinary team to serve in planning, implementation and ongoing governance. The **OPERATION ACCESS** start-up team consisted of the two founding surgeons, one individual who understood and was well-known in

hospital administration and bio-medical ethics, one administrative nurse manager from the public health system, one attorney, and two business/ public health graduate students.

The team was commissioned in part by a small grant from the pilot facility, but perhaps could have accomplished as much on a pro-bono basis. Each individual brought their own skills, resources, and contacts to the group. Everyone contributed by providing contacts, securing endorsements, providing input into the business plan, obtaining funds, and gaining organizational status. The planning committee also identified liaisons at other hospital sites for later contact. This group eventually became **OPERATION ACCESS'** governing board of directors and staff.

- *Alternatives:*

Replication may also work well if a planning team is formed first with appropriate representation and then physician leadership is obtained. This approach is being used with the replication of OA in Orange County. There, a specialty care network planning group has been meeting for several years and providing the initial leadership for successful replication.

Group size is probably as important to success as composition. The small formative group was easy to manage. Close working relationships were formed and communication was candid. Representatives from other disciplines might have added more diverse views and experience early on, but might have made the group less effective given a largely unstructured context. If, in retrospect, we had added more areas of expertise early on, we would have considered primary care, finance/fundraising, systems and accounting. Legal, public health, marketing are additional skill sets important in developing a well-rounded Board.

- *Planning Objectives*

With the leadership and planning team in place, the next important start-up element is to have a concrete objective that will provide parameters for the process of starting a new service. For example, in Orange County, the concrete objective for Access-OC was a specific date in the (near) future when the first surgeries would be provided at one of the local hospitals.

The objective for OA initially was to create a business plan. This plan clearly helped define the mission, objectives, operations, and financial plans for the coalition. The group met once every two to four weeks to embark upon this task. An action plan was used to delegate and to monitor work in progress and task completion. Components of the business plan included a mission statement, goals, needs assessment, volume and cost projections, case management and quality assurance policies. Operational processes were also defined by the document.

Two other planning objectives were pursued concurrent to the business plan: the pilot program and initial grant proposals. Getting approval to test the program at Kaiser Permanente Medical Center involved meetings and correspondence with risk management and medical-legal department administrators at facility and regional levels. The pilot program was instrumental to the planning effort. OA might have strayed some in terms of logistics or expectations had it not had the benefit of valuable operational experience gained from the initial pilot program.

The pilot identified logistic problems with the model that were quickly corrected (financial coding, volumes of patients/sessions, team composition and scheduling). Doing the pilot also lent credibility to what was previously merely an idea. Prospective programs should be piloted for at least several sessions to refine processes and establish volume ranges. As new institutions are added, the pilot concept should be applied to each setting, as problems are sometimes institution specific.

Obtaining endorsements from other organizations was another important step. Securing formal letters from the American College of Surgery, the San Francisco Medical Society, the University of California, San Francisco, School of Medicine, and the Northern California West Bay Hospital Conference also lent critical credibility to **OPERATION ACCESS** during the formative years.

As the business planning effort and the pilot project were culminating, the work group experienced the need for staff to assume some of the workload that the project began to generate. Three grants from private and public foundations were proposed to cover the costs of anticipated supplies and staff.

A need for surgical supplies was indicated but later it was apparent that hospitals could absorb these costs and, in Kaiser's case, preferred to because it was easier for volunteers to use their own supply stock rather than bring in-kind donations from a "foreign" supplier. Offsetting the costs of supplies would have been cumbersome as well, since most of the surgical packs and sutures were purchased in bulk and itemizing and reimbursing hospitals for supplies would have posed difficulties. As implied, funding needs differ substantially depending on available resources, level of in-kind support, and overall objectives.

All dimensions of the planning effort identified and addressed some important issues such as liability, participation, and funding potential, and served to shape the goals and priorities for upcoming implementation and expansion. It should be noted that from the initial planning team formation to a fully drafted business plan, took over a year.

- *Keys to Success:*

The support and pilot program at the Kaiser Permanente- San Francisco hospital, physician leadership and involving the key mix of people early on were the critical success factors during the start up phase for **OPERATION ACCESS**.

III. GETTING ORGANIZED

Recognizing that funding is essential, and charity status is needed in order to receive grants and/or donations, one early objective of the organizational effort was to secure non-profit corporate status as a 501(c)(3) organization and all of the trappings of an organized entity.

OPERATION ACCESS secured the pro-bono services of an attorney to help gain the desired status. The process consisted of drafting articles of incorporation and by-laws, and submitting tax exemption application to both the IRS and to California's Franchise Tax Board. It should be emphasized that details of the incorporation process are specific to individual states. Prospective organizers should seek advice from officials in their host state.

To finalize the organization's early development, a Board of Directors was formed, by-laws were adopted and Director and Officer insurance was obtained to protect the governing body from management and financial liability. The insurance should be in place prior to receiving funds or hiring staff. It should be noted that basic Director and Officer coverage is distinct from contingent professional medical liability coverage, which would indemnify governing bodies from medical claims.

The organizational process also entailed developing a staffing and recruitment plan and appropriate job description for a project coordinator position. It was thought, initially, that a portion of a full-time staff person, operating within one of the institutions or the public health sector, could absorb the administrative component of the program. A project coordinator would have been perfectly appropriate for the primary task of serving as a coordinating body for hospitals, clinics, patients, and volunteers.

If the staff responsibilities are to include fundraising/grant writing, report writing, strategic planning, and establishing relationships with clinics, and hospital administrators and medical staffs, appropriate training and experience would be needed.

In deciding the level of staff required, consideration should be given to the amount of oversight available from physician leaders and the board. Leadership responsibilities and executive committee and fundraising roles of the board may consume enough time that direct management of day to day tasks (accounting, finance, grant writing) would not be desirable.

- *Key to success:*

Anticipate and satisfy legal and administrative requirements. Seek pro-bono legal assistance.

- *Alternatives:*

In terms of organization structure, probably the most frequent alternative would be to operate a new program under the fiscal agency of another body, such as a medical society, public

agency, academic association or hospital system. This is the model being used with Access-OC, the program in Orange County being modeled after **OPERATION ACCESS**.

This alternative is viable and may offer advantages in terms of program costs and overall strength and credibility. Cost savings could be achieved primarily in the area of administration and overhead. The indirect costs of running an independent program are high, which is a distinct disadvantage for a grant dependent agency. (Foundation grants rarely support indirect costs, such as insurance and administrative fees, and if so a limited percentage).

Correspondingly, administrative workload is relatively significant compared to the staff and budget size. Payroll, benefit administration, tax and legal filings, and corporate and public charity reporting requirements are the same as what would be required for a larger organization.

However, the benefits of independent status lie in the freedom to develop strategically, un-beholden to a larger, parent organization. Related to this is a degree of flexibility in responding or changing to accommodate environmental changes (i.e., care practices, public funding). Also, volunteers perceive a very direct connection to patients and to **OPERATION ACCESS**, which enhances recruitment and retention.

IV. GETTING IMPLEMENTED

The planning process, described in the previous sections, guided and also overlapped the implementation of the program. Internal operations were defined by the business plan to include patient referral, follow-up, information flow, and scheduling processes. These were refined by the pilot program and further experience.

Preliminary service scope and eligibility criteria were framed by the founding clinicians' understanding of patient needs. Further refinements were made based on a needs assessment and experience. The needs assessment, in particular, also set the stage for developing a referral base. Preliminary professional networking laid the groundwork for future volunteer and institutional recruitment practices.

- *Patient & Referral Policies*

The needs assessment defined the volumes and types of patients to be treated and subsequently, the level of institutional capacity that would be needed, professional resources, and scheduling policies. Two sources were used to assess patient needs: the existing county hospital records for the types of procedures to be done, and a survey of primary care clinicians who treated uninsured patients. A breakdown of the county hospital procedures by payer type, selecting those defined as patient pay or medically indigent, led to a reasonable approximation of volumes.

It was assumed that these volumes would be a baseline for the actual number of patients to be served, allowing for the possibility that some patients may have needed treatment, but were unable to obtain it due to economic, social, or cultural barriers; these people would not have been reflected in the numbers. The primary care clinic survey asked clinicians, who were also prospective referral sources, to estimate the number of patients seen who would be eligible for and in need of our services. Data from these two sources was then combined to project a range of patient volumes for the start-up period.

Initial criteria for patient selection was whether they fit within the service scope of the program. In other words, the patients had to be in need of one of the services the program could provide. These were services which fell within the clinical expertise of the founders (general surgery), since they would be performing and supervising many of the services. Further constraints on scope limited it to procedures that could be done effectively on an outpatient basis.

Other clinical restrictions were applied so as to reduce the risk complications. Any condition or medication that might increase risk was a criterion for exclusion. While using pre-defined scope as a general guideline, it was important that other referrals for low risk outpatient procedures be evaluated on a case-by-case basis, so that we would not inadvertently restrict viable services without good cause. Doing so allowed the scope to be expanded to procedures not originally considered such as Urology and Otolaryngology.

Financial screening guidelines from the county were used to screen patients economically, using a guideline of 250% of poverty for inclusion (patient screening material attached). Other criteria included the patient's ability to follow peri-operative instructions and a patient contact to provide transportation on the day of surgery.

- *Patient Referral Base*

The needs assessment process defined our preliminary referral base. The first referral point established by **OPERATION ACCESS** was at the county hospital surgical clinic. An eligibility worker, in the admitting department of San Francisco General, was informed of our services and asked to refer patients who met the financial and clinical criteria.

This hospital link served as a funnel for the six area public health clinic referrals. The second layer of the referral network was the private, low income clinics in the area. Both systems had already participated in the needs assessment, were aware of the program, and were receptive to having a new treatment option for their patients.

- *Getting More Patients*

After a few months of experience with private and public health clinic referrals, it was apparent that actual referral volumes were less than projected, presumably due in part to the effect of exclusion criteria; many possible patients suffered from co-morbidities or conditions that precluded treatment through our program. Rather than relax our criteria, which would have placed the program at risk of increased complications, an effort was launched to increase referrals from existing sources and to extend services to two major college health centers

Advertisements were also placed in the local Medical Society journal to extend services to patients via private and group physician practices, although, this has not generated referrals thus far. The faith community, community-based non-profit organizations, and city agencies are invaluable sources of referrals. Outreach is also a valuable method to recruit patients.

- *Volunteer Recruitment*

Volunteer recruitment was done at two levels. First, within the pilot facility, the program's designated surgeon leader spoke to nursing and anesthesiology representatives in routine meetings to recruit volunteers. Second, the surgeons and other board members of **OPERATION ACCESS** contacted individuals at other prospective hospitals and asked them to serve as liaisons for potential implementation at those facilities.

The identification of supportive liaisons at other institutions indicated that patient volume could be shared and the idea of rotating patient sessions among the participating hospitals and their volunteer teams emerged. The plan was to assign patients to the next available location according to referral date, with some allowances made for specialty requirements and clinical urgency.

- *Institutional Participation*

While designation of the prospective hospital liaison described above was an important step, it did, in retrospect, create some undue optimism at our ability to secure the participation of other institutions. It was thought that given an inside “champion” for the program and having successfully tested the project, other institutions’ participation would be forthcoming. This was not the case. The level and speed of participation was overestimated given the complexities and broad-based support needed to implement at new facilities.

Securing institutional participation turned out to be the single, largest barrier to implementation. A number of factors played a part in this. Initially, hospitals and medical staffs were concerned about liability. It had already been determined with the pilot exercise that no incremental liability risk was incurred by participating facilities if the institution had medical liability insurance, the participating physician had malpractice insurance, and the staff volunteered at their place of employment. This was something that had to be articulated repeatedly before administrators became receptive. Risk managers from the prospective hospitals were invited to scrutinize participation along risk dimensions and policies of their own facility.

The second factor that ameliorated concerns of the hospitals: patient demographics. When it was realized that the target population of uninsured consisted more of working poor than transient or homeless people, concerns were assuaged and officials were more agreeable. Engaging the support of the area’s Hospital Council seemed to facilitate support by the council’s agreement to place the initiative on an area-wide agenda.

Implementation initiatives need to involve both hospital administrators and medical/surgical leadership, so as to not to give the impression that one group is being coerced into participation by the other. It should also be noted that political and environmental forces well beyond the scope of participating in the volunteer model were at work and that sensitivity to larger issues, (contracting, mergers, reimbursement, etc) and an understanding of their dynamics was helpful. A focus on the benefits of the project, (improved access, reducing disparities, promoting medical volunteerism, positive community relations, etc.) seemed to work best.

One of the issues that arose at one of the sites surrounded a decision on where to see the patients for pre-operative care—some surgeons found it easier to meet with the patient in his/her own office, others insisted on seeing the patient during clinic hours. This has important repercussions for scheduling and information retrieval and should be decided, in advance, by the medical staff.

The participation of Mt. Zion Medical Center is noteworthy in that it deviates from the “pure volunteer model” undertaken at Kaiser and San Francisco General. Administrators and physicians at Mt. Zion elected to integrate **OPERATION ACCESS** patients into regular clinical and operating room schedules. Given this arrangement, the staff was not volunteering as with the other two hospital teams. The physicians (surgeons and anesthesiologists) do waive their professional fees and hospital charges are absorbed for **OPERATION ACCESS** patients.

An implementation plan was developed, outlining the time frame and steps involved, with the idea that this tool would assist leadership in attending to all the details. Neither of the two hospitals following the pilot elected to take advantage of this tool, rather they preferred to develop and follow their own plan and involve those whom they saw fit and in their own timeframe.

This theme seems to be true for all aspects of planning, implementation and operation—each facility and volunteer is unique with differing needs and resources. There seemed to be an added incentive if teams were allowed to figure things out for themselves. Had we imposed our plan or experience rigidly, outcomes might have been less positive. Since it is not the objective of **OPERATION ACCESS** to mold new teams into an existing agenda, but to allow each facility to participate in the manner desired, this posed no problem for the network. One goal of the program is to make it easy for others to participate. Thus, flexibility is essential.

- *Systems Requirements*

Database software was needed early on in order to track patient and volunteer participation. Capacity to link databases and exchange information with word processing and spreadsheet applications was useful for reporting and monitoring. Programs like Microsoft Access work well for the storage and retrieval of **OPERATION ACCESS** information, though its reporting functions are difficult to customize.

- *Balancing Act*

Recruiting patients, volunteers, and hospitals have all been discussed. What was more important than any single entity was balancing the resources to meet the needs. Initially, we were conservative in the estimates of volume of service we could provide. With experience, it was realized that more patients could be managed, so we launched a campaign to seek more referrals. Then there were too many patients and we had to focus intently on recruiting new hospitals.

Individual volunteers were responsive from the beginning but we also had to be careful with this resource so as to not generate enthusiasm about the project and then not be able to provide patients or operating rooms. It was always necessary to anticipate needs and lulls in patient activity and flex the delivery components accordingly.

Expanding the service scope is another way to improve volume and take advantage of unused capacity. Offering ENT and Urology procedures has extended our scope of services beyond what we initially anticipated.

- *Keys to success:*

Start small, and don't build expectations or enthusiasm until you are prepared to follow up. Assess and anticipate both resources and needs. Capitalize on planning groundwork. Persistence, patience, reasonable expectations, flexibility, and sensitivity to environmental and political issues pay off.

V. MEASURING OUTCOMES

OPERATION ACCESS progress and success is measured through comparison of actual results as compared with the stated objectives. We recognize that effective evaluation does more than collect, analyze and provide data. Effective program evaluation also makes it possible to gather and use information to learn continually and improve the programs that we operate and you help fund.

OA collects information on patient satisfaction and administers surveys to all patients upon completion of their treatment. Patients evaluate their level of satisfaction with multiple facets of their care through OA, including both numerical ratings in 7 categories and narrative comments. The findings are shared with funders and reported in our annual report.

Volunteers and clinics are also surveyed annually to determine if objectives are being met and discover any areas of unmet need or areas for improvement. Through an analysis of responses, **OPERATION ACCESS** consistently works on improving its service delivery.

In addition, staff set performance goals and there are annual performance reviews. The Board holds an annual retreat and does a thorough self-assessment to examine ways it can improve how it operates and also identify ways to strengthen the governance of OA.

OPERATION ACCESS provides each participating hospital with data regarding program numbers and establishes annual goals to strengthen the relationships and community benefit outcomes with each hospital.

It is essential to demonstrate effective, high quality outcomes for any organization. It is important to measure numbers of services rendered and number of volunteers recruited and retained. Drop out of volunteers should be followed carefully to assess problems with service and/or burn out. The number of participating entities (hospitals and clinical teams) is also an important benchmark as are number of communities.

Having quantity and quality measures in place is important for demonstrating a program's value. A program can render numerous services with a high degree of quality, but to no avail if the service is not valued.

OPERATION ACCESS measures value in three dimensions: value to the patient, value to society and value to the healthcare system. **OPERATION ACCESS** aims to demonstrate that there is a real economic benefit beyond patient care itself. Assessment of ability to return to work or work more effectively have been incorporated into patient surveys.

VI. GETTING MONEY

OPERATION ACCESS obtains funding support from corporations, foundations and individuals. The largest source of funding is from participating hospitals/health systems such as Kaiser Permanente and Sutter Health.

We recommend that 3-5 years of committed funding be obtained before launching the program. For many years, the OA budget was in the \$200K - \$300K range with a small staff of 2-3. Over the past several years, the budget has grown to \$1,225,000, the staff is now 14 people, and funds have been obtained to strengthen and expand the program.

For the purposes of fundraising, whether through grants or direct gifts, always assess and maximize your assets. If you have the fiscal oversight of a prominent organization and are seeking support through them, accentuate the relationship. If you are an independent start-up, focus on the entrepreneurial dimension of your organization. It is also important to identify unmet needs you are seeking to address.

Look to your constituency first for funding support. Involve professionals, their families, administrators, medical schools. It makes sense to match the scope of your service with that of your funding sources, and in fact some corporate foundations will not fund organizations from a geographic area where they don't have a formal presence. If you are a small community-based organization, with no large scale growth plans, approach local community foundations, membership organizations, and local employers.

Divide fundraising goals into short-term and long-term objectives, consistent with your mission and planning objectives. Even in seeking short-term support or small grants, long term sustainability is of great importance to funders. Funding plans should incorporate an explicit objective of diversifying funding even at the expense of increased dollars in the short run. Private individual gifts represent almost 90% of philanthropic donations with private and corporate grants approaching only about 10%.

Creating a diverse, long-term funding base is **OPERATION ACCESS'** newest challenge, along with the concomitant need to plan for appropriate staff and systems to support an ever-growing program.

After 14 years of operating, OA hired a full-time development and communications officer to assist in fundraising and strengthen financial sustainability. OA has always had a 100% giving Board. One of the 5 standing Board committees is donor development. Board members and members of the Advisory Council provide names of friends and colleagues who are added to the OA mailing list. There is an annual fund raising appeal letter sent to 2,000 people on our mailing list in early December each year.

VII. MARKETING

Creating greater awareness of the program is a core strategy for **OPERATION ACCESS**. We have found that it is not necessary to have a huge written marketing plan or designated staff in order to do marketing (though it would certainly be ideal). Marketing is more of a mindset for the organization that encompasses fundraising, financial reporting, public relations, communications, and recruitment. It is a service identity that should be woven into all facets of the program.

Marketing is sometimes defined as how an organization is positioned within its environment. The designation of the targeted population, and channels through which you connect with them to provide the service, becomes a core marketing strategy. The needs assessment can serve as basic market research, identifying strengths, weaknesses, opportunities and threats.

OPERATION ACCESS serves uninsured, low-income individuals, and this is reflected and emphasized in grant writing, fundraising brochures, videos and presentations. We access our patients through existing clinic services and use existing labor and hospital capacity. This is another facet of our identity - our efficiency and efforts to not duplicate services - very important from funding and planning perspectives.

Other marketing ideas are to promote the program as an independent, proactive, do-it-yourself, public-private partnership. Services can be promoted as an investment opportunity which not only improves the health of individuals served, but the community as well. In addition, dealing with health problems requiring surgery before an emergency develops helps save money.

Public affairs and media relations are components of a marketing plan. Organizations can plan and implement the activities on their own through sending press releases, approaching city officials, developing a video, and publishing articles in professional journals. Speaking in professional forums and at grand rounds are also good avenues.

We have found that the media is very interested in covering Saturday Super Surgery days, where upwards of 30 people may receive donated surgical care. At one recent super surgery day representatives from a magazine, two newspapers and one TV station were present.

We also view the OA web site as a marketing tool, as well as our Annual Reports. Recently, OA also obtained a service grant from the Taproot Foundation to develop a marketing brochure, aimed at medical volunteers. In addition, we have developed brochures for patients in English, Spanish and Chinese which are distributed at the community clinics. Posters describing our program are also available to be posted at the clinics to inform patients.

VIII. QUESTIONS & ANSWERS

Q: What is OPERATION ACCESS?

OPERATION ACCESS is a volunteer network of healthcare providers, medical institutions and community supporters. Individual providers include anesthesiologists, nurses, surgeons, and operating room technicians. The participating volunteer institutions donate the use of their surgery facilities for the delivery of volunteer surgical care. The charitable goal of this network is to provide surgical services to low income, uninsured patients.

Q: When and where did the program start?

The Ambulatory Surgery Access Coalition, now known as **OPERATION ACCESS**, was incorporated in April of 1993. The program was piloted and implemented at Kaiser Permanente Medical Center in San Francisco in 1994. In 1995, two other San Francisco hospitals, University of California at San Francisco/Mt. Zion Medical Center and San Francisco General Hospital joined the network.

Q: What types of procedures do we do?

OPERATION ACCESS volunteers currently perform outpatient surgical procedures such as hernia repair, biopsies, cyst excision, simple ano-rectal procedures, non-cosmetic reconstructive procedures, and other low risk, elective procedures for eligible patients.

Q: Who are the patients and how do they access the program?

Based on data from the January-September 2009 National Health Interview Survey, a total of 58.4 million (19.4%) persons of all ages across the United States were uninsured for at least part of the year prior to interview. The number of uninsured Californians is estimated to be approximately 5 million, or about 14.6% of the non-elderly population (source: 2007 California Health Interview Survey). In the Bay Area, the percentage of uninsured non-elderly people is estimated to be around 9%.

Part-time service workers, laborers, students, and transiently unemployed individuals represent **OPERATION ACCESS**' patient base. These individuals are typically members of our community's "working poor" socioeconomic class. They are typically employed and have basic food, housing, and social support, but have neither health insurance nor the resources to pay for private healthcare.

The majority of OA patients are non-English speaking, with the largest ethnic group being Latino (70% of patients). 52% are female, and 48% are male. All patients are uninsured, low-income, and unable to qualify for federal or state coverage such as Medicaid. All services provided through OA are free to the patients.

Patients qualify for care through OA if they fit the following criteria:

- Uninsured and unable to obtain job-based or publicly-sponsored coverage
- Earn less than 250% of the Federal Poverty Level
- Have less than \$5,000 in savings
- Diagnosed at a community clinic as needing low-risk outpatient surgery

Uninsured patients face overwhelming obstacles to obtaining necessary treatment. For example, the average cost an uninsured patient would be charged by a private hospital to repair a hernia is approximately \$15,000. This is far out of reach for the population OA serves, (the individual average income is \$8,400, and \$17,900 for a family of 4). These individuals are likely to postpone treatment until symptoms worsen or an expensive emergency develops.

Patients are referred to **OPERATION ACCESS** from their medical home, typically a community clinic. College health services, Planned Parenthood, independent practitioners, and hospital based clinics are also encouraged to refer eligible patients.

Individuals who receive surgical care through **OPERATION ACCESS** have better health status, improved ability to work and enriched quality of life. The family unit benefits as well. A family's capacity to sustain itself is adversely impacted when a parent is debilitated by a health condition. A majority of the patients served by OA are adults with family dependents. The alleviation of pain, disability, and other symptoms improves their ability to work and support their families.

Q: Where do we get volunteers?

Volunteers are primarily recruited by word of mouth at the participating hospitals. Presentations to medical society membership and at hospitals' grand rounds have generated new recruits as well. Recruitment is also conducted through ads in professional newsletters and, more formally, through an annual mailing to the local Medical Society membership.

Q: How does the service work?

A staff program director coordinates patients, volunteer teams, and participating institutions through the **OPERATION ACCESS** program office. Clinics refer patients who meet medical criteria. **OPERATION ACCESS** then reviews the referral for financial eligibility. Patients are screened again by **OPERATION ACCESS** staff and placed in the queue for the next available surgery session. Once assigned to a volunteer team, the patient is scheduled for a pre-operative visit and if surgery is indicated, he or she is scheduled for the next

available surgery date. Surgeons provide one or more post-op visits as needed and then the patient is generally referred back to the original, referring provider and/or clinic for ongoing care and case management.

The volunteer teams participate at their “host” facility to minimize practical problems, risk, and liability concerns. The teams are led and recruited by designated physicians and/or nurses. Sites alternate conducting sessions that typically include six to fifteen patients, once every four to eight weeks, depending on the teams’ preferences and patient volume.

Q: How are we organized?

OPERATION ACCESS is incorporated in the state of California as a non-profit, public benefit corporation and is exempt from federal taxes as a 501(c)(3) organization. It is recognized as a public charity and donations are tax exempt. It operates according to established articles of incorporation and by-laws with a governing Board of Directors. Professionals from the business and healthcare community voluntarily serve on this Board.

Q: How are we supported?

Foundations, corporations and private donors from the community support **OPERATION ACCESS’** administrative costs. Grants, cash, and pro-bono support pay for office operations including rent, phone/fax, computer support, marketing, and staff expenses.

Q: What about risk of complications and costs?

OA’s scope of services is confined to low risk, elective, procedures that minimizes (or “reduces”) clinical and financial risks to some extent. Eligibility criteria exclude patients with co-morbidities that would increase peri-operative risk. In addition, patients must be capable of following post-operative instructions, have a place to stay, and have someone to transport them on the day of surgery.

Patients are screened three times prior to surgery (by the referring clinic, by the program office, and at the pre-operative visit.) In the case that an untoward event should occur, requiring immediate additional care or hospitalization, we have agreements in place wherein the participating medical center has agreed to accept a stabilized patient if the operating surgeon requests a transfer. Since program inception in 1993, only 0.6% of OA’s surgical patients have experienced complications requiring hospitalization.

Thus, our eligibility criteria and screening measures, along with the back-up provision should a complication occur, all serve to mitigate risks to program participants.

Q: What about malpractice risk and liability insurance?

There is no un-indemnified malpractice risk incurred by virtue of participating in **OPERATION ACCESS**. Hospitals have institutional insurance policies that cover the treatment of our patients as they would cover any charity case (or “as they would cover any uninsured patient”). Nurses and other staff are indemnified under these policies as long as they are providing services at their place of employment. For this reason, only nurses and staff employed by the particular hospital can volunteer at that hospital.

Likewise, the professional liability insurance of physicians indemnifies their volunteer activities. Since only physicians with appropriate privileges at the participating hospital volunteer at that site, hospitals have credentials on all their volunteers, and their Quality Assurance program would monitor the physicians’ professional conduct.

The costs and risk of malpractice have certainly been a concern. The perception of this risk has repeatedly emerged as a barrier to participation by volunteers. **OPERATION ACCESS** has had to constantly address this concern and invite participants to explore the issue with medico-legal and risk management experts within their own systems.

Q: What major obstacles have been encountered?

The chief obstacle to implementing the program has been getting institutions (hospitals and medical staff) to approve and participate. The healthcare environment, financial constraints, already high levels of charity care, and competing priorities have all been cited as reasons for reluctance to joining our network.

The perception of risk described above has also been a reason for resistance to participating in the program. Concern on the part of hospitals about “going first” and being placed at a disadvantage, or “getting stuck” treating our patients without others joining in, was also an early obstacle.

Q: How have we addressed these obstacles?

OPERATION ACCESS has not completely resolved the above problems. We have addressed the concerns, to some extent, as evidenced by the fact that we now have a network of 19 participating hospitals. We believe that success in increasing participation has been due primarily to persistence and positive outcomes. We try to address each concern of prospective participants by acknowledging it as legitimate, and by noting that those who are already participating have many of the same concerns. Then, each individual concern is fully addressed.

We offer to participate on their terms, subject to whatever constraints they wish to impose, such as: participating on a pilot basis, limiting numbers or types of patients served, and accepting patients from their own clinics into the program. Lastly, an appeal can be made to

equity: that is, if all hospitals participated then the caseload of low risk surgery for indigent patients would be evenly distributed and no one would be at a disadvantage for doing “more than their share”.

Q: What are our strengths?

The energy and demonstrated willingness of individual, volunteer professionals to donate their time is the program’s substance and sustenance. Physician leadership and participation, in particular, is of inspirational proportions. Funding the project has not been difficult thus far and the organization seems to promote itself readily. The outcome and impact (increased access, improved health, collaborative delivery system, physician leadership) of our project is easy to measure and demonstrate.

Independent corporate structure has been an asset, in that the program is not encumbered by the policies and politics inherent in larger organizations. Independence also affords the capability of changing direction and scope effortlessly, and it lends well to volunteer recruitment and retention. Providers feel “close” to the patients, and perceive no larger entity through which they volunteer--it is a very direct, almost intimate service experience for both provider and recipient of care. In general, the program is viewed by all of our constituents as innovative, efficient, and responsive.

Q: What are our weaknesses?

Independence can also be a weakness. The organization has little “clout” in getting the attention of high level decision-makers and in getting the concept accepted and implemented. It is also susceptible to environmental changes; for example, a new funding stream for women’s services that overlapped with our service scope. The independent structure is relatively costly to maintain in terms of overhead (insurance, occupancy, payroll costs, etc) relative to direct costs.

Q: What threatens the program?

Volunteer burnout is a potential problem, resulting in the need for constant recruitment and recognition efforts. Long-term financial sustainability is uncertain for the non-profit sector as a whole. Foundations can, and often do change their funding priorities or place limits on the number of years an organization can receive funding. The increasingly competitive healthcare environment that dissuades institutional support is an ongoing problem. All of these pose legitimate threats to **OPERATION ACCESS’** long term survival.

Q: What opportunities lie ahead?

Each year OA has grown. There are many opportunities based on the growing demand

and need for our services. Expansion into other communities through replication is a positive opportunity. Provision of other services, again based on an unmet need, represents another opportunity. A diversified funding base for long term security is of paramount importance. Policy objectives to provide incentives for volunteer-based programs (volunteer tax incentives, disproportionate share recognition for hospitals, incentives for corporate support) are other opportunities for the organization to position itself and mature into a more influential network.

OA's vision is to bridge the healthcare gap in the San Francisco Bay Area, while becoming a national model for medical volunteerism. Our 17-year track record of success has led to other communities' interest in replicating our model. Since 2007, two sites in southern California have launched growing specialty care volunteer programs with start-up technical assistance from **OPERATION ACCESS**, and a number of other communities are exploring consultancies with us.

In response to this growing interest, **OPERATION ACCESS** engaged two outside consultants to develop a comprehensive five-year business plan to guide expansion efforts. The OA Board approved the plan in late 2009, and the **OPERATION ACCESS** Institute (OAI) was launched as a new program area in January 2010.

The OA Institute will provide consulting and technical assistance to others interested in replicating the OA model in their community to strengthen the healthcare safety net and improve access to surgical, specialty, and diagnostic care for the uninsured. The Institute offers a menu of expertise and services that can be uniquely packaged for other communities and organizations to use as a foundation for establishing their own domestic surgical volunteerism programs. The **OPERATION ACCESS** program, while scalable and replicable in a "turn-key" fashion as is, could also be merged with components of other existing volunteer models – such as health information technology practices, clinic-based specialist volunteer (or "hub") models, and alternative referral and case management systems.

The **OPERATION ACCESS** Institute's ultimate goal is to catalyze a national learning community to promote domestic medical volunteerism and strengthen the healthcare safety net. As healthcare reform unfolds, this learning community will be a valuable forum for healthcare stakeholders to refine the definition and needs of the underserved, as well as effective models for expanding access to specialty care for this target population. We also plan to convene an inaugural summit in 2011, to promote successful volunteer models and share best practices among healthcare safety net stakeholders.