

HEALTH PRIORITY AREA

LACK OF ACCESS TO HEALTH AND SOCIAL SERVICES

**Adams County
Community Health Plan**
Alliance for Building Communities
2007



Overview/Description of Priority

Strong predictors of access to quality health care include having health insurance, a higher income level, and a regular primary care provider or other source of ongoing health care. Use of clinical preventive services, such as early prenatal care, can serve as indicators of access to quality health care services.

Though the cost of care is the most obvious barrier individuals and families without insurance must overcome to receive needed health care, there are a number of other barriers that prevent them from obtaining these services. Among them are a limited number of free and reduced cost health care services. At the same time, a lack of health education may keep them from effectively utilizing the services that are available. The result is that many individuals enter the health care system with acute and chronic conditions that may have been prevented or treated in earlier states for less cost and with less human suffering.

Community Capacity

Health and social service providers and concerned individuals have been working for years to improve access to health care for people with no insurance and for those insured through Medicaid. The Adams County Health Department's PATCH (Planned Approach to Community Health) initiative focused on this problem as early as 1991. A number of community initiatives grew from the PATCH process, including the Blessing Hospital Community Outreach Clinic which provides ongoing care to individuals with chronic illnesses, the Adams County Dental Clinic, and the MedAssist program, which connects people with prescription drugs.

Despite these efforts, concerns about readily-available, on-going access to physician services for these populations continued. In 2002, a feasibility analysis to

determine the viability of a Federally Qualified Health Center (FQHC) was initiated. That process identified the potential benefits of an FQHC (medical home with comprehensive primary and preventive services, assistance with enrollment in other services, care management, enhanced Medicaid reimbursements), but the financial analysis demonstrated that the ratio of potential Medicaid clients to uninsured clients meant the concept was not viable here.

In the spring of 2005, the Adams County Health Department received a Network Planning Grant from the federal government to support the assessment of our access to care issues and planning for improved access to care. The data and resulting strategic plan strategies are discussed in this section.

Community Themes & Strengths Assessment

Concern over the **affordability of medical care** far outweighed any other issue among community respondents and the key informants. The perception of this issue as a major problem is actually much higher than the actual rate at which residents are encountering inability to access or pay for medical services. The awareness that any major illness or health crisis could cripple a family or a business significantly contributed to the high level of concern over this issue. Also contributing to the level of concern is the high number of uninsured children and adults in the community. An underlying concern for nearly everyone that a significant medical situation would critically affect the financial well-being and self-sufficiency of the family.

The community survey ranked medical care as #1, 25.7% of respondents stated the highest concern.

The key informant survey ranked medical care #2, 20.6% of respondents stated the highest concern.

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Indicator Information - Statistical Data

- Being uninsured is related to educational attainment and household income
- Indigent and low-income, 55-65 age group, those ineligible for transition to Medicare
- Cost of health care and health care insurance is a significant concern of employers and impacts many facets of business. In 2002, U.S. companies saw the price of health insurance increase by an average of 14.7%, the highest annual increase since 1990.
- The consequences of poor access to health care are significant
 - 19% of uninsured use the ER as usual source of care (vs. 3% of insured)
 - 35% of uninsured don't seek care when needed (vs. 9% of insured)
 - Avoidable hospitalizations are 50% higher among uninsured
 - The estimated lost economic value is \$2,000 per individual
- Adams County has less favorable measures (vs. Illinois overall) on several variables known to influence access to care
 - Education
 - Income
 - Usual source of care/personal doctor
 - Percentage of doctors in primary care
- Adams County has less favorable measures on several health care access outcome variables
 - No medical physical in past 2 years
 - Births to women under 18

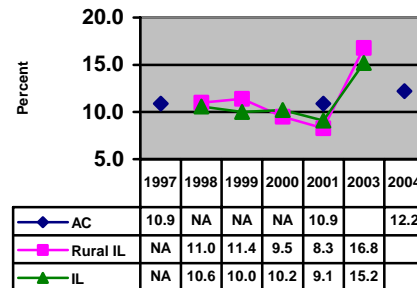
Anecdotal: An employer faced with health insurance premiums increasing 30% to 40% each year over the past 2 or 3 years must reduce other expenses or benefits to continue to provide this benefit to

employees. Hence, no or small wage increases.

Population groups most affected

- Un/underemployed, indigent, single people under 65
- Health care benefits are often not offered to low-wage workers, making them more prone to chronic illness and to missing work, according to the Illinois Families Study. "In 1999-2000, more than 28% of parents who came off of welfare and began working did not have health insurance; and the number of uninsured is rising. They study found fewer than half of working parents' (45%) employers offered health insurance either immediately or even after a waiting period. In contrast, nearly all parents who remained on welfare received coverage through the Medicaid program."

Percentage of Adults Without Health Insurance

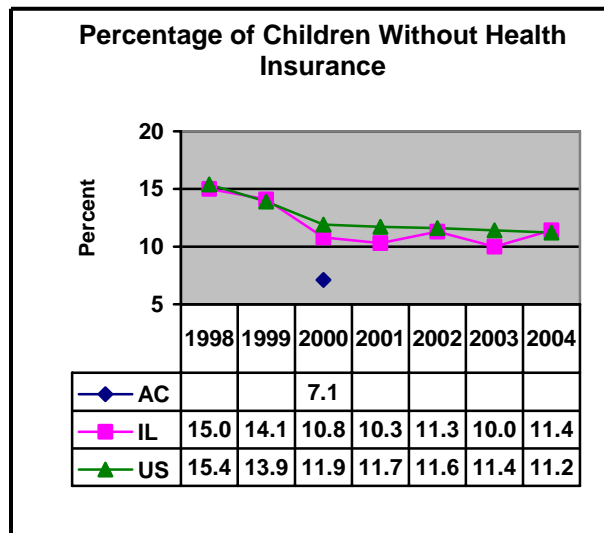


Target population

- 6,558 people in Adams Co. are below the poverty level (10% vs. 10.7% in IL)
- 10,894 people are enrolled in Medicaid (16.1% vs. 12.6% in IL)
- 6,177 have no insurance (12.2% vs. 15.2% in IL)
- 3,830 of these people are employed (62.0% vs. 64.4% in IL)
- 1,143 of the uninsured are under the age of 18

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- After subtracting the children from the total uninsured, it is estimated that as much as 75% of the adult uninsured population is employed.



Existing Services

- Community Outreach Clinic served 845 visits of indigent care in 2001
- General Assistance of the Quincy Township paid \$61,000 for medication and care for 241 medical emergencies in 2001
- Quincy Area Partnership for Unmet Needs disbursed \$2,500 for medical needs in 2001
- Blessing Hospital delivered \$1.7 million in charity care in 2001.
- In 2002, Quincy Catholic Charities MedAssist program served 584 clients and accessed \$476,051 in prescription medications from indigent drug programs of pharmaceutical companies. Quincy Catholic Charities also purchased \$3,500 worth of emergency prescription medications in 2002.

Assets of associations and organizations:

Partnerships/Collaborations—

Collaborative Partners

- Adams County Health Department
- Blessing COC
- Transitions of Western Illinois
- SIU Quincy Family Practice
- United Way
- Salvation Army
- Other Social Service Agencies
- Adams County Medical Society
- Alliance for Building Communities

Local Public Health System Assessment

The essential public health service related to this category is EPHS 7: link people to needed personal health services. This category received the lowest percentage score of 35.2% in the assessment. The following subcategories were included in the service:

- Identification of populations with barriers to system- 42.7%
- Identifying personal health service needs of population- 37.5% (issues related to this component of the assessment include define personal health service needs for all of its catchment areas) 33.3%; assess the extend personal health services that are being provided- 41.1%, and identify the personal health services of populations who encounter barriers to personal health services- 38%)
- Assuring linkage of people to personal health services- 25.5% (issues related to this component of the assessment include assure the provision of needed personal health services) 33.3%; provide outreach and linkage services for the community- 27.5%; initiatives to enroll eligible beneficiaries in state Medicaid or medical assistance programs- 66.7%; assure the coordinated delivery of personal health services- 0% and conducted an analysis of age-specific participation in preventive services - 0%)

Community Health Status Assessment

- The estimated percentage of

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children that are uninsured was lower in Adams County (better) than the percentage in Illinois and the nation in 2000.

- The percentage of Adams County adults without health insurance has been similar to the state and national percentages in recent years.
- The percentage of Adams County adults who reported not accessing needed health care services because of cost has been similar to the state and national percentages in recent years.

access to health care services. An opportunity to impact this force is that the Blessing Hospital COC recently received an Illinois Department of Public Health grant to expand the capacity of the community outreach clinic that provides services to the uninsured adult population in Adams County. A final force related to this issue is provider difficulty in communicating with patient population. An opportunity related to this issue is that health literacy programs are being created in our community.

Qualitative Analysis Assessment Results

In the summer of 2005, the Adams County Health Care Access Planning Committee began the assessment phase for a health care access planning project. For this assessment, the Adams County Health Department engaged The Medical Foundation (TMF), a non-profit organization with expertise in community assessment, planning and health promotion, to assess the issues affecting access to healthcare in Adams County, Illinois. The qualitative data collection was conducted through interviews and focus groups with providers and consumers.

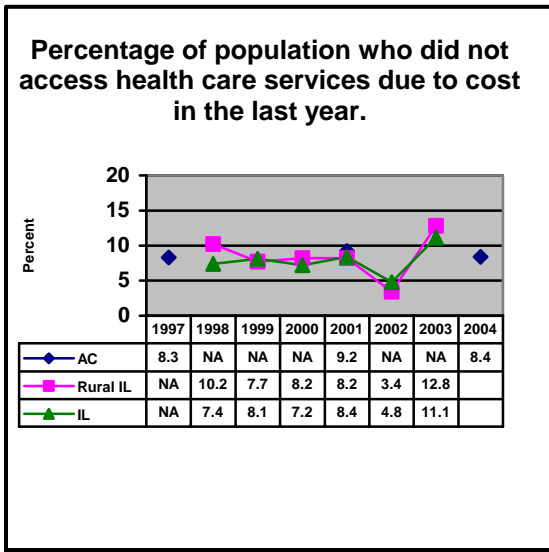
Providers and consumers agreed that the target population wanted and needed a variety of components in the health care system, including:

- Affordable, quality care
- Access to primary care providers
- Access to specialists
- Affordable Pharmaceuticals
- Access to behavioral and mental health services

Providers and consumers cited multiple barriers to accessing health care services. The identified barriers include:

- Lack of transportation
- Lack of financial resources
- Limited availability of services, especially outside of the City of Quincy, Illinois

In addition, providers perceived a lack of education on and awareness of available



Forces of Change Assessment

The largest number of issues identified in the forces of change assessment were related to accessing health and social services. The topic areas identified include: funding for mental health services moving to fee for service from grant funding with the resulting threats of loss of revenue, limited community involvement by mental health staff and some groups may be excluded from receiving services. The second force is

limited psychiatric access, which results in lengthy waiting time for psychiatric appointments and an increase in in-patient care that is provided. A third force is limited

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services and knowledge of how to access the health care system on behalf of the consumers. While consumers cited a lack of employer sponsored health insurance options, a feeling of being stigmatized because they received Medicaid or did not have any health insurance options, a lack of providers having evening or weekend hours, and existing debts to providers.

Individual providers are utilizing a variety of strategies to increase access to services including appointments identified for acute care, increasing the utilization of nurse practitioners and coordinating and collaborating with social service organizations. In addition, there are established programs in the community specifically addressing the needs of the target population. These include Blessing Hospital's Community Outreach Clinic, the Adams County Dental Clinic, Catholic Charities' Med Assist, and the East Adams Clinic.

Healthy People 2010 Goals

- Increase the proportion of care for persons who have a specific source of ongoing care (Baseline: All ages 87%, children and youth aged 17 years and under: 93%, adults aged 18 years and older: 85%)
- Increase the proportion of persons with a usual primary care provider (Target: 85% Baseline: 77% of the population had a usual primary care provider)
- Reduce the proportion of families that experience difficulties or delays in obtaining healthcare or do not receive needed care for one or more family members (Baseline 12%)

Adams County Program Goals

- Improved health for the targeted Adams County population through a coordinated system of care that integrates and maximizes existing health services
- Community receives return on investment in improved health access

Adams County Program Objectives

- Increase the proportion of persons with a usual primary care provider (Baseline 14.9, 2004 Behavior Risk Factor Survey)
- Increase the number of residents who have had a medical physical in the last two years (Baseline 16.2%, 1998 I-plan data)
- Decrease the percentage of adults without health insurance (Baseline 12.2%, 2003 Behavior Risk Factor Survey)
- Decrease the percentage of children without health insurance (Baseline 7.1%, 2000, United States Census)
- Increase the percentage of population enrolled in Medicaid (16.1% of population, 2001 I-Plan Data System)
- Reduce the proportion of families that experience difficulties or delays in obtaining healthcare or do not receive needed care for one or more family members (Baseline will need to be collected)
- Reduce inappropriate use of healthcare services (Baseline will need to be collected)

Community Strategies

Strategy #1 – Community Technology System

The goal of a community linking system is to have a community-wide information and intake system that facilitates social and health services needs identification, referral, enrollment and management, while minimizing the need for multiple client inquiries and referrals. A community linking system was identified by the access to care

strategic planning process as the highest priority program element to put in place to form the basis of a system to improve access.

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management, provider network). Linking systems have the potential to address all these issues including: intake/information gathering, eligibility matching, referral/enrollment, support for care management, network management, reporting/analysis, to assist screened and referred individuals with their appropriate and effective use of the health care system through the provision of care management services.

Strategy #2: Care Management

The recommendation to put this system in place was based on issues uncovered during the assessment phase of this project and the experience and expertise of the dozens of individuals, including health care providers, social service providers, employers and consumers who participated in the strategic planning process. These issues include:

- There are many services available in our community that could improve access to care and help people access care more effectively, but it's not always easy to make the necessary connections
 - Research among our health care providers indicates providers would be willing to accept more uninsured or Medicaid insured patients if those patients were connected to existing services that helped them use the system more effectively
 - Providers and social service agencies do not have an efficient system for connecting people to services, documenting those efforts, eliminating duplicate efforts, etc.

Additionally, as the recommended elements of an access to care system were further researched and developed, it became clear that there is a need for software to connect people to other elements of the system (care

Care management includes helping individuals make appointments with their health care provider; assisting with transportation to appointments; talking to clients after appointments to help them follow their provider's plan of treatment; providing appointment reminders; providing disease education; serving as an advocate for the client when needed; and making sure they are connected to all appropriate health and support programs.



We would like to use existing case management capability from within several agencies, instead of setting up a separate care management program. We have identified almost a dozen agencies with case

management capability. Six of those have provided additional information about the services available, eligibility criteria, funding sources/levels and whether or not the

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elements of care management could be provided to eligible individuals under their existing funding agreements.

An alternative strategy for providing care management would be to hire care managers who would be dedicated to providing care management to clients referred through the linking system. This would require finding new funding sources, but would allow the care managers to specialize in the health care-related needs of the clients. The preference in our planning discussions to date has been to try to use existing case management capability, but the final determination of the best way to provide this service needs to be addressed during implementation.

Clients who would benefit from care coordination will be identified through the linking system or by a medical provider. Within the linking system, care management eligibility criteria will be available just as it will be for many other programs. Criteria will need to be finalized by the agencies providing the care management resources, but might include no insurance or Medicaid plus any one of the following criteria:

- Multiple chronic medical conditions
- Problematic transportation to provider appointments
- Low health literacy as determined by screening questions*
- Health care compliance issues as determined by screening questions*

The Nursing Diagnoses, Outcomes and Interventions Classification System might provide standardized scales for documenting health literacy, compliance or other factors that could be included in the criteria for case management.

Health care providers who believe an uninsured or Medicaid patient would benefit from care management can refer that person to the linking system for care management eligibility screening. The expectation of the access to care program is that the assigned care manager would include in their typical client assessment

elements to identify the particular needs of the client relative to appropriate interaction with the health care system. Based on that assessment, the management/support plan will include specific goals relating to the health system, as well as interventions and activities to help the client achieve the goals. Information about the client's interaction with the health care system will be documented within appropriate modules of the Linking System. Periodic reports on the achievement of the stated goals will be entered into the system as well.

STRATEGY # 3: Network of Providers

By formalizing a network of providers for the uninsured, people who qualify for use of the network can have an identified entry point for the system and distribution of patients can be sensitive to the capacity of participating providers. There are many such networks in operation around the country, some of which share information and ideas under the American Project Access Network (APAN) banner. APAN and other projects have developed program models, including information, policies, procedures and forms, which can be replicated in other communities.



Provider networks are developed by first establishing a sliding fee scale so that the fee that will be collected at the time of service is known to the patient and to the office staff. Not only does this eliminate the inefficiencies inherent in trying to collect more money than a network enrollee has the demonstrated ability to pay, it is also sensitive to the patient's desire to be treated

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like any other patient. Placement of the patient on the sliding scale is done in advance of the first appointment via the network enrollment process.

The successful sliding fee scale networks are physician lead and include participation by all providers. The benefit of broad participation is fair and reasonable distribution of patients. In the development phase, providers are asked how many patients they can accept so that distribution of patients can also be sensitive to a provider's capacity. Providers in other communities have found this sort of system preferable to having these patients use the emergency room for primary care and then be assigned to the next doctor on the list if follow-up care is required.

Individuals are screened for enrollment in the network via an intake process facilitated by the linking system. Eligibility criteria can include having no insurance, not being eligible for Medicaid or Medicare and meeting an established income level. Another variable that could be required to participate in the program is that the participant must have been a resident of Adams County for at least 90 days. If individuals are found to be eligible for Medicaid or Medicare, they are directed to enrollment in those programs. The screening criteria would be developed with the advisory council.

Eligible individuals are typically enrolled for a period of one-year, at which time eligibility must be re-established. Patients sign a "Patient Responsibility Agreement" that includes things like keeping scheduled appointment, complying with treatment plans, reporting changes in income, and applying for other benefits for which they might be eligible. Failure to comply with these is grounds for termination from the program.

Patients are billed for services by the practices based on the level of pay determined when they enroll. Each patient

is assigned a patient ID number, which is displayed on an ID card. This number contains a letter that corresponds to the fee codes established for different levels of income. This is how the provider offices know how to adjust each patient's fee. In the Access Emmanuel (GA) program, patients must pay their fee at the time of services. Some provider network programs ask the providers to generate a HCFA form to forward to network management so that the number of patients served and the nature of services can be tracked and reported.

People enrolled in the network who meet certain criteria (multiple chronic conditions; no transportation; other compliance issues, etc.) will be referred to care managers. The role of the care manager is to assist that person's appropriate interaction with the health care system, via provision of transportation, health education, compliance support, linking to other needed programs, such as prescription assistance, and other support services. The purpose of this referral is to help the patient participate as effectively as possible with the provider in improving and maintaining good health.

To establish a network of health care providers willing to accept an agreed-upon number of uninsured patients, who will pay for services on a sliding fee scale. By having an established relationship with a primary care provider and having access to specialist and hospital care when needed, more people will receive the preventive services they need and the amount of inappropriate uncompensated care provided by the hospital will be reduced. In addition, uninsured patients will be distributed in an equitable and manageable way among providers. The program will gather outcome data to demonstrate overall reduction in costs for the community and improved health outcomes for program participants.

Strategy #4: Three-share insurance program

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With the primary source of insurance for adults in the United States being their employer, a goal of access to care initiatives has to be to expand the number of individuals with employer-based coverage. Since almost 75% of the uninsured adults in Adams County are employed, expanding the number of people insured at work is a priority.

Other communities around the country have experienced success with an approach called “Three-Share” or “Multi-share” coverage. This approach uses a basic benefit design and an employer-employee-community premium share to make health coverage affordable for employers to offer and employees to purchase. The viability of the approach depends on a number of factors, key among them determining the qualifiers for participation and securing the community premium contribution. In Illinois, there is one active program, in Winnebago County, and five other programs, covering seven counties, waiting on approval of a state Medicaid amendment that would certify unreimbursed tax-funded costs of services as state Medicaid expenditures for the purposes of securing additional federal money that becomes the community match. Other potential sources of the community match are local donations or private and federal grants. The key to securing local community support for the third share of the premium is to understand that the community is already paying for inappropriate emergency and inpatient hospital care for people who do not have access to primary and preventive services. In our community, even just a portion of the cost of uncompensated inappropriate care (estimated to be over \$1,000,000 annually) would fund a third of a basic benefit insurance plan for a portion of our uninsured working adults.

Meetings held with three organizations that represent employer interests (Great River Economic Development Foundation, Quincy Area Chamber of Commerce and Tri-State

Health Care Coalition) indicated employer interest in investigating the three-share approach. At the suggestion of this group we obtained information about small employers in Adams County. Adams County has 2000+ employers with fewer than 50 employees. We surveyed 400 of these businesses about health insurance. A summary of the results of the survey is attached. Of 62 responding companies who completed the survey, a little over half do not offer insurance, either because it's too expensive or because employees are covered under a spouse's plan. The comments from companies offering insurance and those not offering were similar, that offering health insurance is or is becoming too expensive for employers and employees.

It is interesting to compare responses between employers offering insurance and those that do not. The average wage for businesses not offering insurance is \$10.51 per hour; for those offering, it is \$12.56 per hour. Both groups of employers largely rate an employee monthly premium of \$40-\$80 as affordable. Amounts above that are considered not affordable by employers not offering insurance. More of the employers offering insurance considered higher employee premiums affordable. When asked to rate the affordability of the employer portion of the premium, the businesses not offering insurance responded the same way: \$40-\$80 was affordable. For the employers offering insurance, a significant number included \$80-\$120 in the affordable category. Currently, these employers report an employee monthly premium of \$172.83 and an employer monthly premium of \$294.60.

The Chamber of Commerce sponsored a focus group lunch at which small employers provided additional insights into health insurance issues. They provided reasons that employees might not take coverage even when it's offered: a perception that taking insurance will remove their kids from Medicaid; some employees (particularly young and healthy ones) don't see the value; the premium is too high. The

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consensus of this group was that an employee premium of about \$80 per month was affordable for small business employees. Research conducted for the state of Illinois identified about \$90 a month as an affordable premium for the targeted employers.

In a discussion of the three-share concept, employers were concerned about eligibility criteria and the need to design criteria so that employers don't drop existing coverage to participate in a three-share plan. The employers were receptive to the idea of designing coverage criteria so that the availability was targeted to low-wage employees who cannot afford coverage even if it's currently offered. They also suggested that support for a three-share program here should be broad-based, including providers, employers and the community at large. Although a very difficult statistic to develop, Blessing Hospital has estimated that the cost of avoidable hospital care for uninsured patients is over \$1.3 million annually. Half of that amount, or \$650,000, would fund one-third of the Unicare plan for 900 or almost 25% of our working uninsureds. This is money that the community is already paying for care that might not have been necessary in the first place. Funding primary and preventive care would be a much better community use of those dollars.

ACCESS TO HEALTH AND SOCIAL SERVICES

<p>POPULATION AT RISK..... Those with</p> <ul style="list-style-type: none"> • Medicaid insured • Uninsured 	<p>HEALTH IMPROVEMENT OBJECTIVES:</p> <ol style="list-style-type: none"> 1. Increase the proportion of persons with a usual primary care provider (Baseline 14.9%, 2004 Behavior Risk Factor Data) 2. Increase the number of residents who have had a medical physical in the last two years (Baseline 16.2%, 1998 I-Plan data) 3. Decrease the percentage of adults without health insurance (Baseline 12.2%, 2003 Behavior Risk Factor Survey) 4. Decrease the percentage of children without health insurance (Baseline 7.1%, 2000) 5. Increase the percentage of population enrolled in Medicaid (16.1% of population, 2001 I-Plan Data System) 6. Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members. (Baseline will need to be collected) 7. Reduce inappropriate use of health care services (Baseline will need to be collected)
<p>RISK FACTORS</p> <ul style="list-style-type: none"> • Multiple chronic conditions • Poverty • Inability to access a coordinated care system • High cost of medical care • Low health literacy • Better integration of behavioral and medical health services • Decrease in affordable providers to un-, under and publicly insured population • Mental and medical health professional shortage • Lack of centralized data collection/evaluation mechanisms • Transportation • Lack of understanding of how to access the social services and medical system • Cultural issues (poverty) that lead to lack of compliance 	<p>HEALTHY PEOPLE 2010 OBJECTIVES</p> <p>1-4 Increase the proportion of care for persons who have a specific source of ongoing care to 96% (1998 Baseline 87%)</p> <p>1-5 Increase the proportion of persons with a usual primary care provider to 85%. (1996 Baseline 12%)</p> <p>1-6 Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members to 7%. (1996 Baseline 77%)</p>
<p>RELATIONSHIP TO ILLINOIS STATE HEALTH IMPROVEMENT PLAN (SHIP)</p> <p>Access to healthcare and public health services, including quality prevention programs, oral health, mental health and long-term was identified as a SHIP strategic issue</p>	
<p>HEALTH IMPROVEMENT GOALS:</p> <ul style="list-style-type: none"> • Improved health for the targeted Adams County population through a coordinated system of care that integrates and maximizes existing health services. • Community receives return on investment in improved health access 	

<p>ASSESSMENT METHODS</p> <ul style="list-style-type: none"> • Behavior Risk Factor • I-Plan Data 	<p>FUNDING SOURCES</p> <ul style="list-style-type: none"> • Illinois Department of Public Health grants to develop community based primary care centers (Secured) • Blessing Affiliate (Secured) • Marion Gardner Jackson Trust (Application) • Network Outreach Grant (Application) • School Foundation (Application)
<p>PROVEN INTERVENTION STRATEGIES</p> <ol style="list-style-type: none"> 1. Establish a community linking system that facilitates social and health services, needs identification, enrollment and management, while minimizing the need for multiple client inquiries and referrals. 2. Establish a care management program using existing case management capability from community agencies to assist screened and referred individuals with their appropriate and effective use of the health care system. 3. Establish a network of healthcare providers willing to accept agreed-upon number of uninsured patients who will pay for services on a sliding scale. 4. Expand the number of individuals with employer-based coverage. 	<p>RESOURCES TO CONTRIBUTE TO IMPLEMENTATION</p> <ul style="list-style-type: none"> • Collaborative Partners Adams County Health Department Blessing OCC Transitions of Western Illinois SIU Quincy Family Practice United Way • Access Health Adams County Structure • Other Social Service Agencies • Adams County Medical Society • Alliance for Building Community
<p>ESTIMATED FUNDING NEEDED</p> <p>In order to fully implement the access to care system and the identified four priorities, approximately \$500,000 is needed.</p>	

LACK OF ACCESS TO HEALTH AND SOCIAL SERVICES HEALTH PROBLEM ANALYSIS WORKSHEET

