

The Project Access Model of Care:
A patchwork approach to addressing healthcare disparities in the United States

By

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DEDICATION

To my Tia Ani,

For believing in my dreams

And making all of this possible.

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
AMPA	Appalachian Mountain Project Access
LEP	limited-English proficiency
MFN	Medical Foundation of Nashville
NAM	Nashville Academy of Medicine
NGO	non-governmental organization
PAC	Patient Advisory Council
PANSC	Project Access Nashville Specialty Care
PFS	Patient Feedback Survey
SETPA	Southeast Tennessee Project Access

INTRODUCTION

The current state of the United States healthcare system leaves the door wide open for already existing health and healthcare disparities to be perpetuated. First of all, insurance is a necessity to access affordable healthcare in the US, and Medicaid still leaves many people without coverage. Despite the Affordable Care Act (ACA) expanding Medicaid, the eligibility rules differ from state to state, often being influenced by political ideologies and creating strict eligibility requirements. As a result, it is up to individual states to address the health barriers which their own legislation have introduced (Khullar & Chokshi, 2019). For those denied Medicaid coverage, private health insurance can be very expensive, even if offered through their employers.

When it comes to individuals with limited English proficiency (LEP), many of the jobs available to these immigrants do not offer health insurance with their employment. While there are ways for these people to obtain affordable healthcare, they often need help navigating the complicated system to get there. For example, not even one fourth of the top hospitals in the United States have Spanish translation available for patients, much less for other less common but still heavily prevalent languages, like Arabic, Mandarin, and Vietnamese (Honeycutt et al., 2021). Latinos are already less likely to use medical services, such as primary and preventative care, than white US Americans (Timmins, 2002). Efforts to make medical information more understandable are clearly needed, which would create a more welcoming medical environment and lead to better health outcomes for LEP patients (Raynor, 2016). While there are other common barriers to care in the United States, such as transportation and medical literacy, insurance, income, and language are the primary hurdles faced by those without access to affordable healthcare.

The Project Access model of care addresses the exclusionary nature of the United States healthcare system by eliminating the barriers of insurance, income, and language, thus reducing healthcare disparities. However, this organization is not well known. In fact, there is a lack of sound

research overall on different models of care. Because of this, there is limited knowledge on the variable impact on quality of care, costs, and patient satisfaction between models. (Tiedeman & Lookinland, 2004). I had never heard of the Project Access model of care before an undergraduate class led me to volunteering at Project Access Nashville Specialty Care (PANSC) as a document translator. Despite there being over 50 Project Access programs across the country, there is neither academic nor public exposure on this model. Increasing public knowledge could result in more clinics and physicians participating in the program leading to more people having access to affordable healthcare.

This model is comprised of referring clinics, a Project Access nonprofit organization, and volunteer medical specialists. The nonprofit coordinates donated specialty medical care for patients who do not have access to health insurance. In this model, the clinics refers their patients to the nonprofit, which then screens the patients for eligibility and places them with the specialist. The initial appointment and all follow-up appointments are always covered, and most labs and tests ordered by the assigned volunteer specialist are covered as well. Enrolling in the program also gives patients access to many nonmedical community resources. The Project Access model of care always strives to have a holistic approach to their patients' health and wellbeing. However, in addition to being a model of care, it is also a form of philanthropy which does not get to the root causes of the disparities and barriers to care in the US healthcare system. Nevertheless, this model can initiate political and social debate, making these issues more apparent and pushing for systemic change.

The focus of this research is to examine the ways which the Project Access model of care superficially addresses and raises awareness on healthcare disparities present in the United States. A literature review will establish how healthcare disparities manifest themselves and go unaddressed in people that do not have access to health insurance. An analysis of PANSC referral and enrollment data and other PANSC secondary materials, such Patient Advisory Council meeting notes and Patient

Feedback Surveys, will follow. This will be supplemented by interviews of PANSC care coordinators and leadership staff. The study population is enrolled patients and employees of PANSC.

BACKGROUND

PANSC was established in 2005 and served patients in Davidson, Rutherford, and Williamson counties. It struggled to grow its impact and coverage until the Medical Foundation of Nashville (MFN) was established in 2018. This helped expand coverage from 3 counties to 32 counties in Middle Tennessee by the end of 2022. Since then, PANSC continued to set new program records and to expand the scope in which the program serves patients. From 2018 to 2022, patients served increased from 772 to 4,510, initial appointments coordinated increased from 219 to 1,081, and total value of donated care increased from \$1.48M to \$5.86M (Medical Foundation of Nashville, 2022a). This growth in patient care and coverage was accompanied by an increase in staffing and operating budget. PANSC currently has 16 staff members while it only had 6 in 2018. Outside of the donated medical care, the program's operating budget covers all other costs. This was \$551,912 in 2020. 75% of this budget came from the Tennessee Department Health. The rest is covered by other contributors, such as United Way, and independent donors during fundraising events (Medical Foundation of Nashville, 2022b). All of these factors combined has allow PANSC to reach a total value of \$56.4M of donated medical care since its foundation in 2005.

While the Project Access model of care has offices all across the country, these offices do not collaborate with each other for the most part and must respond the regional variation to better serve their patients. As a result, PANSC's internal processes, funding sources, and services offered differ from other offices. First of all, the healthcare needs of the uninsured vary per state, often following the trend of whether or not a state expanded Medicaid. The difference in the structuring of Project Access

programs follow this trend as well. Also, not every Project Access office operates out of a medical association. While PANSC operates out of the Nashville Academy of Medicine (NAM), Appalachian Mountain Project Access (AMPA) works out of the Ballad Health hospital system. This is because of the monopoly that Ballad Health has on every level of health care in the area. This monopoly allows AMPA to cover their patients' primary care and emergency room visits, unlike PANSC. They also serve patients from both Tennessee and Virginia. However, the differentiation in structure is more responsive to community needs than policy changes. For example, PANSC has a 100% Spanish-speaking patient-facing staff in order to serve its near-70% Spanish-speaking patient population. This in contrast to AMPA, who only has one bilingual care coordinator and a bilingual receptionist, and to Southeast Tennessee Project Access (SETPA), who has two bilingual care coordinators. The proportion of their patients that speak Spanish is lower than PANSC's, so their staffing reflects that lesser need. Having a receptionist is also a response to patient needs. PANSC does not have a receptionist, as all patient intake is conducted over the phone. However, AMPA offers in-person care coordination due to patient requests and SETPA sees in-person patient intake for 25% of their enrollees. These examples of differences in Project Access office operations just within Tennessee show how the same model of care is provided in different way across the country and how a nationwide approach would be impossible.

LITERATURE REVIEW

This research will establish how healthcare disparities manifest themselves in people that do not have access to health insurance, whether it be due to low income, immigration status, or other external factors. In order to critique the Project Access model of care, it is necessary to understand why and how healthcare disparities exist in the United States.

The United States Healthcare System

The current state of the United States healthcare system leaves the door wide open for already existing health and healthcare disparities to be perpetuated. The United States “stands as the only industrialized nation to ignore the glaring problems that exist” with treating healthcare as a commodity instead of moving towards a fair system that ensures universalized coverage and considers healthcare a right (LiPuma & Robichaud, 2020, p. 258). First of all, Medicaid has not been the answer for everyone to have access to affordable healthcare. Despite the Affordable Care Act expanding Medicaid, the eligibility rules differ from state to state, often being influenced by political ideologies and creating very strict eligibility requirements. Furthermore, Medicaid expansion only benefitted white low-income childless adults by increasing their access to healthcare and improving their health outcomes while having limited positive impacts on healthcare access and health outcomes for Black and Latino communities (Barker & Li, 2020). Additionally, the small improvements made by the Affordable Care Act were negated by the Trump administration allowing insurance companies to deny coverage on the basis of pre-existing conditions and stopping payments to Medicare and Medicaid providers (LiPuma & Robichaud, 2020). As a result, it is up to individual states to address the health barriers faced by immigrants, the less educated, and lower income individuals, which their legislation has introduced (Khullar & Chokshi, 2019). While there is still some safety-net care provided by the United States healthcare system for people without insurance coverage, it is inconsistent across the board and inefficient, resulting in ineffective care coordination (Luft, 2006). Additionally, private health insurance can be very expensive and many of the jobs that immigrants or less educated individuals can obtain do not offer health insurance. In fact, Marketplace enrollees indicated higher levels of worry about their potential access to affordable health insurance and healthcare services in the future than those covered by employer plans (Chen & Page, 2020). While there are ways for these people to obtain affordable healthcare, they often need help navigating the system to get there.

The structure of the United States healthcare system makes health insurance a necessity. While education and income are important factors in an individual's health, consistent health insurance is a clear driver of health with "the effect of health insurance on health status compound[ing] over time, although unevenly by race" (Barker & Li, 2020, p. 815). If treating health insurance as a unique factor impacts health and health outcomes, then the different kinds of health insurance available in the United States must have differing effects as well. High deductible health insurance plans and Marketplace plans present their own challenges. First, Marketplace enrollees are more likely to come across issues establishing themselves with a doctor's office as a new patient, having their health insurance accepted by that office, and leaving with unmet medical needs for not being able to access various services (Chen & Page, 2020). Additionally, there were clear racial differences seen between the deductible levels within health insurance plans with the two higher deductible groups consisting of more white and male enrollees and less black and Latino individuals than the lowest deductible level (Chen & Page, 2020). It has long been argued that adopting a universal healthcare system was the solution to the non-inclusive and inequitable system in place in the United States currently. As a capitalist society, the most common counterargument to that proposition is the lack of profit and the extreme costs associated with a universal healthcare system. First of all, this argument shows that those in power in the United States do not prioritize affordable healthcare or social determinants of health. Furthermore, the costs will be high in the beginning but will be worthwhile and offset in the long term when the United States population is healthier and therefore less of an economic burden (Zieff et al., 2020). This is not to say that a universal healthcare system is the only solution, but it is something that should be looked at more seriously.

In order to properly gauge the strengths and weaknesses of the United States healthcare system, it would be helpful to discuss it in comparison to a country that has a universal healthcare system. This is where the specific points that need to be addressed come to light, as no system is perfect. McAlister, M., and Helton, J. D. do just that in their comparison of the United States system with

that of Austria. Their findings consistently showed that if one of the systems excelled in one function, the other system would be severely lacking. Thus, while the standards of communication and care coordination in the United States leave patients less likely to have gaps in their care or a lack of follow-up from the hospital after leaving, the system would benefit from incorporating aspects of Austria's model to expand access and lower costs for treatment and medications (2021). While they propose the United States has strengths in their healthcare system, many would characterize it as an expensive system that provides variable quality and leaves many without coverage. McAlister and Helton applaud the United States healthcare system's coordination of care, but Luft reports that it is ineffective as a result of the weak attempts to provide healthcare for those without insurance coverage. However, he does agree that with McAlister and Helton that "rather than scaling back the vision for reform because of past defeats, or focusing on adopting systems that may only work in other social and political settings, we should build on the strengths and characteristics of the American political system and social values (Luft, 2006, p. 26). This methodology of building on the system's current strengths has somewhat been applied with some places implementing newer models of care delivery, but a lack of buy-in and uniformity has made it difficult to analyze them. There is too much fluctuation and not enough operational definition within models of care to be able to draw comparisons between them. Therefore, it would not be a sound research practice to draw conclusion on the variable impact on quality of care, costs, and patient satisfaction between different models of care (Tiedeman & Lookinland, 2004).

Despite care coordination being reported as a one of the strengths, if not the only strength, of the healthcare system in the United States, there are still a multitude of challenges that patients experience while navigating the healthcare system. These challenges, referred to as hassles, are correlated with delaying or forgoing care. Using data from a 2016 Veterans Affairs survey, one study found that nearly 40% of participants had experienced four or more hassles while only just over 25% of participants had experience no hassles (Brunner et al., 2020). Concerted efforts to further improve

communication and care coordination would address many of these hassles. While increased access in terms of affordability would be ideal, simpler solutions such as improving appointment availability and offering interpretation and translation services would also have an observable impact.

Language as a Barrier to Care

The United States is a country of immigrants, meaning that this country has people from all over the world that speak different languages. There are eight languages in the United States other than English that each have over 1 million speakers at home, including over 40 million Spanish or Spanish Creole speakers (Zong & Batalova, 2016). However, people with limited English proficiency are struggling to access services in the United States healthcare system, as “immigrants continue to face substantial barriers to medical care. [These] vary greatly according to legal status, and are particularly pronounced for those who are of low-income or undocumented status” (Khullar & Chokshi, 2019, p. 2169). There has been a steady increase in the United States limited English proficient population, with the 2015 American Community Survey indicating that 25.9 million people above the age of 5 in the United States speak English less than very well. This is nearly eight percent of the population being overlooked by the medical field. Language barriers cause decreased patient recall, a misinterpretation of side effects and treatment plan, and decreased patient satisfaction, directly affect the physician-patient relationship (Timmins, 2002). This could lead to inaccessible treatment or medication for the patient simply due to a misunderstanding or worsening their condition or diagnosis by incorrectly applying the doctor’s orders. Essentially, the appointment was a misuse of time for everyone involved.

One would think that the bare minimum is being done to provide patients with LEP with some language resources to facilitate healthcare access. However, various assessments have found otherwise. One investigation into the Spanish Translation of medical websites found that not even one fourth of the top hospitals in the United States have that available for patients (Honeycutt et al.,

2021). This is especially worrying as these are the hospitals that would have the most funding to make this happen. Also, Spanish is the most commonly spoken foreign language in the US (Zong & Batalova, 2016). This means that if the rate is that low for Spanish, it is much less available for other less common but still heavily prevalent languages, like Arabic, Mandarin, and Vietnamese. This was proven by another study which primary language and translation services at comprehensive cancer centers. This study showed that the websites of most comprehensive cancer centers did not have non-English translations available. It would seem more than reasonable to have translation and interpretation services available for at least the top few languages spoken in the area. However, this study also showed that comprehensive cancer centers “located in states or cities with larger self-identifying Hispanic/Latinx populations were not more likely to publish Spanish language resources” (Dhawan et al., 2021, p. e14). The combination of these factors shows that there is not being enough action being taken to solve this problem.

There is some conflicting evidence on what the best way to provide limited English proficient patients with sufficient translations and interpretations services. Proposed solutions include “bilingual health care providers, hiring trained professional interpreters, training volunteer interpreters from the community, participating in interpreter pools to share interpreter costs with other agencies, and using phone interpreting” (Timmins, 2002, p. 90). The issue is not that there has been a lack of attempts, but none have been perfected and some hospitals use different methods between different offices and specialties. There is no uniformity. Patients do not know what to expect or what service to ask for. Some authors have narrowed it down from this list. For example, a systematic review of medical interpreter services claims that trained professional interpreters or bilingual health care providers lead to the most effective communication, highest patient satisfaction, best health outcomes, and least clinical errors (Flores, 2005). However, the literature used in this review was very limited, so its findings might be skewed. One solution that most agree

with is that the medical interpreter needs to be specifically trained for the role and be separate from the medical providers as they should also be advocating for the patient. One study found that “one-third of the uncomplicated cases and two-thirds of the complicated cases ... resulted in errors or significant omissions in the medical chart” when nurses doubled as interpreters (Elderkin-Thompson et al., 2001, p. 1354). Given that there can be various dialects and colloquialisms within the same language, “ensuring the patients have appropriate written information in their native language regarding their diagnosis, treatment, and medications can improve compliance with therapy” (Raynor, 2016, p. 149). This is crucial as translation and interpretation errors can still occur up to 12% of the time with professional hospital interpreters, compared to up to 20% of the time when no interpreter is present (Flores et al., 2012). There will never be a perfectly interpreted conversation, but that expectation is unrealistic anyway as these errors are also seen between healthcare providers and native English-speaking patients. Although the solutions to this problem are not consistent throughout the board and could use additional studies to reach a consensus, there a common shared goal is to minimize these errors as much as possible.

Additionally, language barriers not only affect the clinical setting of healthcare in the United States but also that of gaining access to health insurance. A case study conducted on the Latino population of Dallas County, Texas found that over a quarter of the children in the community that were eligible for subsidized medical insurance were not enrolled, showing that “language difficulties may be a cause of Latinos being under-insured or uninsured” (Prieto, 2008, p. 8). This presents itself in accessing all types of insurance, including private, employer-sponsored, and public, like Medicaid and Medicare. While there are other barriers that may present themselves later in the process, like immigration status and state-issued Medicaid eligibility requirements, language is the first hurdle faced by most immigrants (Dillender, 2017). The language barrier also impacts immigrants’ access to primary care clinics, additional assistance that may reduce or remove healthcare costs, and other

community resources, like food banks and dentist offices. The percentage of immigrants in the United States without health insurance and access to affordable healthcare is disproportionate, and addressing language barriers can help close this gap.

The United States's most common foreign language is Spanish, so it is exceptionally important to investigate how language and cultural differences affect the health and healthcare of this group of people. Apart from experiencing direct language barriers that diminish quality of care, Latinos also experience cultural offenses. The aforementioned study conducted on the Latino population of Dallas County, Texas found that 35% of patients had been culturally offended by providers in healthcare settings. However, this number is probably much higher as many participants wished to change their answer once to *yes* they were given a definition of a cultural offense (Prieto, 2008). The importance of cultural competence for healthcare providers treating fast-growing populations cannot be stressed enough. Those who had interactions with culturally competent providers during emergency room visits, and therefore did not experience cultural offenses, were more likely to follow up with a primary care provider and thus less likely to be readmitted to the emergency room for the same issue (Huffington, 2014). One of the common cultural offenses that probably goes unnoticed a majority of the time is that of treating Latinos as a monolithic population. The Latino population in the United States is extremely diverse in regard to country of origin, cultural practices and beliefs, language and colloquialisms, immigrations status, and the degree of acculturation. It is necessary for healthcare providers to acknowledge the heterogenic nature of the Latino population in the country to more effectively provide health services and eliminate disparities (Weinick et al., 2004). The misconception of Latinos as a monolithic population could also have medical consequences. One report found that there are marked genetic differences among Latino subgroups. There is sufficient genetic variance among Latinos to cause significant differences in drug metabolism, "enough to necessitate dosage levels adjustments to prevent therapeutic failure or toxicity" (Delgado, 2010, p. 41).

Cultural competence is a social skill that will help healthcare providers be more tactful in their approach to patients, but it also carries great medical relevance. There is a need for its increased implementation in medical school curriculum and medical practice.

Social Determinants of Health

The importance of social determinants of health on health outcomes and healthcare access has been rising since 1995, when Phelan and Link developed the theory of fundamental causes, which “attempts to explain why the association of SES to health and mortality has persisted despite the demise of risk factors and diseases that appeared to explain the association” (Phelan et al., 2010, p. S38). While this theory and the idea of social determinants of health have been more and more on the mind of public health researchers and health policy officials, the impact of the social determinants has been the focus of their implementation in traditional healthcare interventions instead of focusing on the upstream social determinants. There have been successful interventions in early childhood education, housing, and urban development, among others. Research, policy, and implementation should focus on scaling up those interventions and applying the same techniques to other social determinants, such as food security and economic stability (Thornton et al., 2016). While these are suggestions on how to better use the concept of social determinants to guide health decisions, there are strong critiques that point out some severe flaws in the way of thinking and call for the complete reworking of the social determinants framework.

One critique is that the way in which the concept of social determinants of health is applied is damaging to its own primary goal of health justice. The social determinant interventions in place in communities have effects that are not being addressed. One suggestion is to make space for material semiotic indeterminacy in public health to respond to the effects of these interventions, that is to not have a predetermined definition of health or goal for the intervention and move away from the linear model of social determinants of health. Material semiotic indeterminacy emphasizes the importance of

addressing feedback loops and gaps in the model but looking into the system that creates inequalities rather than trying to define them from the outside looking in. (Yates-Doerr, 2020). Another concern is that, while social determinants of health have been successful in making people aware of the social, economic, and political factors that drive health and healthcare inequalities, there has not been much progress made on actually addressing them. The continuously increasing prevalence of health and healthcare inequalities has not been enough to increase political will and warrant action be taken on the social determinant of health. A suggested solution to superficial action on the social determinants of health is further interdisciplinary dialogue in order for the government to prioritize health inequalities (Herrick & Bell, 2020). One final critique is that conversations surrounding the social determinants of health advance while not considering all of the factors. One of those factors that is not being included as a social determinant of health is immigration. When immigration is considered as a social determinant, it is only when looking at an individual rather than applying it to the broader framework, like what is done with the other factors, such as housing, education, and economic standing. Although addressing immigration as a social determinant of health would require confronting new upstream structural factors, a determined effort to understand the health effects of immigration would create a more global society (Castañeda et al., 2015). There is not an argument that the social determinants of health framework itself is damaging or counterproductive. However, its superficial application to health policy and healthcare practice is not sufficient to make a lasting difference.

In response to these critiques, reviews have shown how the social determinants of health framework can be improved from where it stands currently instead of having to replace it entirely. For example, supported employment programs were found to be effective in helping mental ill individuals and veterans find and maintain employment. The authors maintain that, while “this is an example where an intervention has not achieved broad dissemination across different patient groups,” studies could be conducted to see how to this social intervention could be applied to more diverse populations (Gottlieb

et al., 2017, p. 725). This way of thinking could be applied to successful and effective social interventions across the country to remove them from the niche in which they are held and make them beneficial to the general public. However, it needs to be accepted that the social determinants of health framework is not as easily applicable to some socioeconomic issues as it is to others. Not only are there variations amongst geographic regions and populations of people with shared characteristics, there is variation between seemingly similar individuals. When it comes to determining which interventions to prioritize, there needs to be an “awareness that the relative importance of different determinants depends on the variation in health to be explained” (Fuchs, 2017, p. 26). Even if the same determinants are in play in two separate locations, they could interact with each other in different ways. The same social interventions can be successfully applied at a large scale, but the awareness of potential caveats and nuances must be present.

With these things in mind, some more concrete approaches have been suggested to better implement the social determinants of health framework in society. Following her 2017 review, Gottlieb proposed four complementary policies in a 2019 paper which healthcare leaders could employ to improve social conditions. These policies were thematically separated, two being categorized as patient care-focused strategies and the other two being under community-focused strategies. While the patient care-focused strategies, including social risk-informed care and social risk-targeted care, are good propositions for interventions carried out by medical providers, the community-focused strategies can be implemented by public health researchers and health policy officials. These include financial investments and partnerships. In response to her own 2017 review, Gottlieb concluded that “despite being focused on broader populations, these activities may have the greatest long-term payoffs if they result in improvements to community-level [social determinants of health]” (L. Gottlieb et al., 2019, p. 250).

While these suggestions do provide a rough plan of action for the implementation of the social determinants of health framework, specific steps have been recommended to be taken in order to not fall back on the previous issues of not addressing the problem at hand or taking too broad of an approach. A small team that is dedicated to working with social determinants could produce more success interventions. Rather than having a clinical committee or community advisory board look, Dr. Shreya Kangovi saw success with a five-person team of people with social determinants experience (Kangovi, 2019). This ensures that the problem at hand is understood and that feasible, reasonable interventions studies, proposed, and implemented. In contrast to Yates-Doerr and her material semiotic indeterminacy, Kangovi also explains how she and her team found it useful to identify a specific problems and define achievable, meaningful outcomes for those problems (Kangovi, 2019). Creating problem-specific solutions also acknowledges Fuchs' suggestions by not treating social determinants of health interventions as a cure-all. This progression of knowledge and application of the social determinants of health framework will build on its increasing recognition in healthcare settings and could lead to more profound impact in society. This is the hope of the social determinants of health programs around the country.

Philanthrocapitalism

Gottlieb included financial investments in the community-focused strategies that was discussed previously, specifically community benefit philanthropy. However, philanthropy has received lots of criticism lately. One study looked at three cases of philanthropy and found some trends of unintended negative consequences amongst them. Some key findings were that “donations may unintentionally cause the beneficiaries to have a sense of dependency on the donation producing negative psychological externality” and that “free products from donors can demotivate... efforts to improve national treatment guidelines” (Kim et al., 2017, p. 12). Dependency on philanthropy and its masking of the systemic change that needs to occur are two principal critiques of the practice. However, these are

just criticisms on the effects of philanthropy. The philanthropists themselves and the act of philanthropy as a whole has been receiving just as much, if not more, backlash than the methods of doing so. Much of this is because of the new wave of philanthropy, philanthrocapitalism.

In short, philanthrocapitalism involves using business sense and a market-based approach to solve the biggest social, economic, and health-related issues. Examples of philanthrocapitalists include Bill Gates and Mark Zuckerberg. Dr. Rob Riech, Stanford University professor, director of its Center for Ethics in Society, and one of the biggest critics of philanthrocapitalism states that “philanthropy is an exercise of power by the wealthy that is unaccountable, non-transparent, donor-directed, perpetual, and tax-subsidized” (Madrigal, 2018, p. 2). And he is not alone in this feeling. Another report shares in Reich’s worry of the lack of accountability and the donor-directed nature of philanthrocapitalist ventures. The only accountability is done by these foundations’ own management committees which have shared interests and passions of the owners. This report introduces another level of critique to donor-directed philanthropy. There is reason to worry that these foundations are led by “individuals successful in the technology or financial sectors, but not necessarily otherwise skilled or experienced in the social and health development of countries and their populations” (Clark & McGoey, 2016, p. 2459). This ties back to Kim et al.’s unintended consequences. While these foundations aim to use their endless wealth to solve societal issues domestic and abroad, there is often misdirection in doing so while being shielded from the legitimate criticism making them aware of it.

Despite the various critiques or oversights of philanthropy, arguments are being made that philanthropy can still play a big role in social, economic, or healthcare development. For example, philanthropy has been proposed to be a partner in North Carolina’s transition to value-based care. This is partially because philanthropy existing involvement in public and community health programs helped recognize the need for this change in the state’s healthcare system to address structural racism and health disparities. They argue that philanthropy’s continued involvement during and after this shift “can

play an important role by acting as a venture capitalist, supporting effort to innovate and test alternative care models” (Collins, 2021, p. 221). While this is calling for philanthrocapitalism to enter the healthcare sphere, Reich actually has a similar viewpoint to Collins. He says that the future of philanthrocapitalism should be primarily about the foundations “making long-time-horizon, risky experiments in social innovation that the government won’t do and the marketplace is unlikely to do” (Madrigal, 2018, p. 4). This emphasis on innovative research could mitigate the unintended negative consequences introduced by Kim, et al. by leading to systemic change to that communities are not as dependent on philanthropy.

Others that have been critical of philanthropy at its current stage also see the potential it has to better serve society in the future. In particular, there has been a call for philanthropy to involve others outside of the foundation. First, the lack of accountability of these foundations could be improved by the addition of “an independent scientific advisory group to monitor philanthropic investments... with a mandate to publish annual reports for public scrutiny (Clark & McGoey, 2016, p. 2459). This would also address the issue of those in technology or financial sectors making investment decisions for social and healthcare sectors. Similarly, it has been argued that philanthropic foundations lack proximity and understanding of low-income communities and communities of color. Because of this, they are unaware of “people doing work out of their churches and homes — amazing, innovative work that was not funded by philanthropy or connected to a mainstream nonprofit” (Bornstein, 2018). Investment in these communities as well as an additional independent community advisory group would help grow these projects and learn from what the public wants and needs. No one is calling for the complete eradication of philanthropy or a shutdown to the rise of philanthrocapitalism, but the problems that could develop with their growth should not be ignored and people are making sure of that.

Implications for Current Study

The United States healthcare system excludes those without access to health insurance and people with LEP. Because health insurance is a necessity in the current state of the healthcare system,

many patients across the country are left without medically necessary specialty care. The Project Access model of care fills this gap by coordinating donated care for those that would be otherwise unable to afford it. This model of care also serves as an advocate for patients who speak languages other than English by offering care coordinators who speak the patients' native languages and are available to them at every step in their care. This serves to break down language as a barrier to care in the United States. Through a profound network of social services, this model of care also connects patients to resources that address social determinants of health. However, this can only be done on a superficial level due to the model's reliance on philanthropy.

METHODS

Employment

I first learned of PANSC when a professor connected me with the program during my undergraduate studies to serve as a volunteer translating their enrollment and renewal documents from English to French and Portuguese. I did this from my entire senior year, from August 2021 to May 2022. In June 2022, I was hired on as a bilingual care coordinator for my language skills and my passion for health equity, a role which I am in currently. I realized that I wanted to research this model of care after starting my employment. I decided to conduct formal research apart from my day-to-day responsibilities. I knew that this program had great potential to be implemented more than it already was. Because of this, the main challenge I faced with this research was maintaining an objective stance while assessing the model of care of the organization for which I am working. While I believe that this program benefits to the local community greatly, I also think that it creates some dependencies and may mask the deeper issues related to access to healthcare. Additionally, being employed by PANSC as a bilingual care coordinator puts me in a difficult position to speak on certain aspects of the model of care.

Design

To counteract any of my biases as a PANSC employee, my initial study proposal had a study design which considered all perspectives of the model of care, those being the referring clinics, PANSC, and the specialist providers. This was eventually rejected by PANSC administrators because of logistical complications and contractual tension that could arise with speaking to the referral coordinators, the medical specialists, and the hospital administration. In response to this, I shifted my focus to defining and assessing the model of care and seeing what negative social implications it might create. While the main focus of this research is a case study on PANSC and the way addresses healthcare disparities by breaking down barriers to care, I also focused on how this philanthropic-dependent system may not be durable.

While a case study was done out of convenience and because of time sensitivity, I acknowledge it does present some limitations. A case study was helpful in this research as it allowed for participant observation in an employment setting. I was not an outsider to the rest of the PANSC staff, so my presence did not impact their behaviors. Additionally, my employment gave me direct access to internal documents and in-depth knowledge of internal processes that would have taken more time and effort to gain at other Project Access offices. I was given this access through employment and gained this knowledge through training as this research was relevant and beneficial to all involved parties. This research served as an extensive review of PANSC's internal processes and patient care coordination. However, using a case study limited my perspective and did not allow me to address the Project Access model of care comprehensively. There is significant regional variation in organization, patient population, and internal processes between Project Access in offices. Nevertheless, I had a good understanding of this going into my research, so generalizability was not a huge issue. Overall, a case study discusses the main overarching characteristics of this model, introduces a baseline for future comparison, and provides a space for interpretive strengths in terms of analytical depth.

Sample Population

While participation in the semi-formal interviews was not mandatory, all care coordinators and leadership staff were asked to be interviewed. PANSC hosts Patient Advisory Council (PAC) meetings, which are a form of focus group used by the staff to speak with patients and examine the impact of the program through their perspective. The PAC is a substitute to having patients on the Medical Foundation of Nashville Board. For the PACs, the PANSC administration selected the patients that participate in them. The criteria for inclusion were not strictly defined. It was based on patients' willingness to participate and being open to share opinions and experiences. Invitations are extended across the board. The two most prevalent populations enrolled in PANSC are Spanish-speaking Latinos and English-speaking US Americans, so those were the two groups of patients in these meetings. There were more female participants in the PACs to reflect the enrollment statistics of the program. All enrolled PANSC patients were mailed the anonymous Patient Feedback Survey (PFS) to complete. Completion of the survey was not mandatory. The response rate was very low, around 3 percent.

Study Instruments

The main instruments I used for original data collection were interviews and participant observation. I conducted interviews with PANSC staff one-on-one in person at the PANSC office in a private setting. Participant observation happened throughout my volunteering, training, and employment at PANSC. The surveys were mailed out to patients by PANSC administration as they were included in their monthly health mailout and could be filled out physically and then mailed back or electronically by scanning the QR code on the survey. I also used qualitative data from gray literature produced by PANSC, such as the PAC meeting minutes, the PFS response report, and patient enrollment and referral data for analysis. These were all secondary sources.

Data Collection

The PACs, a style of focus group, were carried out by the PANSC administration. There were two

PAC meetings, one in April 2022 and the other in September 2022. Both had a Spanish-speaking council and an English-speaking council. I examined the notes taken by the staff during those meetings. The PANSC team produced the questions asked in the PFS. The PANSC leadership staff mailed all enrolled patient the PFS as part of the monthly health mailout in November 2022 and the response report was put together by a PANSC intern. The data set used for the analysis includes enrollment and referral data for 1,857 patients from September 28, 2021 to September 28, 2022. Most patient data used was collected from patients' referral documents faxed from their respective referring clinics throughout Middle Tennessee. The information was compiled exported from the PANSC database, Charisma Salus, and into an Excel spreadsheet by PANSC leadership staff.

Data Analysis

I looked for common themes in both the care coordinator and leadership staff interviews as well as the PFSs. These included the importance of clear and consistent communication, the uniqueness of PANSC's language services, and the reliance on community support. These themes were used to determine how PANSC addresses healthcare disparities, identify how US healthcare system is falling short, and evaluate how the Project Access model of care could be harmful. There were various statistical tests used to manipulate the referral and enrollment data, such as Pearson's chi-squared bivariate analysis test and logistic regression. All statistical tests performed in this study were done in STATA.

Ethical Issues

The risks to participants in this study were minimal. All data collected was deidentified. No personal information was collected. Participation in the study did not affect a participant's standing in PANSC. For the interviews, I provided a consent form to each participant before starting which described the purpose, content, and intended use of the interview. The immediate individual benefits included the chance to share opinions on the program and the opportunity to learn about others' experiences. The

longer-term benefits included a potentially better program for themselves and for all others served by allowing for increased funding, influencing internal changes, and promoting the model of care.

RESULTS AND DISCUSSION

The Project Access model of care successfully eliminates the healthcare barriers of insurance, income, and language, but this model of care is fixing a broken healthcare system in a patchwork way. Patients must place their trust in an external program to walk them through a complicated process, much of which is unknown to them, to ultimately be connected with high quality healthcare. The results of this organizational research show how PANSC has been able to successfully facilitate donated specialty care for thousands of patients over the past few years.

Patient Access

PANSC places patient access at the forefront of their mission, as evidenced by their internal processes. The English-speaking PAC meeting in April 2022 shared that the enrollment process is smooth with lots of means to submit documentation. They had no confusion on the renewal process and understood that PANSC needed to coordinate initial appointments with an assigned volunteer healthcare provider. All five care coordinators I interviewed, as well as myself, agree that PANSC's current internal processes are working well and prioritize patient interest as they were "created with the patient in mind and not the medical system". That is why recent changes have not complicated or restricted patient access to the program. While PANSC now requires proof of residency in the enrollment process as well as an indication when patients will drop by the office, these changes only add extra step to already established processes. They have not directly prevented any contact or enrollment.

PANSC has continued to grow its staff and alter its internal processes in response to patient needs. There are several examples of this, and they range from as big as changing internal databases so

that they can better serve patients to as small as providing a protective plastic sleeve with the paper enrollment cards as the PACs indicated they would be destroyed by the end of the six-month enrollment period. The change in database, from Charisma Salus to FHASES, was mentioned by all care coordinators and all leadership staff as a major change to would improve the patient experience in the program. For care coordinators, FHASES now allows them to text and email patients directly from their chart and track the enrollment process in the database. I have noticed an increase in response rate and a decrease in response time when using this document submission method with my patients. For leadership staff, there are even more features available. FHASES has made it possible for them to track care coordinator productivity, to gauge effectiveness of internal processes, and to monitor metrics with easy data pulls. For both parties, the task assignment feature in FHASES has created better system to keep track of patient needs rather than just writing to-dos on sticking notes. This feature has led to better patient monitoring and care coordination.

Additionally, PANSC leadership staff bases its hiring processes on the patient population. They shared that when Arabic speakers were being referred to the program at a higher rate than usual, they looking at hiring an Arabic-speaking care coordinator to fill that role. Similarly, one care coordinator shared that there was a stall in enrollment two years ago because of insufficient staff, but that there has been a significant improvement in the process since then, now that the team has six full-time care coordinators. Finally, one member of the leadership staff shared that the timing of the referral process was based only on data. In the early years of PANSC, enrollment contact attempts would continue as long as the patient kept saying they would submit their eligibility documents, leading to incomplete referrals being kept for months. In 2020, their research showed that 85% of patients complete enrollment by the 6-week mark, with around 60% within the first three weeks. They made the decision to fax back the referrals to the referring clinics at 6-week mark which would allow the referral coordinators at the clinics to follow-up with the patients. I can testify that this decision paid off, as

patients will often call back at the 9-week mark from their initial referral, showing that the faxing the referrals back to the clinics was serving its intended purpose.

Patient Support

Consistent and effective communication has been a key contributor to PANSC's successful outreach to patients, regardless of their preferred languages or living circumstances. All care coordinators agree that sufficient steps are taken to make sure patients renew in the program if they desire, with one care coordinator stating, "We go above and beyond to enroll and renew patients." The various contact attempts during the enrollment process, as well as the pre- and post-appointment conversations, the monthly case management calls, and the renewal notification letters, show that each patient's journey through the program, and every stage in that journey, are equally important. This emphasizes the importance placed on communication by the program. The rating of helpfulness of these care coordination interactions in the PFSs ranged from neutral to very helpful, with the majority ranking them as very helpful. I can share that patients are almost always very happy to hear from their care coordinators, even if the call lasts 30 seconds because they have no needs at the moment. These are the concerted efforts that are necessary to help prevent many hassles encountered by patients in the US healthcare system (Brunner et al., 2020). The care coordinators share that many patients feel like calling the office is bothersome, so these calls are always received with much appreciation. "When we call, it sends the message that we are not bothered by communication", said one care coordinator. This open line of communication builds trust and, as the patient welcomes their care coordinator as part of their care network, they are more likely to open up and share their needs.

The safe space which PANSC has created has helped all patients open up to their care coordinators about their personal, social, and nonmedical needs. PANSC leadership staff explained that this happened both naturally, by hiring compassionate care coordinators with understanding demeanor, and intentionally, by not asking about immigration status and conducting LEP training and culture and

diversity education. Patients have shared that PANSC treats them like legitimate people. They are in this program because they are in an inequitable system, and their rights are being infringed upon. They do not feel shame. PANSC has effectively, yet indirectly, communicated to patients that they are not in these circumstances by any fault of their own. Apart from the monthly case management calls, patients also receive community resource surveys mailed out with the renewal notice letters, both in their preferred language, to give them the opportunity to make PANSC aware of their needs.

All enrolled patients have access to the PANSC's Social Determinants of Health program. PANSC uses the World Health Organization's definition of social determinants of health. Care coordinators have access to a comprehensive community resource guide to be able to refer patients to where their needs can be met. The program focuses on the needs associated with economic stability, which include food insecurity and housing instability, and those associated with health and healthcare, such as vision and dental hygiene. This follows that advice for social determinants of health interventions to identify specific issues and have achievable outcomes for them (Kangovi, 2019). I have noticed that the sense of relief felt by patients is palpable when they realize all of the opportunities available through PANSC. It is nice for them to know that help is available, even if they do not need it at the moment. Another care coordinator shared that a patient once told them he needed food, was having a hard time at home, and felt useless because he did not have glasses. After expressing those needs to his care coordinator, PANSC sent him an emergency food box through Instacart, connected him with three foodbanks near his home, and referred him to OneSight for a free routine eye exam and prescription glasses. It can be said that this program cannot respond to the critiques that the current social determinants of health framework is not addressing the upstream issues that have led to the continuously increasing prevalence of health and healthcare inequalities (Thornton et al., 2016). While that is true, it helps close the gaps of other nonmedical challenges that patients are experiencing in their lives and could show the need for further interdisciplinary dialogue in order for the government to prioritize health inequalities

(Herrick & Bell, 2020). For PANSC, the connection to external social services is another way to tell the patient that the program cares for them holistically.

The language services which PANSC offers, a rarity in the US healthcare system, provide their patients with LEP a more equitable healthcare experience. These services include a 100% Spanish-speaking patient-facing staff, a telephone interpreter service for patients who speak a language other than English or Spanish, and the ability to schedule an interpreter for patients at their specialist appointments. As described by one care coordinator, these services are “one of the foundational concepts of our program”. It makes patients more comfortable to talk about their health or complain about previous experiences with the healthcare system. That same care coordinator shared, “My parents would not reach out to healthcare professionals until it was urgent because of the hassle in trying to communicate needs in another language. I like to think our patients do not have to go through that internal struggle.” Additionally, studies show that written information in a patient’s native language can improve compliance (Raynor, 2016, p. 149). That is why PANSC offers the majority of their enrollment and renewal paperwork in every language that is served by the program.

However, Spanish-speaking patients in the September 2022 PAC stated that medical paperwork that they receive outside of PANSC is often only in English, which makes understanding their diagnosis and scheduling follow-up appointments very difficult. I cannot count how many patients have called me asking to verify their appointment date and time with the specialist’s office or to ask for them how they should be taking their medication. Internally, language has not proven to be a barrier to care, as a

statistical analysis of the program’s enrollment and referral data for showed that English-proficient patients complete the

Table 1 English Proficiency by Completion of Enrollment		English Proficiency	
		Yes <i>N</i> (%)	No <i>N</i> (%)
Completed Enrollment Process	Yes	357 (53.60)	832 (69.86)
	No	309 (46.40)	359 (30.14)
	Total	666 (100.00)	1,191 (100.00)
		Gamma	-0.33
		Pearson's Chi2	48.99
		Significance	<0.01

enrollment process 53.60% of the time compared to those with LEP who complete the process 69.86% of the time (Table 1). Additionally, a logistic regression predicts that an English-speaking patient is 47% less likely than a LEP patient to complete the enrollment process (Figure 1). One potential reason for the gap between the groups is that individuals with LEP have less resources available to them, as not every medical or healthcare institution offers language services.

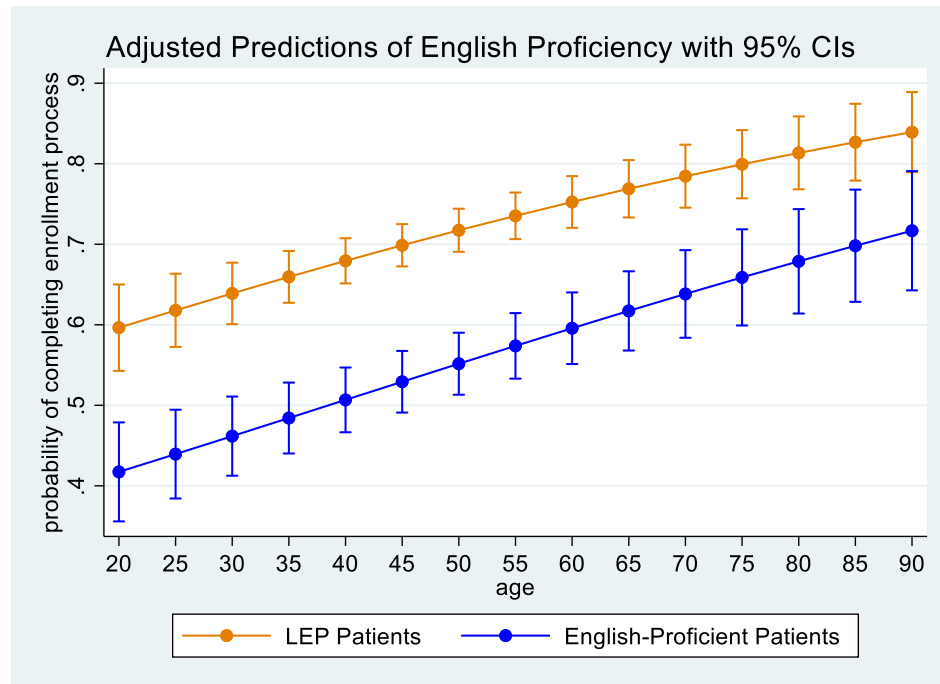


Figure 1 Graphed probability of completing the enrollment process comparing LEP patients and English-proficient patients when controlling for age with 95% confidence intervals.

Limitations of the Model

At an organizational level, PANSC is dependent on strong community support and collaboration to be able to provide donated specialty care and social services to the patients each program serves. At the medical level, the model of care relies on local primary care clinics and hospital systems to learn the intricacies of the program. The program is constrained to the willing participation of these two parties. The primary care clinics must trust the program with their patients’ specialty care. Volunteer physicians in those hospital systems must give their time and resources to PANSC patients without receiving any kind of reimbursement. In regards to social services, PANSC is limited by its grants to the amount of direct assistance it can provide to patients. Therefore, it must partner with community organizations to provide these services. Examples include WorldWide Interpreters as well as Family and Children Services

for language needs; Second Harvest, the Community Resource Center, and Meals for Health and Healing for food needs; and Tennessee's State Health Insurance Assistance Program, OneSight, and Gilda's Club for other patient needs. However, PANSC leadership staff shared that the Safety Net Consortium of Middle Tennessee was instrumental in the founding of the program as community partners were struggling with treating uninsured patients. Thus, community support has not been hard to come by as they are the ones that saw the need for better coordination of care, something that a Project Access program in Nashville could provide. Nevertheless, PANSC relies on the existing infrastructure present because of a flawed healthcare system.

Although integral to the Project Access model of care, the issues pertaining to patient access are rooted in miscommunication by the referring clinics and tend to be outside of PANSC's reach. All care coordinators mentioned this during their interviews, and I vehemently agree. They shared that referring clinics need to communicate better to patients by explaining to them what PANSC does so that they will be expecting the call. This was shown quantitatively by the patient feedback surveys, in which 43% patients indicated that their respective clinics did not make them aware of their PANSC referrals prior to being contacted by the PANSC staff. It is understandable for these patients to be hesitant to share personal or private health information with someone calling from an unknown number. PANSC's response to an incomplete enrollment process is to fax the referral back to the referring clinics after six weeks with the purpose for them to then contact the patient, but not every clinic follows through. While PANSC's processes are very structured and in place to benefit the patient, the clinics' processes vary by location and may delay patient care or place a patient at risk of not receiving the most affordable care available to them.

Similarly, most of the enrolled patients' complaints directed at PANSC fall on the care coordinators because of easy accessibility and trust, but fault usually lies with the referring clinics or the specialist offices. I gathered that the complaints typically come down to three things: the patient was

billed for the specialist services they received, there are long wait periods for studies that need to be approved, or not all primary care providers are briefed on PANSC and the Project Access model of care. In regards to patients being billed, it mainly stems from misunderstanding by specialist offices which leads to them making patients pay for a visit or a procedure. Despite being told multiple times by the care coordinators, verbally and in writing, that the appointments are charity care and having a system in place for PANSC to show up as the patient's method of "payment", it is still common for patients to be billed for specialist services. This can be frustrating and scary patients to get a bill when they have been promised it would be free. Additionally, there is extensive bureaucracy and seemingly unnecessary steps that stands in the way of patients getting approved for surgery or certain out-patient procedures, such as colonoscopies and endoscopies. One care coordinator shared that a patient finally had his pre-op appointment after months of rectal bleeding and the surgery had been approved by the hospital board for charity care, but that the surgery would not get scheduled despite countless voicemails left by the patient's care coordinator. Furthermore, there are certain referring clinics that have quick turnover rates for their primary care providers, and the new ones are often unaware of how PANSC works. Another care coordinator shared, "It would be beneficial for us to be prioritized. These clinics and hospitals keep spreading out tasks instead of consolidating them, and keep adding processes that restrict access. It is really easy for patients to be forgotten through this process." This is evidence of the hassles in the US healthcare system that contribute to delaying or forgoing care (Brunner et al., 2020). While the care coordinators go above and beyond to support patients internally and externally, they can only do so much to make sure the referring clinics and specialty offices do the same.

Philanthropy or Activism

Despite all care coordinators and leadership staff advocating for expansive healthcare reform, they also believe that the Project Access model of care fills a gap in the healthcare system that would remain even if access was greater. This is supported by recent healthcare expansion only benefitting

white low-income childless adults while having limited positive impacts on healthcare access and health outcomes for Blacks and Latino individuals (Barker & Li, 2020). One member of the leadership staff said, “There was lots of misconception when ACA passed that there would be no gaps in healthcare and no need for charity care. Any change in healthcare law generates different perceptions across the country. New gaps will arise, and work will need to be done to find ways to address those new gaps.” While the Project Access model of care is not guaranteed to be stable, relying on relationships with hospital systems and the lack of budget constraints, it will continue to serve the uninsured as long as there are gaps in coverage in the US healthcare system.

However, many care coordinators, including myself, and all three members of the leadership team are not deluding themselves by believing that they themselves are fixing anything. They know that they are simply a reactionary measure to combat the downstream results of the systematic issues with the US healthcare system. While we are employed because of healthcare disparities, many shared in the sentiment of one leadership staff member, who said “I would happily find another job if my job was not needed because people had their healthcare needs met.” PANSC and other Project Access programs have the ability to showcase the immediate healthcare issues in their local community so that they can be addressed with future healthcare policy and reform.

This perspective speaks towards the vocational mindset I found all in care coordinators and leadership staff. No one at PANSC does their jobs simply for employment or salary purposes. One care coordinator grew up interpreting and translating for their mother and took this job so that “others in the same situation would be treated the way I would want my mom to be treated”. Another care coordinator was exposed to healthcare at young age as their mother was a nurse practitioner. They wanted to serve those in need just as she did. To another extent, one leader staff member shared, “Nothing would make me happier than helping my employees find other meaningful jobs. It would mean there is no need for Project Access.” This speaks towards the sentiment that PANSC employees want to

work themselves out of a job, but impossible because philanthropic nature of the model of care. The philanthropic efforts keep patient in need of the program, making them dependent on the program, and also stagnates healthcare policy efforts (Kim et al., 2017). Despite this, efforts are made internally to help patients grow out of the program.

In PANSC, there is a sense of tension between activism and philanthropy. It is not one or the other. The patient-centered approach shows that, internally for PANSC employees, this is activism, despite the philanthrocapitalistic approach to the model of care as a whole. The entire staff always celebrates when patients cannot renew in the program because they now have health insurance. Throughout a patient's time in the program, their care coordinator is always looking for changes in that patient's life that might make them eligible for Medicaid, Medicare, or additional government benefits. PANSC has all of those applications on file as well as applications for other financial assistance programs, such as Ascension Saint Thomas' and Vanderbilt's. That is because, even if a patient does not qualify for PANSC, the care coordinators will connect them with the appropriate program and provide them with the appropriate application so that they can receive the most affordable care available to them. This is not a number game. While we boast growing numbers in patient population and value of donated care, that is because we are proud that our reach is growing. The end goal is for that number to decrease as less and less patients are dependent on a program like PANSC for their healthcare needs.

CONCLUSION

This case study adds to the literature by providing a comprehensive look at an unexplored philanthropic model of care that addresses healthcare disparities. Much of the previous work related to this topic presents healthcare disparities as an issue in the United States healthcare system or generally explains the shortcomings of the social determinants of health framework. While there were

suggestions of what could be done, there was a lack of examples of these concepts in action.

Additionally, there is not much literature on the effect of philanthropy on domestic healthcare. This research presents an environment where all of these factors interact with each other.

Assumptions and Limitations

One assumption of this study is that the participants gave an accurate report of their experiences and opinions, as well as that these experiences and opinions were authentic to them. This is applicable to both the interviews I conducted and the patient perspectives collected in the PACs and PFSs. It can be hard for patients and employees to tell the truth when they are dependent on the PANSC for healthcare and employment, respectively. It was also assumed that each of the participants was forthcoming and did not withhold any information when answering questions or base their responses in a way that would reflect a certain narrative. Interview and PAC participants and PFS respondents could have altered their true answers to something they think would benefit the study. Not being completely honest or withholding information could lead to these findings being inaccurate.

A limitation of this study is the response rate of the PFSs. These findings were not statistically significant or representative of the PANSC patient population as there were only 29 responses to the 900 surveys mailed out. In addition to this, one of the 29 survey responses was invalidated due to conflicting answers on the same questions. Having only a 3 percent response rate, I am unable to draw program-wide generalizations. Nevertheless, the PFSs, conducted anonymously and administered to the entire PANSC patient body, reported similar findings to those of the PACs, showing that the data was telling of PANSC's impact on their patient population.

Another limitation is having a restricted perspective of only looking at one Project Access program. This goes hand-in-hand with my own role in PANSC. The reason I had access to PANSC's documents, knowledge of their internal processes, and ability to interview the staff is because of my employment as a care coordinator. However, this also creates complications with having an objective

perspective. Apart from my advisor helping me control my bias and indicating where I could be more critical, my desire to work towards an equitable healthcare system in the United States drove me to find the positive and negative aspects of the Project Access Model of Care.

Implications for Future Research in Public Health

By virtue of this program seeming like it is beneficial, it diverts the attention away from the real systemic changes that need to happen in healthcare. This research could raise awareness and make the public aware of other organizations that are in place because of a flawed system. NGOs and grass roots movements are happening in healthcare because policy action is not taking place. These similar models could be studied to learn the societal impact of donated care and services and how these organizations are masking or delaying the real change that needs to happen.

PANSC and similar organizations could also be the study site for investigating how a vocational approach to one's job changes the dynamic of the day-to-day. The internal motivations of all care coordinators and leadership staff lead to more profound relationships with patients and a more successful program. It could be important to know if these motivations are perceived by the patients, as these intangibles could make the difference in successful healthcare interventions down the road.

Conclusion

The Project Access model of care eliminates the need for health insurance to access affordable healthcare and removes language barriers for patients. Additionally, it allows trust and relationships to be built between care coordinators and patients by creating a safe space for all patients and by placing an emphasis on consistent and clear communication. However, success depends on a strong reliance of support and buy-in from healthcare, government, and the community. The medical and social services it offers would not be possible with this. While this creates a sense of dependency for the patients and a reliance for the program on the external actors, this localized healthcare equity nonprofit could highlight the areas which regional healthcare policy should target.

The incorporation of the social determinants of health and philanthrocapitalism in domestic healthcare has been interesting, to say the least. There is no question that the social determinants of health framework has been successful in making healthcare workers aware of the structurally and socially violent conditions that can cause health issues. However, the framework has not done much else other than raise awareness. It is up to these community networks that are serving patients affected by these conditions to, not only open their doors for research, but also advocate for upstream structural change. These same community networks should also be pushing towards activism and be pulling away from philanthropy. It is important that the people they serve do not become dependent on their services and that the policymakers do not view the services provided as a replacement for real structural change. The change in the application of the social determinants of health framework and the shift from philanthropy to activism are codependent on each other. Without one, there cannot be the other. These changes could result in significant changes in regards to health and healthcare disparities.

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