OneAthens Health Team
October 5, 2007
12:00-2:00 PM, Athens Regional Medical

Present from the Team: James Shrum (Chair), Pamela Robinson (WellCare), Kathy Hoard (ACC Commission), Alison McCullick (UGA Health Initiative Projects), Tracie Jacobs (Consumer Representative), Jennifer Richardson (Athens Neighborhood Health Center), Monica Knight (CCSD), Mark Ebell (MCG), Sherrie Ford (Power Partners), Lisa Caine (Our Daily Bread), Virginia Day (St. Mary's), Karen Schlanger (Coop Ext)

Present from the Community: Heather Slutzky, Shelby Lacy (ARMC), Marcia Massengill (Northeast Georgia Health District)

Present from Staff: Delene Porter

I. James welcomed group and included Mission and Ground Rules with agenda:
   Mission:
   Create a plan to coordinate and fund basic health services for those in poverty and near poverty.
   Ground Rules:
   1. Start on time and end on time.
   2. Keep an open mind.
   3. Discussion must remain on the initiative being discussed.
   4. Be respectful of one another, which includes not talking over each other.
   5. No person attacks – no personal agendas.
   6. Our meetings are open to the public; everyone is welcome to attend.
   7. Only team members will be allowed to participate in the discussion during the meeting.
   8. Public comments and input related to items on the agenda will be welcome during the last 15 minutes of the meeting.

II. Report from OneAthens Committee Chairs- James
   a. The OneAthens Initiative Chairs met to discuss next steps
   b. Each Team will present its strategy to the community at a meeting in November- date and location still to be determined
   c. After the community there may be a lull is Health Team activities while we wait to hear back from the co-conveners, but there will be more work to be done

III. Summary of Last Meeting- Since there were a small number of Team members present at the last meeting and since Medical Home and Navigator Network were discussed, Delene went over the points of consensus
   a. Medical Home Definition- Team adapted the definition to: Create a local healthcare system that provides the components of a Medical Home. A medical home is defined as:
      1. Establishes a provider network

2. Includes a basket of services: chronic disease management, wellness and health maintenance, and acute illness care (Team added this in today's discussions)
3. Provides reasonable access to network providers by phone
4. Ensures the ability to obtain acute care or advice within 24 hours including nights and weekends
5. Ensures that office visits are well organized and that the schedule and wait times meet recognized standards
6. Provision of and/or capacity for referral for education and social service navigation

b. Medical Home additional goals-
   1. Clinics need to ramp up their services and a network, with electronic records system, needs to be created so that each patient would have a "primary home" and would receive referral and followed-up for other pieces of care- Creating this system will meet the definition of Medical Home
   2. Key is that there is a relationship between a patient and a clinic or person so that if your "home" is the Nurses Clinic and you get referred to another clinic for a treatment, when you go back to Nurses Clinic, they know what happened to you at Mercy and there is someone you can talk and who will follow up with you- Need a person/Navigator who can help you
   3. Team discussed that Medical Records could be expensive and time consuming- need to focus on increasing the collaboration of partners and increase health care access plan

c. Community-Based Health Navigators duties should include:
   1. Assist in Accessing Care and Medical resources (including medications and equipment)
   2. Assist in Obtaining Health Insurance and other fiscal resources
   3. Follow up on "Health Care" visits
   4. Offering Health Advice
   5. Indigenous Health Researchers
   6. Offer Community-based Education

d. Outreach Network Structure should be several layers:
   1. A broader layer would be Navigators who are paid community members who help guide people into the system
   2. The central layer are Case Managers who follow up with patients

IV. Discussion of Referral Network component (Appendix A)-

a. Team discussed the following questions:

   Structure:

   i. The Referral System will include both primary physicians and specialty physicians. How many patients should each physician be expected to take per year?
   ii. Who should manage the referral system?

iii. What type of patient would utilize the Referral System versus the primary care clinics/programs?

Process:

iv. How should physicians be recruited to participate?

Outcome:

v. Are there specific outcome measures that reflect success of this Referral System?

b. Group A (Mark, Sherrie, Lisa, Virginia)

Structure:

i. Weren't sure what was realistic and wanted more data- how much uncompensated care is currently provided, they recommended forming a committee of physicians to determine, also wanted to clarify the difference between encounters vs. patients- maybe specialists would have a number of encounters and general practitioners would take x amount of patients

ii. OneAthens should manage the referral system

iii. Patients that require care beyond what can be provided through the primary Medical Home network

Process:

iv. Leadership from physicians is needed to recruit, hospital's marketing and promotions departments, need to present an detailed rationale, get physician leaders/ opinion setters to help, have evening program with local celebrity

Outcome:

v. Measure reduced ER visits

c. Group B (Karen, Jennifer, Pam)

Structure:

i. Similar to A's answer, weight severity of illness to determine priority

ii. Have the Health Plan mange it or have it contracted by a clinic

iii. People who can't be seen in clinics- overflow

Process:

iv. Leadership from physicians especially from specialists and political leaders- Also need to ensure cultural sensitivity through training and making sure the offices are welcoming

Outcome:

v. Measure reduced ER visits, percentage of physicians participating by specialty, percentage of patients with need are referred, percentage who have no medical home, patient satisfaction, retention of physicians as well as patients (comfort with the care they receive, prevent physician dumping)

d. Group C (Tracie, Monica, Alison, Kathy, James)

Structure:

i. 10 patients per physicians- if they have 4000 visits per year, this is only 1% of their visits

ii. Community Connection or within the OneAthens Foundation

iii. Same as above

Process:

iv. Have a champion- physician in the community, Advertise and promote those who do participate

Outcome:

v. Same as above

e. Group D (Heather, Shelby, Marcia)- Wait until 10 of 15 doctors are participating so that no one gets all the new patients at once, start with specialists, then expand to primary care physicians

V. Next Steps

- Next Meeting will set via email
- This will be the last meeting and will cover potential sources of funding- please email any ideas to Delene
- James will email the Mayor about including Health Team recommendations for General Option Sales Tax as part of the Commission's meeting with State Legislators

APPENDIX A-

Referral System: Buncombe County's Project Access which creates a network and referral system so that indigent patients can see Specialists. The program includes 90% of Buncombe County's physicians who volunteer their time, but aren't overburdened because Project Access distributes clients evenly. This has also allowed the county to increase their capacity to serve primary care patients. Computer systems have been developed to automate the enrollment of clients and monitor their usage. Local hospital's indigent care costs have decreased as a result of the program. Other examples include the Community Health Networks, Gainesville's Access program.

- Needs a lot of work- we need a comprehensive marketing strategy with every physician in town.
- Great idea, hope it works. This is what I proposed in our LEAD Athens questionnaire but maybe it wasn't properly understood.

Another Example: Project Access is a community-based program that coordinates donated medical care and services provided by physicians, hospitals, pharmacies and others for uninsured, low-income people living in Sedgwick County, Kansas. Our program is based on the Buncombe County Project Access model in Asheville, NC. To date, more than 65 percent of our local physicians (members of the Medical Society of Sedgwick County) have agreed to provide donated care for 10-20 patients each year. All area hospitals are treating Project Access patients, and 80 pharmacies fill prescriptions at 15 percent below average wholesale price. The Wichita City Council and the Sedgwick County Commission have committed $500,000 for prescriptions annually. The goal of Project Access is to coordinate patient enrollment and referrals that make a broader range of donated services available for uninsured people. This also frees the physicians and their office staffs from tracking down additional donated services, allowing them more time to provide patient care. Patient health care needs cover a broad range, beyond physician and hospital services. We continually recruit additional providers including physical therapy, diagnostic tests (lab work, x-rays, interpretation of test results, etc.), durable medical equipment, medical supplies, home-based care and other ancillary services.

Eligibility Eligibility guidelines require that patients:

- Must be a U.S. citizen or lawful permanent U.S. resident
- Live in Sedgwick County
- Have no medical insurance
- Are not currently receiving other state or federal medical benefits (although if they qualify, we will assist them in making applications)
- Have a family income that does not exceed 150 percent of Federal Poverty Level (approximately $29,040 annually for a family of four).

Enrollment Patients can be enrolled into Project Access by visiting one of the area's six low-cost, primary-care clinics (Guadalupe, Hunter Health, the Health Department, GraceMed Health, Center for Health and Wellness and Good Samaritan). The Social and Rehabilitation Services area office has co-located six full-time eligibility specialists, one at each clinic. The SRS eligibility specialists enroll patients, gather income verification, and assess patients' eligibility for state programs including Medicaid and S-CHIP (Healthwave in Kansas). Patients may also be enrolled at the request of a participating physician who has an eligible patient already established on his/her caseload or at the request of a number of the area's primary care residency programs affiliated with the University of Kansas School of Medicine-Wichita. Currently, 40 percent of patients are enrolled into Project Access through the six clinics; the other 60 percent are enrolled at the request of physicians in private practice or within the residency programs.