OneAthens Health Team
Meeting Notes, 6-22-07
St. Mary's Hospital

Present from the Team: James Shrum (Chair), Pamela Robinson (Wellcare), Charles McDuffie (UGA College of Pharmacy), Tracy Thompson (Mercy Health Center), Karen Schlanger (UGA Extension), Kathy Hoard (ACC Commission), Tracie Jacobs (Consumer Representative), Deb Williams (Athens Nurses Clinic), Claude Burnett (Northeast Georgia Health District), Lisa Caine (Oconee St. UMC), Monica Knight (CCSD), Sherrie Ford (Power Partners), John Culpepper (ACC), Virginia Day (St. Mary's), Farris Johnson (Physician), Diane Dunston/Jennifer Richardson (Athens Neighborhood Health Center)

Present from the Community: Marcia Massengill (Public Health Department), Shelby Lacy (ARMC), Susie Smith (ARMC), Paul Buchzynsky (Mercy Health Center), Maia Jackson (Community and Wellcare), Lou Kudon (Public Health Department), Anne Hansen (Area Agency on Aging), Carol Burnes (Northeast Georgia Health District)

Present from Staff: Delene Porter, Adam Gobin

I. James welcomed group and asked Claude Burnett to give an update from the Public Health Department

II. Claude discussed Poverty and Health:
- Public funds for health should be spent first on preventive services which are known to be inexpensive and highly effective
- These are not necessarily demand driven, acute care services
- Unwanted or mistimed fertility is a contributor to poverty
- Higher risk of low birth weight, perinatal problems and expense, often life long
- No woman who wants birth control, including sterilization, should be denied for lack of funding
- Family Planning vs. Unwanted Birth- Pay $100 per year vs. pay $3000 per birth, $200,000 food and education, $50,000 if low birth weight
- Total fertility rates- Hispanic 2.7, Black 1.9, White 1.5
- Cardiovascular disease is the #1 crippler and killer in our community, double the rate of cancer, the next largest cause of death
- Its burden falls disproportionately on African Americans, especially males. The solution to alleviating poverty must include increased access to preventive services like treatment of hypertension
- National Health Expenditures- Public health only receives 3% of National Health Expenditures as compared to Hospitals 31%, Doctors 22%, Drugs 11%, Nursing homes 7%, Dental 4% etc.
- A study from Canada shows that the factor which most affects people's health is Personal Behavior (50%) vs. Biology 20%, Environment 20%, and Healthcare 10%
- See Health Department .pdf for more information

Team discussed the critical nature of balancing access to primary care and access to prevention and education as well as the need for specialty care which provided a good transition into looking at models…

III. The Team started its first of two meetings discussing models and best practices from around the country.

   a. James presented information about a model residency program in Montana at the Deering Community Health Center that could tie into the future Navy School plans, but could also stand alone. In Montana the medical college was not located near the training program- details below (#1). Group agreed that having Allison McCullick with Public Health attend to give an update on the Medical School would be helpful as their plans are firmed up. It was stated that we should look at where this clinic started- a partnership between public health, private physicians, and the hospital with community support. This beginning might have lessons for us as well. Also need to know the advantages and disadvantages of working with a residency training program- very expensive and time intensive- could be more efficient with nurses, etc., but the resident training provides wonderful quality over the long term.
   b. Adam presented information about a model- the Marion County Indigent Care Program. They began with a County Commission appointed task force to conduct a needs assessment in 1989, which led to the program. The program has on oversight Board and uses volunteer physicians and specialists and paid advanced registered nurse practitioners, community health services and health department staff. No individual provider runs the program but all participated in decision-making. Charge Medicaid and Medicare, charge a co-pay. They also have a mobile clinic. See below for details (#2).
   c. Adam presented information on 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 cots have decreased as a result of the program. They do consultations and we could have them visit Athens. See below for more details (#3). Dr. Johnson mentioned that they had visited physicians in Athens once before. He also mentioned that physicians might be more willing to donate their time if they could take a tax deduction for their volunteer hours- can we do this in Georgia?
      i. This opened a discussion of the need for a labor pool for physicians and nurses. Need for a coordinating entity for volunteers. HandsOn Northeast Georgia's new Volunteer Center was mentioned as a possible option.
      ii. The Georgia Volunteer Program does provide liability insurance for any professionals (retired or active) who volunteer at a clinic that does not take payments.
      iii. The need for cross functional strategic planning was also mentioned- so many agencies (nonprofit, city, for-profit) are creating strategic plans but not planning together which scatters focus and strength.

This brought up a larger discussion of how to pick a model that will directly reduce poverty. Focusing on fertility and mental health are key in reducing poverty. Teaching wellness in schools is important- having more than a nurse on call in the schools would help. This is an area where the work of the other OneAthens Teams need to be integrated or informed by the Health Team.

But access to primary health care is still key in keeping a job and creating family stability as well. There is a need to focus on more than just "access"- care needs to be appropriate and holistic if we're going to address disparities in accessing basic preventive measures.

Dr. Johnson brought up an example of having a woman come in who had injured her ankle by falling through a whole in her floor. Dr. Johnson asked who her landlord was and called about getting the hole

fixed. If there was a way to have a PPA sticker on the office door so that people knew the physician could connect clients to other services- be a point of contact for every person. Pharmacists are also good health educators because people refill prescriptions more often then the go to a doctor. The concept of "no wrong doors" has been discussed by the PPA Service Providers as well.

IV. To ensure time for public comment the Outcome Measures sub-group will report out at the next meeting. The floor was opened to public input:
   a. The point was made that other resources were available but not discussed- UGA's school of public health and others will be key in making new models successful.
   b. Create a carrot for physicians to volunteer- this will be more successful than other tactics.
   c. Pharmacy school has 300 students who can teach about education and compliance and all need internships.
   d. The point was made that the Team would have to find a balance with the task of increasing access to primary care/medical home, specialty care, and preventive care. Need to know what the committee's boundaries are- can refer to OneAthens charge
   e. Look at tracking health and economic well being.
   f. Need measurable outcomes
   g. Don't kill Better, to get Best. Don't abandon an opportunity to serve more people/reduce poverty now.

**V. Next Meetings:**
   **a. July 13th, 12-2PM at Athens Neighborhood Health Center on the East Side**
   **b. August 3rd, 12-2PM at Power Partners on Newton Bridge Parkway**

(The group discussed holding a meeting on July 20th as well, but to have time to prepare for meetings July 13 and August 3 will be the next two)

## 1. Montana Model

**Deering Community Health Center** (http://www.ycchd.org/dc/)
Yellowstone City-County Health Department (http://www.ycchd.org)
Billings, Montana

**Background Information**
- 11% poverty
- Yellowstone City-County Health Department provides the basis for the federally qualified Deering Community Health Center
- Montana Family Practice Residency Program
- Over 17,000 visits for FY 2005-2006, 13% racial or ethnic minorities
- Large number of patients have mental health and/or substance abuse co-morbidity
- Community Dental Program, 5,500 visits FY 2005-2006

**History**
- Health Department wrote a grant for community health center in 1983
- Of 11%, 32.5% Medicaid and 67.5% without access to care
- Collaborators: Family Services Inc, Montana Rescue Mission, local government and regional newspaper.
- 1992, Residency feasibility study conducted with local and regional physicians, and Indian Health Services
- 1995, Residency program opened as an affiliate of the University of Washington Medical School

**Staffing**
- Team approach. Each team composed of RN team leader, physicians, nurse practitioners and/or physician assistants, RN's, LPN's, medical assistant, and front desk staff.
- Teams give the patient a sense of a medical home.
- Hours 8:00 a.m. to 7:00 p.m. M-F. Physicians on-call 24/7.

**Funding**
- Two local hospitals generate payments according to the Graduate Medical Education portion of Medicare.
- Resident and faculty salaries derived from residency program budget.
- When faculty, NP's and PA's provide direct care to the patient's in the clinic, the residency program is reimbursed from clinic revenues on an hourly basis.
- In 2003, revenue from the resident physicians was $797,180.

**Advantages**
- Residency program more than doubled the number of patients who can access care in a local and timely manner.
- Connection with the health department gives patients greater access to services that compliment and support healthcare (WIC, MCH, hospice, environmental health, visiting nurse service, medication assistance program, Health Care for the Homeless, Breast & Cervical Health, HIV/AIDS services, School Nurse Program, vital statistics).
- Exposes resident physicians to rural and underserved communities. 67% located practices in rural or underserved areas.

- Interdisciplinary teams allow the associated professionals to learn from each other and to better engage the patient in healthcare discussions promoting self-management and prevention.
- Sustainable based upon the revenue generated from Medicare, Medicaid, and private pay sources.

**Disadvantages**

- Cost of scheduling more physicians
- More laboratory tests ordered by inexperienced physicians
- Less efficient use of exam rooms

Article Website: http://archive.naccho.org/modelPractices/Result.asp?PracticeID=71

## 2. Buncombe County Project Access

**Buncombe County Health Department** (http://www.buncombecounty.org/governing/depts/health/)
Buncombe County, NC

**Background Information**

- Project Access is a partnership formed 8 years ago between county government, county physicians, county service agencies, the hospital, and pharmacists.
- The Health Department could handle primary care needs but until Project Access, specialty care had been the problem.
- The Buncombe County Medical Society Foundation created Project Access as a volunteer initiative for physicians to donate their services to the low income and uninsured.
- As a result of Project Access, primary care access has been raised from 78% to 93% by 2000.
- 90% of Buncombe County physicians see between 10-20 patients referred into their program. This is less than 1% of their practice.
- Since Project Access, the Buncombe County Health Center has doubled its primary care capacity to offer to its 15,000+ active clients.
- Computer systems have been developed to automate the enrollment of clients in Project Access and to monitor their utilization and the percentage of physicians who volunteer to see patients in the doctor's free medical clinic has increased.

**Staffing**

- Project Access includes 90% of Buncombe County's physicians, which equates to an estimated 700.
- American Project Access Network Staff

**Funding**

- County Commissioners spend $500,000/yr for drugs given through Project Access, and for administrative costs from the Medical Society.
- The direct cost of the program including operations is $390,000.
- The value of volunteer service by Buncombe County physicians is nearly $3.6 million (2001).

**Advantages**

- The patients are much better served because physicians are treating them.
- The physicians are delighted because of the positive reinforcement of community service and because they are not overwhelmed by too many patients.
- The local hospital's indigent care cost has decreased as a result of the program.
- Project Access opens doors to all kinds of other collaboration within the community.

## Consultation

- Project Access has received national recognition and through a special grant from the federal government, the Medical Society now has a staff that is available to help local communities replicate what was done in Asheville.
- There are now over 20 communities with Project Access type systems and many more in the planning phase.

Article website: http://archive.naccho.org/ModelPractices/Result.asp?PracticeID=24

## 3. Marion County Indigent Care Program

**Marion County Health Department** (http://www.mchd.com/)
Marion County, FL

**Background Information**

- Marion County Indigent Care Program's goals are to establish greater access and availability of primary and specialty care to the medically underserved, low income, and uninsured residents of Marion County.
- The Marion County Indigent Care System is a public private health care partnership.
- Marion County covers an area of 1,579 sq. miles and has a population of 298,390.
- Per capita income is 80% of the state average.
- 80% Marion County residents live in rural areas (there are no mass transportation resources in these rural areas).
- 41% Marion County residents live at or below 150% Federal Poverty Guidelines.
- More than 30% of all households have annual incomes below $15,000.
- Morbidity and Mortality rates per 100,000 are significantly higher in the county than in the state for heart disease, cancer, stroke, and diabetes.

**History**

- Marion County Commissioners appointed a task force to provide a needs assessment of the community in 1989.
- These findings led to the establishment of the Marion County Indigent Care Program.
- Oversight Board Members include the CEOs of the two local hospitals, the county's public health director, and three representatives from the Marion Society, representatives from the local mental health provider, the county's hospital district, and the county commissioners, the school system, the Department of Children and Families, churches, businesses and residents of Marion County.
- During its first couple years of implementation in 1992-93, 14,000 patients with chronic illnesses received continuous primary care, 15,000 patients were provided medical evaluation and treatment, and 1,700 patients were referred to specialty physicians.

**Staffing**

- Primary care physicians (volunteered 3553 hours valued at $2.5 million)
- Specialty physicians (volunteered 1129 hours valued at $54,700)
- Advanced Registered Nurse Practitioners
- Community Health Service and County Health Department staff
- Team-oriented program, so no individual provider runs the program. All providers participate in the program decision-making.

**Funding**

- Both local hospitals in Marion County fund the CHS staff.
- The building is donated by the county who also pays for eligibility staff.
- Clients are screened for eligibility and are charged a co-pay for each visit.
- Drug Assistance Programs provided medication to more than 10,000 clients, valued at greater than $2 million.
- Medicare and Medicaid are billed for services and clients are required to apply within 90 days of initial service.
- Remaining clients receive primary care services at no charge, or are charged on a sliding scale fee.

**Advantages**

- As the community grows, so does the Indigent Care System – more Marion County physicians means more volunteer physicians.
- No one is denied care due to inability to pay.
- Transportation services, extended hours, bilingual staff members and drug assistance programs help insure improved access.
- Applied for a Primary Care Challenge Grant to establish a mobile clinic that travels to the rural areas to provide access to those residents who were unable to travel to established providers.

Article website: http://archive.naccho.org/modelpractices/Result.asp?PracticeID=148