OneAthens Health Team Meeting
August 3, 2007
12:00-2:00 PM, Power Partners

Present from the Team: James Shrum (Chair), Pamela Robinson (Wellcare), Trina von Waldner/Paul Brooks (UGA College of Pharmacy), Kathy Hoard (ACC Commission), Tracie Jacobs (Consumer Representative), Shelby Lacy sub for Deb Williams (Athens Nurses Clinic), Claude Burnett (Northeast Georgia Health District), Monica Knight (CCSD), John Culpepper (ACC), Jennifer Richardson (Athens Neighborhood Health Center), Bob Galen (UGA School of Public Health), Farris Johnson (Family Practice), Sherrie Ford (Power Partners)

Present from the Community: Heather Slutzky, Larry Dendy (OneAthens), Marcia Massengill (Northeast Georgia Health District), Bart Freeman (Power Partners), Ellen Walker (Alps Road Elementary)

Present from Staff: Delene Porter

I. James welcomed the group and asked for introductions. James also reminded the Team of its mission and ground rules:

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. James presented information gathered by Virginia Day on Ascension Health's 5 Step Model for 100% Access. This model has many of the components of other models that the Team has reviewed: they use a computerized Master Patient Index and Central Data Repository; they seek to fill service gaps; they use case managers; and they engaged private physicians based on the Project Access model in Asheville, NC.
   a. Monica Knight mentioned the Dental Van- she will bring information about the service for the Team to review.

III. James presented the Team with the draft Interim Report. Team needs to provide corrections/changes to Delene by Friday, August 10th. She will send a copy via email to the Team later today.

IV. The Athens Healthcare Model- the Team began reviewing the components of Successful Models to Coordinate Basic Health Services for those living in or near poverty that they had examined during the past two meetings. They were asked to think about the pros and cons of each component as it could/should fit into the Athens Healthcare Model. What follows are the comments made on two of the components. A complete list of Components is attached as Appendix A.

A. Outreach Network with Navigators/Case Managers-

1. May be difficult for these case mangers to follow up with everyone
2. Half of the schools have Family Engagement Specialists- they could possibly be trained to help with this along with school social workers
3. The Opportunity for Community-based Navigators to get paid and advance through training is good.
4. Where would they be housed?
5. Wellcare has a system of tracking members- you have to have an IT system so that Navigators can see where patients have been and what resources are out there
6. Navigators would need to work with adults as well as youth
7. This is something that many of the service providers have people doing part-time or in addition to their regular duties- but really don't have a coordinated, complete system
8. Endorse the concept of Plan-Do-Check-Act, may need to pilot this in one neighborhood, with one disease, or with one provider
9. Need to Identify what is being done, then organize, connect and expand/ fill in the gaps- This could not just be done by people who are already inside institutions- part of the community-base is to get Navigators who live in a community, who people feel comfortable with, who are then able to help them connect to the systems
10. Case Management has a negative connotation, really like the concept of a Community-based Navigator for all needs- housing, health, education, financial literacy- these all need to be coordinate with each other- A Navigator would be like a Global Manager
11. SOURCE was created to do this, but needs to be more global- these are the new managed care case mangers and there are several based in Athens

12. In the Ingham Co. model, Navigators actually work out of Neighborhood Engagement Centers that focus on accessing all different kinds of services
13. Need to build on what exists
14. Still need to have this in conjunction with an open-source information system like the VA's VISTA, need a map of where people have been to tell where they need to go
15. It is an interesting concept to Navigate so broadly- used to disease specific navigation, but to expand to all health and then to look at general wellbeing/all services
16. One Navigator would not be enough- need a network at multiple locations
17. Should be tiered with people locations within neighborhoods up into institutions and systems
18. Would like to see some of this done with volunteers
19. Some of the current providers might have to give up the way they currently connect with their clients
20. This will evolve over time- mesh with community change- We need people involved who can help it change the way it does business
21. The Committee should think about funding
22. Need to find people who need the service
23. Combine with a database
24. Does this lead into a One-Stop idea
25. Utilize existing services and have incentives and alternate sources of compensation for services. Multiple locations increases patients choice
26. The Team agreed unanimously that it would like to pursue this as a component of the Athens Health Model

B. Pursue the Federally Qualified Health Center Designation
    1. This designation will help everyone
    2. It will bring in new money
    3. Worth trying
    4. Could help fund more primary healthcare positions/ Doctors from Medical Corps
    5. Need to do a lot of documentation
    6. Could bring in resources but it is a political machine- if you are not careful the time and focus shifts to getting money and position in the community for the Board- this can even reduce the amount of care given. Waycross has had some of these problems.
    7. FQHC should not be considered a cure-all, if done; it must happen in conjunction with other components of models the Team is reviewing. These federal dollars are considered start-up- eventually all activities must be self sustaining
    8. Paperwork and documentation increases exponentially.

9. We could get support from Gov. Perdue
10. Size of ACC is small and we appear to have enough providers. If we went multi count with satellite clinics, we could help explain the need since the catchment area for health services is larger than Athens
11. Need to ensure the focus stays on serving people
12. Still need navigators and a database to keep up
13. Colbert was successful with multi-county site
14. Need to hear from others who run them
15. Team can look at grant and reason for being declined- Jennifer will get that information
16. Another difficulty in proving the need is that Physicians don't accept all insurance so many people are "underinsured"- the census numbers don't show this detail

V. Next meeting will be on Friday, August 17th from 12-2pm at the ACC Planning Department (120 Dougherty Street, 706-613-3515). There will also be a half day retreat on Wednesday, August 29th from 12-5pm, location to be determined.

VI. Public Comment-

A. Heather brought up weather this would connect to the work of other Teams. James said that it would and that the Chairs of the Teams are meeting regularly to talk about all the overlapping areas.
B. Marcia echoed Farris' comments that the Team should be sensitive to using the term "case manager." It has negative connotations in the community. There are many resources and systems that clients have to navigate- we don't want to stigmatize getting this help.
C. Ellen brought information on Maryland's School-based Health Center Program. The SBHC is a "health center, located in a school or on a campus that provides onsite comprehensive preventive and primary health services. Services may also include mental health, oral health, ancillary, and supportive services." These services can be available to youth and to adults. Ellen urged the Team to consider including a Health Center in schools along with other job training, financial literacy, GED, and other community services. She supported Monica's statement that the Dental Van is very successful. She also mentioned that the Health Curriculum is un-evenly taught throughout the School District and this could be a good way to teach prevention and wellness. CCSD's Wellness Plan is pretty good.

Appendix A:

Components of Successful Models to Coordinate Basic Health Services for Those Living in Poverty or Near Poverty

- **Outreach Network with Community-Based Health Navigators, Case Managers and Disease Management**: This Outreach Network will included Nurse Case Managers and Social Work Case Managers from the Hospitals as well as Community-Based Health Navigators, individuals from low-income and marginalized communities who have an interest in helping people engage and navigate the local healthcare system. Navigator could receive training and have opportunities for professional advancement through a certification program in conjunction with Athens Tech. This Outreach Network would help follow clients with high utilization of services (i.e. ER) and chronic conditions (diabetes, hypertension, cardiovascular disease). Utilize system thinking approach that spans the continuum of care. This role would be closely linked with the health department to provide prevention education and disease management. Role: prevention, health promotion, maintenance, restoration, and education. Expected outcomes: decreased ER utilization, decreased hospitalization, decreased hospitalized length of stay, improved client self-management, and decrease fragmentation of care. Hospitals will support this because of the direct benefit to them. The Network would follow-up on every uncompensated ER visit and admission. Overall, promotes that holistic view that Dr. Johnson was talking about – i.e. may arrange to have the hole in the floor fixed. Navigators could first be engaged through a volunteer program via Hands-On NE GA, Community Connection, and faith based community (Outreach Worker from each place of worship?). This idea builds off of the Hillsborough County Florida's Healthcare system that partners with the College of Health for training, Ingham County plan, Community Health Works in Macon, and the Promotores De Salud Initiative in Dalton. Possibly link navigators into community one-stop centers – Ingham County does this.

- **Primary Care Providers (PCP)**: Immediately increase PCP's by 2-3. Maybe one physician, all or the rest would be NP's or PA's to get maximum bang for the buck. How to distribute among clinics?.

- **Medical Home**: Racial and Ethnic disparities in healthcare largely disappear when patients have a medical home. Create a local healthcare system that provides the components of a Medical Home. A medical home is defined as:
  - A regular provider
  - No difficulty contacting the provider by phone
  - No difficulty obtaining care or advice on weekends and evenings. **(24 Hour Access)**
  - Office visits are well organized and on schedule.

- **Demonstrate Need**: Don't make people invisible! Sign people up for assistance programs even if there is no money. Use outreach workers to find people that should be in the health plan.

- **Get Federally Qualified Health Center Designation**: If approval is received in the future, federal money is matched with local support to ensure there is a medical home for the low-income and underserved in an area. The FQHC has to determine where the gaps/needs are for the medically underserved and find a way to meet those needs. This can include primary care, dental care, prevention, etc. In addition to federal money, the FQHC designation also allows a clinic to get physicians from the National Health Service Corps, they would not have to pay $100,000 a year for liability insurance, the federal government would help pay down student loans, would provide support for a pharmacy, etc. The FQHC has to be a group effort, would not just benefit ANHC. Also helps on grants for the other clinics. Part of why the application failed was that Athens is not longer considered a Health Professional Shortage Area. In other words- it appears there are enough physicians to provide care to the area's uninsured. The onus is on the grant applicant to call Drs Offices and document if they are taking any new Medicaid/Medicare or uninsured clients. The best thing would be to have physicians working with the clinics, taking as many clients as they can, and then showing that there is still an unmet need. This also ties into "not making people invisible," signing people up for programs even if they'll be on waiting lists. FQHC stats would help recruit 2 or 3 more physicians. Dr. Dunston estimated that getting this status could help meet 65% of the currently unmet need.

- **Health Plan**: Business type model. May be a way to get specialist and private physicians more willing to see clients. May be a way for clinics to add practitioners rather than direct funding to clinic. This plan is not health insurance, but does provide coverage to uninsured people in Lansing, Michigan. Ingham County's program covers 15,325 uninsured residents and services covered included primary care, specialist consultation, outpatient laboratory and radiology services, and prescription drugs. Does not include Dental, vision, or Mental Health. (MI has a state plan for mental health). Enrollees pay co-payments between $2 and $10. The Ingham Health Department provides enrollment and data management. The program uses Community Outreach Workers. Primary care providers are paid per visit at the same rate as Medicaid. . Team discussed the advantages and disadvantages of "fee for services" versus "a flat rate per member per month." If you limit the rate, you know what your budget will be by the number of enrollees. If you reimburse based on the service, the costs can become volatile. This will need to be discussed further as team looks at strategies. I think it would be an exciting and creative idea to combine a health plan and the distribution system (like Gainesville) to be sure no provider is overloaded. May tie into other PPA initiatives and the business community. Could benefit small business owners. Similar to Access DuPage in Northern Illinois as well.

- **Oral Health Plan**: Needed – don't know how to make it happen or how to fund it.

- **Medications**: Possibly a centralized pharmacy that provides meds for each clinic. Could use samples, collective buying power from hospitals, reduced cost programs via health department, and other assistance programs. Collaborative with UGA School of Pharmacy and/or local pharmacists? Funding?

- **Mental Health**: Unsure what to do. They do have some funding. We could work more collaboratively with them to provide physical health services to their clients. NCM's, SWCM's, and Navigators would help connect people to MH services.

- **Electronic Record and Databases**: Look into open platform World Vista program which is inexpensive and used by the VA to track medical records. Get community IT volunteers involved, hospital IT departments and/or UGA IT help.

- **Medical Residency Program**: Either in conjunction with the Medical College of Georgia or another medical school, create a medical residency program to supply clinics with medical professionals. Based off the model residency program in Montana at the Deering Community Health Center. This 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.

- **Men's Health Focus**: Men of color have less access and worse outcomes than white men and all women. Most programs have focused on women and children. If we want men to be present in the family and to be employed, we must focus on their health. Grant money for men's health may be available. We could create a "specialty clinic" one or two nights a week at existing clinics and market it.

- **Mobile Clinic**: Marion County model has a mobile clinic. They 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.

- **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.

- **Volunteer Coordination**: Need a centralized volunteer coordination program to get medical volunteers. Possible interaction with HandsOn Northeast Georgia's new Volunteer Center.

- **Supplies and Equipment**: Possible collaborative buying power via hospitals.

- **Grant Writing**: Centralized grant writer for all PPA initiatives or grant writer donated by UGA. Is there a need for other types of centralized support?

- **Liability** Coverage: Liability coverage for volunteer physicians through the Georgia Volunteer Health Care Program (aka Health Share Volunteers in Medicine Act). This program authorizes the State of Georgia via the Dept. of Community Health to offer state-sponsored Sovereign Immunity (SI) protection to uncompensated, licensed health care professionals who provide donated care to eligible patients. Another option is Northwest Georgia's Healthcare Partnership which pays volunteers at the health department $1 per month, which allows them state liability coverage.

- **Think Sustainability**: Change things, don't just do projects. Consider sustainability before starting something new.

- **School-Based Clinics**: Engages children and entire family. Removes health care from teacher's responsibilities. Opportunities for health promotion and education.

Other Collaborations:
Establish ongoing collaborative relationships in which UGA departments and local health related schools agree to support (volunteers, ongoing class projects) a specific aspect of our program. Possible collaborators: School of Public Health, Pharmacy School, School of SW, MCG Nursing School, Athens Tech Nursing School and other health related schools, MCG Medical School, Morehouse School of Medicine, Brenau Medical School.