OneAthens Health Team
September 28, 2007
12:00-2:00 PM, Fanning Institute

Present from the Team: Deb Williams (Nurses Clinic), Pamela Robinson (WellCare), Trina von Waldner (UGA College of Pharmacy), Kathy Hoard (ACC Commission), Alison McCullick (UGA Health Initiative Projects), Tracie Jacobs (Consumer Representative), Claude Burnett (Northeast Georgia Health District), Jennifer Richardson (Athens Neighborhood Health Center), Monica Knight (CCSD)

Present from the Community: Heather Slutzky, Shelby Lacy (ARMC)

Present from Staff: Delene Porter

I. Delene welcomed group and included Mission and Ground Rules with agenda:

<u>Mission:</u>

Create a plan to coordinate and fund basic health services for those in poverty and near poverty.

<u>Ground Rules:</u>

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. Discussion of Medical Home component (Appendix A)-

a. Original Definition- 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:
    i. A regular provider
    ii. No difficulty contacting the provider by phone
    iii. No difficulty obtaining care or advice on weekends and evenings. (24 Hour Access)
    iv. Office visits are well organized and on schedule.
b. Team discussed 4 questions:
    i. Does this definition adequately describe your concept of Medical Home? If not, what is missing?
    ii. In what ways do our current services meet this definition?
    iii. In what ways do our current services not meet this definition?

iv. What recommendations does the Team have to ensure that clients have access to all aspects of a Medical Home?
Structure:
Process:
Outcome:

c. Group A (Tracie, Pam, Trina, Deb, Jennifer) answered:
   i. Need to change the definition so that Medical Home becomes a plan not a place so a Medical Home:
      1. Establishes a provider network
      2. Provides reasonable access to network providers by phone
      3. Ensures the ability to obtain acute care or advice within 24 hours including nights and weekends
      4. Ensures that office visits are well organized and that the schedule and wait times meet recognized standards
   ii. ANHC, Mercy, Nurses and Health Dept do have established network of providers and an organized system so you will be seen
   iii. But, there are limited hours of operation, ANHC has a phone # for emergencies, but most don't have phone access
   iv. **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**
      1. Each clinic would work within an area of expertise or service area with operating agreements with the others
      2. A grid, showing clinics and the services they offer would be created so that Navigators could provide intake and referral
      3. Grid would also help locate the gaps so that the clinics could figure out what to do to meet Medical Home definition and a way to pay for other services (like lab work) would be determined
      4. Short term Outcomes- ER visits for acute/non-emergency visits would decrease, absence from school and work would decrease
      5. Long term outcomes- individuals enrolled in the plan and within the Medical Home Network would have better health 10 years out because of early access and prevention

d. Group B (Monica, Claude, Kathy, Alison) answered:
   i. Need to remove sentence about reduction in health disparities since there is not enough evidence to prove this. Start with **"Create a local healthcare system that provides the components of a Medical Home. A medical home is defined as:**

1. **Establishes a provider network (they support Team A's change)**
2. **Provides reasonable access to network providers by phone**
3. **Ensures the ability to obtain acute care or advice within 24 hours including nights and weekends (they support Team A's change- their concern was for no difficulty obtaining advice on evenings and weekends and less difficulty obtaining care on evenings and weekends)**
4. **Ensures that office visits are well organized and that the schedule and wait times meet recognized standards**
5. **Provision of and/or capacity for referral for education and social service navigation (they added this component)**

ii. While all 4 clinics have patients who consider the clinics their medical home, only ANHC meets the definition as currently set and they are at capacity

1. Team B would like to see the Medical Home definition set the standard and figure out how to get all the clinics to increase their capacity to be viable components of this Network
2. Team B prefers thinking of the Medical Home as a System of Care
   a. **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 the IT component**
   b. **Need a person/Navigator who can help you**

e. Group C (Heather and Shelby) added possibility of a Triage phone line with a person who could use the grid to determine where to direct people- medical advice line like 211 service (could be supported by the nonprofits)

III. Outreach Network and Community-Based Health Navigators Discussion (Appendix B)-

a. Team did not have much time remaining, but began to look at the following questions

Structure:

i. What should the Outreach Network be responsible for?

1. Follow up on ER visits
2. Offering Health Advice
3. Assist in Obtaining Health Insurance
4. Assist in Accessing Care

5. Indigenous Health Researchers
6. Other?

ii. Team has discussed having Network workers located in the medical establishment as well as within the community. What key locations/positions should be included in this Network?

iii. Provide guidelines or input on where Network is housed- Hospitals, Clinics, Pharmacies, Physicians, University, Community

Process:

iv. Discuss Training and Supervision needs

Outcome:

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

b. Group B (Claude, Monica, Alison, Kathy) answered:

i. **The Navigators' duties would 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**

ii. There should be multiple levels of Navigators
   1. Someone who is not medically trained, but can help people through the system (maybe school nurses, Promotores)
      a. These people could be based at stable sights (School, AHA, etc.) as well as in mobile units
   2. Someone who can enroll people in they system and do data collection

c. Group A (Tracie, Pam, Trina, Deb, Jennifer) answered:

i. **There should be several layers of the Navigator network.**
   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**

d. Group C (Heather and Shelby) added that Navigators should include trusted community members

IV. Next Steps

- Next Meeting will be on October 5th from 12-2pm, ARMC Private Dining Room #1 (off the cafeteria)

APPENDIX A- Medical Home example:

Racial and Ethnic Disparities in Healthcare

- **There are well-documented racial and ethnic disparities in healthcare access and quality.** (Morehouse, 1999; Lurie & Dubowitz, 2007;Trivedi, Zaslavsky, Schneider, & Ayanian, 2006)

The following are the major findings from a study released June 2007 titled "Closing The Divide: How Medical Homes Promote Equity in Health Care" (Beal, Doty, Hernandez, Shea, & Davis). There were 3,535 participants.

- Disparities of care largely disappear when patients have a medical home. A medical home is defined as:
    a. A regular provider
    b. No difficulty contacting the provider by phone
    c. No difficulty obtaining care or advice on weekends and evenings.
    d. Office visits are well organized and on schedule.

- Hispanics and African Americans are vulnerable: their uninsured rates are higher and they are less likely than whites to have access to a regular doctor or source of care.

- Use of reminders for preventive care is associated with higher rates of preventive screening. Among patients with medical homes, there are no racial disparities in terms of receipt of preventive care reminders.

- Adults with medical homes are better prepared to mange their chronic conditions – and have better health outcomes – than those who lack medical homes.

- Community health centers and public clinics – which care for many uninsured, low-income, and minority adults – are less likely than private doctors' offices to have features of a medical home.

References:

Beal, A. C., Doty, M. M., Hernandez, S. E., Shea, K. K., & Davis, K. (2007). Closing the divide: How medical homes promote equity in health care. The Commonwealth Fund 2006 Health Care Quality Survey, 1-40. Retrieved July 6, 2007 from http://www.commonwealthfund.org/usr_doc/1035_Beal_closing_divide_medical_homes.pdf?section=4039.

Lurie, N. & Dubowitz, T. (2007). Health disparities and access to health. Journal of the American Medical Association, 297(10), 1118-1121.

Morehouse Medical Treatment and Effectiveness Center. (1999). A synthesis of the literature, racial and ethnic differences in access to medical care. Henry J. Kaiser Family Foundation. 1-87. Retrieved July 9, 2007 from http://www.kff.org/minorityhealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13293

Trivedi, A. N., Zaslavsky, A. M., Schneider, E. C., & Ayanian, J. Z. (2006). Relationship between quality of care and racial disparities in Medicare health plans. Journal of the American Medical Association, 296(16), 1998-2004. Retrieved July 6, 2007 from www.jama.com

APPENDIX B- Outreach Network and Community-Based Health Navigators example:

- **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 might 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.
- In an effort to address barriers that prevented the uninsured in Ingham County from enrolling in the Ingham Health Plan, the Grass Roots Outreach Project (GROP) was established to employ community outreach workers to enroll hard to reach uninsured members of the community into the IHP. Over the course of this outreach project, an additional 2,364 people enrolled in IHP.