OneAthens Health Team Meeting
July 13, 2007
12:00-2:00 PM, Athens Neighborhood Health Center- East

Present from the Team: James Shrum (Chair), Pamela Robinson (Wellcare), Trina von Waldner/Paul Brooks (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), Marcia Massengill sub for Claude Burnett (Northeast Georgia Health District), Monica Knight (CCSD), John Culpepper (ACC), Virginia Day (St. Mary's), Diane Dunston/Jennifer Richardson (Athens Neighborhood Health Center), Terry Tellefson (Advantage Behavioral Health Systems)

Present from the Community: Shelby Lacy (ARMC), Lou Kudon (Public Health Department), Gail Hurley (Athens Neighborhood Health Center), Heather Slutzky, Lee Shearer (Athens Banner Herald)

Present from Staff: Delene Porter

I. James welcomed the group and asked for introductions. He opened with a quote from a model that Virginia Day will share with the group (Ascension Health):

> We will not be successful in this endeavor without **"ego-less collaboration with competitors and non-traditional partner organizations"** (Ascension Health, Audio Conference, June 2007).

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 reported on 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. The state will be responsible for litigation as long as the volunteer health care professional acted within the scope of services. Mercy Clinic uses this program with its volunteers.

III. James reported that Adam Gobin called UGA's accounting to find out about Tax deductions for volunteer physicians. The accounting office said, "Services provided to a charitable organization are not tax deductible. However, expenses incurred associated with providing the services may be deducted."

IV. Monica Knight gave reports on Promotores De Salud Initiative in Dalton, Community Health Networks, and Northwest Georgia Healthcare Partnership (see attached reports for more detail).

a. The Promotores De Salud Initiative trains health educators to help engage Latinos in healthcare programs and increase their knowledge of health care issues. The program provides training, certification, and funding for the Latino health educators. It has increased the number of Hispanics receiving medical care by 30%.
b. The Community Health Networks creates a healthcare system for the uninsured- with physicians, clinics and hospitals that triage and track the patients to make sure they are receiving continuity of care.
c. The Northwest Georgia Healthcare Partnership is a multi-partner strategy to provide access to medications, consumer education, indigent care, and care for seniors and youth to Murray and Whitfield Counties. They pay volunteers at the health department $1 per month, which provides them liability coverage. Suzanne Knox would be willing to visit.
d. Group agreed as it started formulating ideas of what the Athens program would look like, they would invite practitioners from other models to discuss with the team.

V. To create sustainable solutions to the underlying causes of poverty, PPA has made it a goal to discuss issues of race and the barriers that discrimination creates. James wanted to make sure that this effort was part of the Health Team's deliberations. James provided the group with a summary of literature on Racial and Ethnic Disparities (see attached reports for more detail):

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

i. Disparities of care largely disappear when patients have a medical home.
    1. 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.

ii. 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.

iii. 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.

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

v. 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.

c. Group agreed that findings in the literature matched what they see in Athens.

d. Group discussed concept of a Medical Home. Day stated that she would like the group to keep this concept in mind as it develops a strategy.

e. Deb Williams pointed out that Nurses Clinic and Mercy can do some of those things, but that they are considered, by their clients, a Medical Home. She also said that we should get the data from ARMC's pediatrics hotline to see if it has reduced ER visits as proof of the importance of being able to get in touch with someone when needed.

f. Karen also mentioned making sure that reducing health disparities and race be included in the outcome measures for the Team strategy.

VI. James presented information about Community Voices provided by Dr. Henrie Treadwell at Morehouse School of Medicine. He specifically focused on key best-practices and advice she had for Athens (see attached reports for more detail):

a. Their most successful models have included a health coverage plan. Use a business model when developing.

b. 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.

c. Use navigators to help people get the help they need. These Health Navigators programs can work with Tech Colleges to get certification with the goal of advancement and higher pay.
d. Consider focusing some efforts on men's health. 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.
e. Change things, don't just do projects. Consider sustainability.
f. The Team discussed 2 questions: Do you see a need for health navigators in Athens? And, Is there a need for a focus on Men's Health? The answer to both questions was yes. Helping clients wade through the agencies and paperwork and figure out how to find a specialist, etc. is time and staff consuming. ANHC's staff does a lot of this work and it contributes to a high overhead, but is necessary to truly serve the low-income population. The Nurses Clinic and Mercy see as many men as the do women. Mercy felt it was because of the evening hours. Athens does not have a place that just focuses on Men's Health. The health department provides some standard tests and Mercy, Nurses, and ANHC can run them as part of an annual exam, but all agreed that it would be helpful to make it a focus and market what they have.

VII. James presented the Ingham Health Plan- which is one of the best practices recommended by Dr. Treadwell. This plan is not health insurance, but does provide coverage to uninsured people in Lansing, Michigan (see attached reports for more detail):
a. 15,325 uninsured residents are covered by this program.
b. 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)
c. Additionally, each client has a Medical Home.
d. Enrollees pay co-payments between $2 and $10
    i. Team discussed importance of co-pay. On one hand, a co-pay helps a client feel responsibility for their participation and value the program; on the other hand, "buy-in" can be created through many other avenues. Mercy Clinic has a donation jar, explains that their services are free, but cost money to provide and give clients an opportunity to volunteer. Many clients do volunteer. There is dignity in asking and in not embarrassing someone who cannot pay. ANHC does bill, but does not go after someone's credit if they cannot pay. ABHS has a sliding fee. This discussion will be continued as the Team selects a strategy.
e. The Ingham Health Department provides enrollment and data management. The program uses Community Outreach Workers.

f. Primary care providers receive a per member per month fee of $40. 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.

VIII. James presented Hillsborough County Florida's Healthcare system. It is similar to many of the models we've discussed. Relevant information included: establishment of a coordinated information technology system, a "Play or Co-pay" model that reduced cash fees for client adherence to medical plan, and their joint collaboration with the College of Public Health to train lay health navigators (see attached reports for more detail).

a. Marcia pointed out that the Health Department uses a similar program for its diabetes patients where loosing weight enables them to not have to pay. It works very well and is another possibility to add to the debate over co-pays and getting "buy in."

IX. Dr. Dunston presented information about the Federally Qualified Health Center designation.

a. ANHC's application did not get approved this year.
b. 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.
c. 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.
d. ANHC did have this designation when it was opened in the 1970s but lost it with many other centers in the 1980s. The Athens Community kept ANHC open and now ANHC is trying to get the FQHC status again.
e. 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.
f. The FQHC has to be a group effort, would not just benefit ANHC. Also helps with grants for the other clinics.
g. 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.
h. 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.

i. 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.
j. May need a subgroup to look into FQHC grant.

X. Public Comment-
a. Heather Slutzky presented information on Access DuPage in Northern Illinois. This health care program enrolls the uninsured for one year, has a minor co-pay and strong prescription program. Only requires residence in DuPage County for 90 days. Uses donated health care and county $ to leverage other grants. It decreased the amount of ER visits for primary care. Heather can get in touch with Director if group would like more information.

XI. Next meeting will be on Friday, August 3rd at Power Partners- 200 Newton Bridge Rd, Athens, GA 30607, (706) 548-3121