OneAthens Health Team Meeting
August 17, 2007
12:00-2:00 PM, Power Partners

Present from the Team: James Shrum (Chair), Pamela Robinson (Wellcare), Trina von Waldner (UGA College of Pharmacy), Kathy Hoard (ACC Commission), Allison McCullick (UGA Health Initiative Projects), Mark Ebell (ACC Board of Health/MCG), Tracie Jacobs (Consumer Representative), Deb Williams (Athens Nurses Clinic), Claude Burnett (Northeast Georgia Health District), Monica Knight (CCSD), John Culpepper (ACC), Diane Dunston (Athens Neighborhood Health Center), Farris Johnson (Family Practice), Karen Schlanger (UGA Cooperative Extension), Virginia Day (St. Mary's Healthcare System), Lisa Caine (Oconee St. UMC/Our Daily Bread), Tracy Thompson (Mercy Clinic)

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

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. Dental Van- As discussed at the last meeting, the Team heard more information about the Dental Van.
   a. Parents fill out forms to verify the source of insurance and send them into the Dental Van Companies (Help a Child Smile and Cool Smile).
   b. The Van Companies go through the paper work and set up an event at central locations.
   c. The exam and cleaning costs $110 for those without insurance or Medicaid

d. There are changes happening through the Medicaid so that the Dental Vans will no longer be able to accept Medicaid as a source of payment
e. The majority of children who use the Dental Vans are on Medicaid- they will still be able to use the regular dentists
f. Team is not longer discussing increasing convenience, we must now look at coverage and access to dental care at all

III. Meeting with Congressman Broun- Rep. Broun requested to meet with the Mayor and Commission last week to hear what needs the community would like him to work on in Washington.
a. James and Delene put together an overview of PPA, the Health Team, and the need for Federally Qualified Health Center designation.
b. Ours was the only written and specific request and was received favorably.
c. Tim Eckles, Broun's Aid, emailed James immediately and planned to follow up with a tour of Athens Neighborhood Health Center.
d. There is not specific date set when the next Request for Proposals will be released. Athens will need to begin preparing now since the RFP only gives a few months before the grant is due and there is a lot that needs to be done for the grant.
e. Collaboration that ensures a seamless system of serving indigent and uninsured in Athens is key to receiving the designation- Group agreed that the designation would only be part of the Athens Health Model and that the model would address ways to collaborate and streamline.
f. One of the issues Broun's office could help with is getting Athens re-designated as a Health Professional Shortage Area- we would also have to help with a survey of physicians.
g. Other communities have gotten re-designations- Virginia Day will find out in which districts this has occurred and will find out who the representatives are so that Broun can speak with them.
h. Farris suggested that we also create a "virtual tour" PowerPoint so that he can see pictures of the clinics, the community, and the people who we are trying to serve. This could be geared towards FQHC for Broun, but will be added on to as the whole health care model is determined- this will help the Team market the model to Athens.
i. Still need a comprehensive business plan- it is about strengthening the agreements to work together and pulling others in.

IV. James presented the Team with the almost final Interim Report. If there are any last minute changes that need to be made, please send them to Delene by Monday, August 20th. She will send a copy via email to the Team later today.

V. The Athens Healthcare Model- the Team continued 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 one of the components. A complete list of Components is attached as Appendix A.

A. Primary Care Providers-

1. Increase but need to know type of PCP, salary, and where they will fit in- the ratio of 1:1 Physician to Nurse Practitioner or Physician's Assistant
2. Need to know focus as well- ANHC has 1 Pediatrician, 1 Generalist, and 1 Family Physician. General Internists overlap with Family Physicians by about 80% but General Internists do less children and minor surgery so Family Physician is most flexible
3. Could come from residency faculty
4. Need to increase PCPs who will help meet the need, but there is also a need for specialists- Orthopedics, Neuropathy, Gynecology, Endocrinology, Neurology, Dermatology- Specialists currently require payment at time of service or don't take Medicaid
5. Hospitals have financial liability and Federal Laws require them to meet the specialist need- they should help meet this need
6. May not need a ratio of 1:1, there can be more NPs and Pas than Physicians, just need to determine a good model and management
7. Need to create a structure that is inclusive- nurses are a part of the equation. Need to not loose sight of increasing capacity for access, especially early access
8. Maybe we need to list the services that are needed under primary health care
9. Chronic disease management is also a big issue- PCPs could target diseases
10. Need to engage the retired medical community as volunteers
11. NP and PAs are a great resource and there is a PA Society in Athens
12. Could staff an after hours clinic in the ER- since that is where people are going already
13. 1 Physician to 4 Nurse Practitioners is the Federal Standard and if we aimed for 1:2 that would meet a large need efficiently
14. Georgia is the only state that has not given Nurse Practitioners the ability to write prescriptions
15. Need to focus on Outcomes
16. Need to figure out how to bend the rules to get things done- not the most expensive, but the most effective

17. Getting the FQHC will help designate Athens as a Healthcare Professional Shortage Area which will help bring in some of the traditional PCPs

VI. Next meeting is a half-day retreat on Wednesday, August 30th from 12-5pm at ARMC's Medical Staff Services Building, Classroom D.

VII. Public Comment-

A. Heather suggested that we put in times throughout the half day retreat for public input so that it does not have to be saved until the end of 5 hours.
B. Marcia brought an example of software that tracks clients called Care Scope. They found her through PPA and are willing to come and do a demonstration.
C. Tracie brought information about the 2nd Annual DFCS Clothing Drive, Wed, Aug 29th, 9am-7pm and Thursday, August 30th, 9am-4pm at DFCS (284 North Avenue, Conference Room A, follow signs to back parking lot)
D. Mercy Clinic is having its ribbon cutting from 4-5pm on Tuesday, August 21 and an open house from 2-5pm on Sunday, August 26

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.