OneAthens Health Team Retreat
August 29, 2007
12:00-4:00 PM, ARMC

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), Tracie Jacobs (Consumer Representative), Deb Williams (Athens Nurses Clinic), Claude Burnett (Northeast Georgia Health District), Diane Dunston (Athens Neighborhood Health Center), Farris Johnson (Family Practice), Karen Schlanger (UGA Cooperative Extension), Tracy Thompson (Mercy Clinic), Sherrie Ford (Power Partners)

Present from the Community: Heather Slutzky, Marcia Massengill (Northeast Georgia Health District), Shelby Lacy (ARMC), Jennifer Richardson (Athens Neighborhood Health Center, Mason McDaniel (Nurses Clinic), Carol Burnes (Northeast Georgia Health District)

Present from Staff: Delene Porter, Jan Coyne

I. James welcomed the group and turned meeting over for Purpose 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.

**Purpose:**

- The product from today will be a draft Athens Model that the Team will finalize at the next meeting
- The exercises are structured to help the Team create and test packages of different components that could constitute the Athens Model
- All of the details for each component have not been determined, but the overarching concepts have been discussed in enough detail to determine initial viability for Athens.

II. Old Business- Interim Report Final Approval

a. Trina said that the other Pharmacy Representatives could be removed
b. Claude wanted clarification for the Health Department- he'll send edits to Delene and James
c. With those changes, the Team approved the Interim report

III. Additional Information about Components (for complete list of Components see Appendix B)
a. Trina gave an update on medications and accessing the free and reduced programs at pharmaceutical companies (See Appendix C)
b. Virginia sent an addition on parish nursing

IV. The Team first defined Impact and Effort, the two criteria by which they would begin to analyze each component for an Athens Health Care Modal
a. Impact would be measured by lowered mortality, fewer hospitalizations, more efficient service, faster recovery, reduced unemployment rate, improved continuity of care, increased primary care capacity, increased access to specialty care, decreased cost for patient and agency, reducing inappropriate ER visits, decreased work and school absenteeism, sustainability (Impact will be judged for structure, process, and outcome)
b. Effort would be measured by cost of care, sustainability, coordination between agencies, coordination of volunteers, cost per visit, patients served, time to implement, visits per patients per year, match supply with demand (hours and days), prioritization- low hanging fruit vs. long term, public education required

V. Team determined components of the Athens Health Care Model- (see Appendix A for process details)
a. Health Plan including electronic information system
b. Federally Qualified Health Center
c. Medical Home
d. Outreach Network
e. Referral System
f. Medications

VI. Next Steps
- Need to Gather information regarding Need- Form sub-committee to pull together information Team has already gathered- Farris, James, Jennifer, Delene, Claude
- Next Meeting will focus on defining Health Plan. Team will work its way down list in descending order of influence.
- Next Meeting is Friday, September 7 from 12-2pm at the Health Department

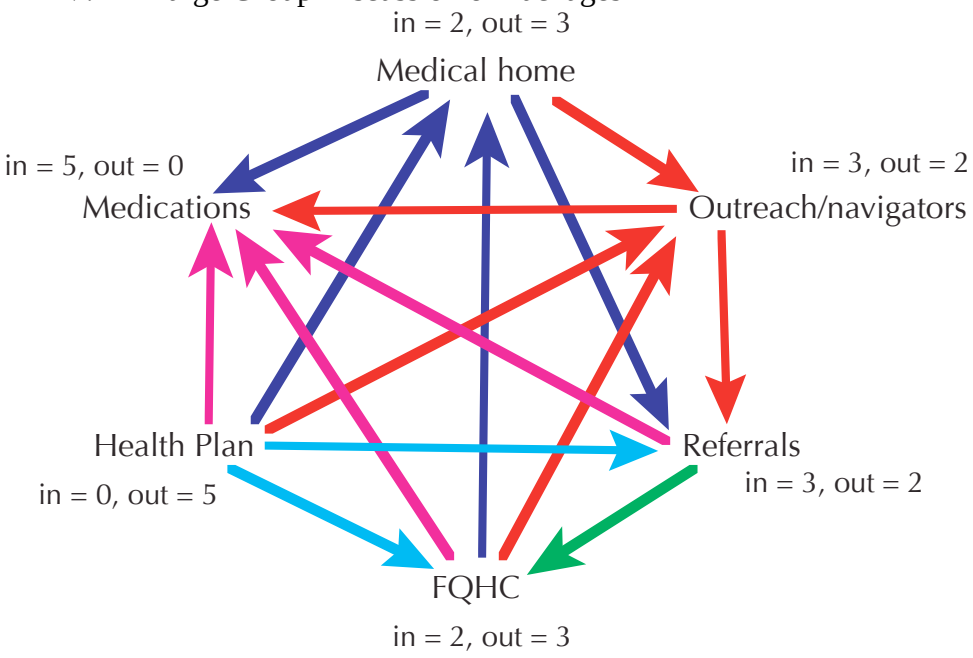
# APPENDIX A- RETREAT PROCESS DETAILS:

I. Team members individually rated each component on Impact and Effort (1 = low and 10 = high)

II. In Small Groups, members discussed:
- Look at the component ratings
- Choose top components for your group's package- 30 minutes
- Discuss how these components could work together/What else needs to be in place for this model to be successful
- Use laptops for taking notes

III. Each group presented packages of components (Details below)
a. Group 1- Sherrie, James, Tracie- Medical Home; Health Plan with Mental and Oral Health; Electronic Medical Records; Referral Clinic to Specialists; Federally Qualified Health Center; Navigator/Parish Nursing
b. Group 2- Karen, Diane, Trina- Medical Home; Health Plan with tracking system; Medications; Referral; Community based navigators; FQHC
c. Group 3- Claude, Pam, Tracy- Demonstrate need; Medical Home (increase primary care providers and residency); Medications; Liability; FQHC; School Based clinic; Navigators as Health Educators
d. Group 4- Kathy Farris, Alison, Deb- Medical Home (mental health, meds, EMR, supplies, Prevention, Case management); Health Plan would cover oral, meds, referral, ancillary services, supplies and equipment- would also be based on units of service (earned, donated, patients could get through continuing education/seminars) barter system, "credits" would be redeemable with local businesses, Drs would get tax credits, Larger OneAthens project; Volunteer Coordination; demonstrate need; Collaboration
e. Group 5- Heather, Mason, Carol, Marcia, Shelby, Jennifer- focused on immediate, visible, and free-ish- Medical Home; Volunteer Coordinator (need money and physical space); Volunteer Coordinator would help oversee EMR, Referral System, Medication plan with UGA School of Pharmacy

IV. Large Group Discussion of Packages




Most Out:

| | |
|---|---|
| 5 | Health Plan |
| 3 | FQHP |
| 3 | Medical Home |
| 2 | Outreach/navigators |
| 2 | Referrals |
| 0 | Medications |

- Are there components common to all small groups?
  - 1, 2, 5, 15, 21, 17, 19
  - 1, 11, 5
  - 1 (13, 6, 5, 7), 3 (4, 11, 5)
  - 1, 3, 5, 11, 19, 21
  - 1, 3, 11, 21, 19, 22
- Does a single package emerge- Top Components:
  - Medical home
  - Health plan (including Info system)
    - Information systems discussion: VISTA (Vet Admin system) would be doable, needs a full time person to do it, at least at first. West Virginia is using it.
    - Some kind of tracking/information system should be used to track services used/needed for individuals across all services provided. Web-based, secure.
  - Medications
  - Referral system

- Outreach navigators, case managers
  - Navigators to outreach network would make it more broad-based.
- FQHC

V. Next Steps

- Question for the future: What will it take to further define and implement each component as part of a whole package?
  - Flesh out the different models. Price tag will be different for different sized things. How much might this cost (ballpark)? Ideal picture with transition plans based on where these start. We're taking what we currently have in place and tailor a system to make use of these, based on what individuals need. A 23-year old healthy person will need different services than a 51-year-old diabetic.
  - We have statistics to use to sell this with; we all know it's important; we just need a plan that's workable with what we have here, and how can it be better with outside assistance. We have to have everyone involved in making this work--for example the bartering system won't necessarily work as well with the people we're dealing with; they don't have much to barter.
  - Implementation: how will we do that with the final plan? How will this start off? Community information, community education, provider education?
  - Parallel track: one track is how would it look fully funded, and one is how would it look if it's all volunteer?
- Need to Gather information regarding Need- Form sub-committee to pull together information Team has already gathered- Farris, James, Jennifer, Delene, Claude
- Relational Influence Diagram:
  - Health Plan
  - FQHC
  - Medical Home
  - Outreach Network
  - Referral System
  - Medications
- Next Meeting will focus on defining Health Plan. Team will work its way down list in descending order of influence.
- Next Meeting is Friday, September 7 from 12-2pm at the Health Department

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**Group 1-**
Medical Home:
All three of us agree that this is one of the top components

Health Plan:

- Agree that this one should be in the top components but include Oral Health and Mental Health in the plan (see #4 and #6). Recall the mobile dental care example/concept that goes to schools…
- Center of the whole strategy – "the glue" – oversight team as part of this
- Oral Health Plan: Needed – don't know how to make it happen or how to fund it.
    - Cover with Health Plan
- 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.
    - Assessment of this client population as to number who have mental health issues- my guess is 40%- needs to have component in our model- need collaboration with Advantage and their monies
    - Family physicians and general internists are very good at providing care for depression, dysthymia, and anxiety disorders. We might want to add a psychologist to the mix – that would be a great resource.

Electronic Record and Databases:

Separate item – not a "component" but an essential aspect of infrastructure – someone will have to go do this regardless of other components selected. Include in Health Plan ?

Referral System:

Agree on this component with concerns of patients' being welcome through this process. And, may be difficult to implement

Outreach Network with Community-Based Health Navigators, Case Managers and Disease Management: This Outreach Network will include Nurse Case Managers and Social Work Case

Agree that we should implement this component – and include in this the congregational parish nursing.

Get Federally Qualified Health Center Designation

Agreed that this one should be included; Senator Broun is engaged in this process now.

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**Group 2-**

1) Medical Home
2) Health Plan with tracking system
3) Medications
4) Referral System
5) Community based Navigators
6) FQHC

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**Group 3-**

- 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.
  - ❖ Access to care – 3 Access is crucial – What is the problem and how are we going to solve it
  - ❖ Demonstrate Health problems – 2 Demand based – what is life threatening, what is chronic need, what results in high cost consequences
  - ❖ Population in need – 1 Identify who needs care and what type of care is needed

- 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:
  2. A regular provider
  3. No difficulty contacting the provider by phone
  4. No difficulty obtaining care or advice on weekends and evenings. (24 Hour Access)
  5. Office visits are well organized and on schedule.
- The residency program would increase capacity which in turn would allow more people to use the local clinics as a medical home.

- Oral Health Plan: Needed – don't know how to make it happen or how to fund it.
  - o Cover with Health Plan and can be addressed by the medical home as well.

- 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?
  - ❖ Low cost – high benefit
  - ❖ Medicine Assistance Programs are extremely high effort but impact is very high
  - ❖ Generic meds high impact and low cost – If Public Health could give access for local clinics to buy meds it would also come with low effort. This is sustainable.
  - ❖ Using partnerships with local hospitals, local docs and drug reps
  - ❖ Supplies and Equipment: Possible collaborative buying power via hospitals.

- 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.
  - ❖ We agree with the above statements. This would be a very high impact with low effort because MCG already has experience with instituting these programs. This would bring Docs to Athens that normally would not come.
  - ❖ The residency program would increase capacity which in turn would allow more people to use the local clinics as a medical home.

- Volunteer Coordination: Need a centralized volunteer coordination program to get medical volunteers. Possible interaction with HandsOn Northeast Georgia's new Volunteer Center.
  - ❖ We need someone to recruit trained licensed volunteers like docs, pharm d, and nurses, etc. This would yield high impact with moderate effort.
- 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.
  - ❖ This is a catalyst for volunteers with little or no effort it is a great benefit.
- 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?
  - ❖ The residency program would increase capacity which in turn would allow more people to use the local clinics as a medical home.
- Get Federally Qualified Health Center Designation
  - ❖ We agree with this! This will take lots of one time effort by everyone in the community but the benefit will be great.
- School-Based Clinics: Engages children and entire family. Removes health care from teacher's responsibilities. Opportunities for health promotion and education.
  - o Do we know how many of our 15,000 are children?
  - o In its ideal form it would have tremendous long term impact with a great deal of effort. Ideally, it would include educating childhood behaviors such as diet, exercise, etc. In the school setting they are a captive audience and some personnel is already in place.

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**Group 4-**
Kathy Hoard Priorities:
Federally Qualified Health Care System

Farris Johnson Priorities:
Medical Home
Mental Health
Oral Health
Medications
Electronic Medical Records

Sustainability is a good concept, but it doesn't take a bullet by itself – its an overall goal.

Case management is a big issue for the model "medical home." Case management is a delivery model – not an overall model concept.

Deb:
Health Plan

Question – what is "health plan"?
Answer – how a patient pays for the provider for their service
DISCUSSION: This is a complicated issue – taxes, appropriations, funding source

Farris idea: Every provider gets a certain amount of "credits" for units of service – a bartering system around town. For example, Dairy Queen makes a donation, and a doctor can go to Dairy Queen for free ice cream due to the efforts OR it can serve as a tax write-off. Similar to any "rewards" program – you gain credit for any work done, just like frequent flier program provides credit for someone who flies their airline often. Doesn't require a stable funding source necessarily.

How can a health plan actually work? It could actually work easily with providers, but how could it work for diagnostic services? How would it work for hospitals?

Hospitals would like it because it would be a reduction in ER visits.

Would doctors participate?

Incentives: free advertising with businesses, banner for business front doors stating that they "Support OneAthens"

How do we get businesses to support the effort? What's in it for me as a business?

Medical Home Discussion:

High effort, but high impact

Could Medical Residency help fill in the gaps? Not for a long term.
Pharmacy discussion: expanding reach of low cost medications. Rite Aid is not willing to go down. Walmart and Publix know they can get you into the store

Other discussion: Money is the biggest driver of finding a solution to this problem.

Other discussion: preventive care/health maintenance is an important piece of a health care model – but the majority of people seen by doctors and nurses are seen for the first time in an acute state

Other discussion: Case management is important – the need of a central location to obtain a case manager is needed. This person would serve as a facilitator to find the patient care and link the patient to doctors/nurses/provider who can assist in his/her situation. It can be efficient and help the patient – i.e. Hospice model is very successful that should be replicated. There is an attending physician, pharmacist, occupational

therapy, etc. A successful case management session would be useful to the whole PPA process.

Other discussion: mental health – we need more information – there are gaps that exist in services for mental health and without finding help for these situations, we will not be successful overall.

Other discussion: the final questions/other concerns: Should illegal immigrants have rights to this model? Some said yes, some said no – there was concern regarding how the front line would manage whether or not a person was illegal – how could the front desk determine if person was legal. Also, this would affect our impacts and efforts – it would send more people to the ER and hospital, which ultimately is more expensive for the community. Some discussion regarding having some strings attached to services for illegal immigrants.

Also, should we serve Athens only? We felt like it should ONLY be Athens, not surrounding counties. OneAthens is focused on Athens, not Oconee, Jackson, Barrow, etc. counties. Question was asked: would this make too much work for the front line when trying to determine where a person arrives?

Co-pay or fee? The person who receives the service has to earn "units" each year - similar to the Habitat system where the person has to volunteer for a certain length of time in order to receive the home.

Drug testing? A great deal of pro's and con's on each side – it may not be the role of OneAthens to require drug testing but something that needs to be discussed further.

Table Decision: We felt there were two overarching pieces that should be included – Medical Home and Health Plan. They would serve as the glue holding together several of the other items.

We also felt that there were several "goals" within the list such as sustainability, volunteer coordination, demonstrating need, and collaborations – this will be important regardless of what type of model is implemented in the Athens-Clarke County area.

MEDICAL HOME:
Mental Health
Medications
Electronic Medical Records
Supplies and Equipment
Preventive Care
Case Management

HEALTH PLAN:
Oral Health
Referral System
Ancillary Services
Medications
Supplies and Equipment

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**Group 5-**
Create a **medical home** based on patient needs and clinic availability. Volunteerism would pay a large role with our program; a paid **volunteer coordinator** would manage both the **EMR** and the **referral system** and **medication education.**

Electronic Medical Records would be centralized and would include a patient identifier, medical history, current diagnosis, current and past medications. It would be developed either through an existing software program or access database with access available to all participants through secure connections.

The referral system would need assistance to get provider buy-in. It may be possible to trade volunteer services {mediation assistance volunteers} to increase benefit for consulting physician. Final vision includes volunteer/volunteer coordinator being able to distribute patients equitably and within the agreed upon limits of the physician.

Medication assistance and education could be cooperative with the UGA Pharmacy school. We did not look at expanding or changing current pharmacy agreements but instead focusing on patient access to medications that are affordable.

This program needs:

- Money to pay for a volunteer coordinator {someone to write the grant to pay for a coordinator}
    - Volunteer Coordinator

    - Fiscal agency to house coordinator
- Computer and technical expertise to set up EMR template/program
- Cooperative agreement with Pharmacy school to provide or train medication assistance

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

1. **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. A regular provider
    b. No difficulty contacting the provider by phone
    **c.** No difficulty obtaining care or advice on weekends and evenings. **(24 Hour Access)**
    d. Office visits are well organized and on schedule.
        **i. I think the Medical Home is a great selling point to the consumer and provider. I would like this concept to be included in our model. The components of course that are the challenging ones are the phone and after hours availability… there are models in place (crisis hotlines, pediatric hotlines, managed care) but of course have costs associated. Could be volunteers but the standards and training, etc. would balance out the actual cost of staffing**

2. **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.
    **a. Interesting concept that we don't even know who of the 15,000 supposed clients without proper care are being served and what percentage. A basic place for volunteers to sign people up for whatever form this action takes, a table at every intersection so to speak- a city/county wide campaign to "meet every client" I do think this is an area that churches, groups, youth, etc. can get on board with.**

3. **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.

   a. **This model appears to encompass all aspects with the exception of Mental Health and Dental. Vision has not been discussed very much by the team. It appears that Athens may need a mediator to bring the PCP and specialist community together to present the concept and get their buy-in.**
   b. **Lots of ideas here…not sure which and what to respond to. I am in favor in theory of a Health Plan for these folks:**
      i. **A way to track them and their usage of the system**
      ii. **A system for new clients to be integrated**
      iii. **System for providers to be compensated**
      iv. **System for small business owners to participate (pro-rated per number of employees)**
      v. **I do think it should be fee per services… negotiated rate, not a monthly rate (like hospice reimbursement)**
      vi. **Whatever we decide, the following services should be included: primary care, specialist consultation, outpatient laboratory and radiology services, prescription drugs, and DENTAL.**

4. **Oral Health Plan**: Needed – don't know how to make it happen or how to fund it.
   a. **Cover with Health Plan**

5. **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?
   a. **Centralized pharmacy is fine or voucher system; I would have a family of participating pharmacies, no samples too complicated and labor intensive. Use buying power of both hospitals. Use of Students from pharmacy school**
   b. **Work to form partnerships with pharmaceutical companies, as well.**

6. **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.
   a. **Assessment of this client population as to number who have mental health issues- my guess is 40%- needs to have component in our model- need collaboration with Advantage and their monies**
   b. **Family physicians and general internists are very good at providing care for depression, dysthymia, and anxiety disorders. We might want to add a psychologist to the mix – that would be a great resource.**

7. **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.
    a. **Farris Johnson should head this committee- resident expert and has been guided the coordination of the hospital with MD offices. Expensive**

8. **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.
    a. **Sounds like a winner…I would vote for a comprehensive approach to a school like MCG or Emory who could supply MD students, nurses, dental students, and any other students (Occupational Health, Etc.)**
    b. **I heard something mentioned in the news the week of August 18th during a meeting about Grady in Atlanta (can not remember the person) mentioned that many of the physicians that attend the residency program would not come to GA otherwise. The medical college in Macon was mentioned and talk of a future residency program at UGA. Have you heard any of this?**

9. **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.
    a. **Interesting…one night a week is sufficient**
    b. **Sentence one is correct. Sentence two is correct, but we are not proposing to do that. Sentence three is speculative – health needs in that age range are not typically disabling.**

10. **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.
    a. **Great idea. I worked in a rural migrant clinic in a trailer in Michigan and it was much needed and appreciated.**
    b. **Not in favor of this at this time- maybe as outreach later**

11. **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.

   a. **Needs a lot of work- we need a comprehensive marketing strategy with every physician in town.**
   b. **Great idea, hope it works. This is what I proposed in our LEAD Athens questionnaire but maybe it wasn't properly understood.**

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

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

14. **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?
    a. **The problem with grants are all the hoops and tending that they take especially with the government and HIPPA regs and all the security that is required…would take staff exclusively to manage this**
    b. **As mentioned, a tracking system to follow patients' care.**

15. **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.
    a. **Would vote to pay a nominal amount**

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

17. **School-Based Clinics**: Engages children and entire family. Removes health care from teacher's responsibilities. Opportunities for health promotion and education.
    a. **Do we know how many of our 15,000 are children**?

18. **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.

a. **Amen**

19. **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.

20. **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?

21. **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.

**22. Other Ideas:**

a. **Congregational Parish Nursing: Based on a national model and local training center at Gwinnett Health System, enlist Athens Regional Medical Center and St. Mary's Health Care System to partner with local churches to financially support (with the hospitals), a congregational nurse who will serve as a health educator, personal health counselor, coordinator of volunteers and navigator through complex medical care systems. The foundations of ARMC and St. Mary's have been approached by an RN coordinator who would volunteer her expertise to establish programs in Athens.**

b. **Other Concerns/Major Questions**

i. **Do illegal immigrants have rights to health care?**
ii. **Is there a co-pay or fee?**
iii. **Do we serve Athens or beyond?**
iv. **Should drug testing be mandatory? I so, what frequency?**
v. **What do "basic' services include?**
vi. **Where do we look for funding?**

# APPENDIX C- PERSCRIPTION ASSISTANCE:

## Prescription Assistance Programs

www.rxassist.org website and program that links patients and providers with drug manufacturers who offer prescription assistance programs for brand name medicines

- Proof of income required for most programs
- Most forms must be signed by physician and include DEA#
- Various rules for how prescription must be written
- 30, 60, or 90 days supply based on manufacturer's guidelines
- Some medications labeled, some mailed to patient's home
- Most medications shipped to physician with no label, just patient name

www.rxoutreach.com website and program that offers generic drugs

- Proof of income not required – but should meet specific guidelines
- Cost: $20, $30, or $40 for a 90 day supply, depending on drug
- Print and complete form, attach prescription and payment then mail
- Must have prescription for 3 month supply
- Mailed to patients home, labeled with directions

www.pparx.org Partnership for Prescription Assistance
website and telephone service to link patients with prescription assistance programs, very similar to rxassist.org, 475 programs; 180 pharmaceutical company programs

NOTE: most drug companies also offer individual programs on their webiste

## Drug Discount Programs

WalMart - $4 for 30 days supply generic drugs www.walmart.com click on Pharmacy then $4 Prescriptions

K Mart - $15 for 90 day supply generic drugs www.pharmacy.kmartcorp.com

Publix – free antibiotics (6 most commonly prescribed generics)
Includes: Amoxicillin, Cephalexin, Sulfamethoxazole/Trimethoprim (SMZ-TMP), Ciprofloxacin (excluding ciprofloxacin XR), Penicillin VK, Ampicillin and Erythromycin (excluding Ery-Tab).

## Group Purchasing & Formulary Management

In House Pharmacy
340B pricing