OneAthens Health Team Retreat
September 7, 2007
12:00-2:00 PM, Health Department

Present from the Team: James Shrum (Chair), Pamela Robinson (WellCare), Trina von Waldner (UGA College of Pharmacy), Kathy Hoard (ACC Commission), Eric Dahl (UGA Health Initiative Projects), Tracie Jacobs (Consumer Representative), Claude Burnett (Northeast Georgia Health District), Jennifer Richardson (Athens Neighborhood Health Center), Karen Schlanger (UGA Cooperative Extension), Lisa Caine (Our Daily Bread), Virginia Day (St. Mary's), John Culpepper (ACC Finance)

Present from the Community: Heather Slutzky, Marcia Massengill (Northeast Georgia Health District), Lou Cudon (Northeast Georgia Health District), Tonya Bell (Northeast Georgia Health District), Heidi Davison (ACC Mayor)

Present from Staff: Delene Porter

I. James welcomed the group, made introductions and went over the 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.

II. Data Sub-Committee update-

a. James held a meeting with Melinda (ANHC), Lou (Health Dept.), Farris (Family Practice), and Delene to gather data to support the 6 components of the Athens Health Care Model.
    i. Health Plan including electronic information system
    ii. Federally Qualified Health Center
    iii. Medical Home
    iv. Outreach Network
    v. Referral System
    vi. Medications
b. The Sub-committee had a lot of questions about the details of each component that would determine what additional data is needed

c. The sub-committee will respond as the details are determined- Lou especially has a wealth of data from the Health Department that can be used to support the model components.

III. Athens Health Plan Discussion (for the Ingham Co. example of this Component see Appendix A)

a. The Team answered questions about the Structure, Process, and Outcomes of a Health Plan.

Structure:

1. Who should the plan cover first- the uninsured, by disease type, etc.?
    a. 3 votes for Enrolling people with a specific disease and then cover all primary health needs (this might get more support from the Hospitals)
    b. 8 votes to Cover the un- and under-insured and have an enrollment process that ensures they are low-income
    c. Need to consider the whole continuum of care from early intervention to prevent need for tertiary care
    d. A demonstration/pilot could focus on cardiovascular care
    e. Team consensus that they wanted to cover the un- and underinsured, but acknowledged that they may need to go in phases starting with specific diseases because of available funding.
2. Should the clients pay a co-pay?
    a. Unanimous consensus that clients should pay a small co-pay, based on sliding scale
    b. But that no one would be refused service
    c. It was felt that contributing something, even if a small about was about dignity and was empowering
3. What do "basic' services include? What diseases should the Health Plan cover- dental, mental health, etc.? (Team broke into small groups to discuss answers)
    a. Team A defined basic services as the front line of care and suggested a phased approach
        i. Phase 1- get people in the door, deal with chronic diseases, pay for medications, cover prevention
        ii. Phase 2- when there is more money, cover dental, vision and mental health
        iii. Need to know, of the uncompensated care given in the ERs how much is non-emergency or could have been prevented
    b. Team B agreed with Team A and said that when this plan is presented, is should not create overly high expectations- need to be honest about how many can be included and how much can be covered
        i. Phase 2- Dental and Mental Health using the other examples (like Ingham Co.) for guidance
    c. The Public Representatives agreed with the other two groups and stressed need to cover long-term follow-up that is usually outside the

provision of immediate services. Also, really need to make sure referrals happen with the Volunteer Referral Network for things that can't be covered by the Health Plan

4. Who is eligible to be reimbursed- clinics, private physicians, specialists? (What standards will they be held to?)
    a. Team had long discussion for this question. Almost everyone wanted to be able to include the clinics, private physicians, specialists, and the hospitals for reimbursement, but the Team agreed that, in the beginning, the Plan would limit its reimbursement to Mercy, Nurses, ANHC, and the Health Department. The Volunteer Referral Network will become very important in getting clients the additional services this group needs.
    b. The Team also wanted to ensure that the reimbursements don't just go for the clients currently seen, but really help increase the capacity of the clinics to see more, be open long hours, etc.
    c. All reimbursable parties will also need to be held to current medical care standards and sign contracts with the health plan, outlining what they will provide and discussing a price.
5. What other requirements must be in place?
    a. Should drug testing be mandatory? Team voted NO
    b. Should the plan cover people with residence in ACC or beyond? Team voted just to cover people in ACC
    c. Should the plan cover undocumented residents? Team voted to cover undocumented residents
    d. Team said that the information to meet these requirements should be part of an intake process (see the Good News Clinic's intake for an example), but to make sure that there is a way for homeless people to prove residence
6. Who oversees the creation and implementation? Who administers the program?
    a. Team agreed that a representative Advisory Board or Board of Directors would need to be formed
    b. Team decided that the "who" depends a lot on the funding source
    c. Team will revisit this question later
7. Will the amount of reimbursement be determined as a flat rate per visit or by service provided?
    a. In looking at Ingham Co. and ACC, if plan covered 36,000 visits at $40 each it would need $1.465 million not including co-pay
    b. Need to be flexible so it can change with time
    c. Team decided that this question was too much detail and should be determined by the implementing organization
8. Should the Athens Health Plan provide financial reimbursement or a combination of monetary and in-kind/barter compensation?
    a. Team doubted that private physicians would be interested in a minor payment and that they could use the tax write off for volunteer services
    b. Team did like the idea of compensating the enrollees however

i. This could be done through barter, reduced co-pay etc.
ii. Team also wondered about getting clinics repayment through discounts on utilities, etc.
iii. Volunteers appreciate a Thank You so some recognition should be in place (use for retention)
iv. If you're going to involve physicians, you need a physician spokesperson

9. Do we want to call it something other than a Health Plan?
   a. Team wanted to know the legal restrictions and avoid looking like "insurance"
   b. Don't want to be misleading- this is not a comprehensive plan
   c. Lowercase health plan- not title, but think
   d. Needs to reflect what it is- Health Assistance Reimbursement Plan (HARP)

The remaining questions would need to be answered in the future, but were at a level of detail that Team decided could be determined by the implementing organization

Process:

10. What start up staff is needed?
11. How will people be enrolled/the public educated?
12. Where do we look for funding?

Outcome:

13. Can outcomes be measured via Electronic Medical Records System = cost of care, sustainability, coordination between agencies, cost per visit, patients served, time to implement, visits per patients per year, match supply with demand (hours and days), prioritization

IV. Public Input:
   a. Jennifer reminded the group about the upcoming annual ANHC meeting, September 12 at the Lyndon House at 6:15pm. Paul Broun will be the speaker.

V. Next Steps
   - Next Meeting will focus on defining Medical Home.
   - Next Meetings will be Friday, September 28 from 12-2pm, location TBD and Friday, October 5th from 12-2pm, location TBD

APPENDIX A- Health Plan example:

1. **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.**