OneAthens Health Initiative Team
6/8/07, 2007 from 12-2PM
Clarke County Health Department

Present from Team: James Shrum, Paul Brooks, Claude Burnett, Lisa Caine, Anita Lewis (substitute for Virginia Day), Jennifer Richardson, Mark Ebell, Sherrie Ford, Kathy Hoard, Farris Johnson, Monica Knight, Charles McDuffie, Pamela Robinson, Karen Schlanger, Terry Tellefson, and Deb Williams

Present from Community: Dr. Louis Kudon (Northeast Georgia Health District and chairman of Athens Area Healthy Community Coalition) and Maia Jackson (Member Outreach Coordinator for Wellcare)

Present from Staff: Delene Porter

James welcomed the group and asked for introductions. He reminded the group of the 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 personal 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.

## Pearls from the first Health meeting (5/25/07):

James went over key elements from last Health Team meeting:

- Many of the providers don't apply for grants because of the bureaucracy and administrative requirements.

  **Opportunity for administrative support?**

- The drug most dispensed by Mercy Clinic is Insulin. Mercy buys it at SAM's for $19.98. Clarke County Health Department gets it for $7.00, but they aren't allowed to give it or sell it to Mercy. Mercy spends $27,000 on drugs per year. The drugs most dispensed by Nurses' and Athens Neighborhood Health are blood pressure medications. Nurses' clinic spends about $75,000.

  **Opportunity for buying power from hospitals?**

- There is a big need for IT connectivity. All providers are using paper records. There is no tracking mechanism to determine if patients are going to more than one clinic or what was done at that clinic.

  **Opportunity to get community IT people together to provide a solution?**

- If patients owe money they will not go back to a provider.

**Opportunity to have common payment philosophy or have coordinated referrals among the providers?**

- Demand is difficult to measure. No one is keeping a record or how many patients are turned away. (See demand & capacity summary below)

**Opportunity to clarify the demand and capacity. Both hospitals will participate in a phone conference to establish a consistent method of counting indigent care in the ED.**

Other observations:

- Providers do not think there is a duplication of services, but they seem to agree there is a need for better coordination of services.
- Biggest need is dentistry and medications, followed by increased capacity.
- Commissioner Hoard feels that this is a regional problem and has of efforts to send uninsured patients to ACC.
- It is extremely difficult to find health educators fluent in Spanish and English.
- Wide philosophical differences on use of volunteers.
- Access to specialists is a major problem.
- Prevention may compete with primary care. Suggested that we view all of it as early intervention.

Group agreed with the "pearls" and further discussed the possibility of a communal release form and the World VISTA program which is free and has been used by the VA to track medical records.

It was pointed out that "best practices" are learned through the sharing of information which is enabled by standardized information gathering. It's no use going to an electronic format if you're gathering poor or incomplete information on you paper forms.

## Advantage Behavioral Health System:

James asked Terry to provide update on Advantage Behavioral Health Systems:

ABHS serves 10 counties and provides services for mental health, developmental disabilities, and substance abuse. They have a new crisis stabilization unit with 14 beds that operates 24/7. Patients stay around 3-4 days and this unit is always full. They also have a Women's Recovery Residential Program where women and have residential substance abuse treatment and have their children stay with them. This unit is also always full. ABHS gets between 1 and 2 calls a week for their residential programs and they have to turn people away- leaving people with staying in a hospital or nursing home equaling more expensive treatment.

ABHS also offers multiple outpatient programs including group and individual therapy and a crisis hotline. Requests for help are handled by their Access Unit which follows up with an intake within 24 to 48 hours, but follow up with a psychologist may take 4-6

weeks after intake. Funding is constantly being reduced- they've lost 25 positions and are starting their FY07-08 budget with a shortfall of $2.4 million. Even so, ABHS is one of the top 20 employers in the area. Their funding comes from State and Federal funds, DHR grants, Medicaid Fees, Waivers, contracts, client fees, other fees, local funds, private insurance and other areas. 97% of their customers live on less than $22,800 annually.

ABHS has had to restrict who they can serve to people with Axis I or II diagnoses- these are people with chronic and/or persistent mental illness. They no longer have the resources to serve dysthymic or mildly depressed individuals since they would only get 6 visits and this isn't enough to get them on medications that need to be monitored and are expensive.

All patents have a Community Support Case Manager and should have a primary care physician. In the case of patients without insurance, Mercy Clinic, Nurses' Clinic, and ANHC may be considered to be their primary care physician. ABHS does refer clients to Nurses, ANHC, Mercy, and ARMC. 20-30% of Nurses clinic clients are ABHS clients as well.

During the discussion it was pointed out that clinics are primary care providers and do not currently track who goes where. Is there excess utilization- clients shopping around? Either way, clients don't get followed longitudinally. Don't have communication/holistic approach. Mental health and physical health are seen as separate arenas, but mental health is a critical component of primary health care for this population. Mercy, Nurses, ANH are primary healthcare and triage for many ABHS patients. The Health Department's services are more specialized.

It would be good to coordinate primary care physicians and clinics with ABHS case managers. Even if case manager has not seen client in a long time- many of these conditions are relapsing. Farris expressed interest in coordinating with the Case manager. Laurie Wilburn would be the person to contact at ABHS.

## Outcome Measures:

Group discussed the importance of having measurable outcomes to determine the success of a plan to improve health at lower costs. Need to create a plan that increases Early Access/Intervention (which includes both prevention and primary care). One measure would be whether these efforts were leading to a decrease uncompensated care in the ER. But, also need to reduce unhealthy outcomes that affect poverty.

How should the Health Team measure its outcomes? A subcommittee will look at possible measures- Karen Schlanger, Claude Burnett, Mark Ebell by phone, and Deb Williams.

## ER Volume of Uncompensated Care:

ARMC and St. Mary's had to first agree on how to count uncompensated care within their ERs. They defined uncompensated care as visits that were categorized for billing as

charity, indigent care, and self pay. They exclude bad debt because they were unable to separate out people who could pay, but were not paying. Self pay is a better indicator of clients who do not have insurance and cannot pay their bills. "Charity" is determined by Federal guidelines. If someone makes less than $12,760 per year they are considered 100% indigent; if they earn between $12,760 and $20,000, they are charity; and if they earn between $20,000 and $40,000, they are partial charity.

54% of ARMC's uncompensated care comes from Athens-Clarke County patients. St. Mary's is similar. An additional 36% of ARMC's uncompensated care comes from patients from Madison, Jackson, Oconee, Barrow, Oglethorpe. (So these 5 counties represent 90% of ARMC's uncompensated care.) 6 counties, Athens, Madison, Jackson, Oconee, Barrow, Oglethrope, and Watlon account for 85% of St. Mary's uncompensated care.

## LEAD Athens Survey:

Mark Ebell gave summary of the results from a LEAD Athens Survey which polled 119 medical practices (Full results are below). 29 practices with 83 providers responded to the survey. Claude offered that the Health Department has a liaison to the primary care physicians in town and could take follow up surveys to those that did not respond.

Survey Highlights include:

- 62% accept patients without health insurance but require payment at the time of service (PATOS) and 7% do not accept patients without insurance. Remainder only accept uninsured by referral and may still require PATOS
- Only 36% do volunteer work (Mercy Clinic; health fairs; serving on community boards; administering diabetes education programs; Athens Justice Project; etc)
- 78% would not accept referrals from clinics for the uninsured
- Responses to the question "What would make it possible for your practice to see more patients with Medicaid and/or patients who are uninsured?" are shown below. Most physicians were concerned with inadequate or delayed payment, lack of resources or capacity at their site, and perceptions about the behavior of patients with Medicaid and the uninsured.

Overall, there is a perception that doctors are doing their fair share already and volunteering is not attractive. There is a great need- with Orthopedics a patient can't get in with Medicaid- only if they go to the ER and an Orthopedist is on duty.

## Uncompensated Care: Demand and Capacity Summary

Using the information presented by each provider at May 25th's meeting, James and Mark compiled a summary of Athens' demand and capacity for health services.

### Demand for ACC: 35,625 visits per year-

Assumptions

- 19% uninsured rate for ACC (from *Georgia* Health Policy *Center/*Georgia State University and GA County Guide; 2005 Census Estimate)

- Average visits per person per year = 2.5

Capacity for ACC: 10,000

Assumptions

- Mercy current volume = 1,100
- Athens Neighborhood Health Center current volume = 5,300 uncompensated (16,000 annual visits x 0.33 uncompensated)
- Nurses Clinic = 3,600

## Demand/Capacity Gap = 25,625

## Primary Care Provider Gap = 6 providers short

Assumptions

- A providers can see 3 patients per hour
- They have about 7 contact hours per day
- They work approximately 46 weeks a year
- Group consensus was that they could do about 4500 visits per year per provider
- 25,625/4500 = 5.69 or about 6 providers short

The group agreed with this logic and acknowledged that they could not just "better coordinate" their way into increasing their capacity by 6 providers per year. Some providers indicated that there was enough physical space between the Nurses Clinic, the new Mercy, and ANHC to almost meet the increase in volume needed to serve the gap, but that the issue was paying for physicians/nurses/technicians/staff.

The group also recognized that his number did not address the need for an increase in specialty care as well.

If the uninsured in Athens were seeing primary care physicians 2.5 times per year, they might generate more work for the hospitals and specialty providers, but the symptoms would be caught earlier and have fewer complications. This may reduce ER visits but not hospital admissions, but may lead to shorter stays.

Group discussed need to change both perception and reality of Medicaid hurtles so that specialty care would begin to accept Medicaid patients again.

## Next Meeting: Models of Coordination and Meeting Demand

The next meeting will focus on other community models for coordinating services and meeting demand. James spoke with the Georgia Health Care Foundation and got several examples for the group to investigate:

1. Macon- Greg Dent (Monica will follow up)
2. Dalton- Nancy Kennedy (Monica will follow up)
3. Georgia Association of Primary Health Care- Duane Kavka (Jennifer will follow up)

4. August MCG- Dean of Nursing (Deb will follow up)

Team members should find out what they are doing and how their work could translate to meeting our community's needs.

Group also suggested that we look at models for medical schools to serve as primary health care site for indigent care- possible for MCG in Athens.
**Next meeting will be Friday, June 22 from 12-2PM at St. Mary's.**

**Update:** ANHC did not get the Federally Qualified Health Center grant and will be unable to take patients that cannot pay for services as they have in the past.

# LEAD Athens Survey (March, 2007) – Executive Summary (Mark Ebell MD, MS)

**Provider Demographics**

- Of 119 practices approached, 29 practices with 83 providers responded to the survey.
- The typical practice has 2.4 physicians and 0.6 mid-level providers.
- The range of physicians was 1 to 8 and of mid-levels was 0 to 4.
- 24% provide primary care for adults and 28% for children
- 60% provide specialty care
- 14% do x-ray, blood tests and minor surgery

**Patient demographics**

- Race: approximately 60% non-Hispanic white 29% African-American, 8% Hispanic, 3% other
- Payment source: approximately 44% private insurance, 30% Medicare, 16% Medicaid/PeachCare, 10% self-pay
- Medicaid is as little as 0% and as much as 70% of responding practices
- Self-pay is as little as 0% and as much as 20% of responding practices

**Accepting new patients**

- 50% are accepting new patients with Medicaid, 29% are not, and 21% have some other policy (i.e. only children or only in consultation)
- 62% accept patients without health insurance but require payment at the time of service (PATOS) and 7% do not accept patients without insurance. Remainder only accept uninsured by referral and may still require PATOS

**Volunteer work**

- Only 36% do volunteer work (Mercy Clinic; health fairs; serving on community boards; administering diabetes education programs; Athens Justice Project; etc)
- 21% said they would volunteer if they could not be sued for malpractice; 40% still would not volunteer; 39% were unsure.
- 78% would not accept referrals from clinics for the uninsured

**General comments**

Responses to the question "What would make it possible for your practice to see more patients with Medicaid and/or patients who are uninsured?" are shown below. Most physicians were concerned with **inadequate or delayed payment**, **lack of resources or capacity** at their site, and **perceptions about the behavior** of patients with Medicaid and the uninsured.

They are grouped into sections by area of concern:

*Inadequate payment*

- Payment and no payment/referral hassles
- We see all the Medicaid we can afford to see since we take new babies with Medicaid
- To be properly compensated for the services rendered

- Increased reimbursements, less restrictive guidelines (prior approval, referral requirements, etc.) more prompt reimbursement. Medicaid system is not working
- If Medicaid would fix their computers so we could bill once and get paid the expected amount without having to submit and correct their errors and if they paid in a timely fashion. Medicare costs literally more in time to get bills paid than they pay
- If Medicaid were not so hard to deal with, we discount ~50% to Medicaid rates and we have to fight to get paid that. Before the change to Medicaid payment was low but at least they paid promptly. Of we get paid reasonable fee from insured pts. We could afford more time for indigent care. Costs to our practice go up and reimbursement goes down (all carriers) leaving very little time for volunteering or indigent care
- For Medicaid to pay better and pay on time

*Inadequate staffing or support*
- The ability to hire additional medical staff
- We are currently trying to recruit 3 additional physicians and we are already extremely over-extended
- Better administrative support. Many of these patients have complex medical and social problems which tie up administrative resources especially in a small office
- We are already at our max for uninsured patients. We receive 5+ uninsured patients weekly
- We'd need additional healthcare providers
- We see Medicaid and uninsured. Need is to have a POP or office of clinic for these pts. To be seen upon direction from hospital at SMH our group admits whoever needs admission through ER regardless of ability to pay.

*Perceptions regarding patient behavior*
- We do not limit Medicaid now- these 2 groups of patients can be extremely difficult to manage and are also very non-compliant
- Less paperwork and restrictions from moneyed Medicaid! Better show rate from the patients
- A "thank you" would be great-- from the patients

*Other comments*
- We only deal with workers compensation patients, pre-employment physicals, and drug screening
- Nothing at present time would change current office policies
- We do not turn away any pregnant patient with Medicaid therefore Dr. Desai has no time for any other volunteering
- Nothing
- We accept Medicaid, will accept if payment arrangements are made before
- We do not accept Medicaid, Peachcare, Amerigroup or Wellcare. Private pay pts. Are welcome with payment due at time of service
- We already feel like we do more than our share!