

OneAthens Health Team - Final Report

January 4, 2008

A message from the OneAthens Health Team:

Our team motto has been, “We will not be successful in this endeavor without ego-less collaboration with competitors and non-traditional partner organizations.” We have worked diligently to move beyond the status quo and to create a new model for basic health services for the underinsured and uninsured residents of our community. The economic impact from the lack of health insurance coverage on our residents, businesses, hospitals, and government is tremendous.

The cost of the uninsured goes beyond dollars – it is about community values. We know that the uninsured experience a 25% higher mortality rate, are more likely to experience pain and suffering, are less likely to receive preventative care, and children are less likely to achieve developmental and educational milestones, (Institute of Medicine, 2003a). We choose to believe that the residents of Athens-Clarke County value the dignity of every person within our community. As a matter of fairness, social decency, and economy, the OneAthens Health Team strongly encourages the co-conveners, the residents of Athens, and the State Legislature to support this plan.

OneAthens Health Team – Final Report

EXECUTIVE SUMMARY

Recommendation:

Create the OneAthens Healthcare Plan to serve the primary health care needs of the estimated 14,250 uninsured in Athens. The Plan will operate as a 501(c)3 (non-profit, tax-deductible organization) and have an initial work program with the following goals:

1. Create a local health coverage plan for primary care
2. Support designation as a Federally Qualified Health Center for Athens Neighborhood Health Center
3. Develop clinics into Medical Home model
4. Create a Health Outreach and Navigator Network
5. Create a Physician Referral System
6. Create a Medication Assistance Program
7. Develop Fundraising Strategies

Return on Investment:

- If fully funded, the benefit to ACC will be between \$7.62 and \$15.21 for every \$1.00 it invests in the OneAthens Healthcare Plan.

Background:

- 19% of Athenians are uninsured.
- There is the equivalent of only two full time providers (physicians, nurse practitioners, or physician’s assistants) dedicated to providing care for the uninsured among ACC’s three clinics serving this population.
- Five more full-time primary care providers are needed to provide a “medical home” to uninsured residents of ACC.
- 48% of uncompensated care in the local emergency departments is for residents outside of ACC.
- Many Athens physicians are reluctant to care for uninsured patients and either do not accept patients without insurance or require payment at the time of service. Some specialty medical care is unavailable for patients with Medicaid or without insurance.
- Racial and ethnic disparities in health care access and quality largely disappear when patients have a “medical home.”
- A change in rules for distribution of indigent care funding has resulted in a financial crisis for some clinics and the health department.
- There is currently no structure to facilitate collaboration among health care providers for the underserved population.
- There is no information system to connect clinics, hospitals, and providers. Lack of an information system could compromise patient safety, inhibits continuity of care, and is an obstacle to data collection.

INTRODUCTION

Access to quality health care must be a part of any initiative to reduce poverty. Without health, it is difficult to work, learn, and participate in the community. An ineffective health care system results in underserved populations accessing the most expensive and least consistent health care – the emergency departments. One way or another, we all pay for health care for the poor. A family of three with a household income of \$50,000 pays about \$800 annually toward the cost of the uninsured (Georgia Health Policy Center, 2006).

Physical and Mental Health was one of the original focus areas of the Partners for a Prosperous Athens (PPA) initiative. Since the launch of PPA on March 27, 2006, a Health Committee received feedback and discussed health issues for the underserved populations in Athens-Clarke County (ACC) and the region. Informed by the recommendations of the Health Committee, the PPA Steering Committee made health care a top priority for action and formed the OneAthens Health Team to “Create a plan to coordinate basic health services and develop a health foundation for those in and near poverty.” (www.prosperousathens.org). Many committee members were eager to discuss funding due to chronic and acute under funding especially in light of the recent changes in regulations for the Indigent Care Trust Fund which eliminated significant funding to clinics and health departments throughout Georgia. While these changes have made stable and sufficient funding even more elusive for community health care providers, the Health Team recognized that an innovative plan to provide care must be created before discussing funding. Further, the OneAthens Health Team recognized that a health foundation may not be a feasible solution to funding needs and it has refocused its mission to “Create a plan to coordinate and fund basic health services for those in poverty and near poverty.” The Team decided to divide its work of meeting this mission into four phases:

- Phase One: Demand and Capacity
- Phase Two: Successful Models
- Phase Three: Create OneAthens Healthcare Model
- Phase Four: Funding

This report provides a complete accounting of Phases One through Four and includes the summary of the Health Team’s final recommendation to the Co-conveners (see Appendix A).

PHASE ONE: DEMAND AND CAPACITY

We have not been successful in locating a comprehensive data source related to the health care for the underserved in our area. In some cases, we took pieces of data from various sources and made assumptions supported by anecdotal observations of committee members. In our opinions, poverty in ACC is well documented and ultimately this Team is an action team, not a research team.

Demand

There are approximately 14,250 uninsured Athenians. This was determined by multiplying the population of ACC without the students – 75,000 (Georgia County Guide; 2005 Census Estimate) by the 19% uninsured rate for the county (Georgia Health Policy Center, 2006). Patients visit their primary care doctor an average of 2.5 times per year. To reach every person living in poverty, the health system needs the capacity for 35,625 visits (14,250 x 2.5) a year.

The emergency departments of St. Mary's Health System and Athens Regional Medical Center treated 25,501 uncompensated care patients in 2006. Fifty-two percent of these visits were from ACC residents. Another 38 % were from the neighboring counties of Madison (11%), Jackson (10%), Oconee (6%), Barrow (5%), Oglethorpe (3%), Walton (2%), and Morgan (1%). The remaining 10% consist of other Georgia counties (8%) and out of state (2%).

There are three primary care clinics serving low-income individuals in Athens: Athens Neighborhood Health Center (two locations), Athens Nurses Clinic, and Mercy Health Center. Collectively the clinics handle 11,100 uncompensated care visits per year. Uncompensated care visits for each of the three clinics is:

- Athens Neighborhood Health Center: 5,300 (plus 10,700 visits with some compensation such as Medicaid)
- Athens Nurses Clinic: 3,600
- Mercy Health Center: 2,200

Additionally, the Clarke County Health Department (CCHD) provides many primary care programs focused on specific health problems.

Capacity

Clinics

The services offered by primary care providers at the three clinics only total approximately two full time positions. We arrived at this figure by determining the total number of hours of care delivered by primary care providers (physicians, nurse practitioners, and physician's assistants) available at each clinic. Athens Neighborhood Health Center is staffed by three full time physicians, five days a week, but only a third of their caseload is uncompensated care. The other two thirds of Athens Neighborhood Health Center's patients are covered by Medicaid, Medicare, and other private insurance. This means that ANHC has the full time equivalent of one primary health care provider dedicated to the uninsured. The Nurses clinic is open 16 hours per week and

has two nurse practitioners on staff. In looking at a full-time, 40 hour work week, the Nurses clinic has the full time equivalent of 0.8 (2 providers x 16hrs / 40) primary health care providers serving the uninsured. Given Mercy Health Center's primary care schedule of six hours every Thursday night and six hours on the second and fourth Tuesday of the month, we looked at their hours of care over a full-time, 80 hour two week time span. Mercy has 3 primary care providers giving care on both Thursdays (3 providers x 12hrs) and 2 primary care providers giving care on a Tuesday (2 providers x 6hrs) totaling 48 hours of care over a two week period. This translates into the full time equivalent of 0.6 (48hrs / 80hrs) primary health care providers. When the provider hours for all three clinics are added together, the total is the full time equivalent of 2.4 primary care providers dedicated to serving the uninsured. Staffing may vary depending upon provider availability, therefore the 2.4 full time equivalents is the maximum that the current system provides. These calculations do not take into account the primary care programs offered by the Clarke County Health Department (see below for more information).

Athens-Clarke County needs the equivalent of five more full-time primary care providers (physicians, nurse practitioners, or physician assistants) to accommodate the needs of the uninsured. We arrived at this figure by taking the demand for primary care visits by the uninsured (35,625) and subtracting the current number of visits to the three clinics (11,100) to determine that there is a need to increase the capacity by 24,525 visits per year. We assumed that a provider could see approximately 4,830 visits per year based upon three patients per hour, seven contact hours per day, and working five days a week for 46 weeks per year. We arrived at the five provider deficit figure by dividing the unmet need (24,525) by the provider visits per year (4,830), which equals 5.08 additional providers needed. This estimate may be low, since uninsured patients and patients in poverty may have greater healthcare needs than national averages such as higher rates of hypertension, diabetes, depression, substance abuse, and anxiety disorders.

There is enough physical space (empty exam rooms, potential for expanded hours of operation, etc.) in the clinics to accommodate five additional providers. The clinics report that their greatest challenges are funding, affordable medications, oral health, translators, and specialists. An information system linking the clinics and hospital would improve the continuity of care and facilitate data collection. There is no overarching structure currently in place to promote collaboration among the existing clinics and associated providers.

Medical Community

It is difficult to determine how much of the need is being met by primary and specialty care physicians in the community. During the PPA community listening phase, Athenians shared stories about the dwindling number of physicians accepting Medicaid; difficulty in scheduling appointments; payment required prior seeing the physician; and specialists refusing to see anyone who is uninsured. The Health Team accessed two surveys as well as the expertise of Health Team members to understand this issue further.

In a March 2007, twenty-nine practices representing eighty-three physicians responded to a LEAD Athens survey. 78% of the responding physician practices indicated that they would not accept a referral from clinics for the uninsured. Nearly two-thirds of the respondents (62%) indicated they would accept uninsured patients as long as they are paid at the time of service, 3%

said they generally don't accept uninsured patients, 7% accept uninsured patients without any restrictions, and 27% will accept uninsured patients with restrictions such as a payment plan, only if admitted through the emergency room, etc. In other words, if a patient is uninsured and can't pay up front, over 65% of Athens physicians will not provide care to the patient (See Appendix B).

Comments by the LEAD survey participants indicate concern about being overloaded with uninsured and Medicaid patients, frustrations with the Medicaid bureaucracy, and being overworked. Comments to committee members by physicians confirm concern about being overloaded with uninsured and Medicaid patients. This is not unique to our community. While implementing a health plan for the underserved population of Ingham County, Michigan, many physicians expressed skepticism. Ingham County found that some physicians expressed "donor fatigue" and were reluctant to accept more patients in addition to the services they already provide to low-income individuals.

From August to November 2007, the Athens Clarke County Health Department interviewed 166 physicians in Athens-Clarke County to determine their attitudes and practices regarding acceptance of Medicaid patients as well. They found that 34% of primary care physicians do not have any Medicaid patients and 59% are not accepting any new Medicaid patients. When specialists and primary care physicians are combined, 77% are not accepting new Medicaid patients.

Some specialists are not available to Medicaid patients or are minimally available. No orthopedists are accepting new Medicaid patients. Only 29% of Family Practice physicians, 33% of Internal Medicine physicians, 33% of Cardiologists, and 40% of Dentists are accepting new Medicaid patients. The Health Department survey found that overall only 15% of physicians who responded volunteer their services (See Appendix C).

Mercy Health Center has been successful in attracting medical volunteers; however the clinic hours are very limited. The Good News Clinic in Gainesville, Georgia has approximately 40 physician volunteers. In Buncombe County, North Carolina, a system known as Project Access was developed to evenly distribute patients among physicians who agreed to participate. Approximately 90% of Buncombe County physicians agreed to participate. The medical society recruits physicians into the program and each physician is guaranteed that they will only receive a predetermined number of patients. This program is now in place in over 20 communities throughout the United States. It should not be overlooked that there are many wonderful examples of nurses, physicians, and other health professionals in the Athens community who are donating their time to improve our community. Since the OneAthens Health Team's work has become public, many people in the health care community have stepped forward to ask how they can help.

Clarke County Health Department

The Clarke County Health Department (CCHD) provides many primary care programs focused on specific health problems. It offers immunizations; reproductive and women's health services, birth control, STD treatment, breast and cervical cancer screening and treatment; Women, Infants, and Children (WIC) nutrition program; TB testing and treatment; hypertension and

diabetes treatment and medication; prenatal services; HIV/AIDS testing and treatment; Children's Medical Services including treatment for asthma, hearing, orthopedic, and other problems; early intervention for babies with major developmental problems such as autism and cerebral palsy. CCHD sees approximately 50,000 visits (20,000 patients) per year. The CCHD funding has been significantly impacted by the change in the rules for distribution of the Indigent Care Trust Fund and Medicaid that have kept the health department functioning as county funding has fallen off over the last 20 years.

Advantage Behavioral Health Services

Mental health and physical health providers tend to operate in separate silos of care. Advantage Behavioral Health Services (ABHS) serves 10 counties and provides both in-patient and outpatient services for mental health, developmental disabilities, and substance abuse. ABHS turns away one to two calls a week for their residential programs, which are always full. This results in patients staying in more expensive treatments such as a hospital or nursing home. Requests for help are handled by the Access Unit that follows up within 24 to 48 hours, but follow up with a psychologist may take 4-6 weeks.

Ninety-seven percent of their clients live on less than \$22,800 annually. Mental Health stability is a major component in maintaining a job, following physical health guidelines, and staying out of poverty.

Racial and Ethnic Disparities

There is a substantial body of research and literature indicating that there are racial and ethnic disparities in health care access and quality (Institute of Medicine, 2003b; Lurie & Dubowitz, 2007; Morehouse, 1999; Trivedi, Zaslavsky, Schneider, & Ayanian, 2006). Disparities largely disappear when patients have a medical home, insurance coverage, and access to high quality services and systems of care (Beal, Doty, Hernandez, Shea, & Davis, 2007). 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
- Office visits are well organized and on schedule

Recognizing the value of the medical home concept, the OneAthens Health Team adapted the definition to incorporate it as part of its strategy. The OneAthens definition of medical home is a local healthcare system that:

1. Establishes a provider network;
2. Includes a basket of services: chronic disease management, wellness and health maintenance, and acute illness care;
3. Provides reasonable access to network providers by phone;
4. Ensures the ability to obtain acute care or advice within 24 hours including nights and weekends;
5. Ensures that office visits are well organized and that the schedule and wait times meet recognized standards; and
6. Provision of and/or capacity for referral for education and social service navigation.

PHASE TWO: MODELS

There is no perfect model that will meet all the healthcare needs of the underserved population in every community. The Health Committee needed to study models from different communities to identify common successful strategies that would stimulate creative thinking about what would be successful in Athens-Clarke County. In addition to studying the models, we contacted key people in successful communities, at Foundations, or in academic institutions to find out information that may not have been published. The Health Team identified several models and model components that could be applicable to Athens. A complete list of models and components studied has been included as Appendix D.

After looking at all of the possibilities, the Health Team determined which components would be most effective in Athens and developed the OneAthens Healthcare Model.

PHASE THREE: ONEATHENS HEALTHCARE MODEL

Create the OneAthens Healthcare Plan to serve the primary health care needs of the estimated 14,250 uninsured in Athens. The Plan will operate as a 501(c)3 (non-profit, tax-deductible organization) and have an initial work program with the following goals:

1. Create a local health coverage plan for primary care
2. Support designation as a Federally Qualified Health Center for Athens Neighborhood Health Center
3. Develop clinics into Medical Home model
4. Create a Health Outreach and Navigator Network
5. Create a Physician Referral System
6. Create a Medication Assistance Program
7. Develop Fundraising Strategies

Health Coverage Plan

This plan is not health insurance, but does provide basic primary care and prevention coverage to uninsured people. The plan would provide limited coverage for primary care and prevention for the 14,250 uninsured individuals in Athens. Individuals would need to be enrolled to become members of the health coverage plan. The enrollment process would ensure clients are in or near poverty and do not have any health insurance. The plan will also be limited to ACC residents and will require a co-payment. In the beginning stages, Athens Neighborhood Health Center, Nurses Clinic, Mercy Health Center, and the Health Department would be the only providers eligible to apply for reimbursement and quality controls will ensure that the clinics have provided service before reimbursement is made. Reimbursements will be similar to the average Medicaid reimbursement. Reimbursements from this health coverage plan will allow the clinics to receive funds from clients who currently cannot pay as well as new clients. Improved reimbursement to the health clinics via the health plan will eliminate the deficit of primary care providers. If funding were available, Phase 2 would provide expanded coverage for dental, vision, and mental health. The plan will have oversight from a Board of Directors.

Federally Qualified Health Center

Federally Qualified Health Centers (FQHC) are often the cornerstone of community systems to provide health care to underserved populations. If approval is received, federal money is matched with local support to ensure there is a medical home for the low-income and underserved in an area. In addition to federal money, the FQHC designation allows a clinic to obtain physicians from the National Health Service Corps, decreases liability insurance costs, provides loan forgiveness for healthcare professionals, provides medications for reduced cost, etc... FQHC designation would help all the clinics, not just Athens Neighborhood Health Center (ANHC). The ANHC applied for FQHC designation and was denied. Facilitated by the efforts of OneAthens Health Team, Congressman Broun's office is working with ANHC to obtain designation when the next application period becomes available.

Medical Home Model

Within the context of the OneAthens Healthcare model, a Medical Home is defined as a provider network that:

1. Establishes a provider network;
2. Includes a basket of services: chronic disease management, wellness and health maintenance, and acute illness care;
3. Provides reasonable access to network providers by phone;
4. Ensures the ability to obtain acute care or advice within 24 hours including nights and weekends;
5. Ensures that office visits are well organized and that the schedule and wait times meet recognized standards; and
6. Provision of and/or capacity for referral for education and social service navigation.

While the clinics do not currently meet this definition individually they have agreed to work towards meeting these goals. Increased funding through the health coverage plan and the Federally Qualified Health Center as well as increased community outreach through the Outreach and Navigator Network and Physician Referral System will ensure that indigent patients have a regular provider, are able to contact their provider, and have coverage on evenings and weekends.

Health Outreach and Navigator Network

The Health Outreach and Navigator Network will provide holistic follow-up for low-income Athenians who utilize the clinics and ER to help them navigate the healthcare system as well as enroll hard to reach uninsured members of the community into the health coverage plan.

Community-Based Health Navigators' duties should include:

1. Assist in Accessing Care and Medical resources (including medications and equipment)
2. Identify appropriate and available resources
3. Follow up on "Health Care" visits
4. Community-based Health Researchers
5. Offer Community-based Health Education

Outreach Network Structure should involve several layers: A broader layer would be Community-Based Navigators who are community members who help guide people into the system and the central layer are Nurse and Social Work Case Managers who follow up with

patients and help with the paperwork of enrollment in the health coverage plan as well as accessing other health and social service resources.

Case Managers and Community-Based Navigators will help decrease visits to the ER by providing disease management, health promotion reminders, and connection to existing resources.

Physician Referral System

The Physician Referral System coordinates donated medical services provided by primary and specialty care physicians in their offices for uninsured and low-income Athenians. System staff coordinates patient visits and follows up with patients to connect them to other resources. This System is an affordable way to increase the number of physicians serving the uninsured in Athens and expands the reach of the healthcare coverage plan by providing health plan members and nonmembers with greater access to primary and specialty care. The System will evenly distribute patients to physicians in order to increase physician's willingness to provide uncompensated care.

Medication Assistance Program

A Medication Assistance Program will help patients access medicines at affordable rates. Discount programs already exist through drug manufacturers, but patients need help filling out the extensive paper work. In addition, clinics can coordinate buying power with pharmacies and hospitals. This Program will develop in conjunction with the Federally Qualified Health Center designation and the Case Managers from the Health Outreach and Navigator Network.

PHASE FOUR: FUNDING

Cost

The OneAthens Health Team has worked diligently on a volunteer basis to develop this Plan; however, the time has come to hire staff to bring this Plan to fruition. The Plan’s extensive collaboration, coordination, organization, and evaluation will require full time attention; therefore we recommend that a director of the overall program be hired immediately. Other positions, such as manager of health plan, manager of outreach/navigation, and case managers, will be needed soon depending on when funding is available.

The estimated annual costs for this plan are:

1. Local Health Coverage Plan for primary care.
 - Estimated costs: \$2,200,000 (\$61 per visit x 35,625 visits)
2. Federally Qualified Health Center designation for Athens Neighborhood Health
 - Estimated costs: Application consulting services currently donated to ANHC
3. Develop clinics into Medical Homes
 - Estimated costs: Commitment obtained from clinics to move in this direction with funding from Local Health Coverage Plan
4. Health Outreach and Navigator Network
 - Estimated cost: Four nurse case managers, two social work case managers, and nurse program manager. (See estimated summary of costs below)
5. Physician Referral Network.
 - Estimated Cost: \$280,000. This is a mid-range estimate based upon Gainesville, GA (\$170,000) and Buncombe County, NC (\$390,000).
6. Medication Assistance Program
 - Estimated cost: Part of #'s 2 and 4.

Estimated Summary of Costs

Overall Director	\$125,000
Manager of Health Plan	\$100,000
Manager of Outreach/Navigation	\$ 75,000
Nurse Case Managers	\$208,000
Social Work Case Managers	\$ 83,200
IT Manager	Volunteer or donated
Health Plan	\$2,200,000
Referral Network	\$ 280,000
Estimated Total	\$3,071,200

Funding

Funding for this plan will likely come from a variety of sources. We recommend working with ACC, state government, the federal government, area hospitals and foundations to secure funding for a five-year period. Sustaining funding will be developed during the initial five-year period.

Return on Investment

It is difficult to calculate the exact financial return that an investment in healthcare makes for a community, but all of the evidence shows the economic returns are great. The two hospitals provided \$79 million in charitable and uninsured care in 2005. The average cost of an emergency department visit in the U.S. is \$319. Athens Regional Medical Center and St. Mary's had 25,501 uncompensated emergency department (ED) visits last year and, taking into account the typical ED visit cost, this means they provided \$8,134,819 in uncompensated emergency department care. If these 25,501 uninsured patients were all treated through the OneAthens Healthcare Plan the total cost would be \$1,555,561.

Research has shown that the entire community suffers when there is a high uninsured rate. Even for people who have insurance, health services are less available and overburdened in communities with a large uninsured population. Public health spending for disease prevention, communicable disease control, immunizations, and other services is often reduced due to competing demands for funding. There are overall increased costs for public programs and decreased employee productivity (IOM, 2003a). One way or another, we all pay for health care for the poor. A family of three with a household income of \$50,000 pays about \$800 annually toward the cost of the uninsured (Georgia Health Policy Center, 2006).

The cost of the uninsured to the individual and the community are tremendous. According to a report from the Institute of Medicine (IOM) (2003a) "the economic value of the healthier and longer life that an uninsured child or adult forgoes because he or she lacks health insurance ranges between \$1,645 and \$3,280" for each year without coverage (p. 3). Multiplying these figures by the number of uninsured people (14,250) in ACC results in an annual economic cost to this community of \$23.4 to \$46.7 million annually.

For \$3,071,200, the Athens-Clarke County community receives a return of between \$7.62 and \$15.21 for every \$1.00 it invests in the OneAthens Healthcare Plan.

This return on investment is staggering; however, attending to healthcare needs cannot be effective if other needs are not also met. Research affirms the multi-faceted approach that PPA and OneAthens have developed. Dr. Anne Beal, author of "Closing the Divide: How Medical Homes Promote Equity in Health Care," found that health outcomes are impacted equally by health care issues (access, effectiveness, safety, and financing) and non-medical issues such as living and working conditions, income, and stress. To create the healthiest Athens and achieve the best return on its healthcare investment, the community must recognize that all barriers to prosperity are interconnected and that any successful strategy to address healthcare needs must happen alongside the other PPA and OneAthens strategies that address non-medical issues.

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APPENDIX A: OneAthens Healthcare Plan

Create the OneAthens Healthcare Plan to serve the primary health care needs of the estimated 14,250 uninsured in Athens. The Plan will operate as a 501(c)3 (non-profit, tax-deductible organization) and have an initial work program with the following goals:

GOAL 1: CREATE A LOCAL HEALTH COVERAGE PLAN FOR PRIMARY CARE

- Focus: reimbursement for primary care services for the 14,250 uninsured in Athens
- Initially, this Plan will reimburse for primary care provided to Plan members being seen at Athens Neighborhood Health Center, Nurses Clinic, and Mercy Health Center, and some primary care services at Clarke County Health Department. This will increase capacity (both hours and number of staff) of the clinics.
- Estimated costs: \$2,200,000 (\$61 per visit x 35,625 visits – patients visit doctor on average 2.5 times per year)

GOAL 2: SUPPORT DESIGNATION AS A FEDERALLY QUALIFIED HEALTH CENTER FOR ATHENS NEIGHBORHOOD HEALTH CENTER

- Focus: FQHC designation ensures improved reimbursement rates, creates access to best prices for pharmaceuticals, and includes gaining status as a health professional shortage area which allows doctors, dentists, mental health professionals, and nurses to work with clinics to pay off student loans.
- Estimated costs: Application consulting services currently donated to ANHC

GOAL 3: DEVELOP CLINICS INTO “MEDICAL HOMES”

- A Medical Home is defined as a provider network that establishes a provider network; includes a basket of services: chronic disease management, wellness and health maintenance, and acute illness care; provides reasonable access to network providers by phone; ensures the ability to obtain acute care or advice within 24 hours including nights and weekends; ensures that office visits are well organized and that the schedule and wait times meet recognized standards; and provision of and/or capacity for referral for education and social service navigation.
- Focus: ensure indigent have a regular provider, able to contact provider, coverage on evenings and weekends.
- Estimated costs: Commitment obtained from clinics to move in this direction with funding from Local Health Coverage Plan

GOAL 4: CREATE HEALTH OUTREACH AND NAVIGATOR NETWORK

- This Outreach Network will provide holistic follow-up for low-income Athenians who utilize the clinics and ER to help them navigate the healthcare system as well as enroll hard to reach uninsured members of the community into the Coverage Plan.
- Focus: Case Managers and community-based volunteers decrease visits to ER, provide disease management, health promotion reminders, and connection to existing resources.
- Cost: Four nurse case managers, two social work case managers, and nurse program manager. (see cost structure below)

GOAL 5: CREATE A PHYSICIAN REFERRAL SYSTEM

- The Physician Referral System coordinates donated medical services provided by primary and specialty care physicians in their offices for uninsured and low-income Athenians. System staff coordinates patient visits and follows up with patients to connect them to other resources.
- Focus: Evenly distribute patients to physicians in order to increase physician's willingness to provide uncompensated care.
- Cost: \$280,000 to coordinate the recruitment of volunteer physicians and the disbursement of patients. This is a mid-range estimate based upon Gainesville, GA (\$170,000) and Buncombe County, NC (\$390,000).

GOAL 6: CREATE A MEDICATION ASSISTANCE PROGRAM

- A Medication Assistance Program will help patients access medicines at affordable rates
- Focus: Discount programs already exist through drug manufacturers, but patients need help filling out the paper work. In addition, clinics can coordinate buying power with pharmacies and hospitals for pharmaceuticals not included in discount programs.
- Cost: Part of Goals 2 and 4

GOAL 7: DEVELOP FUNDRAISING STRATEGY

- Work with ACC, State Government, the Federal Government, area Hospitals, and Foundations to secure funding for a five year period. Sustaining funding will be developed during the initial five year period.

OneAthens Healthcare Plan Estimated Staffing Timeline

Action	Target Date
Support Federally Qualified Health Center designation for Athens Neighborhood Health Center	Ongoing
Hire overall director	4/1/08
Director coordinating with agencies, government, & local contacts to establish funding, policies, & support. Coordinates other pieces of the recommendations. Applies for grants. Establishes legal structure (501c3). Hires other key people.	4/1/08 – 8/30/08
Hire Manager of Health Plan	6/1/08
Engage volunteer IT manager	6/14/08
Hire Outreach/Navigation Manager	8/1/08
Implement Health Plan	9/1/08
Hire Case Managers	10/1/08
Establish Navigators/Outreach workers	12/1/08
Establish Referral Network	5/1/09
Create Medication Assistance Program	Ongoing

Estimated Summary of Costs

Overall Director	\$125,000
Manager of Health Plan	\$100,000
Manager of Outreach/Navigation	\$ 75,000
Nurse Case Managers	\$208,000
Social Work Case Managers	\$ 83,200
IT Manager	Volunteer or donated
Health Plan	\$2,200,000
Referral Network	\$ 280,000
Estimated Total	\$3,071,200

APPENDIX B: LEAD Athens Physician Survey Results

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 Health Center; 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!

APPENDIX C: Health Department Survey of Athens Clarke County Doctors

From August 2007 to November 2007, 166 physicians in Athens-Clarke County, Georgia were interviewed to determine their attitudes and practices regarding acceptance of Medicaid patients. Interviews were conducted primarily by in-person questioning of office staff or the practicing physician. Data was compiled and percentage of response determined for each category. The questions asked are appended at the end of the summary tables.

Summary Table

Question	Percent
All Physicians Accepting Medicaid Now	68
All Physicians Accepting New Medicaid Patients	23
Primary Care Physicians Accepting Medicaid Now	66
Primary Care Physicians Accepting New Medicaid Patients	41
Physicians Volunteering Services	15

Percent Volunteering Services By Specialty

Specialty	Percent
Cardiology	17
Dentistry	25
Dermatology	0
Eye Doctor	46
Family Practice	24
Internal Medicine	9
OBGYN	6
Oncology	0
Orthopedists	25
Pediatrics	0
Pulmonologists	0

Percent Accepting Medicaid Now By Specialty

Specialty	Percent
Cardiology	83
Dentistry	45
Dermatology	25
Eye Doctor	91
Family Practice	76
Internal Medicine	76
OBGYN	72
Oncology	100
Orthopedists	25
Pediatrics	100
Pulmonologists	100

Percent Accepting New Medicaid Patients By Specialty

Specialty	Percent
Cardiology	33
Dentistry	40
Dermatology	25
Eye Doctor	73
Family Practice	29
Internal Medicine	33
OBGYN	61
Oncology	50
Orthopedists	0
Pediatrics	43
Pulmonologists	100

Reasons for Not Accepting Medicaid Patients

Problem	Percent Reporting
Too much paperwork	4
Too Costly	14
Not receiving Reimbursements	2
Patients too Difficult	3

Medicaid Survey

1. What is your medical specialty?

2. Are you a primary care provider? Yes No

3. Do you volunteer your services other than for hospital on-call? Yes No
Unknown

4. Do you accept Medicaid now? Yes No
If not, why not?
 - a. too much paperwork/hassle
 - b. reimbursement amount doesn't cover costs
 - c. reimbursements never received
 - d. too many changes at legislative level
 - e. patients are difficult to deal with
 - f. uncertainty whether services will be covered
 - g. difficult to resolve problems with a claim
 - h. not the type of patient I want to see
 - i. other: _____

5. Do you currently accept new Medicaid patients? Yes No

APPENDIX D: Health Care Models Studied from Other Communities

Ingham County Health Plan: This is a basic health coverage plan in the Lansing, Michigan area. The plan has been replicated through out Michigan and now covers 53 counties.

Website: <http://www.communityvoices.org/Community.aspx?ID=10>

Community Voices: Originally established with a grant from the W.K. Kellogg Foundation, this program is now administered by the National Center for Primary Care at Morehouse School of Medicine. The purpose of Community Voices is to make health care available to all. They have eight community-base demonstration projects designed to serve as learning laboratories to sort out what works and what doesn't in meeting the needs of those who receive inadequate or no health care. The eight demonstration projects are in the following locations: Ingham County, Michigan; Baltimore; Miami; Albuquerque, New Mexico; Oakland, California; Denver; New York; and Pinehurst, North Carolina.

Website: <http://www.communityvoices.org/>

Hillsborough County Florida: The goal of this community health plan is, "To assure within available resources, the delivery of quality health care for the County's eligible medically poor residents who lack other coverage" (Hillsborough County Florida, 2005, p. 8).

Website: <http://www.hillsboroughcounty.org/hss/hhcprogram/resources/publications/hscFinalReport.pdf>

Project Access, Buncombe County, North Carolina: This is a referral service to connect underserved patients with volunteer physicians. The patients are seen in the physician's offices and the referral service evenly distributes patients so that no physician is overloaded. The program is now in place in over 20 communities.

Website: <https://www.projectaccessonline.org/pa/pp/>

Buncombe County also has a health foundation,

Website: <http://www.buncombecounty.org/governing/depts/health/PHF/phFoundation.htm>

Promotoras de Salud: Outreach workers work to improve the health of the Hispanic community. This program is currently in place in Dalton, Georgia.

Community Health Works: Seven counties in central Georgia use this program to provide services for uninsured clients with diabetes, hypertension, cardiovascular disease, and/or depression. The program offers case management, pharmaceutical assistance, a medical home, and tracking of hospital and emergency department utilization. Website:

<http://www.chwg.org/>

Ascension Health's 5-Steps to 100% Access: Ascension Health is the largest Catholic and largest nonprofit health care provider in the United States. The goal of this project is to provide 100% access to health care by 2020 in the communities they serve. A demonstration project in Travis County, Texas was successful in improving access to care, reducing emergency department visits, providing a broader scope of care, and improving physician satisfaction. Major components of the plan included Project Access referrals to medical

homes; case management; disease management; an information system linking providers, clinics, and hospitals; dental care, and pharmacy assistance.

Montana Model: Located in Billings, Montana, this model is a partnership between a community health center, the health department, and a family medical residency program from the University of Washington Medical School.

Website: <http://archive.naccho.org/modelPractices/Result.asp?PracticeID=71>

Marion County, Florida Indigent Care Program: This is a public private partnership to coordinate health services to the underserved population. Services include prevention, primary care, minor emergencies, specialty physician care, and hospital based inpatient and outpatient services. A mobile clinic is used to reach those residents who are unable to travel to established providers.

Website: <http://archive.naccho.org/modelPractices/Result.asp?PracticeID=148>

Components of Models

The following are key components of the above models:

- **Outreach Network with Community-Based Health Navigators:** The Outreach Network often includes Nurse Case Managers and Social Work Case Managers as well as Community-Based Health Navigators. Navigators may be individuals from low-income and marginalized communities who have an interest in helping people engage and navigate the local healthcare system. Case Managers help clients with high utilization of services (i.e. ER) and chronic conditions (diabetes, hypertension, cardiovascular disease) to find a medical home. They utilize a system thinking approach that spans the continuum of care. 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
- **Primary Care Providers (PCP):** Increase PCP's utilizing a mixture of physicians, nurse practitioners, and physician's assistants.
- **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.
- **Federally Qualified Health Center Designation:** FQHC's are often the cornerstone of systems to provide health care to underserved populations. If approval is received, federal money is matched with local support to ensure there is a medical home for the low-income and underserved in an area. 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. FQHC designation would help all the clinics, not just Athens Neighborhood Health Center.

- **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 basic health coverage to uninsured people. May tie into other PPA initiatives and the business community.
- **Oral Health Plan:** Oral health is closely linked to overall health.
- **Medications:** A major need identified by the clinics, the community and is a part of most models.
- **Mental Health:** According to the case manager in the emergency department of Athens Regional Medical Center, the vast majority of repeat uninsured visits are for mental health or substance abuse.
- **Information System:** Important for continuity of care, case management, and collection of data.
- **Medical Residency Program:** Either in conjunction with the Medical College of Georgia or another medical school create a residency programs in primary care specialties (Internal Medicine, Family Medicine). These residents would see patients without insurance or with Medicaid in their residency clinic. This could tie into the future Navy School plans, but could also stand alone.
- **School-Based Clinics:** Engages children and entire family. Removes health care from teacher's responsibilities. Opportunities for health promotion and education.
- **Men's Health Focus:** According to Dr. Teadwell, Director of Community Voices, 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.
- **Mobile Clinic:** Marion County Florida and Dekalb County Georgia have used mobile clinics to take health care to the hard to reach populations.
- **Referral System:** Physicians volunteer their time, but aren't overburdened because Project Access distributes clients evenly.
- **Volunteer Coordination:** A centralized volunteer coordination program to get medical volunteers.
- **Supplies and Equipment:** Possible collaborative buying power via hospitals.
- **Grant Writing:** Centralized grant writer for all PPA initiatives.

APPENDIX E: Health Team Participants

Team Members:

James Shrum, *Chair, PPA Steering Committee & Athens Regional Medical Center*

Trina von Waldner, *UGA School of Pharmacy*

Claude Burnett, *Athens-Clarke County Health Department*

Lisa Caine, *PPA Steering Committee & Our Daily Bread*

John Culpepper, *Athens-Clarke County Finance Department*

Virginia Day, *PPA Steering Committee & St. Mary's Healthcare System*

Diane Dunston or Jennifer Richardson, *PPA Steering Committee & Athens Neighborhood Health Center*

Mark Ebell, *Athens-Clarke County Board of Health & Medical College of Georgia Faculty*

Sherrie Ford, *Power Partners*

Bob Galen, *UGA School of Public Health*

Kathy Hoard, *Athens-Clarke County Commission*

Tracie Jacobs, *Athens-Clarke Consumer Representative*

Farris Johnson, *Family Practice*

Monica Knight, *PPA Steering Committee & Clarke County School District*

Pamela Robinson, *WellCare*

Karen Schlanger, *UGA Cooperative Extension*

Terry Tellefson, *PPA Steering Committee & Advantage Behavioral Health Systems*

Tracy Thompson, *Mercy Health Center*

Deb Williams, *Nurses Clinic*

Alison McCullick, *UGA Health Initiatives*

Staff:

Delene Porter, *Faculty, UGA Fanning Institute*

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