Full Committee Meeting Notes

Committee: **Access of Quality Health Services**
Date of Meeting: **February 23, 2005, 10am – 12pm**
Location: **University of Maryland**
655 West Baltimore Street, Room BRB 14-007
Baltimore, Maryland

In Attendance

Committee:

Co-Chairs Dr. Claudia Baquet, Ms. Sherry McCammon

Members

Tashuna Albritton, Barbara Andrews, Susan Antol
Harolyn Belcher, Donna Brown, Stacey Davis
Lisa Green, Keri Hyde, Joanne Kraus
Donna Lee, Nicole A. Leonard, Christine Moghimi
Stephanie Parker, Keisha Perrin, Elisha Pulivarti
Alison Shipley, Loretta Wall, Joan Washington
Rebecca Wiseman, Melissa Wu, Janet Yoder
Laurie Zephyrin

New Members:

Last Name	First Name	Title/ Affiliation
Rubio	Cynthia	Frederick Co. Parish Nurses
Ryan	Karen	Johns Hopkins Hospital

Co-Staff: Arlee W. Gist, Lead Staff

MHHD Staff: Carlessia Hussein, Janet Adams

Total Attendance: **29**

Meeting Summary and Key Points

- Attendee introductions were made.

- Dr. Baquet confirmed the committee's acceptance of the January 25, 2005 meeting notes. No changes were made to the notes.

- A proposed problem list was presented to the committee**.** The problems were listed under the following subheadings: (1) Barriers to quality once care is obtained; (2) Fiscal

barriers to obtaining care; and (3) Manpower distribution barriers to obtaining care. It was determined that the problem list might be a good reference for future committee work. NOTE: The problem list was drafted using notes from the January 2005 meeting, co-chair feedback, and conclusions from other minority health plans across the United States.

- A proposed format for the June 30th report was also presented. The format was drafted by MHHD staff and approved by co-chairs in advance of meeting. The proposed report chapters for this committee are (1) System Barriers to Quality Services; (2) Financial and Geographic Barriers to Access; and (3) Improving Health Promotion and Disease Prevention. The format outline includes sections for determining problems and developing goals, solutions (recommendations) and strategies in response to the problems.

- Everyone agreed to break out in sub-committees to better address the multi-faceted tasks of the [full] committee. Sub-committees will use the proposed report's chapters as assignment focus. Volunteer sub-committee chairs are (1) Lisa Green, (2) Stacey Davis and (3) Donna Lee. Each sub-committee is responsible for identifying a scribe to take notes during their sessions and forward the notes to the Committee Lead Staff (Arlee Gist). Ms. Gist will attach sub-committee notes to the [full] committee meeting summary for distribution.

- Members selected the sub-committee best suited for them and the groups worked on their assigned chapter outline for one hour.

- The [full] committee re-convened and subcommittee chairs reported:

  <u>Subcommittee (1)</u> focused on the [problems] associated with system barriers to quality services. The problem list included a shortage of providers; the fragmentation of systems; inadequate system tracking; lack of advocacy; patient/customer illiteracy; lack of access to providers with specialized services (e.g., dental services, mental health services). { See subcommittee notes}

  <u>Subcommittee (2)</u> reported that financial and geographic barriers to access are relative to the insured (patient) and insurer [problem]. The subcommittee also noted enrollment barriers as a problem. One [goal] considered during the session was to promote partnerships and linkages between government and community sectors. {See subcommittee notes}

  <u>Subcommittee (3)</u> identified several [problems] and [challenges] with health promotion and disease prevention. The list included lack of cultural sensitivity; poor provider/patient communication; disregard for the importance of patient medicine management at home; technological barriers; and patient illiteracy (general and health). The subcommittee presented objectives and [strategies] to improve communication, patient self-efficacy, health literacy and provider bed-side-manner. {See subcommittee notes}

- Dr. Hussein and Dr. Baquet closed the [full] committee meeting commending the subcommittees for their productive sessions.

FOLLOW-UP

Action Steps

- Each subcommittee will determine how their group will communicate between[full] meetings. Subcommittees will summarize group work and forward notes to Arlee Gist. Notes will be attached to [full] committee meeting notes and distributed. MHHD will not staff subcommittees.

- MHHD staff will resend "Invitation to Join Committees" email to support committee new member recruitment.

- **Next meeting will be on Thursday, March 24, 2005 at from 10:00am – 12:00pm.** The location has not been determined.

- Send information and address questions to Arlee Gist, Committee Lead Staff; email agist@dhmh.state.md.us.

Parking Lot Items – NONE

Sherry Livick McCammon led the subcommittee's discussion on 2/23/05. Attendance was recorded.

Definition of Chapter's Area of Concern: Systems Barriers to Quality Services following when an individual has been "assigned a system" to pay their health care expenses. (i.e. Medicaid, Medicare, Privet Insurance, County Program, Hospital Charity Care, FQHC, etc.) Identify what the problems are with using the system as it exists now.

Two known sources of information relevant to the subject at hand that the subcommittee plans to review during upcoming discussions include:

- Inventory of Available Services Previously Completed; refer to Alma Robertson
- AHRQ-Conceptual Models that have already addressed this concern; to be provided by Lisa Green via e-mail

Specific Barriers to Quality Health Care Services:

- Shortage or lack of specific health care provider(s) in an area or region of the State (i.e. Dentists on the Eastern Shore); a true "manpower" shortage to serve residents in a specific location in the State. There is a need to specifically address the concerns for dental and mental health services.

- Lack of established Volunteer System (especially on Eastern Shore and in Western Maryland).

- Transient individuals

- Fragmented entry into the Health Care Delivery System; Lack of one point of entry

- Lack of client/patient tracking system through the various types of providers at various locations. Lack of the use of existing Information Technologies. Examples include:
  - Individual using a variety of pharmacies therefore receives medications that may be contraindicated or duplicative of products already being used.
  - Clients using two or more physicians/provider and neither understands that the client has more then one provider.
  - Hospitals and emergency rooms do not having reliable patient information.

- Patient may be a poor historian and/or not understand what directions he is being given regarding his health care.

- Lack of consistent way of maintaining an individual in services once a client has an assigned provider.

- Lack of health care advocates, case managers and/or navigator of our health care system as it is not user friend to those who are non English speaking, illiterate, or are unable to

comprehend the complexities of the existing system. Individual has a lack of health literacy.

- Existing biases or discrimination as a result the type of insurance an individual has and/or ethnicity/race of provider and/or client.

- Lack of compliance with health care directions by a client. Client does not take responsibility for his own actions; suggestion for the need to contract with the client to impact his understanding of need to follow health care directives.

- Layered expectations of Health Care Providers such as excessive administrative burdens (i.e. paper work) resulting in lack of time for the client.

- Lack of quality indicators for Health Care Providers to comply with. Lack of "Minimal Standards for Quality Care". Lack of performance indicators.

- Lack of financial incentives for providers to delegate health care services to others due to malpractice/tort concerns.

FOLLOW-UP

❑ Action Steps

Barbara Andrews recorded discussion points for the subcommittee and sent a copy of these points to Sherry McCammon.

Lisa Green will provide Barbara Andrews an electronic copy of an AHRQ-Conceptual Model of "Systems Barriers to Quality Services". Ms. Andrews will forward the Conceptual Model to Ms. McCammon via e-mail.

Sherry McCammon will share notes of the meeting and the AHRQ-Conceptual Model via e-mail to all members of the subcommittee by March 9, 2005.

Lisa Green agreed to Chair the "Systems Barriers to Quality Services" Subcommittee for future meetings.

MARYLAND PLAN TO ELIMINATE HEALTH DISPARITIES

Access of Quality Health Services Committee

Subcommittee 3 Notes: Improving Health Promotion and Disease Prevention

The subcommittee for 'Improving Health Promotion and Disease Prevention' used the proposed format for the June 30, 2005 Report to address their assignment.

A. Problems, Challenges, and Historical Trends

(1) Oral and written communications lack of cultural sensitivity
(2) There is a lack of health education
(3) Providers lack time to provide quality health and prevention education
(4) It is assumed that patients can read and or comprehend health literature
(5) Providers lack bed-side-manners
(6) Terminologies and definitions used by providers may not be understood by patients
(7) Patients don't ask questions because they perceive physicians as [authorities] who are unapproachable or expert
(8) Patients may experience technological barriers when trying to access health and disease information on health agency websites.

B. The Goal

A [goal statement] was not fully developed. The group discussed key [objectives] to address the problems:

(1) To promote optimal communication between medical providers and recipients in an effort to promote health care and prevent disease

(2) To promote health empowerment and self-efficacy—physically, spiritually, mentally, culturally and economically.

(3) To promote health literacy education in a relevant culturally competency manner

(4) To address the issue of lack of fiscal support for prevention and health promotion services

C. The Solutions

The committee did not work on recommendations during this session.

D. The Strategies

The committee listed strategies, actions with measurements to solve the problems and meet outlined objectives:

Strategy 1: Develop tools and institute policies that increase the effectiveness of provider/patient communications

Actions:

1) Produce culturally sensitive literature
2) Create curricula and mandatory CME/CEUs for health providers on the subject of cultural competency care.
3) Provide cultural sensitive training in educational institutions
4) Make health provider websites more user-friendly
5) Partner with major health agencies to develop health education literature that speaks to minority and underserved populations

Measurements:
- Increased in culturally sensitivity literature
- Results from pre/post tests for CME/CEUs

Strategy 2: Increase patient health literacy and commitment to preventive health

Actions:

1)Produce health care literature and tools that support different patient educational levels
2) Provide in-home medicine management training for patients
3) Provide community health educators and liaisons who can encourage preventive health care

Measurements:
- Results from Behavioral Risk Surveys
- Decreased in emergency room visits
- Increased in preventive testings, (i.e. PAP, PSA, colonoscopy, mammograms, oral care screenings, smoking rates.)

Strategy 3: Increase community outreach and participation efforts that support health promotion and disease prevention

Actions:

1) Provide on-site health education at community organizations, senior homes, health fairs, and schools
2) Coordinate faith-based health promotion activities such as parish nurses training
3) Provide targeted health initiatives for males, homeless persons, low-income patients and specific minority groups

Measurements:
- Increased community activities targeting minorities and underserved populations
- Increased community buy-in