

STATE OFFICE OF RURAL HEALTH
ADVISORY BOARD MEETING MINUTES
August 1, 2013

Presiding:	Steve Barber, Board Chairman
Present:	O.J. Booker, Member Robin Rau, Member Jennie Wren Denmark, Board Vice-Chairperson Sandra Daniel, PhD, RN, CPNP, Member (via teleconference) Ann Addison, PhD, PA, MSN, FNP-C, Member (via teleconference) LaDon Toole, Member
Absent	Stuart Tedders, PhD, Board Secretary Ajay Gehlot, Member Gregory Dent, Member Carla Belcher, Member Toni Barnett, PhD, APRN, BC, CNE, Member
SORH Staff:	Charles Owens, Ex-Officio David Glass, Director, Primary Care Office Patsy Whaley, Director, Hospital Services Sheryl McCoy, Recording Secretary
Visitors:	Duane Kavka, CEO Georgia Association of Primary Health Care Glenn Pearson, Executive Vice-President Georgia Hospital Association

Opening Remarks:

The regular scheduled meeting of the State Office of Rural Health (SORH) Advisory Board was held at Community Health Works, Macon, Georgia, on Thursday, August 1, 2013. The meeting convened at 10:30 a.m.

Steve Barber, Chairman, called the meeting to order and welcomed the Board members.

Charles Owens introduced the guests on the agenda, Glenn Pearson, Executive Vice-President, Georgia Hospital Association (GHA) and Duane Kavka, CEO, Georgia Association of Primary Health Care (GAPHC). He explained they were invited today because so much interest was shown at the last Advisory Board meeting about the Accountable Care Organizations (ACO).

Chairman Barber asked for approval of the March 7, 2013 minutes. The minutes were approved as submitted. Chairman Barber then asked for the members to participate in a time of bragging and discussion.

Jennie Wren Denmark shared that the Baxley Clinic now has permanent funding and is in full operation.

Ann Addison shared her facility received Patient Centered Medical Home Status.

Robin Rau stated that her facility has two contracts with physicians from the 3RNet website. One physician has a contract for FY 2013 and another for FY 2014. She complimented the success of 3RNet, which is managed by the State Office of Rural Health, Primary Care Office. She stated results are much better from the free 3RNet website versus other companies who charge a large fee. She also reported they are talking with General Contractors about the construction of a new Dialysis Facility.

LaDon Toole shared their hospital, Grady General Hospital, won the 2013 FHA National Award for being the only hospital in Georgia and 40th in the Nation for their Hospital Engagement Network (HEN) work on unattended births and 30-day re-admissions. He complimented his staff for their hard work on this project.

Charles asked Glenn Pearson, Executive Vice President, GHA, to begin his presentation on Accountable Care Organizations (ACO).

Mr. Glenn Pearson gave a detailed presentation on the ACO concept and its framework. Some of the key points are listed below:

- The concept
 - Align the delivery of care up and down the continuum of care centered around the patient's need in the most appropriate setting
 - Align financial incentives to support this approach to care
- 3 "Big Picture" Steps
 - Determine which providers must be part of the ACO for the full continuum of care and structure relationships accordingly
 - Develop required infrastructure to support clinical integration
 - Develop overarching culture to support ACO operation as unified, coordinated organization
- Are ACOs relevant in Rural Georgia?
 - Not likely in the immediate future but perhaps in 5+ years
 - Providers should consider coordination of community-based services
 - Health departments, FQHCs, Telemedicine, consolidation of physicians groups, hospitals with physicians, home health, long term care, hospice and other specialty groups
- So what should we be doing now?
 - See the changing environment as a new opportunity rather than a threat
 - Look for possible players you may be able to partner with
 - Realistically assess your attractiveness as a partner
 - Position yourself to complement the services and strategies of potential larger hospital partners
 - Make sure you have your community's and your governing body's support
 - Look at other outside groups as potential collaborators, even if there have been "territorial" issues in the past
- Final thoughts
 - Evaluation is hard in a world mixed with both FFS and fixed payments
 - Providers are skeptical about the ACO model
 - Trying to provide solid data by gathering input from all providers
 - This will be a long slow process but hopefully will yield a solid program

The entire Powerpoint presentation to include specific trends and margins is available upon request.

LaDon explained that he had been approached by a group called Ideal Doctor. Basically, an insurance company would partner with provider and provide an alternative for patients who need to go to an ER or urgent care clinic. They would provide two nurses to be on call 24 hours a day. Patients would call in and tell the nurses on duty their symptoms. The nurse calls the physician and gives him the information and the physician then calls the patient. The physician evaluates the problem over the phone and then calls a prescription to the pharmacy. Primary Care physicians consider this process a

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threat. However, for areas who have physician shortages, it can be deemed an opportunity to provide care to the growing number of patients.

LaDon also stated the possibility of hospitals staffing with mid-level professionals is a controversial issue at present, but the world is changing and the way medical care has been provided is definitely going to change.

Robin also shared that physicians years ago could not have grasped being able to read medical records from miles away but with recent electronic progress, it has become a reality. It is an example of how something that may have been perceived as negative is now a positive way of medical care.

Glen shared he just recently talked with New York City physicians who have developed a program that allows physicians to prescribe certain applications for their smart phones. The hospitals will evaluate the security and integrity of medical web sites and approve a list of acceptable apps to the physicians. The physicians will be able to prescribe them to patients for reference. There are so many medical applications out there that are harmful and possibly dangerous, this will be a safety measure for the public. This program will help manage healthcare and address the issue of lack of primary care physicians. To give an example, someone with diabetes will have a list of acceptable apps they can reference in particular situations. Mr. Pearson said he hopes they will be able to partner with that organization.

LaDon referenced his former conversation concerning the Ideal Doctor. He compared the customer service aspect of sitting for hours in a physician's office or emergency room to the minutes of time they would spend on a call with the physician. The convenience of that process is very positive for the patient.

Next on the agenda, **Duane Kavka**, Chief Executive Officer (CEO), Georgia Association of Primary Health Care, gave a presentation on the Georgia Federally Qualified Health Center's ACO. Over the years they have encouraged their members to work as networks. They now have 28 individual FQHC organizations in 81 counties and have 141 clinic sites.

They were approached by a number of companies to participate in an ACO. They settled on working with Universal American because of the positive references. Nineteen of their twenty-eight members signed to participate. There are four additional members interested in joining at the next open enrollment.

The application was very complex with very specific questions but everyone worked diligently and completed it successfully. The data they have received from the members from beginning to present had been very good. One main focus is to work with providers to provide quality of care and coordination. Those are major keys to good health care and the access of health care. There needs to be a care or case manager in place to help make decisions, to help patients understand and educate them on personal health care needs. This will be a safety net for the uninsured and patients on Medicaid. There have been no major issues in developing the program.

He shared a few key points of the ACO program in the FQHCs:

- ACO – lower costs and high quality
 - Manage “episodic costs”
 - Using evidence-based medicine guidelines
 - “Right care, right setting, right cost”

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- The provider selection will only work with efficient specialists, hospitals and ancillary providers
- Patient support of chronic conditions and risk factors
 - Empower patient to self-manage, improve compliance and improve quality metrics
- Apply analytics to identify cost savings and quality improvement opportunities
- Technology Integration will include
 - Patient Engagement
 - Personalized self management plan
 - Monitoring and assessments
 - Education tools
 - Mobile device support
 - Care Management
 - Evidence-based medicine guidelines
 - Care coordination
 - Disease management
 - Analytics and reporting
 - Trend and cost reduction
 - Shared savings calculation and distribution
 - Quality improvement
 - Provider score cards
 - ACO performance tracking
 - Government and private payer reporting
 - Provider
 - Gap in care alerts
 - Episode of care and self-management monitoring
 - Patient advocate notes
 - Longitudinal health history
 - Patient communication

Jennie Wren shared that it is a huge learning experience and continues to be a difficult task to make sure everyone involved is able to explain the program to the patients according to the regulations. Extensive training was required for all the staff to attend

Duane explained that it would have been extremely difficult to do the application on their own because of the risks involved. Universal America provided funding to hire staff, begin the program and assume the risk.

LaDon asked, “How will the hospital be related to the FQHC part of the ACO program.”

Duane answered, “Sharing data is the only relationship to hospitals.”

Charles asked Jennie Wren to explain her statement about the big changes the in-take person had to learn.

Jennie Wren stated they will have to answer all the questions people will ask when they come into the clinic. The regulations state specific information that needs to be included in their response.

Duane explained there is no down side to the program. They can make money, but they will not lose any money. Hiring Universal American was the best deal they found primarily because they would assume the risks. The ACO has a separate board and they are involved in how the system works.

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Charles remarked that as long as you meet the benchmarks they set, you get a set number of dollars. Then he asked, “In order to get shared savings, must you be a member of an ACO?”

Duane answered, “I believe so at the present time.”

Charles also asked how much start-up funds Universal American invested.

Duane remarked they invested \$1.1M. They provided all the initial needs for the start up of the program, i.e., administration fees, training and materials.

LaDon stated that the hospitals are already tracking most of the information required by the ACO program, so it is only a matter of partnering with the company.

Patsy responded that some hospitals are consistent with keeping track of their data and have good managed care in the hospitals. However, many of the hospitals change personnel so often they lose the skill set and the momentum to continue tracking the information necessary. It then becomes necessary to re-train the staff all over again. It is often hard to keep trained staff to maintain the required information current.

Robin said it is all about covered lives. The hospitals manage the care while they are in the hospital. The primary care providers are trying to manage the care to keep them out of the hospitals. Ultimately it is the number of lives we are able to control. She stated that Patsy is trying to help hospitals understand that things are changing in the way they are paid. It is necessary to be attractive so that one of these groups will want to adopt you.

Charles asked if anyone has counted the number different Electronic Medical Records (EMRs) used at the hospitals.

Duane answered the EMR companies are buying each other out and then hospitals have to start over with a new product. He said he is not sure of the number, but he reiterated that technology is the key to tying all of this together.

In summary, so far things have worked well and people are satisfied with the participation and management of the ACO. He stated that maybe he can come back next year and give some numbers on the results of the program.

Jennie Wren reported that she has received the Notice of Grant Award (NGA) from the grant for Appling County.

Charles reported that Clyde Reese, III, Esq. is the new Commissioner of The Department of Community Health and Marsha Hopkins is the new Chief of Staff. The Commissioner will be visiting the SORH office soon.

New projects for the year include:

- \$25k Firefighters (on hold)
- \$500k for FQHC development with GAPHC for Dawson and Chatham Counties

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He stated there are four health center projects coming to a close soon. The projects have been very successful and provided good health care access. He thanked Duane Kavka for providing the funds to develop health centers in 81 counties of Georgia.

He shared about two events coming up soon. The GA Alliance of Community Hospitals and GA Rural Health Association are sponsoring a Medical Fair at Lake Lanier on August 23 – 25. Another event will be sponsored by the Georgia Rural Health Association. The conference will be held in Savannah on October 21 – 23. He encouraged attendance to those meetings.

He said it is exciting to hear Robin has hired two physicians from the 3RNet website. David works very hard to keep the website current and keep the physicians and providers informed.

It is also exciting to report the PCO has awarded all 30 J-1 slots for the year 2013. This is the first year since 2003 they have all been filled.

Patsy Whaley gave an update on the FLEX and SHIP grants. She reported on her attendance to the recent FLEX conference. She stated the theme for most of the speakers seemed to be centered around the transition of the Critical Access Hospitals from cost based reimbursement to value based purchasing model. Everything FLEX is doing right now is moving toward the change in payment source.

The new project is a 2 year grant for the State Office of EMS to initiate and pilot a Community Paramedicine Program. There is a huge interest in Paramedine throughout the state. At the FLEX conference she met with Gary Winegrove from Minnesota who has developed one of the most advanced Community Paramedicine programs in the country. He has agreed to work as an advisor as the program is developed in Georgia. One of the first things they are doing is outreach to see how much interest there is in the communities. They also hope to identify challenges and barriers that need to be addressed. The primary reason they are looking at the program is to reduce the non-acute, non-emergent calls for EMS. The other reason is to try to help hospitals reduce avoidable readmissions. It will take a minimum of 300 hours training for the program.

David Glass gave a brief update on the Primary Care Office.

- Telehealth School based Clinic – working with Georgia Board for Physician Workforce for a FQHC Loan Repayment program. It is a two year project to provide loan repayment for dentist to work in FQHCs.
- The second project is to work with Georgia Partnership for Telehealth to start three school-based telehealth programs

After some discussion about conflicts with the next meeting date, the next meeting was rescheduled for December 5, 2013. The meeting adjourned at 2:45 p.m.

Respectively,

Chairman

Secretary

Recording Secretary

Date Approved

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