STATE OFFICE OF RURAL HEALTH
ADVISORY BOARD MEETING MINUTES
Thursday, February 2, 2012

Presiding:	Steve Barber, Chairman
Present:	Grace Newsome O.J. Booker LaDon Toole Ajay Gehlot Robin Rau Gregory Dent Stuart Tedders (Teleconference)
Absent:	Jennie Wren Denmark Ann Addison Sandra Daniel David Zammit
SORH Staff:	Charles Owens, Ex-Officio Patsy Whaley, Director, SORH Hospital Services Brittany Brown, Program Operations Specialists/Hospital Services Sheryl McCoy, Recording Secretary
Visitors:	Matt Caseman, Executive Director, GA Rural Health Association Laura B. Gillman, Archway Public Health Professional Carie Summers, 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, Thursday, February 2, 2012. The meeting convened at 10:35 a.m. Steve Barber, Chairman, called the meeting to order and welcomed the Board members and visitors.

Chairman Barber reminded the Board that it was time to appoint officers for the Advisory Board. Motion was made by Greg Dent and seconded to reappoint the current officers. Motion carried. The current officers, Steve Barber, Chairman, Jennie-Wren Denmark, Vice Chairperson and Stuart Tedders, Secretary, will remain in office for the next two years.

Chairman Barber asked for approval of the November 4, 2011 meeting minutes. The minutes of the meeting was approved as submitted.

Charles Owens introduced Matt Caseman, Executive Director, Georgia Rural Health Association (GRHA), and shared that Mr. Caseman would be speaking on current legislative issues. Mr. Caseman has recently returned from the National Rural Health Association Conference in Washington D.C.

Matt Caseman shared that he has a background in public affairs. He spent 16 years at the Capitol working in various capacities. He worked as Director of the Public Information Office for the House of Representatives and Press Secretary for the Speaker of the House, Tom Murphy.

He stated the 2012 Legislative Session is underway and the Governor has presented his budget recommendations. Prior to the announcement of the budget, GRHA presented an agenda to the Governor. The 2012 R.U.R.A.L. Legislative Agenda is as follows:

- **R**aise the Medicaid Reimbursement Rate
  - First raise in 10 years
- **U**pgrade and Expand Trauma Care Network
- **R**einvest in Primary Care
  - Shortage of primary care and specialty care in rural areas
- **A**dvocate for Rural Health Safety Net Program
  - CAH, SORH, FQHCs, Rural Health Safety Net and outreach grants
- **L**ower Smoking Rates
  - Raise to $1 – need revenue and would lower smoking numbers

LaDon Toole stated that the original plan was to fund the trauma program with the revenue collected from the tax increase on cigarettes.

Greg Dent said some of the legislators want to restrict the funding for health care, but another group of legislators want it to be available for other programs. Greg said it would benefit health either way.

Matt presented Governor Deal's budget for fiscal year 2013. The budget is $19.2 billion which is $900 million above this year's spending level. The state government has taken about $3 billion in cuts since the Great Recession began four years ago. However, revenues are beginning to increase. There are two budgets to be considered when the legislation comes together in January, the 2012 amended budget and 2013 state budget. Listed below are important points on the budgets and health care priorities to be discussed in the 2012 Legislative Session:

- Health care highlights of Governor Deal's budget proposals (Amended 2012 budget and 2013 state budget):
  - $5 million to help Georgia Health Sciences University become a national cancer center designated by the National Cancer Institute
  - $10 million to establish more "accountability courts" in Georgia which would include drug courts and mental health courts, created to help offenders avoid jail time through rigorous rehabilitation programs.
  - $3.7 million in additional funding for more school nurses
  - Funding for 400 new residency training slots in hospitals across the state for graduates of Georgia medical schools.
- House of Representatives Health Sub-Committee of Appropriations (FY 2012 Amended)
  - Restored Mercer School of Medicine cuts (operating grants) $417,454
  - Restored Morehouse School of Medicine cuts (operating grants) $220,865
  - Restored cuts to private institutions (MSM, Mercer, Emory) under graduate medical education program - $56,537
  - Added two additional slots to GBPW for loan repayment program $40,000
  - Added $1.2M to "Grant in Aid" line

Matt stated that GRHA will be trying to find funding to reinstate the Medical Fair. It seemed to be a valuable tool that has been cut from the budget. He further explained that these proposals will have to go to the Senate and possibly a committee before the final wording is published. He continued with the presentation as listed below:

- Medicaid and PeachCare redesign
  - Department of Community Health contracted with Navigant, a consulting firm, to re-evaluate how Medicaid services are organized. The report lists three options:

- Expand current "Healthy Families" managed care program to enroll all Medicaid patients.
- Move to a managed care program, increase patient copayments and deductibles and use other strategies intended to encourage healthy behaviors.
- The third option would give Medicaid members a credit for private insurance.

The GRHA had a contingent of six representatives visiting congressional offices January 31st in Washington D.C. The visits were a part of the National Rural Health Association's Annual Policy Institute. The rural health advocates took three "Asks" to Capitol Hill. They are:

- The continuation of rural Medicare "Extenders"
- Modifying the Medicare sequestration process set to begin in January 2013 to avoid disproportionate harm to the rural health safety net
- Appropriate funding levels for rural health programs through fiscal year 2013

Matt stated there is a movement in the state that relates rural health care to the local economy. Usually in a small community the hospital or the school system is the largest employer. As much as 20% of the local economy is dependent on the local hospital. One doctor in a small community can bring in as many as 20 additional jobs.

Carie Summers asked why legislators do not make the connection between funding and, for example, Medicaid. It seems it is perceived as putting money in a black hole. They don't understand the money is going to the providers in a community and how the money trickles down in an economic impact.

Matt responded that he didn't know.

Carie stated it would be good for economic development. When an industry is looking for a community in which to locate, they look for a healthy community with a hospital. They want access to hospital care, physicians, primary care and behavioral care.

O.J. Booker shared that a school has the ability to levy taxes in local communities. A hospital also has critical issues but does not have that opportunity.

LaDon remarked that Legislators are receiving complaints about the health care system not requiring patients to be accountable for their health care. For example, patients visiting the emergency room do not share in the accountability process and take ownership for their health. It is possible there will be more said about that subject in the future.

Robin Rau echoed LaDon's comments about accountability. She stated the patient accountability issue was not addressed in the study to redesign Medicaid. Robin said accountability is especially problematic among the Medicaid population.

Carie reported that GHA recently met with Commissioner Cook and they discussed the accountability issue. He was very interested in a solution for that issue. He is interested in getting waivers to require Medicaid patients to pay co-pay and have deductibles, but doesn't think it will be passed at this time. Carie said the Affordable Care Act also doesn't address the patients' behavior. DCH is still working on the Medicaid redesign to accommodate 600,000 new members that will be eligible under the Affordable Care Act.

Ajay Gehlot expressed concern from the primary care perspective. The Medicaid population is not motivated to change their behavior because health care is free. There needs to be change in the process that will cost them financially in order for it to affect their behavior.

Charles related the Medicaid accountability to the wellness plan State Health Benefit Plan (SHBP). The plan allows for $500 up front for healthcare and then it moves into the deductable part of the plan. After the first year of being on the plan, people began to realize it would be necessary to practice conservative health care. Wellness is covered and isn't deducted from the $500. People are learning to spend less money on health care and practicing better wellness practices.

Carie expressed that the expense for SHBP is a lot lower than the National trend. The trend for SHBP is about 4 per cent and the national trend is 6 or 7 per cent. The plan is working for that particular population, but a financial penalty may not work for Medicaid. It may take a program focusing on incentive to cause change in their behavior.

Charles explained Ty Cobb's approach for wellness behavior is a five fingered approach. It doesn't just focus on smoking, but covers several problem areas of health care. They gave incentives to improve in those areas.

Steve shared there has been some improvement with that program. Last year the total cost of the whole program dropped almost $1M.

Matt concluded by extending an invitation to join GRHA and the benefits of membership.

Charles introduced Laura Gillman, Archway Public Health Professional, University of Georgia (UGA) Archway Project, to give her presentation.

Laura Gillman began by explaining the purpose of the total program, Archway Partnership, and explained she will share specifics as the presentation progresses. The Partnership is an outreach of the University of Georgia to provide resources to Georgia's communities. The Partnership is housed at UGA. Some important facts are:

- UGA Archway Partnership
    - A system to provide GA communities with greater access to the University System of Georgia diverse resources
    - Grassroots approach by getting communities to commit to collaboration with each other and Archway – a neutral platform for local collaboration
    - Archway Executive Committees represent most aspects of the community and ensure community driven approach
- How UGA Archway Partnership Works
    - Archway Professional in each Archway community
        - Facilitates community needs assessment process
        - Facilitates Archway process and local collaboration to create effective and sustainable solutions to priority issues
- Archway's Goal is to build the capacity within Georgia's communities for the following:
        - Ability to identify key issues that affect the entire community and take ownership of issues
        - An understanding of the University System of Georgia and how to access available resources

        - Ability to collaborate locally; develop effective and sustainable solutions in addressing priorities
- Archway Partnership: Health
    - An initiative within Archway to create a health related outreach platform for Archway Communities
    - Partnership with the UGA College of Public Health Office of Outreach and Engagement – connects Archway Public Health Professional with a wide range of resources to community priorities
    - Archway Public Health Professional – implement Archway process around priority health related issues
- Current Archway Health Sites
    - Colquitt County – began in 2005 and has graduated
    - Washington, Pulaski, Sumter, Glenn, Clayton, Hart, Dalton/Whitfield
        - Selection Process – Community collaboration and provision of matching funds
- Archway Public Health Professional
    - Establishes office within the community and becomes a part of the community
    - Ensures a neutral platform within collaborative
    - Builds trust and understands the dynamics of the community
    - Facilitates needs assessment
    - Organizes a Health Advisory Committee
    - Overall goal is to teach community leaders to take ownership of issues and be a part of the solution

Laura stated that Washington County was selected as the first site in 2008. The Health Advisory Committee for Washington County consisted of local physicians, hospital representation, public health, community health, education system, business and industry. They established three top priorities for Washington County and they are:

- Improving access to health care professionals
    - Connected with Georgia Statewide AHEC Network to establish the Georgia Rural Medical Scholar Program to build a relationship with medical students
    - Connected Sandersville health care professional to the RN Bridge Program with Darton College
- Leadership development within healthcare arena - Healthcare Professional Leadership Development
- Medicare Outreach and Education- partnered with Agency on Aging to provide one on one assessments and still continues each year

LaDon expressed his excitement about becoming a part of the Archway Partnership. He said it is exciting to see the various professions come together to talk about the issues of their county and become willing to be a part of the solution.

Laura spoke a few moments about the Georgia Public Health Training Center (GPHTC) and their function:

- Assess the training and learning needs of the current Georgia public health workforce
- Deliver learning opportunities and training based on workforce needs throughout Georgia
- Provide tailored technical assistance to the public health workforce

- Create new and strengthen existing internships for public health students, especially in medically underserved areas in Georgia
- Evaluate the effectiveness of our efforts on learning objectives, core competencies and selected public health outcomes.
- Working with Archway communities to create regional hubs in GA
- Grant/community match funds to support Archway staff to implement Archway Health structure and coordinate GPHTC activity for region

Charles remarked it is sad they aren't speaking about regional development. Neighboring counties work and shop in other counties. To move rural forward, it seems it would be necessary to focus on regional approach. He also asked how a community can become the next Archway project.

Laura said first, let them know. She said she can be a vehicle and a voice to the College of Public Health. She serves in that capacity for the GRHA. The County must provide Archway with an application and matching funds. She stated a lot of networking brought Archway to Grady County.

Charles acknowledged that she is a member of the SORH Migrant Advisory Board. Pharmacy students from the College of Public Health are working with the Migrant Health Clinics to improve their pharmacy process.

Carie Summers stated that 501c3 hospitals are now required to do Needs Assessments. She asked if they have reached out to Archway for help with that process. She inquired if Archway could help statewide with hospitals seeking help.

Laura said she has not been approached about that project, but it might be an area Archway could provide resources. She will take the idea to Archway and see if they can connect appropriate resources with those hospitals.

Carie suggested sharing Best Practices for Needs Assessments as a helpful tool. It would provide them with the information on how to do an assessment and also help with the improvement plan in their follow-up process.

Laura shared that the Colleges of Public Health around the state could possibly be a vehicle for hospitals seeking help.

Charles stated that Public Health Departments' Needs Assessments requirements are the same as 501C3 hospitals. He is a member of a committee with the CDC to develop a toolkit to help communities address that problem. Charles shared an idea of creating a Needs Assessment that would fit all the various groups. Everyone participates in identifying needs and working toward solutions.

O.J. said the Needs Assessments are usually done by hospitals for self preservation rather than the true needs of the community. It is getting harder to support the infrastructure of a rural hospital. Some areas may not need a hospital, but may need a different type of local health care system.

Robin remarked that in her area there are two hospitals within 20 miles. They were built when transportation was a problem to many people. With the improvement in transportation and vast knowledge in technology, the system is obsolete. However, the hospital still provides an economic value to the community. She said at the end of the day, it's all about quality health care.

Charles said it is necessary to diversify as needs change.

Charles introduced Patsy Whaley, Director, Hospital Services to give her presentation on the Small Hospital Improvement Program (SHIP) and Medicare Rural Hospital Flexibility Program (FLEX) hospital programs.

An overview of the SHIP Grant for the Past, Present and Future is listed below:

Past FY 2012/2011:

- Eligibility for SHIP
  - 49 or less staffed beds
  - Verified as rural by the HRSA Rural Health Grants Eligibility Analyzer
- Funding Categories
  - Perspective Payment System (PPS)
  - Accountable Care Organizations (ACO)
  - Value-Based Purchasing (VBP)
  - Bundled Payments
- Total Funding for FY 2012/2011 - $534,055.61 ($8,755 per hospital) – 61 participants
- 4 Consortia/Programs
  - Draffin & Tucker Recovery Audit Contractors (RAC)
  - GHA Quality Improvement
  - GHA CMS Conditions of Participation and Perspective Payment System Compliance
  - HomeTown Health's Health Information for Economic and Clinical Health (HITECH) Electronic Health Record (EHR) Compliance Network
- Hospital Specific Projects
  - Develop patient and staff education library
  - EHR software
  - Strategic planning
  - Coding and compliance audits
  - Electronic InterQual criteria
  - Clinical training materials
  - Purchase of laptops computers
  - Obtain firm to complete and monitor HCAHPS
  - Purchase tablet PCs
  - Purchase 12-lead EKG machine

Present FY 2012/2012:

- Funding for FY 2011/2012 - $512,024.00 ($8,828 per hospital) – 58 participants
- 5 Consortia/Programs
  - Draffin & Tucker – "Compliance Program Existence Does Not Mean Compliance Program Effectiveness"
  - Draffin & Tucker – "Preventive Medicine to Treat the Cost Report Payment Blues"
  - GHA – Value Based Purchasing Quality Improvement Consortium
  - GHA – CAH Future Directions Consortium
  - HomeTown Health – Developing Your Rural Hospital ACO Strategy
- Hospital-Specific Projects
  - Purchase of EHR technology to assist with ED and EMS EHR
  - DRG validation audits and engagement of firm to conduct and monitor HCAHPS

Future FY 2012/2013:

- 66 Participants – Funding TBA

- 5 Consortia
    - Draffin & Tucker CFO Collaborative
    - GHAREF ACO/Bundled Payment
    - GHAREF Value Based Purchasing Quality Improvement
    - HomeTown Health – Developing Your Medicaid Shared Savings Strategy

An overview of the FLEX Grant for the past, present and future is listed below:

- The FLEX Grant is organized into four Core Areas:
    - Support for Quality Improvement
    - Support for Financial and Operational Improvement
    - Support for Health System Development and Community Engagement
    - Support for the Conversion to Critical Access Hospital Status
- Support for Quality Improvement – Improve quality of care outcomes
    - 2010/2011 (Past)
        - Provide 34 CAHs and 26 eligible PPS small rural hospitals with a uniform QI data collection and reporting system
        - Supports FLEX-eligible hospital participation in performance, data-driven, internal QI and statewide QI collaborative
        - External CAH and small rural hospital peer-review program
        - Reporting to Hospital Compare
    - 2011/2012 (Present)
        - Participate in the HRSA Medicaid Beneficiary Quality Improvement Project (MBQIP) Phase 1 CMS Core Measures – heart failure and pneumonia
        - Eliminating Preventable Harm-Hospital-Acquired conditions and Infections
        - Development of Georgia's Hospital Consumer Assessment of Health Care Providers and Systems (HCAPHS) Program
        - Reporting to Hospital Compare
    - 2012-2013 (Future)
        - MBQIP
        - Continuation of Inpatient Core Measures- heart failure and pneumonia
        - Outpatient Core Measures
        - Initiation of HCAPHS Programs
        - Reporting to Hospital Compare
- Support for Operational and Financial Performance
    - 2010/2011 (Past)
        - Provided eight 2-day in-person workshops in each region of the state and six post-workshop webinars in CAH Leadership Training Course
    - 2011-2012 (Present)
        - Provide eight 2-day in-person workshops in each region of the state and six post-workshop webinars in CAH Leadership Training Course
    - 2012/2013 (Future)
        - Modified CAH Fiscal Analysis focused on revenue cycle financial indicators

- Support for Health System Development and Community Engagement
    - 2010/2011 (Past)
        - Project: Development of the Southwest Georgia Regional Health Collaborative (Miller and Decatur counties)

- 2011/2012 (Present)
  - Project: Rural EMS Director Leadership Training Program
    - Goal: Improved management of rural EMS
- 2012/2013 (Future)
  - Project: Developing Regional ST Elevations Myocardial Infarction (STEM) Systems of Care

Robin Rau shared that the Health System Development and Community Engagement project is about to close. The $100,000 funding accomplished bringing the partnerships together to begin to move in towards patient collaboration and integration of services. In the future they will possibly focus on the economies of scale and further integration of services with a third partner.

Charles thanked everyone for attending the meeting. There being no further business, the meeting was adjourned at 3:00 p.m.

Respectively,

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Chairman Secretary

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Recording Secretary Date Approved