David A. Cook, Commissioner *Nathan Deal, Governor* *Charles F. Owens, Executive Director*

STATE OFFICE OF RURAL HEALTH
ADVISORY BOARD MEETING MINUTES
Thursday, November 4, 2011

Presiding: Steve Barber, Chairman

Present: Grace Newsome
Ann Addison
O.J. Booker
LaDon Toole
David Zammit
Sandra Daniel
Jennie Wren Denmark
Ajay Gehlot
Gregory Dent

Absent: Stuart Tedders
Robin Rau

SORH Staff: Charles Owens, Ex-Officio
David Glass, Director, Primary Care Office
Brittany Brown, Program Operations Specialists/Hospital Services

Visitors: Kelly Gonzalez, MS, PMP, CUA, Georgia Department of Community Health Information Technology, Interim State HIT Coordinator
Jacqueline Koffi, Georgia Department of Community Health Information Technology, Medicaid Incentives Program
Ophelia Spear, Project Manager on Challenge Grant, Matt Kolfman, Georgia Rural Health 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, August 4, 2011. The meeting convened at 10:35 am. Steve Barber called the meeting to order and welcomed the Board members and visitors.

Chairman Barber asked **Charles Owens** to introduce guest. He introduced Georgia Department of Community Health's Kelly Gonzalez, Interim State HIT Coordinator and Director of HIT; Jacqueline Koffi, Medicaid Incentives Program Director, and Ophelia Spear, HIT Program Manager. He also introduced Brittany Brown, a new employee at SORH who served as the recording secretary in the absence of Sheryl McCoy, and David Glass. David joined as a Program Operation Specialist hired to work with the J-1 Visa program, National Health Service Corps, and 3RNet recruitment and retention program. He has assumed the role of the Director of the Primary Care Office after Donna Crews resigned. Charles acknowledged Matt Caseman from the Georgia Rural Health Association.

Chairman Barber asked for approval of the August 4, 2011 minutes. The minutes of the meeting were approved as submitted. Chairman Barber commented that the PowerPoint presentations are attached to the minutes in the official file. He suggested that the presentations may be obtained from Sheryl McCoy upon request. He thanked everyone for coming and asked Charles to introduce the presenters from DCH.

Charles Owens opened the floor to **Kelly Gonzalez**, MS, PMP, CUA, Georgia Department of Community Health Information Technology, Interim State HIT Coordinator, who prefaced the presentations. She turned the floor over to Jacqueline Koffi, Georgia Department of Community Health Information Technology, Medicaid Incentives Program Director.

Charles asked **Jacqueline Koffi**, Georgia Department of Community Health Information Technology, Medicaid Incentives Program, to discuss her role. She responded that her job is to inform people of the Georgia Medicaid EHR Incentive Program and the Georgia Health Information Exchange and the Challenge grant. Medicaid EHR payment program is designed to incentivize providers to adopt, implement, or upgrade to an EHR. She explained that some providers have already received these incentives while others are pipelined to receive incentives.

- The program is funded by 100% stimulus money. The Department elected to collaborate with 12 other HP (Hewitt Packard) states to share the costs and resources for HP to serve as the financial agent for the Medicaid information management system. (Statewide claims processing center).
- Incentive system must "tie in" with the Medicaid information management system.
- A core system was developed that was relevant to each state and then customized for Georgia providers.
- MAPIR is the state level EHR system for processing Medicaid incentive payment patient volume data and it integrates with the state MMIS.
- Since September 5, 2011, $11M have been paid through the program.
- There is a federal and state level of registration.
    - All providers must register at the federal level (Medicaid and Medicaid only)
        - Semi background and eligibility check
    - State level must provide a patient volume calculator to determine eligibility
        - Physician, PA, Dentist, Nurse Practitioner
            - 30% Medicaid patient volume (excluding PeachCare)
        - Pediatrician
            - 20% Medicaid patient volume (excluding PeachCare)
        - Providers with at least 50% of the time spent at FQHC and RHC
            - 30% of "medical needy"
    - Must provide documentation for a Certified EHR system

Ajay Gehlot asked if FQHCs could provide an individual or group patient volume calculator.

Jacqueline responded that FQHCs and RHCs should never do individual patient volume calculators. They should always do a group proxy patient volume calculator, where the providers are seeing at least a 30 per cent "medically needy" population for the entire center.

Charles asked how a "medically needy population" is defined. Jacqueline responded that the term is difficult and she would work with people individually with specific questions.

Jacqueline continued that RHCs and FQHCs should attest as a group. When uploading the patient volume calculator in the state registration, the provider information will be the same. The difference will be the identifying information for that provider of which the information is being uploaded. She further explains the process for registering with the state and the common issues with identification numbers. Jacqueline also announced that the last day to attest for incentive payment for the 2011 calendar year is February 29, 2012.

Ajay Gehlot asked that since his FQHCs started implementing EHR in May 2011, one by one, by Oct finished implementing EHRs in all 15 of the clinics. He asked if his eligible providers will receive an incentive since the 2011 year is almost over.

Jacqueline responded: The patient volume calculator is for calendar year 2010; you didn't have to implement the EHR in 2010 to receive the incentive.

O.J. Booker re-clarified the question: If you have an EHR already implemented in 2011, do you still upload the patient volume calculator for 2010 and be able to receive the incentive given that you have documentation for a certified EHR?

Jacqueline responded “Yes”.

Ann Addison questioned: According to a previous seminar it was said that a physician assistant be paid if they were the lead provider for the clinic or if the PA was the highest productive leader in the clinic. Is this still true?

Jacqueline responded that the statement is not in the final rule. She also provided resources to find the most current information regarding the Medicaid Incentive Program.

Steve Barber asked should we expect that there will there be a change in vendors [HP Medicaid financial agent]?

Jacqueline responded that the contract is set for seven years with HP with a year by year renewal option. She concluded that there will be a Medicaid Fair on Nov. 17th at the Macon Coliseum. She encouraged office managers and administrators to attend.

Ann Addison asked if PowerPoint would be distributed to SORH.

Charles responded yes, he then asks Kelly Gonzalez to introduce herself.

Kelly Gonzalez, Director of Health IT, and Interim State HIT Coordinator. She stated the Medicaid Incentive program is contract for 10 years and that hopefully they will only have one vendor. Area of responsibility is overall health information technology for DCH it includes the Medicaid Incentive Programs, the Health Information Exchange, and the Challenge Grant from OFC. She started with DCH in 2010, only in role of HIT Coordinator for 15-16 weeks. She gave a presentation on The Georgia Health Information Exchange Inc.

A. The Health Information Exchange

- Mission and Vision is centered around coordinating care
    - The Pillars are aligned to the National Quality Standard
        - Improving health care quality
        - Reduction of health care costs
        - Improving the health of Georgia
    - Supporting the transport of health data
        - Provide coordinated care among patient the healthcare system
        - Consumer assess and engaged consumers
        - Reduction of harm caused by care delivery
        - Avoidable ER admissions
            - Pilots will be held in communities
    - Goals and Objectives
        - Build trust of stakeholders
        - GA HITREC and GA HIE INC collaboration
- Governing Structure
    - There is a collaborative approach amongst government and public entities
    - Committees and workgroups
    - DCH approves and enforces the recommendations
        - Participants will abide by these
- OHP has three goals that it wants the HIE to focus on
    - E-prescribing
    - Exchange of lab results
    - Expanding of HIE
- Phased Approached of delivery
    - Phase 1: Direct Messaging services
    - Phase 2: Four Anti-priority services
    - Phase 3: Product and services that Georgia wants

- DCH town hall meeting Dec.15th in Atlanta

B. Challenge Grant
    - 3 clinic $1.7 million grant
    - Involves sending data from a physician clinic to a personal health record
    - How does bidirectional flow of data affect patient survival?

Kelly introduces **Ophelia Spear** as the project manager of Challenge Grant.

Charles introduces David Glass, received a degree in Communication from Georgia Southern University, began with the Office in the recruitment programs, and now has taken over the Director Primary Care Office position. Charles stated that we [SORH] would like to be of great aid in the recruitment and retention of providers in rural Georgia and are taking a more proactive, aggressive role assisting our providers.

David Glass presented on Health Care Workforce Recruitment and Retention:

- National Health Service Corps (NHSC)
    - Program to provide clinicians with financial support in the form of loan repayment and scholarships.
    - Full time program offers up to $60,000 in a tax free loan repayment for 2 years of service and up to $170,000 for a 5-year service commitment.
    - Eligible providers include: Physicians, Nurse Practitioners, PAs, Certified Nurse Midwife, Dentist, Dental Hygienist, etc. (See PowerPoint)
- NHSC Scholarship Program
    - Payment for tuition and required fees
    - Some other tax-free educational costs
    - A monthly living stipend
        - NHSC Approved Service Sites Eligibility
            - Located in a HPSA
            - See all patients regardless of ability to pay
            - Provide services on a discount fee schedule (see PowerPoint)
        - CAHs site pilots
            - Affiliated with an Outpatient, Ambulatory Care Facility
            - Meet NHSC site requirements
- 3RNet
    - National Rural Recruitment and Retention Network assists health professionals in locating practices in rural areas throughout the country
- Conrad State 30 J-1 Visa Waiver Program
    - Sponsors international medical graduates holding J-1 Visa
    - Physicians must apply for the waiver to remain in the US
        - 30 waivers annually (1st come, 1st served)
    - H-1 B Visa
        - Allows immigrant to work for US employer

David Glass PCO Director asks if the members were familiar and satisfied with the J-1 Visa Waiver Program. The majority of the members are aware of the program. Some have had J-1 Visa participants in the past. Some suggests that having a J-1 is a time challenging due to immigration issues. They suggest having a close relationship with an immigrant attorney.

Greg Dent shares with the group The Georgia Community Health Works commercial he also discusses his Nov. 3rd event. **Charles** also comments on rural health networks and ways to promote healthier rural residents.

Jennie Wren Denmark gives a progress report Migrant Health Committee, Advisory committee and the site administrators. She explains that there is difficulty in seeing patients due to the new Georgia law. She also explains

it is challenging in creating a joint policy for clinical outcomes. She cites the variety of FQHC and all facets of migrant health centers lead to this difficulty. She closes by stating that the members of this committee have been partner together to meet the deliverables of the grant and to come up with best practices. There was no funding awarded for any new site applications.

Charles Owens gives a report on the SORH update. He begins stating that the Rulemaking Committee did complete the negotiated rule making report. He shares with the board members a summary of "The Negotiated Rulemaking Committee (NRMC) on the Designation of Medically Underserved Populations and Health Professional Shortage Areas". He announces that he will make the whole report available by supplying the link to the website. He then gives an overview of the rule. He states that a consensus was not reached. The majority of the contents were agreed upon. There was disagreement surrounding having real-time data of the primary care providers. The final report was submitted to the Secretary of Health and Human Services on October 31, 2011. Sections of the Summary of Recommendations that were mentioned include:

- Rational Service Areas (RSAs)
  - An RSA is defined as meeting the following criteria:
    - Composed of discrete geographic basis areas
    - Are continuous (no "holes")
    - Different parts of the RSA must be interrelated
    - Must be distinct from adjacent contiguous areas
      - In Georgia RSAs are defined as counties
- Population to Practitioner Ratio (P2P)
  - Recommended that MDs and DOs be counted as 1.0 FTE for those working full time.
  - Hospitalist shall be excluded
  - OB/GYN would be counted as .25 FTE for those working full time sue to time spent in surgery and hospital based follow up.
  - Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives shall be counted as .75FTE
  - PAs specializing in OB/GYN will be counted as .25 FTEs
  - The following practitioners will be excluded from counts of local resources:
    - NHSC scholars and loan repayment recipients
    - J-1 visa waiver physicians
    - SLRP recipients
    - FQHC look-alike providers
    - Providers at hospital-based or independent RHCs that accept patients regardless of their ability to pay
    - Indian Health Service (HIS) physicians with scholarships or loan repayment obligations (see handout)
  - HPSA designations can be done through hour work calculation and Medicaid claims data.
- Medically Underserved Areas (MUAs)
  - Health status
  - Availability of health professionals
  - Access to barriers to care (will select 2 of 5 barriers)
    - Population density of area
    - Percent of population with limited English proficiency
    - Percent of non-white racial group
    - Percent of population with a physical, sensory, cognitive, or developmental disability
    - Percent of population that is both uninsured and has incomes at or below 400% of the Federal Poverty Level
  - Ability to pay
- Medically Underserved Population (MUP)
- Geographic HPSA

        - Applicants are eligible for geographic HPSA if their P2P exceeds 3000:1 or falls between 1500:1
        - Frontier areas will have one P2P threshold of 1500:1 for designation without the need for consideration of additional data indicators
- Population Group HPSA
    - Pop
- Facility HPSA
    - The majority are health centers and correctional facilities
    - A new MUP designation - Magnet clinic
        - More than 50% of encounters provided by primary care clinicians to one or two specific population groups which may include those listed in the MUP section

Ann Addison asked if you have a family practice and 10% of 40 hr week dedicated to inpatient care will that count as .9 FTE.

Charles responded yes.

OJ: Will there be an audited to ensure correct data?

Charles: No, the system is built on an honor system; however there are ways to ensure that the data is correct. (e.g. Google, rural health networks, etc.)

Jennie Wren Denmark: Do the previous exclusions apply to geographic HPSA?

Charles: Yes, it applies across the board.

Ann Addison asked when the PCO reviews HSPA designations which criteria will they use?

Charles responded that when the report becomes a rule, at that date the PCOs will then convert to the new rule.

Charles gives an update on the Primary Care Office. He states that the deadline for HSPA designations is December this year. There are 40 due to be updated. He also states that since the Federal Registry has been updated the counties that were in the status proposed for withdrawal have been removed.

He then gives a status update on the works of Hospital Services. The Flex grant available this upcoming grant cycle include: Quality Improvement Grant, CAH leadership Grant, EMS Network Director Training Grant. The SHIP grants provide money to small rural hospitals and CAHs to fund training in ACO, VBP, or a specialized project. The Office is also looking to provide assistance with community needs assessments.

He then shares with the members an overview of the meeting that he attended at Mercer University concerning telemedicine programs in nursing homes and school clinics. He also shares with the group an overview of an AHEC meeting that he had attended in October. He discusses the possibility of creating a network residency program

There being no further business, the meeting was adjourned at 2:50 p.m.

Respectively,

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Chairman	Secretary
____________________	____________________
Recording Secretary	Date Approved