STATE OFFICE OF RURAL HEALTH

Advisory Board Meeting Minutes

Wednesday, December 2, 2009

Presiding: Charles Owens, SORH Ex-Officio

Present:
Ann Addison (via telephone)
Sandra Daniel (via telephone)
Stuart Tedders (via telephone)
Jennie Wren Denmark (via telephone)
Greg Dent
Steve Barber
David Zammit
Grace Newsome
O.J. Booker

Absent:
Ajay Gehlot
Robin Rau

SORH Staff:
Tony Brown, Deputy Director
Sheryl McCoy, Recording Secretary
Patsy Whaley, Director, Hospital Services

Visitors:
Vi Naylor, Georgia Hospital Association (GHA)
Rhett Partin, Georgia Hospital Association (GHA)
Andrew Honeycutt, Minority Health Services
Michael Murphy, Minority Health Services
Linda O'Donnell, Southwest Health District
Beckie dela Mothe, Gordon College, Nursing Program
Lorna Martin, Georgia Hospital Association
Rena Brewer, Georgia Partnership for Telehealth
Courtney Terwilliger, GA Association of EMS
Renee Morgan, Office of Preparedness and Trauma
Kay Floyd, Monroe County Hospital CEO
Paula Guy, GA Partnership for Telehealth
Jimmy Lewis, HomeTown Health
Brittany Hendley
Lewis Kelley, Chatuge Regional Hospital (via telephone)

Opening Remarks

The regular scheduled meeting of the State Office of Rural Health (SORH) Advisory Board meeting was held at Community Health Works, Macon, Georgia, Wednesday, December 2, 2009. The meeting convened at 10:40 a.m.

SORH Advisory Board Minutes:
The minutes of the September 9, 2009, meeting was approved as submitted.

Mr. Owens explained that Chairman, Kevin Taylor, would not be able to attend the meeting. Mr. Taylor's term of service on the Advisory Board will end in January 2010. The Commissioner has our recommendations and the appointment of new members is in process. Jennie Wren Denmark's term will also end January 2010, however, she has asked to be considered for re-appointment.

Mr. Owens asked Tony Brown to give a report from the Migrant Sub-Committee.

Mr. Brown reported that the numbers for the migrant program look good this year. There were 13, 630 total medical patients seen this year. The Competing Continuation Grant for $2,532,756 has been completed and submitted. The annual reports and UDS report are due in January. The ARRA CIP funding grantees have received funding and are moving ahead with projects. Three of the sites will purchase mobile units and one will purchase a modular unit. All six sites have been funded the ARRA IDS funding. Five of the sites received funds to increase personnel and one site for a pharmaceutical project. He also reported that Phoebe Sumter has closed temporarily.

Mr. Owens gave an update on the SORH office:

- State budget directive to fund 50 per cent State Grant awards and fund 50 per cent at later date
- Katrice Brown Taylor, Director, Migrant Program, resigned and Tony Brown is interim until new hire approval
- ARRA program ongoing
    - Reporting is massive
    - Site visits scheduled once a month to ensure proper reporting
- PCO CMS ER Diversion grant $2.5M moving well with all sites on board
    - 4,929 patient encounters through September 30 – majority from Southwest Georgia Health Care
    - Triage protocols strengthened
    - Patient education a common issue – hospital ER versus non-emergent clinic
- Shortage Designations will update 75 to 100 sites next year
- Recruitment and Retention
    - 3RNet has 128 position vacancies posted and 53 providers
        - As a result five vacancies were recruited in past six months
- J1 Visa Waiver program applications ended September 30, 2009 – numbers down
    - At present 27 J-1 physicians serving 32 counties – 16 Primary Care, 3 Primary Care/Specialists, seven specialists and one ARC/PC
    - Recruited during 2009 – Five Primary Care slots, two Primary Care/Specialists and five specialists
    - Policy change approved to allow flexibility after six months of the J-1 Year beginning in October 2009 – should attract hospitalist to apply
- National Health Service Corps (NHSC) – 40 Loan Repayment serving 37 sites, 13 Scholarship serving 10 sites – total for Georgia is 51 NHSC serving 42 sites
    - Processed 53 site applications since January 1, 2008 with seven applications pending
- FLEX and SHIP awaiting signature from DCH and then they will be out – 52 hospitals, $9,100 funding

Mr. Owens stated that the meeting would transition to the FLEX part of the meeting. He shared that the FLEX program is changing. Listed below is how FLEX looks now.

- Quality Improvement – GHA
- Fiscal Analysis – Draffin & Tucker

- 3 Rural Health Networks
    - Georgia Partnership
    - Community Health Works
    - Medows Regional
- EMS Network – Emanuel Medical Center
- Program Evaluation

He pointed out the FLEX guidance is being shaped and input is welcomed. Two program areas recommended to continue are Quality Improvement (QI) and sustainability. Mr. Owens shared that he had attended a conference recently in Austin, Texas, where Tom Morris, Director, Federal Office of Rural Health Policy, spoke and inferred that trauma preparedness will possibly be a big part of the FLEX focus. He explained that Paula Guy has received a Telehealth grant that encompasses a network of providers. Georgia was one of 10 states invited to a Quality Improvement interview and recognized nationally. The Critical Access Hospitals (CAHs) that participated in the Fiscal Analysis will soon complete the third phase. A re-evaluation would be valuable to see the progress in sustainability. The guidance for the FLEX will be out January 4, 2010. The SHIP grant will be out as well.

Mr. Owens asked Paula Guy, Georgia Partnership for Telehealth, to give a presentation.

Paula Guy gave a presentation explaining the Georgia Partnership for Telehealth; who they are, how they are funded and their vision and goal:

- GA Telemedicine began as a large statewide videoconferencing infrastructure for education and telemedicine
    - Schools
    - State Offices
    - Rural Health Care Facilities
- Funded through GA Technology Authority and the Distance Learning and Telemedicine Act of 1992
- 2001 funding source changed to Oxendine's Rural Health Initiative for $100 million over the next 20 years in rural capital bonds - $11.5 million for Statewide Telemedicine Program over 3 years
- Mission is to improve and promote the availability and provisioning of specialized healthcare services in rural and underserved areas of Georgia; educate and provide training to hospitals and healthcare facilities with Telemedicine programs; reduce the service barriers that exist for patients who live in rural areas of Georgia at a distance from hospital and other medical facilities
- Telemedicine increases the quality of care by striving to provide all rural Georgians with access to specialty care within 30 miles
- Provides network technology through Private Internet...Intranet, IP video conferencing
- Currently the Telemedicine network has:
    - 127 presentation sites/Hospitals, FQHCs, PCPs, Nursing Homes, Community Mental Health Boards
    - 27 Specialty/Specialist sites
    - 105 specialist representing 37 specialties
- Opportunities:
    - TeleTrauma
    - TeleStroke
    - Community Mental Health Service Boards
    - Skilled Nursing Home Facilities
    - Corrections
    - County Jail
    - Chile Advocacy0Child Abuse)
    - Child/Adult Protective Services

- TeleTrauma saves lives, increases efficiency and is cost effective, improves level of care and decreases unnecessary transfers

Steve Barber commented that this program can be a huge benefit for physicians. Also beneficial as a Continuing Medical Education (CME) tool using webinars.

Paula Guy shared that hospitals are beginning to use internally as an opportunity to work with Hospitalist in a pilot program.

Jimmy Lewis commented of the profound growth of the program that grew from 45 to 127 sites. The program empowers them to interact with nursing homes and correctional facilities, which creates tremendous savings for those facilities.

Vi Naylor asked for explanation of the facility fee.

Paula Guy explained it as a monthly charge of $25 for the facility to have the program and an initial fee of $475.00.

Charles Owens asked if a survey has been done to show retention for providers.

Paula Guy answered that the physicians are 90 – 95% satisfied with the program, but no survey has been done to show negative to positive retention. In the future, they hope to use the program as a tool to attract physicians to the State of Georgia.

Greg Dent inquired about the usage based on payor mix.

Paula Guy commented that the physicians would not take uninsured patients.

Greg Dent asked how the issue can be taken to the Legislative budget committee. There needs to be more physicians to volunteer, especially in the specialist field.

Vi Naylor stated that the Georgia Partnership for Caring has a list of volunteer physicians that might be useful. Another resource is The Good News Clinic, Gainesville. They are a free clinic that has negotiated with area physicians to volunteer a certain number of hours each month to the clinic.

Charles Owens introduced Renee Morgan, Trauma Systems Manager, Division of Emergency Preparedness and Response, Department of Community Health, and asked her to give an update on the status of the Georgia Trauma System.

Renee Morgan shared that she has an EMS background and now works with DCH as Trauma Systems Manager. A Georgia Trauma Care Network Commission was established when Governor Perdue signed Senate Bill 60 into law and appropriated $58.9 million to trauma care providers. The commission is comprised of a nine member Board who will oversee state money set aside to assist trauma care hospitals. The commission has the task of developing and organizing the network of state trauma centers that have the ability to treat the most critically injured patients. Georgia's trauma death rate is above the national average because Georgia does not have an adequate statewide trauma system.

Ms. Morgan explained that access to trauma care is a matter of life and death and trauma is the number three cause of death across all age groups. There are 15 trauma centers in Georgia serving at four levels of care:

- Level I – staffed by the most specialized personnel and equipped with the latest medical technology
  - Georgia has four
- Level II – similar to Level I, but may not have research and education component – care level same
  - Georgia has 7 adult and 2 Pediatric
- Level III – has lots of resources, but may lack in specialty care component
- Level IV – limited capabilities
  - Morgan County and Walton County

Accomplishments of the past year include the purchase of 56 ambulances. They hope to double that number next year and to purchase remounts for certain areas. Another focus in the future is to work on rural health education for trauma health in their facility. Programs in the mid-western states have found that focus to be fruitful.

Telemedicine is also a valuable tool that can be used effectively for trauma care. Through telemedicine, they are able to access medical care otherwise unavailable to them in a small hospital. A trauma center is a positive factor to ensure more revenue. It builds confidence among the community for the facilities ability to care for any injury.

Ms. Morgan stated that a past rural trauma pilot project in Columbus with a Critical Access Hospital was not a complete success and they have learned from those mistakes. Because of a high turn over in personnel, they were unable to keep the program functioning properly. To correct that issue, they have contracted with a person to serve several hospitals to ensure consistency with data collection.

Ms. Morgan said they will assist anyone who has an interest in becoming a trauma center.

The meeting dismissed for lunch and returned to hear Vi Naylor, Georgia Hospital Association, give a presentation.

Vi. Naylor, GHA, gave a presentation on the following:

- Continuing FLEX Focus
  - Collaboration
  - Physician Peer Review
  - Data Analysis Services
    - Outpatient Program
  - Quality and Safety Improvement
    - Process, Outcome and Top Ten/Reliable Process Program
- Hospital Outpatient (HOP) Measures
  - Acute Myocardial Infarction
  - Chest Pain
  - Outpatient Surgery
  - Imaging
- Benefits of Hospital Outpatient Quality Data Reporting Program (HOP QDRP)
  - Less elements to abstract than Inpatient measures
  - Easier to abstract than Inpatient
  - Three of the measures are claims-based with NO abstraction required
  - More relevant measure of CAH quality
  - Less time involved abstracting
    - Average time to abstract an inpatient case – 45 minutes
    - Average time to abstract an outpatient case – 20 minutes

- Georgia CAH's gaining on National CAH's
  - US Average Nationwide = 93.0%
  - Georgia Average = 92.4%
  - Honor Roll = 91%
- Completed 21 Physician Peer Reviews
- GHA Strategic Board Initiative to move Georgia to the top ten
  - Made Quality a standing Board agenda item
  - Communicated Board's action
  - Stepped up Trustee Education
  - Increased public recognition
  - Increased physician and CEO engagement
  - Invitational Conference: From Worse to First
  - Created infrastructure to implement conference recommendations
- Appropriate Care Measures needing attention
  - Reliable Process Design
  - Sharing Best Practices
  - Sample Improvement Studies
  - Data Driven Quality and Patient Safety Improvement
  - Hospital Mentor Program
- Created "Right Care Every Time" Honor Roll in three levels
  - Chairman's Honor Roll (98 - 100%)
  - Presidential Honor Roll (93 - 97%)
  - Honor Roll (91 – 92.9%)
- Recognized past CAH Patient Safety Award Winners ('02 – '08)
  - Mountain Lakes Medical Center
  - Louis Smith Memorial Hospital
  - Brooks County Hospital
  - Higgins General Hospital
  - Peach Regional Medical Center
  - Bacon County Health System
  - Monroe County Hospital

Patsy Whaley, Director, SORH Hospital Services, initiated a discussion to obtain suggestions for the next FLEX grant projects. She explained there will be two required projects, CAH Sustainability and Quality Assurance. She asked Charles Owens to share information from a recent conference he attended.

Charles Owens reiterated the required projects would be CAH Sustainability and Quality Assurance. He then explained electives will be related to EMS, Rural Health Networks and Program Evaluations. Since the FLEX program has recently completed the program evaluations, it may not be feasible to initiate another evaluation so soon. He suggested focusing on EMS and how to maximize that program.

After much discussion, a consensus of the following projects was concluded:

- Cost Ratio
- Engage in revenue cycle management
- Charge Master
- Strategic Planning

Charles Owens thanked Mr. Dent and his staff at Community Health Works for hosting the meeting. There being no further business or public comment, the meeting was adjourned.

Respectfully,

_____ _____

Kevin Taylor, Chairman/Date Sheryl McCoy, Recording Secretary/Date

_____

Stuart Tedders, Secretary/Date