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February 2011

HEALTH REFORM:

From Insights to Strategies, A Variety of Perspectives



Georgia Health Policy Center
Andrew Young School of Policy Studies
Georgia State University

 Georgia
Health Policy
Center

COMMEMORATING
15
YEARS

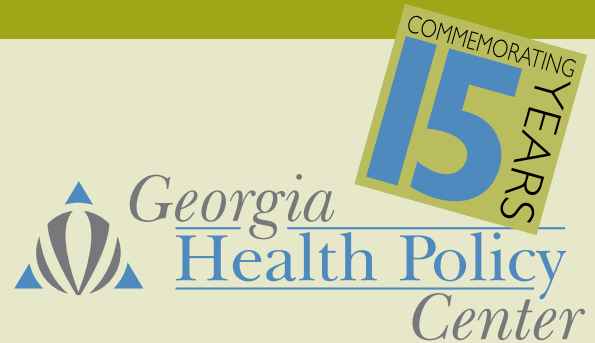
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University | ANDREW YOUNG SCHOOL
OF POLICY STUDIES

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February 2011

HEALTH REFORM: From Insights to Strategies, *A Variety of Perspectives*



Foreword

The Affordable Care Act (health reform) has significant implications for health care financing, service delivery, coverage, access, quality, and ultimately the well-being of all Georgians. For the past year, the Georgia Health Policy Center, housed within Georgia State University's Andrew Young School of Policy Studies, has been studying health reform and seeking ways to translate what we learn so that it can be used by key stakeholders to make informed decisions.

To discern how the Act might specifically affect Georgia's health care system, we chose to commemorate our 15-year anniversary by conducting strategic consultations of the likely impact of health reform on a diverse group of stakeholders: provider organizations, rural and urban community-based groups, small and large businesses, professional associations, and local and state government entities. Following these consultations, we hosted an all-day Health Reform Symposium to share discoveries and potential implications for a broader array of organizations and communities throughout the state.

We are pleased to share this summary of our efforts and hope that it will help community and state leaders better understand and respond to the technical and adaptive challenges of health reform. Through strong leadership, collaborative partnerships, education and information sharing, we can continue to make progress in meeting the complex health needs of Georgia's residents.

A handwritten signature in black ink that reads "Karen Minyard".

Karen Minyard
Executive Director, Georgia Health Policy Center

Acknowledgments

We wish to acknowledge the willingness of 15 innovative agencies and associations that participated in a strategic consultation of the likely impact of health reform on their organizations' staff and constituents.

- Academy of Independent Pharmacy
- Board of Regents of the University System of Georgia
- BrownRichards & Associates, Inc.
- Community Health Works
- Division of Aging Services, Georgia Department of Human Services
- Effingham Hospital and Care Center
- Georgia Association of Community Service Boards
- Georgia Dental Association
- Georgia Free Clinic Network
 - Coastal Medical Access Project
 - Good Samaritan Health and Wellness Center
 - Troup Cares Network
- Georgia Nurses Association
- Laurens County Health Department
- Meriwether County Health Department
- Piedmont Primary Care Practice
- Primary Care of Southwest Georgia, Inc.
- Richmond County Board of Health

In addition, a debt of gratitude is due for the tireless work of the health reform team, comprised of experts from across Georgia State University in the Andrew Young School of Policy Studies, College of Health & Human Sciences, and the J. Mack Robinson College of Business. Without their collective wisdom and teamwork, this initiative could not have succeeded.

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Angela Snyder

John Butts

Jim Marton

Natalie Towns

Rachel Campos

Karen Minyard

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Cindy Davis

Tamanna Patel

Naima Wong

Dame Epiphane

Bruce Perry

Mei Zhou

Rachel Ferencik

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Background

The Georgia Health Policy Center (GHPC), housed within Georgia State University's Andrew Young School of Policy Studies, provides evidence-based research, program development, and policy guidance to improve health status at the community level. Since 1995, the GHPC has focused on solutions to the toughest health care issues including insurance coverage, long-term care, children's health, social determinants of health equity, and the development of rural and urban health systems. Center staff currently work throughout Georgia and in more than 220 communities in 50 states.

Since the passage of the Affordable Care Act (health reform), GHPC and its health reform team have been studying its implications for the state, community-based organizations, health providers, and businesses. The team is comprised of experts from across Georgia State University including faculty and staff from the Andrew Young School of Policy Studies, the J. Mack Robinson College of Business, and the College of Health & Human Sciences. They have expertise in: policy, health administration, economics, insurance, financing, employee benefits, risk management, long-term care, public health, and more.

The GHPC's aim has been to translate the many features of the Affordable Care Act (ACA) so that stakeholders throughout Georgia can use them to make informed decisions. This requires not only a deep understanding of the ACA's details but also of how it plays out "on the ground." Consequently, in commemoration of its 15-year anniversary, the GHPC offered to conduct strategic consultations of the likely impact of health reform on 15 diverse Georgia stakeholder groups, one for each year of the center's existence. Potential groups included provider organizations, rural and urban community-based groups, small and large businesses, professional associations, and local and state government entities. The GHPC viewed these consultations as its opportunity to "give something back" to the organizations and communities that have supported the center since its inception and offered them free of charge.

The consultations culminated in a Health Reform Symposium on October 21, 2010 in Atlanta, Georgia. Representatives from the 15 sites were joined by additional stakeholders

interested in learning about the consultations and the implications for their own organizations and communities.

This report briefly summarizes the health reform legislation, outlines the process used during the on-site consultations and symposium, highlights findings and lessons learned, and captures the insights of a wide range of perspectives for responding to the challenges of health reform.

Other Work of the GHPC

Legislative Education Initiative

In response to legislative requests, the GHPC created the Legislative Health Policy Certificate Program for state lawmakers who want to improve their understanding of health and health care. The objectives of the program are to develop a cadre of legislators with more in-depth knowledge and understanding of health policy issues and to use system dynamics and systems thinking to encourage broader and more systemic approaches to policymaking.

Community Health Systems Development

The Community Health Systems Development team provides programmatic and organizational sustainability assistance to grantees on behalf of the Office of Rural Health Policy, Health Resources and Services Administration. The program focuses on helping communities build local capacity to increase access to primary care and improve the health status of their residents.

Health Insurance Coverage

The GHPC helps shape how Georgia addresses the costs – both monetary and societal – of those without health insurance coverage. Private foundations and state and federal agencies invest in a wide range of projects to: examine the role of community initiatives in managing care for the uninsured, study health care coverage for young adults, develop a strategy for providing affordable health insurance, and evaluate existing services.

Long-Term Care

Since its founding, the GHPC has worked with local, state, and national public and private partners in contributing to and evaluating long-term care policy, striving to make a difference in the lives of Georgia's older adults and adults with disabilities.

Health Care Reform

Health reform, known as the *Affordable Care Act (ACA)*, was signed into law in the spring of 2010. One of the driving concepts of health reform was to provide more Americans with health insurance coverage. Once the law is fully in effect, the percentage of uninsured Americans will decrease from the 2008 level of 17% to an estimated 6% (in Georgia the percentage decreases from 19% to 5%).

The ACA calls for changes in four major areas.

1. **Changes in public coverage:** Eligibility for the Medicaid programs will be expanded to include all Americans up to 133% of the Federal Poverty Level. This expansion will increase the number eligible for Medicaid by approximately 16 million Americans, with the largest increase being men who are not currently eligible. The full cost of this expansion will be paid by the federal government in 2014, with a phase-in of state share starting in 2017.

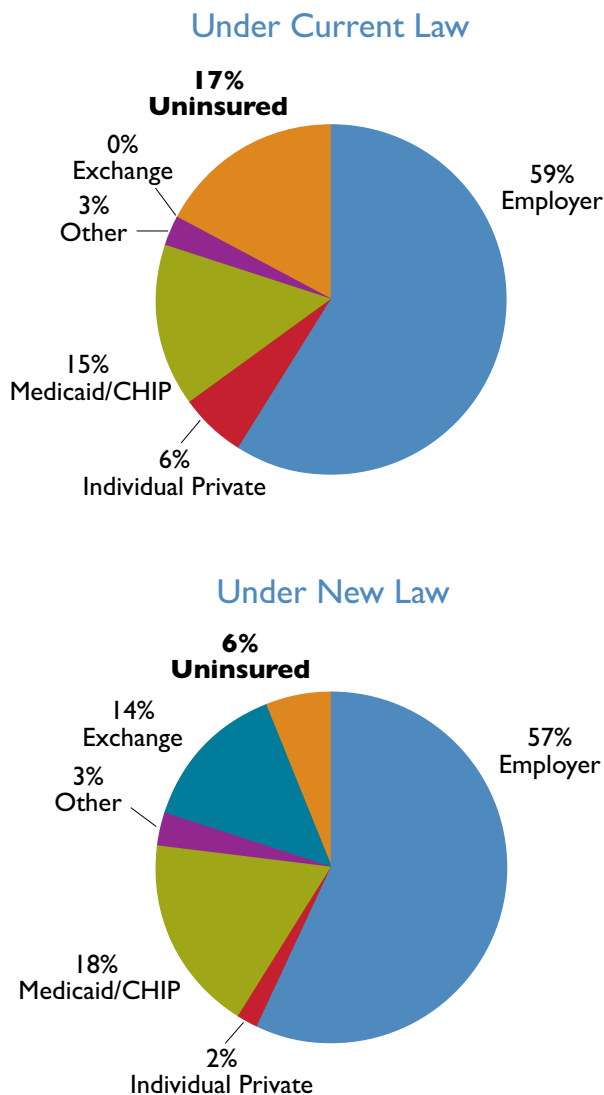
2. **Changes in private coverage:** Modifications in current insurance regulation practices include: community rating rather than risk-adjusted premiums; no pre-existing condition exclusions; no lifetime and very limited annual benefit caps; prior approval of rate increases; and mandatory medical loss ratio of 80 or 85% (by group size). The legislation also creates a high-risk pool as a bridge to provide a way to obtain coverage until other insurance market reforms are fully implemented. In addition, it allows for health insurance exchanges, an organized market for health insurance with the structure determined by each state. The exchanges will: establish common rules for benefits and pricing; offer consumers a choice of plans; provide consumers information about their choices; facilitate plan enrollment; and administer the subsidies for people who earn less than 400% of the Federal Poverty Level.

3. **Changes in health care quality:** A variety of strategies address the need for improved quality of care: incorporating best practices and systematically collecting and analyzing health care data; streamlining and coordinating care, as well as encouraging interdisciplinary treatments; instituting a series of quality-driven incentives and penalties for providers; and funding to study and implement evidence-based practices related to the financing and delivery of Medicare. Many of these strategies focus on decreasing the overall cost of health care.

4. **Changes in health:** Efforts to improve health and well-being will be coordinated by a national council, supported by research and innovation, and implemented through insurance coverage requirements and state

Figure 1

Health Insurance Coverage



These charts represent the non-elderly and are preliminary estimates subject to revision.

and community programs. Wellness and prevention services and research will be expanded to focus on physical activity, nutrition, emotional wellness, smoking cessation and other chronic disease priorities. Public and private insurers will be required to provide preventive and wellness services in their qualified health plans, and employers will be permitted to incentivize employee participation in wellness programs. State and local agencies will be given opportunities to apply for federal funds to implement programs to create healthier communities.

Information shared in this report is based on the law as it is known at this time and is our best interpretation of the data. As the law is written into rules, it will be further interpreted. Many details are subject to change.

For more information about health reform, see www.gsu.edu/ghpc.

The Consultations

GHPC offered to conduct strategic health reform consultations for 15 diverse organizations in Georgia to better understand the issues individuals and organizations are grappling with and help them think systematically about how to respond. In lieu of consultation fees, GHPC requested that interested groups commit the time needed for successful completion of the consultation.

To get the process started, GHPC informed a wide variety of Georgia organizations and agencies of the opportunity to participate in these free consultations. They included a diversity of provider and employer groups as well as a balance of urban and rural entities: hospitals/clinics, federally qualified health centers, small businesses, local and state governments, school clinics, community-based organizations, public health departments, safety net providers, nursing homes and other long-term care providers, legislators, home visitation programs, and academic health providers.

Each interested group submitted a letter of interest and completed the interest form. (Figure 2) Once the 15 groups were selected, GHPC staff followed up with a telephone call to obtain additional contextual information and then conducted background research and analysis with input from other key stakeholders, policy analysts, and subject matter

experts on the health reform team. As each analysis was completed, GHPC staff met onsite with the stakeholder group to present findings and facilitate a two- to three-hour strategic consultation session on understanding and adapting to health reform. They also began to explore the issues that were of most concern to them and what their next steps would be (see Appendix for more detailed information about each consultation). When all site visits had been completed, the team convened to debrief on their experiences and identify lessons learned.

Figure 2 The Process

- Request for Letters of Interest
- Telephone Assessment Interview
- Background Research
- Document Review
- Health Reform Work Group Input
- On-site Strategic Consultation
- Team Debrief on Site Visits
- Think Session on Cross-Cutting Themes
- Report on Consultations & Symposium

Lessons Learned from the Consultations

Several critical insights emerged from the strategic consultations. Four that are particularly noteworthy revolve around the perspectives from which individuals view health reform, the challenges they face, the opportunities for innovation, and the role the GHPC can play in this arena.

Perspectives on health reform

The changes inherent in health reform have extensive implications for all aspects of the U.S. health system: financing, service delivery, coverage and access, quality, and ultimately, well-being. As a result, consultation participants are affected

in many ways – personally as individuals and family members, as leaders or members of an organization or trade, and as part of larger communities and health systems. (Figure 3)



Ultimately, the questions they ask and the actions they will take over the next few years will largely be determined by which of these perspectives they use as a point of reference for decision making.

On a personal level, consultation participants viewed the changes inherent in health reform from an individual perspective as consumers, patients, purchasers of insurance, employees and professionals. At this level, questions and reactions revealed that they were concerned with issues

related to their own well-being and that of family members and friends. An example of a personal level question might be *“Will I be able to continue using my longtime family doctor?”*

The GHPC discovered that as individuals' personal questions were answered, they were able to move to a broader perspective and examine the changes and issues through an organizational or trade lens – wearing the “hat” of employer, provider, insurer, or board member. An example of an organizational level question is *“How will health reform affect my business or my organization?”* At this level, conversations were more strategically oriented, focused on positioning institutions and professions for success and meeting health needs over the long term.

Occasionally during the consultations, stakeholders moved to the broadest perspective, the larger health care system. At this level, stakeholders sought to understand how the various elements of reform fit together, how changes in one part of the system impact other components, and how or whether system goals such as health improvement or maximization of resources could be achieved. An example of a system level question is *“How does access to mental health care factor into the whole health reform initiative?”*

Because all of these perspectives are linked and because change in one level affects the others, broad transformations such as health reform are very difficult to navigate.

Technical and adaptive challenges

Marty Linzky and Ronald Heifetz, leaders in the field of management consulting, talk extensively about the differences between technical and adaptive challenges. Technical challenges, while not “simple,” are solvable. Through research and practice, effective approaches have been designed and adopted, even if they require intense skill and expertise (such as brain surgery).

Adaptive challenges, on the other hand, are quite different. They have rarely, if ever, been solved and often they are being seen for the first time. There is no expert, no one with “the answer.” Solutions require both experimentation and innovation.

“Great athletes must simultaneously play the game and observe it as a whole”

– Heifetz and Linsky¹

Figure 4

Types of Challenges

Technical Challenges

- **Ready made solution exists**
- **Someone has *The Answer***
- **Standard Operating Procedures (SOPs)**
- **Even if they require intense skills, some expert knows exactly what to do...**

- **Examples**

Building a hospital

Fixing a broken computer

Brain surgery

Adaptive Challenges

- **Never solved issue**
- **Perhaps new, never seen before**
- **No one's got *The Answer***
- **Must be solved by collaboration**

- **Examples**

Poverty

Reforming public education

Health reform

through this uncharted territory of health reform, leaders must be able to deviate from their plans as learning takes place.

During the consultations, both types of questions were posed. Initially, participants were universally “hungry for technical information and detail” about the ACA. Once these questions were answered, however, participants were able to begin thinking about adaptive challenges, seek diverse perspectives and pursue collaborations to prepare for implementation. Some of the more common questions asked in light of adaptive challenges include:

- How long will it take us to see the results we anticipate, and how can we reduce or tolerate delay? If there were no delay, would we still do it?
- Is there a consequence of my action that I'm not seeing?
- Are we missing good solutions because they will help us in the long-term but hurt us first? Can we learn to reduce or tolerate the short-term hurt?
- If a solution helps us right away, what are its long-term delays? Are we likely to regret it later?
- How can I change a small thing to get big results that will endure?

Diversity and innovation

The consultations reinforced the value of gaining insights from diverse perspectives, particularly in light of health reform's complex adaptive challenges. A whole new health care system is emerging, with great opportunities for innovation. New and creative ideas will come from organizations, agencies and individuals working “on the ground” at the community level to deliver quality care to Georgia's residents.

GHPC's unique role

Feedback from the sites underscored the value of an agency like the GHPC, that has been working throughout the state, understands Georgia's unique issues, and has carefully studied health reform. Bringing this knowledge together to help organizations navigate the changes ahead – through information, resources and technical assistance – is of great benefit.

Health care reform presents both types of challenges. (Figure 4) Some are routine and technical (e.g., who will be eligible for Medicaid, who will be eligible for subsidies), while others are adaptive and require planning, building partnerships, gathering information and building capacity. To navigate

¹ Ronald A. Heifetz and Marty Linsky, “A Survival Guide for Leaders,” *Harvard Business Review*, June 2002, pp. 65-74.

THE SYMPOSIUM



The October symposium was designed to share what was learned through the consultations and to lay the groundwork for strategic action and innovation within the broader context of health reform. Specifically, the GHPC hoped participants would gain:

- An expanded view “from the balcony” of the implications of health reform for various stakeholder groups and the system as a whole;
- Insight regarding common interests and challenges among providers, businesses, professional organizations, and communities revealed through the 15 case examples and dialogue among participants; and
- Ideas and strategies for providing organizational and system-wide leadership during this critical period of transformation.

The lessons learned during the consultations shaped several unique features of the symposium.

The participants

The 130 symposium attendees ensured a diversity of perspectives: 25 participants were part of GHPC's consultation team; 50 worked at the 15 sites and participated



in consultations; and 55 were GHPC partners and other stakeholders interested in learning more about health reform, the consultations, and the implications for themselves, their own organizations, and Georgia's health care system.

Rather than the traditional classroom style seating (with chairs in rows), participants were assigned to one of 15 round tables to deliberately mix perspectives and allow ample opportunity for varying views to be shared.

The agenda

The day was structured to focus first, during the morning, on the technical aspects of health reform and to then explore the adaptive challenges that participants are likely to face. Three presentations to provide information and establish a base of common knowledge were interspersed with breakout sessions to give participants a chance to explore that knowledge with others at their assigned tables or in small groups, and begin to grapple with its implications. Following each breakout session, a spokesperson from each group shared the highlights of their discussion with the full assembly. (Figure 5)

Also undergirding the symposium agenda was the GHPC's commitment to giving participants ample opportunity to view health reform from a personal "on the ground" level before moving to an organizational level and finally "getting on the balcony" to examine system-wide implications for

Figure 5

Mix of Presentations and Discussions During the Symposium

The morning

- Presentation on the basics of health reform – the "technical" aspects, a refresher for some but new information for others – followed by a breakout in which participants could ask, and get answers to, their specific "burning" personal questions
- Presentation on the general lessons learned from the 15 consultations, followed by a breakout in which participants from the sites shared their reflections on the consultations with those at their table, actions taken as a result, and recommendations for other organizations

The afternoon

- Presentation on a framework for dealing with the "adaptive" challenges of health reform – viewing the different levels of system change that are a part of the reform effort and identifying key leverage points for system change – followed by a breakout in which participants could visit multiple stations throughout the room to discuss the implications of eight common adaptive challenges
- Presentations on each consultation – facilitated by the leader of each consultation using posters summarizing the relevant study question, analysis and conclusions – followed by a final breakout in which participants identified what more is needed to act strategically in response to health reform

communities and the state as a whole. (Figure 6) Ultimately, the goal was for stakeholders to leave the symposium with a deeper understanding of the basics of reform and,

perhaps more importantly, ideas and strategies for providing organizational and system-wide leadership during this critical period of transformation.

Figure 6

A Sampling of Burning Questions

A wide range of questions were posed prior to and during the consultations, as well as during the symposium. Some pertained to personal issues, many conveyed organizational concerns, and several applied to the system as a whole.

Personal concerns

- Will I have to pay more to stay with the doctor of my choice?
- What are the limitations for adult children, ages 23-26, with respect to being enrolled in health care plans?

Organizational/Trade concerns

- Will insurance options be of the same basic quality?
- What will be the future of free clinics? How will they be sustained?
- Who will control the health insurance exchange in Georgia?
- Are there any incentives for specialty care in rural communities?
- How can we access benchmark outcomes?
- What impact will health reform have on providing care for the large undocumented population?
- What federal or state entity is developing the package of benefits?
- What is the role of lobbyists in these policies?
- Will health reform cause a rise in bureaucracy?
- Will doctors be required to participate in the plans within these health insurance exchanges?
- Is it “all or nothing” for a physician to participate in the exchange? Does health reform address scope of practice differences across states, for example, advanced practice nurses?

System concerns

- What is the role of the state of Georgia in all of this reform, especially with respect to its implementation?
- How do we consider the trend regarding the cost of medication?
- How will the system guard against fraud?
- Where is education and training within the state strategy?
- Will health reform make it more difficult to access care?
- How will the system deal with malpractice issues?
- What are some of the fines, taxes, penalties involved with, imposed by health reform?
- What is the status of the lawsuit from the state of Georgia opting out of health reform?
- Will people be able to afford the available services and plans?
- How does this change behavior with respect to accessing care?

Common Themes

The themes that emerged from the consultations related primarily to the adaptive challenges of health reform. By their very nature, these challenges have no ready answer or response; instead, community leaders must “learn as they go,”



making sense of what is happening as it unfolds and adjusting accordingly. Eight of these themes were explored during the symposium to better understand their complexities and identify opportunities for strategic action. In this section of the report each theme is introduced as it related to the onsite consultations, using a few illustrative examples, and then described further as it was explored at the symposium.

Influencing decisions about health reform

Many, if not most, of the decisions for implementing the Affordable Care Act have yet to be made. This leaves a tremendous opportunity for state and local groups to potentially influence the decision-making process and the outcomes.

The ACA includes several provisions expected to benefit community pharmacy as an industry. Most significant among these are the growth in predicted demand and the expansion in third-party payment for prescription medications, equipment and supplies. To influence decisions about health reform, the **Academy of Independent Pharmacy (AIP)** plans to further cultivate their interdisciplinary relationships and networks in order to be ready for new collaborative opportunities, keep abreast of developments in the implementation of

the law, seize opportunities to help shape regulations, and seek ways to stay informed and help customers understand health reform as it rolls out.

The Division of Aging Services (DAS) focused on the ability of the state's aging network to address the health and long-term care needs of Georgia's older adults, individuals with disabilities and caregivers. The group was particularly interested in changes related to Part D and Medicare Advantage plans. Realizing that these changes have the potential to alter the way care is delivered to a more team-based model, DAS committed itself to take advantage of opportunities related to such new care teams.

The Georgia Association of Community Service Boards (CSB) shared three major needs: a strategic discussion around the CSBs' role in advocacy, commitment to the rehabilitation model versus adopting a medical model, and the possibility of local CSBs forming separate 501c3 agencies. These themes all came from a collective realization that as the benefit packages are designed, mental health services provided by the CSBs may no



longer be viable. The consultation illuminated the likely influx of new managed care patients and the possibility of losing federal and state funding. To prepare for this situation, the most important next step is to determine

the Association's role going forward. Complementing this step, CSB plans to: develop a way to monitor regulations, decide among themselves if they need to advocate for rehabilitation services or convert their services to adhere to the medical model, and think about workforce development.

The Georgia Dental Association (GDA) seeks to become more knowledgeable about dental provisions in the law. The association wants to know when regulations and further decisions pertinent to dental provisions will be made so they can help inform the decision-making process. As a first step, the GDA will conduct more research on the national level committees identified in the ACA and ensure that dentists have representatives on them. Another major step is to communicate with the American Dental Association to be sure that they have a full understanding of health reform, especially the benefits for children, and begin educating their membership about how health reform will impact them – especially as small businesses.

Symposium attendees suggested influencing decisions through legislators, community forums, social media, reacting to government “calls for response,” staying networked to information, and convening diverse stakeholder groups.

Educating others about health reform

As a result of each of the on-site consultations, participants felt that they were far better informed about the technical aspects of health reform. In some cases, confusion and



anxiety were still present but to a far lesser degree. They also had a greater appreciation for the need to educate others, be they employees, constituents, community residents, stakeholders, policymakers, or those with a stake in the health system changes that have or will take place.

The Board of Regents of the University System of Georgia was concerned about how health reform affects its ability to offer a benefit package that is cost-effective and competitive. Consultant information and actuarial analyses suggested that health reform would have limited effect in the near term. Conversation focused on educating members about the importance of healthy behaviors, managing health care utilization, and identifying and rewarding cost effective providers.

Community Health Works (CHW) was interested in exploring how the ACA may serve as a catalyst for the region and encourage collaboration among local partners to provide input at the regional, state and national levels to the development of rules and regulations of the Act. The different roles CHW might play include: convening important players in health and health care to more closely examine the ACA; serving as a resource for education and information for individuals, small businesses or other entities affected by reform; or participating in implementation planning work at the local, state and national levels.





Planning in times of uncertainty

Because the changes in the health reform law will take place over several years, organizational leaders are faced with the daunting prospect of making decisions without complete information. In addition, they are acutely aware that the provisions of the law itself may change.

Leaders of the **Coastal Medical Access Project (CMAP)** were concerned about the best model to adopt in order to continue their valuable role as the primary care safety net in coastal Georgia: the current model, Federally Qualified Health Center (FQHC), sliding fee scale, free clinic only, chronic disease management only, or some other option. As a result of their consultation, CMAP plans to take the following steps to make this and other strategic decisions:

- Convene a larger community discussion of a “future’s task force” made up of key stakeholders to determine what the new needs of the community will be and how they can be addressed
- Begin with internal strategic planning to determine the key players, a timeline for implementation, and a funding strategy to cover planning costs
- Take advantage of the materials and technical assistance offered by the Georgia Free Clinic Network in determining how to have larger community conversations that proactively shape the future

During the symposium, participants identified several priority groups to be educated about health reform: Georgia county coordinators, staff and boards of public health agencies, media, chambers of commerce, Division of Family and Children Services (DFCS), faith-based institutions, employers, legislators, students in medical and public health programs, charity groups, Family Connection and – last but not least – family and friends. Key leaders and “multipliers” (e.g., in school systems and extension agencies) should participate in, or even lead, educational sessions since they will instill confidence and trust as they spread accurate information and messages.

Resources that could be helpful leading health reform discussions included:

- Frequently Asked Questions (FAQs) handouts
- A website specific to Georgia, much like healthcare.gov
- A clearinghouse of information
- A train-the-trainer program, to provide information efficiently and consistently
- A primer with the basic information
- “Just in Time” press releases
- A listserv to share and exchange information.

Regardless of the method, information should be neutral (“just the facts”), simple, accurate, and accessible to those with and without computers or other technology. Using the HIV/AIDS educational model was also suggested.



- Develop a local strategy, aligned with a state strategy, on how to meet the needs of patients given workforce shortage concerns
- Conduct a community benefit assessment with the local hospital and university as potential partners.

Troup Cares Network was particularly concerned about how a free clinic network could remain financially viable and medically relevant as health care reform is implemented. While the ACA does not specifically address free clinics, its provisions will have a significant impact on the type of clients seen and the scope of services provided at free clinics. Essentially, charity programs can develop a new model and treat Medicaid and newly insured individuals; continue doing exactly what they are doing now; fill in the gap for the uninsured; or dissolve. Troup Cares agreed that they wanted to maintain their local, community-focused orientation and continue to “fill the gaps” by providing quality care. In addition, leaders are committed to pursuing opportunities to enhance current partnerships and develop new collaborations to meet unmet needs such as the provision of care coordination, patient navigation, health education, health promotion and other social services.

Symposium participants discussed what has worked in similar situations of great uncertainty as possible strategies for planning the health care transition. These included:

- Identify the most likely scenarios and the givens “you can bank on,” and then use them as a foundation for planning
- Pursue good ideas that make sense even in the absence of health reform
- Invest in strong, creative, reassuring and trusted leadership
- Build good information systems to track progress and identify needed adjustments
- Keep staff informed and engaged, and listen carefully to validate concerns
- Seek reliable and accurate information
- Look for “win-wins” that can be gained through collaboration with multiple agencies
- Remain flexible and proactive.



Staying abreast of new information that emerges

Given the length and complexity of the ACA, it is challenging to stay on top of all of the regulations, administrative decisions and guidance that has been, and will continue to be, issued from various sources. Even more difficult is sorting out what this information means and how it should be used.

As a small employer, **BrownRichards** wants to provide a good health plan for its employees. Currently, employees are allowed to select their own individual health plan and the company pays up to 60% of the cost, which is then reported on the employee's W-2 form. Using the GHPC's 50-State Health Reform Calculator for Small Businesses®, it was estimated that this small firm could receive a tax credit. It was also suggested that BrownRichards look into





setting up a flexible spending account. BrownRichards saw health reform as an opportunity to provide employees with health insurance and thus boost its recruiting capacity. As a result, the firm will:

- Explore with its accountant and insurance broker the possibility of applying for a small business tax credit
- Increase its understanding of the IRS code related to flexible spending accounts
- Identify wellness initiatives they may want to offer their clients
- Continue to stay informed about health reform through organizations such as GHPC, the Chamber of Commerce and the national Employee Assistance Program (EAP) association.

Additional sources of information suggested by symposium participants included: the Federal Register, national associations, healthcare.gov, grants.gov, listservs, and clearinghouses at the state level. To better utilize these sources requires staff dedicated to research opportunities, supportive infrastructure, grant-writing capacity, partnering, feedback from federal agencies on unsuccessful grant applications, and the ability to “benchmark”.

Creating partnerships

New collaborations are critical to the success of health reform. This theme was echoed repeatedly throughout all onsite consultations.

Laurens County Health Department identified several areas in which they may need to do business differently: seek and apply for new funding, explore a fee-for-service business model, and build capacity to bill a third party payor. It is likely that more providers will be needed to serve the population enrolled in the programs operated by the department. Improving collaboration among health departments, primary care providers, and the local community was seen as a priority. In addition, utilizing other providers such as their expanded role-nurses (RNs with additional training restricted to specific areas and protocols) will be vital.

The major area of concern for **Meriwether County Health Department** was how health reform will change their relationships with the local FQHC and whether it would turn the current cooperative situation into a competitive one. After learning more through the assessment, however, their fears were allayed. They felt that service needs would be increased for both parties and had a better handle on where the changes will occur. If uninsured become mostly young and healthy groups, they felt it may help them attract paying customers.



Symposium participants suggested that some of the partnerships needed to implement health reform involve coalitions between and among Community Health Centers (CHCs)/FQHCs, provider communities (clinical and administrative), hospitals, businesses, public health departments, local chapters of national associations, universities, governing authorities, community social service organizations, community-based organizations, faith-based communities, legislators, Medicare recipients, AARP, Division of Aging, senior centers, and Area Agencies on Aging. To forge such partnerships, the convener must be a neutral, respected expert that is not a recipient agency, possibly a civic organization or professional association.

“All of a sudden I noticed a remarkable shift in the room, when symposium attendees no longer focused on their personal questions but had moved to a broader system perspective. This symposium enabled them to change the lens through which they viewed the opportunities and challenges of health reform. Many of them had participated in the consultations, but some made this transition in the short span of the meeting day.”

— GHPC staff

Building capacity of Georgia’s primary care workforce

Rough estimates indicate that there will be an additional 1.2-2 million physician visits per year in Georgia as a result of increases in the number of people who have health insurance. This could translate into an additional shortfall of 300-400 physicians in the state. The elimination of copays, deductibles, and coinsurance for many preventive services may also increase the demand for primary care providers.



The **Georgia Nurses Association** agreed that more detailed economic analysis on workforce and the context of the practice environment could advance development of solutions to address barriers and shortages in nursing. They also recognized that to be cost effective, larger health care systems will likely move to a service model where a nurse practitioner (NP) is the first point of contact. Similarly, physicians in solo or small practices will probably benefit from forming stronger partnerships with NPs and other providers such as physician assistants. Several opportunities for partnership and collaboration include: the increased need for placing patients in medical homes, strengthening relations among professional provider organizations, and supporting the reinstatement of a statewide joint practice committee.

Piedmont Primary Care Practice was concerned about workforce needs, interaction with health insurance exchanges, changes to payment rates, risk management, and reform financing. Through the assessment, they learned that the significant increase in the number of insured is likely to result in increased demand for primary care services. ACA provides a number of programs and funding streams to address and strengthen the primary care workforce, including dedicated funding to further develop mid-level provider capacity, and incorporating physician assistants, nurse practitioners, and other physician extenders in the delivery of primary care. The practice currently utilizes a cadre of mid-level providers, but may be able to tap into these resources to expand its ability to provide even more primary care services.

Primary Care of Southwest Georgia (PCSG) decided that there are strong opportunities in health reform for FQHCs and preventive care, but they will need to expand their workforce to accommodate many of the expected changes. Workforce needs include additional providers, front office staff to help people enroll in Medicaid, and business staff to process reimbursements. They felt that the costs of additional providers could be covered through Medicaid and other insurance payments.



Effingham Hospital and Care Center (EHCC) derives a high proportion of its revenue from Medicare reimbursement. As a result, it will need to capture an increasing share of quality data in order to remain compliant with regulations likely to emerge from Centers for Medicare & Medicaid Services (CMS) as the law is implemented. Ensuring that EHCC's electronic records and practice management systems are up to the task will streamline this process and help avoid last minute adaptive problems. A crucial first step is speaking with software vendors about how their systems can adapt to these changes.

Given their role in the community as the local government public health agency, the **Richmond County Board of Health** sees itself in the unique position to serve as a repository for surveillance data and other public health information. In addition, the board is preparing to convert to an electronic records system and recognizes the need for that system to interact with a statewide network and with any forthcoming statewide health insurance exchanges.

Symposium participants discussed the need for additional primary care providers and specialists in family and internal medicine, pediatrics, and gynecology. In addition, they projected a shortfall of non-physician primary care clinicians such as nurse practitioners and physician assistants, dentists, pharmacists, behavioral health specialists, and health educators. To meet this shortfall will require incentives to retain providers in the needed locations; educational initiatives to ensure that the pipeline produces providers that match workforce needs; and better utilization of the current workforce. Additional recommended strategies were to: increase funding, establish a neutral convening body with a "charge from the top;" design care collaboratives at the local level, expand team definitions, offer incentives for student loans to be paid off, and utilize physician extenders through tele-medicine and other forms of creative technology.

Building capacity of information technology

The Affordable Care Act will stimulate demands for electronic records and other health data, and increasingly require complex data sharing systems.

The general sentiment among symposium participants was that information technology (IT) needs and requirements vary and often reflect the idiosyncratic and unique nature of the organization. The most likely IT capacity needs involve:

- Designing patient management and clinical management systems
- Sharing data between systems
- Building IT systems to handle additional claims, provider information, etc.
- Developing data system standards for health.

"I realized how different the needs are for participants from different parts of the state."

— **Symposium attendee**

Several attendees lamented over the lack of collaboration, coordination, and sharing of data and information among various state agencies. In some cases, IT systems “cannot talk to each other” because of technological, bureaucratic, political or organizational barriers preventing data sharing. Among the suggestions for strategic actions were the need to approach vendors, budget strategically and seek technical assistance in defining a common data set with prevention primary care measures, using the banking system as a model, and compiling and disseminating best practices.

Building capacity for care coordination

The ACA includes a number of features for improving coordination of care including: a requirement that health insurance exchanges contract with professional associations and local organizations to provide exchange navigator services; funding to support improved care transition services for high-risk Medicare beneficiaries; establishment of community-based interdisciplinary health teams; and grants to promote comprehensive, coordinated, and integrated health care services for low-income populations.



Good Samaritan Health and Wellness Center plans to seize the opportunity to assume the “navigator” role for their patients. Some patients may need help navigating a complicated eligibility process (e.g., Medicare, PeachCare, individual exchange and small group exchange), interpreting insurance options and completing enrollment procedures. Navigators can also help patients find the appropriate provider for their needs – a provider who will accept their insurance and be easily accessible – and help change access patterns away from emergency rooms. Several grant opportunities exist in the ACA, including contracts for exchange navigators and training opportunities for patient navigators.

To build capacity for care coordination, symposium attendees expressed the need to:

- Understand the administrative requirements
- Have “reimbursement education”
- Link different types of care, e.g., primary and specialist
- Influence decisions about health reform
- Help health networks get pertinent information (perhaps through a website/clearinghouse for information)
- Possess the technical ability to collect information
- Create a two-way flow of information
- Look for grant opportunities.



Implications

At the end of the symposium, participants completed a standardized survey questionnaire to provide feedback and suggestions. Based on their responses, informal comments made during the day, and a debriefing session by the GHPC team, several conclusions can be drawn about the symposium and continuing needs for responding strategically to health reform.



The Symposium accomplished its goals.

As a result of the symposium, the vast majority of participants felt ready to take steps to strategically implement health reform. Seventy-one percent ranked their level of readiness very high (a 7 or higher on a scale of 1 to 10). The symposium helped participants move from the personal level to the organizational and systems levels and view the challenges of health reform as part of a broader system change process.

Collaboration with new partners is essential.

During the day, stakeholders had a chance to share a variety of perspectives, make connections, and build new or expanded networks. Partnerships formed in the meeting room resulted partly from the mix of table assignments and partly from reports of the breakout sessions.

“The benefits of partnerships and collaboration are worth pursuing – with or without health reform. It is important to tie the solution to the problem, rather than strictly to health reform.”

– Pat Ketsche

Attendees shared their appreciation for this opportunity and commented on its value in learning from one another and generating creative solutions to adaptive problems. As one example, partnerships between businesses and community leaders were felt to be essential for ensuring access to care at the local level. Also suggested was an expanded role for mental and dental health in the context of integrated care.

There is an urgent and continuing need for tools and resources on health reform.

To build on the momentum of the symposium and assist participants in leading through health reform, the GHPC provided additional resources for educating and having the conversations with others “back home” in their organizations and communities. These included: a bound version of the consultation summaries, a health reform toolkit on a flash drive with the overview of health reform presentation, a guide for using the toolkit, and policy briefs prepared by the GHPC on health reform. (Visit www.gsu.edu/ghpc)

These resources were very well received, but participants offered other suggestions to enhance communication and information sharing:

- Compile and share the vast array of information about the State of Georgia’s activities (from the Governor’s Office, state agencies, etc.), the myriad facets of specific health care initiatives, budget data, as well as the nature of the workforce and provider distribution.
- Develop a statement of best practices for adaptive approaches to facilitating health reform, along with providing clearer definitions of health outcomes.

- Create a general Frequently Asked Questions (FAQ) form on the technical approaches to facilitating health reform. Such an FAQ should be updated regularly and written to be understandable for a lay audience.
- Establish an electronic clearinghouse for Georgians to visit, check on what other people and professionals are doing, and learn about success stories.
- Create a Georgia version of healthcare.gov.
- Provide accessible information for those without technology resources.

Ongoing efforts are needed to educate and inform others.

A perennial theme emerged which echoed earlier calls during the formal presentation to “educate others” about the often complex nature of health reform. Suggested actions were to:

- Encourage legislative action in Georgia, as well as education for providers and for the public, to foster understanding of the various health care practices.
- Support and encourage policymakers to engage stakeholders.
- Establish ongoing mechanisms for information exchange and education of provider groups.
- Increase the dialogue at the local level about health reform through such strategies as Train-the-Trainer courses, recognizing the “hunger for a balanced community strategy” and the challenges of engaging in “hard conversations.”

- Provide technical assistance to enable communities to have sustained conversations about implementing health reform.



- Empower the school system to distribute information.
- Enable the GHPC to facilitate and replicate the health reform consultations in other sites throughout the state and help develop community implementation plans.
- Conduct “opposition research” to better understand what it is that people want to stop or what it is that they are against specifically.

Strong leadership is crucial, particularly in this time of uncertainty.

Strategic system changers are needed to help navigate health reform and are characterized by:

- An approach with a strategic mind set
- Adaptive leadership through experimentation and innovation
- Ability to build strong diverse coalitions and partnerships
- Collaborative leadership
- Effective communication skills
- Ability to match community resources with the new tools and resources available in health reform to support people who were previously uninsured.





Conclusion

The GHPC is pleased with its efforts to date in helping translate the elements of the Affordable Care Act for stakeholders throughout Georgia. Through the 15 strategic consultations and the subsequent symposium, the center has been able to help community and state leaders better understand the Act, grapple with its implications from personal, organizational and systems levels, and prepare to make informed strategic decisions. Much remains to be done to implement the ACA and its complex technical and adaptive challenges. Meeting these challenges will require strong leadership, new partnerships, ongoing education and communication, information sharing, tools and technical assistance.

It is an opportunity to begin to think strategically and adapt to the reform of tomorrow and the need for more collaboration.

— Symposium attendee

GHPC Resources

The following resources are available online on our Health Reform Resources page.

Visit <http://aysps.gsu.edu/ghpc/4171.html>.

- GHPC Health Reform Policy Brief Series:
 - “An Overview of Health Reform” – This brief takes a broad look at health reform, the impact on Georgia, and the changes occurring over the next few years.
 - “State Implications of Health Reform in Georgia” – This report focuses on the leverage points available to state policymakers and agencies to shape the health care system in Georgia.
 - “Implications of Health Reform for Community-Based Organizations” – This brief addresses elements of the health reform law that are significant to community health initiatives.
 - “The Impact of Health Reform on Health Care Providers” – This publication summarizes the impact health reform may have on health care providers (physicians, hospitals, etc.).
 - “Health Reform Implications for Employers” – This policy brief focuses on provisions in the Affordable Care Act specific to employer-sponsored health insurance plans.
- The 50-State Health Reform Calculator for Small Businesses® – GHPC developed this online tool for small businesses (for-profit and non-profit) to estimate eligibility for tax credits through health reform.
- Basic Components of Health Reform – This fact sheet shares the following four basic areas of health reform outlined by the GHPC:
 - Sources of Coverage in the United States
 - Funding & Spending
 - Major Changes
 - Time Line
- Health Reform Resource Guide – Key terms and helpful websites are highlighted in this guide.
- Leading Through Health Reform – A presentation created to share the basics of health reform and the timeline, and to help people learn to lead in their communities.

STRATEGIC CONSULTATIONS

ACADEMY OF INDEPENDENT PHARMACY

**BOARD OF REGENTS OF
THE UNIVERSITY SYSTEM OF GEORGIA**

BROWNRICHARDS & ASSOCIATES, INC.

COMMUNITY HEALTH WORKS

**DIVISION OF AGING SERVICES,
GEORGIA DEPARTMENT OF HUMAN SERVICES**

EFFINGHAM HOSPITAL AND CARE CENTER

GEORGIA ASSOCIATION OF COMMUNITY SERVICE BOARDS

GEORGIA DENTAL ASSOCIATION

GEORGIA FREE CLINIC NETWORK

- COASTAL MEDICAL ACCESS PROJECT**
- GOOD SAMARITAN HEALTH AND WELLNESS CENTER**
- TROUP CARES NETWORK**

GEORGIA NURSES ASSOCIATION

LAURENS COUNTY HEALTH DEPARTMENT

MERIWETHER COUNTY HEALTH DEPARTMENT

PIEDMONT PRIMARY CARE PRACTICE

PRIMARY CARE OF SOUTHWEST GEORGIA

RICHMOND COUNTY BOARD OF HEALTH

Appendix

Strategic Consultation Snapshots

At the conclusion of the 15 strategic consultations, the GHPC team prepared brief summaries of the critical issues, relevant background information, and onsite deliberations. These “snapshots” were shared as poster presentations during the symposium and are offered here in this Appendix, in the hope that they would not only be useful to the 15 groups but also to other organizations and agencies throughout Georgia facing similar challenges in implementing health reform.

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ACADEMY OF INDEPENDENT PHARMACY

Atlanta, GA



OVERVIEW

The Academy of Independent Pharmacy (AIP) was formed as an academy of the Georgia Pharmacy Association (GPhA) in 1993 to represent the state's independent pharmacists. Owners of approximately 500 of Georgia's 615 independent pharmacies belong to AIP; members also belong to GPhA and to the National Community Pharmacists Association (NCPA). AIP has a 15-member board of directors. The executive director and other staff have offices in Atlanta. AIP leaders describe independent pharmacists as a highly resourceful and resilient group operating under challenging business conditions. They consider community pharmacies to be among the most accessible of health care providers – particularly in rural areas.

STUDY QUESTION

The primary question was: How will health reform affect independent, community pharmacy in Georgia, particularly in rural areas? A secondary question stemmed from the initial interview: How will health reform affect AIP members as small business owners? In addition, the initial interview revealed pharmacists' desire for information and resources to help them educate their customers about health reform.

CASE STUDY ANALYSIS

The case study process included an assessment interview with the executive director and four board members on August 18, 2010; document review and analysis; and an on-site presentation and consultation with the director and five board and at-large members on September 16, 2010.

CONCLUSION

The Affordable Care Act includes several provisions expected to benefit community pharmacy as an industry. Most significant among these are the growth in predicted demand and the expansion in third-party payment for prescription medications, equipment and supplies. As more individuals have health insurance coverage, more will access medical care and receive necessary prescriptions. With pharmacy designated as an essential benefit for plans in Insurance Exchanges and federal programs, more of the medicines and

supplies prescribed will be paid by insurance. The phased elimination of the Medicare Part D "donut hole" also contributes to these trends.

In addition, the Act presents potential opportunities for pharmacists to expand the services for which they receive compensation. An example is the already-growing trend for pharmacists to be compensated by insurers for medication therapy management (MTM) services. The ACA established a program to provide grants or contracts to eligible entities to implement MTM services provided by licensed pharmacists as a collaborative, multidisciplinary approach to the treatment of chronic diseases for targeted individuals; and beginning in 2012, Medicare part D prescription drug plan sponsors will be required to offer MTM services to targeted beneficiaries on an opt-out basis. Community-based collaborative care networks and interdisciplinary health teams are other programs in which pharmacists could play a role.

On the other hand, some provisions of the ACA are likely to be adverse to AIP interests. A strongly-expressed concern of the assessment participants, for example, was the burden of administrative requirements, which may increase under the new law. Changes to FSA and HSA rules and the expanded 1099 reporting requirement are two examples. AIP members maintain that such uncompensated demands on their time impact independent pharmacists more, proportionately, than they do large chains.

Certain market factors are also significant existing concerns of AIP members; for example, the relative power and influence of pharmacy benefit managers (PBMs) and the size of volume discount percentages that large chains enjoy. The ACA does not directly address these structures; and independent pharmacists' concerns are heightened by this silence and the unknowns of implementing regulations.

Changes in the law that will affect AIP members as small business owners include new tax credits for those that offer health benefits to employees; employees' future access to a range of plans, and some to federal subsidies; through health insurance exchanges; the increase in the Medicare tax; and the

elimination of the federal tax deduction for retiree drug subsidy payments. Employers will need to examine the formulas for tax credits and penalties to determine what route is in their best interest; the GHPC 50-State Health Reform Calculator for Small Businesses® can help them do that.

Nearly all participants felt less confused and anxious about health reform after the assessment than they did before it. Most said that, initially, they got much of their information on the subject from customers, and acknowledged that this information was highly variable in depth, accuracy and impartiality. These individuals felt they had a better understanding of the legislation after the assessment and were more confident in being able to help customers sort out the issues. Some of the anxiety that remained had to do with current challenges independent pharmacists face for which the ACA does not appear to offer relief, and the many unknowns yet to be determined through rules and regulations. Participants also were concerned about the effectiveness of the financing plan for the new law; and they wondered whether the law might be partially overturned.

Three broad next steps for the organization in regard to health reform are to:

- 1) further cultivate their interdisciplinary relationships and networks within their communities in order to be ready for new collaborative opportunities;
- 2) keep abreast of developments in the implementation of the law and seize opportunities to help shape regulations; and
- 3) seek ways to stay informed and help customers understand health reform as it rolls out.



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

COASTAL MEDICAL ACCESS PROJECT

Brunswick, GA

OVERVIEW

The Coastal Medical Access Project (CMAP), formalized as a nonprofit in 2002, is a free clinic whose mission is to build healthier communities in Coastal Georgia through programs that increase access to healthcare. CMAP provides three distinct but coordinated services to the uninsured or underinsured residents of Camden, Glynn and McIntosh counties. Those eligible for services have incomes less than 200% of the FPL.

Through partnerships formed with over 70 volunteer physicians, pastors and their faith communities, housing authority officials, service organizations, private businesses, the Southeast Georgia Health System, the Coastal Health District, Georgia's Department of Family and Children's Services, school systems, and other volunteers, CMAP offers clinic services including primary, specialty, dental and vision care; Medicaid prescription assistance; and chronic disease prevention and management. Since 2003, CMAP has served 2,389 unique individuals with 13,093 patient visits. Their strong, mission-driven board of directors is comprised of healthcare professionals, private industry, government employees, and community members.

STUDY QUESTION

What is the best model for CMAP to adopt in order to continue as the primary care safety net in coastal Georgia when health reform is fully implemented – current model, FQHC, sliding fee scale, free clinic only, chronic disease management only, or some other model?

CASE STUDY ANALYSIS

An initial phone interview was conducted with the organization's interim CEO, Resource Development Consultant, and the Nurse Practice Manager on August 17, 2010. To gather additional information about the organization's history, mission, and programmatic design, research was conducted using the organization's website and patient case load monthly summaries.

The onsite strategic session was held at the Brunswick clinic location on October 13, 2010 from 8:00 a.m. – Noon. The six participants included two board members, the Interim CEO, the Resource Development Consultant, the Executive Assistant, and the Director of the Georgia Free Clinic Network.

CONCLUSION

The major themes of the onsite strategic assessment were:

Projected Uninsured

Once fully implemented, the Affordable Care Act (ACA) is expected to cut the uninsured in Glynn, Camden, and McIntosh counties by roughly 35 percent, but the remaining number of uninsured will still be significant. A majority of the patients currently served by CMAP's programs will be eligible for Medicaid or have annual incomes low enough to qualify for tax subsidies.

Those remaining outside of the newly expanded system of coverage will include: non-citizens, those still without affordable coverage options available to them, those choosing to pay tax penalties instead of enrolling in coverage, and those eligible for subsidized coverage but who do not enroll in it for a variety of reasons. These populations will continue to face the challenges experienced by the uninsured today, and CMAP and other community stakeholders will need to determine how to serve them under the new system.

Staff of GHPc produced a rough estimate of the uninsured projected for each of the counties in CMAP's service area:

Glynn County			
Population	# uninsured	% uninsured	% uninsured <200% FPL
2007 74,932	13,361	18%	81.08
2016 87,371	4,712	5.4%	2,859
McIntosh County			
Population	# uninsured	% uninsured	% uninsured <200% FPL
2007 11,420	2,022	18%	1,426
2016 14,377	713	5%	503
Camden County			
Population	# uninsured	% uninsured	% uninsured <200% FPL
2007 48,689	9,107	19%	5,847
2016 61,774	3,211	5.2%	2,062

Workforce Shortage and Access

Workforce shortage problems are prominent in the three counties served by CMAP and is only expected to increase due to the anticipated increased demand of the newly insured under the new act. Board members and staff of CMAP considered building the capacity of primary care by using CMAP as a training site for physicians and nurse practitioners and by partnering with area educational institutions, particularly the newly established College of Coastal Georgia.

Resource Development

CMAP board and staff believe the new system of care provides a unique opportunity for them to expand their current model. Under the new model, they can continue to provide primary care and disease management services with an opportunity to become a partially reimbursable model, while continuing to serve the needs of the uninsured. They do worry that this shift in their new model could create the illusion that no longer need volunteer providers and that the uncertainty of how some aspects of the act will be implemented can impact their current fundraising efforts and operations.



Next Steps and New Opportunities

As a result of the assessment, the staff and board identified the following as next steps they need to take to prepare them for health reform:

- Convene a larger community discussion of a "future's task force" made up of key stakeholders to determine what will be the new needs of the community and how they can be addressed.
- Begin with internal strategic planning to determine the key players, a timeline for implementation, and a funding strategy to cover planning costs.
- Take advantage of the materials and technical assistance offered by the Georgia Free Clinic Network in determining how to have larger community conversations that proactively shape how things will play out in their community.
- Develop a local strategy, aligned with a state strategy, on how to meet the needs of patients given workforce shortage concerns.
- Conduct a community benefit assessment with the local hospital and university as potential partners.
- Develop and operate patient navigation and education services by assisting patients in navigating the enrollment process, interpreting insurance options, and determining the appropriate providers to address their healthcare needs.

After the onsite strategic assessment, they felt less anxious about how to retrofit free clinics into the new legislation and more energized about the opportunities to provide a continuum of care for their patients. They were eager to consider how the new changes would not only affect CMAP services and operations but how they could be leaders in determining and addressing the needs of the larger community.

CMAP is a member of the Georgia Free Clinic Network (GFCN). This network is the statewide association of the 104 free and charitable medical and dental clinics in Georgia. The GFCN mission is "provide a collaborative support system to foster growth and development of medically underserved across the state." The GFCN focus is 1) Unifying assistance and collective purchasing; 2) Development, implementation and replication of data gathering resources regarding the uninsured; 3) Strengthening the infrastructure to serve GFCN membership; 4) Assisting in the development of services in areas of highest unmet need.



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

COMMUNITY HEALTH WORKS

Macon, GA

OVERVIEW

Community Health Works (CHW) is a non-profit organization that serves Central Georgia. Community Health Works seeks regional integration of whole person healthcare. Formed in 2001, CHW positions itself as "a Regional Center for Health Innovation" with three core service areas: contractual and fee-based services, cancer services, and innovation and incubation services. CHW's portfolio of contractual services includes IT consulting, care management, and service utilization management. As part of its cancer services, CHW is the administrative home of the Central Georgia Cancer Coalition, a partnership focused on screening, prevention, expanding access and reducing cancer-related disparities in the region. As a regional "incubator" for expanded health care access, CHW has been instrumental in securing funding for feasibility studies of multiple new-start Federally Qualified Health Centers in Central Georgia. CHW's service area includes the following counties: Bibb, Crawford, Houston, Jones, Monroe, Peach and Twig.

CHW has a staff of 15 and a Board of 22 individuals representing county government, hospital administration, behavioral health, clinical health care, local business and the nonprofit sectors.

STUDY QUESTION

Community Health Works would like to explore the development of an Accountable Care Organization or similar entity in Central Georgia, with the emphasis being on transformational change of the healthcare and delivery in Central Georgia.

CASE STUDY ANALYSIS

The consultation included a phone interview on September 17, 2010, document review and analysis, and a site visit October 15, 2010 with CHW staff and Board Members.



CONCLUSION

Central Georgia has a strong institutional infrastructure with a medical school, a couple large medical centers, and a strong Federally Qualified Health Center and new start sites coming along soon. The attendees discussed how the health reform act may serve as a catalyst for the region, encouraging collaboration among local partners to provide input at the regional, state and national levels to the development of rules and regulations of the Act.

The group discussed potential opportunities for Community Health Works to contribute to the implementation of health reform in Central Georgia. CHW sees itself as playing the role of a "convener" for the region in developing the region's approach to Accountable Care Organizations (ACOs). CHW could assess what is currently being considered by partners in the area, learn about any proposed national models for ACOs, and ensure that diverse community groups are at the table as the region's approach to ACOs is developed and implemented.

Attendees started the meeting feeling generally positive about health reform and its effect on health care access, but expressed reservations about how to pay for it. They also had questions about implications for the organizations they represent on the Board of CHW. Following the presentation and ensuing discussion, participants thought they had a better grasp of the main points within the health reform act, but came away with additional questions about specific portions of the act, and felt they had a fair amount of follow-up work to do to better understand health reform and its local implications. For example, participants stated that they need to learn more about specifics of health reform: What will Accountable Care Organizations look like? Are there any proposed national models to study? And importantly, what do local partners plan to do about ACOs in the region?

As a result of the meeting, the participants plan to take the Health Reform Overview presentation back to the full Board of Community Health Works. Throughout the meeting, participants discussed different roles that CHW might play in the region as it relates to the planning and implementation of health reform. These roles include convening important players in health and health care to more closely examine the act, with an eye for opportunities for the region, participating in the implementation planning work at the local, state and national levels, or serving as a resource for education and information for individuals, small businesses or other entities affected by reform. Community Health Works will look to its full board to define its role moving forward.



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

DIVISION OF AGING SERVICES

Atlanta, GA

OVERVIEW

The Division of Aging Services (DAS), a part of the Georgia Department of Human Services (DHS), serves 47,000 Georgians directly and about 500,000 indirectly through 300 local government agencies and small businesses across 12 Area Agencies on Aging (AAA). DAS is the state appointed agency that carries out the requirements of the Older Americans Act, and it is its unique relationship with service contractors that makes it one of the most outsourced agencies in state government.

STUDY QUESTION

DAS wanted GHPC to focus on the ability of the state's aging network to address the health and long-term care needs of Georgia's older adults, individuals with disabilities, and caregivers. After meeting with the GHPC health reform group, their questions were narrowed down to the following issues related to health reform:

- Changes in numbers and locations of those DAS serves
- The CLASS Act
- Medicare and Medicaid
- Workforce issues—particularly rural workforce
- Care transitions, care coordination, and patient navigation

CASE STUDY ANALYSIS

The onsite interview took place at the Health Policy Center office on August 16, 2010 and the onsite meeting was held September 9, 2010. Six people attended the initial interview and 10 individuals attended the strategic assessment.

CONCLUSION

Changes in numbers and locations of those served
County level maps were created using data from the Governor's Office of Planning and Budget to show the growth in the population age 60 and above from 2010–2015, 2010–2025, and 2010–2030. The maps showed the greatest growth in the population DAS serves will be in the coastal area around Brunswick, the outer suburbs of Atlanta, and the Georgia mountains. These areas of growth are in line with where the DAS team thought they would have the greatest demand for services.



2011–2014; and, FMAP incentives to offer HCBS services in rural areas, which could increase demand for long-term care services. None of the cited opportunities are currently funded through appropriations.

Care transitions and care coordination

Several grant opportunities were presented, including grants for community health teams; grants for community-based collaborative care networks (FY11–FY15); community-based care transition grants (FY11–FY15); grants to incentivize Medicaid members to participate in evidence-based activities that reduce the impact of chronic diseases (calendar year 2011–2015); grants for a national diabetes prevention program (FY10–FY14); contract opportunities for exchange navigators; and training opportunities for patient navigators (FY10–FY15). Only the community-based care transition grants, the incentives for participation in chronic disease prevention, and the patient navigator training program currently have appropriated funding.

The three major themes of the on-site discussion were:

- Impact of the CLASS Act on the potential need for service providers
- Impact of Medicare changes on the volume of calls to their information lines
- Identity/paradigm shift/messaging and marketing

CLASS Act
The CLASS Act establishes a national, voluntary (opt-out) long-term care insurance program. The Act provides for "actuarially sound" monthly premiums (estimated by the CBO to be \$123 per month to start), adjusted for experience over time. Premiums, however, will be as low as \$5 for the "poorest individuals" and those under age 22, and working or going to school full-time. Anyone can enroll. There is no underwriting, but an individual must pay premiums for 60 months to get any benefit and must meet the same quarterly earnings requirements within those 60 months as with Social Security. Enrollment is automatic through an employer if the employer chooses to participate – the employee must opt-out. The Secretary is charged with creating a mechanism for individuals to enroll even if they do not have an employer who is participating. The benefit is a minimum of \$50 per day (cash), with annual COLA increases, based on functional ability. There is no lifetime or aggregate limit. The CBO estimates that the CLASS Act will cut the deficit by \$72 billion from 2010 to 2019, but costs would exceed premium income by the third decade.

Medicare and Medicaid

The Medicare and Medicaid timeline was presented to the group. The group was particularly interested in changes related to Part D and Medicare Advantage plans. There is a concern that older people are easy prey for being told they need to buy some new benefit when they do not really need it, and the information presented will help DAS communicate about the changes that will take place. There was also a realization that the Medicare changes have the potential to change the way care is delivered to a more team-based model and that DAS needs to position itself to take advantage of opportunities related to those care teams.

Workforce

Several workforce opportunities were presented, such as grants for training for direct care workers, including rural areas, effective 2011–2013; grants available to entities that operate geriatric centers to offer fellowships that train faculty members in medical schools, effective 2011–2014; geriatric incentive awards for the allied workforce; effective



EFFINGHAM HOSPITAL AND CARE CENTER

Springfield, GA



OVERVIEW

Effingham Hospital and Care Center (EHCC) is located in Springfield, Georgia about a half hour from Savannah. EHCC is a Critical Access Hospital and skilled nursing facility that serves Effingham County's population of 52,000. Effingham County has a current complement of 11 primary care physicians, significantly below the identified need for 14 primary care physicians. EHCC houses approximately 25 beds for inpatient care and an additional 105 long-term care beds, including a dedicated unit for Alzheimer's care. EHCC's payer mix is 32.1 percent Medicare, 6.4 percent Medicaid, 41.7 percent Commercial, and 19.8 percent Self-pay. The hospital employs four family medicine physicians and one general surgeon.

STUDY QUESTION

How will healthcare reform impact small and rural hospitals, more specifically, critical access hospitals and nursing homes?

CASE STUDY ANALYSIS

EHCC's preliminary interview took place on August 23, 2010. EHCC's CEO, CFO and Corporate Compliance Officer all participated in the initial assessment. The on-site assessment was conducted September 15, 2010. Over 20 participants attended, representing the local physician community, hospital authority, hospital executive staff, support staff and others involved in the Effingham County health care market.

CONCLUSION

The three most prevalent themes in the meeting were:

- 1. Workforce and access:** Concern was expressed that Effingham's current physician shortages will be magnified by an increase in demand from newly-insured patients. Under a new set of rules where insurance coverage is nearly universal, with an insufficient supply of physicians, primary care may have to be rationed across the board. Providers spoke about having to decrease the number of Medicaid patients or other public payers they see, increasing stress from longer hours, and spending more time filing claims and maintaining compliance with a growing set of regulations.
- 2. Integration:** There was anticipation of an increasing need for providers to affiliate with one another in formal partnerships, resulting in both positive and negative consequences. The positive side of integration is improved patient flow and efficiency with the potential for a higher level of care. The negative side of integration is the potential for larger payers and hospital systems to subsume the smaller providers operating at the margins in rural markets such as Effingham County.

- 3. Coverage:** Expecting significant increases in insurance premiums and a shift of dollars from Medicare to Medicaid were central themes of the discussion. Participants fear that reductions to Medicare spending in the form of reducing the 110-120 percent reimbursement level currently received by Medicare Advantage managed care would have an impact on the reimbursements for standard Medicare as well. Additionally, with an increase in patient demand, and the possibility of a decrease in the number of providers taking Medicaid, coupled with the elimination of Disproportionate Share payments, participants expressed concern that patients will seek care at the ER in greater numbers than today. Since the hospital must take ER patients, there is a fear that uncompensated care will become a local concern, specifically a concern of those who own property and thus pay the majority of local taxes.

EHCC's Position in a Changing Marketplace: EHCC's status as both a Critical Access Hospital and a nursing home requires multiple answers to questions related to their future. First, with a high proportion of their revenue from Medicare reimbursement, EHCC will need to capture an increasing share of quality data in order to remain compliant with regulations likely to emerge from CMS as the law is implemented. Ensuring that their electronic records and practice management systems are up to the task will streamline this process and help avoid last-minute adaptive problems. Speaking with software vendors about how their systems can adapt to these changes is a crucial first step. Second, believing that care integration is a central component to reform, ensuring that they play a major role in the continuity of care for local patients will position EHCC for a reasonable revenue model that is fully adapted to the changing landscape of health care. Speaking with large tertiary care facilities and entering into referral and transfer agreements are prudent moves. Engaging the primary care community in the county and the surrounding areas will help ensure that patients are referred to EHCC's services as opposed to those of a competitor. Third, under reform, Medicare provides more generous reimbursement for general surgery at

Critical Access Hospitals. Growing this area of their practice could help mitigate some of the losses from the elimination of Disproportionate Share funding. Fourth, elderly and long-term care are growing fields both in terms of demographic shifts, and in terms of changing payment structures. Home-based services are a potentially massive growth area. Transparency rules related to ownership of facilities, quality, and outcomes could level the playing field for local, not-for-profit providers. Having a local name behind those services could be beneficial from a marketing perspective, and having agreements in place to provide high-quality, continuous care could help EHCC retain its competitive edge in their service area.

While participants' overall level of anxiety remained unchanged through this process, significant progress was made around identifying areas of the changing health care landscape that may have significant benefits for their operations. One such area is in long-term care. As a skilled nursing facility with a good local reputation, EHCC is well-positioned to take advantage of an aging county population as well as changes to Medicare reimbursement and long-term care insurance. With an increase in demand for home-based services, EHCC should take advantage of their existing position, and seize opportunities related to expanding their offerings, as they have already done with the hiring of a general surgeon. Additionally, partnering with other providers could help reduce the impact of a deluge of new patients and costly emergency room visits. Management seemed keenly aware of many implications related to reform and will continue to plan in a strategic, systematic way to ensure their continued success as a hospital.



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

GEORGIA ASSOCIATION OF COMMUNITY SERVICE BOARDS

Atlanta, GA



OVERVIEW

The Georgia Association of Community Service Boards (CSB) is the statewide organization for the local community service boards in Georgia. The CSBs serve primarily individuals with severe mental illnesses who are Medicaid recipients, the uninsured, and the working poor. There are 25 local CSBs that serve all 159 counties. CSBs were established by HB 100 in 1993 as public agencies to administer mental health, developmental disabilities, and addictive diseases (MHD/DAD) services. They became public corporations in 1994. Six regional offices fund and administer state contracts with the CSBs. Most of the funding for CSBs is generated through service provision; the CSBs receive no entitlement funding or committed state funding. The State Mental Health Block Grant, which is a federal block grant, provides some funding for infrastructure support. CSBs seek grant funding for diversification and to help provide services not covered by Medicaid.

STUDY QUESTION

The initial request of the CSB Association was to conduct an assessment of the potential impact of health reform on expanding access to and availability of community mental health services, and on integrating such care holistically with other health care services to improve the prevention, treatment and outcomes of mental illnesses which affect one in five of our population. However, after further discussion more specific questions emerged about benefits packages and how mental health was defined in the law.

CASE STUDY ANALYSIS

GHPC staff engaged in an information gathering interview meeting with the Director of the Association and four representatives of local CSB agencies on August 17, 2010. GHPC staff reviewed the health reform legislation to gather specific language of the sections with implications for mental health services and providers, as well as, several documents produced by

the National Alliance on Mental Illness, the Congressional Research Service and the Bazelon Center on Mental Health. The on-site consultation was conducted September 15, 2010.

CONCLUSION

At the on-site meeting, GHPC staff addressed the questions posed in the information gathering meeting. The term mental health was either defined in the document, referenced codified law where it was previously defined, or stated that it would be defined by the Secretary, as in the case of the definition of mental health rehabilitation services (which will be part of the essential benefits provided in exchange plans). GHPC staff reported that many of the specifics of the exchange plans had yet to be determined. The design of the plans, funding, structure and administrative issues would be determined through regulation or in the State's design of the exchange.

Three major themes that emerged from the facilitated discussion were the need for a strategic discussion around the CSBs' role in advocacy, commitment to the rehabilitation model versus adopting a medical model in lieu of health reform, and the possibility of local CSBs forming separate 501(c)(3) agencies. These themes all came from a collective realization that as the benefit packages are designed, mental health services provided by the CSBs may no longer be viable or profitable.

The facilitated discussion also revealed that the participants viewed the major impacts of the health reform legislation to be an influx of new managed care patients and the possibility of losing federal and state funding. They felt the most important things to do to prepare were to consider the possibility of new reporting requirements, develop a way to obtain regulations as they are released, decide among themselves if they need to advocate for rehabilitation services or convert their services to adhere to the medical model, identify whether issues should be handled at the

Association level or by the local CSB agencies, and to think about workforce development. The participants viewed their next step should be to determine the Association's role going forward.

At the beginning of the on-site consultation, the participants shared that they liked the idea of health reform, but were skeptical about the cost of it; they were concerned about the limits of the government's role versus personal responsibility; and they thought the legislation was not a true reform of health, but more a reform of the health care system. They were anxious about the amount of federal and state funding that it would take to implement the legislation, health care access, and what will happen to the legislation after the November elections. The participants expressed confusion about why the legislation is called health reform since it does not reform health and the financing of the new system.

At the end of the meeting, the participants continued to feel that the legislation is not true health reform, instead it seemed to be a reform of health insurance. They also reported that while price is important, quality is too and it is important to begin considering that now. The participants still felt the legislation was a bit confusing because there is so much uncertainty. They concluded that it was important for them to plan for all possible alternatives in preparation for the implementation of the health reform legislation.



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

GEORGIA DENTAL ASSOCIATION

Atlanta, GA



OVERVIEW

The Georgia Dental Association (GDA) is the statewide professional dental organization and is the second oldest professional association in the state. GDA was established in 1859, celebrating its 150th anniversary in 2009. Its 3,300 members represent all specialties within dentistry. The Association has five officers, seven trustees, and a 21-member elected board in which the President of the organization is a voting member. The Association has staff members that support the organization and its for-profit subsidiaries, which are located at GDA headquarters in Atlanta.

STUDY QUESTION

Generally, GDA staff wanted to know about preventive care, children's dental services, quality controls, and how dentists would be affected as small business owners in the health reform legislation.

CASE STUDY ANALYSIS

On August 11, 2010, GHPC staff engaged in an information gathering interview meeting with four staff members of GDA. During this meeting, GDA staff shared organizational information and history, in addition to clarifying their initial health reform study question.

GHPC staff reviewed documents provided by GDA to better understand their organization and its history and the history of dental care in Georgia. Documents produced by the Academy of General Dentistry and American Dental Hygienists Association were initially used to identify parts of the legislation that affect dentistry. In addition, the health reform legislation was reviewed to identify any potential implications for dentistry.

CONCLUSION

On September 17, 2010, the on-site consultation was conducted at the GDA headquarters in Atlanta. The four GDA staff from the initial information gathering meeting were in attendance, in addition to the President of the Association. Due to a lack of time, the participants chose not to have the entire facilitated discussion. However, after the presentation, GDA participants had a conversation highlighting the most important things the Association needs to prepare for, their next steps, and how their perceptions differed after the presentation.

Throughout the presentation, GHPC staff provided the following answers to the study questions posed by GDA staff. The sections of the health reform legislation pertaining to dentistry, especially those highlighting preventive care, were discussed. The mandatory children's dental coverage, options for adult coverage, and details about the exchange were also presented with as much information that was available at the time. GHPC staff also presented the small business module which explained the exchange and the implications for businesses that join the exchange.

GDA participants felt that one of the first things the Association needs to do to prepare for health reform is to create an action plan with strategies. The participants acknowledged that, initially, they were unsure about all of the information within the health reform bill that was pertinent to dentistry, but now that they have a better understanding, they need to identify four to five items to target. Given that the GDA has a small staff and must focus their resources, the items they choose must be what they deem to be most important. Additionally, they identified that they need to do more research on the national level committees identified in the bill and

ensure that dentists have representation on them. Another next step the staff plan to take is communicating with the American Dental Association, continuing to know about benefits related to children, and finding out who is making decisions to provide them with information. Many times these groups do not include dentists; however, the dentists should be involved to help inform decision-making.

Lastly, the participants felt it was important to begin educating their membership about how the health reform legislation will impact them—especially as small businesses.

When asked if their perceptions of the health reform law had changed, a range of answers were given. Uncertainty, confusion and anxiety were still present, but to a lesser degree. The participants felt they knew more than they did before the presentation, even though much of the legislation is still unclear because regulations have yet to be written. Most importantly, although they still do not have all the information, the participants felt they have a better understanding of what is and is not in the bill, and where they have remaining questions.



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

GEORGIA NURSES ASSOCIATION

Atlanta, GA



OVERVIEW

The Georgia Nurses Association (GNA) was founded in 1907, and is a statewide professional association headquartered in Atlanta, Georgia. The GNA has 2,000 members with local chapters throughout the state and is a constituent of the national American Nurses Association. The Georgia Nurses Foundation (GNF) is the philanthropic arm of the GNA and provides leadership development, scholarships, and special projects that aim to advance the well being and professional development of nurses across the state. The GNA and GNF are led by a 12-member board and supported by 8 in-house staff members who cover programs in the area of leadership, membership development, nursing practice, workplace advocacy, legislative public policy and marketing and communications.

STUDY QUESTION

How will reform impact the need for increased numbers and better utilization of Advanced Practice Registered Nurses (APRNs)—in particular Nurse Practitioners (NP)—in primary care settings in Georgia?

CASE STUDY ANALYSIS

Background information was collected and an assessment interview was conducted on August 19, 2010 with the GNA President, CEO, Chief of Programs, and Marketing and Communications Director. An on-site meeting was held at the GNA headquarters in Atlanta, GA on October 7, 2010 with approximately 15 GNA board members, staff, and member nurses. Major topic areas covered during the on-site meeting were an overview of the Affordable Care Act (ACA), impact on nurses, workforce shortages, partnership and grant opportunities, reimbursement changes, and the remaining uninsured.

CONCLUSION

Three major themes that emerged from the facilitated discussion were:

1. Increasing Demand for Primary Care

Analysis suggests that demand for primary care will increase by an average of one additional visit per patient annually for Georgians seeking care. This creates a shortage of approximately 300 to 400 additional providers that will be needed for wellness and prevention visits alone. To reach the national average, Georgia will need an additional 600 NPs. One point raised during the facilitated discussion was that much of the press coverage has focused on providers as one group, without breaking out the types of providers that will be required to serve increased demand. Subsequently, the group agreed that more detailed economic analysis on workforce and the context of the practice environment could advance development of solutions to address barriers and shortages in nursing.

HEALTHCARE WORKFORCE SHORTAGE IN GEORGIA AND THE UNITED STATES

	GA	USA	# Required for GA to be at US level
Total Physicians	180.6	216.2	3,400
Primary Care Physicians	65.5	79.4	1,300
Nurse Practitioners	35.8	42	600

2. Partnership and Collaboration

Several provisions in the ACA support and incentivize a collaborative team approach to health care delivery. It was recognized that to be cost-effective, larger health care systems will likely move to a service model where an NP is the first point of contact. Similarly, physicians in solo or small practices will likely benefit from forming stronger partnerships with NPs and other providers such as Physicians

Assistants (PAs). Several opportunities for partnership and collaboration were highlighted during the discussion, including the increased need for placing patients in medical homes, strengthening relations among professional provider organizations, and supporting the reinstatement of a statewide joint practice committee.

3. Scope of Work Regulations

Several provisions that elevate NPs in health care delivery are included in the ACA; however, a major theme that emerged from the discussion was that legislation that regulates the scope of work for nurses varies by state. In Georgia, NPs may not be able to take full advantage of the ACA opportunities because state law limits what nurses can perform. This limitation, as a consequence, may hinder the ability of Georgians to access care that could be provided by APRNs. Subsequently, raising stakeholder awareness and policy advocacy were identified as critical next steps.

Several participants stated that, prior to the assessment, the legislation was confusing for both providers and patients. Many were concerned about financing and the ability of the system to be able to handle increased demand for care. In addition, concern was also expressed that the level of care may be inaccessible even for the insured; that is, covered patients still may not be able to access care or the level of care needed. After the assessment presentation, many felt better informed; however, the information did not reduce anxiety about costs and implementation.



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

GOOD SAMARITAN HEALTH AND WELLNESS CENTER

Jasper, GA

OVERVIEW

Good Samaritan Health and Wellness Center is a non-profit, rural free clinic, whose mission is "to provide the medically underserved in our community with compassion and individualized health care and related services in an atmosphere of respect and dignity." They provide services for uninsured adults with incomes <200% of FPL who live or work in Pickens County. The board has fifteen directors comprised of volunteer physicians and other leaders in the community. There is a unique confluence of two populations in the community: rural, poor Appalachians and wealthy retirees.

Since 2002, 6,500 individual patients have been seen at the Center. Almost all of Good Samaritan's volunteer medical providers are retired. Some specialists in the area will take patients at reduced fees (Medicare rates). In 2009, they had a total of 13,064 patient visits, spent ~\$40,000 in specialty care for their patients and secured > \$1,000,000 in prescription drugs for patients through drug assistance programs.

STUDY QUESTION

What is the impact of health reform on a rural free clinic?

CASE STUDY ANALYSIS

The consultation included a phone interview with the Executive Director on August 12, 2010, document review and analysis, and a site visit with staff and five board members on August 23, 2010.

CONCLUSION

While the Affordable Care Act (ACA) is expected to provide insurance coverage to a large number of the 46 million uninsured in this country, millions will remain uninsured and free clinics will continue to play a major role as a safety net provider for those unlikely to be covered. However, several issues remain for the residents in Pickens County currently receiving free care at Good Samaritan. Many of Good Samaritan's patients are at income levels less than 133% FPL and will qualify for Medicaid. Many others have incomes low enough to qualify for tax subsidies. Good Samaritan leadership is uncertain whether patients will take up the subsidy or find the penalty to be minimal enough that they choose to not purchase insurance. Most importantly, Good Samaritan's leadership is



uninsured because they are exempt from purchasing coverage, choose to opt-out and pay a penalty, or are transitioning between plans or jobs.

The Good Samaritan staff and board are concerned about how the ACA will impact funders and volunteers. If they change their business model, will funders and volunteers still give if the clinic is no longer "free"?

As a result of this consultation, Good Samaritan staff and board plan to take the following steps:

- Explore opportunities for expanded patient navigator role about the ACA
- Continue FQHC Taskforce research on implications of converting
- Improve current data systems

The Good Samaritan Health and Wellness Center is a member of the Georgia Free Clinic Network (GFCN). This network is the statewide association of the 104 free and charitable medical and dental clinics in Georgia. The GFCN mission is "provide a collaborative support system to foster growth and development of charitable clinics and improve access to quality health-care for the medically underserved across the state." The GFCN focus is 1) Unifying clinics serving Georgia's uninsured through advocacy, technical assistance and collective purchasing; 2) Development, implementation and replication of data gathering resources regarding the uninsured; 3) Strengthening the infrastructure to serve GFCN membership; 4) Assisting in the development of services in areas of highest unmet need.



committed to ensuring that their patients receive quality, uninterrupted care as they transition into reform.

The current private provider mix in Pickens County is not sufficient to support the increased demand for services that can go along with increased coverage, through Medicaid or private insurance. The ACA calls for slow but steady provider rate cuts. As rates for Medicaid decrease, and if providers accept fewer Medicaid patients, the strain on the local pool of providers in Pickens County could increase.

Good Samaritan offers dental services to many patients and will continue to provide this service into the future.

Data systems will be critical to Good Samaritan and their patients into the future. It is important that data systems capture demographics and income so that they can forecast who will be eligible for various coverage options. It is also important for Good Samaritan to capture health status and utilization information to help newly insured patients navigate to the appropriate providers.

There are many opportunities for Good Samaritan to assume a 'navigator' role for its patients. Patients may need assistance navigating a complicated eligibility process (e.g., Medicare, PeachCare, individual exchange and small group exchange). A navigator can serve as an interpreter of all the insurance options as well as help with enrollment. With new provider options – or even a limited, strained provider system – navigators can help patients find the appropriate provider for their needs who will accept their insurance and be easily accessible. Patient educators and navigators can help facilitate appropriate care by changing access patterns away from the ER. Several grant opportunities exist in the ACA, including contracts for Exchange Navigators and training opportunities for patient navigators.

Many of Good Samaritan's patients need specialty care that they currently cannot obtain and will not be able to get until they are insured. There is a promising potential that these patients will receive the specialty care they need. There is also a payment structure that can help primary care providers by modestly increasing payment to these providers during the first few years of implementation.

By 2014, Pickens County may see the number of uninsured drop from 5,168 to approximately 1,600. These residents may be

HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

LAURENS COUNTY HEALTH DEPARTMENT

Dublin, GA



OVERVIEW

Laurens County Board of Health d/b/a Laurens County Health Department is located in Dublin, GA. This public health department serves 22% of Laurens County's total population (49,000) and the majority of their patient population is uninsured. Laurens County Health Department services include: Nutrition Services; Women's Health Services; Child and Adolescent Health Services; Adult Health Services; Environmental Health Services; Community Health Promotion & Policy Development; and Emergency Preparedness. In addition, Laurens County has been influential with the following health intervention programs: immunizations are at 100% for Kindergarten to 6th graders; seat belt usage for school-aged children has increased from 68% to 90%; the hypertension rate has been reduced; the Ryan White Program has quadrupled in size in the last 3 years; and the Emergency Preparedness programs are equipped to vaccinate their entire service area.

STUDY QUESTION

How will the new health care reform legislation affect the delivery of primary care services in the local health department? This information would be beneficial in the following areas:

- Long range planning and staff recruitment.
- Design of pending new health department.
- Better practice management and patient service

CASE STUDY ANALYSIS

The Laurens County initial interview call took place August 19, 2010 with key staff members of the health department. Over ten participants attended the on-site assessment conducted September 30, 2010.

CONCLUSION

The three major themes in the meeting were health promotion funding, coverage, and collaboration and capacity.

Health Promotion Funding

Laurens County Health Department discussed, given health reform, what they may need to do more of or differently. Numerous opportunities exist for health departments through health reform; preparing themselves to seek and apply for future funding was important to the group. As part of their strategic plan, they discussed hiring a grant writer or improving their grantwriting skills through staff professional development. They will do some additional research on the availability of Title V funding. Health reform opportunities specific to health promotion programs such as smoking cessation and chronic disease will be closely monitored to expand what is currently being done at the health department.

Coverage

The health department currently serves the uninsured; however, with health care reform, many will have coverage by 2014. Due to this increased coverage, public health will need to identify other populations to serve. In addition, next steps include exploring a fee-for-service business model as well as building capacity to bill a third party payor.

Collaboration and Capacity

It is likely that more providers will be needed to serve the population enrolled in the programs operated by the department. Improving collaboration among health departments, primary care providers, and the local community was seen as a priority. In addition, utilizing other providers such as their expanded role-nurses (RNs with additional training restricted to specific area and protocol, not NPs) will be vital.

Before the assessment, most participants were anxious over the cost of health care reform and the perceptions of government control of the health care system. They were confused about what was in the bill, how it would be implemented, and what it means for them (both individually and organizationally). Some were optimistic because everyone will have some form of access to care. After the assessment was completed, the perceptions among the group were mostly optimistic. They were excited about the funding opportunities available and, with a better understanding of health care reform, they were more curious about the implementation of reform at a systems level. While remaining overall optimistic and hopeful, anxiety was still present among some people with respect to cost and implementation.



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

MERIWETHER COUNTY HEALTH DEPARTMENT

Meriwether County, GA

OVERVIEW

The Meriwether County Health Department, part of Georgia's Public Health District Four, is over 50 years old. Meriwether County is 502 square miles with a population of approximately 2,000. The health department is co-located with a Federally Qualified Health Center (FQHC) and maintains a good partnership with them, including a good will agreement not to compete on the same services. The health department maintains a good relationship with the school system and provides child health checks and flu shots for faculty, staff, and students in the schools. It is led by a 7-member board that includes the school superintendent, a local physician, the chairman of the county commission, the mayor, and a local advocate for the poor and elderly.

STUDY QUESTION

How is our client base going to change once health care reform is implemented, given the unique nature of our county and our special relationship with local FQHCs?

CASE STUDY ANALYSIS

The case study process involved an assessment interview on August 30, 2010 with several representatives of Public Health District Four and the Meriwether County Health Department. The assessment interview was followed by document review and analysis of the Affordable Care Act to respond to their question. Findings were presented to key stakeholders, including representatives of Public Health District Four and the Meriwether County Health Department on September 13, 2010.

CONCLUSION

Findings were summarized into three major themes:

- 1) how many people will still be uninsured in Meriwether County,
- 2) what groups will make up the uninsured, and
- 3) workforce implications for FQHCs.

How many uninsured in Meriwether County

The following data were provided regarding the projected number of uninsured.

2007 ESTIMATES OF POPULATION NEEDS

	Georgia	Meriwether County
Non-Elderly Population	8,596,726	19,577
Share of Population < 200% FPL	32%	44%
# Uninsured	1,632,319	3,571
% Population Uninsured	19%	18%
# Uninsured < 200% FPL	985,518	2,403

Groups that may make up the uninsured

Approximately 1/4 to 1/3 of the uninsured may be non-citizens. Those who are uninsured are likely to be younger and healthier than those currently uninsured and those who become insured. In addition, transience in eligibility for Medicaid and insurance subsidies is likely to occur for those with incomes between 100% and 250% of poverty due to income volatility.

Workforce implications

Rough estimates indicate that in Georgia there will be an additional 1.2-2 million physician visits per year as a result of increases in the number of people who have health insurance coverage. This could translate into an additional shortfall of 300-400 physicians in Georgia. The elimination of copays, deductibles, and coinsurance for many preventive services may also increase the demand for primary care providers.

The Affordable Care Act provides resources to assist with this increased demand. These include:

- \$11 billion to increase/expand FQHCs
- Reallocation of unused medical residency sites with preference to high need states (Georgia is one)
- State workforce planning grants
- Loan repayment and scholarship programs
- Primary Care Extension Program
- Increases in Medicare and Medicaid payments for primary care providers



Attendees were asked before the presentation how prepared they felt to make strategic decisions about how health reform will affect them. They stated that their key areas of concern were: How will their relationship with the local FQHC change? Will the reform turn this cooperative situation into a competitive one? Other concerns included impacts on funding, personnel, service delivery, and quality of care. One participant said, "It's exciting to think about expanded access, but what will that do to us?"

As a result of the information provided, Public Health District Four and Meriwether County Health Department staff decided it is not likely that there will be increased tension or competition with their FQHC partner. Instead, they felt that service needs would be increased for both parties. They felt they had a better idea of where the changes will occur. If uninsured become mostly young and healthy groups, they felt it may help them attract paying customers. Staff also commented that there are many details that have not yet been determined, which could impact their planning efforts. Next steps included spending more time discussing the legislation, asking more questions, and thinking about how they'll fit in.



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

PIEDMONT PRIMARY CARE PRACTICE

Atlanta, GA

OVERVIEW

The primary care practice is located in metro Atlanta on the Piedmont Hospital campus and is a member of the Piedmont Physicians Group network. Their practice consists of seven internal medicine physicians, two physicians' assistants, and one nurse practitioner with two of the physicians sub-specializing in rheumatology. This practice dates back to the early 1900's and is one of the older primary care practices in the Atlanta area. They were the first practice to join the Piedmont Physicians Group in 1994.

They provide comprehensive primary care services to approximately 150-200 patients a day, including annual physicals, wellness counseling, preventive care, immunizations, and health screenings. Their patients primarily have private insurance, but about a quarter are on Medicare. Similar to other practices within Piedmont Physicians Group, they work within a hybrid model that allows the physicians to operate much as a private practice with access to, and support from, the larger Piedmont Healthcare system. This practice was an early adopter of electronic health records (EHRs) and the first within the Piedmont Group to integrate this technology. As a result of their efforts in this area, the practice was presented with a national Nicholas E. Davies Award of Excellence for HIT in 2006.

STUDY QUESTION

Under health reform, how will Health Insurance Exchanges and changes to reimbursement rates impact primary care practitioners in the private sector?

CASE STUDY ANALYSIS

An initial in-person interview was done with a subset of physicians and staff on August 25, 2010 to gather background information for the assessment. An on-site visit was later conducted on September 28, 2010 with a larger group of practice providers and Piedmont Physicians Group administrative staff.

CONCLUSION

With current uncertainty around details of the rules and regulations guiding reform, concerns within this practice include interaction with health insurance exchanges, changes to payment rates, risk management, reform financing, and workforce needs. The Affordable Care Act (ACA) is regarded as a "work in progress" and, as such, will require constant monitoring

of its implementation. It was acknowledged that, in this changing healthcare landscape, new payment and care delivery models will need to be considered in order for their practice to adapt and thrive.

Health Insurance Exchanges

Estimates project that as a result of the ACA, over 1 million Georgians will become insured through either public sources (e.g., Medicaid, PeachCare) or private insurance sold through newly created health insurance exchanges. The significant increase in the number of insured is likely to result in increased demand for primary care services, especially among the population within 300-395% of the Federal Poverty Level (FPL).

Though the current patient mix of this practice does not include Medicaid clients, the significant increase in the number of insured is likely to result in increased demand for their primary care services. Not enough is known at this time about how the exchange will function, but there is hope that primary care providers should retain viable practices once the uptake is as predicted and reimbursement rates are determined.

Accountable Care Organizations

Only 25% of the practice clientele are Medicare beneficiaries. Physicians and staff note that there already exists a challenge for many practices to provide services to the elderly as the cost of service delivery far exceeds reimbursement rates. Faced with impending cuts to Medicare reimbursement rates over time and limited direct changes to the current fee-for-service system, some physicians may withdraw from serving that population. The ACA provides some incentives for both consumers (e.g., no copays for preventive services) and providers (e.g., 10% bonus for providing primary care to Medicare patients). While these are positive in the short term, it is likely they will only have a limited impact toward improving access for Medicare recipients. Consequently, this practice and others within the Group are concerned about their ability to meet the needs of their Medicare clients, while remaining economically viable in the long term.

In order to address these issues proactively, discussants believed it important for their practice to be on the forefront of new models of care delivery that focus on improved coordination, quality, and health outcomes. This practice is particularly well positioned for these new integrated care models with its expertise in EHR. One such model proposed under ACA is the establishment of Accountable Care Organizations (ACOs) to serve this population. To that end there may be opportunity for the practice to:



- develop ACOs pilot programs and other integrated care systems focused on improved quality and health outcomes
- leverage expertise as primary care providers in the prevention and control of chronic disease to lower costs
- maximize vertical integration within their health delivery systems
- assume some role as health insurers

Mid-level Practitioners

Based on current workforce needs and the anticipated growth in demand for services, there will be a significant shortfall in the supply of primary care providers, both nationally and in Georgia, leading up to the establishment of the HIEs and patient medical homes. The ACA provides a number of programs and funding streams to address and strengthen the primary care workforce, including: \$11 billion for Federally Qualified Health Centers (FQHCs); \$1.5 billion for the National Health Service Corps (NHSC); and \$168 million for expansion of primary care residency slots. As part of this investment in the primary care workforce, funding has been dedicated to further develop mid-level provider capacity, incorporating physician assistants, nurse practitioners, and other physician extenders in the delivery of primary care. This practice currently utilizes a cadre of mid-level providers, but may be able to tap into these resources to expand its ability to provide even more primary care services.

Prior to the presentation, participants were generally guarded in their expectations of health reform. Overall, there was minimal change in that view after the presentation was made, though some expressed optimism about the opportunities presented. Most participants seemed resolved to search out potential reform opportunities while protecting the practice against threats to its viability.



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

PRIMARY CARE OF SOUTHWEST GEORGIA

Blakely & Thomasville, GA



OVERVIEW

In 2006, Primary Care of Southwest Georgia (PCSG) established a Federally Qualified Health Center (FQHC) in Blakely, GA and in 2007 they established an FQHC Look-Alike in Thomasville, GA. The locations are 80 miles apart. The Thomasville location will be applying for FQHC status in 2011, and there are other expansion sites under consideration.

PCSG is governed by a local board of directors made up of twelve community members, nine from Blakely and three from Thomasville, with an even split for gender and African American/Caucasian. As each new site is added, 2-3 more board members from that community will be added.

They have grown from ten employees accommodating 400-450 patient encounters per month to 26 employees accommodating 800 encounters per month. They recently hired the community's first pediatrician, and have also recruited two physicians, a physician assistant, and a nurse practitioner to an area that is experiencing a significant provider shortage.

PCSG serves as a medical home for the uninsured. Their high quality of care is facilitated by an electronic medical records system that has helped them improve patient outcomes and their partnership with the local hospital, which has been highlighted by a federal agency as a collaborative success story.

STUDY QUESTION

Primary Care of Southwest Georgia posed the following questions as they relate to the Affordable Care Act of 2010:

What is the potential for increased demand for services and the ability of FQHCs to respond to this increased demand?

How many people will be uninsured, in what categories, and how will these changes impact payment?

How can we project our budgets based on our need for providers, changes in patient profiles, and physical infrastructure?

CASE STUDY ANALYSIS

The case study process involved an assessment interview with the CEO on August 24, 2010, document review and analysis of the Affordable Care Act to respond to her questions, and presentation of findings to key stakeholders from PCSG on September 7, 2010. Key stakeholders included PCSG staff and Board members.

CONCLUSION

Findings were summarized into three major themes: 1) how many people will still be uninsured, 2) what groups will make up the uninsured, and 3) workforce implications.

How many uninsured

The following data were provided regarding the projected number of uninsured for the counties where both clinics are located.

Early County		Population	# uninsured	% uninsured	# uninsured <200% FPL	% uninsured <200% FPL
2007	11,836	1,565	13%	1081	69%	
2016	11,563	552	5%	381	69%	

Thomas County		Population	# uninsured	% uninsured	# uninsured <200% FPL	% uninsured <200% FPL
2007	45,237	6,379	14%	3,870	61%	
2016	51,428	2,249	4%	1,365	61%	

Groups that may make up the uninsured

Approximately 1/4 to 1/3 of the uninsured may be non-citizens. Those who are uninsured are likely to be younger and healthier than those currently uninsured and those who become insured. In addition, transience in eligibility for Medicaid and in insurance subsidies is likely to occur for those with incomes between 100% and 250% of poverty due to income volatility.

Workforce implications

Rough estimates indicate that in Georgia there will be an additional 1.2-2 million physician visits per year as a result of increases in the number of people who have health insurance coverage. This could translate into an additional shortfall of 300-400 physicians in Georgia. The elimination of copays, deductibles, and coinsurance for many preventive services may also increase the demand for primary care providers.

The Affordable Care Act provides resources to assist with this increased demand. These include:

- \$11 billion to increase/expand FQHCs
- Reallocation of unused medical residency sites with preference to high need states (Georgia is one)
- State workforce planning grants
- Loan repayment and scholarship programs
- Primary Care Extension Program
- Increases in Medicare and Medicaid payments for primary care providers

PCSG staff were asked before the presentation how prepared they felt to make strategic decisions about how health reform will affect FQHCs. They stated that their key areas of concern included understanding who would make up the uninsured, what the expectations would be for small agencies, and how to educate people about their eligibility. After the presentation was completed, attendees stated that their state of preparation had improved.

As a result of the information provided, PCSG staff decided there are strong opportunities for FQHCs and preventive care, but they will need to expand their workforce to accommodate many of the expected changes. Workforce needs include additional providers, front office staff to help people enroll in Medicaid, and business staff to process reimbursements. They also felt they would need to devote resources to educating people about their eligibility for insurance. They thought the costs of additional providers could be covered through Medicaid and other insurance payments. In terms of planning, staff felt that a toolkit that staged out a timeline would be helpful. For example, specific preparations completed by specific dates according to the dates that different elements of the legislation would be enacted. Staff also commented that there are many details that have not yet been determined, which could impact their planning efforts.



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

RICHMOND COUNTY BOARD OF HEALTH

Augusta, GA



OVERVIEW

Richmond County Public Health (RCPH) is located in Augusta, Georgia and is the lead county for East Central Health District #6. According to the 2009 US Census estimates, the county population is about 199,800. RCPH is led by a 12-member Board of Health (BOH) and staffed by several departments that cover Administration, Billing & Records, Child & Adolescent Health, Infectious/Communicable Diseases, TB Clinic, General Medical and ID Clinic, Dental Health, Mental Health, Women's Health, HIV, PCM, Purchasing, Teen Health, WIC/Nutrition Services, and the South Augusta Branch. In fiscal year 2010, RCPH had 61,875 client visits and an unduplicated payer mix of 73.1% Self-pay, 23.8% Medicaid, 1.7% Private Insurance, and 1.4% Medicare. Fees for services are charged on a sliding scale.

STUDY QUESTION

What do health departments need to do to become a viable component of the health care system under health reform—that is, maintain, increase, diversify and attract other payer sources?

CASE STUDY ANALYSIS

Background information was collected and an assessment interview was conducted on August 12, 2010 with 5 BOH members and 5 management level staff. An on-site meeting was held in Augusta on September 21, 2010 with 22 BOH and staff members. Major topic areas covered in the on-site meeting were an overview of the Affordable Care Act (ACA), uninsured estimates before and after ACA, and details about public health funding opportunities.

CONCLUSION

Three major themes that emerged from the facilitated discussion were:

1. Public Health Opportunities

RCPH recognized the plethora of health education, prevention and wellness opportunities that will be available through the ACA and the Prevention and Public Health Fund. They agreed that one of their next steps will be engaging in the preparation work necessary to apply for federal grant funding. This work was outlined as promoting the public health services they already offer and building stronger partnerships within the county. Partner stakeholders were identified as

community-based organizations, non-profit organizations, and the private sector. It was also recognized that while funding for the Prevention and Public Health Fund may have increased, many of the dollars were still subject to appropriation. Among the grant programs with appropriated funding, the dollars allotted were less than what was legislated. Participants were also concerned that, given the national scope of potential applicants, the competition for receiving grant funding would be a challenge. Despite this concern, they thought that preparing for grant opportunities was a critical next step.

2. Strategic Planning and Positioning

In alignment with preparing for grant opportunities, a prominent theme emerged around engaging in strategic planning and positioning for both RCPH internally and the health serving community county-wide. They identified both strategic and tactical needs including capitalizing on evidence-based wellness promotion, marketing existing prevention and education services, and contributing to the evidence-base through improved program and service evaluation. Given their role in the community as the local government public health agency, they saw themselves in the unique position of being a repository for surveillance data and other public health information. Another internal strategic area they thought could be pursued was serving as the local resource for information about the ACA. In addition, it was widely recognized that ACA implementation will require partnership and collaboration among diverse health serving entities, and, a local strategic plan could serve as a first step towards improved public health and health care delivery.

3. Health Information Technology

In the changing data exchange environment, RCPH is preparing to convert to an electronic records system. They view this change as important for the operations of the local health department and recognized the need for the system to interact with a statewide network. In addition, the interoperability of their system with the forthcoming statewide Health Insurance Exchange was noted.

Participant reactions to the ACA before and after the assessment were mixed. Prior to the on-site presentation, reactions could be categorized into three general sentiments: 1) some participants thought that reform would improve

coverage for the uninsured, meet people's needs, and increase access; 2) others saw reform as overwhelming, unaffordable, confusing, and ambiguous; and 3) some were more neutral in their assessment, but recognized the "devil will be in the details" and saw the change as having major implications for health care delivery. Many participants were also concerned about how the ACA would not only impact the RCPH, but also their own personal health care and that of their families and friends. The presentation led to a lowered anxiety level for some participants and increased anxiety for others who became more concerned about the details of cost and implementation as they learned more. The major theme among reactions was the need for more information about forthcoming changes.

2007 ESTIMATES OF POPULATION NEEDS FOR GEORGIA AND RICHMOND COUNTY

	Georgia	Richmond
Non-Elderly Population	8,596,726	169,609
Share of Population <200% FPL	32%	44%
# Uninsured	1,632,319	30,851
% Population Uninsured	19%	18%
# Uninsured < 200% FPL	985,518	18,521



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

SMALL AND LARGE EMPLOYERS

Atlanta, GA



BROWNRICHARDS & ASSOCIATES

OVERVIEW

BrownRichards & Associates, created in 1977, is a human resources consulting firm whose mission is to provide innovative, high-quality work/life consultation and services that enable employers to offer programs that assist their employees and their families to balance personal and work responsibilities. It is a privately held, Women-Owned Business Enterprise (WBE) headquartered in Atlanta, Georgia. The core business is dependent care resource and referral with over 50 percent of its revenues coming from the online product. The company also offers consulting services ranging from benefit studies to the development and implementation of on-site childcare services, and provides a full range of training opportunities for educators, childcare center directors, staff and administrators of early care and learning centers.

BrownRichards currently has corporate referral accounts that represent over 2.3 million employees, as well as, serving as the "backroom" to many national Employee Assistance Programs (EAPs) and Behavioral Health Companies. The BrownRichards' clientele include large and small, public and private firms, covering a broad range of industries – academic, financial, legal, communications, medical, and manufacturing.

The company employs 6 full-time workers and 5 part-time, with offices in Georgia and Connecticut.

STUDY QUESTION

How will health reform impact my small business and do we qualify for the small business tax credit?

CASE STUDY ANALYSIS

As a small employer, BrownRichards wants to provide a good health plan for its employees. Currently, employees are allowed to select their own individual health plan, and the company pays up to 60% of the cost, which is then reported

on the employee's W-2 form. From the preliminary discussion, it appeared that BrownRichards could qualify for a small business tax credit. Using the Georgia Health Policy Center's 50-State Health Reform Calculator for Small Businesses® during the consultation, it was estimated that this small firm could receive a tax credit ranging from \$4,800-\$6,500 a year. It was also suggested that BrownRichards look into setting up a flexible spending account under the IRS Section 125 tax code, prior to full implementation of health reform in 2014. Additional discussion ensued about the CLASS Act, as well as, the exchanges, and whether premiums will increase. A significant amount of time was spent on discussion about the exchanges and it was explained that the purpose of the exchanges is to equalize the costs of premiums for healthy groups vs. unhealthy groups.

CONCLUSION

Based on the consultation, the group's understanding of health reform significantly increased, but there was still anxiety because of the uncertainties of the law and the obvious need to stay informed and educated about the opportunities and challenges. BrownRichards staff saw health reform as an opportunity to provide employees with health insurance, thus improving its recruiting capacity. As a result of the consultation, BrownRichards will:

- Explore with the accountant and insurance broker the possibility of applying for a small business tax credit.
- Increase its understanding of the IRS Section 125 eligibility requirements.
- Identify opportunities the company might want to pursue related to wellness initiatives they may want to offer their clients through their information and referral services.
- Continue to stay informed about health reform through organizations such as GHPC, the Chamber of Commerce and the national EAP association.

BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA

OVERVIEW

The University System of Georgia (USG) is comprised of 35 colleges and universities; four research universities, two regional universities, 13 state universities, eight state colleges, and eight two-year colleges. These institutions enroll approximately 302,000 students and employ over 40,000 faculty and staff to provide teaching and related services to students and the communities in which they are located. Including retirees, USG offers coverage to over 100,000 lives.

STUDY QUESTION

How does health reform affect the USG's ability to offer a benefit package that is cost-effective and competitive?

CASE STUDY ANALYSIS

An advisory board appointed by the Board of Regents meets regularly as part of a strategic review process. Consultants were brought in to both inform the process and facilitate a strategic review. As part of the process, information was presented to the Board about health reform and its impact on the University System.

CONCLUSION

Consultant information and actuarial analyses suggested that health reform would have limited effect in the near term. Conversations focused on encouraging healthy behaviors, managing health care utilization, and identifying and rewarding cost effective providers.



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES

TROUP CARES NETWORK

TROUP COUNTY, GA



OVERVIEW

Troup Cares Network is a not-for-profit network that supports the working uninsured of Troup County, Georgia. Located in LaGrange, it is a broad-based community partnership that includes a free clinic, pharmaceutical support, dental clinic, foundation, hospital, physicians groups, information and referral service, drug store, patient screening service, an FQHC, and United Way.

Established in 2007, the mission of Troup Cares is to "identify opportunities, seek solutions, and organize community resources to improve access to health services resulting in a healthier and more economically viable Troup County." The organization is governed by a 17-member board of directors, has three full-time staff (with one more to be added this fall), and engages 32 volunteer primary and specialty care physicians and nurses.

A free clinic is open three days a week and one evening, and network prescription assistance and care management is available five days a week. About 50 to 60 patients are seen each week. They primarily serve individuals who do not have appropriate health care coverage and are at or under 200% FPL, residents of Troup County, employed, 19 and over, and U.S. citizens. A local church that is part of the network houses a dental clinic.

Troup Cares has an annual budget of about \$250,000, receiving support from United Way, Callaway Foundation, the city of LaGrange, the Lions Club, and a federal rural network development grant.

STUDY QUESTION

How can a free clinic network remain financially viable and medically relevant as healthcare reform is implemented?

CASE STUDY ANALYSIS

The initial phone interview was conducted with the Executive Director on August 16, 2010. The on-site consultation with staff and Board members occurred September 8, 2010. Document review and analysis was conducted throughout

the process. It was determined that, since most of the coverage provisions in the newly enacted health reform legislation will not be fully implemented until 2014, there will continue to be a need for services for the uninsured between now and then. While there will be uninsured individuals living in Troup County in 2016, it is estimated that the currently targeted group for Troup County, that is, those \leq 200% FPL, will decrease from 5,370 to 1,894 as a result of health reform's likely impact on the county.

The health reform legislation does not specifically address free clinics, but other provisions will significantly impact the type of clients seen and the scope of services provided at free clinics. Essentially, as a result of health reform, charity programs can develop a new model and treat Medicaid and newly insured individuals; continue doing exactly what they are doing now; fill in the gap for the uninsured; or discontinue.

CONCLUSION

During the on-site consultation, the attendees agreed they wanted to maintain their local, community-focused orientation and continue to "fill the gaps" by providing quality care. They were particularly interested in the analysis of their population. Who would be covered? What would the premiums be, by income category? Who will be uninsured and what will be their needs? Of those needs, which will be addressed by health reform? Throughout the discussions, concerns were expressed about the health and well-being of the patients they serve, the financial sustainability of the network, the future workforce, the ability of patients to pay the premiums, and the consequences for patients not complying with premium payments as well as the implications for clinics serving non-compliant patients. Additional themes were the opportunities to enhance current partnerships and develop new collaborations to meet unmet needs such as the provision of care coordination, patient navigation, health education, health promotion, and other social services. While they still felt anxious about the impact of health reform, they now felt more knowledgeable about how to move forward. Next steps include enhancing their understanding of the uninsured, holding additional conversations with other Board members and partners about the opportunities and challenges presented by health reform,

working with other free clinics throughout the statewide network to identify ways to creatively collaborate, and continuing to "keep on keeping on" providing quality care to the working poor.

Troup County	# uninsured	% uninsured	# uninsured <200% FPL	% uninsured <200% FPL
2007	8,946	14%	5,370	60%
2016	3,155	4.2%	1,894	60%

Troup Cares Network is a member of the Georgia Free Clinic Network (GFCN). This network is the statewide association of the 104 free and charitable medical and dental clinics in Georgia. The GFCN mission is "provide a collaborative support system to foster growth and development of charitable clinics and improve access to quality healthcare for the medically underserved across the state." The GFCN focus is 1) Unifying clinics serving Georgia's uninsured through advocacy, technical assistance and collective purchasing; 2) Development, implementation and replication of data gathering resources regarding the uninsured; 3) Strengthening the infrastructure to serve GFCN membership; 4) Assisting in the development of services in areas of highest unmet need.



HEALTH REFORM: FROM INSIGHTS TO STRATEGIES, A VARIETY OF PERSPECTIVES



The Georgia Health Policy Center is a leading independent resource for public and private organizations and government entities seeking evidence-based research, program development and policy guidance to improve health status at the community level. The center was established in 1995 and is a research division of Georgia State University's Andrew Young School of Policy Studies in Atlanta, Georgia.

For more information about the center, visit www.gsu.edu/ghpc.