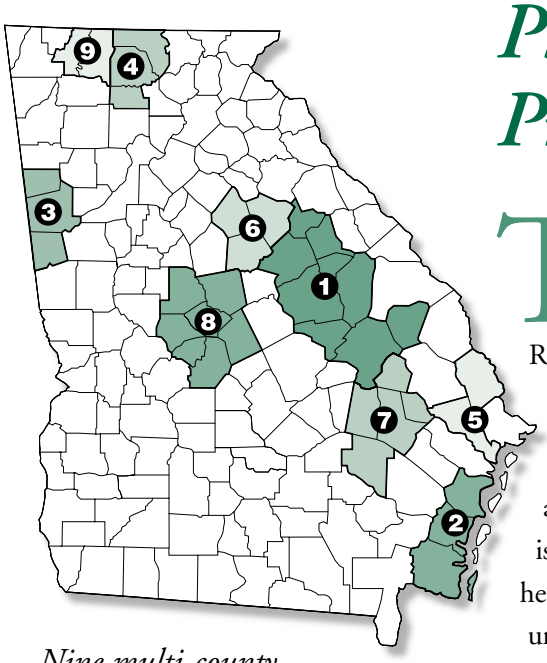
UPDATE
Winter, 2002
PHILANTHROPIC COLLABORATIVE FOR A HEALTHY GEORGIA

Philanthropic Collaborative Promotes Rural Health



Nine multi-county awards will collectively reach 37 counties

1 ***East Georgia Health Cooperative***
Emanuel, Glascock, Hancock, Jefferson, Jenkins, Johnson, Taliaferro, Warren, and Washington

2 ***Coastal Medical Access Project***
Camden, Glynn, and McIntosh

3 ***Tanner Health System***
Carroll, Haralson, and Heard

4 ***Appalachian Health Alliance***
Fannin, Gilmer, and Pickens

5 ***Regional Health Intervention Program Community Network***
Bryan and Effingham

6 ***Greene Morgan Putnam Health Network***
Greene, Morgan, and Putnam

7 ***South Georgia Access Network***
Appling, Candler, Evans, Tattnall, and Toombs

8 ***Health Care Central Georgia***
Bibb, Crawford, Houston, Jones, Monroe, Peach, and Twiggs

9 ***Northwest Georgia Alliance***
Murray and Whitfield

The second major initiative of the Philanthropic Collaborative for a Healthy Georgia is now effectively underway. On January 15, 2002, the Collaborative issued nine multi-county awards under its *Access Georgia* Rural Health Matching Grants Initiative. Grants ranged from $185,000 to $200,000, for a total of $1,757,805.

This Rural Health Initiative focuses on improving access and health status and reducing health disparities for underserved populations in rural areas. It is a direct response to the growing concern among community leaders and healthcare providers that Georgians living in rural areas are not as healthy as their urban neighbors. Chronic health problems, such as heart disease, diabetes and cancer, occur more frequently among people living in poor rural areas. Rural healthcare systems are often fragmented and ill equipped to address the complex needs of individuals with these long-term conditions – and the number of uninsured rural Georgians continues to rise.

Applicants were afforded great latitude in proposing innovative strategies to meet their rural community's unique health needs. Funded grantees thus vary in their focus, approach, structure, and timeframe. Four grantees formed multidisciplinary boards as the lead agents, two used hospitals, two identified county commissions, and one is the local health department. Four of the grants will last only one year; five span two years. A few of the networks existed prior to the grant award but, with an infusion of additional funding, will be able to make even greater strides. The majority are

Continued on page 7

About this issue...

The Philanthropic Collaborative for a Healthy Georgia serves as a forum for bringing foundations together to better understand and explore the health-related challenges facing Georgia.

This issue of Update focuses on the second initiative of the Collaborative: Access Georgia Rural Health Matching Grants. The Initiative's vision and goal, the review process, and key features of the grants are described. Progress on two other major Collaborative initiatives is also shared.

Access Georgia INITIATIVE

The Matching Grants Initiative is part of a larger, more comprehensive effort spearheaded by the Office of Rural Health Services (ORHS) in the Department of Community Health (DCH). This Initiative, called the Access Georgia Rural Health Initiative, aims to optimize the health status and eliminate the health disparities of persons in rural and underserved areas of Georgia through the development of regional systems of quality healthcare. Underlying this effort is the belief that it is no longer acceptable for Georgians to have some of the poorest health status indicators in the nation. Rural communities must intensify their focus on improving the health status of their citizenry by fundamentally restructuring their health care systems. This restructuring involves developing mutually beneficial relationships among different types of providers and community stakeholders locally and regionally.

Recognizing the challenge that such restructuring entails, ORHS and the Georgia Health Policy Center (GHPC) will provide technical assistance to the nine matching grant recipients. Assistance will be tailored to each network, and can range from leadership development to strategic planning to mediation to the development of quality assurance mechanisms. If requested, technical assistance may also be provided to other emerging networks around the state.

In addition, all grantees have agreed to participate in state-level evaluation and replication activities, including the development of appropriate statewide systems and tools to support local and regional efforts. These may include state-level information systems, infrastructure to support local pharmaceutical access projects, and innovative reimbursement strategies for care management. Through these coordinated, broad-based efforts, innovations can more rapidly permeate the state and improve the health status of all rural and underserved communities in Georgia.

Spotlight on Grants

All funded networks must meet certain expectations established by DCH and the Collaborative. A closer look at these requirements and the unique approaches adopted by each grantee testifies to the challenges inherent in improving rural health in Georgia.

Grantees must establish functioning regional systems of care.

The requirement that rural healthcare systems cover multiple counties is fundamental to the Collaborative's Matching Grants Initiative. The majority of grantees include two or three rural counties in their regional systems. In the case of the **East Georgia Health Cooperative** (EGHC), nine counties are involved (Emanuel, Glascock, Hancock, Jefferson, Jenkins,

Johnson, Taliaferro, Warren, and Washington counties). EGHC is one of the more mature networks in the state, having begun as early as March 1999 to examine the potential for pooling regional resources. Commonly referred to as the "poor belt" of Georgia, this area has higher unemployment rates than state and national averages. Over 25% of the residents live in poverty and have less than a 9th grade education; and their health status is worse than any other region of the state. The network is fortunate, however, to have a wealth of local healthcare resources: four rural hospitals, three community health centers, about 60 primary care physicians, and public health departments in each county. With *Access Georgia* grant funds, EGHC will use these resources to build on its ongoing diabetes program. Expanded outreach will improve local access to specialty care services, discounted or free eyeglasses, and other medical supplies. Through a partnership with the Medical College of Georgia, EGHC will also offer mobile diabetic retinopathy screening and expanded dental services.

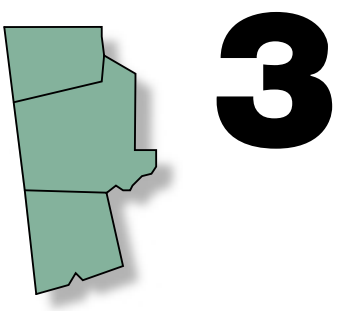
Program design must be specific to community needs and build on local resources.

Grantees used community needs assessments to identify and address priority health issues. With such information, the **Coastal Medical Access Project** (CMAP) recognized the necessity to provide medical access to the underserved and uninsured (estimated to be over 22,390 residents) in the 3-county community (Camden, Glynn, and McIntosh counties). CMAP designed a multi-faceted "system" that includes: access to pharmaceuticals; access to medical services (including network linkage to existing services); and a case management component. The project anticipates reaching 1,120 uninsured residents with these new services by the end of the first year of funding. While still in the early stages of planning and development, CMAP

hopes to improve the health and quality of life for previously underserved individuals and the entire community, reduce "sick days" for schools and employers, decrease the number of inappropriate emergency room visits and the accompanying costs of avoidable treatments and hospitalizations, and reduce the "indigent care" burden for the community.

Networks must create new services and/or new points of access to existing health care systems.

Grant funds could not be used to directly finance the purchase of healthcare services, nor could they supplant or duplicate existing services or programs. Instead, grantees were asked to explore creative ways to enhance resources already available. The **Tanner Health System** (Carroll, Haralson, and Heard



counties) plans to meet this challenge through its West Georgia Chronic Disease Initiative. With a focus on improving the health status of low-income patients with diabetes and hypertension, Tanner will: expand its current diabetes clinic program by adding a diabetes education component, new services to hypertension patients at all clinic sites, and three new clinics; begin a new medication assistance program; expand vision screening; and add several new wellness and health promotion projects using an innovative outreach strategy. By using mobile units, education and screening programs will move into the community targeting churches, community centers,

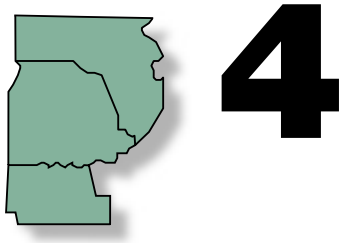
Continued on page 4

Continued from page 3

mobile home parks, shopping centers, small worksites, senior centers, and public housing facilities. Another innovation features workshops for middle school students to teach healthy habits and blood pressure monitoring techniques.

Systems must target the underserved and uninsured.

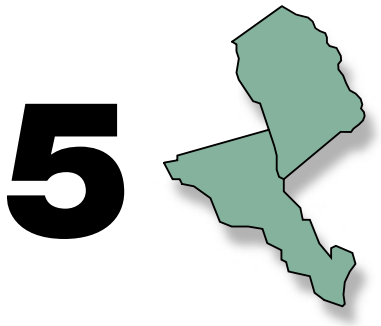
A primary goal of *Access Georgia* is to reduce health disparities for underserved populations. Thus, the vast majority of Georgians served by grant funds are poor and/or unemployed. In Fannin, Gilmer, and Pickens counties, 15% of the general population and almost 25% of the children live in poverty. Health care takes a distant backseat to more pressing needs of food and shelter. Dental disease, substance abuse, and addiction are common; and the heart attack rate is high. Life-threatening emergencies in this mountainous North Georgia area often require



expensive helicopter flights out of the region. The new **Appalachian Health Alliance** addresses its healthcare challenges by better coordinating existing services, expanding dental services at public health clinics using volunteer dentists, improving availability and delivery of substance abuse services, upgrading existing emergency transport units, and providing defibrillators for first responders.

Networks must demonstrate a commitment to community collaboration.

In its proposal, each applicant was asked to prepare a Health Systems Table enumerating community partnerships. Formal agreements with



these partners were also required to document specific commitments and respective roles. The list of partners can be quite lengthy, as is the case with the **Regional Health Intervention Program (HIP) Community Network** (Bryan and Effingham counties). Together, these partners plan to build on an existing county-level Family Connection collaborative; use a common intake and referral system through United Way; and provide a variety of prevention, health promotion, and wellness programs to reduce health disparities in the community, especially for cancer and other chronic diseases. HIP's comprehensive array of health and social service providers includes: hospitals, behavioral health partners, county public health departments, other health and human service agencies, local government, local businesses, faith institutions, county public schools systems, civic organizations, and other relevant stakeholders.

Plans must include a mechanism for ongoing community input and feedback.

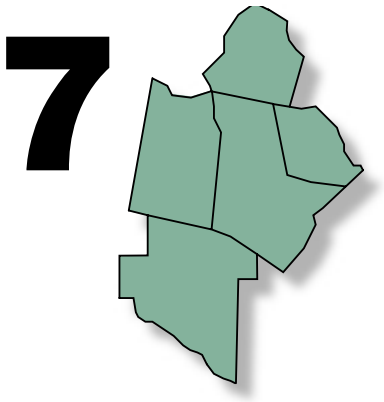
Continuous involvement from the community is critical to success. Community leaders in the **Greene Morgan Putnam (GMP) Health Network** recognized this two years ago when they first began to strategically shape the region's health services. Their process initially involved population-based telephone surveys of community and leader perceptions

and analyses of the current health care system, economic health care dollar flows, and demographic and health status information. To assure continued local involvement, Greene, Morgan and Putnam counties each have a local healthcare council dedicated to meeting the needs of their respective county's population. A regional council exists as well, to look after the needs of the

larger GMP Health Network. A representative from each of the local health care councils sits on the regional council, joined by county commissioners, hospital administrators, physicians, and public health managers from each county. Regular monthly meetings provide ample opportunity for all interested providers, agencies, community organizations and health care consumers to offer feedback on activities and programs, and to identify gaps and needs for future attention.

Programs must pursue opportunities for sustainability.

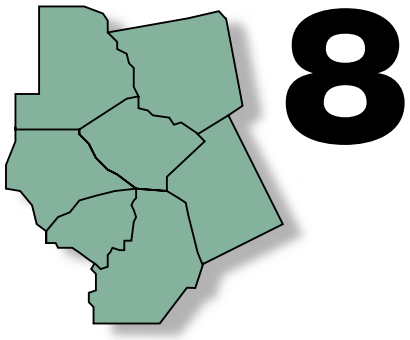
Because grantees received funding for at most two years, it behooves them to plan now for sustaining progress. Improving health status, particularly when it depends on behavioral and systems change, demands long-term investments. One of the most ambitious sustainability plans came from the newly established **South Georgia Access Network**. This 5-county Network (Appling, Candler, Evans, Tattnall, and Toombs counties) focuses on chronic disease and will offer comprehensive health risk appraisals to underserved and uninsured residents. Those at high risk for cardiovascular disease (CVD), cancer, or diabetes will be enrolled in lifestyle management programs. Two new cardiac rehabilitation programs will help those already diagnosed with CVD. The Network does not base its future solvency on obtaining other grants, state funds, or other uncertain sources. Instead, its leaders believe that sustainability ultimately depends on



the sale of network services, improved health outcomes, and demonstrated cost savings to reimbursement sources (payers). They have asked for only one year of funding, and expect continued stability and growth as a result of: operating efficiencies, publicity, increased volume of health risk appraisals and lifestyle management enrollments, allocation of some overhead costs to other Network projects, expanded use of technology and internet-based access to services, use of in-kind staffing, maximized Medicaid funding, and foundation support.

Networks must evaluate progress and impact.

The Collaborative is committed to learning from this matching grants experience – not only to strengthen the nine funded networks but also to share that knowledge with others throughout the state and the nation. Consequently, grantees are required to document and evaluate changes in access, health status, disparities, and cost. The evaluation plan of **Health Care Central Georgia** (HCCG) relies on many of the methods and data sources used during the planning and design phase. In 1999, HCCG analyzed hospital discharge and outpatient encounter data, and discovered that the region's most prevalent chronic conditions were heart disease, diabetes, hypertension, and depression. A pilot project was started in Monroe County early in 2001, to provide the full range of basic primary healthcare services (prevention, screening, assessment, health promotion



and education, and outpatient management of acute conditions), integrated care management from a multidisciplinary team of clinical and psychosocial providers, and access to and financial support for pharmaceuticals. Based on interim evaluation results, HCCG expanded the pilot to Houston County late last year and, with the recent grant, will refine and expand the model to the remaining five counties in the region

Continued on page 6

Continued from page 5

(Bibb, Crawford, Jones, Peach, and Twiggs counties). Success will be gauged by changes in access for HCCG members and the region's uninsured, health status, economic impact of uncompensated care on providers, member utilization (amount, timeliness, and type), and patient and provider satisfaction with services.

Systems must attend to diversity and cultural competence in outreach, the provision of services, and interactions with the public.

Georgia is fortunate to have a heterogeneous population. With this diversity comes the responsibility to address varied social, cultural, and economic needs when delivering health care. The **Northwest Georgia Alliance** fully appreciates this challenge. Once an agricultural community, northwest Georgia is now an industrial area – due primarily to the growth of the carpet industry. The population consists of a large, semi-skilled workforce mainly of Hispanic origin. A high proportion is uninsured, and over one-third reports receiving their primary care at

9

the hospital emergency department. Focus groups reveal a lack of interest and/or value in health insurance, particularly among adult men, and cite cost, language, and transportation as major barriers to receiving health care. This 9-year-old network of leaders in Murray and Whitfield Counties plans a creative delivery scheme to serve its population. A voucher system negotiated with the taxi services in both counties will enable residents to be transported for medical appointments. A new health clinic, staffed by a bilingual registered nurse, will be opened at the International Inclusion School that is largely attended by Hispanic children. Clinic services will include hearing, vision and dental screenings, immunizations, referrals to other health care providers, community awareness of services, and health education for both students and their families.

www.philanthropiccollaborative.org

Other Collaborative Initiatives

In July 2001, the Collaborative funded thirteen Georgia communities under the School Health Matching Grants Initiative. These communities have hit the ground running and, over the next 1-3 years, will make great strides in improving the physical and mental health of low-income and medically underserved school-age children through comprehensive school health programs. This program continues to receive national recognition and attention. In February, the Collaborative and GHPC delivered an invited presentation at the CDC 2002 National Leadership Conference on Healthy Kids Healthy Communities: Integrating Health and Education. The audience included representatives of federal, state and local school health programs.

The Philanthropic Collaborative is now designing the framework for its next major initiative focused on cancer. The beauty of the Collaborative's structure is its flexibility to address each health issue in a manner uniquely suited to the purpose at hand. Unencumbered by standardized processes and requirements, the Collaborative can serve as an impartial broker between the foundation community and the citizens of Georgia.

Progress on all of these initiatives will be shared on the Collaborative's website and in future Update issues.

The Review Process

The Collaborative's Access Georgia Rural Health Matching Grants Initiative was announced during a Rural Health Symposium in August 2001. Presentations from local, state and national experts explored the issue of rural health in Georgia and opportunities for partnerships. The Request for Proposals (RFP) was prepared by a rural health technical advisory committee composed of representatives from DCH's Office of Rural Health Services, the foundation community, the Division of Public Health, the Georgia Health Policy Center (GHPC), and an independent rural health technical expert. Shortly thereafter, the RFP was issued and posted on the Collaborative's website. Notices announcing the RFP were sent to over 1,100 organizations. Eligible applicants included government entities, units of local/state government, and nonprofit organizations located in counties other than the ten counties in Georgia with the highest populations according to the 2000 U.S. Census (Fulton, DeKalb, Cobb, Gwinnett, Chatham, Clayton, Richmond, Muscogee, Bibb, and Cherokee).

Like the school health matching grants, GHPC coordinated the review process on behalf of the Collaborative and the DCH. Proposals were assigned to four review teams comprising a 12-member Internal Review Committee. Each team had three members and included representatives from the foundation community, DCH, and GHPC. Using an evaluation tool, members independently reviewed the proposals, and then met with their assigned teams to discuss them. Criteria examined how well the applicant assessed the healthcare needs of their communities, collaborated with existing providers and community groups, designed a feasible and innovative plan, proposed a realistic budget (with a local match), and planned to evaluate their success. The Committee then met as a group to deliberate the merits of all applications and make recommendations to the Commissioner of the Department of Community Health, who made the final selections.

Collaborative Promotes Rural Health
continued from page 1

essentially new regional groups formed in direct response to the Collaborative's Initiative. Underlying these differences, however, is a shared commitment across all networks to strong local and regional collaboration among various service providers and with other community stakeholders.

The Collaborative's grants initiative represents a partnership between state and national private grant makers and the Georgia Department of Community Health (DCH). The Collaborative and DCH jointly identify common areas of interest and then leverage funding to address them. For the rural health grants, the foundation community's donation was matched by DCH, and then further increased by required local matches of in kind services and cash. Local contributions ranged from $50,000 to $314,000, bringing the total resource pool for rural health to $2,783,553.

Summary of Grant Awards

Grantee	Lead Agent	No. Counties	Years
Appalachian Health Alliance	Nonprofit Entity	3	2
Coastal Medical Access Project	Health Department	3	1
East Georgia Health Cooperative	Nonprofit Entity	9	2
Greene Morgan Putnam Health Network	Nonprofit Entity	3	2
Health Care Central Georgia	Nonprofit Entity	7	2
Northwest Georgia Alliance	County Commission	2	1
Regional Health Intervention Program Community Network	County Commission	2	2
South Georgia Access Network	Hospital	5	1
Tanner Health System	Hospital	3	2

Philanthropic Collaborative for a Healthy Georgia

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