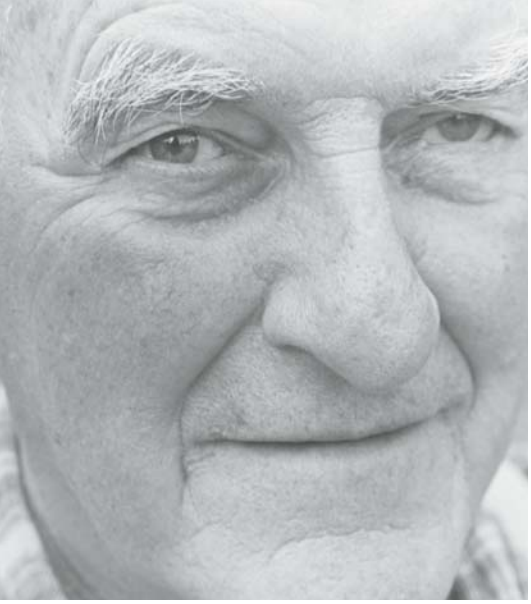
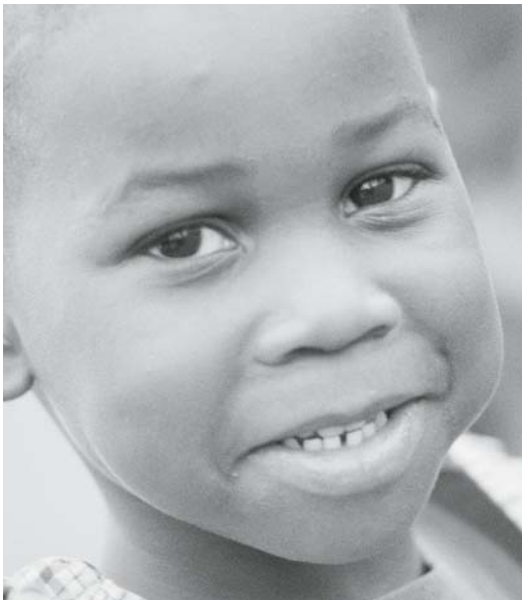


Celebrating Georgia's Rural Health Networks Sustainability and Resource Acquisition Intensives

prepared for

Georgia Department of Community Health


Karen J. Minyard, Ph.D.
Executive Director

Georgia Health Policy Center

Georgia is a state of great health need driven largely by high rates of poverty and disease outside the metropolitan Atlanta area. There is a lot to be concerned about when it comes to rural health in our state. However, there is much to celebrate.

Across our state, individuals, civic groups, healthcare workers, cities, counties, and regions, are pulling and working together to meet the healthcare needs of their rural communities. More than 64 rural Georgia counties work within rural health networks to fill gaps in access and availability to health and human services.

Georgians living in rural areas are not as healthy as their urban counterparts. Chronic illnesses, such as heart disease, diabetes, and cancer, occur more frequently among people in rural Georgia. The number of uninsured people in rural Georgia is higher than the number of uninsured in urban areas. Many rural communities do not have enough primary care physicians to meet the basic healthcare needs of their residents, and many rural hospitals are either closed or at risk of closure. The lack of physicians and hospitals in rural Georgia is just one example of how rural communities are often ill-equipped to address complex physical, behavioral, and social service needs.

In 1996, Georgia's rural health crisis came to the forefront. A Medicaid case study confirmed the state's need for improved healthcare delivery systems in rural Georgia. Since 1996, Georgia state government and its partners have invested in an evolving strategy to organize, support, and build capacity for sustainable rural health networks.

Rural health networks play an increasingly important role strengthening rural healthcare systems to increase access to health and human services and improve health status. Georgia's rural health networks help bridge the healthcare gap between rural and urban areas and meet the needs of the communities they serve. During tight economies, rural health networks are challenged to meet the health needs of their communities, provide care for more people, and continue their work to improve Georgia's healthcare safety net, all with less funding.

Since 1997, 19 rural health networks have evolved and four have disappeared, leaving 15 to serve high need areas in the state. That's why in 2004 the Georgia Department of Community Health's Office of Rural Health Services, the Woodruff Foundation, the Georgia Health Policy Center, and 12 rural health networks made a $220,000/seven month investment to build rural communities' capacity and support 34 new initiatives within 64 rural Georgia counties.

The 12 rural health networks now have sustainability plans in action that have the potential to create, over a span of four years, more than 50 new jobs in rural Georgia and save local hospitals and other providers more than $18.4 million, via free care clinics, prescription assistance, and care management for the chronically ill.

Rural health networks play an increasingly important role strengthening rural healthcare systems to increase access to health and human services and improve health status.

PERINATAL HEALTH PARTNERS

Southeast Georgia is pulling together to improve the health of high-risk pregnant women and their infants and is becoming a model program for the state of Georgia. More women in the Southeast Georgia Health District 9-2 go without timely prenatal care than anywhere else in the state. The rate of births to women who receive late or no prenatal care is 18.1/1,000, compared to 12.7/1,000 for the state. Lack of prenatal care increases risks of stillbirth, low birth weight, neurologic damage, and congenital abnormalities.

The sprawling region covers a land area of 8,800 square miles, which is about the size of Massachusetts, and includes 16 counties: Appling, Atkinson, Bacon, Brantley, Bulloch, Candler, Charlton, Clinch, Coffee, Evans, Jeff Davis, Pierce, Tattnall, Toombs, Ware, and Wayne counties.

The average weight of Perinatal Health Partner infants was more than 35% greater than the average birth weight of infants prior to the network.

Between 1999 and 2001, 236 very low birth weight babies and 1,180 low birth weight babies were born between 1999 and 2001, accounting for $36.8 million in medical care. This does not include the costs of the mother's care or the long-term costs of maternal and infant morbidity/mortality. Every time a high-risk pregnancy in southeast Georgia results in the delivery of an infant weighing 1500 grams or less, the cost of initial care is approximately $156,000. Because families in rural Southeast Georgia need help accessing resources and coordinating care for mothers and babies, who are at risk for adverse outcomes, a rural health network is addressing the need.

Perinatal Health Partners, founded in 2001, is a voluntary association of health and human service providers who commit time, attention, and fiscal resources to improving perinatal health outcomes in its service area. The partnership is a product of collaboration between Savannah's East Health District and Brunswick's Coastal Health District to develop a Southeast Regional Perinatal Health strategic plan. The 118 committee members, who worked on the perinatal health planning process, developed a plan to offer a seamless circle of quality care for southeast Georgia women and the babies they bear.

In one year, 2003-2004, Perinatal Health Partners staff made more than 2,400 home visits to southeast Georgia women, and the average weight of PHP infants was more than 35 percent greater than the average birth weight of infants prior to the network. The network combines in-home case management with nursing assessment and care coordination for high-risk pregnant women and their infants. The network currently operates in 10 of the district's 16 counties and collaborates with more than 72 active partners, including public and private providers, such as obstetricians, pediatricians, and birthing hospitals, public health and community agencies.

The network plans to expand into the district's remaining six counties. These six counties, which do not receive Perinatal Health Partner services, have the highest number of Neonatal Intensive Care Unit admission rates to Memorial Health University Medical Center in Savannah, Ga. As Perinatal Health Partners expands district wide, it projects a reduction in the number of pre-term deliveries by 10 percent, thus providing a healthcare savings cost of more than $3.6 million over a three-year period.

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COMMUNITY HEALTH WORKS

Five years ago, seven Central Georgia counties, Bibb, Crawford, Houston, Jones, Monroe, Peach, and Twiggs, teamed to improve the health of their region. Despite its abundance of hospitals, physicians, clinics, and a medical school, health professions college, district health office and at least one public health department in each county, Central Georgia faces major health challenges.

All or portions of each county are designated as "medically underserved." None of the seven counties has an "excellent" overall health status rating, and five are rated as "fair" or "poor" in health. More than 33% of the region's citizens rely upon public forms of health insurance coverage, which is more than the rest of Georgia, and more than 17% of the population is uninsured. The region's primary causes of disease and disability are hypertension, heart disease, diabetes and depression – all of which can be prevented.

Public and private healthcare providers, county governments, local foundations, and social service agencies in Central Georgia team to explore ways to improve the health of their communities. They span county lines, disciplines, and rural and urban backgrounds to try something new – a partnership to improve access to healthcare for the uninsured in their region. The seven-county regional partnership, **Community Health Works,** offers care management services to a particular segment of the uninsured by targeting individuals with hypertension, diabetes, depression, and heart disease.

Today, these seven counties have coordinated more than $20 million in healthcare for the uninsured in their region through Community Health Works. Since its inception in 1999, the network has helped more than 3,000 patients through care management. The network has almost 1,600 enrolled patient members at a savings of more than $1.3 million per thousand members per year. Its members' healthcare costs are substantially less than the national average of healthcare costs for the uninsured. Through pharmaceutical assistance programs, Community Health Works has received more than $1.3 million in free medicines for its patient members, and its members use the emergency room 31 percent less and are hospitalized 49 percent less than a national control group.

The decline in emergency room visits and hospitalizations of the uninsured helps hospitals maintain a healthier bottom line, but Community Health Works helps even more through its information system. Community Health Works coordinates data to recover expenses across all seven counties and throughout its network of 105 physician, three clinic, 22 pharmacy, and five hospital partners. To date, Community Health Works has recovered more than $1.8 million in health coverage costs for partners. More than $752,000 of it would have been completely lost without the efforts of Community Health Works.

These savings are especially important to Monroe and Peach County hospitals because they are critical access hospitals. Critical access hospitals provide essential services to a community and are reimbursed by Medicare on a "reasonable cost basis" to improve their financial performance and thereby reduce hospital closures. Monroe and Peach County Hospitals rely upon Community Health Works to coordinate care through emergency rooms and physicians and ultimately help reduce the number of emergency room visits.

Community Health Works' patients use the emergency room 31% less and are hospitalized 49% less than a national control group.

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SPRING CREEK COLLABORATIVE

An innovative multi-county partnership is changing the way southwest Georgians manage their health, and it is saving taxpayers millions of dollars. The counties of Early, Miller, Calhoun, and Clay joined in 2001 as the **Spring Creek Health Cooperative** to improve access to healthcare for and health status of the uninsured. Since then, the network's mission has evolved to help those at risk for chronic disease in its service area better utilize the healthcare system and make healthier lifestyle choices.

This Southwest Georgia region is one of the financially poorest regions in the state. It is burdened with poverty, illiteracy, and chronic disease. Each of the four counties has an unemployment rate that exceeds the state average. The region's per capita income is 20.7 percent lower than the state average, and more than one out of four members of its population lives below the poverty level. The region suffers from a sagging farm economy, and its small employers rarely offer affordable health insurance. Approximately 17 percent of southwest Georgians lack health insurance, and the region documents rates of coronary heart disease and use of the emergency room for non-emergent cases that are higher than the state average.

Through its partnerships with Calhoun County Hospital, Early Memorial Hospital, Miller County Hospital, and public health departments, the Spring Creek Health Cooperative works to meet the health needs of this population and provide education to reduce and prevent the costly complications associated with chronic disease.

The Spring Creek Health Cooperative offers case management services for the low-income, indigent and un- or underinsured patients with chronic disease. The Cooperative manages cases by connecting its targeted patient population with the resources they need to take charge of their health. From regular physician visits and education to helping patients obtain medications at little or no cost, Spring Creek Health Cooperative is producing substantial results in improving the health of its communities.

The Cooperative provides case management to more than 250 patient members and pharmaceutical management for an additional 250+ members. These management services add up to a healthier community and more than $1.65 million in savings per year for taxpayers. These savings are especially important to hospitals in Miller, Calhoun and Early counties because they are critical access hospitals. Critical access hospitals provide essential services to a community and are reimbursed by Medicare on a "reasonable cost basis" to improve their financial performance and thereby reduce hospital closures.

Before Spring Creek Health Cooperative, the indigent, underinsured population in Southwest Georgia largely was ignored, and the region had no history of collaboration upon which to build. As the Cooperative enters its fifth year of operation, it aims to expand its program by enrolling 400 new patients into its case management program, 500 new patients into its pharmaceutical program and decreasing inappropriate emergency visits and hospitalizations of its case management patients by five percent annually.

The impact of Spring Creek adds up to more than $1.65 million in savings per year for taxpayers.

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NORTHWEST GEORGIA HEALTHCARE PARTNERSHIP

Northwest Georgia is the carpet capital of the world. More than 70 percent of the world's tufted carpet is produced in northwest Georgia. It is also home to the largest Latino population in the state of Georgia.

Latinos comprise more than 23 percent of Whitfield County's population. More than 60 percent of all children in Dalton's city schools are Latino, and in some of the schools, the percentage is more than 85 percent. Many of these immigrants, adults and children, have chronic untreated health problems, lack of preventive care, and inadequate or unhealthy family support systems.

Local surveys reveal that approximately 57 percent of the region's Latinos are uninsured. Many do not speak English or have limited English proficiency. Providers often misunderstand cultural beliefs and practices specific to the immigrants, and most Latinos do not know how to navigate the U.S. health system nor can they afford quality healthcare services.

The **Northwest Georgia Healthcare Partnership** has implemented a program to empower Latinos to take control of their health by teaching them how to access appropriate healthcare and community resources and increasing their healthcare literacy. The Partnership launched in 2004 a new program, Promotores de Salud.

NGHP has implemented a program to empower Latinos to take control of their health.

The Promotores de Salud is a Latino healthcare outreach program modeled from similar research-based programs in Mexican border states. Bi-lingual, culturally-competent, community health workers establish trust with clients in community settings to provide a bridge to understanding and navigating the healthcare system. The Promotores de Salud bring immigrants into care, provide care management, and conduct individual and group education.

The Promotores de Salud program, in its first year of operation, received 204 referrals from schools, medical providers, and social service agencies, reached more than 18,600 individuals via health fairs and community events, initiated a prescription assistance service, and provided care management for 65 individuals with illnesses such as diabetes, cancer, high-risk pregnancy, and dental emergencies. The program provided HIV/AIDS education to 500 individuals and testing for 150, published more than 50 health-related newspaper articles, and hosted 50 one-hour health-related radio call-in programs.

Founded in 1992, the Northwest Georgia Healthcare Partnership serves Murray and Whitfield counties and is a collaborative effort between healthcare providers, business and industry, local government, educators, and public health agencies. Its mission is to help improve the community's health status by serving as a convener, facilitator, and incubator for innovative programs such as a community MedBank, which offers pharmaceutical assistance to indigent and uninsured, Volunteers in Medicine & Dentistry, and Promotores de Salud.

By helping Latinos appropriately access healthcare services and promoting healthy behaviors, the Northwest Georgia Healthcare Partnership's Promotores de Salud program is on track to expand its service offering by 20 percent, increase its sustainability, and improve the health status of its Latino population.

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TRI-COUNTY PLUS RURAL HEALTH NETWORK

Tri-County Plus tracks 500 key measure outcomes of cardiovascular patients and provides more than $1.1 million in free prescription medication.

The four east Georgia counties of Warren, Glascock, Taliaferro, and Hancock often are referred to as the "poor" belt of Georgia. According to the Georgia Rural Development Council, their unemployment rates are much higher than state and national averages; over 25% of their population lives in poverty and has less than a 9th grade education; and their health status is worse than any other region of the state. Approximately 22 percent of the estimated 20,000 residents within the east Georgia region are Medicaid recipients, and 20 percent receive Medicare. More than 67 percent of the population in the four counties are low-income and African-American.

Founded in 1978, **Tri-County Health System**, Inc is the primary source of healthcare in the region. It is the only source of healthcare in two of the four counties. With this in mind, in October 2000, healthcare providers from Tri-County Health System, Inc., Medical College of Georgia (MCG) and Hancock Memorial Hospital saw an excellent opportunity to join forces to improve access and health status for the local citizens in the four-county area by forming the Tri-County Plus Rural Health Network. Tri-County has a 25-year history of collaboration with the MCG. MCG is a tertiary hospital that provides services for many of Georgia's indigent population. Unfortunately, Hancock Memorial Hospital, the only local hospital in the region, closed its doors in March 2001.

From the loss of this local hospital, the network convened community leaders from organizations and agencies to form a health council who focuses on improving the quality of life, health, and well-being of its citizens. The council's community health assessment and community forums revealed a severe health crisis in eastern Georgia. According to a 1999 Georgia State of the Heart report, 49 percent of all deaths in Warren, Glascock, Taliaferro, and Hancock counties were the result of heart disease and stroke, and Glascock alone has an alarming 76.5 percent death rate from diabetes-related complications. Each year, heart disease and diabetes, account for more than $7.4 million in hospitalization fees.

The network maintains a cardiovascular database of more than 500 patients to track key measure outcomes and provides more than $1.1 million in free prescription medication. The network currently offers support groups and health education programming targeted towards residents with chronic conditions such as diabetes, high blood pressure, and high cholesterol. It plans to do more.

The Tri-County Plus Rural Health Network teams with numerous partners, including the Medical College of Georgia (MCG) to provide specialty care for acute patients, referral services, and outreach. Beyond MCG, the network collaborates with the Area Health Education Centers, Grady Hospital, Georgia Primary Care Association, the Georgia Diabetes Coalition and Georgia Cardiovascular programs, Georgia Southern University and the University of Georgia. Its goal is to bring the best information and best partners together to provide the right mix of health services, in the right location, and with the right quality.

Going forward, Tri-County Plus Rural Health Network aims to increase access to quality health services in its four county service area through improvements such as new community health centers, access to pharmaceutical drugs, onsite labs, expanded dental services, case management and nutrition services. The network is also planning to expand its health promotion programs for disease prevention and control including community walking clubs, fitness centers, and health education classes.

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ALBANY AREA PRIMARY HEALTH CARE

As the nation's baby boomer population ages, the need for specialized geriatric medical services will increase rapidly. A rural health network in Southwest Georgia is preparing now to meet the demands of its aging population.

Albany Area Primary Health Care provides primary care services to individuals seeking care in underserved areas of southwest Georgia. The organization serves more than 26,000 patients in Dougherty, Lee, Baker, Calhoun, and Terrell counties. More than 19 percent, or 4,600, of its patients are over the age of 65, and U.S. Census data indicates that each county in Southwest Georgia, except for Lee, has a higher percentage of senior adults than the state of Georgia as a whole.

Southwest Georgia currently has no primary care facilities devoted to the specialized needs of the elderly. Care of geriatric patients often is fragmented by the care of multiple providers and specialists. This fragmented care often results in duplication of services and over-medicated patients, which is not detrimental to them, but does raise concerns from caregivers and families. In addition to fragmented care, the geriatric population often has difficulty leaving their residences due to physical disability, illness, or cognitive impairment.

For these reasons, **Albany Area Primary Health Care** aims to develop GeriCare, a program to serve the elderly and aging population of Southwest Georgia by providing comprehensive geriatric care in both outpatient and residential settings. GeriCare will provide access in an environment sensitive to the special needs of seniors with a staff trained to meet those needs. The 'one-stop shop' for elderly patients will include a physician, pharmacist, nutrition counseling, insurance education, and advanced directive planning. By improving the quality of care, GeriCare will contribute to a more cost-effective and efficient system of care that meets the clinical and functional needs of the elderly and aging.

The GeriCare model has the potential to impact the bottom lines of local hospitals by reducing length of stay, re-admission rates, and emergency room rates. The network projects to reduce by 10 percent per year the number of hospital admissions amongst those 65 and over and to save local providers and hospitals more than $300,000 in admission costs alone.

Albany Area Primary Health Care continues to serve as a leader in developing innovative programs, such as the Rural HIV model, Southern Cohort Cancer in Blacks, and as a pilot program to provide case management to the Medicare population and decrease nursing home admissions. The network is well poised to take its innovation to southwest Georgia's aging population.

Albany Area Primary Health Care has a 25 year history of successfully providing primary care services to the medically-underserved residents of southwest Georgia. The network already employs three geriatricians and operates seven centers to provide care, including health education, preventive health services, primary care services for acute and chronic illnesses, prescription assistance, laboratory services, and follow-up in area hospitals and nursing homes.

More than 19% of Albany Area Primary Care's 4,600 patients are over the age of 65.

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TURNER COUNTY HEALTH NETWORK

South central Georgia looks similar to other rural areas in terms of rates of poverty, unemployment, and illiteracy. It, like other rural areas, has high numbers of uninsured citizens and a low number of healthcare providers. According to a recent study on economic vitality commissioned by the Georgia Rural Development Council, Turner County is considered a "lagging rural" county, performing below average on economic and social indicators. It also lags in its health status ranking.

Many of its residents have spent years ignoring health prevention activities. By the time many residents reach middle age, their health status is already deteriorating. In 1998, 56 percent of all Turner County deaths were due to heart disease, stroke, and diabetes.

In 1998, 56 percent of all Turner County deaths were due to heart disease, stroke, and diabetes.

Turner County Health Network is committed to providing the resources and services its families and children need to be healthy. The collaborative provides chronic disease management, community health education, and coordinates a community volunteer program to connect people with the healthcare resources they need, when they need them.

Since August 2004, the Turner County Health Network has served more than 127 patients with needs such as transportation, medications counseling, scheduling, follow-ups, nutrition counseling, and prescription assistance. To date, the network has coordinated more than $428,000 in free prescriptions for its residents.

The network plans to increase its capacity to aid in the early detection and management of diabetes, high blood pressure, and high cholesterol. The network's Community Wellness Initiative targets business and faith communities to reach more than 1,000 adults with preventive screenings to identify hypertension and/or diabetes.

The Turner County network also plans to continue its diabetes case management and reduce the costs of unnecessary care. By serving its care management program to 120 patients, Turner County will likely yield a cost savings of more than $155,000, in terms of unnecessary emergency room visits and hospitalizations.

In addition to health education and diabetes case management, the network plans to increase access to dental services for at least 1,500 children and adults in five counties, Ben Hill, Irwin, Turner, Wilcox, and Worth. Dental disease is more prevalent than most people realize. Fifty percent of all children and 27 percent of all adults have dental problems. The consequences of a lack of early dental care can have life-long repercussions. Poor health can negatively impact a child's ability to perform in school and contributes to absenteeism.

The network is a functioning committee of the Turner County Connection. It is comprised of local and regional healthcare providers, two private physician practices, the health department, public and private social service organizations and agencies, pharmacists, the school system, county government, and the faith-based community, who all share a vision and commitment to develop community-based health resources for the hard-to-enroll and traditionally underserved populations.

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GMP HEALTH NETWORK

Lake Oconee, one of Georgia's largest lakes, was formed in 1979 when Georgia Power completed construction of Wallace Dam. Located mid-way between Atlanta and Augusta, the lake is bordered by three rural counties: Greene, Morgan, and Putnam. This area continues to experience high economic and population growth due, in large part, to an influx of affluent, well-educated retirees to the lake.

In the middle of this wealth, however, live farmers, dairymen, small business owners and other rural residents, who are far less fortunate in terms of income and education. The poverty rate in this three-county area is higher than that of the state as a whole, 19.27 vs. 16.8 percent, respectively. Nearly 20 percent of the region's residents qualify for Medicaid, and more than 10,000 people are uninsured. These demographics present significant healthcare challenges and a nagging concern that health service delivery, if left unchecked, would become a two-tiered health system: one for the wealthy and one for the poor.

Fortunately for the residents of these three counties, community leaders refused to be satisfied with the natural evolution of the healthcare system. Instead, they initiated a major effort to strategically shape health services. The effort, **GMP Health Network**, is an umbrella organization made up of a large number of service providers, social service organizations, government representatives and individuals, who are committed to putting aside personal agendas to work collaboratively to ensure access to healthcare services for all individuals, irrespective of their ability to pay.

GMP's health education initiative has reached more than 30,000 residents over the past five years.

Since its inception in 1999, GMP Health Network plays an increasingly important role. GMP Health Network provides prescription assistance and health education and case management for chronic disease to the un- and underinsured. The network has secured approximately $3 million in free medications for more than 15,000 residents of the three-county area. Further, the network's health education initiative has reached more than 30,000 residents over the past five years.

The GMP Health Network continues to set its goals by assessing the needs of its service area and strategically mapping out a path to reach them. Today, GMP is in the process of developing a system to focus on chronic disease management and connect qualified indigent residents with appropriate social services, including Medicaid and PeachCare.

Each year hospitals have to write off a large amount of patient debt due to inability to pay. A typical Critical Access Hospital, for example, will write off more than $1 million in uncollectible charges from patients without any form of healthcare coverage. The GMP Health Network proposes to assist its service-area hospitals by locating alternate revenue streams to offset financial loss for uncompensated care.

The network will evaluate individuals without any ability to pay for healthcare services to determine their ability to qualify for Medicaid and other alternative sources of payment. A similarly modeled program in another southern state estimates 30 percent of those evaluated will be qualified and receive funding at a projected savings of $100,000 for the area's local hospitals.

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STEWART WEBSTER RURAL HEALTH, INC.

More than 90 percent of diabetes-related hospitalizations in Stewart Webster's service area are preventable.

Stewart Webster Rural Health, Inc., is a multi-site Federally Qualified Community Health Center providing comprehensive medical and dental services to a rural nine county area in southwest Georgia. These contiguous nine counties are Stewart, Webster, Randolph, Clay, Quitman, Sumter, Marion, Schley, and Chattahoochee.

These nine counties lag behind the rest of the state in all areas from healthcare access to economic improvements. The minimal healthcare systems serving these communities are fragmented and ill-equipped to address the most basic primary care needs. The socioeconomic profile of the nine counties highlights its poverty, lack of education, and high unemployment rates.

Since 2004, most of the area's manufacturing industries and hometown businesses have closed resulting in a significant increase in unemployment and loss of health insurance. The number of uninsured in the service area is growing faster than the state or national averages. Chronic diseases are on the increase, as is tobacco use and substance abuse. Another lifestyle behavior of concern to the communities is a rapid increase in the incidence of obesity and a rise in complications from it.

Stewart Webster Rural Health's Diabetes Registry shows a 480 percent increase between January 2000 and October 2004, and its Cancer Registry shows a 42.67 percent increase during the same period. Its cardiovascular disease numbers are also on the rise and exceed the state's Age-Adjusted Mortality Rate for cardiovascular disease.

The network aims to focus its services on the area's three leading causes of death, diabetes, cardiovascular disease, and cancer, through a Chronic Disease Prevention Program. Education, prevention, and appropriate management of chronic illnesses is proven effective in improving health outcomes.

Diabetes can be controlled outside of the hospital, and 90 percent of the diabetes-related hospitalizations in Stewart Webster Rural Health's service area are preventable. Stewart Webster Rural Health's efforts to better manage diabetes within southwest Georgia have the potential to produce cost savings of more than $1 million to hospitals and providers and more than $26 million in direct costs for the diabetic population of the area.

Like diabetes, rates and costs of cardiovascular disease and cancer in southwest Georgia can be reduced through education, prevention, and appropriate management. The network projects cost savings of more than $6.8 million in avoidable cardiovascular disease costs for five counties in its service.

Stewart Webster Rural Health brings a comprehensive and collaborative approach to changing lifestyle behaviors to improve health status. The network will implement its Chronic Disease Prevention Program through its main medical center in Richland and three satellite medical centers in Lumpkin, Plains, and Georgetown. Through collaboration with a broad spectrum of agencies and organizations, including schools, Family Connection, Head Start, and the West Georgia Cancer Coalition, the network aims to bring new users to its health centers and increase the impact of its medical services.

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COASTAL REGIONAL HEALTH COLLABORATIVE

Over the past decade, many rural hospitals have been forced to close their doors and many others are in financial straits. The continued struggle of rural hospitals to remain viable and meet local healthcare needs has a multitude of causes but few clear solutions. A rural health network serving the 150,000 residents of Bacon, Candler, Effingham, Liberty, and Screven counties is addressing the threats to its local hospitals in a new way: uniting them.

Coastal Regional Health Collaborative, founded in 2001, is newly reorganized and consists of five critical access hospitals: Liberty Regional Medical Center in Hinesville, Screven County Hospital in Sylvania, Bacon County Hospital and Health System in Alma, Candler County Hospital in Metter, and Effingham Hospital in Springfield. This Collaborative meets on a regular basis to discuss healthcare issues, identify common problems, and solve these problems as a group.

Coastal Regional is working to improve the viability of five critical access hospitals in Southwest Georgia.

Critical access hospitals are the safety net, integrated delivery system, and primary source of healthcare for the communities they serve, and they face similar problems. The Coastal Regional Health Collaborative is examining ways to improve managed care reimbursements, streamline operations, and develop a program to provide free prescription medications to indigent patients.

The power of managed care seems to increase every year. Hospitals are challenged to maximize reimbursement across a broad spectrum of plans. While joining more plans can make good economic sense, the differing details of different plans can be a challenge. The Coastal Regional Health Collaborative is researching plan payment rates and how it can negotiate with the plans to maximize reimbursement across all five hospitals.

Critical access hospitals have common high cost issues, and the Coastal Regional Health Collaborative also is working to find a common way to reduce these costs. By streamlining basic hospital needs, such as laundry service, radiology service, and physician recruitment and retention, the network can help maximize the efficiency of overall operations of its critical access hospitals.

Many patients in the network are either private pay, uninsured, or lack the funds to purchase prescribed medication. Patients who cannot afford to purchase prescribed medication when they need it, usually make return trips to the emergency room, which drives up the cost of healthcare and decreases the opportunity for good patient outcomes. The Coastal Regional Health Collaborative aims to create a program to provide indigent patients with the necessary medications and connect them with a free clinic or alternative ways to seek pharmaceutical assistance.

The Coastal Regional Health Collaborative is committed to sustaining its local hospitals. In all of its efforts, the network focuses on improving health and providing value to its members by facilitating improvement of healthcare quality and delivery through collaborative efforts.

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COASTAL MEDICAL ACCESS PROJECT

CMAP is ramping up its services to meet the healthcare needs of its growing uninsured population.

The southeast region of Georgia is the second fastest developing area of the state. The population in the region increased more than 17 percent between 1990 and 2000, and the growing trend shows no signs of decline. As the region's population continues to rise, so does the demand upon its existing healthcare system.

Leading citizens in the three coastal counties of Camden, Glynn, and McIntosh, in 2001, became concerned about the healthcare access of their populations due to business downsizing and immigrant influx. Recognizing the need to provide medical care to the more than 22,000 underserved and uninsured residents in the three-county community, the citizens formed the Coastal Medical Access Project.

The **Coastal Medical Access Project** offers three distinct, coordinated services: two volunteer free care clinics, pharmaceutical assistance, and intensive case management. Its clinics, since the network's inception in 2002, have provided more than 2,900 patients visits, arranged more than 200 specialist visits and nearly 25 surgeries, and its MedBank has served more than 2,100 patients, who have received more than $5.7 million retail value in free pharmaceuticals.

The uninsured working population in coastal Georgia is growing rapidly. More than two out of three uninsured in the region are employed. Being uninsured means going without needed care, minor illnesses become major ones because care is delayed, and one significant medical expense can wipe out a family's life savings.

The problem of the uninsured is getting worse. As the price of healthcare continues to rise, fewer individuals and families can afford to pay for coverage. Fewer small businesses are able to provide coverage for their employees, and those that do are struggling to hold on to the coverage they offer. A survey of employers in Camden, Glynn, and McIntosh, counties reveals the region employs more than 45,500 workers, and more than 9,000, or 20 percent, of these workers do not have access to employer-sponsored health insurance.

The Coastal Medical Access Project is ramping up its services to meet the healthcare needs of its growing uninsured population. The network aims to increase the number of people it serves, improve, and expand the delivery of its current services, and develop programs and infrastructure to become self-sustaining.

Its free care clinics currently operate one session per week in Camden and one-and-a-half sessions per week in Brunswick. While it takes two volunteer doctors and nurses, one volunteer social worker, and four lay volunteers staff each clinic session, the network has a cadre of 29 primary care and 40 specialist physicians, 35 nurses, and 100 lay volunteers. While the network's volunteers are very generous with their time, the combination of an increase in technology and staff support can help increase the number of patients seen per session by 20 percent. Improvements in storing and transmitting electronic medical records between physicians, performing case management, coordinating treatment with education, and improving the network's scheduling system will allow more patients to be seen with more effective outcomes.

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EAST GEORGIA HEALTH COOPERATIVE

It's commonly called "the diabetes belt," and it's a region of Georgia that least needs or desires the designation. That's because it already suffers from widespread and deep poverty, has limited prospects for a substantial economic jump-start, and is home to a rural population which averages a 9th grade level of education.

Eleven counties – Emanuel, Glascock, Hancock, Jefferson, Jenkins, Johnson, Taliaferro, Tattnall, Treutlen, Warren, and Washington – encompass approximately eight percent of the state's population, even though the region spans nearly 4,000 square miles.

Although it sits within a geographic triangle anchored by Augusta, Savannah, and Macon, the east Georgia region is removed from the relative prosperity of those cities. The residents of these 11 counties are typically poorer, less educated, and sicker than their urban counterparts.

The **East Georgia Health Cooperative** is a provider-based organization: Four community hospitals with associated rural health clinics, three community health centers, affiliated physicians, and an urban medical center. The Cooperative works to enhance the access, scope, and viability of healthcare services throughout its service area by coordinating existing resources.

Diabetes is extremely prevalent in the 11-county region, particularly as a contributing cause of death. Because of its high prevalence within the region, the network's board and clinicians view diabetes as the first community health need to address with conditions, including stroke, cancer, and asthma, to follow.

Emanuel and Jefferson counties are the region's two counties served by a diabetes case management pilot program. Through the East Georgia Health Cooperative, a nurse and nurse practitioner provide intensive case management for high-risk patients identified by hospitals, physicians, and other community providers. Diabetes education is beneficial in improving the health status of patients and saving medical costs associated with complications. Every one dollar invested in outpatient training to help people self-manage their diabetes can cut healthcare costs up to $8.76.

The network aims to expand the number of counties and patients served to its maximum capacity, while improving reimbursement for its services. By increasing the availability of services within these 11 east Georgia counties, the East Georgia Health Cooperative broadens the access of those services among a historically underserved population.

EGHC coordinates existing health and human services within its 11-county service area to enhance the scope, access, and viability of healthcare services.

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