

GHPC Now

Advancing health and well-being for 25 years



The Georgia Health Policy Center is celebrating its 25th anniversary in 2020.

25 for 25

Join us as we commemorate this milestone with 25 activities throughout the year including:

- Speaker & film series
- Co-sponsored partner events
- Capstone reception
- Staff appreciation events
- Community & service opportunities

ghpc.gsu.edu/anniversary

Follow us on social media with #25for25.



GHPC Now

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Creative director: Teri Wheaton
Staff photos: John Amis

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This magazine commemorates and promotes the Georgia Health Policy Center's 25 years of service, research, and promotion of health and well-being, as well as the outstanding accomplishments of its staff.

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From the CEO



A Strong Foundation to Grow On

In the early 1990s, health policy discussions reached a fervent national pitch. As a result, Gov. Zell Miller created the Governor's Commission on Health Care in 1993 to conduct a two-year study and make recommendations for the state. When the commission's term ended, enthusiasm for health reform had stalled, but it had become clear that there was a need for an entity to provide state policymakers reliable health policy research in Georgia.

With the state-level recommendations in hand and the vision of leaders at Georgia Health Decisions, the Georgia Health Policy Center (GHPC) was born. This nascent research center persevered under the Georgia Coalition for Health and then under the School of Policy Studies at Georgia State University (later renamed for Andrew Young). It has grown from a two-person shop (Jim Ledbetter and Mary Ann Phillips) with just a few funders to 86 staff and 26 affiliated faculty today, having worked with more than 167 unique funders.

I often think back to our first report, *Directions for Change*. It involved bringing together diverse stakeholders, facilitating difficult discussions, crunching numbers, cultivating working partnerships, and developing recommendations for the governor. What emerged as the big challenges facing Georgia — uninsured children, closure of rural hospitals, and aging baby boomers — seem remarkably familiar today, as does our commitment to how we do our work.

Twenty-five years later, we remain the go-to health policy research center for legislators, state agency leadership, and governors in Georgia, as well as for federal agencies and national philanthropies. How have we managed to remain relevant in an era of divisiveness in politics and dramatic changes within the health care system?

- We continue to provide objective, credible, and timely health policy guidance and evidence to support excellence.
- We advocate for a way to approach problems, rather than for a specific solution.
- We remain committed to building strong partnerships based on the principles of trust, value, and support.

The stories and profiles here tell only a part of our amazing journey and the dedication of our entire staff. I remain excited to work at GHPC each and every day. I hope our first magazine provides you with an appreciation for the center's broad scope of work, and more importantly our commitment to how we approach opportunities to transform the health system.

Karen Minyard, Ph.D.
CEO

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



Ann DiGirolamo, Ph.D., M.P.H.

*director of
behavioral
health*

Fun Facts About Ann

Years at GHPC: 7

Hometown:
New York City, N.Y. (Bronx)

Favorite movie:
Life is Beautiful

Favorite place: Italy



Which GHPC values most resonate with you? How do you live them?

The three values that stick out the most for me are continuous learning, genuine personal relationships, and integrity. Continuous learning is an important piece for me because it is something that I value in terms of professional growth for myself, for my staff, and the people that I work with. It is not just through conferences and webinars, but I think we are continuously learning with and from each other, and with and from our partners. That's critical. It really is a colearning process.

Genuine personal relationships are one of the things I really value about being here at GHPC. People are authentic; they are genuine. Our work environment places emphasis on genuine relationships not just with each other, but also with our partners. It is my hope that our partners see this, experience this, and it is a reason why they keep coming back to work with us.

As far as the integrity piece, I couldn't work at a place where integrity wasn't a critical value. The fact that we are continuously challenged to maintain a neutral presence — to provide an objective platform and objective research — means we really have to consciously think about if and how we are doing that. I think working in this environment, it makes integrity

even more important. It requires checks and balances, which are really helpful.

Talk about a project that you've been involved in that has had significance for both the center and you personally.

Our school-based mental health work comes to mind. We were able to be involved in this program at the beginning when it was really small and just in its nascent stages. It has grown tremendously and we have been able to continue to grow our involvement and our learnings. We have been able to really partner with the Georgia Department of Behavioral Health and Developmental Disabilities, and also increasingly with the Georgia Department of Education.

This program really reflects some of the core work of the Center of Excellence for Children's Behavioral Health and GHPC as a whole. We are able to bring in our expertise in training and technical assistance, research and evaluation, policy and systems level thinking, and children's behavioral health. This is such an important and worthwhile program and a vital way to address access issues that we know exist here in the state and nationally.

Working with this program has personal significance for me because I have a 13-year-old in the local school system. I heard that her middle school was doing a mental health first aid training for the teachers and staff. And I thought, wow, that's awesome. The more that we can begin to address these issues and increase awareness in the schools, the better.

What is the most pressing issue facing the health care system and community's health right now?

I think it is the workforce shortage. The shortage applies to both behavioral health and physical health. I think we see it surfacing locally, but this is an issue nationally, too. Related to the workforce shortage is potential workforce burnout because there is just so much need and not enough providers. You can see that there is a lot of stress that's happening among the staff who are on the front lines. And so I think we need to think creatively about training, building capacity, and strengthening the workforce.

How has working at GHPC changed you?

One is really increasing my awareness and expertise in the policy arena. I previously had done research and work on programs, but I really longed for more experience around policy and that is exactly what I have gotten here.

I think I also have grown in my understanding of working with state partners and what they face in the work that they do. I have expanded and developed different types of partnerships and learned more about what is important in these environments.

Lastly, being here has really encouraged me and pushed me to grow in my leadership and management skills. This is helping me to grow professionally and personally.

Training to Transform Patients' Lives

The Center of Excellence for Children's Behavioral Health at GHPC are the statewide trainers for the rollout of the Recovery-oriented Cognitive Therapy model.

She gets 30 minutes. Thirty minutes to juggle medications, to deal with food insecurity and homelessness, and to try to improve the life of a patient with a chronic, severe psychotic disorder.

"It is pretty impossible to feel like we accomplished something in 30 minutes. You feel powerless, like you have nothing to offer your patients," recounts Britnay

Ferguson, an adult outpatient physician assistant for psychiatry at Grady Health System in Atlanta.

Ferguson is not alone. Burnout and frustration are common among mental health care providers.

"I had patients that were in and out of the hospital, they didn't have any personally meaningful activities. If you asked them what

is going well in their life, they would say nothing," Ferguson says. "Now, they are home, working, volunteering, or in a basketball league. I am seeing all of this positive change."

What changed? Ferguson credits these breakthroughs to her training in Recovery-oriented Cognitive Therapy (CT-R).



Georgia Is a Leader

CT-R, developed by Aaron T. Beck, M.D., and Paul Grant, Ph.D., at the Beck Institute, is a treatment model for individuals with severe mental illness that focuses on understanding what motivates each individual and helping each patient achieve their personal aspirations.

Unlike other models that focus on therapeutic goals, like day-to-day functioning, CT-R focuses on activating patients based on their interests (music, playing ball, etc.); understanding not just their behaviors, but their beliefs about themselves and the world around them (outward aggression may stem from the belief they can't connect with people); and helping them achieve the life they want through skills development, strengthening positive beliefs about themselves, and drawing learnings from positive experiences.

The state of Georgia has become a national leader in the use of CT-R. It is the first to fully implement the model statewide through the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) provider network.

"We were in the early phases of implementation of the Americans with Disabilities Act settlement agreement with the U.S. Department of Justice — moving patients that we could out of state institutions and into the

- CT-R training includes:**
- An intensive multiday, in-person workshop
 - A six-month consultation period with weekly video conferencing calls with trainers
 - Required evaluation of competency of submitted audio recordings of treatment sessions for certification
 - Quarterly sustainability webinars, along with technical support from peers and trainers
 - Required recertification after two years

not just mean finding more people. You have to train people to be comfortable and feel competent that they can treat these individuals, so that they won't run away from their job."

Since 2015, GHPC's Center of Excellence for Children's Behavioral Health has partnered with DBHDD to train more than 230 community-based mental health professionals providing care to youth and adults with severe mental illness in a variety of treatment settings.

"There are stories of patients that had been in the hospital for 10 years that hardly spoke, mostly in a disassociated state, and once they started incorporating some of the strategies from CT-R, this person just started to come alive," says Johnson. "The bottom line for CT-R is that everybody has something that they want to do. It is about bringing out that person that is still in there behind the psychosis. If I stopped working in this field today, this will have been one of my top five most amazing things that I got to experience."

Implementation of the CT-R model in the state is not only transforming patients' lives, but improving the professional lives of therapists, too.

"CT-R increased my confidence as a provider," says Ferguson. "I feel very effective, and I could not say that before this training."

233
providers in the DBHDD network attended the in-person CT-R workshop

92
providers completed the CT-R training and consultation process

72
providers achieved CT-R certification

community. But the community was not ready," recalls Monica Johnson, the director for the Division of Behavioral Health at DBHDD. "Having a workforce does

Therapy in Schools Expands Mental Health Access for Georgia's Kids



GHPC's Center of Excellence for Children's Behavioral Health partners with the Georgia Department of Behavioral Health and Developmental Disabilities to expand school-based mental health services.



“Ryan” needed help.[†] He was having a difficult time staying focused, staying in his seat, and keeping his hands to himself each day at school. He was 5 years old when he entered the Georgia Apex Program with a diagnosis of attention deficit disorder. Through the program, he was able to receive medication, individual therapy, and community support services. Two years later, he is excited to be at school, he has shown improvement with his behavior, and he is taking the test to enter the gifted program.

Nearly one in five U.S. school-age children has a treatable mental health disorder, yet half are not receiving treatment.*

Recognizing that schools are a natural environment to identify youth and address unmet mental health needs,

the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) is expanding school-based mental health services. The Georgia Apex Program provides funding to community mental health providers to partner with schools and provide school-based mental health services for referred students, in addition to professional development for school staff and opportunities for mental health promotion and awareness.

“When a child is struggling, parents often feel desperate, unsure of how to move forward or where to seek help,” says Susan McLaren, assistant project director at GHPC and lead evaluator of the program. “The Georgia Apex Program offers children the chance to succeed in school and, ultimately, in life.”

Now in its fifth year, the Georgia Apex Program still pursues three basic goals:

- Detection — Provide early detection of child and adolescent behavioral health needs.
- Access — Improve access to mental health services for children and youth.
- Coordination — Promote increased coordination between Georgia’s community mental health providers and local schools and school districts in their service areas.

Ongoing evaluations, conducted by GHPC’s Center of Excellence for Children’s Behavioral Health, show the program is succeeding.

“Increased access is the greatest impact that I have seen. By receiving needed

mental health services and supports in schools, we are helping students to sustain wellness and remain in school,” says Danté McKay, director of the Office of Children, Young Adults & Families at DBHDD. “Prior to Apex, if a child needed to see a therapist, he or she would have to miss part or all of the school day, and a parent or guardian would have to be available to take the child to the appointment — if they could get an appointment. In addition to the parent having to take time off from work, some families do not have reliable access to transportation. In rural Georgia, those barriers are further exacerbated because schools are farther apart and there are fewer transportation resources.”

The Center of Excellence also assists new providers and schools in

implementing the program by helping with relationship development, community engagement, formalizing agreements (memorandum of understanding and data-sharing), and a needs assessment. For experienced providers, the center’s technical assistance supports continuous quality improvement and program sustainability.

How Does the Apex Program Work?

Most referrals come from school counselors. For the 2018-19 school year, top referral reasons included behavior outside the classroom (74%), classroom conduct (65%), and symptoms of depression (52%).

Once a student is referred, the provider can conduct an assessment or provide treatment based on an existing

diagnosis. They can then tailor services to meet that child’s needs, including individual outpatient services, community supports and individual services, group or family outpatient therapy, and crisis intervention.

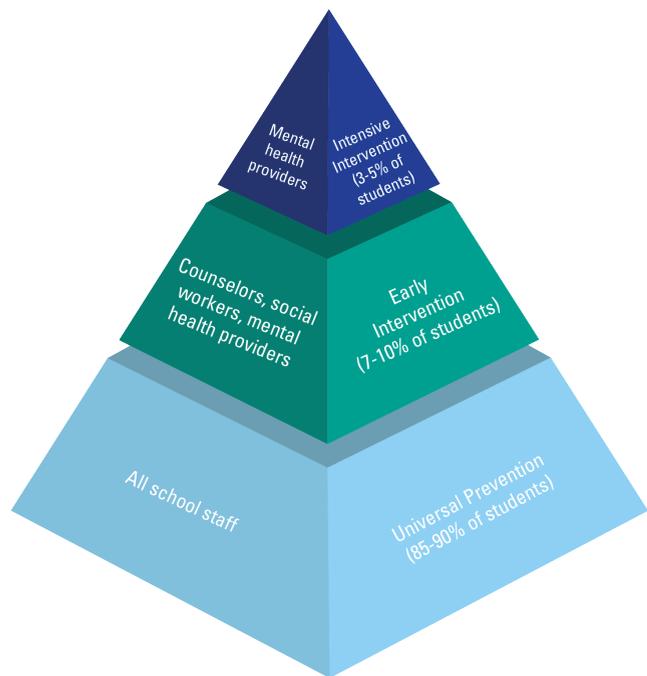
The most common diagnoses during the 2018-19 school year included disruptive impulsive control and conduct disorders (38%), depressive disorders (30%), and trauma and stress-related disorders (9%).

Depending on the arrangements within each school, providers can deliver services during school hours (48%), after school (26%), or during school breaks (26%).

Schools report seeing positive results from participation in the Georgia Apex Program, including decreased reports

[†]The student’s real name is not being used to protect his identity.

Mental Health Activities with Apex Schools, 2018-2019



Adapted from: Bieber B, Hotchkiss & Palmer, B. (2007). *A Guide to School Mental Health Services*. Denver, CO: Colorado Department of Education.

In the 2018-19 school year:

- 31 Apex behavioral health provider agencies partnered with schools
- 436 schools across Georgia engaged in the Apex Program (78% rural; 46% elementary)
- 5,419 students received first-time services
- 89,642 services were provided in schools
- 319,003 students had access to school-based mental health services

of bullying, out-of-school suspensions, and unexcused absences, as well as increases in perceptions of a positive school climate.

“The wonderful part of the Apex Program is that it has decreased the stigma of behavioral health,” says Marnie Braswell, who leads the Child and Adolescent Program at the Community Service Board of Middle Georgia, the largest Apex provider agency in the state, with 17 therapists serving 60 different schools in 16 counties. “Families have shied away because of judgment from schools and communities. But the integration in the school gives parents less of a reason to shy away from getting their child help.”

Despite the noticeable improvements, Steve Smith, superintendent of the Bleckley County School District, says

the need remains great.

“The nearest town with access to care is 30 miles away, so there is just very limited access in Bleckley County,” says Smith. “We are seeing a growing number of students who, at younger and younger ages, are exposed to just some horrific issues at home. There is anger involved, especially if there is an incarceration involving one of the parents. Apex has provided the means to allow these kids to get some additional help that they sorely need.

“We are leaps and bounds ahead of where we were a few years ago. Our teachers and our administrators see a ray of hope, but we still have children not being served adequately, just because of funding limitations. Whatever services they are providing, we could have double the number of

therapists and still have them all have a full caseload.”

In the state’s 2019 amended budget, DBHDD received an \$8.4 million one-time appropriation to expand the program to more schools.

“There is a great confluence of interest at all levels — Gov. Brian Kemp, the Georgia General Assembly, schools, state agencies — and it has helped with provider and community responsiveness, awareness of the program, and interest in collaborative efforts to grow the program,” McKay says. “I believe the majority of stakeholders are aligned and on the same page, recognizing the importance of school-based mental health.” ●●

* Whitney, D.G. & Peterson, M.D. (2019). U.S. national and state-level prevalence of mental health disorders and disparities of mental health care use in children. *JAMA Pediatrics*, 173(4): 389-91.





What is special about GHPC?

GHPC is like my second family. I think that is because of the people who work here that I have been able to develop relationships with over the years.

It is fun to come to work. Our work is different all the time. We learn all the time. Health and health care are not static topics. So there's always something new.

Which GHPC value most resonates with you? How do you live it?

Adherence to commitments. I take that very seriously. As we have gotten bigger, I think that value is more challenging to instill across the organization.

But I like the thought that our partners know when we say we are going to do something or commit to supporting something, we are all-in. In my mind that means big things and little things — little things as simple as getting back to people ahead of time and really showing them that you are responsive to them. That means a lot to me and it means a lot to people who work with me.

Tell us about a project that has had personal significance to you.

Georgia has an Indigent Care Trust Fund and it is how Georgia distributes federal disproportionate share dollars, which are federal dollars that help hospitals that serve disproportionate numbers of low-income people offset their financial losses. In the early 2000s, Georgia had a primary care requirement that required hospitals to take 10% of that money and devote it to primary care.

So, in one of my earliest projects, Georgia Medicaid wanted to know what hospitals were doing to meet that primary care requirement. I visited every hospital in the state that used those funds — more than 90 of them.

Most of the hospitals I visited were in rural areas, and I think it reinforced our learning about how rural communities try so hard to make do with very little resources. They can be very creative.

I decided I would get a map of Georgia and I put a red dot on the map for each of those hospitals. As I visited them over three years, I turned them to green dots. I liked the map and I always had this on the back of my door as a reminder that Georgia is not just Atlanta. That project always left an impression on me.

How has working at GHPC changed you?

It is hard for me to know whether it is working here or just that I have aged in the 21 years since I started here. It might be that I am becoming older and wiser, but I think I am a more patient



person. I listen more and I reflect more. I am not as quick to respond, which I think we hope we instill in everybody who works here. Working at GHPC has made me understand other perspectives better and understand that people view the world differently than I, and that's OK.

What is the most pressing issue facing the health care system?

Poverty, poverty, poverty. Everything comes back to poverty. If we could fix poverty, I think we would start a chain reaction. We would have better educational outcomes. We would see that with better education come better health outcomes. I think it's all about poverty.



Glenn Landers, Sc.D., M.H.A., MBA

director of health systems

Fun Facts About Glenn

Years at GHPC: 21

Hometown: Springfield, Mass.

Favorite book: *A Christmas Carol*

Favorite movie: *Shawshank Redemption*



A Focus on Sustainability Fosters Rural Grantee Success

GHPC helped the Health Resources and Services Administration's Federal Office of Rural Health Policy develop a sustainability framework to evaluate the impact of rural health community investments.

Mellie Bridewell credits a sustainability workshop in Helena, Ark., for changing the trajectory of health care in southeastern Arkansas.

"I grew the Arkansas Rural Health Partnership from being a community network in a single county to now covering 14 hospitals in 22 counties in southeast Arkansas because of what I learned in that training," says Bridewell, CEO of the Arkansas Rural Health Partnership.

From its inception, GHPC has provided support to rural communities to expand access to care for rural residents, develop rural health systems, and, ultimately, better the health status and well-being of rural populations. GHPC's Sustainability Framework[©] provides a logical progression of activities to support communities in accomplishing their goals. It guides technical assistance around the areas of

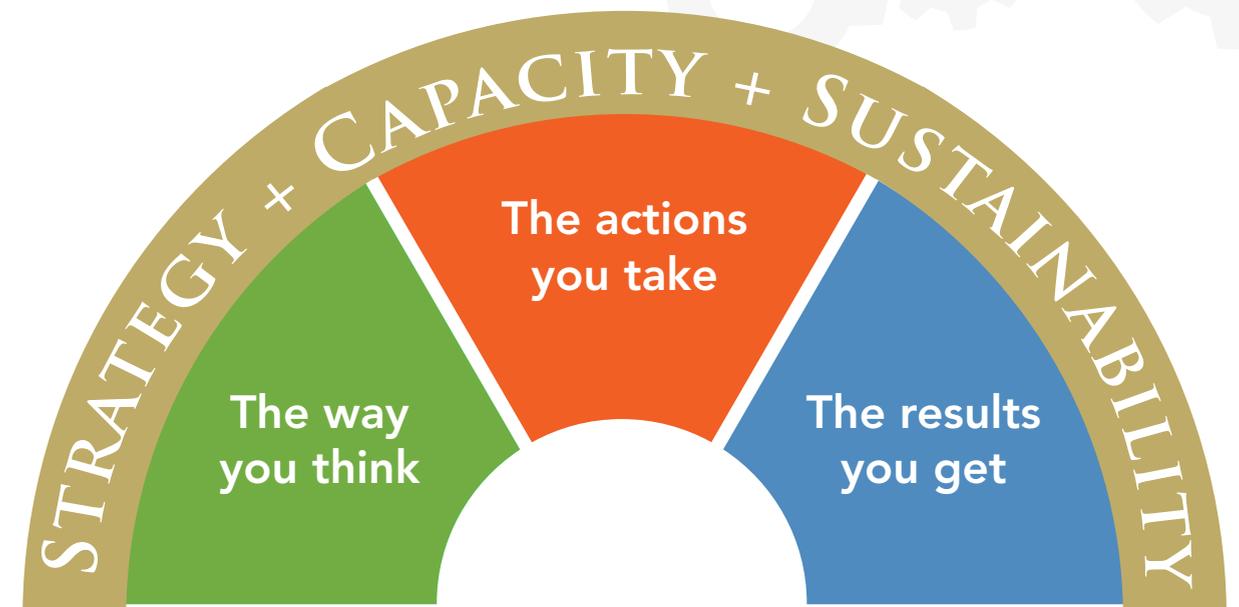
- strategic vision
- collaboration

- leadership
- relevance and practicality
- evaluation and return on investment
- communication
- efficiency and effectiveness
- organizational capacity
- resource diversification

GHPC has provided comprehensive technical assistance to more than 1,000 grantees funded by the Health Resources and Services Administration's Federal Office of Rural Health Policy since 2002.

Through tailored technical assistance GHPC helps communities and organizations position for long-term sustainability from the beginning — by cultivating a strategic mindset and building capacity for action.

"One of the great features of our community health funding is that it is noncategorical, meaning that the community decides what their greatest need is and then they design a project to address that need," says Tom Morris, associate administrator for rural health policy at the Health Resources and Services Administration. "That is not the typical way grants run, but it was designed



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purposefully to be flexible to meet the broad range of needs in rural communities."

The challenge, Morris explains, comes in assessing the impact of the grantees when each is doing something a little bit different. It did not lend itself toward traditional performance measurement in a way that easily quantifies the impact.

"With GHPC, we hit upon this idea of sustainability. And now that's the core performance metric for this program," says Morris. "When you can tell somebody that you've invested \$25 million or \$30 million into community health projects and that 80% of them are sustainable beyond federal funding, that is a pretty powerful metric."

GHPC's Sustainability Framework[©] is built upon identified factors that drive organizational and programmatic sustainability. It provides a logical progression of activities to support communities in accomplishing their goals. It guides technical assistance around the areas of strategic vision, collaboration, leadership, relevance and practicality, evaluation and return on investment, communication, efficiency and effectiveness, organizational capacity, and resource diversification. Through technical assistance, GHPC works with

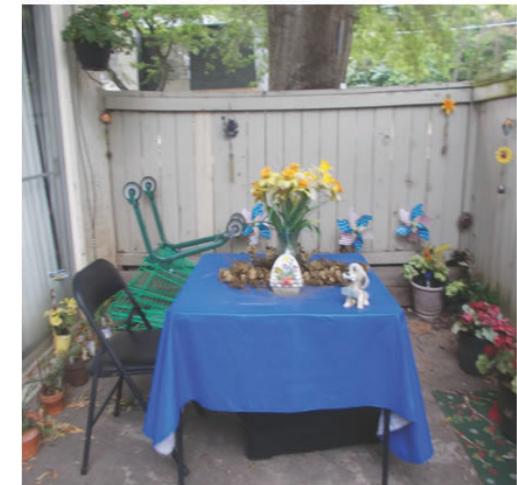
communities to focus on these components that can then be integrated into partnership development and programmatic implementation plans.

What does a focus on sustainability mean for the people living in southeast Arkansas? In an effort to overcome known factors that affect access to care for rural patients — provider workforce shortages, geographical barriers, and other social needs — the Arkansas Rural Health Partnership has grown and broadened its efforts, which now include training and educating health care professionals, empowering patients and communities with education, and providing mental health and substance use treatment and prevention, as well as direct patient support and assistance services.

"Our goal is to ensure access to quality and local health care through collaborative efforts that strengthen the infrastructure and health care delivery system in rural Arkansas," says Bridewell. "There is nothing in Arkansas, as far as rural health initiatives up to the state level, that we are not involved in. From state policy to implementing local projects, we provide support to all the hospitals and the 59 clinics in south Arkansas. We now strive to be a model for rural health innovation and collaboration across the state and nation." ●●

The Taste of Freedom

GHPC was the first in the nation to apply Photovoice to its annual evaluation of the Money Follows the Person program in Georgia to better assess the impact of the program on participants' quality of life.



For Patricia, home tastes like sweet and sour meatballs, mashed potatoes, and broccoli.

Several years after her favorite homecoming meal, she still smiles at the memory.

At age 57, Patricia stayed in a nursing home for more than two years due to complications from multiple sclerosis.

“Being in a nursing home was not a piece of cake. Besides losing your freedom, you lose all your privacy and most of your decision making,” Patricia recalls. “I was only 57, so I felt like I had a lot more to offer life. Most people probably feel this way, when you go in, but rarely do they leave. And then all of a sudden, because my friend found the Money Follows the Person program, I was in an apartment, a nice apartment, and I had furniture. I had a life



again.”

Help to Move Home

Money Follows the Person (MFP) is a national Medicaid

demonstration program, sponsored by the Centers for Medicare & Medicaid Services. The program, awarded to the Georgia Department of Community Health in 2008, helps people

who are living in institutions, such as psychiatric residential treatment facilities, nursing homes, or other long-term care facilities, return to their homes and communities while continuing to receive supportive services — thus, increasing access to home- and community based services and lowering long-term care costs.

MFP helps people with developmental disabilities, physical disabilities (under age 65), traumatic brain injury, and older adults or youth with a mental health condition. MFP services enable the transition to the community by paying for things not typically covered by Medicaid, like security and utility deposits, furnishings or basic household items, moving costs,

modifications to make a home or apartment accessible, and connections to other community services.

Since 2010, the Georgia Health Policy Center has conducted ongoing evaluations of the MFP program implementation in the state.* As of July 2019,

- Georgia has successfully transitioned more than 3,000 individuals from institutional care to home- and community-based services.
- On average, MFP saves more than \$11,700 in health care expenditures per participant.
- Pre- and 2-year-post-transition surveys show that quality of life has improved for Georgia’s MFP participants, with greater satisfaction related to living situation, choice and control, community integration, and health status, and global life satisfaction.

In Their Own Words and Pictures

Photovoice is a participatory action research method that encourages participants to record, reflect, and share their experiences through photography. In the first evaluation of its kind nationally, Georgia MFP participants used Photovoice to assess their quality of life following their transition.

Themes from participants’ photographs and narratives

identified programmatic successes, as well as opportunities for continued enhancement of long-term care services provided in home- and community-based settings.

“Photovoice gave us the opportunity to put the many voices together and amplify them,” explains Kristi Fuller, an assistant project director at GHPC, and the lead of the MFP evaluation. “We selected Photovoice as a way to engage participants — to put them in the driver’s seat to tell the full story of their transition.”

GHPC hosted the exhibition, Gaining Freedom, Coming Home, in November 2016, showcasing the photography and stories of five MFP participants, including Patricia. The participants chose “freedom” for the title, as it best reflected their quality of life as a result of MFP.

“It was nice to think about what things were most important to me, what I missed, and what I was really grateful for having again,” says Patricia. “It really gave me the freedom to express myself and get out all the feelings that I had. You don’t realize that there are people in nursing homes that aren’t on death’s door, that are still vibrant on the inside.” ●●

* Landers, G., Fuller, K., & Zhou, M. (2017). Medicaid savings continue in the year after end of participation in the program, Money Follows the Person. *Journal of the Georgia Public Health Association*, 7(1):42-44.



Cooking Passion

“I renewed my passion for cooking and found a way to do it regardless of my disability. They served chicken every day at the nursing home for two-and-a-half years and the rest of the food was awful. ... I wanted a balanced diet and variety.”



Card Games With Kids

“I’m still able to have children come to my house and experience their love, energy, and curiosity. I wouldn’t be able to have that had I not gotten out of the nursing home.”



Freedom Ride

“My Cadillac of a scooter that keeps me mobile. God bless my mother for buying me this for outdoor travel and Money Follows the Person for getting me my power wheelchair for indoor mobility.”

**Once upon a
time in**

Georgia



The History of the Georgia Health Policy Center



GHPC Founders Circle

Bill McClatchey, M.D.

Charlie Harman

Joe Parker

Beverly Tyler

Jim Ledbetter, Ph.D.

GHPC Works with Georgia Governors



Zell Miller
1991 - 1999



Roy Barnes
1999 - 2003



Sonny Purdue
2003 - 2011



Nathan Deal
2011 - 2019



Brian Kemp
2019 - present

Andrew Young School of Policy Studies Deans



Roy Bahl
1996 - 2007



James Alm
2007 - 2008



W. Bartley Hildreth
2009 - 2010



Mary Beth Walker
2010 - 2017



Sally Wallace
2017 - present

**GHPC
Past and Present**



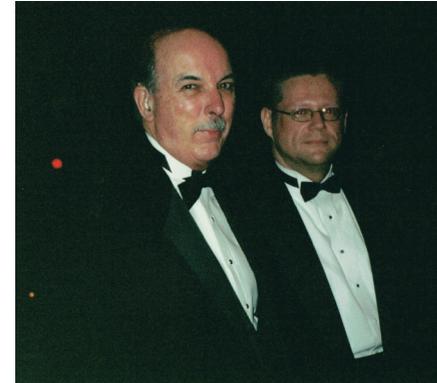
1 Park Place



**55 Park Place,
our current home**



14 Marietta Street



The People of GHPC

GEORGIA COALITION FOR HEALTH BOARD

GEORGIA HEALTH POLICY CENTER

GEORGIA HEALTH POLICY CENTER



1995

1996

2020

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Karen Minyard, Ph.D.
Cindy Clark

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Georgia State University
Pat Ketsche, Ph.D.
Georgia State University
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Jana Covington
Rex Crawford
Ursula Davis
Dimple Desai
Ann DiGirolamo
Jimmy Dills
Dame Epiphane
Deana Farmer
Kristi Fuller
Sacha Gayle
Wendasha Hall
Emily Heberlein
Ann Hedges

Brandy Holloman
Renee Johnson
Ashley Jones
Debbie Kibbe
Ana Laboy
Tina Ladson
Glenn Landers
Daniel Lanford
Kathryn Lawler
Jumanne Lee
Alyssa Lowe
Amanda Phillips
Martinez
Erin McDaniel
Lisa McGarrie
Susan McLaren
Breyanna Mikel
Karen Minyard
La'Keidra Mitchell
Giselle Moses
Attiyya Mujahid Ali
Lisa Musto
Eric Napierala
Lannda Oden
Chidinma Ogojiaku
Carrie Oliver
Chris Parker
Tamanna Patel
Sashoy Patterson
Torrian Percy

Aliza Petiwala
Annette Pope
Alice Prendergast
Astrid Prudent
Shafeeq Rashid
Bill Rencher
Wendy Avila
Rodriguez
Michelle Rushing
Lavon Scott
Colleen Smith
Huronda Smith
Jessica Smith
Angie Snyder
Lori Solomon
Criss Sutton
Coleman Tanner
Mondie Tharp
Kodasha Thomas
Dee Priest
Washington
Teri Wheaton
Ani Whitmore
Karla Williams
Georgina Wilson
Meck Xayavongsa
Mei Zhou



GHPC Now

25

In addition to 86 staff, GHPC has the honor of working with 14 student assistants, 15 graduate assistants, and 26 affiliated faculty.



A 25-Year Retrospective



1995

GHPC is founded as the research arm of the Georgia Coalition for Health to advise the state on health care reform efforts under the leadership of Jim Ledbetter.

1997

GHPC begins an eight-year, long-term care research project that ultimately identifies *The Churning Effect*.



PeachCare for Kids®
1999

GHPC helps design the state's Children's Health Insurance Program, PeachCare for Kids.

2000

GHPC serves as the administrative and research arm for the Philanthropic Collaborative for a Healthy Georgia.



2003

GHPC studies five communities nationally to understand how specific initiatives developed and sustained financing to provide care for the uninsured.

2008

GHPC launches the first Legislative Health Policy Certificate Program in the country, applying systems thinking to state health policymaking.



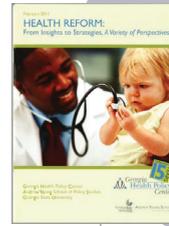
2005

GHPC convenes more than 800 Georgians at the Summit for a Healthy Georgia to identify health priorities for the state.



2010

Health Reform: From Insights to Strategies, A Variety of Perspectives is the culmination of a yearlong effort to provide strategic consultations on the likely impact of health reform for a diverse group of stakeholders in the state.



2014

State-based Surveillance for Selected Hemoglobinopathies (published in *Genetics in Medicine*), demonstrates the viability of population-based surveillance for sickle cell disease and lays the foundation for efforts to establish a nationwide evidence base to support clinical and public health advances.



Georgia
Center of Excellence
in Child and Adolescent Behavioral Health

2012

The Center of Excellence for Children's Behavioral Health is established within GHPC, in partnership with the Georgia Department of Behavioral Health and Developmental Disabilities.

2017

GHPC launches work internationally in Sudan, Nigeria, and Ireland under its population and global health portfolio.



2016

GHPC begins a self-evaluation of research activities and begins implementation of research strategic plan to advance its academic research capacity and infrastructure.



1996

At the request of then Gov. Zell Miller, GHPC studies Medicaid reform and delivers the report *Directions for Change to the Georgia General Assembly*.



1998

GHPC becomes part of the School of Policy Studies, which soon after is renamed in honor of Amb. Andrew Young.



2002

GHPC begins ongoing work with the Federal Office of Rural Health Policy to apply insights gained from firsthand experience in Georgia to help rural communities across the country develop relevant and viable health systems.



2001

Karen Minyard becomes director of GHPC.

2004

GHPC launches its systems thinking work with a focus on social determinants in a study of the underlying social factors creating barriers to health in eight Southern states.



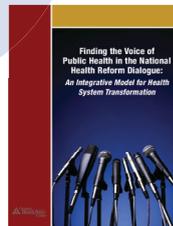
2006

GHPC conducts an assessment of Georgia's public health system to define public health's "core business," which launches a public health transformation journey and conversation in the state.



2007

GHPC, the Centers for Disease Control and Prevention (CDC), and the National Network of Public Health Institutes (NNPHI) collaborate to broaden the health reform conversation to include public health — health promotion, health improvement, and disease prevention.



2009

Informed by the work of the Philanthropic Collaborative for a Healthy Georgia, the Georgia legislature passes the SHAPE Act (HB 229).



2011

The Atlanta Regional Collaborative for Health Improvement launches under the leadership of the Atlanta Regional Commission, the United Way, and GHPC using a collective impact approach to address the region's health disparities.



2013

GHPC, along with the CDC and NNPHI, develop *Leading Through Health Systems Change*, an online planning tool to assist public health practitioners to plan for strategic action and innovation during a time of health system transformation.



2015

GHPC conducts the first health impact assessment of a qualified allocation plan for low-income housing tax credits in the country, identifying how these tax credits can support health-promoting affordable housing development.



2018

Bridging for Health: Improving Community Health Through Innovations in Financing, sponsored by the Robert Wood Johnson Foundation, concludes with national lessons and continued learning about local wellness funds.



2019

GHPC is selected to lead the Robert Wood Johnson Foundation's initiative, *Aligning Systems for Health: Health Care + Public Health + Social Services*.

Annette Pope, M.P.A.

director of administrative services



Fun Facts About Annette

Years at GHPC: 12

Hometown:
Toledo, Ohio

Favorite book:
Phenomenal Women: Four Poems Celebrating Women
by Maya Angelou

Favorite food:
My mother's meatloaf

Favorite hobby:
Crocheting

What is special about GHPC?

Our staff is what makes GHPC special — staff, faculty, and students. It is rare to have a group of professionals striving toward the same goal with a sense of keen professionalism, dedication, and desire to help those we serve. This is at the core of GHPC. The sense of team and camaraderie is like that at no other organization I have encountered. While some organizations may slow down under the pressure of rapid growth, GHPC is looking toward a bright future where we are making strides and positive impacts in health policy. I feel fortunate to be a part of the GHPC family.

What about the center's work makes you most proud?

There is not one particular product that I point to, but rather I am proud of our approach to the work. There are no projects too large or small. If there is a need or some way that we can help our stakeholders, we will. This approach keeps the work exciting and promotes continuous learning and knowledge sharing. This approach keeps GHPC relevant and on the forefront of innovation. Every day is different, with something new to experience and learn each day.



Kelli Burgos, MBA

associate director of communications and marketing

Fun Facts About Kelli

Years at GHPC: 1

Hometown:
Queens, N.Y.

Favorite movie:
The Color Purple

Favorite place:
London

I would feel successful, if...

GHPC continues to grow its footprint on the national and global level. Knowing that the work we do here positively impacts people in other states and countries makes me feel that the work I do on a daily basis matters and that I am contributing to the betterment of all people.

Was there a moment you realized the impact of the center's work?

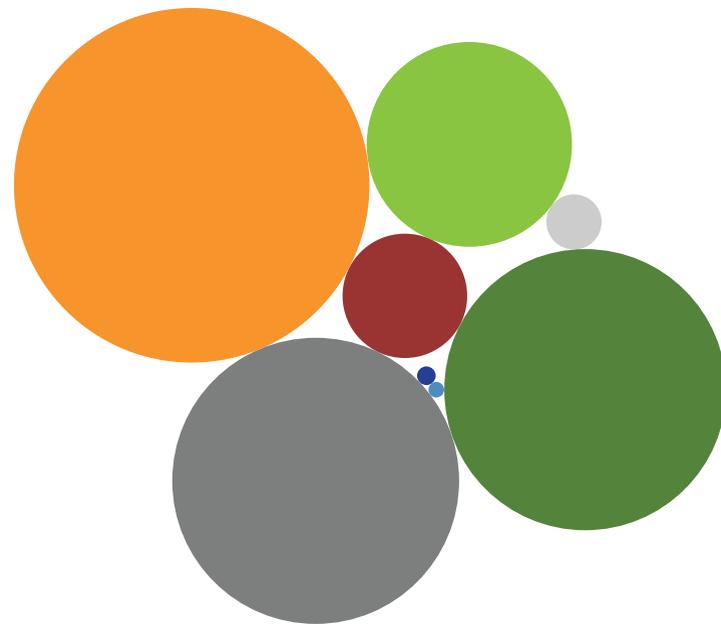
The moment I realized the impact of the center's work was at a breakfast meeting for the Atlanta Regional Collaborative for Health Improvement. A local woman gave a heartfelt speech about the challenges she experiences every day as she tries to improve and maintain her health. They included challenges with health coverage, transportation, housing, prescriptions, etc. My realization that GHPC works tirelessly to address all of these aspects so that people like her can live better touched me in a huge way. It gave a face to the work we do and made me proud to be a part of this organization.

GHPC's Growth

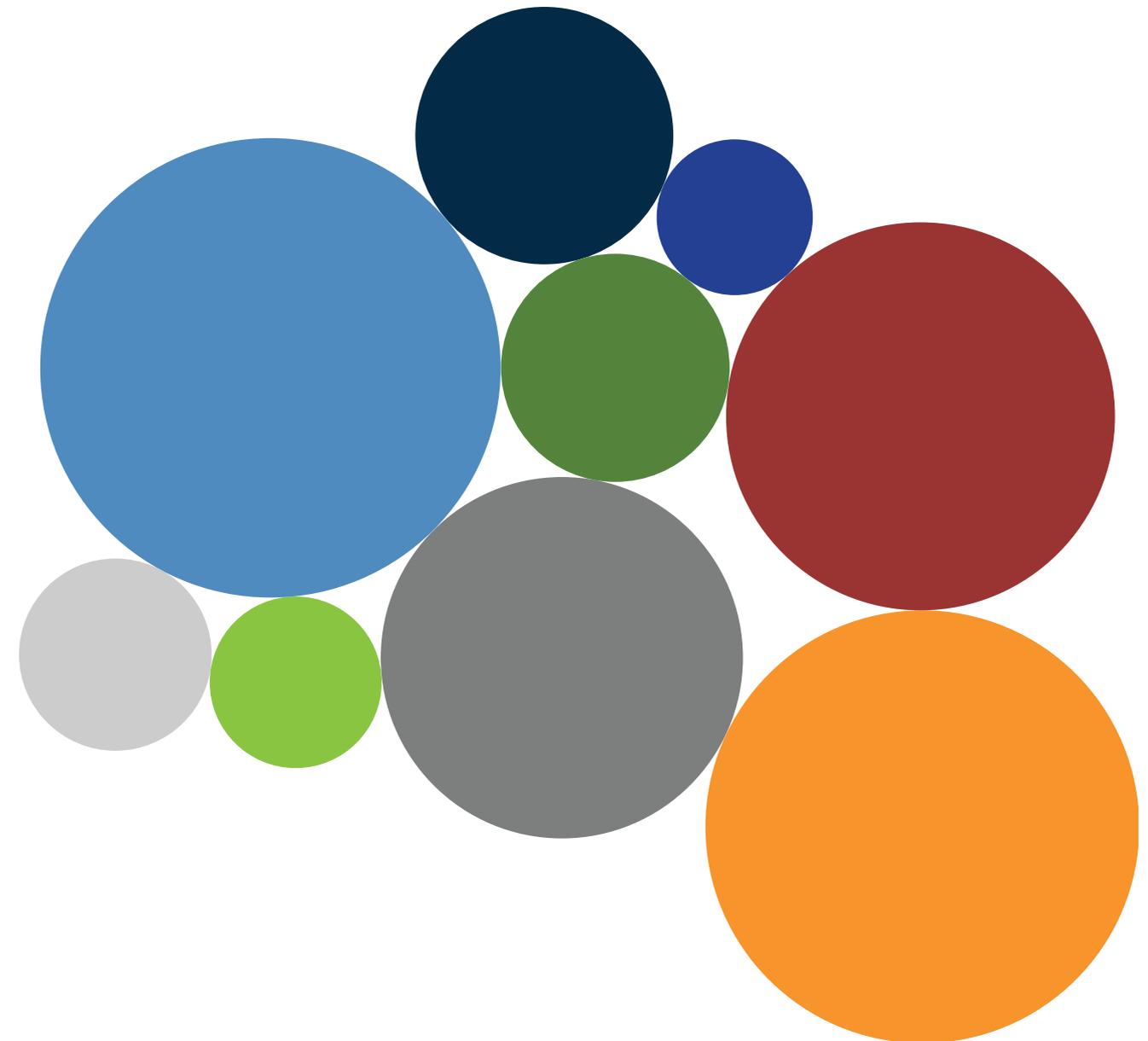
GHPC launched with \$2 million from two funders. The center's initial work focused on health and health care financing, rural health, long-term services and supports, and children's health and well-being. While those remain core areas of work, the center's areas of expertise have expanded, as has its scope of work. In 2019, the center reached \$12.3 million in annual, external funding, having worked with 167 unique funders over its 25 years.

Comparing the clusters below shows GHPC's growth in areas of work and relative scope of funding.

1995 - 2008



2009 - 2020



Areas of Expertise

- Behavioral Health
- Child Health & Well-Being
- Health & Health Care Financing
- Health in All Policies
- Health System Transformation
- Population & Global Health
- Rural Health
- Long-Term Services & Support
- Other

Data visualization by Eric Napierala

Reflections

As a key financial officer at GHPC since 1995, I've had the opportunity to watch our funding portfolio diversify immensely. I witnessed the total number of active awards climb from less than five to nearly 85 in 2019. It has been so amazing to see how a few small, state- and local-funded opportunities helped to spearhead our current standing to include national and global opportunities. Along with the financial growth, there has been the growth of our staff from five when I arrived to more than 85. I am so honored to be a part of such a wonderful organization and can't wait to see what happens in the upcoming years.

Cindy Clark
employee No. 5 at GHPC,
current assistant director of business operations

The very first project that I worked on with GHPC was Medicaid reform under Gov. Miller. It was hard, detailed, and personal work. It was boots-on-the-ground work. It helped shape policy both locally and statewide and it helped grow the center's influence beyond the state, especially in rural health. But what was unique was that GHPC assembled a group of researchers, both within Georgia State and in the broader academic community in Atlanta. GHPC has always been eager to make connections with who would be most helpful in addressing a specific issue. And once those connections are made, it builds a web of knowledge that continues to be utilized in addressing the next problem.

William Custer, Ph.D.
GHPC affiliated faculty, J. Mack Robinson College
of Business, Georgia State University

GHPC was established, grew, and flourished because of the continuing value it placed on retaining and expanding its relationships. It was because of these relationships that we came to work each day knowing we could make a difference. It was a privilege to have had a 20-year involvement with an organization that truly impacted and improved the lives of others.

Mary Ann Phillips
employee No. 2 at GHPC

To have durability over 25 years is a testament to GHPC's ongoing public support. The center has made a valuable contribution beyond research and education in terms of impact on state and national policy. GHPC is a national asset that everyone at Georgia State should be proud of.

Mark Becker, Ph.D.
president, Georgia State University

GHPC forges important relationships with key partners and it allows the center to have credibility with the community and get like-minded people in the room who would not otherwise be in a room together. It is not about them as a center or the staff getting any accolades. They are very much about how they can provide a service to partners that elevates what the collaborative is doing to address the greater need.

Evonne Yancey
former director of community benefit
and community affairs,
Kaiser Permanente of Georgia

What I really appreciate about GHPC is that they often take the kernel or the essence of some ideas that we have and through a combination of dialogue, investigation on the ground, and thoughtful reflection, they make what we think is a good idea into a much better idea. As a funder of a particular project, we cannot even anticipate how something gets into the workstream, so to speak, at GHPC and brought into the collective thinking and experience of the center. But the center makes that connection, possibly from a totally unrelated project, and there are insights gained. GHPC takes what other places might see as discrete projects and turns them into transformative applications for the fields of public health and health care.

Paul Kuehnert
former associate vice president
- program, Robert Wood Johnson
Foundation

GHPC serves as a real model for commitment to quality policy research, which I value and which is important for the Andrew Young School of Policy Studies. The center has worked tirelessly to translate quality policy research and applied research into the academic realm. That's unique, and the ability for health policy research to reach audiences in both the policy world and in the academic world increases its visibility and impact.

Sally Wallace, Ph.D.
dean, Andrew Young School of
Policy Studies,
Georgia State University



**population
and global
health**

Why was it important to you for GHPC to begin global work?

When you think about policy, since we are talking health, we are talking humanity, which transcends race, creed, and geography. Given the global economy and world that we live in now it just feels like if you are going to be really serious about health policy, then you should be thinking about it broadly.

Personally, because I am from “away,” I recognize there is an opportunity for bidirectional exchange that strengthens health systems. While, I think, there is always this perception that if we live in developed countries, there is a lot that we can offer to low-income countries. But there are things that are happening there precisely because they do not have the resources that might find applicability in some parts of developed nations where there are less resources, like in rural communities. So, for that reason, I have always advocated that there are things that happen in low-income countries that we can borrow from and use here.

For example, people talk about abuse of the emergency room (ER) and how much it costs. In some of these low-income countries we know that the health care-seeking pattern is for folks to show up in the ER with nonemergent conditions. So there are clinics that are colocated there, and patients are redirected. There are opportunities for what we call “glocalization” — using global solutions to address local problems — and that excites me.

Tell me about a project that had personal significance to you.

There is a way in which state dollars are allocated to counties and health districts to take care of public health. Back in the 1990s, early 2000s, some urban counties like Gwinnett were growing like crazy. There were alarms raised about it not being fair for large counties with greater public health needs to receive less state funds per capita than counties that were in more rural parts of the state, for example, Southwest Georgia, and whose populations were contracting.

Back in the 1970s they had actually attempted to revamp the public health funding formula. To say to folks, “We are going to take some of your money back to give to somebody else” just

doesn't go well.

So, we were brought in to pull together a small group of stakeholders to come up with a formula. We started out using our usual meeting design principles and got people to a place of agreement on what principles should govern the conversation. We used a simple spreadsheet method to preload columns with the allocation by county at the time, and then, using the agreed upon principles as guideposts, the group came up with the criteria to revise the funding formula. Using those criteria, they ran the numbers to see the impact on each county.

They realized that some counties would be hurt fiscally, but it did not stop them from sticking to what seemed to be fair. We facilitated them through a process realizing that some of the results are not what they wanted, so how do you mitigate that?

Instead of abandoning the formula, they came up with some policies to guide the implementation in a way that would attenuate impact. The formula still is in place today. There was no major pushback and I had a great sense of satisfaction and contribution, given that I managed those difficult conversations. It was extremely fulfilling to see them get to that place, to see it adopted, and to see it still being used today, when previous attempts had failed.

Was there a moment when you realized GHPC's impact, an aha moment?

The Centers for Disease Control and Prevention engaged us to try and get the voice of public health into health reform. That was the first time since I began working at the center that we were really catapulted into the national limelight. I recognized that this little center, GHPC, was now operating in a place where the people listening were not in Georgia, and people were seeing us in a little bit different light.

A lot of the language that came out of that meeting ended up in the Prevention and Public Health section of the Affordable Care Act, Title IV, I believe, which scared and excited me at the same time. I recognized that we were able to have a major national impact, and at the same time, recognized that it is the Affordable Care Act. Not everybody loved it, and so I questioned whether this might be perceived as a potential

compromise to our neutrality. But that portion of the act was really about how to ensure that people have what they need to attain their best health, and there is not a lot of disagreement across the political spectrum on that.

How does being a physician shape your work?

I came here thinking that this was nirvana — everybody went to the United States for health care. And then I learned pretty quickly that no, unless you had not just insurance coverage, but good insurance coverage, a lot of people had worse health than in the other parts of the world, including where I was coming from, and that bothered the heck out of me.

I also recognized that I probably would not make a good physician here. I took my bag to people's homes, and if grandma needed an IV, instead of having her family pay to get her in a cab to send her to a hospital, I would put the IV up, sit down in the house and have a conversation until the bag of fluid was done. That's not going to work, not in metro Atlanta.

I really have tried to make people aware that it is not uncommon for physicians to be in the space of trying to think about why they are seeing what they are seeing in their practices. Many physicians are just as passionate about trying to push things further upstream.

My heart has always been for the folks who do not have much materially, and as a consequence, have life a whole lot harder. What am I doing in my little realm to try to alleviate some of that suffering? I am now in this lane of population health still trying to make it happen for folks who cannot find their own lane.



Chris Parker, M.B.B.S., M.P.H.

director of global and population health

Fun Facts About Chris

Years at GHPC: 16

Hometown: Kingston, Jamaica

Favorite actors: Ben Kingsley and Melissa McCarthy

Favorite food: Cornflakes with condensed milk

Pooling Funds to Drive Community Wellness

GHPC is leading a national effort to advance the practice of establishing and using local wellness funds to improve community health and well-being.



Housing, education, poverty, food availability, access to safe recreational areas. These are all factors that drive health and wellness in a community. Yet, health care budgets are not designed to tackle these difficult social challenges.

Communities around the nation are thinking innovatively about how to bring together partners and align streams of resources to sustainably support initiatives of shared interest and importance. Local wellness funds are a promising approach. GHPC, with support from the Robert Wood Johnson Foundation (RWJF), is working to advance the practice of establishing and using local wellness

funds to improve community health and well-being. The two-year national effort will expand understanding and dissemination of tools to establish these funds and successfully grow and implement them.

“Communities often live grant to grant. Even large federal grants end. And at the end of that funding, the work often slows or ends,” says Pamela Russo, M.D., a senior program officer at RWJF. “The idea behind a local wellness fund is that communities can continue their work and they can evolve the areas of work that are priorities for them as times change and emerging issues arise.”

Interest in local wellness funds emerged, in part, from Bridging for Health: Improving Community Health Through Innovations in Financing (led by GHPC and supported by RWJF). After exploring potential financing innovation, all seven participating sites pursued a local community wellness fund to address primary prevention of chronic conditions or an upstream driver of health.

After collectively receiving \$1 million in varied support for their local efforts, the Bridging for Health sites together amassed more than \$5.2 million for the start of their local wellness funds.

“It is becoming clear that these funds have the potential to attract and deploy large amounts of resources to support population health,” said Chris Parker, director of population and global health at GHPC. “Over the past several years, we have learned a lot about what it takes to initiate a local wellness fund. Knowledge and mindset change are not enough to propel community collaboratives into effective fund development. Groups will benefit from new tools and blueprints that will support their innovation acceleration.”

In studying emerging local wellness funds nationally,

GHPC found they are often established through blending and braiding of resources from a mix of philanthropic grants; revenue from a tax or other state-funded source; hospital community benefits dollars; and contributions from businesses, insurers, and community banks. The involvement of a broad group of stakeholders ensures potential benefits from the local wellness fund will be seen across sectors as the health and wellness goals of a community are met.

local wellness fund

A locally controlled pool of funds created to support community well-being and clinical prevention efforts that improve population health outcomes and reduce health inequities. Sources of funding may be public or private.



“We are trying get to a place where people are literally thinking about new and different ways of sustaining the financing for upstream health,” says Parker. “It could make a major difference to not just overall health care cost, but to making people be more well. If people are eating differently and having the spaces to play and exercise, I think the potential impact is real.” ●●

If you have experience developing a local wellness fund or are interested in other’s learnings, please take this brief survey (bit.ly/wellness_funds) or share your experience with us at localwellnessfunds@gsu.edu.



*GHPC Develops First
Health Policy Certificate
Program for Legislators
in the Nation*

GHPC prepares state legislators and staff
to address complex health issues

“We need our own mindset change.”

A SIX-QUESTION FRAMEWORK FOR EVALUATING POLICY

- 1. WHAT is the important (perhaps troublesome) trend related to health in Georgia? What is the shape of this trend over the past several years?
2. WHO are the stakeholders concerned about the trend?
3. WHY this trend (what's the cause, what is responsible)?
4. WHERE is there leverage (some policy) to address the underlying cause of the trend?
5. HOW will it work? How will it play out over time? How might unintended consequences occur? How might the policy positively or negatively impact:
a) Health status?
b) State health spending?
c) Health care system?
d) Health equity?
6. WHEN would the policy create an impact on health status? When would you see an improvement in some other indicators (i.e., spending, services)?

© Georgia Health Policy Center, 2017



Hearing these words were nothing short of thrilling to GHPC’s CEO Karen Minyard.

The context: Georgia state lawmakers were talking about factors contributing to children’s behavioral health as part of GHPC’s Legislative Health Policy Certificate Program.

The lawmaker’s revelation: The state’s three strikes incarceration approach was having unintended consequences for the mental health and well-being of children in the state.

The patience-pays-off moment: Several years later, Minyard was in her car when the local National Public Radio affiliate announced Georgia was implementing substance use and mental health courts — a policy decision that required administrative, legislative, and judicial agreement.

“The person who had a mindset change in our legislative education session had drafted that legislation and carried it through to make it happen,” recalls Minyard. “We are helping legislators to think about the system — not just the tip of the iceberg, but what are the systems, the policies, the mindsets, the patterns of behavior that are contributing to the problem. This is also an example of the kind of

patience that is required. You keep focusing on the system. And then something pops out, sometimes years later, that is just incredible for a lot of people’s lives.”

The First-of-Its-Kind Certificate Program

State legislators make tough health policy and financing decisions regarding access to care, health status, and insurance coverage, which directly impact their constituents. With support from the Robert W. Woodruff Foundation, GHPC created the first-of-its-kind Legislative Health Policy Certificate Program in 2008 to build systems thinking competencies and health content knowledge among lawmakers and their key staff. The education initiative provides a framework for not only understanding the reasons behind Georgia’s traditionally poor health rankings, but also for changing the way policymakers make decisions

about health-related issues. As in any state’s general assembly, Georgia legislators are expected to know about a lot of issues, but can realistically only become experts in a few policy areas. These areas often relate to their field of study or vocation, or a deep passion that they champion throughout their legislative careers.

“As a physician, the most valuable thing for me personally was having a baseline level of data, because until we understand the data, our assumptions could very well be wrong,” says state Sen. Kay Kirkpatrick, M.D. (R-District 32), who completed the certificate program in 2017. “It has been really important to me to develop this relationship with the people who could get me data that I needed on any particular health care issue. GHPC is a great resource because in the heat of the session it is easy for me to call up the center and say, I really need their quick take on

whatever topic we are voting on.” To date, 157 legislators and key staff members have attended the Legislative Health Policy Certificate Program, with 101 completing the required four sessions to earn a certificate. Additionally, 62 attendees have progressed to the Advanced Health Policy Institute, with 32 earning commendation for completing the two required sessions.

“Not only do I learn things that can help me out as a legislator, but also as a business owner and personally — the conversational capacity piece and the adaptive leadership piece,” says state Rep. Dexter Sharper (D-District 177), who enrolled in the Advanced Health Policy Institute in 2019. “It takes that conversational capacity to help recognize conflict, and when there is conflict, to say, ‘What am I missing? What are they missing? And what are we both missing?’ With that philosophy, it



2017 certificate presentation (left to right): Torrian Percy (GHPC), Rep. Derrick Jackson, John Powell, Rep. Pat Gardner, Karen Minyard, Rep. Demetrius Douglas, Rep. Billy Mitchell, Leigh Alderman (GHPC), Rep. Deborah Silcox, Rep. Mable Thomas, Rep. Karen Mathiak, and Rep. Betty Price

“We are helping legislators to think about the system – not just the tip of the iceberg, but what are the systems, the policies, the mindsets, the patterns of behavior that are contributing to the problem.”

- Karen Minyard

puts you in a position to listen more, to be quiet, patient, and to be in a position to learn and process things before you say things.”

Reflective of the program’s goals to bring credible, reliable, and unbiased information to policymakers and to develop methods to have productive conversations among lawmakers, attendees represent both political parties nearly equally.

“I understand that if you align yourself with a political party, you lose everybody else. So we

have been very steadfast not just in our neutrality, but in focusing on our support of excellence in government,” says Minyard. “To support excellence in government, you meet policymakers where they are, you understand what they are concerned about, and you help them do the best that they can. We value having this trusted relationship where we give every bit of information we have, even if that contradicts current perceptions. It is about providing evidence for excellence, giving them the best of what we have, and then just sitting back.” ●●

health policy and financing

Angela Snyder, Ph.D., M.P.H.

director of health policy and financing

Fun Facts About Angie

Years at GHPC: 14

Hometown: Mobile, Ala.

Favorite movie: *Inception*

Favorite food: Fish tacos from Taqueria del Sol

What's special about GHPC?

Unlike other positions in government that I have had, GHPC offers me the opportunity to use my programmatic management skills, my policy skills, and my research skills.

Instead of having to choose one, I get to use all of them in my position. It makes the role feel entrepreneurial and has allowed me the flexibility to make the job into what I want it to be.



What project has had the most personal significance for you?

The Medicaid project was the first project that I worked on at GHPC. I learned about Medicaid and Medicare in my Ph.D. program, but I had never worked with Medicaid data before. It is complex and after 13 years, I still don't know everything there is to know about Medicaid.

But after working with the Georgia Department of Community Health, the agency that administers Medicaid in the state and getting familiar with the Medicaid data, it has really opened the door to other opportunities. Because a lot of my work is translational, I can bring what I've learned about Medicaid into other projects that I've been involved with at the center. So not only has it had personal significance for me in terms of my professional growth, but it has also been an engine of growth for the center.

From the center's beginning we had folks that worked

with Medicaid and we had folks that worked with public health. As I grew in my career, I started to have projects that overlapped. Some of our newer work, including with the Center of Excellence for Children's Behavioral Health, we got because we understood Medicaid. This experience has helped us to grow and bridge our work across government agencies.

Based on our experience we have developed a really comprehensive way to think about financing and paying for health services. It is now foundational to our work, like the Center of Excellence for Children's Behavioral Health and our work as the Hemoglobin Disorders Data Coordinating Center in Georgia. So, for me, Medicaid rounded out my knowledge of how the whole health system works. It is exciting for me because I like to think of things from a system-level perspective.

Was there an 'ah-ha' moment you realized the center's positive impact?

So my aha moment came when we started working with the Centers for Disease Control and Prevention (CDC) on the Voice of Public Health. Prior to this, the last time health reform came up at the federal level was during the Clinton administration. But in 2010 CDC saw this movement at the federal level and wanted to be at the table — to be part of the conversation. But in reality the focus was health systems, health financing, and health insurance, and public health was not part of it.

So since we had this experience with both Medicaid and public health, the CDC asked us to help them think about the role of public health in the upcoming version of health reform.

It took all of us working together at the center to find the voice of public health. It was our first big project with CDC, and the whole team did a lot of work collecting and synthesizing information. We did interviews and held several convenings to bring this image to life. It came about from knowing the health system, knowing about public health, and recognizing the importance of how the social determinants of health impact everything we do. The really exciting part was seeing other people realize this and then realizing that when the Affordable Care Act came together, public health was at the table. Our work was part of making that happen.

As one of the only research centers that was integrating this work between Medicaid and public

health, including the private sector, it really poised us for our exceptional growth and to think in a comprehensive way about financing and paying for health services.

What keeps you up at night?

The center's growth keeps me up at night for both worry and because it is exciting. I think it is super exciting that we are growing and that we are able to share our collective knowledge with younger professionals. It also allows us to be more helpful to the state and do our jobs better. The worry, though, is that we are growing. GHPC has been special for me because of its entrepreneurial culture and that I was able to bring together all my experiences and make my job into what I wanted it to be. I just hope that as we grow, that experience is still available to newer staff. As we grow, it may be harder to have an entrepreneurial culture and I do not want us to lose what I find so special about GHPC.

You would feel successful if ...

If I could accomplish one thing before I retire it would be that we have all the child data packaged in a nice way. Over my time here we've made some baby steps toward that and now I am working with the Andrew Young School of Policy Studies' Child Policy Labs.

When I started working in child policy I wanted to work on projects across environments for kids. School data emerged as one source. I would love to merge the Medicaid data with the school data to see how academic characteristics and school-based interventions impact health and how health interventions impact kids in schools. At times it has felt like pie in the sky to do things like that, but I have just put my head down, gained experience, and kept moving. So now fast-forward, and we have, in fact, done a lot of cross-agency projects, especially through the Center of Excellence and the Georgia Interagency Directors Team. But we still don't have all that data in a nice packaged way.

So if before I retire, we actually do have multiagency data around kids we can help the state make better policy decisions because they can see the policy that they're making — whatever their sphere of influence is — is also having an impact on other areas that the state's responsible for, like health, education, and social services.

GHPC Builds Data Surveillance to Better Lives of Patients With Sickle Cell

Georgia is one of two states in the nation using longitudinal data as part of the Sickle Cell Data Collection Program to study trends in diagnosis, treatment, and health care utilization for patients with sickle cell disease.

Since 2004, there have been 3,509 babies born with sickle cell disease in Georgia. Nearly one in four of these children live more than one hour from any specialty sickle cell care offering daily appointments.

Currently, there are two comprehensive pediatric sickle cell disease programs in the state — in Atlanta and Augusta — with five associated pediatric outreach clinics in middle and south Georgia offering appointments monthly. There are two additional pediatric treatment centers in Macon and Savannah, with plans to increase outreach through specialized community health workers in several areas.



The situation is even more difficult for adult patients, as there are fewer providers willing to see adults with sickle cell disease.

“The data is really starting to be put into action within the state of Georgia. It was already well documented there are challenges with access to health care for individuals with sickle cell, in part because there are not enough providers who have expertise in hematology, especially as patients age into adulthood,” says Mary Hulihan, Dr.P.H., a health scientist at the Centers for Disease Control and Prevention’s Division of Blood Disorders. “But the surveillance project is able to find pockets of patients that do not have access to a nearby health care provider who knows how to take care of sickle cell disease. Those voids have been well known for a long time, but there has not been a way to necessarily quantify where those voids exist or how large of a population they impact. This data now provides real evidence of that.”

Gathering Data to Improve Lives

GHPC is the data-coordinating center for several statewide projects focused on surveillance of and health



promotion for individuals with blood disorders.

With clinical and state agency partners, GHPC has built a unique, comprehensive dataset that enables a better understanding of sickle cell-related diagnoses and health care utilization since 2004 for more than 10,000 patients. Data sources include:

- State newborn screening program
- Death records
- Clinical data from four sickle cell treatment centers in the state (Augusta University, Grady Health System, Children’s Healthcare of Atlanta, and Savannah Memorial)
- Administrative claims data from Georgia’s Medicaid, Children’s Health Insurance Program, and the State Health Benefit Plan
- Hospital and emergency department discharge data

To date, these data have been used to determine how many people have the disease, where these patients live across Georgia, trends in morbidity and mortality, use of inpatient and emergency department health care services, and providers’ adherence to recommended clinical practices and guidelines.

“The data is being used successfully in a number of ways clinically. Georgia was able to clearly document that there is a marked increase in health care utilization and death rate in young adults with sickle cell disease,” explains James Eckman, M.D., professor emeritus at Emory University, and founder of the world’s first 24-hour comprehensive acute care sickle cell center at Grady Memorial Hospital in Atlanta. “Pediatric care is very structured. Then as patients get to be young adults, they’re on their own and they drift away from care and just use the emergency rooms, and really don’t have ongoing care and don’t have preventive care. Realization of this problem has really gotten pediatricians around the state — and

around the country actually — to start focusing on the importance of transition and making sure that the youth are well prepared for that process.”

Another way the data is being used to improve care is for older adults with sickle cell disease. Once considered a childhood disease because few patients survived to adulthood, there have been great improvements in life expectancy, with the average life expectancy reaching more than 40 years. Some sickle cell patients in Georgia are actually living into their 70s and 80s.

“Using mortality data we found that the older adults with sickle cell in Georgia are not necessarily dying of complications of sickle cell disease, they are dying of the usual diseases of older age,” says Eckman, who consults with GHPC. “That is really going to be changing our care models for sickle cell patients, where we will have to focus on primary care types of activities and prevention of things like cancer and hypertension.”

Using the data to drive changes in clinical practice is possible only through engaging a multidisciplinary group of state partners.

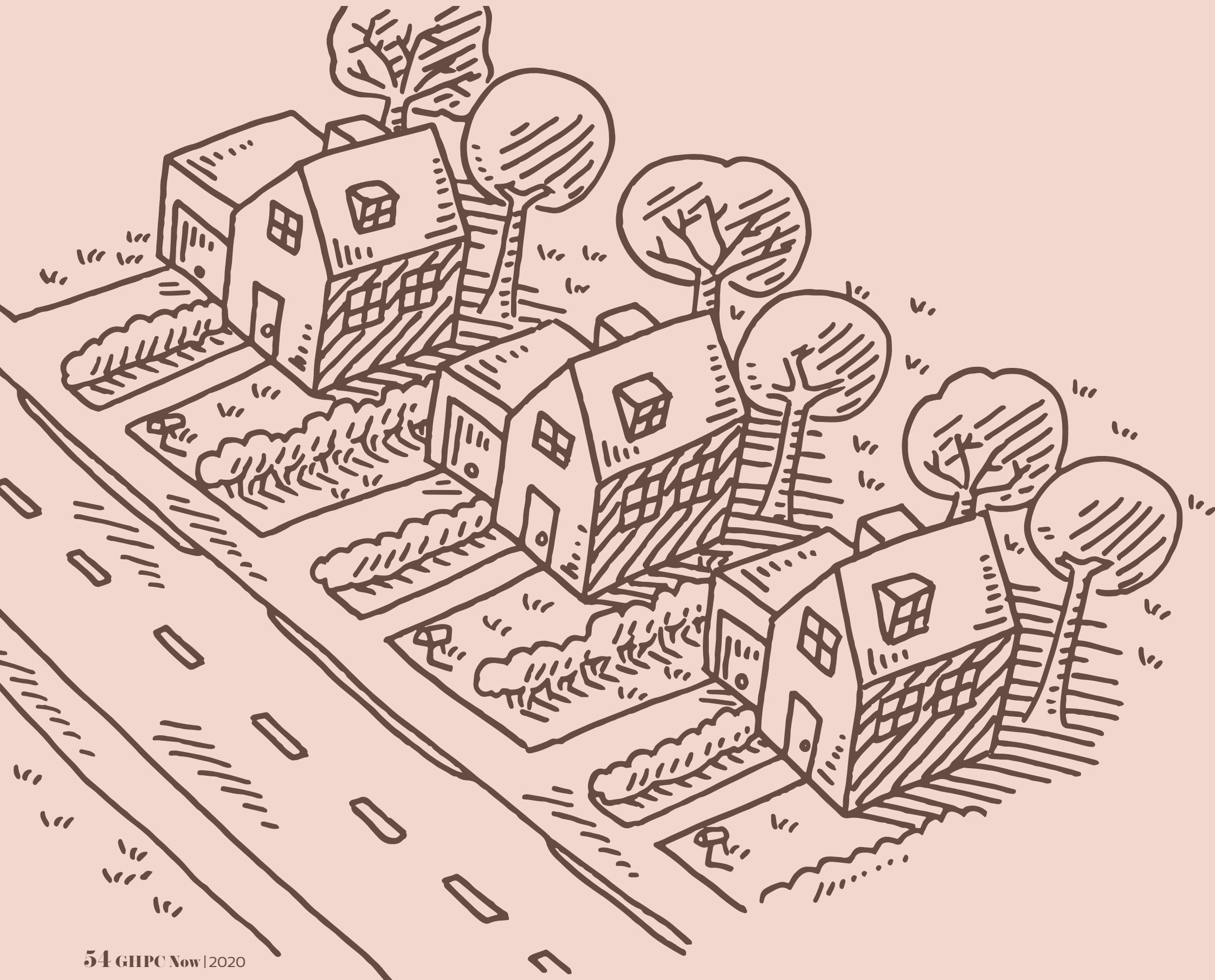
“GHPC is very good at gathering multidisciplinary partners to discuss not only what the surveillance system looks like, but how the information from the surveillance system can be used to really improve the lives of people living with sickle cell disease,” says Hulihan. “While this is a very data-heavy project, at the end of the day, there is no reason to collect all of this data and analyze it if you are not using it to do something to really benefit the patients, the families, and the community living with sickle cell disease. By engaging with them, GHPC is able to make sure that their voices are at the table to help guide the project and that they are also able to benefit from the rich information that comes out of the project.” ●●

Many people who have sickle cell disease and another inherited blood disorder, thalassemia, get blood transfusions to stay healthy. But there are risks from having multiple transfusions. The risks of transfusion reactions are much lower when the blood patients receive is a closer match to their own.

GHPC leads the REDHHoTT (Registry and Education for Hemovigilance in Hemoglobinopathy Transfusion Therapy). Its goal is to reduce complications of blood transfusions for people who have sickle cell disease or thalassemia.

REDHHoTT created MySleevesUp.com to help diversify the blood supply. Become a lifesaver. Roll up your sleeve and donate blood.

MySleevesUp.com



Home Is Where Health Begins

GHPC conducted the nation's first health impact assessment to inform how low-income housing tax credits are allocated in the state, with a focus on how siting, design, and operations can impact residents' health and well-being.



Photo by James Dills

“Home sweet home.”

The cheerful wreath adorning unit 606A represents much more than a pleasant message.

Bright peach and blue paint. New blinds. Warm shutters. Though inviting, these aesthetic touches are only the finishing touches, masking the true transformations that enabled the redevelopment of this affordable

housing complex in LaGrange, Ga.

Where you live can have long-lasting effects on your health. But policies directing development of affordable housing traditionally have not explicitly included health outcomes as a consideration. “How can we make a platform that changes the entire home and the people?” asks Zsa Zsa

Heard, CEO, City of LaGrange Housing Authority. “The building that surrounds them is just the infrastructure, the shelter, but not a home. Our goal is the entire community. My job is to disrupt that poverty and blight so we can get a better person and a healthy home.”

One developer, housing authority, or financier cannot transform a system alone. It takes a broad approach and a mindset shift to recognize that housing policy is health policy.

Tax Credits Drive Affordable Housing Development

Low-income housing tax credits are the largest financing source for new affordable housing in the country. Each state creates an annual federally mandated Qualified Allocation Plan to guide allotment of these tax credits.

The Qualified Allocation Plan outlines criteria for scoring developers' applications.

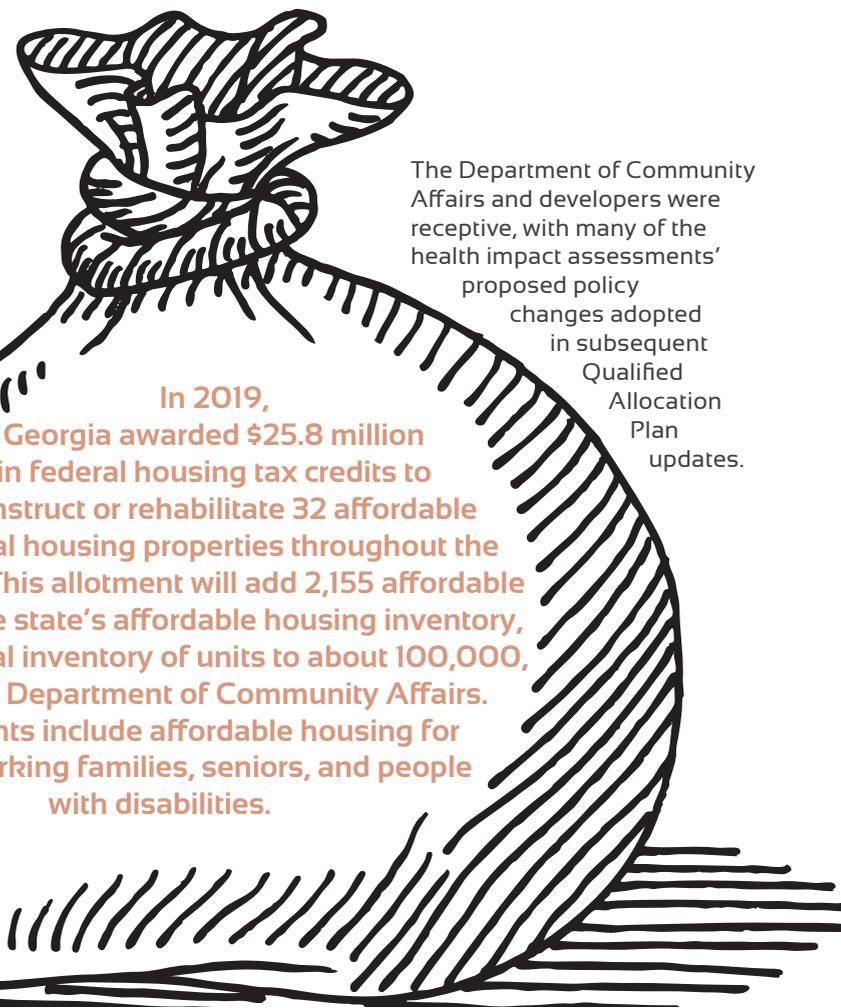
These competitively awarded tax credits are prized by developers, and thus, the scoring criteria in allocation plans are powerful drivers for where developers will build affordable housing and the features they will include.

“Back then, I really thought health was just about how long it would take you to get to a doctor. That is what health and housing meant to me,” says Laurel Hart, the former director of housing finance and development at the Georgia Department of Community Affairs.

GHPC, in partnership with the Georgia Department of Community Affairs, conducted the nation's first health impact assessment in 2015 to inform how health factors could be more explicitly included as criteria in the tax credit allocation plans.

“I think change is always hard. It's hard for people. But it's really, really hard for government,” says Hart. “I would say that for years nothing changed with the tax credits program. The comfort was its predictability.”

But then, in part because of the disruption posed by the Great Recession, the agency



In 2019, Georgia awarded \$25.8 million in federal housing tax credits to construct or rehabilitate 32 affordable rental housing properties throughout the state. This allotment will add 2,155 affordable units to the state's affordable housing inventory, bringing the total inventory of units to about 100,000, according to the Department of Community Affairs. The developments include affordable housing for working families, seniors, and people with disabilities.

The Department of Community Affairs and developers were receptive, with many of the health impact assessments' proposed policy changes adopted in subsequent Qualified Allocation Plan updates.

was open to change.

“If we were going to survive as a program we had to do something bigger and we could not think of ourselves as developers or administrators,” Hart recalls. “We had to think of ourselves as transformers — transformers in people's lives and transformers in local communities.”

GHPC made recommendations in its health impact assessment for strengthening connections between properties and their surrounding communities, encouraging access to educational opportunity, and promoting healthy design and operation (e.g., having a menu of service options that include fitness classes and creating walkable communities).

For instance:

- “Health outcomes for residents” became a stated priority for tax credit allocation.
- The Healthy Housing Initiatives section was added to the 2017 Qualified Allocation Plan.
- Mentions of health in the Qualified Allocation Plan increased from 12 in 2014 to 72 in 2018.
- The number of applications for siting affordable housing developments near high-performing schools increased threefold in 2015.
- Adoption of health-related criteria into the allocation of low-income housing tax credits has indirectly influenced the

66 More Reflections



well-being of residents in over 10,000 units of affordable housing across the state.

- GHPC has had direct influence on over 1,100 of these units through ongoing partnerships with housing developers in urban, suburban, and rural communities.

Broadening Efforts to Expand Reach of Healthy Housing

GHPC has worked directly with over 30 housing developers, local housing authorities, and other stakeholders to implement recommendations from the initial health impact assessment, to identify new opportunities for partnership, and to more fully integrate

health into the mindset of affordable housing decision-makers.

“Previously, as a private developer, we were about making money and we needed to make money so we could get to the next project and keep moving. Often times we felt like we had given the resident or homeowner the four walls and a roof and some really nice things — what more could they want?” says Tim Johnson, senior construction manager, Housing Development Corporation, a nonprofit real estate company revitalizing neighborhoods through affordable and workforce housing. “Then, with my current job, I began to get to know some residents, especially in the senior communities. And I found out that there is a little bit

more to this. There are mental health issues — not necessarily that somebody needs a doctor for this issue as much as it is, ‘I can’t feel safe in my home.’”

Johnson says this realization, or mindset shift, is changing development practices. These changes include things like building an after-school computer center where kids can safely do their homework while waiting for their parents to return from work, as well as other amenities that help to restore a sense of community.

“I see that sense of community coming back to some of those communities that had basically been destroyed because of things we, as an industry, had been allowed to let go or omit,” Johnson says. ●●

There was a lot of energy around forming the Georgia Coalition for Health and bringing people to the table. It was clear that the center needed to be neutral and nonpartisan or people would not trust the data. But the public’s voice was equally represented. There was no doubt about the value of the public voice, and the consumer voice has remained attached to the work of Georgia Health Decisions, the Georgia Coalition for Health, and the Georgia Health Policy Center.

Beverly Tyler
executive director at Georgia Health Decisions, which represented the voice of consumers at the Georgia Coalition for Health

It was the view of the Georgia Chamber of Commerce in the mid 1990s, much like today, that the equation of access, quality, and value was under pressure. My board thought that it was important to try to strike a balance for the consumer, providers, and business. There needed to be a place, or a space, where honest dialogue and research could be conducted and where, to the extent possible, politics and conflict were minimized. The coalition’s founders believed that there was a need for transparency and that facts matter.

Charlie Harman
former president of the Georgia Chamber of Commerce, instrumental in bringing the voice of business to the Georgia Coalition for Health

At that time health care was changing, and we realized that we had to come together and try to work together to protect our membership and make sure that our members felt they had a voice in what was going on. There were several other provider representatives and all agreed that we would come and discuss and not fight with each other around that table. And I think that was a big part of what made it work. We agreed to do that; plus Jim Ledbetter was a major factor in making it work.

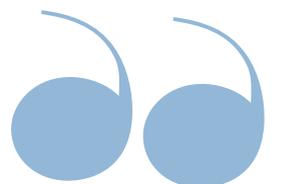
Joe Parker
retired executive director of the Georgia Hospital Association, instrumental in bringing the voice of providers to the Georgia Coalition for Health

At Georgia Health Decisions we thought we could make a positive impact by understanding what values Georgians had regarding health care. With a grant from the Woodruff Foundation we ended up with a fairly cohesive understanding of what values people held — the aspirations and anxieties people had about health care. But, overall Georgia was kind of a vacuum, as there really was not any organized policy organization within the state to impact these health policy discussions. Out of that came a pretty firm conviction that there needed to be an academic policy organization that would serve as a source for data on what was going on with health in the state — a center that transcended existing governmental institutions. I am not surprised by GHPC’s success, as I think it is due to a combination of really good leadership throughout its history and that it is fulfilling a significant need on the behalf of the state.

Bill McClatchey, M.D.
retired physician, co-founder of Georgia Health Decisions, and on the board of the Georgia Coalition for Health

It is sort of overwhelming, when you think about where GHPC is today. I think unbiased research was certainly seen as something that was critical, and the involvement of a broad array of stakeholders was also a value that we embraced, and which has continued. To the staff’s credit and Karen’s credit, GHPC has remained a viable institution, even in the midst of political changes and gubernatorial changes. As I envisioned, the center remains a source of valuable information in Georgia, but now it is nationally recognized, too.

Jim Ledbetter, Ph.D.
former commissioner of the Georgia Department of Human Resources, and GHPC’s first director



Seeking Solutions for Complex Behavioral Health Care

GHPC conducted a realist synthesis to guide design of integrated systems to improve outcomes for individuals with a co-occurring diagnosis.

Working with the Ireland Research Board enabled GHPC to help foster connections between the loosely aligned realist community globally. As a result, GHPC is leading organizing efforts for the *International Realist Conference 2020*, March 24-26 in Dublin, Ireland.



The challenge of coordinating services for people with co-occurring mental health and substance use disorders is one of those complex environments that Schön refers to. Recognizing that critical shortages of integrated services plague behavioral health systems worldwide, the Ireland Research Board and the Georgia Health Policy Center looked to a realist review to provide real-world and evidence-based insights to shape how Ireland could develop a system of integrated care between its mental health and drug and alcohol services.

Rather than testing whether an intervention works, a realist approach examines how it works. Ideally suited for complex situations, the realist approach describes patterns of relationships between how an intervention is delivered, contextual factors, and the observed outcomes.

The realist synthesis of the literature was combined with perspectives of service users and providers in Ireland providing a comprehensive examination of why certain interventions work (or do not work) for some people with dual diagnosis and under what conditions.

One of the key things about doing a realist synthesis of the literature is understanding the mechanisms, says Karen Minyard, GHPC's CEO, who led this project. Mechanisms can include resources — the intervention itself — as well as

changes in mindset, reasoning, decisions, or actions that are or are not triggered by the introduction of resources into a particular context.²

“But, mechanisms are not always apparent in the literature, particularly in randomized control trials. So, we had to get really smart about how to tease out the mechanisms,” says Minyard. “At the individual level, what leads a person to be ready to be in treatment? The things we discovered included trust, hope, and having a stable home, employment, food, and social support. At the organizational level, of course institutional and financial support emerged as key factors, but so did having a common language, a culture of hope, and provider confidence.”

Understanding mechanisms at four levels — policy/system, organization/provider, service/treatment, and individual/family — can help to demystify some of the complexity of the behavioral health care system, which Minyard says is not only a great contribution to Ireland, but a hallmark of how GHPC approaches problem-solving.

¹ Pawson, R., & Tilley, N. (1997). *Realistic Evaluation*. Thousand Oaks, CA: Sage Publications.

² Dalkin, S. M., Greenhalgh, J., Jones, D., et al. (2015). What's in a mechanism? Development of a key concept in realist evaluation. *Implementation Science*, 10, 49.

“There is a high, hard ground where practitioners can make effective use of research-based theory and technique, and there is a swampy lowland where situations are confusing ‘messes’ incapable of technical solution. ... In the swamp are the problems of greatest human concern.”

— Donald Schön
American philosopher
and industrial consultant,
in *The Reflective Practitioner* (1983)

The realist approach was first introduced by Ray Pawson and Nick Tilley in 1997. In contrast to evaluation approaches that seek to answer “Does an intervention work?” or “Was it effective?” the realist approach provides a framework for discovering “What works for whom in what circumstances?”¹

Growing Forward



In the spirit of Mario Andretti, I often say, "If you feel like you are in control, you are not going fast enough."

Roy Bahl, the first dean in the Andrew Young School of Policy Studies, gave me specific goals by which my performance would be evaluated. These goals were to:

- Continue policy analysis and implementation work to make the Georgia Health Policy Center the place of choice for health policy advice in the state
- Develop GHPC to become a nationally prominent center
- Lead the raising of external funds
- Manage the center efficiently and prudently
- Implement a strategy that makes GHPC an integral part of the academic and research mission of the Andrew Young School

These goals still guide me today. The key to accomplishing them is learning fast.

I often call GHPC a knowledge organization. Continuously learning within and across projects, and most importantly applying this knowledge, creates a virtuous learning cycle. This sharing occurs both internally and externally. As we have grown, it becomes harder and requires more deliberate ways for staff to know about all of the work happening in the center and learn from each other. But this dissemination of knowledge also happens outside of

our office. We are committed to finding creative ways to share with others what we have learned. I believe this reinforcing loop of knowledge is where our impact is greatest.

I think of our impact as multidimensional — across topical areas; at the intersection of research, programs, and policy; and through alignment of local, state, and national goals.

This requires a systemic approach and a commitment to innovating. We take a broad view of health, examining all systems, policies, and upstream factors influencing well-being, and looking for inclusive, cross-sector, and transformative solutions to achieve health equity. By simultaneously working at many levels and in many arenas, we learn fast and work smart to connect the dots.

This has been our approach from the beginning. And that is what I mean about going fast. We are doing it all, remaining nimble, learning from it, and applying that knowledge to even more challenging problems.

As I look to what I anticipate the next 25 years will hold, GHPC will work to remain the center of choice. We will do this by remaining true to the "GHPC way" — upholding our commitment to genuine personal relationships, to continuous learning, and to bringing credible and relevant information. By fostering an environment where effective communication and collaboration can occur, together, we can advance health and well-being in communities throughout this country and across the globe.

Karen J. Minyard

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404.413.0314
ghpc.gsu.edu
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Georgia Health Policy Center
55 Park Place NE
8th Floor
Atlanta, GA 30303
404.413.0314
ghpc@gsu.edu