

Georgia Flex Program Evaluation — SUMMARY REPORT

DECEMBER 2009



INTRODUCTION

An evaluation of the Georgia Medicare Rural Hospital Flexibility (Flex) Program occurred from April 10 through December 31, 2009. Approximately 100 state, regional and local stakeholders participated in the evaluation. This report is a summary of the full evaluation report which documents the evaluation methods, findings and outcomes and makes recommendations to advance Georgia's Flex Program.

Rural Health Solutions, a rural health program development and research firm located in Woodbury, Minnesota, conducted the evaluation and prepared this report. Evaluation activities included: key informant interviews, Critical Access Hospital (CAH) site visits, CAH administrator survey, community health care provider survey, program documentation review and CAH financial report review. The evaluation focuses on Flex Program activities completed from 2006-2009.



MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

The Balanced Budget Act of 1997 established the Flex Program. It is a national program that includes Georgia and 44 other states. The Flex Program comprises two components: **1)** federal grants to states to assist them with implementing state specific program activities that advance the goals of the national Flex Program (Flex Grant Program) and **2)** a CAH-based operating program, which provides cost-based Medicare reimbursement and unique operational requirements for hospitals that convert to CAH status. The U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), Office of Rural Health Policy, administers the Flex Grant Program. The Centers for Medicare and Medicaid Services (CMS), also located in DHHS, administers the CAH-based operating program.

Six priority areas have been established for states implementing the Flex Program:

- Creating and implementing a state Rural Health Plan
- Converting hospitals to CAH status and supporting and sustaining CAHs
- Fostering and developing rural health networks
- Enhancing and integrating rural Emergency Medical Services (EMS)
- Improving the quality of rural health care
- Evaluating Flex Program activities and related outcomes.

All states participating in the Flex Program are required, at a minimum, to support activities addressing rural health quality improvement, CAH support, EMS integration and enhancement and Flex Program evaluation. The Georgia program currently focuses on all aspects of the Flex Program. It features activities that are implemented by the Georgia State Office of Rural Health (SORH) along with a number of contractual agreements with program partners.



Tallulah Gorge, Georgia

METHODS

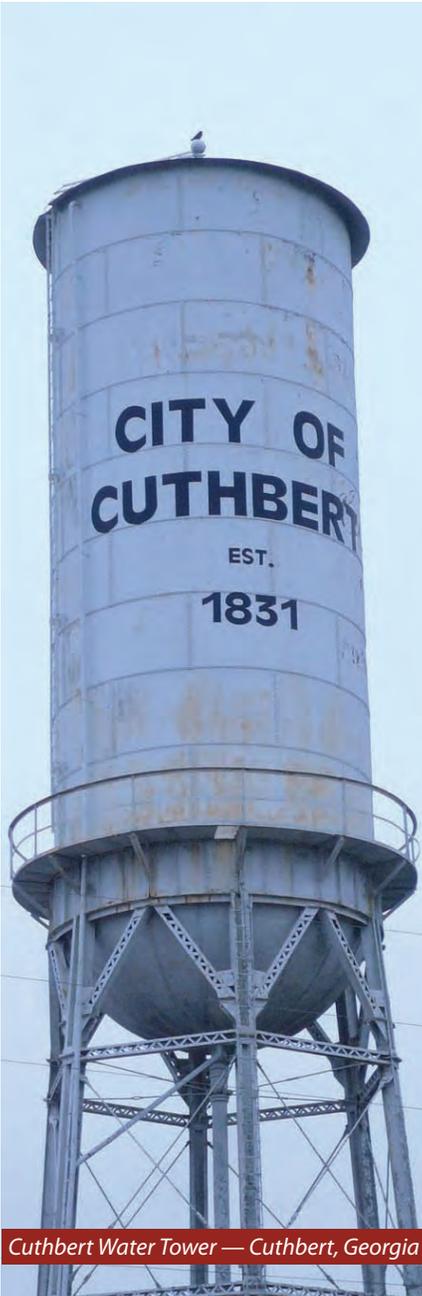
The Georgia Flex Program evaluation was an eight-month project that included two surveys, 25 key informant interviews, four CAH site visits, a review and analysis of program documentation and a review of CAH financial information. The evaluation goals were to:

- 1) Measure satisfaction with activities performed at the state level by grantees in CAHs and communities
- 2) Identify and report grantee project outcomes
- 3) Identify and present stakeholder involvement in the development and implementation of the Flex Program
- 4) Determine consistency of program goals whether the Georgia program is meeting state and national Flex Program goals and objectives
- 5) Report specific CAH and community outcomes on supporting and sustaining CAHs, quality improvement and other aspects of the Flex Program
- 6) Identify program strengths and weaknesses
- 7) Identify key program and rural health needs
- 8) Make recommendations for program development and improvement
- 9) Present strategic/planning/program development opportunities for the coming grant years

As part of the evaluation process, Rural Health Solutions' staff spent nine days on-site in Georgia reviewing documents, collecting data, meeting with and interviewing Georgia Flex Program stakeholders, visiting CAHs, interviewing CAH staff and interviewing state and local EMS directors. All data collected have been aggregated for reporting purposes. Anonymous quotes from the evaluation process are used to provide additional insight into stakeholder views, program involvement, activities, outcomes and recommendations.

Documentation Review

Program information was reviewed to provide a historical perspective of Georgia's Flex Program's development and funding support, to identify the roles of entities involved and to understand stakeholders' level of program participation. The review also illuminated the relationships between program implementation activities and program outcomes.



Cuthbert Water Tower — Cuthbert, Georgia

METHODS (CONT.)

*CAH Survey*

A web-based survey of all Georgia CAHs was conducted from August 14 through October 22, 2009, with e-mail and telephone follow-up for non-respondents. All CAH hospital administrators/chief executive officers (CEOs) received an email outlining the survey, how the survey data would be used and requesting that the survey be completed online via the identified link. In addition, Flex Program staff from the Georgia State Office of Rural Health emailed all CAH CEOs requesting their participation in the survey. All CAH survey responses were made online. Thirty-three of 34 CAHs responded resulting in a 97 percent survey response rate.

CAH Site Visits and Staff Interviews

Four CAH site visits were a part of the evaluation. CAH administrators, quality improvement (QI) coordinators, directors of nursing/ chief nursing officers (CNOs) and financial officers were interviewed at each site, as well as local EMS officials, as available. The site visits served as a unique opportunity to ask follow-up questions to the CAH administrator survey (above), to obtain more in-depth information about the state's Flex Program and its accomplishments, as well as to better understand the CAHs, their needs and those of the communities they serve. A total of 17 CAH and local EMS staffs were interviewed at all four sites.

State Stakeholder Interviews

Twenty-five Flex Program state/regional stakeholders participated in structured interviews to: 1) measure their satisfaction with program operations, management and implementation; 2) discuss their involvement in Flex Program activities; and 3) identify Flex Program planning, development and implementation needs and next steps. Interviews occurred between August 12 and December 9, 2009. When possible, interviews were conducted in person. Interviews lasted between .5 and 2.25 hours each.

Community Healthcare Provider Survey

The Community Healthcare Provider Survey was mailed to 96 health care providers working in five CAH communities. Community health care providers were identified using search engines on the web. The initial survey was mailed June 15, 2009, with a follow-up mailed August 3, 2009, completing the survey collection August 17, 2009. Twenty-nine health care providers/managers responded, including: physicians, chiropractors, local public health directors, dentists, pharmacists, mental health providers, nursing home administrators, optometrists, pharmacists and alternative health providers. The number and type of providers surveyed varied across communities; however, physicians were the most frequent survey respondents. The survey response rate was 30 percent.

CAH Financial Reports Review

The Flex Monitoring Team develops annual reports on the financial status of CAHs by state: **CAH Financial Indicators Report: Summary of Indicator Medians by State.**¹ Data from past reports (2005 – 2009) were tallied for Georgia, across all reporting years, to examine trends with each aggregated financial indicator reported for CAHs in the state and U.S. In addition, findings from the reports **Critical Access Hospital Financial Analysis – 2008**, August 2008 and January 2009 by Draffin and Tucker, LLP, were also reviewed.

¹ Flex Monitoring Team, retrieved December 16, 2009, <http://www.flexmonitoring.org/prodresults.php?field=1>.

STAKEHOLDER TERMS AND USE

For the purposes of the evaluation, the following terms are used to identify stakeholders included and represented in the evaluation:

State Stakeholder — Any organization identified in Table 1 of this report (e.g., Georgia Hospital Association and Georgia Health Policy Center).

CAH Staffs — CAH staff interviewed during the four CAH site visits including: CAH administrators, chief nursing officers, chief financial officers and quality improvement coordinators.

Flex Program Stakeholders — all state stakeholders and CAH and local EMS staffs that participated in the evaluation.

RURAL HEALTH AND GEORGIA



Tallulah Gorge, Georgia

Georgia is both geographically and demographically diverse. It is the largest state east of the Mississippi River (59,424 square miles). It has four distinct topographical regions: the Atlantic coastline area that is the eastern side of the state, a low coastal plain that covers the southern half of the state, rolling foothills in the central part of the state and a mountainous area in the northern part of the state (including both the Blue Ridge and Appalachian Mountain ranges). It has 159 counties, significantly more than states of similar size and more than double the national average (62.2 per state).² Georgia is the eighth fastest growing state in the U.S. in terms of population (9,685,744). Its population is getting younger and it has the third largest African American population compared to other states.

Georgia's economy ranks 10th in the U.S. in terms of its gross domestic product (GDP). In addition, it boasts 15 Fortune 500 companies and 26 Fortune 1000 companies.³ If it were its own country, Georgia would have the 28th largest economy in the world.⁴ Georgia's rapid population growth rate and its Hartsfield-Jackson International Airport (the busiest airport in the world) are testaments to its economic strength; however, interviews with Flex Program stakeholders reflect a decline in rural-based industry and the local tax base.⁵

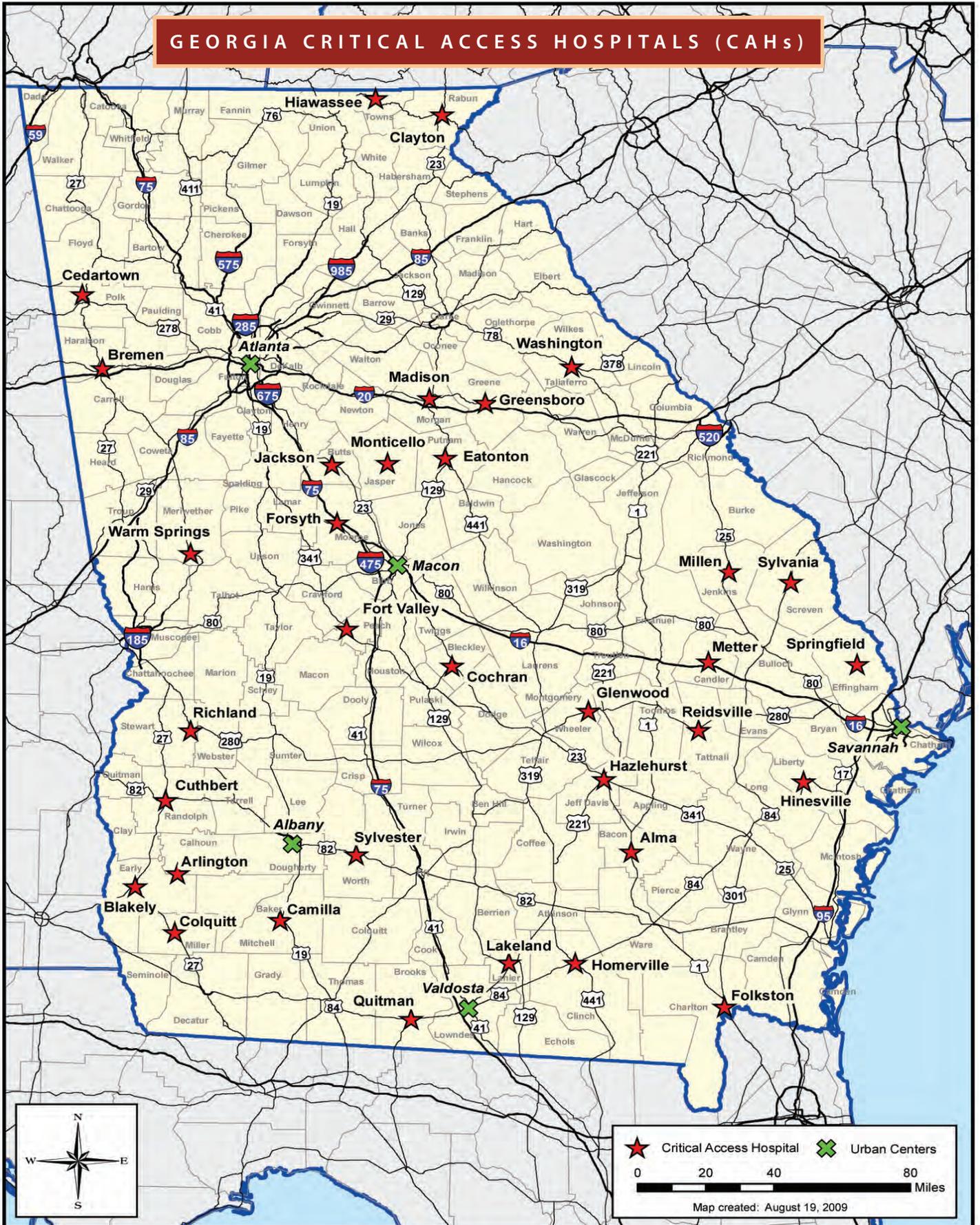
Despite an increasing population, approximately 80 percent of the state's land mass is classified as rural with 19 percent of the state's population residing in these areas. Georgia's rural areas are characterized by agriculture and forest land. Agriculturally, Georgia ranks first in the U.S. in the production of young chickens weighing less than 2.5 pounds, peanuts and pecans; second in acreage of cotton and rye; and third in the production of tomatoes and peaches. Demographically, Georgia's rural areas have an African-American majority and a poverty level that is higher than state and national averages. Georgia's rural population is more likely to be under-insured or uninsured, more likely to suffer from heart disease, cancer, obesity and diabetes, and is considered less healthy than its urban counterparts. Georgia's rural population is older, less educated and has a lower median income when compared to urban areas.

² Number of counties by state as reported by <http://www.charlestoncounty.org/stats/bystate.htm> and U.S. state area rankings as reported by <http://www.enchantedlearning.com/usa/states/area.shtml>

³ [http://en.wikipedia.org/wiki/Georgia_\(U.S._state\)](http://en.wikipedia.org/wiki/Georgia_(U.S._state))

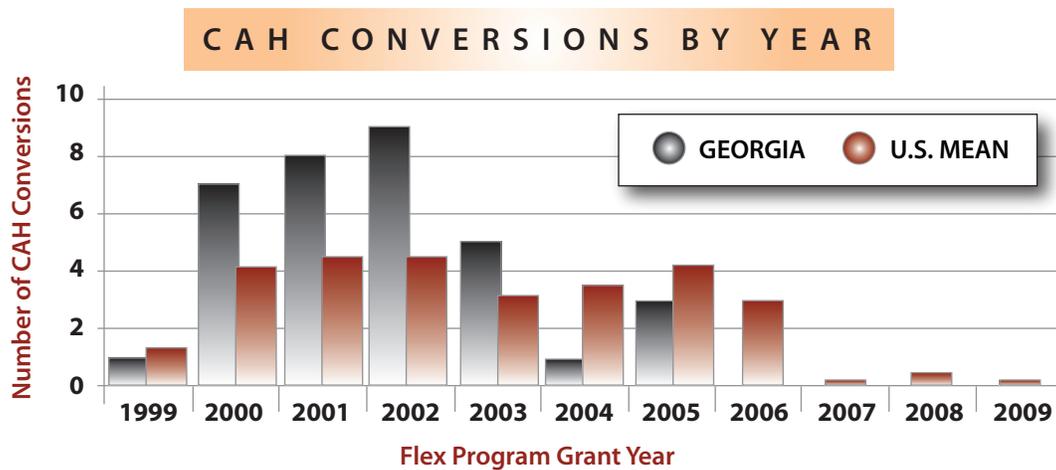
^{4,5} *ibid.*

GEORGIA CRITICAL ACCESS HOSPITALS (CAHs)



RURAL HEALTH AND GEORGIA (CONT.)

As of December 2009, there are 34 CAHs in Georgia. This is above the national average of 29 CAHs per state.³ Georgia CAHs represent approximately 19 percent of all hospitals in the state.⁴ Over the past 11 Flex Program years, 21 hospitals have closed in Georgia, including one CAH, one hospital that was re-opened as a CAH and three tertiary centers that were re-opened or replaced. As displayed on the map on the following page, CAHs are scattered throughout the state with clusters within 35 miles of urban centers. No CAH in Georgia is 35 miles from the next nearest hospital or 15 miles in mountainous terrain or on a secondary road, but all meet the state's Necessary Provider requirements. No hospital is currently seeking CAH status; however, four CAHs are considering converting back from CAH status.



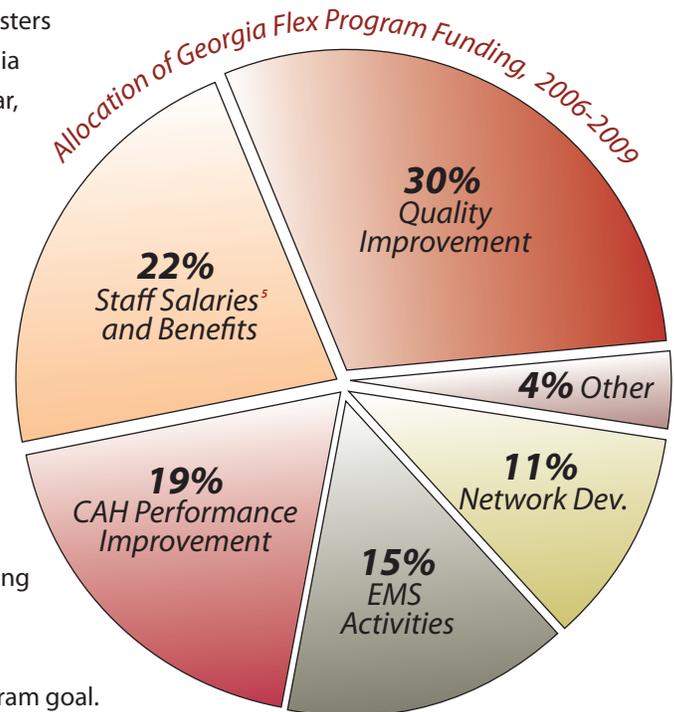
Georgia is divided into 10 EMS regions that are staffed with a program director, training specialists and/or licensing personnel. Georgia's EMS system includes 206 licensed ambulance services which all have some level of advance life support (ALS) patient care. EMS service areas vary with some ambulance services serving over 500 square miles. The majority of ambulance services are county-operated and fire-based, with some private ambulance companies and others that are hospital-owned. At least one is corporately owned by a Georgia Pacific paper mill. There are many military bases in Georgia and there is some cross training between those stationed at the three Air Force bases and EMS. Some military bases also contract with local EMS for ambulance services. There are approximately 700 emergency medical technician – basic (EMT-B), 11,000 emergency medical technician – intermediate (EMT-I) and 7,000 paramedics in the state. They responded to approximately 1.2 million calls in 2008. EMS agencies are staffed by paid EMTs and paramedics which is uncommon when compared to other states (as most states' rural ambulance services are staffed by volunteers).

⁶ Flex Monitoring Team, July 30, 2009, www.flexmonitoring.org.

⁷ There are approximately 175 acute care hospitals in Georgia.

PROGRAM ACTIVITIES

The Georgia Department of Community Health (DCH), SORH, administers the Flex Program in Georgia. During the past eleven years, the Georgia Flex Program obtained \$5,359,120, or an average of \$487,192 per year, from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, to implement the Flex Program in Georgia. It is the 27th highest funded program nationally. Over the past three years, the Georgia Flex Program has focused on supporting and sustaining CAHs, EMS, quality improvement and rural health planning as a part of its program activities. To accomplish this, Georgia Flex Program funding has been directed to: staff salaries and benefits (22 percent), CAH performance improvement (19 percent), EMS activities (15 percent), quality improvement (30 percent), network development (11 percent), and other activities (e.g., travel, supplies, evaluation, four percent).⁶ Most funding supports program goals through contractual arrangement with key Flex Program stakeholders, such as the Georgia Hospital Association. Below is a summary of activities completed as part of each Flex Program goal.



Rural Health Planning

Two Georgia Rural Health Care Plans were created through the Flex Program, most recently the 2007 plan. The first plan, completed in August 2000, was the guide for CAH conversions in the state.⁷ The 2007 plan was a multi-year plan that engaged a number of state stakeholders in creating a vision and goals for rural health in Georgia, describing the population and current state of health of rural Georgians, and detailing the health services in rural Georgia. The Rural Health Plan was established as a rural health resources guide and set state priorities. In addition to developing the plans, the SORH and the Flex Program, as part of their program operations and management, host regular meetings of Flex Program stakeholders, including CAHs.

CAH Support

The Georgia Flex Program supports CAHs by providing general program information and responding to questions/inquiries, providing network development technical assistance, facilitating annual stakeholder meetings and conducting CAH financial studies. During 2003-2004, the Flex Program invested in the development of HomeTown Health University, a web-based training program for hospital staff. The training continues to be available and updated for use by CAHs for a fee, typically paid for through the Small Rural Hospital Improvement Program (SHIP).

⁶ Although Flex Program staff are fully funded, they also administer the SHIP as it has no funds to cover its program administration and management costs.

⁹ Allocations are estimates based on Flex Program funding for the 2006 – 2009 grant years.

¹⁰ Rural Health Care Plan, Critical Access Hospital Steering Committee, Rural Health and Hospital Technical Advisory Committee, August 18, 2000, http://dch.georgia.gov/vgn/images/portal/cit_1210/8/30/37803168cah_plan.pdf.

PROGRAM ACTIVITIES (CONT.)

Quality Improvement

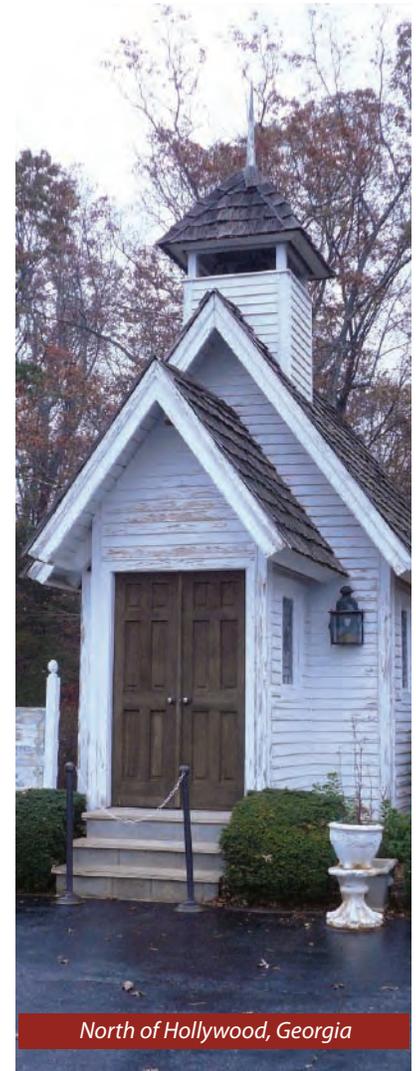
Quality improvement has been a goal of the Georgia Flex Program since its inception; however, in 2006 it became a required goal for all state Flex Programs. Georgia's Flex Program quality improvement activities have been allocated the largest portion of its state's funding over the past three years. Since 2004, its quality improvement-related funding has been directed to the Georgia Hospital Association (GHA) for tools that support data collection, benchmarking, monitoring and reporting, as well as a peer review network. Originally the funds supported the development of the web-based programs to store, analyze, and report data. Today the funds are used to maintain the programs and support hospitals in their use. In addition, in 2009, steps were taken to add outpatient measures to the data collection and reporting tools. This is notable as Georgia is one of few states that supports quality improvement activities related to outpatient measures.

The GHA's quality improvement system, or CARE Program, has four key components: CARE2, the Medical Evaluation Module of CARE (MedEval), CARE core and HIGH RISK.⁸ CARE2 is a web-based tool that allows hospitals to enter quality improvement indicator data, drill down to clinical service areas and use 27 benchmarks. MedEval provides physician level reporting, has drill down capabilities to each service line, diagnosis related group (DRG), or patient level, as well as other features. CARE core and high risk are patient safety and compliance and high risk patient safety modules to assist hospitals with compliance, clinical process improvement, patient assessment and reportable events.

In 2008, the Georgia Flex Program used carryover funds to develop online tools and resources to assist hospitals (including CAHs) with implementation of the CMS Outpatient Prospective Payment System (OPPS) measures. The Project included: Programming the CARE Conversion Utility Tool, which allows hospitals to easily import outpatient data into CART (CMS Abstraction and Reporting Tool), and begin the data abstraction process and creating the OPPS module.

In addition to quality improvement data collection and reporting, the Georgia Flex Program supports a peer review network that was originally focused on CAHs but has expanded to include other rural hospitals. The network is used for cases that are "difficult to review" and can be accessed for no fee.

Georgia's rationale for focusing Flex Program funding on quality improvement relates to the quality status of hospitals in the state. The GHA Board recognized the opportunities for improvement for CMS measures and included it in its strategic plan to move its hospitals to the top 10 of all states. Although Georgia hospitals have made strides towards achieving this goal, other hospitals around the U.S. are also improving their quality of care, which makes the state's quality improvement-related goals more challenging.



North of Hollywood, Georgia

¹¹ CARE is a Collaborative Approach to Resource Effectiveness.

PROGRAM ACTIVITIES (CONT.)

**EMS**

Over the past three years, the Georgia Flex Program has directed approximately 15 percent of program funding to EMS. This has occurred through contractual arrangements with the Georgia State Office of EMS and a regional EMS network. The funding has supported EMS data collection tools, web-based EMS training and tracking and a regional EMS pilot project focused on quality improvement and EMS staff training. Staff turnover at the state EMS office resulted in many project delays; however, its training website was launched in August 2009. The site can be accessed by EMTs and paramedics and had 1,400 subscribers during its first three months.

A regional EMS pilot project received Flex Program funds in April 2009. It is a consortium of five counties that will measure paramedic competencies using baseline and follow-up tests, and it will include a training component to address EMS providers' training needs. This project includes three CAH communities.

SUMMARY OF FINDINGS

The Georgia Flex Program evaluation resulted in many program findings that are noted throughout the report. Some of the key program findings are summarized and highlighted here.

A . FLEX PROGRAM IMPLEMENTATION

- There are 1.5 full time employees (FTE) staff who administer and manage the Flex Program in Georgia
- There has been no Flex Program staff turnover in the past three years
- Flex Program stakeholders spoke favorably of the work of program staff and the SORH
- CAHs survey respondents most frequently identify the SORH, HomeTown Health, LLC, and staff within those organizations as places where they turn first with questions or concerns and for regular CAH updates/information
- CAHs most frequently identify the SORH, the GHA, other CAHs, the CMS and their accounting firm as where they obtain CAH related updates, information and regulatory changes
- Many Flex Program activities are contracted to other stakeholder organizations
- The Flex Program has received an average of \$487,193 per year in funding over the past 11 years
- Georgia ranks 27th of 45 states in terms of the federal funding it has received, and 33rd in terms of funding per CAH
- 63 percent of CAHs report they are aware of and 12 percent report they use the Georgia Rural Health Care Plan

SUMMARY OF FINDINGS (CONT.)

- Most Flex Program stakeholders report they would like to know more about the program
- Most Flex Program stakeholders report they would like to have a more active role in program planning process

B . C A H s

- Georgia was the 13th state to have a CAH
- There are 34 CAHs in Georgia
- All Georgia CAHs are considered necessary providers as none are 35 miles from the next nearest hospital or 15 miles in mountainous terrain or on a secondary road
- No hospital is currently seeking CAH status
- Four CAHs are considering converting back from CAH status
- Ninety percent of CAHs are aware of the Flex Program
- Eighty-eight percent of CAHs are “very satisfied” or “satisfied” with the Flex Program and no CAH reports being “dissatisfied” with it
- CAH Flex Program satisfaction increased from 2007 to 2009
- No CAH visited during the site visits reports knowledge of Flex Program funded EMS activities
- Considering all Flex Program funded initiatives targeted to meet the needs of CAHs, they use and are most satisfied with the CAH financial analysis completed by Draffin and Tucker, LLP, and least use the network development technical assistance
- CAHs’ financial status has improved since conversion
- CAHs have increased access to health care services by increasing the types of services provided locally



Chattahoochee National Forest

SUMMARY OF FINDINGS (CONT.)

- Fifty-eight percent of CAHs report they have referral and transfer issues with their network hospital(s)
- Finances and physician recruitment and retention are CAHs' greatest concerns
- Five CAHs are reportedly on the verge of closure and three additional CAHs are financially fragile

C. NETWORK DEVELOPMENT

- Eighty-one percent of CAHs report they are interested in engaging in network development
- 20 CAHs would like to network with other CAHs
- 16 percent of community health providers report their referral patterns to CAHs have changed in the past five years



Outside Homerville, Georgia

D. QUALITY IMPROVEMENT

- Flex Program funding has focused on hospital quality improvement
- Most CAHs report they are participating in Flex Program funded quality improvement initiatives while some CAHs (including their quality improvement coordinators) are not familiar with/aware of Flex Program funded quality improvement initiatives
- Indicators exist reflecting Flex Program quality improvement initiatives are improving quality of care
- Georgia is one of few states that supports data collection and reporting for outpatient quality improvement measures

E. EMS

- Almost all EMS agencies in Georgia are paid services
- Fifteen percent of Flex Program funds have been directed to EMS
- Web-based EMS training opportunities have been developed using Flex Program funds resulting in 1400 subscribers

RECOMMENDATIONS

Since the Flex Program is administered by the DCH, SORH, the evaluation recommendations are primarily targeted here. However, given the limited resources of the Flex Program as well as the roles and activities of other rural health stakeholders around the state, recommendations should also be seen as an opportunity for improvement by all Flex Program stakeholders, in particular: GHA, Georgia Office of EMS, local and regional EMS, Area Health Education Centers, Georgia Medical Care Foundation and CAHs. Recommendations are not reported in order of priority.

1) PROGRAM INFORMATION AND EDUCATION:

Georgia should educate program stakeholders further about the Flex Program and its intended goals. Although many Flex Program stakeholders are aware of the Flex Program, many stakeholders operate within silos related to each Flex Program goal (e.g., those working in quality improvement only have information about quality improvement). This limited knowledge prohibits the program from tapping into new ideas and identifying complimentary program development activities that leverage the knowledge, expertise and resources of each organization and its staff.

2) STRATEGIC PLANNING:

Georgia should conduct a formal strategic planning process. Flex Program stakeholders interviewed and surveyed have differing and often vague views of the goals and objectives of the program as well as the program's planning process. Although annual program planning meetings are currently being conducted, the state should consider expanding them.

3) CAH FINANCES:

Georgia should use a CAH specific approach to address their financial challenges. Although some CAHs' financial status has improved since conversion to CAH status, other CAHs are struggling financially and may be on the verge of closure. In addition, although some support provided to CAHs can be provided using a multi-CAH approach; some services may need to be more long-term and CAH specific.

4) WORKFORCE:

Georgia should work towards addressing physician workforce issues. CAHs report physician recruitment and retention as one of their greatest issues and concerns. A lack of physicians affects access to health services and the financial viability of all hospitals.

5) OTHER CAH ISSUES AND NEEDS:

Georgia should respond to other key CAH and EMS issues and opportunities identified in the evaluation, such as: CAH network development, hospital diversion issues, CAH conversions back from CAH status and CAH-EMS relations. Many CAH and EMS issues and challenges were identified during the evaluation. Some are of higher priority and many fall within the goals of the Flex Program. In addition, although many Flex Program goals can be addressed using a statewide approach, need to be more targeted.

6) EVALUATION:

Georgia should continue to monitor and evaluate Flex program activities; however, this should occur within the context of program planning and implementation with predetermined objectives, strategies and outcome measures as indicated in the program strategic plan.

ADDITIONAL INFORMATION

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www.rhsnow.com

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