



Rural Hospital Stabilization Committee

Final Report to the Governor

February 23, 2015

**Rep. Terry England
Sen. David Lucas
Co-Chairs**

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Background

In April 2014, Gov. Nathan Deal announced his appointments to the Rural Hospital Stabilization Committee, which was created to identify needs of the rural hospital community and provide potential solutions.

“In March of this year, I proposed three revisions to the way we approach rural health care, with one being the Rural Hospital Stabilization Committee,” Deal said. “I recognize the critical need for hospital infrastructure in rural Georgia and remain committed to ensuring citizens throughout the state have the ability to receive the care that they need. This committee will work to increase the flow of communication between hospitals and the state and improve our citizens’ access to health care. I am proud to welcome this team and look forward to what we stand to accomplish.”

Members of the Rural Hospital Stabilization Committee	
Rep. Terry England, <i>Committee co-chair</i>	Georgia House of Representatives
Sen. David Lucas <i>Committee co-chair</i>	Georgia Senate
Jimmy Lewis	HomeTown Health
Temple Sellers, Esq.	Georgia Hospital Association
Greg Hearn	Ty Cobb Regional Medical Center
Scott Kroell	Liberty Regional Medical Center
Maggie Gill	Memorial Health
Wade Johnson	Lincoln County Commission Chairman
Dr. Angela Highbaugh-Battle	Pediatrician
Charles Owens	Georgia Department of Community Health, State Office of Rural Health
Molly Howard	Jefferson County Superintendent
Jimmy Allen	Business Owner and Tift Regional Hospital Board Member
Dr. Thomas Fitzgerald	Tanner Medical Center, Emergency Medicine
Ronnie Rollins	Community Health Systems
David Sanders	Fannin Regional Hospital
Dr. Jeffrey Harris	OB-GYN

The Committee members represent a variety of constituencies in and perspectives on the healthcare system, from legislators, CEOs, and healthcare professionals to business owners and local officials. All brought their unique perspective to help shape the recommendations contained in this report.

The Committee respectfully submits this final report to Governor Deal for his consideration. This report contains Committee approved recommendations, and represents the culmination of over six months of dedicated review and analysis by the Committee.

Committee Findings

The Committee heard testimony that four rural hospitals have closed in recent months with total of eight having closed or attempted to reconfigure in last two to three years. Additionally, fifteen rural hospitals are considered financially fragile, with six operating on a day-to-day basis.

One of the main areas of focus for the Rural Hospital Stabilization Committee was to address Emergency Department (ED) stressors in rural hospitals that can contribute and lead to their closure. In an effort to address this issue, a process to scale down hospital operations and create a stand-alone ED was proposed. After testimony and research it was determined that stand-alone EDs are not financially viable, due to several reasons. There are issues with the reimbursement mechanisms and there are extremely high labor costs and capital investments. National trend data also shows most of these being developed in wealthier, suburban areas as opposed to rural areas. It was determined that it takes approximately 15,000 ED visits to break-even which equates to a needed population of approximately 35,000. However, Georgia has virtually no rural hospitals in counties capable of supporting an ED without outside subsidies

The committee also agreed that rural healthcare is facing many transformations due to the Affordable Care Act, changes in the State Health Benefit Plan (SHBP), and the continued reduction of reimbursements. ,

Research by the committee highlights the many resources we have throughout Georgia that can assist in maintaining our rural healthcare infrastructure. Federally Qualified Health Centers (FQHC) report 156 access points in Georgia. There are 55 school systems that have already adopted telemedicine through their school nurse program and there are in excess of 20 nursing homes that are telemedicine equipped. Georgia is also fortunate enough to have 1,000 ambulances already equipped with locator systems and WIFI capabilities. Many of these also have telemedicine capabilities. Georgia has skilled physicians, both independent and hospital owned, that are serving our rural patients. The committee is supportive of Governor Deal's initiative to grow residency slots in Georgia to address physician shortages, especially in primary care. It is the hope of the Committee that these young doctors will establish their careers in Georgia, especially in our underserved and rural communities.

These findings helped guide the Committee to the recommendations included in the remainder of this report.

Final Committee Recommendations

Below are the Rural Hospital Stabilization Committee's final recommendations to Governor Deal.

Four Site "Hub & Spoke" Pilot Program
Legislative
Budgetary

Four Site "Hub & Spoke" Pilot Program

The Georgia Department of Community Health, State Office of Rural Health will be designated as the oversight entity for the proposed pilot program implementation and monitoring. This pilot seeks to build out an integrated "Hub and Spoke" model to prevent the over-utilization of the ED as a primary care access point. Rural hospitals often see over-utilization in patients with congestive heart failure, chronic illnesses (diabetes), and social disease states. The "Hub" systems have, in addition to the hospital, nursing home, home health, and rural health clinic components. The four proposed hubs are Union General, Appling Health System, Crisp Regional, and Emanuel Regional Medical Center. The "spokes" would include the following:

- Smaller Critical Access Hospitals
- Ambulances- WIFI and Telemedicine equipped
- School Clinics- Telemedicine Equipped
- Federally Qualified Health Centers
- Public Health Departments
- Local Physicians

The goal of the "Hub and Spoke" model is to best use existing and new technology to ensure that patients are being treated in the most appropriate setting thus relieving some of the cost pressures on the smallest rural hospitals' emergency departments. Using many of the resources outline above, healthcare professionals can ensure that each patient is being transported to the appropriate setting, monitor chronically ill patients to help them avoid repeat trips to the hospital and address frequent fliers that clog our small emergency rooms. Using methods such as health apps with medical reminders, social and community services like Meals on Wheels and mobile monitoring will relieve some of the most costly pressures on small hospitals.

It should be noted that these methods and technologies will need to be accepted and recognized by both the CMOs and the State Health Benefit Plan in order to ensure that services provided receive the appropriate reimbursement. Additionally, it is the desire of this committee to see this pilot operate as a public-private partnership. Thus, it is important that the state's CMOs, SHBP administrators, private insurers and local governments are willing to work collaboratively with the Department of Community Health, State Office of Rural Health on this pilot program.

These four pilot sites and the various spokes will need to address software systems and process improvements to ensure this model can work. These include:

- Fully installed Electronic Health Records (EHR)
- Fully developed ICD-10 software and processes
- Advanced case management processes
- Physician Office process improvements (Amerigroup pilot)

Additionally, the Committee encourages the four pilot sites to continue to work with the Department of Community Health, to seek improvements in the regulatory system. It was discovered that there are regulations and rules in place that might hamper the implementation of some of the above ideas. Any changes to regulations should be considered with compliance with federal statutes like EMTALA in mind.

The Committee fully agrees that this model is not the complete or the only solution to the many problems facing rural hospitals. It is, however, a method of testing best practices and determining what works best in our communities so that they can be replicated across the state.

Legislative

The Committee determined that in order to maintain and protect the fragile rural hospital infrastructure existing Certificate of Need (CON) laws need to be maintained. Further, the Committee recommends the expansion of the scope of practice for mid-level providers, such as nurse practitioners and physician assistants. With a growing physician shortage, it was determined that these expansions could help bolster healthcare resources in rural communities.

Budgetary

The Committee is requesting \$3,000,000 to be appropriated to the Georgia Department of Community Health, State Office of Rural Health (SORH). The Department's SORH would then grant this money to the four sites for hardware, software, program development, process improvements and training needs as well as the implementation, monitoring, and evaluation costs.