GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

The Rural Hospital Stabilization Program

A Comprehensive Report

Background of the Rural Hospital Stabilization Grant Program

and

Outcomes of

Phases One Through Three

December 2019

SORH
State Office of Rural Health
A Division of the Georgia Department of Community Health

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Table of Contents

Introduction.....Page 2

Executive Summary.....Page 2

Rural Hospital Closures: A National Concern.....Page 3

Hospital Closures In Georgia.....Page 4

The Rural Hospital Stabilization Committee.....Page 4

Final Report to the Governor's Office.....Page 7

The Rural Hospital Stabilization Grant Program.....Page 9

Rural Hospital Stabilization Grantees.....Page 11

Where Are They Now? Retrospective Evaluation.....Page 21

Where Are They Now? Financial Analysis.....Page 28

Summary.....Page 47

Sources.....Page 48

Appendix.....Page 50

Acknowledgements.....Page 51

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Introduction

The Georgia Department of Community Health (DCH), State Office of Rural Health (SORH) has the priviledge of administering the Rural Hospital Stabilization Grant Program (RHSGP) for rural hospital grantees in the state of Georgia. The purpose of this report is to provide a background on the program as well as an overview of the use and benefit of funding provided to grantee hospitals during the first three fiscal years of this program. This report includes data related to the sustainability of projects after grant funding ended, a synopsis of overall impact of individual grant projects from the perspective of the grantee, and a financial comparison of hospitals prior to and after termination of grant funding.

Executive Summary

During the 2014 General Assembly, Governor Nathan Deal acknowledged growing concerns regarding the increasing number of rural hospital closures in Georgia. The Rural Hospital Stabilization Committee was appointed to evaluate hospital closures as well as the overall global issue of access to health care in rural areas. The final recommendations of the Committee led to the creation of the Rural Hospital Stabilization (RHS) Grant Program.

During the first three years of the RHS Grant Program, it was noted that no rural hospital had been forced to close due to financial stress. To determine if this may be a result of the grant, the State Office of Rural Health elected to conduct a retrospective evaluation of the benefit and sustainability of programs funded through the grant, and a comparative financial analysis of the participating hospitals prior to and after receiving grant funds.

Specific to benefit and sustainability of grant funded projects, grantees reported that care-coordination projects proved the most impactful, and telemedicine projects proved to be the least impactful overall. Eighty-three percent of the projects were still on-going as of June 2019, and sixty seven percent of those projects were financially sustainable post-grant.

Regarding the financial analysis, overall, the hospitals in phases one through three reflect relatively stable results considering the significant changes they have encountered in the past five years. None of these hospitals have closed during the period under review.

Due to many variables beyond the scope of the grant program, it would be difficult to draw the definitive conclusion that the Rural Hospital Stabilization Grant Program prevented additional hospital closures. However, specific to the intent to "stabilize" hospitals and communities with this initiative, it is reasonable to conclude that this program appears to have met its intended goal.

These hospitals will continue to be evaluated on an annual basis, and future reports will incorporate the results of phase four and phase five hospitals.

Rural Hospital Closures: A National Concern

Concern for the growing number of rural hospital closures across the country has been a frequent topic of national conversations since 2005. Between 2005 and 2017, one hundred eighty five rural hospitals closed, with the highest number of hospital closings per year occuring in years 2013, 2014, and 2015.

While this document primarily focuses on closures between 2005 and 2017, the most recent report from the North Carolina Rural Health Research Program has indicated a record high of nineteen rural hospital closures during the calendar year 2019.

In the 2019 American Hospital Association Rural Report, seven areas were identified as persistent challenges encountered by rural hospitals across the United States. These challenges are: 1) Low Volume, 2) Challenging Payer Mix, 3) Challenging Patient Mix, 4) Geographic Isolation, 5) Workforce Shortages, 6) Limited Access to Essential Services, and 7) Aging Infrastructure and Access to Capital.

With respect to these seven areas, a post mortem review of circumstances associated with the eventual closure of rural hospitals across the country would demonstrate that most, if not all, of these challenges existed for several years prior to the ultimate decision to shutter the doors.

There is no simple solution to this crisis. It is apparent that rural communities should not be abandoned and left to deal with the fall-out of rural hospital closures on an individual basis.

The 2019 American Hospital Association Rural Report summarized the need to address this issue as a group, as quoted below from the *Conclusion* of their report:

> *Although rural hospitals have long faced unique circumstances that can complicate health improvement efforts, more recent and emergent challenges are exacerbating their financial instability – and by extension, the economic health of their communities. Individually, these are complex, multifaceted challenges. Taken together, they are immense, requiring policymakers, stakeholders and communities to work together, innovate and embrace value-based approaches to improving health in rural communities.*
>
> *The federal government must play a principal role by updating policies and investing new resources in rural communities. A complete listing of AHA policy priorities and recommendations for America's rural hospitals and communities is available in the 2019 Rural Advocacy Agenda, 2019 Advocacy Agenda and the Task Force on Ensuring Access in Vulnerable Communities Report; all are available at www.aha.org.*

Rural Hospital Closures in Georgia

Notable concern about rural hospital closures in Georgia actually began in 2001 when two rural hospitals were forced to close due to financial stress. As the issue with rural hospital closures began to generate conversations across the country, another rural hospital in Georgia was forced to close in 2008.

When state level conversations began in 2014, the Department of Community Health recognized this issue was not a new problem, but had reached a point of great concern. Between 2010 and 2014, Georgia was leading the country in the number of rural hospital closures as four Critical Access Hospitals closed within a twelve month period.

Hospital Closures in Georgia

Hospital	Location in Georgia	Type	Year Closed
Hancock Memorial Hospital	Sparta	Rural	2001
Dooly County Hospital	Vienna	Rural	2001
Taylor Telfair Regional Hospital	McRae	CAH	2008
Calhoun Memorial Hospital	Arlington	CAH	2013
Stewart Webster Hospital	Richland	CAH	2013
*Charlton Memorial Hospital	Folkston	CAH	2013
Lower Oconee Community Hospital	Glenwood	CAH	2014
*Charlton Memorial Hospital	Folkston	CAH	2014
North Georgia Medical Center	Ellijay	PPS	2016
Chestatee	Dahlonega	PPS	2018

**Charlton Memorial Hospital originally closed in 2013. In an effort to evaluate all possible options for re-opening the hospital before losing the Certificate of Need, the hospital re-opened for two days in 2014. No viable options were presented and the hospital was permanently shuttered.*

The Rural Hospital Stabilization Committee

The Rural Hospital Stabilization Committee was ultimately formed to evaluate the global issue of access to health care in rural areas.

During the 2014 General Assembly, Governor Nathan Deal acknowledged the increasing concerns regarding the financially fragile status of rural hospitals and the recent closure of four Critical Access Hospitals. Leadership with the Georgia Department of Community Health met with Senator David Lucas and House Representative Terry England to discuss substative first steps that could be taken. Toward the end of the Legislative Session, Governor Deal presented a three part initiative to the Rural Caucus of the General Assembly:

Part 1 - Delegate to Department of Community Health Commissioner Clyde Reese the responsibility of naming a point-person for the initiative.

Part 2 - Identify the Rural Hospital Stabilization Committee Members.

Part 3 – Allow rural hospitals within certain parameters to step down and offer a lower level of services.

Selection of a Point of Contact

In response to this initiative, Commissioner Reese appointed Charles Owens, Executive Director of the State Office of Rural Health as the designated point of contact to organize Committee meetings, as well as collect, compile, and report information to and from the Committee as needed.

Identify the Rural Hospital Stabilization Committee Members

Sixteen very experienced and diverse individuals were selected to participate as the Rural Hospital Stabilization Committee, with Representative Terry England and Senator David Lucas serving as Co-Chairs of the Committee.

Original Members of the Rural Hospital Stabilization Committee

Rep. Terry England, *Committee Co-chair*	Georgia House of Representatives
Sen. David Lucas, *Committee Co-chair*	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
Angela Highbaugh-Battle, MD	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
Thomas Fitzgerald, MD	Tanner Medical Center, Emergency Medicine
Ronnie Rollins	Community Health Systems
David Sanders	Fannin Regional Hospital
Jeffrey Harris, MD	OB-GYN

Allow a Lower Level of Service

In an effort to provide an alternative for rural hospitals considering closure (or those that had closed within the last twelve months) the Department of Community Health began discussions to allow hospitals meeting specific criteria the option of stepping down and offering a lower level of service to their communities. Currently, two types of authorizations are required to operate as a health care facility in Georgia:

1. planning authorization through the Certificate of Need program
2. licensure component

The Department of Community Health administers both through the Healthcare Facility Regulation Division.

For the purpose of state licensure, all hospitals are governed by Georgia law and Healthcare Facility Regulation's Rules and Regulations for Hospitals 111-8-40. Discussion specific to revising the rules began during the Legislative Session and DCH was able to move quickly through the process. This administrative rule was adopted and promulgated allowing the option for a hospital to offer a lower level of service referred to as a *Rural Freestanding Emergency Department.* Revised HFR Rule 11-8-40-.02 became effective May 2014.

Timeline for Revised Hospital Rules

March 24, 2014	DCH Board Approved Initial Adoption
April 15, 2014	Public Hearing and Comments
April 29, 2014	DCH Board Approved Final Adoption
May 19, 2014	Rules Became Effective

The Department of Community Health planned an aggressive schedule for Committee meetings between June and December of 2014. Meeting agendas and recordings of each of the meetings in the table below can be located on the SORH page of the DCH website at https://dch.georgia.gov/archive-rural-hospital-stabilization-committee.

Rural Hospital Stabilization Committee Meeting Dates and Locations

Date	Site	City
June 9, 2014	Department of Community Health	Atlanta
August 25, 2014	State Office of Rural Health	Cordele
November 20, 2014	Ty Cobb Regional Medical Center	Lavonia
December 5, 2014	Department of Community Health	Atlanta

Final Report to the Governor's Office

The full report from the Rural Hospital Stabilization Committee was presented to Governor Deal in the February 23, 2015 *Final Report to the Governor.*

As quoted in an excerpt from the report:

> *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."*
>
> *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.*

Within the final report, the Committee provided a three-part recommendation to the Governor. These recommendations were:

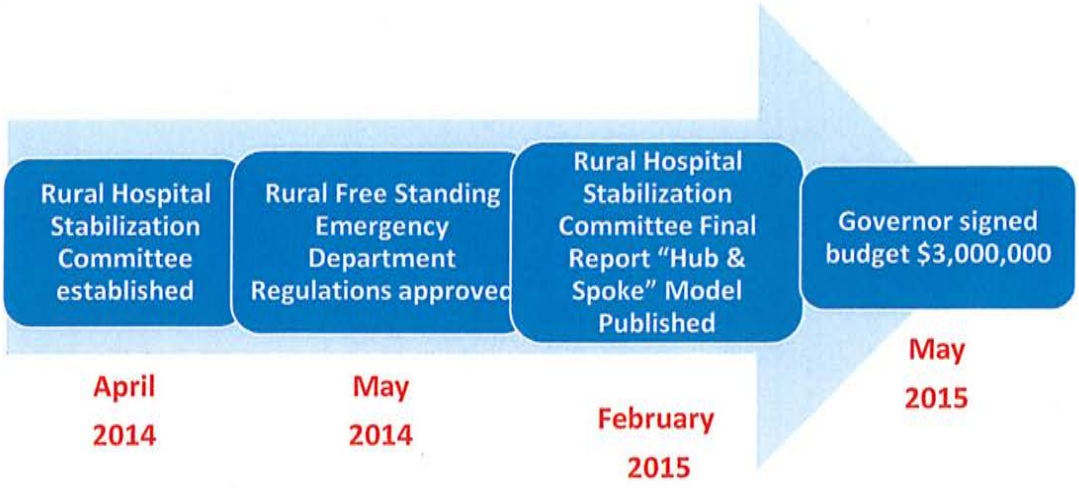
1. Implementation of a grant funded Rural Hospital Stabilization Pilot Program utilizing a "Hub and Spoke" model approach to four designated hospital recipients

2. Legislative support to maintain and protect the fragile rural hospital infrastructure

3. Budgetary support of $3,000,000 to be appropriated to the Georgia Department of Community Health, State Office of Rural Health to grant the funding to the four designated hospital recipients and oversee the Rural Hospital Pilot Program

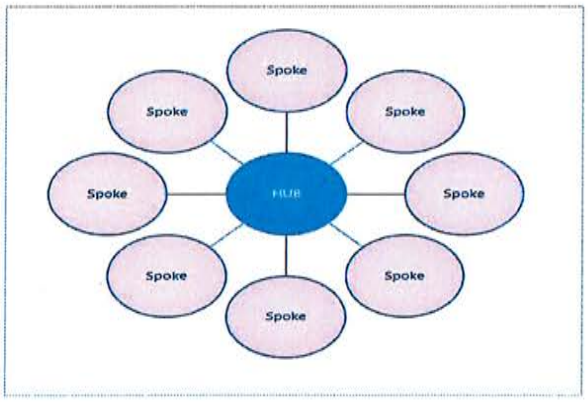
As a result of these recommendations, Governor Deal allocated $3,000,000 in state funding for Fiscal Year 2016 to support the Rural Hospital Stabilization Grant Pilot Program.

A timeline for the Rural Hospital Stabilization Committee progress is noted in the graphic below:



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.

Through the "Hub and Spoke" model, grantee hospitals will function as the "Hub" for the project. The "spokes" would include other local health care partners and stakeholders in each respective community, to include but not limited to, tertiary hospitals, physicians, nursing homes, public safety agencies, public health departments, home health and behavioral health facilities, educational institutions, local businesses and industry, and faith-based partners.



The *Press Release* and complete *Rural Hospital Stabilization Committee Final Report to the Governor* can be located in *Appendix A* and *Appendix B* of this document.

The Rural Hospital Stablization Grant Program

The State Office of Rural Health was designated as the oversight entity for the proposed pilot program implementation and monitoring. Prior to implementation of the pilot program, the structure and performance metrics had to be determined to ensure thorough and consistent management, documentation and evaluation during the pilot phase.

To ensure adherence to the Hub and Spoke model framework, Grantees would be required to assemble community stakeholder groups to identify the root causes of their communities' health issues and develop recommendations for community action.

Projects selected as a result of community engagement efforts had to depict a design that would ensure patients are provided with the appropriate level of care in a timely manner, and at the most appropriate facility equipped to meet their medical needs.

Selecting Program Goals and Performance Measures

The four pilot hospitals were brought together on August 14, 2015 to discuss their strategies for meeting the goals set forth in the recommendations report (see *Rural Hospital Stabilization Grantees* section of this report for a listing of the pilot program grant recipients). Using the Hub and Spoke model framework, the hospital leaders started a brainstorming session with the premise, "What are we trying to accomplish?" and worked through pertinent data regarding financial and operational performance, market share, federal penalty program performance, and the patient perception of care.

To support the *"Right Care, at the Right Time, and in the Right Setting"* philosophy of the program, four overarching goals were established:

- Increase market share
- Reduce potentially preventable readmissions
- Reduce non-emergency care and "super users" served in the Emergency Department
- Increase access to primary care

During the funding period, grantees would be required to provide quarterly progress reports to the RHSGP Program Manager at SORH. Reporting would include data collected quarterly specific to a pre-determined set of core performance measures. Therefore, the performance metrics for the program were decided as follows:

Metric	*Source for Data Collection*
Overall Proxy Measure of Financial Stabilization - Hub Focus	Hospital Financial Statement
Overall Proxy Measure of Financial Stabilization - Community Focus	Hospital Financial Statement
Access to Care - Inappropriate Utilization of Emergency Department Care	Hospital Claims Data
Readmission Reduction – All Cause 30 Day Hospital-Wide Readmissions	Hospital Claims Data
Mental Health – Average Daily Boarding Hours for 1013 Hold	Hospital Claims/Medical Record Review
Out-Migration Inpatient and Outpatient	Hospital Industry Data Institute Analytic Advantage
Improved Fidelity – Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)	Hospital HCAHPS Vendor Report – Question #22 (Willingness to Recommend)

Commitment Funds

The Rural Hospital Stabilization Program Commitment Funds requirement was established as an indicator of each hospital's community level commitment. This Commitment was demonstrated through the collection of funds from the grantee hospital upon grant execution.

A restricted fund source was established so that the community commitment proceeds are dedicated to the Rural Health Stabilization project. This restricted fund source is not subject to lapse and surplus funds are protected from being returned to the treasury.

The commitment amount for the Pilot Program was set at $100,000.00 per community. Authority for the collection of funds from each of the grantees was established on the signature page of the executed Notice of Grant Award Agreement.

Rural Hospital Stabilization Program Continuation of Funding

As annual funding for the program continued each fiscal year beyond the intial pilot effort, the Department of Community Health elected to continue using the original goals and performance measures identified for the pilot project for each subsequent phase of the program.

Commitment funds in the amount of ten percent of grant award continued to be collected from each grantee upon execution of the grant for each new funding cycle.

Rural Hospital Stabilization Grantees

Hospitals selected to participate each year in the Rural Hospital Stabilization (RHS) Program are determined at the legislative level. The Department of Community Health is notified of the selected participants and the Executive Director of the State Office of Rural Health communicates with the Chief Executive Officer (CEO) of each hospital to determine interest in participation in the program. Hospitals may choose to participate or decline the offer.

Participating hospitals for phases one through three of the Rural Hospital Stabilization Grant Program are described below, indicating the phase of participation, funding amount, and the funding period. A description of the hospital and services offered, as well as description of the county in which the hospital is located is also included. A color-coded map denoting the location of each site can be located in *Appendix C* of this document.

Rural Hospital Stabilization Grant Program Sites: Phase 1 (Pilot)

Four Sites Selected • ***Appling Healthcare System*** • ***Crisp Regional Hospital*** • ***Emanuel Medical Center*** • ***Union General Hospital***	***Fiscal Year Funding: 2016*** ***$3,000,000 (annual) award*** ***$750,000 award to each site*** ***Project Period: July 2015 - December 2016***

Appling HealthCare System
163 East Tollison Street
Baxley, Georgia 31513

Opened in 1951, Appling HealthCare System is a non-profit acute care medical facility which continually dedicates its purpose of providing patients with the highest quality of medical care. Appling HealthCare System is licensed for 64 beds (of which 30 are dedicated to the Geriatric Behavioral Health Unit) and offers a variety of technologically advanced and high-quality impatient and outpatient health care services to Appling County.

Appling HealthCare System is located in the city of Baxley, which is the county seat of Appling County. As of the 2010 census, the county's population stood at 18,236 residents, comprised of 8,512 housing units and 4,894 families residing in the county. Appling County has a total of 512 square miles with 507 square miles of land and five square miles of water.

Crisp Regional Hospital
902 7th Street North
Cordele, Georgia 31015

Established in 1952, Crisp Regional Hospital offers Crisp County and surrounding areas high-quality hospital and outpatient care for family and emergency medicine, obstetrics/gynecology and over 20 other specialties. With a Level III trauma center and more than 50 physicians who practice in a high-tech hospitalist environment, Crisp Regional offers a comprehensive network of facilities that include a 143-bed nursing home, retirement home, dialysis facility, home health program, hospice and home care program and rural health clinic.

Crisp Regional Hospital is in the city of Cordele, which is the county seat of Crisp County. According to the 2010 census, the county's population stood at 23,439 residents, comprised of 10,734 housing units and 6,295 families residing in the county. Crisp County has a total of 281 square miles with 273 square miles of land and approximately eight square miles of water.

Emanuel Medical Center
117 Kite Road
Swainsboro, Georgia 30401

Emanuel Medical Center features a healthcare team of over 450 employees, over 40 physicians and provides quality care, close to home, for families in Emanuel County and surrounding communities. The hospital is equipped with 18 patient rooms, all furnished with full bathrooms, telephones and televisions, 15 Senior Behavioral Health private rooms, 49 nursing home beds and eight Critical Care rooms.

Emanuel Medical Center is located in the city of Swainsboro, which is the county seat of Emanuel County. As of the 2010 census, the county's population stood at 22,598 residents, which is comprised of 9,968 housing units and 5,833 families residing in the county. Emanuel County has a total of 690 square miles with 681 square miles of land and approximately nine square miles of water.

Union General Hospital
35 Hospital Road
Blairsville, Georgia 30512

Located in North Georgia, Union General Hospital serves all communities in the North Georgia area with high-quality care. Due to its location, Union General Hospital is in the

unique position of providing a plethora of healthcare needs to citizens in Blairsville and Gainesville, as well as Murphy, North Carolina, Greenville, South Carolina and Chattanooga, Tennessee. From its humble beginnings as a small outpatient clinic that opened in 1959, Union General Hospital has advanced into one of Georgia's most state-of-the-art and technologically advanced hospitals.

Union General Hospital is located in the city of Blairsville, which is the county seat of Union County. As of the 2010 census, the county's population stood at 21,356 residents, comprised of 14,052 housing units and 5,833 families residing in the county. Union County has a total of 329 square miles with 322 square miles of land and seven square miles of water.

Rural Hospital Stabilization Grant Program Sites: Phase 2

Four sites selected; one declined • ***Habersham Medical Center*** • ***Miller County Hospital*** • ***Upson Regional Medical Center***	***Fiscal Year Funding: 2017*** ***$3,000,000 (annual) award*** ***$1,000,000 award to each site*** ***Project Period: September 2016 – June 2018***

Habersham Medical Center
541 Historic Highway 441 North
Demorest, Georgia 30535

Habersham Medical Center is a 53-bed not-for-profit acute care medical facility that prides itself in offering award-winning health care to more than 80,000 residents in Habersham and surrounding counties. Habersham Medical Center employs more than 600 healthcare workers who strive daily to meet and exceed patient expectations.

Habersham Medical Center is located in the city of Demorest. Per the 2010 census, the county's population stood at 43,041 residents with 18,146 housing units and 11,307 families residing in the county. Habersham County has a total of 279 square miles with 277 square miles of land and two square miles of water.

Miller County Hospital
209 North Cuthbert Street
Colquitt, Georgia 39837

Opened in 1957, Miller County Hospital is a 25-bed critical access not-for-profit hospital named by HomeTown Health as "The Hospital of the Year" in both 2000 and 2015.

Miller County Hospital delivers a spectrum of inpatient and outpatient services to the residents of Colquitt and surrounding areas and is dedicated to delivering high-quality health care for Southwest Georgia residents.

Miller County Hospital is located in the city of Colquitt, which is the county seat of Miller County. As of the 2010 census, the county's population stood at 6,125 residents, made up of 2,426 housing units with 1,674 families residing in the county. Miller County has a total of 284 square miles, with 282 square miles of land and two square miles of water.

Upson Regional Medical Center
801 West Gordon Street
Thomaston, Georgia 30286

Upson Regional Medical Center is an acute care hospital that is home to more than 500 employees who daily strive to maintain "the cleanest hospital in the state" by listening to their customers and continually improving based on feedback. Upson Regional Medical Center is constantly adding new services, including cardiology, new technology and new physicians, who strive to offer the highest quality care on a daily basis.

Upson Regional Medical Center is located in the city of Thomaston, which is the county seat of Upson County. As of the 2010 census, the county's population stood at 27,153 residents made up of 12,161 housing units and 7,382 families residing in the county. Upson County has a total of 328 square miles, with 323 square miles of land and approximately five square miles of water.

Rural Hospital Stabilization Grant Program Sites: Phase 3

Twelve sites selected; One declined • *Bacon County Hospital* • *Chatuge Regional Hospital* • *Cook Medical Center* • *Effingham Health System* • *Irwin County Hospital* • *Jasper Memorial Hospital* • *Liberty Regional Medical Center* • *Memorial Hospital & Manor* • *Mitchell County Hospital*	*Fiscal Year Funding: 2018* *$3,000,000 (annual) award* *$250,000 award to each site* *Project Period: July 2017 – June 2018*

• *South Georgia Medical Center-Lanier Campus* • *Washington County Regional Medical Center*	

Bacon County Hospital
302 South Wayne Street
Alma, Georgia 31510

Bacon County Hospital is a 25-bed, acute care general medical-surgical hospital which is part of a medical complex that comprises 11 acres and over 25,000 square feet. Bacon County Hospital prides itself on providing compassionate care matched with up-to-date technology and services to the community of Bacon and surrounding counties.

Bacon County Hospital is located in the city of Alma, which is the county seat of Bacon County. As of the 2010 census, the county's population stood at 11,096 residents, comprised of 4,801 housing units and 2,960 families residing in the county. Bacon County has a total area of 286 square miles, with 259 square miles of land and 27 square miles of water.

Chatuge Regional Hospital
110 South Main Street
Hiawassee, Georgia 30546

Chatuge Regional Hospital is located along Highway 76 North, tucked into the beautiful North Georgia Mountains. An affiliate of Union General Health System, Chatuge Regional Hospital features a state-of-the-art Emergency Center with an air ambulance service providing access to major trauma and cardiac facilities. First named Lee M. Happ Jr. Memorial Hospital, the hospital changed its name to Chatuge Regional Hospital in 1994.

Chatuge Regional Hospital is located in the city of Hiawassee, the county seat for Towns County. According to the 2010 census, Towns County has a population of 10,471 residents with 7,731 housing units and 2,981 families residing in the county. Towns County has a total of 172 square miles, with 167 square miles of land and approximately five square miles of water.

Cook Medical Center
706 North Parrish Avenue
Adel, Georgia 31620

Cook Medical Center, now renamed Southwell Medical, recently moved to a new location as part of the new Cook Medical Plaza. The new 120,000-square-foot facility is fully operational with a rehabilitation department, sleep center, and a full-service laboratory with outpatient surgical services to be offered soon in a variety of specialties. Southwell Medical now also offers an extensive medical imaging department as well.

The hospital is located in the city of Adel, which is the county seat of Cook County. As of the 2010 census, the population stood at 17,212 residents, with 7,287 housing units and 4,594 families residing in the county. Cook County has a total area of 233 square miles with 227 square miles of land and six square miles of water.

Effingham Health System
459 Georgia Highway 119
Springfield, Georgia 31329

Effingham Health System is a Level IV Trauma Center, with state-of-the-art treatment rooms for trauma, stroke, and cardiac patients with a proven track record of providing high-quality advanced trauma life support. Effingham Hospital prides itself on having an entire team of residency-trained, board certified Emergency Medicine Specialists prepared to treat all patients, from newborn through geriatric. The nursing staff of Effingham Hospital is Trauma Nursing Core Certified, all with training in the rapid discovery of life-threatening injuries and comprehensive patient assessment.

Effingham Health System is located in the city of Springfield, which is the county seat of Effingham County. As of the 2010 census, the county's population stood at 52,250, with 19,884 housing units and 14,139 families residing in the county. Effingham County has a total area of 483 square miles, with 478 square miles of land and five square miles of water.

Irwin County Hospital
710 North Irwin Avenue
Ocilla, Georgia 31774

Irwin County Hospital is a 34-bed acute care facility offering a wide range of medical services to Irwin and surrounding counties. Governed by a seven-member Board of Directors, Irwin County Hospital is a non-profit corporation backed by a 66 member staff

who is committed to promoting healthier lives for patients by emphasizing core values such as quality, teamwork and a patient-centered perspective. Irwin County Hospital's emergency department handles more than 5,000 visits annually while its Birthing Place delivers over 400 babies a year. Additionally, the on-site nursing home maintains full capacity.

Irwin County Hospital is located in the city of Ocilla, which is the county seat of Irwin County. As of the 2010 census, the county's population stood at 9,538 residents, with 4,033 housing units and 2,475 families residing in the county. Irwin County has a total of 363 square miles with 354 miles of land and eight square miles of water.

Jasper Memorial Hospital
898 College Street
Monticello, Georgia 31064

Designated in January 2000 as a Critical Access Hospital, Jasper Memorial Hospital is a licensed, 17-acute-care bed facility, with a 24-hour emergency room that offers high-quality care provided by contract physicians staffing through Schumacher Clinical Partners. Equipped with advanced cardiac monitoring, Jasper Memorial Hospital offers outpatient and ambulatory care services and prides itself on having an average wait time of less than 30 minutes for all emergency room services.

Jasper Memorial Hospital is located in the city of Monticello which is the county seat of Jasper County. As of the 2010 census, the county's population stood at 13,900 residents, with 6,153 housing units and 3,779 families residing in the county. Jasper County has a total of 373 square miles, with 368 square miles of land and approximately five square miles of water.

Liberty Regional Medical Center
462 Elma G. Miles Parkway
Hinesville, Georgia 31313

Opened in 1961 as Liberty Memorial Hospital, Liberty Regional Medical Center is a 28-bed acute care hospital serving over 50,000 patients a year in Liberty County and surrounding areas. Liberty Regional Medical Center prides itself in its use of advanced technology and teams of top-notch physicians and nurses backed by a caring staff of other clinical and non-clinical personnel.

Liberty Regional Medical Center is located in the city of Hinesville, which is the county seat of Liberty County. As of the 2010 census, the county's population stood at 63,453 residents, with 26,731 housing units and 16,566 families residing in the county. Liberty County has a total of 603 square miles with 490 square miles of land and 113 square miles of water.

Memorial Hospital & Manor
1500 East Shotwell Street
Bainbridge, Georgia 39819

Opened in 1960, Memorial Hospital & Manor employs over 450 health care personnel and offers a wide range of health care services to Bainbridge and the surrounding areas. An 80-bed acute care hospital, Memorial Hospital & Manor has expanded its facilities throughout the years to accommodate needs of a growing community, including opening Memorial Manor, a 67-bed Long-Term Care Facility, in 1972 followed by Manor II in 1979 which added another 40 beds to the nursing home. Memorial Hospital & Manor also offers an intensive care unit and maintains continuous renovations of patient rooms in the hospital as well as resident rooms in the Manor. Plans are currently underway for a Same Day Surgery center at the hospital, which will expand the facilities for Radiology, Laboratory and other various departments.

Memorial Hospital & Manor is located in the city of Bainbridge, which is the county seat of Decatur County. As of the 2010 census, the county's population stood at 27,842, which is made up of 12,125 housing units and 7,255 families residing in the county. Decatur County has a total of 623 square miles with 597 square miles of land and 26 square miles of water.

Mitchell County Hospital
90 East Stephens Street
Camilla, Georgia 31730

Mitchell County Hospital is a 25-bed critical access hospital that offers personalized inpatient and outpatient services to Mitchell County residents and surrounding areas. As part of the Archbold network, Mitchell County Hospital is a critical part of a system with a dedicated staff regarded for high-quality, compassionate medical care.

Mitchell County Hospital is located in the city of Camilla, which is the county seat of Mitchell County. As of the 2010 census, the county's population stood at 23,498

residents with 8,996 housing units and 5,761 families residing in the county. Mitchell County has a total of 514 square miles, with 512 square miles of land and approximately two square miles of water.

South Georgia Medical Center Lanier Campus
116 West Thigpen Avenue
Lakeland, Georgia 31635

South Georgia Medical Center (SGMC)-Lanier Campus, formally the Louis Smith Memorial Hospital, operates as a 25-bed critical access hospital which provides acute and sub-acute care to Lakeland and surrounding communities. With the distinction of being the largest employer and economic generator in the Lakeland community, SGMC Lanier Campus is proud to offer a variety of quality services with the personal touch of a small community hospital including programs for preventive and wellness medicine, acute and chronic disease management, immunizations, health coaching and minor emergencies.

South Georgia Medical Center-Lanier Campus is located in the city of Lakeland, which is the county seat for Lanier County. As of the 2010 census, the county's population stood at 10,078, which consisted of 4,249 housing units and 2,626 families residing in the county. Lanier County has a total of 200 square miles with 185 square miles of land and 15 square miles of water.

Washington County Regional Medical Center
610 Sparta Road
Sandersville, Georgia 31082

Opened in 1961, Washington County Regional Medical Center (WCRMC) is a licensed general acute care 56-bed hospital which provides a scope of services including comprehensive inpatient and outpatient surgery, a 24-hour physician staffed emergency room as well as an Imaging Center, Rehabilitation Services and Ambulance Services. WCRMC serves patients from five counties and it committed to providing their patients with the highest quality care and play an instrumental role in the community's health and happiness.

Washington County Regional Medical Center is located in the city of Sandersville, which is the county seat of Washington County. As of the 2010 census, the county's population stood at 21,187 with 9,047 housing units and 5,269 families residing in the county.

Washington County has a total of 684 square miles with 678 square miles of land and six square miles of water.

Phase Four and Phase Five of the Rural Hospital Stabilization Grant Program

Two additional phases of the Rural Hospital Grant Program have been funded in fiscal year 2019 and fiscal year 2020.

Rural Hospital Stabilization Grant Program Sites: Phase Four

Four Sites Selected • *Burke Medical Center* • *Clinch County Hospital* • *Elbert Memorial Hospital* • *Evans Memorial Hospital*	*Fiscal Year Funding: 2019* *$3,000,000 (annual) award* *$750,000 award to each site* *Project Period: July 2018 – June 2019*

Rural Hospital Stabilization Grant Program Sites: Phase Five

Ten Sites Selected; Two Declined • *Candler County Hospital* • *Dodge County Hospital* • *Dorminy Medical Center* • *Jeff Davis Hospital* • *Jefferson Hospital* • *Stephens County Hospital* • *Wayne Memorial Hospital* • *Wills Memorial Hospital*	*Fiscal Year Funding: 2020* *$3,000,000 (annual) award* *$300,000 award to each site* *Project Period: September 2019 – August 2020*

A detailed evaluation using the same methodology described in the next section of this report will be completed for Phase Four and Phase Five Grantees and will be provided as an addendum to this document in December 2021.

Where Are They Now? A Retrospective Evaluation of Outcomes for the Rural Hospital Stabilization Grant Program Phases One Through Three

The "Hub and Spoke" model, described previously in this report, is the foundation for the Rural Hospital Stabilization Grant. Grant deliverables require Hospital Grantees to select projects that will support the *"Right Care, at the Right Time, and in the Right Setting"* philosophy of the program. Grantees are also expected to design the projects with input from the community obtained through community engagement meetings, and develop budgets appropriate for project needs.

Eighteen hospitals participated in phases one through three the RHS Grant Program. The number of projects per site was left to the descretion of the grantee and guided by the amount of the funding award.

In April 2019, the State Office of Rural Health began compilation of a comprehensive report to evaluate the RHS Grant Program outcomes for grantee hospitals that had participated in phases one through three.

The purpose of the evaluation was to determine the overall benefit of the grant to each hospital and the surrounding community, and the sustainability of the projects funded through the program.

As a requirement of the grant, each site had designated a Project Manager responsible for oversight of the grant and providing quarterly and final reports and invoices to the State Office of Rural Health. The Chief Executive Officer, the Chief Financial Officer, and the Project Manager at each site were asked to partner together to provide the requested information for the report.

Methodology

A comprehensive questionnaire was designed to collect qualitative and quantitative data specific to:

- benefit, outcomes, and sustainability of the projects selected by each grantee
- hospital financial, operational, and statistical data prior to and after funding period

The questionnaire, referred to as the *"Rural Hospital Stabilization Grant Program: Where Are They Now?"* document, provided instructions for completion of the survey and a deadline for submission of the completed document to SORH.

The questionnaire was divided into four sections:

1. General Grantee Information
2. Project Specific Details
3. Overall Impression and Benefit of RHSGP
4. Financial Data Collection

The questionnaire was distributed to the CEO at each Grantee Hospital by way of electronic mail communication.

Section Two of the questionnaire required the Grantee to respond to a series of questions specific to each project that had been selected and funded through the RHS Grant. The number of projects chosen by each Grantee varied, however the questionnaire was not considered to be properly completed without including the requested information specific to *each* project funded.

Specific to Section Four of the questionnaire, SORH obtained written permission from the Chief Executive Officer or the Chief Financial Officer at each Grantee Hospital to allow Draffin Tucker, LLP, to utilize and summarize the hospital's financial data from audited financial statements and other grant-specific financial information provided for this report.

A copy of the questionnaire template used for the collection of this information can be located in *Appendix D* of this document.

Findings: Project Manager

The RHS Grant allowed Grantee Hospitals to select a Project Manager from within or hire from outside the organization. Grant funds could be used as salary support for a currently existing employee or fund a portion, or all, of a new employee's salary.

Questions specific to the status of the Project Manager

Question	Findings/Results
Was the Project Manager selected from staff already employed with your facility or hired from outside of your organization?	**72%** of Project Managers were already employed by the Grantee Hospital **28%** of Project Managers were hired specifically to manage the grant
Is the Project Manager still an employee of your organization? If so, in what capacity?	**78%** of Project Managers were still employed by the hospital as of June 2019

Specific to the Project Managers' employment status after termination of the grant, those Project Managers who were employed with the organization prior to receiving the grant continued in their same role after grant termination. Those Project Managers who were hired from outside the organization were either placed into an open position within the organization, or a position was created/modified, most often in a community outreach or marketing role.

Findings: Specific Projects Funded

Section Two of the questionnaire required that each respondent complete an "Attachment A" document (see *Appendix D*) for each individual project that had been selected by the Hospital Grantee and funded through the RHS Grant. The number of projects selected by each site varied with some hospitals selecting only one project and some hospitals selecting as many as six projects.

For the purpose of data collection, the following information is specific to the combined number of projects for all eighteen sites. Collectively, the projects were grouped based on similarity of design allowing an opportunity to evaluate the most commonly selected projects as well as the most unique.

A combined total of 52 projects were funded through the grant during this evaluation period. The categories in which the projects were grouped are listed below:

Grouping of Projects	Number of Projects
Telehealth/Telemedicine	13
Community Paramedicine	5
Emergency Department Renovations	3
Upgrades	2
New Service Lines	9
New Designations	4
Mental/Behavioral Health	5
Chronic Condition/Care Coordination	7
Unique/Miscellaneous	4

The top four most commonly selected groups of projects are detailed below:

1. *Telehealth/Telemedicine*

   The most commonly selected projects were those involving telemedicine as a primary component. These projects included telemedicine utilized within school-based clinics, behavioral health facilities and nursing homes. Two projects included telemedicine

utilization in the field to enhance triage and destination selection for patients presenting with signs of a stroke, and one project was specific to consultation with a Nephrologist, allowing patients to report to their local hospital for follow up evaluation and treatment instead of traveling several hours to a facility in an urban area.

2. *Community Paramedicine and Chronic Condition/Care Coordination*

Care coordination projects were the second most commonly selected. For the purpose of the data collected for this report, "care coordination" included a variety of methods in which patient care was managed in an effort to ensure the *"right care, at the right time, and in the right setting"*. Therefore, two groupings have been combined for this report.

Five of the projects were provided through an arrangement with the local Emergency Medical Service to provide care to the patient in their home environment to reduce unnecessary 9-1-1 calls and emergency department visits, as well as reduce the number of hospital readmissions within a 30-day period. Other types of care coordination projects included Patient Care Coordinators, in which hospital staff worked with patients after discharge to ensure discharge instructions were followed and follow-up appointments were met. Other projects included hospital emergency department triage to re-direct non-urgent/non-emergency patients to walk-in clinics, Nursing Home rounds provided by advanced practice providers to prevent unnecessary transports to the emergency department, and the utilization of Community Health Workers and Community Health Coaches.

3. *New Services*

Funding from the grant program was used to create new services offered by Hospital Grantees. These new services included the construction of new facilities such as walk-in/non-emergency and charity care clinics (some included expanded hours of operation), remodeling existing structures to offer Geriatric Psychiatric in-patient facilities, occupational medicine, and weight loss/wellness programs. One Hospital Grantee used funding to re-open the Intensive Care Unit within the hospital, which had been closed for several years.

4. *Mental/Behavioral Health*

The fourth most commonly selected type of projects were those designed to provide or enhance mental and behavioral health care within the community. All Grantee Hospitals acknowledged these projects led to a strengthened relationship with the local Community Service Board during the design of the project. Projects included the provision of both out-patient and in-patient services (in some cases where none had existed previously). Projects

with a specific patient-population focus included services for senior adults (age 55 and older), adolescent/youth programs, or programs designed specifically to address opioid addiction.

The questionnaire also included questions specific to the benefit and sustainability of the projects.

Project Specific Details

Question	Findings/Results
Is this project still on-going?	**83%** of original projects were still on-going as of June 2019
Was/Is this project financially sustainable after termination of the grant?	**67%** of original projects were considered financially sustainable post-grant
Would your hospital have selected/funded this project if the RHSGP had not been available?	**20%** of the projects would have been done at some (later) point
Did this project lead to relationship development with other partners and subsequent additional projects?	**75%** of the projects led to project-specific new relationships

As indicated above, the RHS Grant Program allowed twenty percent of Grantee Hospitals the opportunity to implement programs which had been identified for future efforts, as well as allowing eighty percent of Hospital Grantees the opportunity to explore new ideas and initiatives.

With Hospital Grantees reporting that eighty-three percent of the projects were still on-going, and sixty seven percent of those projects were financially sustainable post-grant, it is evident that communities have benefited from the effort to design programs to address specific community needs.

Overall Impression and Benefit of the Rural Hospital Stabilization Grant Program

Section three of the questionnaire was designed to collect information specific to the RHS Grant Program as a whole and determine which projects Hospital Grantees felt had the most and least impact.

Specific to the overall benefit of the program, the following questions were asked:

Question	Findings/Results
Based on your experience with the RHSGP, do you feel this program met its intended objective to ensure patients receive the *"right care at the right time in the right setting"*?	**100%** (*18/18*) of recipients felt the RHSG Program did meet the objectives.
Did your facility seek other grants/funding sources to expand or sustain any work begun through the RHSGP?	**44%** (*8/18*) of recipients did choose to seek additional funding to continue or strengthen projects begun with RHSGP funds.
Based on your experience with the RHSGP, if given the opportunity to start your project over, would you have made the same decisions, choices, done anything differently, etc.?	**83%** (*15/18*) of recipients would have made different decisions or choices about some aspect of their projects or selected an entirely different project all together. **17%** (*3/18*) of recipients would have made no changes at all to decisions or projects.
Based on your experience with the RHSGP, what suggestions or advice would you offer to a new RHS grant recipient?	See *Appendix E* for a complete list of responses

Hospital Grantees who indicated they would have made different decisions or choices about projects explained their positions in a commentary format. Most respondents felt they chose too many, or too ambitious projects specific to the time constraints of the funding period. Other comments reflected a desire to have been more selective when choosing vendors for the projects. Clarification for this question is reflected in many of the suggestions or advice that was collected and reported in *Appendix E.*

Specific to the overall impact of the program, two questions were asked:

Question #1. "Overall, what do you feel was the <u>most</u> beneficial or impactful component of your projects? Please explain."

Specific to the most beneficial or impactful component, overwhelmingly, respondents indicated that community engagement and stakeholder collaboration was the most beneficial result of the program. Hospital Grantees indicated that, due to the "Hub and Spoke" model design, new and improved relationships with their communities had resulted in an increase in utilization of services, improved perception and reputation of the hospital, and a rebuilding of "faith and trust" in the providers and system in general.

Specific to the most beneficial group of projects funded through the grant, respondents cited Community Paramedicine/Care Coordination projects as having the most positive impact for patients. Commentary provided with the responses indicated that working directly with patients in a one-on-one capacity resulted in improved patient compliance with discharge instructions, increased follow up with primary care providers, improved ability for self-care, increased utilization of other resources available to the patient, and decreased dependency on emergency services, both fixed and mobile.

Question #2: "Overall, what do you feel was the <u>least</u> beneficial or impactful component of your projects? Please explain."

Interestingly, while Telemedicine/Telehealth projects were the most commonly selected, Telemedicine was also identified as the least beneficial or impactful project funded through the program.

Commentary provided by respondents indicated that, while telemedicine had been identified as one of the most promising services for the provision of health care in rural areas, providers and patients were slow to embrace the concept. Also, establishing relationships with specialists could be time consuming and costly in the initial phases of building telehealth programs between rural and urban providers.

Another barrier was described as the "failure of a 360-degree commitment". Telemedicine requires a two-party agreement between those who will present patients to the provider, and the provider who treats the patients presented. For both sides of the relationship to work effectively, guidelines and processes must be established, equipment must be purchased and maintained, and presenters and providers must be trained and proficient in the use of the equipment. Some respondents indicated that a *less-than-enthusiastic* attitude demonstrated by either one of the required parties resulted in failure of the program. Other challenges were described as frequent turn-over by trained staff participating in the program without proper training for new staff, and a lack of overall understanding of the technology.

Findings: Financial Analysis

Section Four of the questionnaire was completed by Draffin Tucker, LLP. As previously detailed in this report, permission to access hospital financial records was obtained from each Grantee Hospital prior to beginning the analysis.

Methodology

Financial, operational, and statistical data was gathered from all of the hospitals in phases one through three. This data was obtained from audited financial statements, cost reports, and other sources provided by the hospitals. The individual hospital data was summarized to calculate and present financial ratios, indicators, and other information.

The most recent five years of available data is presented with reporting to the closest corresponding fiscal year. All hospital data was presented without consideration for the various start dates of the three phases. For reference, start dates and number of hospitals for the various phases are as follows:

- Phase One – July 2015 – four hospitals
- Phase Two – September 2016 – three hospitals
- Phase Three – October 2017 – eleven hospitals

The most recent fiscal year data was utilized if any of the years were incomplete for an individual hospital. For example, if *Hospital X's* 2018 audited financial statements were not completed, then *Hospital X's* 2017 audited financial statements would be used for 2017 and 2018 without any adjustments.

Certain individual hospital data elements were excluded if the data element was not consistently prepared. This reflects the practice where some hospitals are reported as departments and do not prepare individual stand-alone balance sheets separate from the overall multi-hospital system consolidated balance sheets. Certain data elements from two individual hospitals was excluded as a result.

Comparative ratios are presented where applicable and are from the 2019 Almanac of Hospital Financial and Operating Indicators (the Almanac) published by Optum360. The ratios reflected in this report primarily reflects 2017 data from Medicare Cost Report filings as published in the Almanac. Almanac ratios for specific categories include:

- Georgia – average of all Georgia hospitals
- National Rural – average of rural hospitals with revenues less than $90 million

As applicable, each ratio presented will include several key pieces of information:

- Ratio Type
- Desired Trend
- Definition
- Formula

Overall Summary Findings

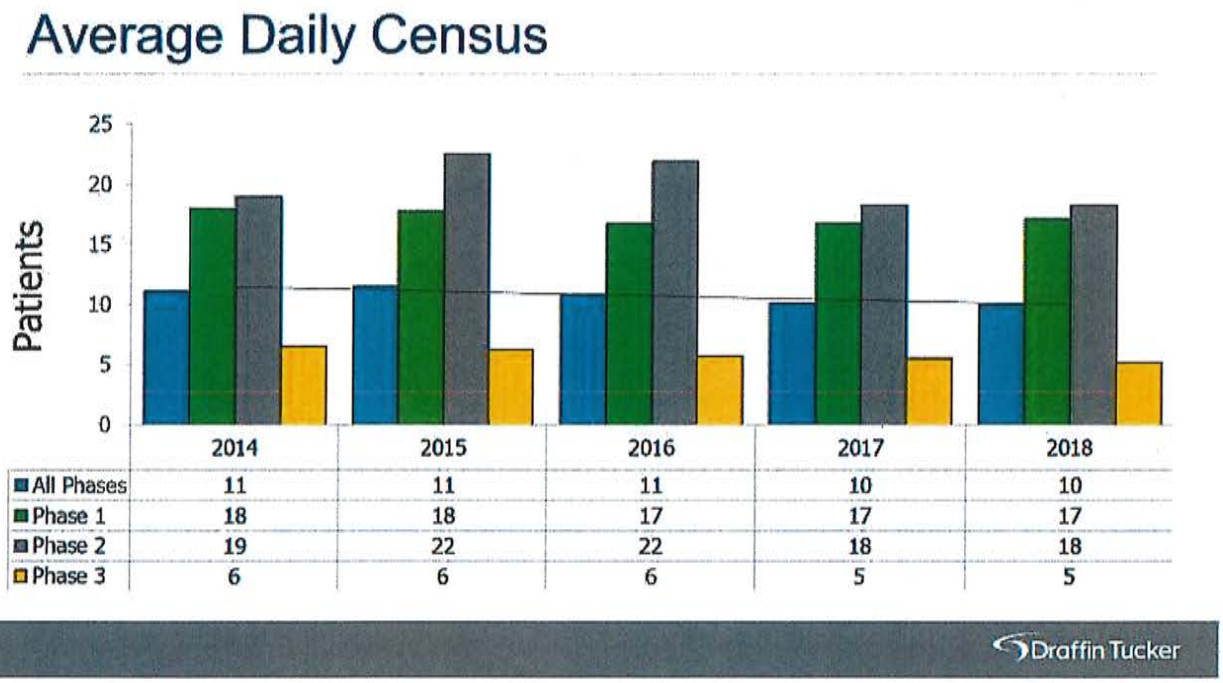
Over the past five years, the hospitals in these first three phases have faced a variety of factors including changing or declining demographics, varying patient preferences, shifts in service patterns from inpatient to outpatient, introduction of new reimbursement mechanisms and models, increasing salary and other costs, and adjusting regulatory or policy impacts. The hospitals are working to address these challenges and adapt to this changing health care environment. Hospitals are compelled to grow revenue to offset increasing expenses, develop new service lines, reduce costs, and implement other operational and financial actions to keep the hospitals' doors open and continue to serve the community.

Overall, the hospitals in Phases One through Three reflect relatively stable results considering the significant changes they have encountered in the past five years. None of these hospitals have closed during the period under review. These hospitals will continue to be evaluated on an annual basis, and future reports will incorporate the results of Phase Four and Phase Five hospitals.

Detailed Analysis

Average Daily Census

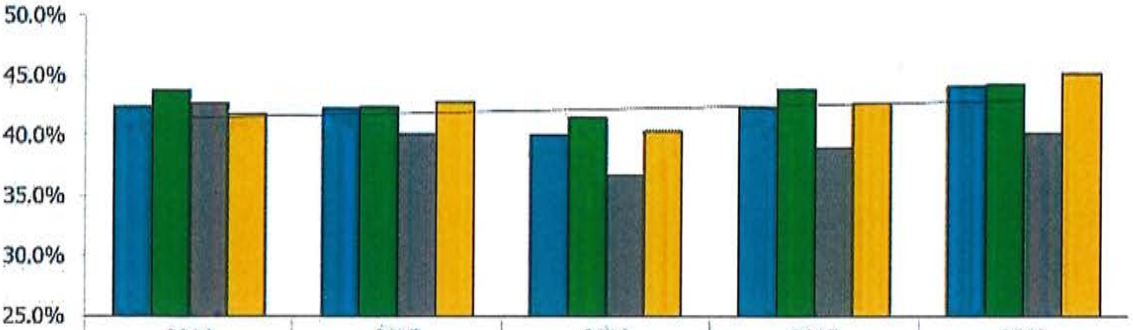
- Ratio Type - Volume
- Desired Trend - Increasing
- Definition – Measures the average number of adult and pediatric inpatient days over a fiscal year. Excludes swingbed and nursery days.
- Formula – Total Adults and Pediatrics Inpatient Days / 365



As reflected in the data, the number of patients reported as inpatient is not a large number for all phases or the individual phases on average for the year. These numbers will fluctuate based on surgical cases, flu season, or other reasons, and the hospital will have to adjust its staffing, medical supplies, and other items to meet the varying demand for services. The trend for these five years reflect an overall decrease in average daily census from 2014 to 2018.

Patient Mix – Inpatient Days – Payer Percentage and Days

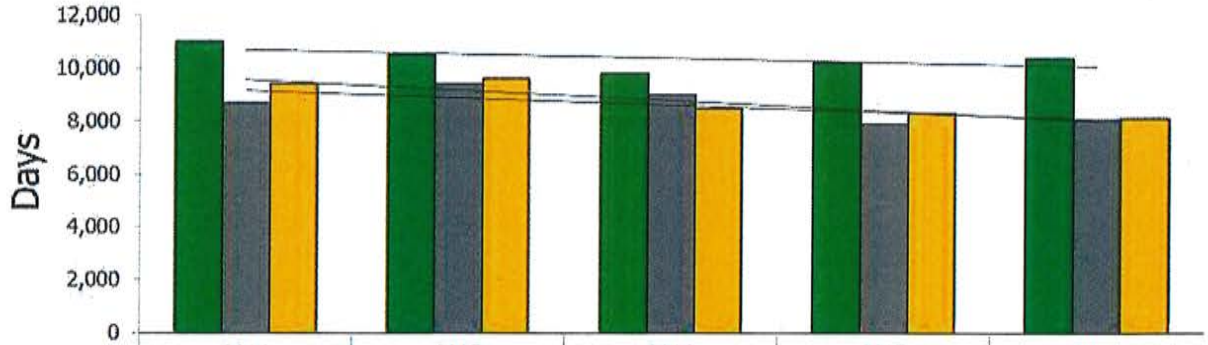
Patient Mix – I/P Days – Medicare %



	2014	2015	2016	2017	2018
All Phases	42.3%	42.2%	40.0%	42.3%	44.1%
Phase 1	43.7%	42.4%	41.5%	43.8%	44.2%
Phase 2	42.7%	40.1%	36.7%	39.0%	40.2%
Phase 3	41.7%	42.8%	40.4%	42.7%	45.2%

Draffin Tucker

Patient Mix – I/P Days – Medicare Days

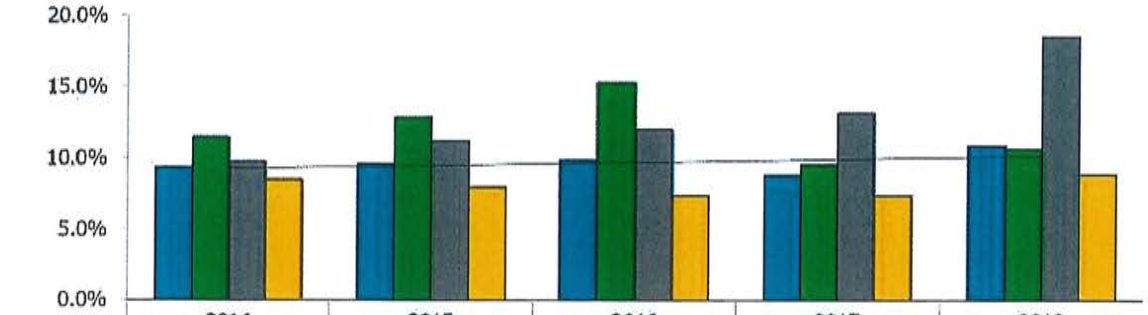


	2014	2015	2016	2017	2018
Phase 1	11,008	10,515	9,809	10,209	10,359
Phase 2	8,668	9,392	9,006	7,899	8,035
Phase 3	9,388	9,587	8,471	8,297	8,080

Draffin Tucker

For Medicare, the inpatient days mix is increasing from 42% to 44%, but the actual patient days declined 6% for Phase One, 7% for Phase Two, and 14% for Phase Three.

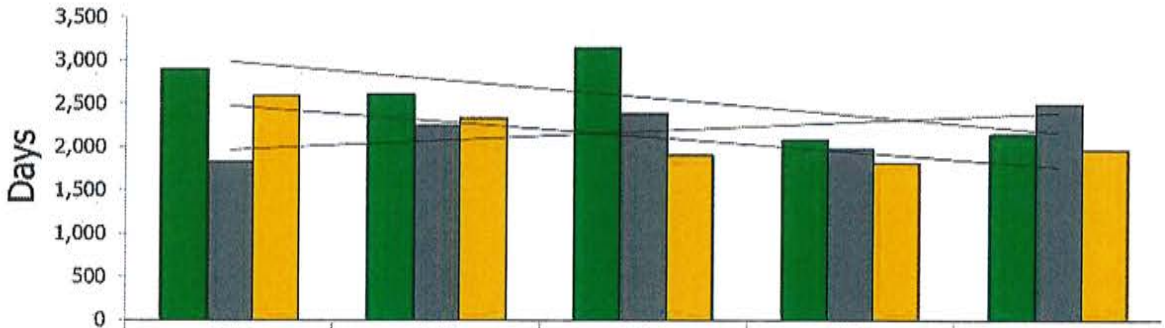
Patient Mix – I/P Days – Medicaid %



	2014	2015	2016	2017	2018
All Phases	9.3%	9.6%	9.9%	8.8%	10.9%
Phase 1	11.4%	12.8%	15.3%	9.5%	10.6%
Phase 2	9.8%	11.2%	12.0%	13.2%	18.5%
Phase 3	8.4%	7.9%	7.3%	7.3%	8.8%

Draffin Tucker

Patient Mix – I/P Days – Medicaid Days

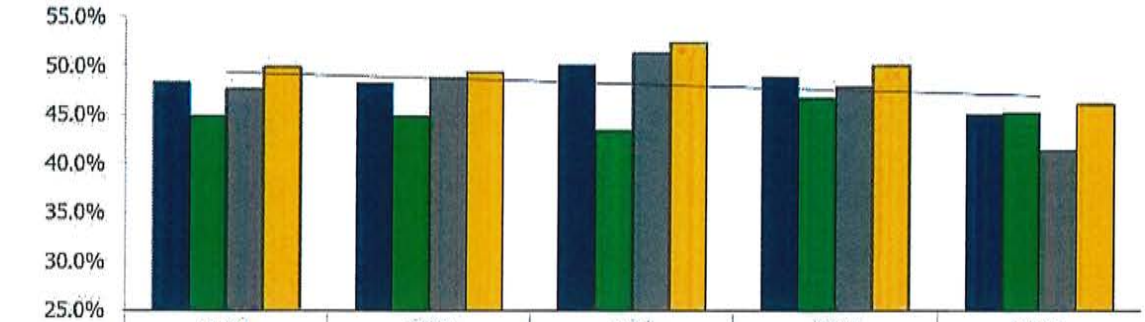


	2014	2015	2016	2017	2018
Phase 1	2,894	2,607	3,138	2,077	2,137
Phase 2	1,825	2,243	2,376	1,973	2,485
Phase 3	2,588	2,330	1,904	1,808	1,959

Draffin Tucker

For Medicaid, the overall inpatient days mix is increasing from 9% to 11%. However, inpatient days mix stayed relatively consistent for Phase One and Three. Phase Two Medicaid inpatient days mix went from 10% to almost 19%. Actual Medicaid patient days declined 26% for Phase One and 24% for Phase Three while Phase Two increased 36%.

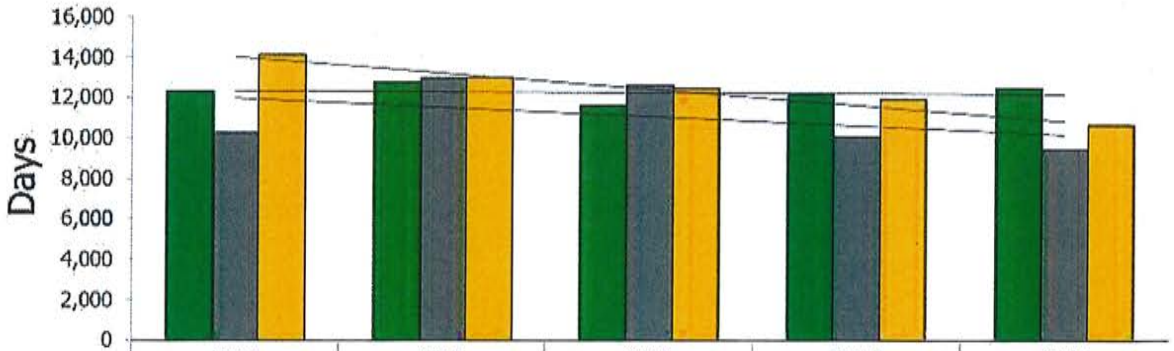
Patient Mix – I/P Days – Other %



	2014	2015	2016	2017	2018
All Phases	48.3%	48.2%	50.1%	48.9%	45.0%
Phase 1	44.8%	44.8%	43.3%	46.7%	45.1%
Phase 2	47.6%	48.7%	51.3%	47.8%	41.3%
Phase 3	49.8%	49.3%	52.3%	50.0%	46.0%

Draffin Tucker

Patient Mix – I/P Days – Other Days



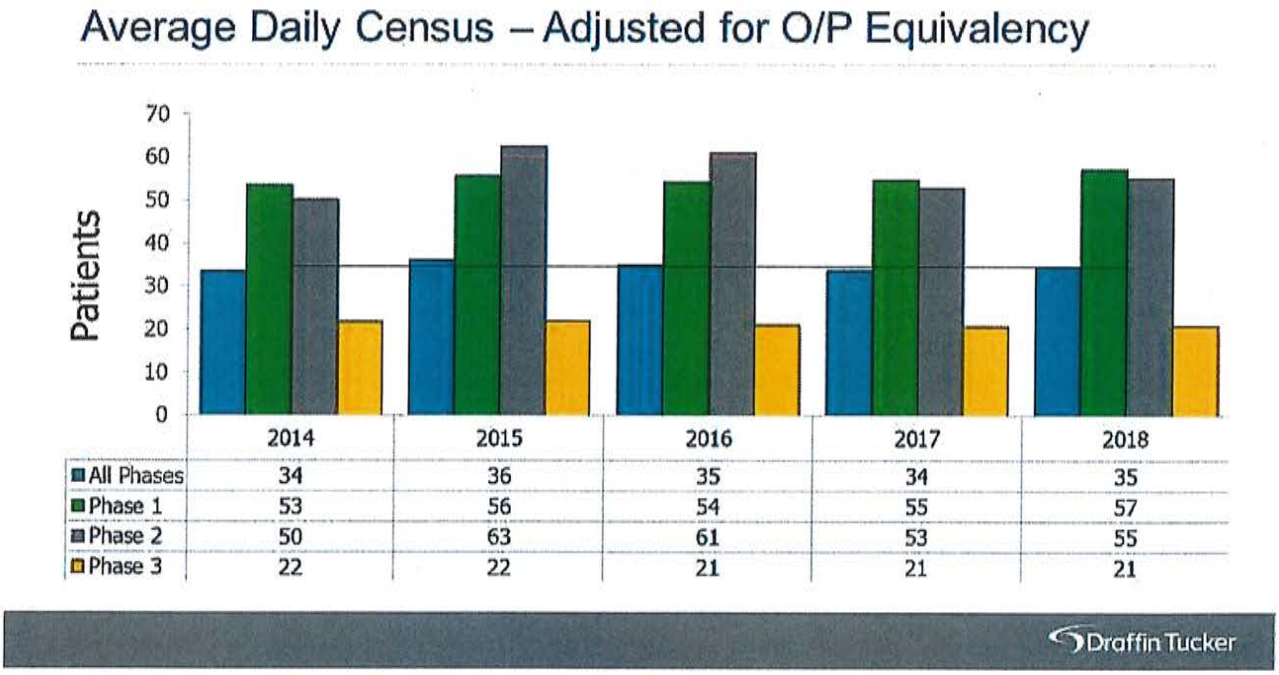
	2014	2015	2016	2017	2018
Phase 1	12,315	12,751	11,602	12,157	12,435
Phase 2	10,258	12,951	12,626	10,061	9,441
Phase 3	14,103	12,998	12,442	11,892	10,640

Draffin Tucker

Other payers for inpatient mix is decreasing from 48% to 45%. Actual patient days for other payers stayed relatively the same for Phase One. Phase Two reflects an 8% decrease, and Phase Three reflects a 25% decrease.

Average Daily Census – Adjusted for Outpatient Equivalency

- Ratio Type - Volume
- Desired Trend - Increasing
- Definition – Measures the average number of adjusted patient days over a fiscal year. Numerator consists of inpatient adult and pediatric days plus outpatient equivalent days. Unit measure of volume incorporating outpatient services.
- Formula
  - Outpatient Equivalent Days = Outpatient Revenue / Average Inpatient Revenue per Day
  - Adjusted Patient Days = Inpatient Days + Outpatient Equivalent Days
  - Total Adults and Pediatrics Inpatient Days / 365



	2014	2015	2016	2017	2018
All Phases	34	36	35	34	35
Phase 1	53	56	54	55	57
Phase 2	50	63	61	53	55
Phase 3	22	22	21	21	21

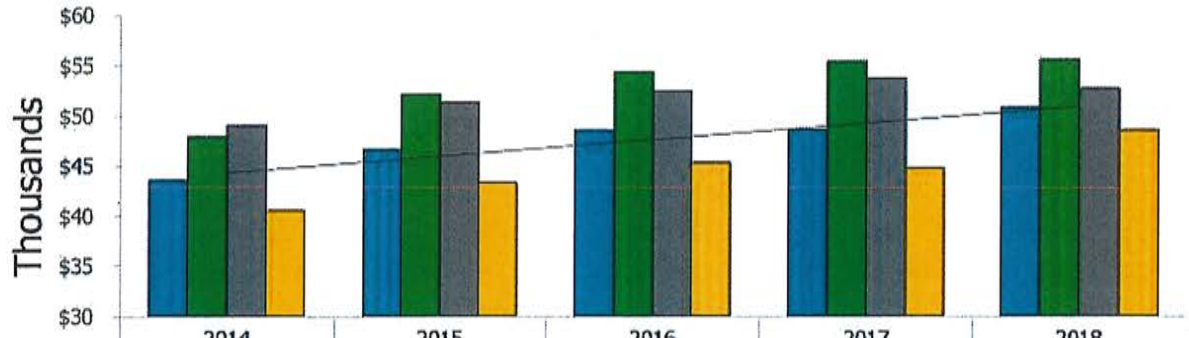
This ratio converts outpatient services to incorporate into an adjusted average daily census. It helps to better reflect the volume, work effort, and activities of the hospital. As noted earlier in the report, average daily census was an overall average of 10 to 11 patients. Including outpatient activity, average daily census is now averaging 34 to 35 patients. Approximately two-thirds of the hospital activity is attributable to outpatient services.

Salary per Full Time Equivalent

- Ratio Type – Unit Cost of Inputs
- Desired Trend - Depends
- Definition – Measures the average salary per full time equivalent (FTE). Full time equivalent determined by dividing total fiscal year paid hours by 2,080 hours (40 hours times 52 weeks). Salaries are typically the largest resource item used in the provision of healthcare services.
- Formula – Total Salary Expense / FTEs

Salary per FTE

Georgia - $59,685
Nat'l Rural - $50,970



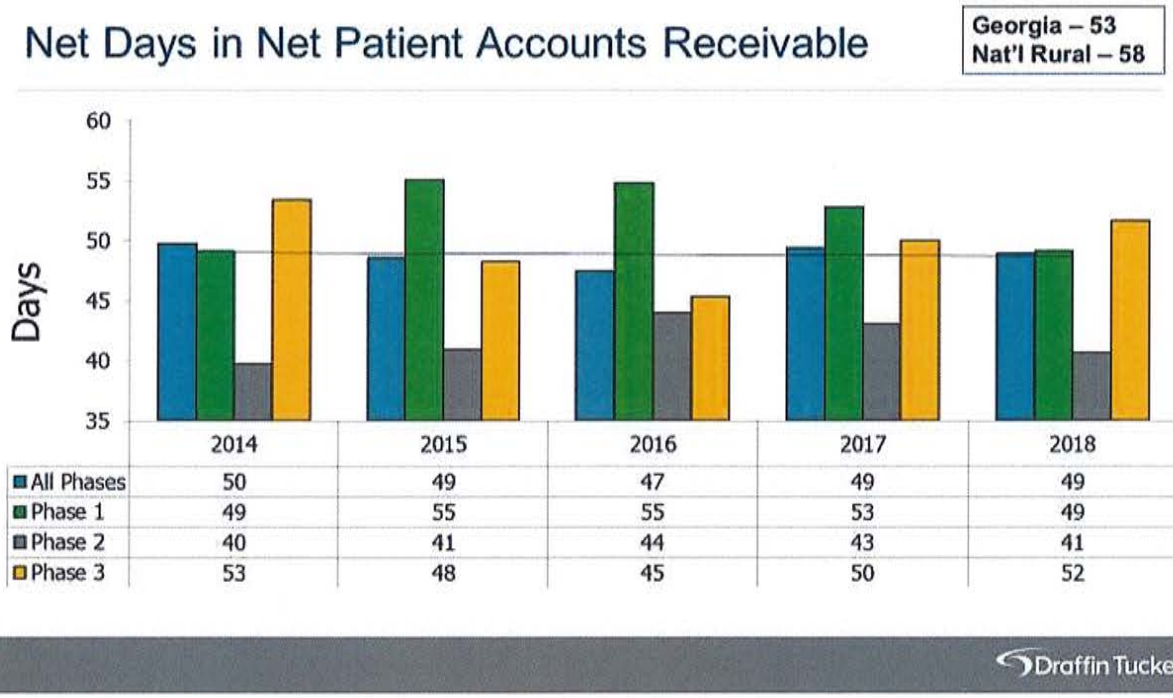
	2014	2015	2016	2017	2018
All Phases	43,617	46,632	48,552	48,664	50,820
Phase 1	47,927	52,128	54,396	55,417	55,573
Phase 2	49,021	51,361	52,460	53,721	52,749
Phase 3	40,576	43,343	45,361	44,830	48,565

Draffin Tucker

Salary per FTE helps to analyze the cost of the employed labor providing the services at the hospital. This cost does not include benefits, recruitment and retention costs, and external contractors. There is an overall 17% increase since 2014 or an average salary increase of 4% per year.

Net Days in Net Patient Accounts Receivable

- Ratio Type – Liquidity
- Desired Trend - Decreasing
- Definition – Measures the average time that receivables are outstanding, or the average collection period. High values imply longer collection period and thus a need for the hospital to finance its investment in accounts receivable.
- Formula – Net Patient Accounts Receivable / (Net Patient Service Revenue / 365)

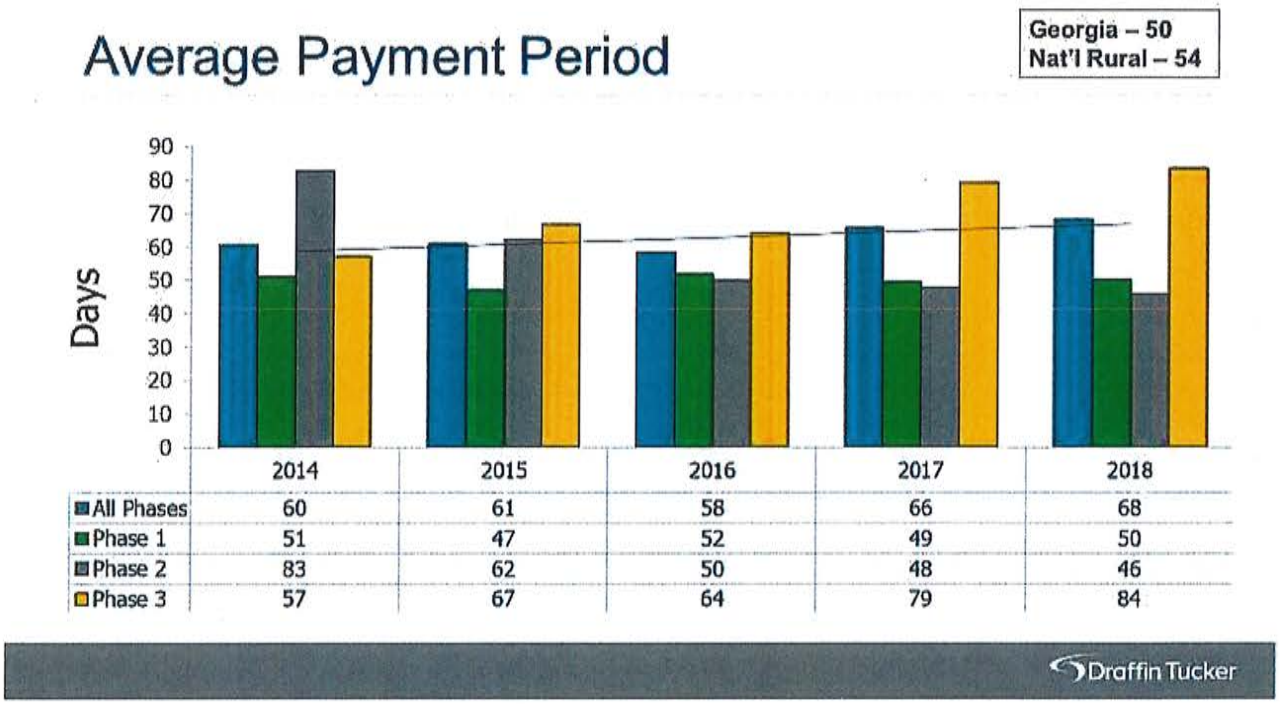


	2014	2015	2016	2017	2018
All Phases	50	49	47	49	49
Phase 1	49	55	55	53	49
Phase 2	40	41	44	43	41
Phase 3	53	48	45	50	52

Net days in net patient accounts receivable stayed relatively consistent on an overall basis with some variations within the phases during the five year period. The data indicates it takes an average of 49 days for hospitals to receive payment for services for the most recent year.

Average Payment Period

- Ratio Type – Liquidity
- Desired Trend - Decreasing
- Definition – Measures the average time that elapses before current liabilities are paid. The denominator is an estimate of the hospital's average daily cash expenses minus depreciation. Creditors regard high values for this ratio as an indication of potential liquidity problems.
- Formula – Current Liabilities / [(Total Expenses – Depreciation) / 365]



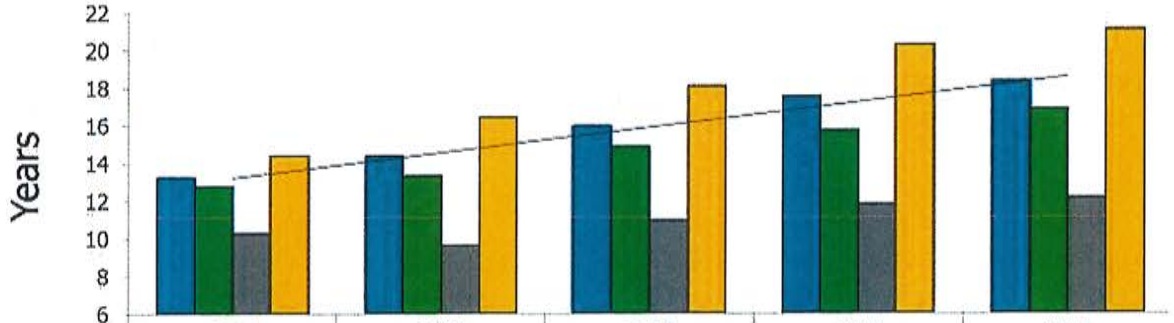
Average payment period is a liquidity measure which shows the average time it takes the hospital to pay its vendors. The trend for this ratio should be decreasing; however, the data reflects the ratio at an average of 68 days in 2018 which is a 13% increase from 2014. In 2018, the individual phases range from a low of 46 days for Phase Two to a high of 84 days for Phase Three. Phase One is at 50 days for 2018.

Average Age of Plant

- Ratio Type – Asset Efficiency
- Desired Trend - Decreasing
- Definition – Measures the average age of the hospital's fixed assets in years. Lower values indicate a newer fixed asset base and thus less need for near term replacement.
- Formula – Accumulated Depreciation / Depreciation Expense

Average Age of Plant

Georgia – 13
Nat'l Rural – 13

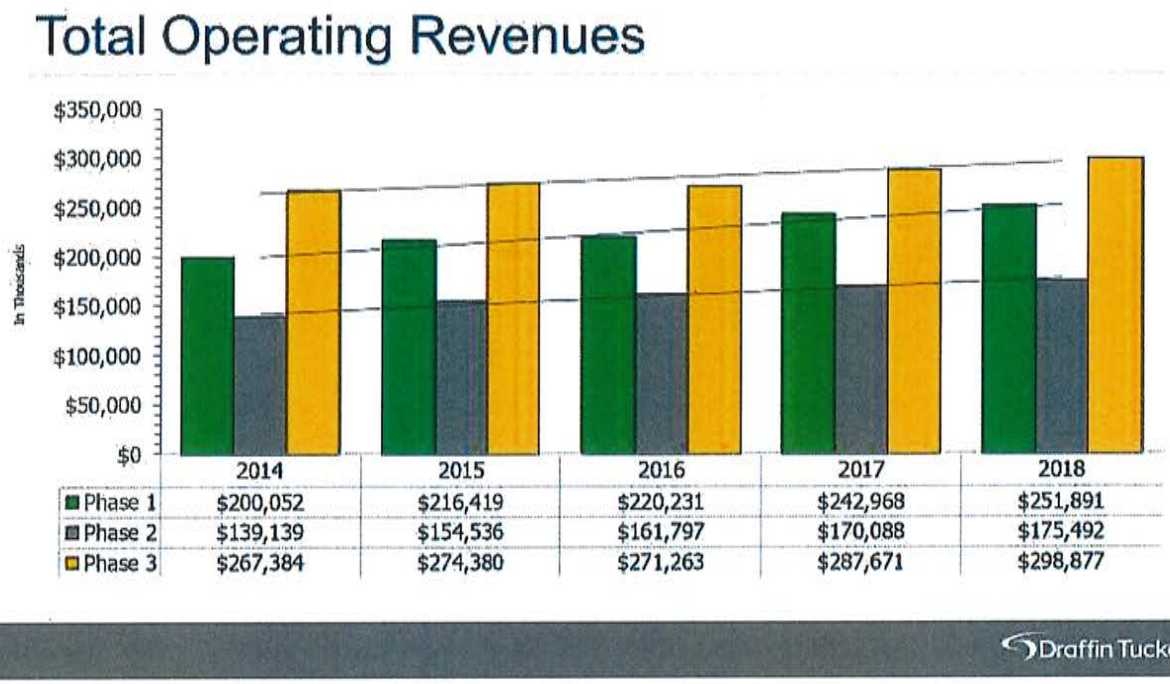


	2014	2015	2016	2017	2018
All Phases	13	14	16	18	18
Phase 1	13	13	15	16	17
Phase 2	10	10	11	12	12
Phase 3	14	16	18	20	21

Draffin Tucker

Average age of plant is an indicator for how old the equipment, building, and other fixed assets of the hospital are and shows the potential need for replacement or updating. From 2014 to 2018, there was an overall aging of fixed assets from 13 to 18 – an increase of 5 years or 39% increase in the average age of plant.

Total Operating Revenues



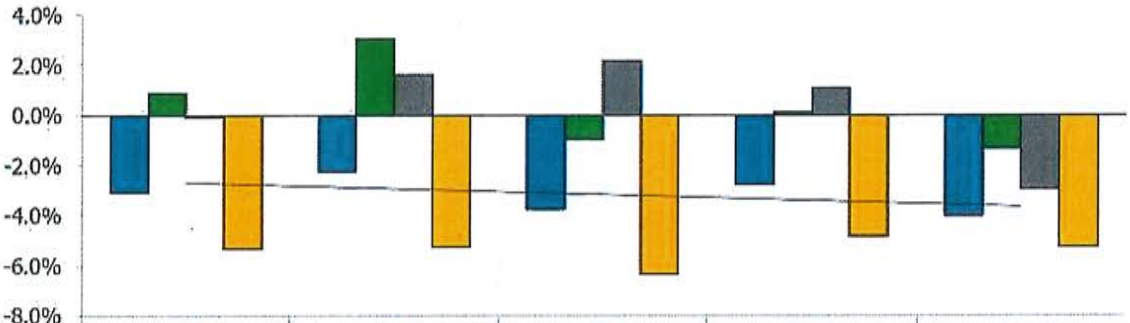
Total operating revenues includes revenue from patient services and reflects the gross charges of the hospital adjusted down to the amounts actually expected to be collected from payers and patients. There is an increase in all phases from 2014 to 2018. Phases One and Two report a 26% increase or approximately 5% per year over this time period. Phase Three reflects an 11% increase or less than 3% increase per year over the time period under review.

Operating Margin

- Ratio Type – Profitability
- Desired Trend - Increasing
- Definition – Reflects the proportion of operating revenue retained as income and is a measure of a hospital's profitability from the provision of patient care services and other hospital operations.
- Formula – (Operating Revenue – Total Expenses) / Operating Revenue

Operating Margin

Georgia – Positive 0.2%
Nat'l Rural – Negative 3.3%



	2014	2015	2016	2017	2018
All Phases	-3.1%	-2.3%	-3.7%	-2.8%	-4.0%
Phase 1	0.9%	3.1%	-1.0%	0.1%	-1.3%
Phase 2	-0.1%	1.6%	2.2%	1.1%	-2.9%
Phase 3	-5.3%	-5.3%	-6.4%	-4.9%	-5.3%

Draffin Tucker

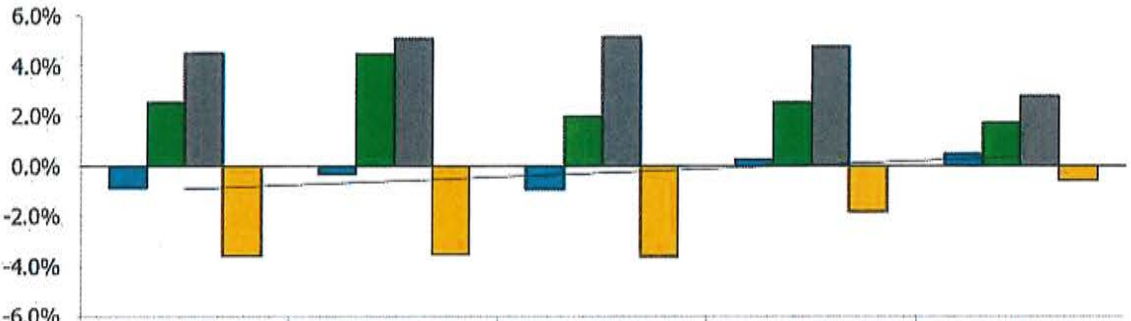
Operating margin is a profitability measure focused on the provided hospital services and generally does not include investment income, donations, nonoperating amounts, or unusual adjustments. Overall operating margin hovered around a loss from 3% to 4% with mixed results by individual phases with all phases ending up at the same or decreased margins in 2018 as compared to 2014.

Total Margin

- Ratio Type – Profitability
- Desired Trend - Increasing
- Definition – Defines the percentage of total revenue that has been realized in the form of net income or excess revenues over expenses. Used by many as a primary measure of hospital profitability.
- Formula – Excess of Revenues (Expenses) / Total Revenue

Total Margin

Georgia – Positive 1.8%
Nat'l Rural – Negative 1.9%



	2014	2015	2016	2017	2018
All Phases	-0.9%	-0.3%	-0.9%	0.3%	0.5%
Phase 1	2.5%	4.5%	2.0%	2.5%	1.7%
Phase 2	4.5%	5.1%	5.1%	4.8%	2.8%
Phase 3	-3.6%	-3.5%	-3.6%	-1.8%	-0.6%

Draffin Tucker

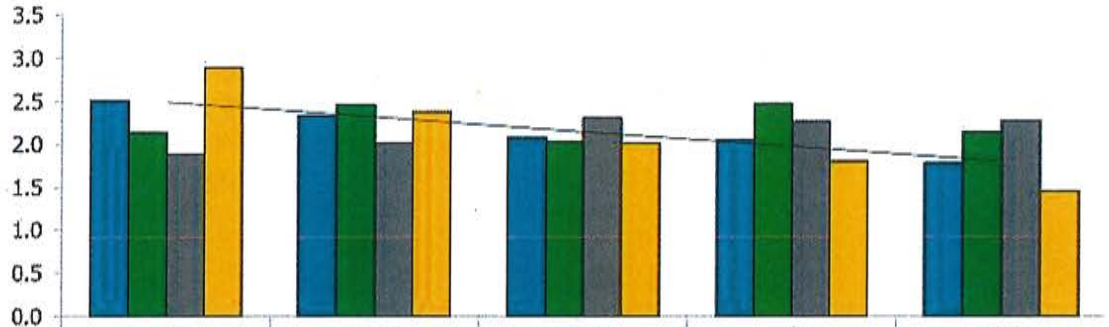
Total margin includes all revenue and expenses, including donations and investment income. Overall results for all phases went from -0.9% (negative margin) in 2014 to 0.5% (positive margin) in 2018. Positive margins are reflected in Phases One and Two and an improving margin in Phase Three.

Current Ratio

- Ratio Type – Liquidity
- Desired Trend - Increasing
- Definition – Measures the number of dollars held in current assets per dollar of current liabilities. Most widely used measure of liquidity. High values imply a good ability to pay short term obligations and thus a low probability of technical insolvency.
- Formula – Current Assets / Current Liabilities

Current Ratio

Georgia – 2.1
Nat'l Rural – 1.6



	2014	2015	2016	2017	2018
All Phases	2.5	2.3	2.1	2.1	1.8
Phase 1	2.1	2.5	2.0	2.5	2.2
Phase 2	1.9	2.0	2.3	2.3	2.3
Phase 3	2.9	2.4	2.0	1.8	1.5

Draffin Tucker

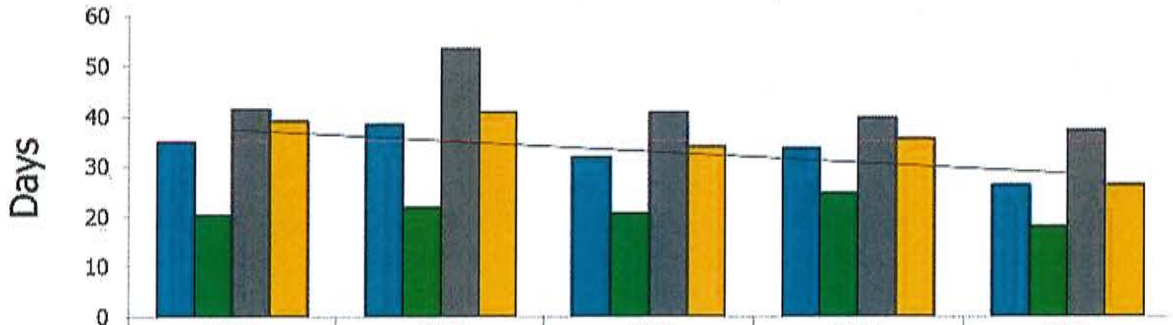
Current ratio reflects liquidity of the hospital with two times current assets over current liabilities. Phases One and Two hovered around 2 between 2014 and 2018 while Phase Three dropped from approximately 3 to 1.5.

Days Cash on Hand – Short-Term Sources

- Ratio Type – Liquidity
- Desired Trend - Increasing
- Definition – Measures the number of days of average cash expenses that the hospital maintains in cash and marketable securities which are classified as current assets. The denominator measures the average daily cash expenses less depreciation. High values usually imply a greater ability to meet short-term obligations and are viewed favorably by creditors.
- Formula – (Cash + Short-Term Investments) / [(Total Expenses – Depreciation) / 365]

Days Cash on Hand – Short-Term Sources

Georgia – 9
Nat'l Rural – 15



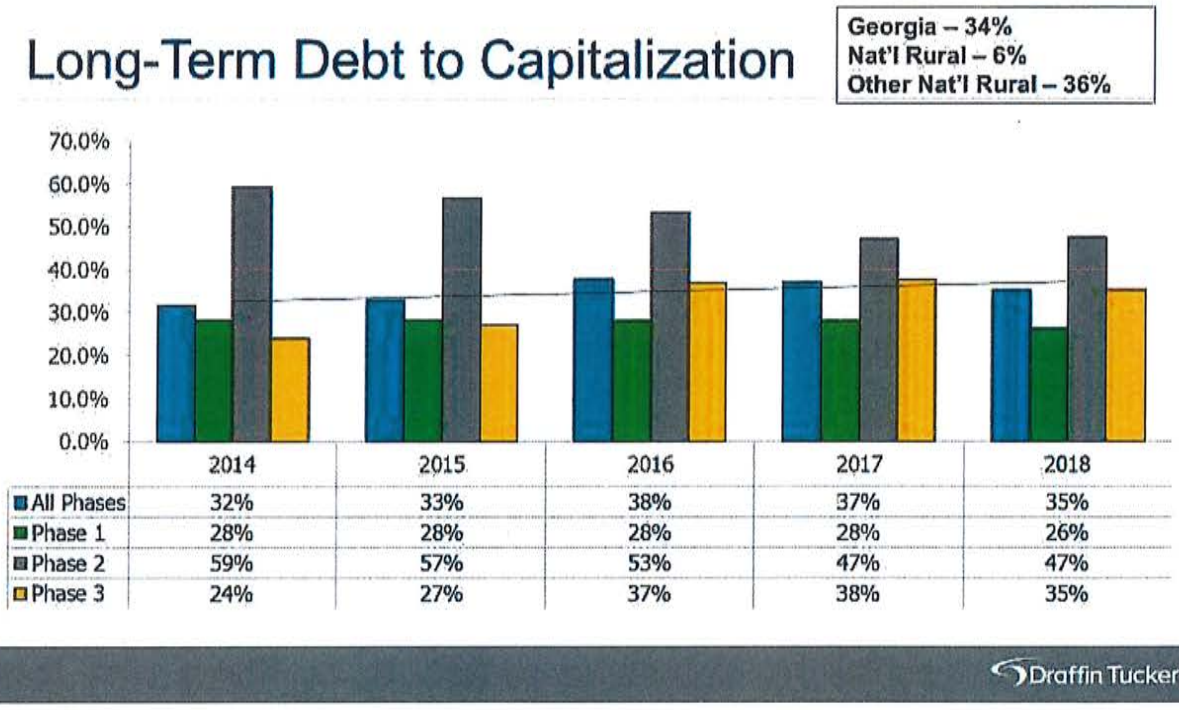
	2014	2015	2016	2017	2018
All Phases	35	38	32	34	26
Phase 1	20	22	21	25	18
Phase 2	42	53	41	40	37
Phase 3	39	41	34	36	26

Draffin Tucker

Days cash on hand from short-term sources show declines over the time period with 35 in 2014 to 26 in 2018, a 26% decrease in liquidity. All individual phases showed declines in this ratio with decreases of 10%, 12%, and 33% in Phase One, Phase Two, and Phase Three respectively.

Long-Term Debt to Capitalization

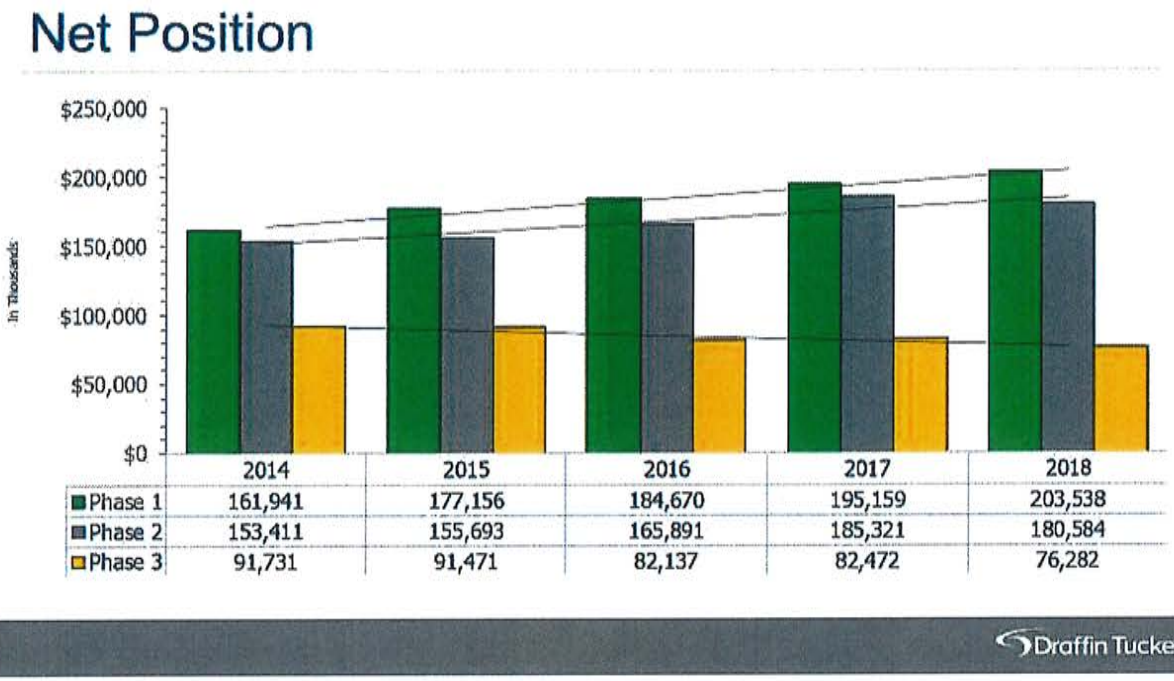
- Ratio Type – Capital Structure
- Desired Trend - Decreasing
- Definition – Measures the relative importance of long-term debt in the hospital's permanent capital structure. Net assets and long-term liabilities are often referred to as permanent capital since they will not be repaid within one year. Hospitals with high values have relied extensively on debt as opposed to equity to finance their assets and are said to be leveraged. Meaning risk may be viewed unfavorably by many creditors.
- Formula – Long-Term Debt / (Long-Term Debt + Net Assets)



	2014	2015	2016	2017	2018
All Phases	32%	33%	38%	37%	35%
Phase 1	28%	28%	28%	28%	26%
Phase 2	59%	57%	53%	47%	47%
Phase 3	24%	27%	37%	38%	35%

Long-term debt to capitalization reflects if the hospital is using debt to finance its operations. The expected trend for this ratio is decreasing; however, for all phases, the ratio went from 32% in 2014 to 35% in 2018. Both Phase One and Two showed declines from 2014 to 2018, but Phase Three went from 24% in 2014 to 35% in 2018 resulting in the overall summary increase for all phases.

Net Position



Net position is comparative to stockholders' equity and reflects how the hospital's overall net assets are performing. Both Phase One and Phase Two have increased over the time period with 26% and 18% increases, respectively. Phase Three declined 17% over the same time period.

Findings: Other

Through additional commentary collected within the questionnaire, as well as meetings and discussions with Grantees during the funding period, it was recognized that the RHS Grant Program reinforced the need to focus on some basic business practices and principals.

Some of the generalized recommendations offered as a result of the "lessons learned" from this program are:

- Every hospital should build and/or improve existing relationships with the community; don't take the community for granted.
- Recognize the importance of engaging (and staying engaged with) stakeholders, providers, and community partners.
- Re-evaluate services offered by your hospital; eliminate or add services based on need, utilization, cost, and ability to generate revenue. Don't continue "doing what has always been done" simply due to 'tradition' or out of 'fear of change'.
- Marketing is extremely important; don't assume your community is aware of the services you offer or the quality of your care. Marketing, promoting your services, and educating your community on what you have to offer is the first step in reducing out-migration.
- Invest in your employees. Improve employee morale and workplace satisfaction. Solicit input from staff and implement reasonable suggestions. Maintain high expectations for professionalism, productivity, competency, and quality of work. Above all, lead by example.
- Show pride in the facility. Improve the appearance of the hospital, parking lot, and surrounding areas. Sometimes huge improvements can be made by simply cutting the grass, trimming the bushes, perking up the flower beds and picking up trash in the parking lot. First impressions are lasting.
- And last, ensure *all* staff understand the importance of creating a friendly and welcoming environment for visitors and co-workers alike. Offering a smile, being kind and polite, professional and respectful, and "going the extra mile" can improve the reputation of a hospital without the need for a budget increase.

The State Office of Rural Health asked the Chief Executive Officers of Grantee Hospitals to provide a statement regarding their experience with the grant program. A full listing of responses can be located in *Appendix F* of this document.

Summary

The spotlight on the rural hospital closure crisis across the country and the conversations that began because of the closures brought this situation to the Nation's attention. Georgia is fortunate that Governor Deal chose to address this crisis in an aggressive manner.

Continuing into Governor Kemp's Administration, Georgia is providing on-going support for rural hospitals through the Rural Hospital Stabilization Grant Program and other rural-focused initiatives. The RHS Grant Program has allowed an opportunity to determine which grant funded projects have or haven't worked, and all hospitals, even those that have not been part of the Stabilization program, can and will continue to benefit from the results of this funding.

Grantees acknowledged that due to the requirements of the grant, they began evaluating their day-to-day practices and reviewing hospital data from a different perspective. Many rural hospitals had been functioning in a "survival" mode for so many years that selecting projects and making decisions about effective ways to spend grant funds was surprisingly challenging to some. The value of an up-to-date Strategic Plan was recognized by Hospital Grantees through this program.

The State Office of Rural Health reports frequently on the RHS Program in local, regional, and state level meetings. As the goals of the program and the results of projects selected by grantees is spotlighted in these public forums, all hospitals are encouraged to place a higher emphasis on internal assessments and strategic planning.

Other states have now taken the lead in hospital closures, but the visibility and success of the Rural Hospital Stabilization Grant Program has allowed other states to bring *this* program into *their* conversations as they begin to address these problems in their own states.

The State Office of Rural Health is fortunate to have the responsibility of administering this grant and will provide follow up information on Phase Four and Phase Five outcomes as an addendum to this report in December 2021.

Sources

2019 American Hospital Association Rural Report, www.aha.org.

Georgia: 2010 Population and Housing Unit Counts 2010 Census of Population and Housing. U.S. Department of Commerce, www2.census.gov/library/publications/decennial/2010/cph-2/cph-2-12.pdf.

"About Appling HealthCare." *Appling Healthcare*, www.ahcs.org/.

"About Crisp Regional Health Services." *Crisp Regional Hospital*, www.crispregional.org/about/.

"Welcome to Emanuel Medical Center." *Emanuel Medical Center: About*, www.emanuelmedical.org/about/.

"Union General Hospital, Inc." *Hospital in Blairsville, GA | Union General Hospital*, www.uniongeneralhealthsystem.com/ugh.

"Get To Know Your Habersham Medical Center." *About Habersham Medical Center | Habersham County Medical Center in Demorest GA*, www.habershammedical.com/about/.

"About Miller." *Hospital Authority of Miller County*, www.millercountyhospital.com/about-us/.

"Upson Regional Medical Center." *URMC*, urmc.org/.

"Hospital History." *Bacon County Hospital*, www.baconcountyhospital.com/getpage.php?name=history&sub=BCH%2BHistory.

"Chatuge Regional Hospital." *About Us | Union General Hospital*, www.uniongeneralhealthsystem.com/crh

"TRHS News." *New name and location for Cook Medical Center*, http://www.tiftregional.com/body.cfm?id=385&action=detail&ref=1606

"Inpatient and Outpatient Care." *Effingham Health System*, www.effinghamhealth.org/our-services/inpatient/.

"About Us." *About Us - Irwin County Hospital*, irwincntyhospital.com/about-us/.

"About Us." *Welcome To Jasper Memorial Hospital*, www.jaspermemorialhospital.org/about-us/.

"Our History." *Liberty Regional Medical Center*, www.libertyregional.org/getpage.php?name=history.

"History." *Memorial Hospital & Manor*, 31 Aug. 2017, www.mh-m.org/about-us/history/.

"Mitchell County Hospital." *Archbold Medical Center*, archbold.org/mitchell.

"About Us." *Archbold Medical Center*, archbold.org/about.

"SGMC Lanier Campus." *South Georgia Medical Center*, www.sgmc.org/our-locations/sgmc-lanier-campus/.

"Welcome to Washington County Regional Medical Center." *Washington County Regional Medical Center: About*, www.wcrmc.com/index.php?id=235.

Appendix

The following documents can be located in this section of the report:

Appendix A

Press Release - *"Deal Releases Rural Hospital Stabilization Committee Report"*

Appendix B

Rural Hospital Stabilization Committee Final Report to the Governor

Appendix C

Map of Funded Sites

Appendix D

"Where Are They Now?" Project Questionnaire Template

Appendix E

Responses to Questionnaire

Appendix F

Quotes from Chief Executive Officers

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Appendix A

Press Release

"Deal Releases Rural Hospital Stabilization Committee Report"

SORH
State Office of Rural Health
A Division of the Georgia Department of Community Health

Governor Nathan Deal
Office of the Governor

For immediate release
Feb. 23, 2015

Office of Communications
(404) 651-7774

Deal releases Rural Hospital Stabilization Committee report

Immediate action to be taken in order to meet the needs of rural hospitals across state, governor says

Gov. Nathan Deal today released the final report of recommendations from his Rural Hospital Stabilization Committee, which was created last April to identify and provide solutions for the needs of Georgia's rural hospital community.

"When a rural hospital struggles, a community struggles," said Deal. "Back in April we stood at a critical juncture for some of our state's rural health care systems, and this committee was just one of the paths taken to ensure that Georgians, no matter where they live, have the ability to receive adequate care. These recommendations, a result of countless hours of dedicated analysis and review of a system that affects not only our citizens' wellbeing, but also our local economies, will serve as a strong starting point toward providing high-quality health care throughout rural Georgia."

Included in the recommendations is the establishment of a four-site pilot program, based upon an integrated "hub and spoke" model, to relieve cost pressures on emergency departments and ensure that the best, most efficient treatment is received by patients. The program aims to increase the utilization of new and existing technology and infrastructure in smaller critical access hospitals, Wi-Fi and telemedicine equipped ambulances, telemedicine equipped school clinics, federally qualified health centers, public health departments and local physicians. The four proposed hubs of initial implementation are Union General, Appling Health System, Crisp Regional and Emanuel Regional Medical Center.

"Just as a medical emergency can't wait, neither can we wait to act upon these recommendations," said Deal. "An additional $3 million will be allocated in this year's budget to the State Office of Rural Health within the Georgia Department of Community Health to fund the necessary tools the four hubs need to effectively implement this pilot program. It is my hope that these efforts are not a temporary fix, but rather the beginning of a long-lasting road to recovery for our rural health systems."

The committee, which included health care professionals, legislators, local officials and business owners, also recommended the maintenance of existing Certificate of Need laws to protect existing rural hospital infrastructure. Other legislative fixes include the expansion of the scope of practice for midlevel providers, such as nurse practitioners and physician assistants, who could help bolster health care resources in rural communities.

"First of all, I want to thank the governor for listening to my concerns about the plight of rural hospitals and health care in rural Georgia and for creating this committee," said Committee Co-Chair and state Sen. David Lucas. "Since April, we have worked to put together meaningful solutions to address these needs. On behalf of the entire Rural Hospital Stabilization Committee, I thank the Governor Deal and his staff for instituting programs to start the process of trying to address health care in rural Georgia."

"The Rural Hospital Stabilization Committee tasked by Governor Deal has worked hard to achieve our goal of identifying and providing solutions for our state's most challenging rural health care needs," said Committee Co-Chair and state Rep. Terry England. "Together, with the support of the General Assembly, the Governor's Office and state agencies, we are committed through these recommendations to improve our rural hospitals, and by extension, the quality of life of all Georgia citizens."

Brian Robinson
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Merry Hunter Hipp
mhhipp@georgia.gov

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Appendix B

Rural Hospital Stabilization Committee Final Report to the Governor

SORH
State Office of Rural Health
A Division of the Georgia Department of Community Health

Rural Hospital Stabilization Committee

Final Report to the Governor

February 23, 2015

Rep. Terry England
Sen. David Lucas
Co-Chairs

Table of Contents

Report

Background	3
Findings	4
Final Committee Recommendations	5-6

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, *Committee co-chair*	Georgia House of Representatives
Sen. David Lucas *Committee co-chair*	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 approximately15,000 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.

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Appendix C

Rural Hospital Stabilization Grant Program

Map of Funded Sites

SORH
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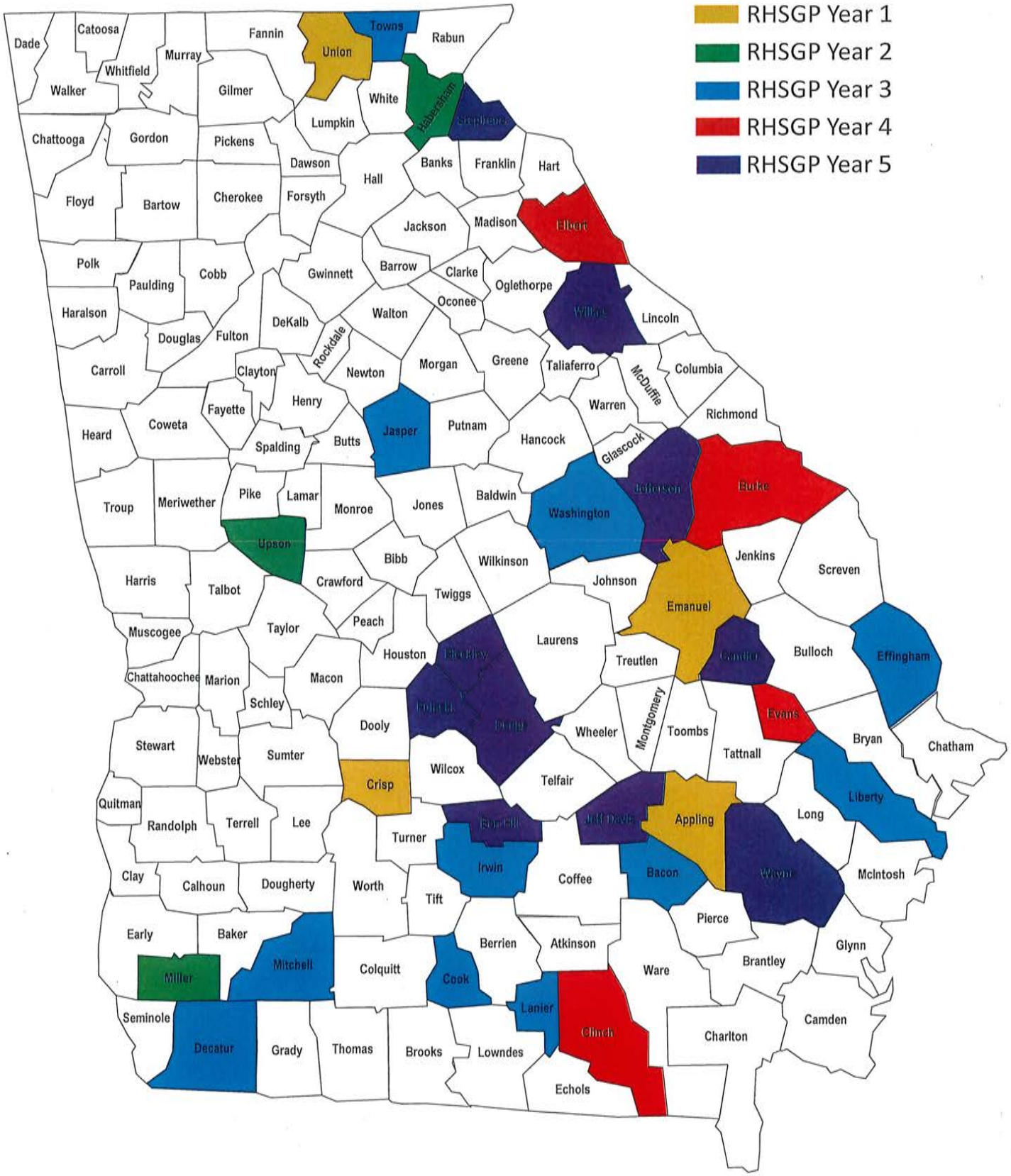
RURAL HOSPITAL STABILIZATION GRANT PROGRAM
FUNDED SITES



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Appendix D

Rural Hospital Stabilization Grant Program *"Where Are They Now?"* Project Questionnaire Template

SORH
State Office of Rural Health
A Division of the Georgia Department of Community Health

State Office of Rural Health
Rural Hospital Stabilization Grant Program
"Where Are They Now?" Project

Introduction, Project Purpose and Goal:

The Rural Hospital Stabilization Committee (the Committee) provides oversight of the Rural Hospital Stabilization Grant Program (RHSGP) administered by the State Office of Rural Health (SORH). Each November, SORH organizes a meeting to provide the Committee with an update on the RHSGP, the projects selected by each grant recipient, and a status update of those grant funded projects.

SORH will be presenting a comprehensive written report to the Committee at the annual meeting on November 7th, 2019. To assist in preparing this report, each recipient of a Rural Hospital Stabilization (RHS) Grant is requested to complete a questionnaire detailing projects funded through the RHS Grant, the impact of those individual projects, and the sustained benefit of the program to both the recipient hospital and the surrounding community.

Through the financial support provided by the RHSGP, the State of Georgia has demonstrated a genuine interest and investment in our rural hospitals. Our goal for the *Rural Hospital Stabilization Grant Program: Where Are They Now?* report is to provide the Committee with factual, meaningful information specific to the investment of these grant funds.

Instructions:

We are asking that you carefully review this questionnaire, review any necessary records or data required for this report, and respond to these questions with as much detail as possible.

This questionnaire is divided into four sections: 1) General Grantee Information, 2) Project Specific Details, 3) Overall Impression and Benefit of RHSGP, and, 4) Financial Data Collection.

Sections 1 and 3 are **self-explanatory.**

Section 2 **will require** you to complete *Attachment "A", Narrative* for **each individual** project funded through the RHSGP. *Attachment "A"* is included with this document.

Section 4 acknowledges the intent for SORH to partner with Draffin Tucker to utilize and summarize your hospital's financial data from your audited financial statements and other provided grant-specific financial information. Draffin Tucker will provide SORH with a multi-year trend analysis and summarized results of the RHS Grant recipients.

Section 4 *does not require a signature*. SORH staff will follow up with the CEO (or designee) to confirm approval prior to compiling this component of the report.

We respect your time and realize this report will require a significant effort on your part. To ensure you have adequate time to prepare your response, **we are requesting this report be returned to the State Office of Rural Health *on or before the close of business on Tuesday, April 30, 2019.***

Please e-mail your completed report to Nita Ham at nham@dch.ga.gov.

If you have any questions or need any additional information, please feel free to reach out to Nita at the above e-mail address, or by telephone at 229-401-3086.

SORH
State Office of Rural Health
A Division of the Georgia Department of Community Health

State Office of Rural Health
Rural Hospital Stabilization Grant Program
"Where Are They Now?" Project

Section 1: General Grantee Information

The information below was collected from your RHS Grant documents. If any errors are identified, please make your corrections on this document.

Name of Grantee (Hospital)	

The funding period for your RHS Grant is listed below:

Date Funding Began:	***Date Funding Ended:***

The total award amount to your facility is listed below:

Total Award Amount	

The projects selected by your facility and funded with Rural Hospital Stabilization Grant Program monies are listed below:

Projects Selected by Your Facility	1. 2. 3. 4.

Please provide information in all areas shaded in green.

In the space below, please provide information about the designated RHSGP Project Manager (PM).

Name of PM:	***Was the PM selected from staff already employed with your facility, or hired from outside your organization?***
	Is the PM still an employee of the organization? If so, in what capacity?

Section 2: Project Specific Details

For ***each*** individual project you have identified above, **please complete *the Attachment "A" Narrative.*** **Attachment "A"** ***Narrative*** is a separate form that has been **included in your e-mail** along with this document.

Submit all Attachment A documents with this completed questionnaire on or before the identified deadline.

State Office of Rural Health
Rural Hospital Stabilization Grant Program
"Where Are They Now?" Project

Section 3: Overall Impression and Benefit of RHSGP

Please review the question in the column on the left and provide your response in the green box.

Based on your experience with the RHSGP, do you feel this program met its intended objective to ensure patients receive the "right care in the right setting, at the right time and for the right cost"? Please explain how your projects supported this objective.	
Did your facility seek other grants/funding sources to expand or sustain *any* work begun through the RHSGP?	
Overall, what do you feel was the *most* beneficial or impactful component of your projects? Please explain.	
Overall, what do you feel was the *least* beneficial or impactful component of your projects? Please explain.	
Based on your experience with the RHSGP, if given the opportunity to start your project over, would you have made the same decisions, choices, done anything differently, etc.? Explain.	

Based on your experience with the RHSGP, what suggestions or advice would you offer to a new RHS Grant recipient?	

Section 4: Financial Data Collection

The State Office of Rural Health will partner with Draffin Tucker to review pre and post grant financial data, which will be included in the report to the Committee. **Reporting of this information will be blinded; hospital-specific information will *not* be provided or identified in either the written or verbal report to the Committee.**

Hospital financial data to be utilized:	Audited financial statements from fiscal year 2014 through your most current fiscal year.

SORH staff will contact the CEO (or desired designee) to obtain permission for Draffin Tucker to access hospital specific information for this report. Below, please provide the name and contact information of your CEO or his/her designee.

Individual to be Contacted:	**Current e-mail address and phone number:**

While compiling this report, additional information may be requested by SORH staff.

***Please submit the completed questionnaire and all Attachment "A" documents* to the State Office of Rural Health *on or before the close of business on Tuesday, April 30, 2019.* Please e-mail your report to Nita Ham at nham@dch.ga.gov.**

Thank you!!

State Office of Rural Health
Rural Hospital Stabilization Grant Program
"Where Are They Now?" Project

Attachment "A"
Narrative

Name of Grantee (Hospital)	

Instructions: *For <u>each</u> individual project funded through your Rural Hospital Stabilization Grant Program (RHSGP), please complete this Narrative by responding to each item/question in column on the left. Provide your responses in the green sections to the right of each item. Please be thorough and thoughtful.*

Project Number 1	
Amount of funding provided for this project.	
Goal(s) of this project.	
Detailed description of this project.	
How did this project benefit your community?	
Is this project still on-going?	
Was/is this project financially sustainable after termination of the grant? Explain.	
Would your hospital have selected/funded this project if the RHSGP had not been available? Explain.	
Did this project lead to relationship development with other partners and subsequent additional projects? Explain.	

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Appendix E

Responses to Question:

"Based on your experience with the RHSGP, what suggestions or advice would you offer to a new RHS grant recipient?"

SORH
State Office of Rural Health
A Division of the Georgia Department of Community Health

Questionnaire Responses to the Following Question:

"Based on your experience with the RHSGP, what suggestions or advice would you offer to a new RHS Grant recipient?"

Listed below (in no particular order) are the responses received:

- "Have a committee come together to discuss the most prominent needs in the community and focus on the top ones to get the most benefit from the grant."
- "Define the measures of success, understand the frequency of reporting, fully access areas to see if change is possible. Appreciate how hard change is and know the change curve you are facing. Be sure there is a willingness to change but also build a case for change and innovation before beginning."
- "Take risks. Collaborate with other partners."
- "Based on our experience, we would suggest common sense implementation projects and choosing projects that any other parties involved are committed to the chosen project and the resources needed to implement."
- "Learn from the experiences of others. One of the greatest benefits, besides what I learned from my own personal experience, is the knowledge that I learned from the project managers before me. Other than that, do your research and find out what the community needs. Communities are like fingerprints; they are all unique. What works for one might not work for another. One thing that I can say is invest in primary care. Access to a physician will help keep patients in your community more than anything else."
- "The best advice I can offer is the same I received from grant recipients that came before me: limit your project numbers and if possible choose ones that will complement each other so as you work on one, it will impact the other projects positively too. I feel we did this with the choices we made."
- "Go for it! Think outside the box some and don't be afraid to stretch your organization and yourself. Remember the interrelationships of your operations and the need for consistent integration. Be nimble, unafraid to adapt, and ready to revise your plan if need be and it can be justified. Your hospital will be better for having made the effort to improve even if it a little short of your planned expectations. Build a team of three people to work on the project so that if you lose a player, the other two can continue seamlessly. Share all aspects of the venture including the presentations to SORH. Knowledge shared is knowledge gained – both for the group and the presenters. Smile and always say "please and thank you"! Thank you!"
- "Align your project(s) with your organization's strategic plan. First, assess the needs from an organizational level (admin, BOD, etc.), then from the input of employees, then

from the community. If it's been done before, find out by whom, and utilize that resource."

- "Evaluate the infrastructure of any project that is undertaken, and the ongoing fiscal needs of that project. Do not take on multiple projects during the year."
- "To make sure that you have a very detailed plan from the start. Begin spending the grant money and invoicing the SORH as soon as your timeline will allow you to."
- "This program was such a tremendous opportunity for us to take part in. I would advise any hospital to take full advantage of it and the assistance from the staff at the State Office of Rural Health. Patsy, Lisa and Nita are so knowledgeable and so willing to help you in any way. I truly appreciate their guidance and help in all that they did to make our Grant successful."
- "We would advise a new recipient to choose one or two impactful and sustainable projects and not commit to too many projects, especially ones that cannot be sustained."
- "Consider reducing the amount of data reporting for the grants that are smaller."
- "Select one project that your organization can make the most impact in. There is an abundance of paperwork that is involved with each project so a good portion of staff time is spent completing that requirement."
- "We recommend when possible with such limited funds that a facility try to do as much of the construction and renovations internally. We were able to identify internal talent and hire a local tile and painter to reduce our costs of construction. The facility must have a dedicated project manager that is experienced in construction and hospital renovations and work with others to get consultations on what needs to be done to have the unit built correctly for patient care."

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Appendix F

Quotes from Chief Executive Officers of Rural Hospital Stabilization Program Grantees

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A Division of the Georgia Department of Community Health

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Quotes from Hospital Grantee Chief Executive Officers Specific to the Rural Hospital Stabilization Grant Program:

- "We are extremely thankful for your time and the funds entrusted to us, with this has come opportunities to travel down roads we would otherwise could not have done without this help and support."
- "I have enjoyed the challenge of managing different projects with the ultimate goal of contributing to stabilizing rural health care not only in our county, but one day perhaps to help another rural county hospital."
- "This has given us the ability to explore new strategies and care opportunities that otherwise might not have been an option due to lack of capitol and risks."
- "We never anticipated the amount of physician opposition to these projects."
- "The project that has been the least expensive with the most results is the Community Paramedicine Program. It would be wonderful if DCH could explore funding options for regionalization of EMS and find ways to standardize and reimburse for CPP."
- "While some projects focus on reducing readmissions, they also enhance the level of care we provide our patients and improve their overall quality of life, which is our overall goal."
- "The project forced me as a CEO, to look at potential activities for the hospital that I would not have considered, ones which are not either saving us money or generating additional revenue."
- "Although we discussed the need for collaboration, I believe the need is greater than I realized."
- "You need a physician champion."
- "Change is difficult but necessary for rural hospital survival."
- "Care coordination works especially in terms of improving individual's health; however, to really have an impact on a population's health, you need to have enrollees from different levels of complexity. The first 7 we enrolled were 7 of the most complex in our community."
- "I spoke in favor of using telemedicine to bring specialty care back to our community; however, I don't think I realized how far it could go."
- "To really implement these projects will take 2 years, I wish this project had been funded for that time frame."
- "I hope there continues to be efforts to develop a payment model for community paramedicine."
- "The Pilot Project has been more time-consuming than anticipated."
- "We have learned a great deal about our own data; this was helpful in deciding on specific projects."

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State Office of Rural Health
A Division of the Georgia Department of Community Health

- "Community Paramedicine – this service can be a benefit to the community and patients at risk. However, there is no reimbursement for this costly service."
- "Need to work closely with primary care physicians and pediatricians as they feel threatened by this project and think you are trying to steal their patients."
- "One of the most valuable lessons has been communication and education regarding our local CSB. We didn't know them and they didn't know us before now. We are working together for the benefit of our mental health patients."
- "ED throughput, this is our most successful project to date. Simply taking the time to research your most problematic areas from a perception standpoint and then focusing on solutions was all we had to do."
- "One-year time frame was unrealistic because it takes months for some projects, maybe a year to just get the projects off the ground and up and running. You then need time to implement and monitor. A 2-year time frame is probably more realistic."
- "I do feel that a year is not enough time to truly get an accurate picture on ROI for each project as we are nine months in and are just now overcoming some obstacles, w that said, I would like to continue to monitor progress through our performance measures."

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Representative Terry England, Chairman, House Appropriations Committee
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RHSGP Recipients, Chief Executive Officers, Chief Financial Officers, and Project Managers
Lisa Carhuff, Former RHSGP Project Manager
Nita Ham, Director, SORH Program, RHSGP Project Manager
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