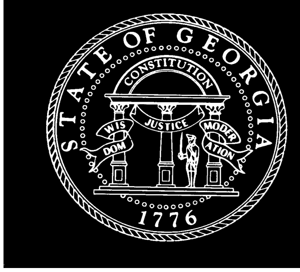

THE STATE OF GEORGIA

RURAL HEALTH CARE PLAN

To establish eligibility for
Critical Access Hospital (CAH) Status

Adopted by Health Strategies Council
August 18, 2000

Developed by
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GEORGIA RURAL HEALTH CARE PLAN

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I. PURPOSE

This plan was developed by a large consortium of organizations whose work involves advocating on behalf of the citizens of rural Georgia. The purpose of this plan is twofold:

- To provide policy direction in rural healthcare for the State of Georgia, as recommended by the Rural Health and Hospital Technical Advisory Committee of the Health Strategies Council and adopted by the Health Strategies Council; and

- To provide a framework for Georgia's participation in the Medicare Rural Hospital Flexibility Program (MRHFP);

The Medicare Rural Hospital Flexibility Program authorized by Section 4201 of the Balanced Budget Act of 1997, replaces the seven-state EACH/RPCH program with a new program under which limited-service hospitals known as critical access hospitals (CAH) are designated.

Any state may establish a MRHFP providing certain assurances are developed including the development of a rural healthcare plan that provides for the creation of rural networks, promotion of the concept of regionalization of health services and, improvement of access to health services for rural residents of the state. This model provides an alternative for small rural hospitals to match community needs to provider capabilities.

Effective November 1999, new federal regulations amended the Balanced Budget Act of 1997 (MRHFP). This plan was updated to reflect those program changes.

II. INTRODUCTION

A. Overview of Rural Health Care Problems

The plight of the rural health care delivery system has been the subject of considerable attention nationally and in Georgia. Numerous researchers have attempted to document both the reasons for the rural health care delivery system distress, particularly hospitals, and to develop strategies to strengthen rural health care delivery systems. Two of the common findings among researchers include the need for a realistic reorganization of the rural health care delivery system and increased emphasis on the development of appropriate health care systems to assure access to health care services that are provided in the most appropriate and cost-effective manner.

The existence of a viable rural health care delivery system infrastructure is critical to Georgia residents. This includes meaningful programs addressing long-term treatment of the problems plaguing rural health care delivery systems. At the same time, Georgia should address short-term solutions to meet immediate problems. Given that rural hospitals are operating in an environment of declining inpatient occupancy and the "technology gap" between rural and urban hospitals is increasing, it is important that rural providers develop strategic plans to diversify their services into profitable areas including the provision of non-medical services.

The core problems facing rural health care providers include:

- Declining population;
- High percentage of the elderly;
- Poorer health status indicators;
- Difficulty recruiting and retaining medical and administrative staff;
- Difficulty maintaining sufficient inpatient occupancy and outpatient volume to cover costs;
- Inability to achieve economies of scale;
- Difficulty securing capital to renovate old physical structures and to replace new medical equipment, particularly routine medical equipment;
- A high percentage of Medicare/Medicaid and indigent/charity patients and few commercially insured patients.

According to a 1997 publication entitled "Health, Education and Economics: The Rural Connection," economic development, education, transportation and other problems have contributed to the creation of critical health problems in rural communities. A literature search suggests that the physical condition of the hospital is important in shaping the patients' perceptions of the "quality of care." A number of rural health care facilities in Georgia are in need of refurbishing and modern medical equipment. For example, in recent years, at least three rural hospitals have been granted Certificates of Need (CON) for total facility replacements. At the same time a number of rural nursing homes have been issued CONs for major renovation projects.

It is also important to recognize that demographic conditions are different in each rural community. Rural health care issues are often discussed as if the health care problems of rural communities are the same. In reality, rural communities are the same only in not being urban. Rural health care delivery systems are as unique as the communities in which they have evolved. When a system "breaks down," the reasons are often the result of a combination of particular local events and conditions. Because of the complexity of rural health care issues, various options need to be addressed. The same response does not always present itself the same way in different communities. By the very nature of the complexity, solutions relating to rural health and health care should go beyond maintenance of the status quo or the initiation of fragmented "band-aid" programs. New alternatives to the present health care delivery system should be encouraged.

Many factors interact to cause problems unique to rural communities. Some of these problems are recent, while others are historical. Some problems are the result of poor management, lack of planning and the inability to adapt to a changing health care environment. Still, others relate to changing reimbursement practices. Recent problems can be traced to Medicare and other third party payment practices, including managed care, which have resulted in providers' inability to shift costs. Changes in reimbursement practices have decreased significantly the length of stay in hospitals which has negatively impacted inpatient occupancy levels. This shift has resulted in more outpatient treatment for medical problems than were traditionally treated on an inpatient basis.

B. Planning Process and Structure

In May 1997, Georgia's Health Strategies Council voted to establish a technical advisory committee (TAC) to explore planning and regulatory issues and problems pertaining to rural health and hospital services, particularly in view of the critical nature of these problems in some of Georgia's rural communities. The purpose of the TAC was to identify current problems and issues and to advise the Council and the Agency on resolution of these issues. The TAC was charged also with the following:

- Addressing concerns about the changing healthcare environment (i.e., managed care, changing healthcare personnel, etc.) and its impact on rural health care;
- Exploring possible healthcare strategies that may be available to assist rural communities to deal with problems and which recognize the uniqueness of rural communities; and
- Developing both short and long-range policy and planning recommendations, with short-range strategies, to be included in the Council's Annual Report to the Legislature in January 1998.

The Rural Health and Hospital TAC, with a broad-based membership of more than 60 people, held its first meeting in September 1997. Its two work groups, *Barriers Unique to Rural Communities* and *Payment Practices and*

Financing, met in October and November. As a result of this work, the TAC met on November 19 and approved recommendations which were presented to the Health Strategies Council on December 4.

Highlights of the short-range recommendations from the TAC, and approved by the Health Strategies Council, which were sent to the Georgia Legislature in the Council's Annual Report in January 1998, include the following recommendations. An update of each recommendation is included.

- Pursue development of a State Rural Health Care Plan to allow Georgia to participate in the Medicare Rural Hospital Flexibility Program of the Balanced Budget Act of 1997.

  Outcome: Effective May 1998, The Healthcare Financing Administration approved Georgia's Rural Healthcare Plan. This plan is showcased as a model for other states participating in the Critical Access Hospital program.

- Recommend a statewide payment rate under the Division of Medical Assistance's Inpatient Hospital Payment Methodology which eliminates rural/urban disparities.

  Outcome: This recommendation was presented and approved by the Health Strategies Council. It has been implemented by Georgia's Division of Medical Assistance.

- Support "Essential Rural Provider Access" legislation to allow rural hospitals to negotiate for managed care contracts.

  Outcome: This legislation was passed during the 1998 legislative session;

  and

- Develop a proposal for a Rural Health Systems Program with revenues from the state budget surplus for one-time grants to rural communities.

  Outcome: This proposal was developed and presented to the legislature, unfortunately no monies were allocated.

Long-range recommendations and the TAC's final report were completed in April 1998 and forwarded to the Health Strategies Council for adoption at the May 22, 1998 meeting. The Council reviewed and accepted each of five recommendations for inclusion in the Annual Report:

1. Oppose any further state budget redirect. Additional cuts in services will increase the damage to the health care system which is occurring in rural and other communities in the state.

2. Adopt the policy to seek dollars to strengthen core health and medical services, especially for rural areas, before establishing new services. For enhancements that are approved, avoid as much as possible, using dollars redirected from other services if redirection is necessary.

3. Support the fraud and abuse goals of the Division of Medical Assistance(then Department of Medical Assistance) to the extent that they are consistent with the most recent guidelines of the

Office of the Inspector General and the U.S. Justice Department, regarding healthcare investigations.

4. Recommend that the Office of Planning & Budget and the Governor's Office carefully review and consider the far-reaching implications of all redirection goals. Be sure that there are no unintended negative impact on rural providers.

5. Endorse the concept of the TAC's proposal from last year for a Rural Health System's Program for one time grants to rural communities. Incorporate recommendations from the Bed Banking Work Group.

The TAC's Bed Banking Workgroup explored the bed banking concept in many forms. This concept, as the workgroup had intended, would result in a process where hospitals, using their medical/surgical hospital beds as collateral, would receive loans from the state. These loans would not be repaid. The committee explored additional mechanisms that would provide an infusion of capital to rural hospitals. Members agreed to augment the Rural Health Systems Program through the addition of a "Favorable Consideration" category. In order for hospitals to qualify for monies under this category, they would have to meet the definition of "Necessary Provider" and would have to agree to decrease the hospital's evaluated bed capacity to no more than some percent of the hospital's average daily census or some minimum number of beds. Further investigation of this process determined that a loan would be considered a "gratuity" and would be an illegal practice under state law. These concepts were abandoned.

a. Steering Committee

Under the auspices of the Rural Health and Hospital Technical Advisory Committee (TAC), Georgia moved forward to develop a State Rural Health Care Plan by establishing a Steering Committee consisting of the following agencies and organizations. Note: (**Appendix A** shows the membership of the Steering Committee and the TAC).

- Department of Human Resources/ Office of Regulatory Services
- Department of Community Health/ Office of Rural Health Services
- Georgia Dept. of Community Health/Division of Health Planning
- Georgia Dept. of Community Health/Division of Medical Assistance
- Georgia Health Policy Center/Andrew Young School of Policy Studies
- GHA: An Association of Hospitals and Health Systems
- Administrator of a Rural Hospital
- Association of County Commissioners of Georgia
- Medical Association of Georgia.

The Steering Committee recognized the importance of collaborating in development of the Plan and assuring coordination with other rural health planning efforts in the State. The Steering Committee began meeting in October 1997, holding meetings two to three times a month. During these meetings it was decided that the Georgia Dept. of

Community Health/Division of Health Planning, in conjunction with the Health Strategies Council and the Council's Rural Health and Hospital TAC, would be the lead agency for development of the Plan, and that the State Office of Rural Health Services would be the lead agency for the Critical Access Hospital Program.

b. Public Input

In addition to the coordination achieved through the Steering Committee and the membership of the Rural Health and Hospital Technical Advisory Committee (TAC), a review of special studies and community input over the past ten years in Georgia was conducted by the TAC. This review went back to a 1987 Rural Hospital Task Force and included special legislative commissions and committees as well as other broad-based efforts to assess public opinion on rural health problems, issues and solutions in Georgia.

Highlights from the work of these groups included common themes and issues such as the following:

- Recruitment, retention and training of health care personnel;
- Access to basic health services;
- Need for regional/community planning;
- Concerns with reimbursement issues;
- Discrepancies between rural and urban health care; and
- Need for flexible regulations.

In addition to the public scrutiny of rural health issues described above, this proposed Plan will go through the same public comment process that all health plans developed by the Health Strategies Council undergo. This includes oversight by the TAC, review by the Strategies Council, and solicitation of comments through a thirty-day public comment period and one or more public hearings. The results of this process will be incorporated into the final approved Plan.

C. Philosophy and Vision

Philosophy

Georgia envisions rural health care systems which are integrated community-based human services networks providing access to high quality affordable healthcare for all of Georgia's rural citizens. The focus is on the community healthcare system, not just the hospital. However, the hospital is often the anchor of the community healthcare system and is usually central to the problem and the solution. The objective of rural health networks is to help communities improve the financial stability, quality, and appropriateness of their local healthcare services, including a reinvention of the rural hospital.

The problems in the local healthcare systems are very complex and are often interconnected with deep economic, and community leadership issues. Providers and communities are expected to establish, often in very short order, new and complex intra-community organizations involving multiple providers and provider types, while working simultaneously to develop regional affiliations and networks involving multiple communities. The magnitude of the changes facing most communities is unprecedented and destabilizing, and usually very disruptive.

Effective community and provider-based initiatives repeatedly have been shown to be the best determinants of how well rural communities sustain and strengthen their healthcare systems. While most of the work to establish initiatives must be done by the communities, liberal external consultation and technical assistance are crucial to long term success.

Successful rural health network development requires that adjacent rural communities efficiently share resources. Only after communities have strengthened their local healthcare systems and partnered with adjacent rural communities to the extent possible are they in the position to establish mutually beneficial relationships with regional tertiary partners.

Rural Health Networks are defined as organizational arrangements that use resources and/or governance structures from more than one existing organization. The organization and structure of existing rural health networks vary according to the goals of participants, the availability of providers, and the characteristics of rural communities.

The purpose of rural health networks is to encourage creative collaborative relationships among service providers in rural areas. Individual members of a network might include such entities as hospitals, public health agencies, physicians, home health providers, mental health centers, substance abuse service providers, rural health clinics, social services agencies, health profession schools, local school districts, emergency services providers,

community and migrant health centers, civic organizations, etc. The roles and responsibilities of each member organization should be clearly defined. Critical to the success of rural health networks is the collaboration of local, adjacent, and regional healthcare facilities/resources to assure the most comprehensive community health care systems.

The best way to facilitate the development of stronger community health systems is to aid in the community development process, including providing assistance with assembling accurate information, and technical assistance with great emphasis on decision making and implementation of plans. Often planning efforts have left communities with good plans, but without the leadership resources to implement them. The provision of direct community assistance is a very time consuming process. For the State of Georgia, successful implementation of such an effort will require the mobilization of all state organizations and agencies concerned with rural health toward the goal of supporting rural communities in the development of their healthcare system.

Vision

Integral to the work of the Rural Health and Hospital Technical Advisory Committee (TAC) and this Plan is a common understanding about the overall vision and goals for a rural health system in Georgia. After consideration of the issues identified by the TAC and discussion of several examples, the following vision was adopted:

Georgia envisions rural health care systems which are integrated community-based human services networks providing access to high quality affordable health care for all of Georgia's rural citizens.

III. STATE PROFILE

A. Description of the State

Georgia 's land area of 57,919 square miles makes it the largest state east of the Mississippi River (24th overall). Georgia falls within five major physiographic regions: The Blue Ridge Mountains in the northeast, the Ridge and Valley Province and the Cumberland Plateau in the northwest, the Piedmont across Georgia's center, and the Coastal Plain in the south. Elevations range from sea level to 4,784 feet at Brasstown Bald in the Blue Ridge Mountains.

The Blue Ridge mountain area features the southern terminus of the Appalachian Trail, a 2,100 mile hiking trail ending in Maine. The mountain range's peaks were once higher than the Rockies, but many years of erosion have worn them down to about a quarter of their original height. The Piedmont area is home to the red clay soil of Georgia

and its rolling hills and valleys. Southwest Georgia is known for its abundant farmland. The Coastal Plains feature the tidal swamps and lowlands of the coast and the northern reaches of the Okefenokee Swamp. The Piedmont and the Coastal Plains are separated by the Fall Line, an imaginary line marked by waterfalls and rapids, where rivers abruptly descend from the upland terrain to the lowland. This line also divides the diverse species of birds, trees, and plants found in Georgia.

All of Georgia's rivers are formed either within the state or along its boundaries. No river flows into Georgia from another state. Georgia has more than 67 thousand acres of state park land, on which the state operates 48 state parks and 14 historic sites.

With Atlanta as its economic engine, Georgia has become a leader in the South. The State has 4.6 major corporate headquarters per million population, the eleventh highest ratio in the nation, fourteen Fortune 500 firms and is the headquarters of five large non-profit organizations. There are 16 foreign consulates in the state as well as 25 foreign Chambers of Commerce and 39 trade, tourist, and cultural offices operated by 27 countries with 30 honorary consuls. Agriculture plays a strong role in Georgia's economy. Peanuts, cotton and pecans are the state's top crops. Also, Georgia ranked second nationally in poultry production (eggs and broilers) in 1994. In 1991, Georgia had a State Gross Domestic Product (GDP) of $144 billion, the 13th largest state GDP in the nation.

Nationally, Georgia has the 9th highest number of institutions of higher education. Of these 115 institutions, 69 are public, and 46 are private. Georgia is surpassed by only California, Texas, New York, and North Carolina in its number of public institutions of higher learning. There are ten urban public transit systems and twelve military bases in the state. Georgia has 159 counties, 533 municipalities and nearly 800 registered local government authorities. (*Georgia County Snapshots, Georgia Department of Community Affairs)*

B. Overview of the Demographics of Georgia

According to 1998 population estimates from the Office of Planning and Budget, the State of Georgia has 7,272,505 residents. By the year 2002, the state is estimated to have a population of 7,714,788. In 1998, sixty-nine percent (69.2%) of all Georgia residents live in areas designated as urban counties as determined by Metropolitan Statistical Area (MSA) status. The vast majority (69.2%) of Georgia's population resides in forty-two (42) urban counties; these counties represent 26.4% of all counties in the state. In addition to urban areas, the table below delineates rural areas as either secondary or primary using definitions developed by the Georgia Dept. of Community Health/Division of Health Planning. In 1998, 9.8% of Georgia residents resided in Secondary Rural Areas and 21.0% in Primary Rural Areas. Many of the counties are designated as primary or secondary rural have been designated Medically Underserved Areas and/or Health Professional Shortage Areas (**Appendix B**).

Population Estimates and Projections by Rural/Urban Areas, Georgia 1996, 1998 and 2002

Rural/Urban Area	1996		1998		2002	
	Total	Age 65+	Total	Age 65+	Total	Age 65+
Urban	4,835,953 (68.8%)	404,873 (60.4%)	5,031,711 (69.2%)	418,098 (60.8%)	5,383,127 (69.8%)	461,367 (62.1%)
Secondary Rural	692,377 (9.9%)	75,649 (11.3%)	712,129 (9.8%)	77,355 (11.2%)	750,611 (9.7%)	81,860 (11.0%)
Primary Rural	1,500,499 (21.3%)	190,184 (28.3%)	1,528,665 (21.0%)	192,543 (28.0%)	1,581,050 (20.5%)	199,994 (26.9%)
Total	7,028,829 (100.0%)	670,706 (100.0%)	7,272,505 (100.0%)	687,996 (100.0%)	7,714,788 (100.0%)	743,221 (100.0%)

Source: *Office of Planning and Budget Population Data*. Definitions: Urban = Inside Metropolitan Statistical Area; Secondary Rural = Outside MSA, county having population density greater than or equal to 100 per square mile; Primary Rural = Outside MSA, county having population density less than 100 per square mile

IV. OVERVIEW OF GEORGIA'S RURAL HEALTH ISSUES

A. HEALTH STATUS

Health status indicators are measures used to gain insight into a population's health. A 1997 report (Schafer, E., Ph.D. et al) indicates that health status in rural Georgia is positively related to the number of physicians, the number of employees in a county, the per capita income level in the county, and the educational level of the county. One health status indicator, infant mortality rate, is a critical measure of access to healthcare services. Georgia ranks 48th in the nation in infant mortality. The rate of infant mortality in Georgia's rural counties is 11.4/1,000 while it is 10.1/1,000 in urban counties. Areas in Georgia without adequate medical infrastructure had 33% higher infant mortality rates as compared to areas with adequate medical infrastructure. However, there has been a substantial drop in deaths due to Sudden Infant Death Syndrome (SIDS), the leading cause of infant death in Georgia. In the past three years, 33 percent fewer babies have died of SIDS. The rates of low birth weight births are also higher in rural counties.

Vast racial and geographic differences exist in health status in the state. The racial distribution in rural counties compared to urban counties is similar. However, disparities in mortality rates are evident. In 1995, whites were more likely to die as a result of suicide, lung cancer, and heart disease. Blacks, on the other hand, were more likely to die as a result of homicides, hypertensive disease, diabetes, and infectious diseases.

In 1995, the top ten major causes of death among Georgians were the following:

Cause of death	Rate/per 100,000 Population
Heart Disease	135.5
Cerebrovascular Disease/Stroke	57.1
Lung, Tracheas, Bronchus Cancer	54.9
Infectious and Parasitic Disease	38.4
Breast Cancer	27.9
Motor Vehicle Accidents	21.7
Diabetes Mellitus	17.0
Hypertensive Disease	16.8
Suicides	11.6
Homicides	10.3

Source: *Georgia Vital Statistics Report, 1995*

One troubling health issue facing Georgia's rural communities is teen pregnancy. The average teen birth rate in urban counties is 36.5 as compared to 53.7 in Georgia's rural counties. This represents a 68% higher rural teen birth rate. Distant rural counties have the highest rates of births to teens (Schafer, E., Ph.D. et. al).

Too many of Georgia's rural citizens live in poor, isolated areas without adequate transportation or access to local healthcare providers. Many families live from day to day in inadequate homes. The health status of these 2,192,876 people who reside in rural Georgia is fair to poor. Large proportions of the individuals and families in Georgia's rural counties cannot afford adequate healthcare, and local government is unable to provide help because long-term poverty undermines the tax base. In comparison, urban counties exhibit either a "very good" or "good" health status, according to a 1997 report entitled Health Education and Economics: The Rural Connection. Georgia's rural areas exhibit the following:

- Infant mortality rates are 10% higher;
- The rural child death rate (ages 1-14) is 29% higher;
- Poverty rate is 58% higher;
- Percent of the population living in poverty is higher;
- Percent of the population that is uninsured is higher;
- Those receiving inadequate prenatal care (<or =4 physician visits) 47% higher;
- Cancer death rate is 33% higher;
- Deaths from motor vehicle accidents are 68% higher; and
- Adults with educational levels less than the ninth grade are two times higher

Source: Schafer, E., Ph.D., Tedders, S.H., Ph.D., & Davis, S., BBA, *Health, Education, and Economics: The Rural Connection, November 1997*

Socioeconomic and Health Characteristics

Health is a complex issue which is closely associated with economic development, education, transportation and ecology. A recent study completed by Mercer University School of Medicine entitled, *Health Education, and Economics: The Rural Community Connection* demonstrated that the health status of rural Georgia has great socioeconomic dependence. According to this report, though thirty-two percent (32%) of Georgians reside in rural counties, approximately forty percent (40%) of those who die each year are rural residents.

Based on data collected through this same report, there is clear evidence to show that the socioeconomic, demographic, and health status characteristics of urban and rural Georgia are vastly different. These data indicate that the proportion of households earning less than $10,000 annually is considerably higher in rural counties. Data also suggest that persons in rural counties are considerably less educated than urban residents. According to the 1990 census, 22% of adults in rural Georgia lacked high school diplomas.

Data from the Office of Planning and Budget indicate that in 1998 a total of 2,240,794 (30.8%) of Georgians live in rural areas. More than 39% are 65 years or older. Almost half of Georgia's rural residents live in counties designated by the United States Department of Agriculture (USDA) as persistent poverty counties. In these counties, the proportion of the population with household income below the federal poverty level has exceeded 20% for more than 40 years as indicated by U.S. Census data. More than 1,103,718 people live in rural persistent poverty counties in Georgia. These counties are often characterized by dangerous occupations (e.g., mining, farming, logging), dangerous recreational activity (e.g., hunting and swimming in farm ponds), unsafe homes (e.g., increased fire risks), and adults and children working with dangerous agricultural equipment, pesticides, and herbicides. Large proportions of the families in these counties cannot afford adequate health care. According to a recent study, Georgia's rural areas experience a poverty rate is that is 58% higher than urban rates. Additionally, both the percent of the population living in poverty and the percent of the population that is uninsured is higher than their urban counterparts.

Migrant farm workers and their families are estimated in Georgia to total as many as 100,000 persons during peak seasons. These families often do not access traditional healthcare services, even in areas where it is available. Their acute medical conditions often present a tremendous challenge to the fragile hospital systems in Georgia. A majority of their ER visits have been sufficiently documented as primary care.

The Georgia Primary Care Access Plan developed by the State Office of Rural Health Services, prioritized the 159 counties of the state for intervention using health status and census data. Based on selected healthcare indicators, (i.e., infant mortality, low birth weight rate, cardiovascular and cancer deaths, elderly population and poverty), counties with the rates that exceed the state rate using these criteria were targeted for primary care intervention. Over half of Georgia's 159 counties were targeted for primary care intervention. All of these counties are rural.

Low educational levels in rural communities also contribute to poverty and are associated with more dangerous occupations. As noted earlier, data from the U.S. Census for 1990 indicates that 22% of adults in rural counties lack high school diplomas, and 18.3% of adults dropped out of high school with less than a ninth grade education. Lack of education further limits the ability of individuals to fully participate in health care decisions. More than 40% of the population 25 years old or older living in rural counties in Georgia have less than a high school education. This is compared to 23.6% of the population living in urban areas. Industry in rural counties is more heavily centered around agriculture and manufacturing when compared to either the state or urban counties of Georgia. More than twenty-eight (28%) percent of industry in rural Georgia is manufacturing. More than eighteen (18%) percent of rural residents earn less than $10,000 per year. This compares to 11.1% in urban areas.

Georgia's rural economy continues to be in jeopardy due to the lack of corporate or industrial businesses. Inadequate health care resources and the lack of a healthy workforce are further barriers to attracting industry to the area. In many rural counties the hospital is the primary economic engine, unfortunately a number of rural hospitals are at risk for closure. A low ratio of healthy workers to dependents further drains the local economy.

B. HEALTHCARE DELIVERY SYSTEM

Overview of Georgia's Healthcare Facilities

Current data from the Division of Health Planning and the Office of Regulatory Services indicate that the following number of healthcare facilities exist in the State of Georgia:

- 159 General Hospitals;
- 28 Specialty Hospitals;
- 359 Nursing Homes;
- 1,808 Personal Care Homes;
- 122 Home Health Agencies;
- 58 Federally Funded Community Health Center sites;
- 137 Rural Health Clinics;
- 5 State-funded Primary Care Centers.

Health Utilization Statistics

Following is a brief summary of data collected from the Department of Community Health/Division of Health Planning during FY 1999:

Most Surgeries Conducted on an Outpatient Basis;

Ambulatory surgery procedures represented 66.5% of all surgeries performed in 1998, compared to 52.6% of total surgeries in 1990;

Growth in Cardiovascular Services

Some 10,256 open heart surgeries were performed in 1998, compared to 7,506 surgeries in 1990. Cardiac catheterizations in the state rose from 57,305 in 1992 to 74,150 in 1998. The increase in cardiac catheterizations were fueled primarily by the number of diagnostic catheterizations performed, which comprised 79% of total catheterizations during this period.

Drop in Home Health Utilization

After steady increases in the number of patients receiving home health services from 1990-1996, the number declined slightly in 1997 (159,097) and even more in 1998 (147,293). The average number of visits per home health patient also declined, falling from 69.6 visits per patient in 1995; 62.6 visits per patient in 1997; and 40.7 visits per patient in 1998.

Medicare as Primary Payer of Home Health

In 1998, Medicare was the primary payer for home health patients, comprising 73.2% of total patients, followed by Medicaid and CCSP with a combined total of 9.1% of total patients.

Minimal Increase in Nursing Home Beds

In 1997, Georgia had 38,766 nursing home beds. The average annual rate of increase in nursing home beds since 1990 has been less than 1%.

Medicaid as Primary Payer of Nursing Home Services

In 1997, Medicaid paid for 77.8% of total days, compared to 6.5% for Medicare and 15.6% private pay.

Dramatic Increase in Personal Care Home Beds

In 1999, Georgia had 32,948 beds in licensed personal care homes-more than twice the number of beds reported in 1993 (12,676). The number of beds nearly doubled between 1997 and 1999.

A major issue facing many facilities is survival due to managed care market penetration and decreasing resources. Small rural hospitals are having a particularly difficult time surviving as shown by the current hospital closure trend in the state. An updated document dated August, 2001 from the Georgia Dept. of Community Health/Division of Health Planning indicates that (12) general hospitals have closed since 1990. Of those, eight are located in rural counties, representing a loss of 291 beds. **(See Appendix C**) Other issues facing rural healthcare facilities include:

- Recruiting and retaining providers;
- Retaining Medicaid patients;
- Lack of state-of-the-art equipment and modern facilities which are not consistent with technological and industry changes make it difficult for rural facilities to be competitive;

- Rural facilities may be unable to pay competitive salaries and benefit packages to recruit administrative and support staff due to insufficient funds;

- Large proportion of rural residents seek health care outside of their local health care system;

- Changes in the funding structure of community health centers is threatening their survival.

Accessibility of Services

Accessibility, affordability, and the range of services offered are key issues related to the provision of health care services in rural areas. Despite major gains in access to care, rural residents continue to face greater barriers to care than urban residents. Rural emergency medical services are less well developed and they must travel farther for care than urban residents. Distance affects accessibility as well as the costs and remains an ongoing issue for most residents in rural communities because of the lack of transportation and the smaller number of facilities that provide services to people who are unable to pay for care.

Accessibility involves the location of the facility near the population it serves, the ability of the facility to offer several payment structures, operating hours, the degree to which a facility can handle walk-ins, and the extent to which the population perceives these aspects of accessibility as convenient. Though a facility may be considered accessible based on the above criteria, patients may not receive care because they are unable to reach the facility due to transportation difficulties. As previously noted, a high percentage of Georgia's rural population live below the federal poverty level and are unable to afford health care. It is critical that community-based health care systems collaborate to provide care to the uninsured and to Medicaid and Medicare populations.

Primary Care

Lack of access to primary health care has become one of the major problems plaguing the rural health care delivery system in Georgia. Access continues to be a problem of distribution rather than one of aggregate supply. Reasons for this distribution problem include general drawbacks of rural and poverty settings, lower compensation, longer hours, heavier patient loads, lack of practice resources and lack of peer physicians. With the rapid changes occurring in the health care system, the demand for primary care providers will be even greater in the future.

The Federal Bureau of Primary Health Care/ Division of Shortage Designation estimates that approximately 80% of Georgia's rural counties have primary care shortages hence are designated as Health Professional Shortage Areas (HPSAs). Region IV leads the nation in the number of Primary Care HPSAs; and Georgia not only leads this region but follows only California and Texas in the entire nation. (A list of HPSA's in Region IV appears as **Appendix D)**

Utilization of primary care services is reviewed, in part, on the basis of Medicaid and Medicare claims filed from rural facilities. Although rural primary care providers add large numbers of uninsured patients to their patient mix, these numbers are not fully reflected in reporting mechanisms. According to 1996 Census Population Survey data, 18% of Georgia s population is uninsured. A recent report of the Georgia Board for Physician Workforce(formerly Joint Board of Family Practice) indicates that the percentage of Family Practice physicians accepting Medicaid and Medicare patients continues to be higher in rural areas than urban areas.

Approximately 175,000 patients were seen for primary care in fiscal year 98 through community-based primary care. Twenty-two (22) of the 58 sites are located in rural counties. National trend data from the Association of Rural Health Clinics suggests that a minimum of 25% of patients seen in RHCs are Medicaid and/or Medicare recipients. The Georgia Migrant Health program served in excess of 17,000 patients in FY 96. State funded primary care centers reported serving 11,000 patients in FY 96. Much of the access for rural and under served populations in Georgia is created through several primary care programs that make up the rural safety net." Managed Care continues to present a tremendous challenge to rural safety net providers in Georgia. The Georgia Health Policy Center/Andrew Young School of Policy Studies is currently working throughout the state to develop strategies for maintaining the rural health safety net.

According to documents from the Georgia Division of Medical Assistance, in 1999, Georgia's Medicaid Program paid for health care services for 1,243,926 individuals. This total is up by 97% since 1996. Both cost-based reimbursement and Georgia’s Indigent Care Trust Fund (ICTF) have been major sources used to support and sustain primary care in rural Georgia. The ICTF is in its ninth year of operation. For smaller rural hospitals, funds are used to relieve some of the financial burden of providing uncompensated care to indigent patients. Approximately 75% of the hospitals participating in the Fund are located in rural areas of Georgia. The ICTF requires hospitals to utilize 15% of their trust fund receipts to provide and expand primary care services.

Payment reforms in both provider payments and cost-based reimbursement will have a direct bearing on the financial resources to provide primary care services in rural areas of the state. Issues of a single conversion factor for physicians and the phase-out of cost-based reimbursement for years 1998-2002 will have significant impact on financial viability, as the uncertainty of a potentially capitated system emerges.

The majority of rural hospitals experience extreme difficulty in accessing capital. This access issue makes it virtually impossible for many to make facility or equipment improvements, consequently, rural facilities are often less attractive to physicians. Grants from donations, private foundations and other local initiatives are not a reliable source,

yet these remain the predominant mechanisms that many rural hospitals in Georgia can obtain capital for purchases or improvements.

Broader financing options must involve the commitment of state policy makers, as well as the addition of more options for providers, (i.e., the Critical Access Hospital model). State officials will play a key role by addressing these issues and investing in alternative models to protect the future of the rural health delivery system.

On July 1, 1999, the Department of Community Health (DCH) was established in Georgia. The DCH has been given the responsibility for insuring two million (30%) of the state's population. Additionally, planning for health coverage of the uninsured as well as administering funds from a landmark tobacco settlement case was added to DCH's charge. Financial resources from the tobacco settlement offer a tremendous opportunity for providing primary care services to the state's uninsured and underinsured residents.

Some primary care initiatives which the State of Georgia has undertaken include:

- **Community Health Centers** - Federal operational grants allow community-based health centers the resources to maintain fees at reasonable levels, offer sliding fee discounts to patients who cannot afford to pay, and reach out to all community residents regardless of financial status. Community health center sites are located in more than 31 medically underserved counties in Georgia with service areas that encompass an additional 30 underserved counties. Services are provided or directed by board-certified primary care physicians (Family Practice, Pediatrics, OB-GYN, Internal Medicine) and multi-disciplinary teams which may include physician assistants, nurse practitioners, registered nurses, nutritionists, health educators, social workers and other clinical support staff. Approximately 83 primary care providers were employed in community health centers in FY 96. Sixty-three (63%) percent of community health centers reported having difficulty recruiting physicians. In 1998, community health centers, the single largest providers of comprehensive primary care for the underserved, uninsured, and under-insured in Georgia, provided ongoing medical care to more than 175,000 patients.

- **Rural Health Clinics (RHCs)** also serve as a source of locally-based primary care. There are 137 RHCs in Georgia as of January 2000. RHCs are required to provide outpatient primary care services. The majority of RHCs in Georgia are owned by hospitals and some are co-located within hospital emergency rooms to address primary care needs. All RHCs in Georgia are required to employ non-physician primary care providers. Some clinics have physicians who provide care on a full-time basis. Non-physician primary care providers have a higher rate of practice in rural Georgia than in urban areas.

- **Primary Care Centers** receive an operational subsidy through state grant-in-aid funds. Five centers are located throughout the state and each is staffed with one full-time Family Nurse Practitioner.

- **Migrant Health Centers** provide limited primary care services to migrant and seasonal farm workers and their families. Five project sites cover 18 counties in Georgia. The total state program employs one part-time Family Nurse Practitioner, one full-time Nurse Practitioner and one part-time family physician in select sites. A large number of patients are referred through individual voucher programs to local primary care physicians.

Other Resources

- **Rural Perinatal Transportation Grants**: The Georgia Chapter of the March of Dimes Birth Defects Foundation introduced this program in 1997. This program assists communities with resources to provide transportation to pregnant and postpartum women to healthcare appointments. Two grants were awarded in Georgia (Dalton and Talbot counties).

- **Rural Health Information Clearinghouse**: The Rural Health Information Clearinghouse (RHIC) is an information service. The purpose of RHIC is to provide information to health care planners and providers as well as others interested in Georgia rural health care delivery system issues. The Georgia RHIC is a network of resources at multiple sites throughout the state and elsewhere in the nation that represents a knowledge base of both print and non-print (electronic) resources. While this service is primarily targeted to the information needs of healthcare planners and administrators working in or with rural communities, RHIC access is available to all Georgia residents and Internet users. The primary clearinghouse resources are located at the State Office of Rural Health Services, the Georgia Dept. of Community Health/Division of Health Planning, Georgia Southern University's Center for Rural Health and Research and Mercer University School of Medicine. Additional resources include other state rural health programs and the Federal Government.

Public Health Departments

The State of Georgia has health departments in each of its 159 counties. The Board of Health is the authority at the county level responsible for the Public Health functions of assessment, policy development and assurance. Boards of Health in each county operate under O.C.G.A. 31-3-1. The responsibilities of the boards of health include protecting the health of the public, evaluating the health status of citizens of the county and planning strategies to address the health needs of the county. Boards are composed of seven members, representing local government and health care groups.

County health departments in the state are organized into ten health districts with some subdistrict structure. Districts have varying staffing patterns. However, the District Health Director is a physician. The District Health Director typically serves as the executive director of each board of health. There are approximately 5,000 people employed by county boards of health in Georgia. These employees are responsible for management and oversight of all public health programs in the county including the provision of health services, environmental health services and limited primary care services.

Health Departments in Georgia are funded by a combination of state grants, county revenues and collected patient fees. Funds are passed to local boards of health from the Georgia Department of Human Resources through contracts which specify service programs which must be operated. While some health departments receive direct federal grants, approximately half of the funding to local health departments are from the state government, 25% from county appropriations and 25% from patient fees. Medicaid is the primary payer source. The Division of Medical Assistance's reimbursement methodology is changing from a cost-based system to a capitated reimbursement system. This change has had significant revenue implications for county health departments in Georgia.

As is true in other states, county health departments in Georgia are struggling with the transformation of the healthcare system from a fee-for-service system to a capitated one. Concerns include reduction of the ability of safety net providers to treat indigent patients, quality of care and continuity of care by managed care providers and reduced levels of federal funding for indigent care. In many areas of the state, local health departments are the only source of healthcare. Should continual changes in the healthcare system force the elimination of public health departments, Georgia's rural communities will continue to be severely impacted.

Hospitals and Health Systems

Data from the Division of Health Planning/Department of Community Health indicates that in 1999 there were 159 general acute care hospitals in Georgia, eighty-six (86) of which are located in rural counties. There are 28 psychiatric and other specialty hospitals. The healthcare landscape continues to change. Data from the Division of Health Planning supports the following hospital trends:

- *Decline in Hospital Inpatient Days:*
  The average stay in a general hospital was 4.8 days in 1998, down from 5.8 days in 1990;

- *Hospital Outpatient Visits*
  Outpatient visits to hospitals almost doubled from 1990-1997, increasing from 4.1 million visits in 1990 to 7.7 million in 1998. Emergency visits have been relatively stable in recent years, with only a slight increase in emergency room visits reported from 1997-1998.

- *Hospitals Losing Money*

  Based on the 1998 Hospital Indigent Care Survey, 62 general hospitals experienced financial losses;

- *Hospitals Linking Up*

  In 1998 more hospitals participated in networks and bought physician practices than in 1996 or 1997. Approximately 55% of general hospitals participated in a network in 1998, compared to 39% in 1996. Hospitals owning or operating a primary care practice increased from 31% in 1996 to 40% in 1998. The proportion of hospitals belonging to an alliance remained constant (41%) for 1996 and 1997 and increased slightly in 1998 (42%).

- *Uncompensated Indigent/Charity Care*

  The revenue foregone by general hospitals for providing unreimbursed indigent and charity care stayed stable at $508 million in 1997 and 1998. In 1998, uncompensated care represented 4.6% of general hospitals' adjusted gross revenues.

- *Government as Primary Payer of Hospital Services*

  Since 1990 more than 60% of hospital patient days were covered by government payments. Medicare patient days comprised 48.8% of total patient days for hospitals in 1998, while Medicaid accounted for 15.4% of total patient days.

Supply and Utilization of General Hospitals by Rural/Urban Areas, Georgia 1998

Rural/Urban Area	Number of Hospitals	Capacity Beds	Beds Per 1000 Population	Admissions	Patient Days	Occupancy Rate
Urban	72 (45.3 %)	16,891 (69.4 %)	3.4	575,293 (71.0 %)	2,876,643 (73.0 %)	46.5 %
Secondary Rural	15 (9.4 %)	2,737 (11.2 %)	3.8	107,800 (13.0 %)	485,339 (12.0 %)	48.3 %
Primary Rural	72 (45.3 %)	4,713 (19.4 %)	3.1	131,180 (16.0 %)	571,728 (15.0 %)	32.9 %
Total	159 (100.0 %)	24,341 (100.0 %)	3.3	814,273 (100.0 %)	3,933,710 (100.0 %)	44.1 %

Source: *Annual Hospital Questionnaire, Georgia Dept. of Community Health/Division of Health Planning, 1998* (As of 4/38/00)

Definitions: Urban = Inside Metropolitan Statistical Area (MSA); Secondary Rural = Outside MSA, county having population density greater than or equal to 100 per square mile; Primary Rural = Outside MSA, county having population density less than 100 per square mile

As shown in the above chart, during 1998 there were 24,341 acute care beds (capacity beds) with an average occupancy of 44.1%. Among these general acute care hospitals the average length of stay is declining.

Urban hospitals report an average occupancy rate of 46.5% while rural hospitals average 40.6%. The table also shows the variations among rural and urban hospitals, with a lower occupancy rate 32.9% for primary rural hospitals (the "most" rural category).

Georgia's urban general hospitals show differences in Medicare and Medicaid admission patterns as compared to their rural counterparts. Data from the Georgia Dept. of Community Health/Division of Health Planning indicates that in 1998 Medicare and Medicaid admissions in urban hospitals represent 34.9% and 14.1% respectively while rural general hospital Medicare and Medicaid admissions were 44.2% and 19.9%. Differences in Medicaid and Medicare patient days are also evident. Medicare patient days for urban hospitals represent 45.1% of admissions and 15.1% of Medicaid Days. In rural hospitals Medicare days represent 54%; while Medicaid days represent 15.8 %.

Phenomenal change has taken place in the role of the hospital in the healthcare industry. These changes have precipitated among other things, an increase in the number of mergers, consolidations and shifting of ownership. The nature of these system changes gives rise to the need to develop a viable network of rural hospitals. Through the community planning and development process, it may be that some hospitals will close in favor of a stronger regional system that is more equipped to provide a wide array of services that can more appropriately meet the needs of the community and preserve access to care.

Telemedicine in Georgia

In November 1991, the Medical College of Georgia introduced an alternative healthcare system-telemedicine in the State of Georgia. Utilizing an interactive voice and video telecommunication system integrated with biomedical diagnostic instrumentation, the telemedicine system allows a physician at a specialty referral hospital the ability to examine a patient at a rural location. By electronically transporting the expertise at the referral hospital the Telemedicine healthcare delivery system has the following advantages:

- Providing immediate access to specialty consultation;
- Retaining the patient at the rural community hospital;
- Reducing delays in providing acute care;
- Maintaining continuity of care with the patient's primary care physician;
- Providing effective continuing medical education (distance learning), and
- Expanding medical capability as well as the ability to supervise non-physician healthcare personnel;
- Decreasing healthcare costs.

The impact of this system in the State of Georgia has been significant. Thirty (30) sites are operational in the state however more than 50 additional sites are planned. During 1997, more than 913 clinical encounters were

recorded. This contrasts from 125 encounters in 1992, the year that this technology was implemented in the state. More than eighty-three (83%) of these encounters were conducted in a clinic setting. Eighty-six (86%) percent of encounters involved a non-physician to physician consultation. Fourteen (14%) percent of consultations involved physician to physician interaction. This system is credited with saving more than $68,000 in Medicaid transportation costs and patient out-of-pocket expenses.

In order to further ensure that this system continues to serve our rural residents, the Georgia Legislature has enacted a Universal Service Fund. This fund ensures that rural health providers will receive discounts for a range of telecommunications services. The 1996 Telecommunications Act defined the Universal Service Fund as a mechanism for providing equity between rural and urban providers as it relates to Internet access, telemedicine, and other basic telecommunications services.

Long-Term Care

1998 data from the Division of Health Planning and the Office of Regulatory Services indicates that the State of Georgia currently has 359 Nursing Homes, 1,808 Personal Care Homes and 122 Home Health Agencies, of the home health agencies, (7) are not operational and (6) are temporarily closed. During this same reporting period, the state's nursing homes experienced over 35,600 admissions representing 13,152,645 patient days. At the same time, home health agencies reported over 151,012 patients 5,995,723 visits. Personal Care Homes reported a bed supply of 33,534 or 31.43 beds per 1,000, age 65+.

Data from the 1998, Annual Nursing Home Questionnaire indicates that the average occupancy rate for nursing homes in the State of Georgia was 93%. The rural areas of the state have experienced the highest statewide nursing home utilization, an average of 94.7% while urban nursing homes were 91.7% occupied. This is likely due to the unavailability of alternative long term care services in rural counties. In 1996, nearly 80% of nursing home patient days were paid for by Medicaid.

Supply and Utilization of General Nursing Homes by Rural/Urban Areas, Georgia, 1998

Rural/Urban Area	Number of Nursing Homes	Capacity Beds	Beds/Per 1000 Population Age 65+	Admissions	Patient Days	Occupancy Rate
Urban	170 (47.4%)	20,858 (53.8%)	49.9	22,743 (63.8%)	6,978,423 (53.1%)	91.7%
Secondary Rural	45 (12.6%)	4,663 (12.0%)	54.8	4,904 (13.8%)	1,619,825 (2.3%)	95.3%
Primary Rural	144 (40.0%)	13,258 (34.2%)	71.7	7,926 (22.4%)	4,554,397 (34.6%)	94.1%
Total	359 (100.0%)	38,779 (100.0%)	56.4	35,612 (100.0%)	13,152,645 (100.0%)	93.0%

Source: *Annual Nursing Home Questionnaire, Georgia Dept. of Community Health/Division of Health Planning, 1998*

Definitions: Urban = Inside Metropolitan Statistical Area (MSA)
Secondary Rural = Outside MSA, county having population density greater than or equal to 100 per square mile
Primary Rural = Outside MSA, county having population density less than 100 per square mile

During the early 1990's home health agencies experienced phenomenal growth in total capacity. Data from the Division of Health Planning indicates that the number of patients increased, from 148,090 patients in 1994 to over 163,081 patients in 1996. Patients 65 and over increased eight-fold. However, between 1996 and 1997 several changes were evident. The number of patients receiving home care decreased (163,409 in 1996; 159,098 in 1997) and the number of visits decreased (10,854,560 in 1996; 9,963,074 in 1997).

A significant declined continued to occur in the number home health patient base and the number of patient visits. Data from the 1998 Annual Home Health Survey indicates that the number of patients receiving home health services declined from 159,098 in 1997 to 147,293 in 1998. At the same time, the number of patient visits also declined from 9,963,074 to 5,995,723 respectively. 89.1% of all home health visits in the State of Georgia were paid for by Medicare.

C. HEALTHCARE PERSONNEL

In 1996, there were 14,739 physicians in the State of Georgia, according to a Georgia Board for Physician Workforce (formerly Joint Board of Family Practice) publication, *Physician Workforce 1998.* Sixty-seven (67%) percent of all physicians are located in the nine counties with a population greater that 150,000, which represents 44% of the

state's population. Additionally, only 17 of Georgia's 159 counties are above the GMENAC standard of 191 physicians per 100,000 population. This same document further states that in 1998 there were not enough physicians in the majority of Georgia counties to meet the demand for medical services, however when current Graduate Medical Education National Advisory Committee (GMENAC) standards of 191 physicians per 100,000 population are applied, Georgia will have a surplus of approximately 920 physicians in the year 2000. Data from The Georgia Board for Physician workforce indicates the following:

- In the eight year period (1990-1998), the State of Georgia has seen increases in most specialty areas including the following: family physicians 35.5%, internists 72.3%, Pediatricians 103%,OB/GYN's 42.4%, General Surgeons 25.5%;

- Applying both the GMENAC standards and the Georgia Board Policy standard for each discipline, each of the above mentioned specialties, with the exception of family practice, will experience excess capacity of physicians needed in Georgia in the year 2000. on-physician health care providers in rural areas are increasing due in part to the shortage of physicians in rural communities. A 1995 study conducted by the Center for Rural Health & Research, entitled *Census of Georgia Nurse Practitioners, Certified Nurse Midwives and Physician Assistants*, concluded that non-physician health care providers see more than 65,000 Georgians per week. Further that these providers play an important role as primary care providers and contribute toward improving the imbalance of primary care providers in rural counties. They constitute more than twenty percent (20%) of the primary care providers in the state. Seventy-five percent of these providers work in areas that are designated as Health Professional Shortage Areas. Mid-level providers include nurse practitioners, certified nurse midwives, and physician assistants.

Area Health Education Centers (AHECs) have worked toward the goal of improving access to quality care in underserved areas by increasing the supply of primary health care professionals in rural Georgia. This has been accomplished by linking communities with academic health science centers, in a manner that promotes cooperative solutions to local health needs. There are six AHECs whose planning areas cover over three-quarters of the state. AHECs are involved in the following activities:

- Developing community based clinical training opportunities within regions;
- Providing appropriate and needed continuing educational opportunities to practitioners working in the region;
- Developing collaborative partnerships to provide expanded program offerings;

- Assisting with the design and development of active learning resource centers and systems within regions to support students, faculty, and practitioners in AHEC regions;
- Recruiting local youth into health professions educational programs;
- Supporting local students through tutorials, mentoring and shadowing;

One major primary healthcare issue facing Georgia's rural communities is the maldistribution of primary care providers. This is due to the difficulty in recruiting personnel to these areas. Some of the recruiting difficulties include the following:

- Providers want to reside in or near a metropolitan area;
- Providers feel isolated from the medical community;
- Most of the population in the rural areas are Medicare/Medicaid recipients and/or are uninsured;
- There are fewer opportunities for on-call coverage and time off;
- Rural physicians have to work longer hours to earn the same amount of money as their urban counterparts;
- State-of-the-art equipment and technologies are often unavailable;
- Patient referrals and transportation in emergency cases may be difficult.

Source*: Starfield, Barbara, Primary Care, Oxford University Press, Inc., 1992*

Recruitment and Retention Strategies

Several governmental and private programs have been implemented in order to increase the supply of resources and to improve rural residents' ability to obtain services. The State of Georgia has been successful in securing some of these grants and has initiated programs to increase access to care for rural citizens. Among them are:

- **Rural Network Development Grant:** This program is designed for organizations that wish to establish vertically integrated systems of care in rural communities. The grant supports organizational development activities and services that may result from these activities.

- **Rural Health Outreach Grants**: These grants are available to support the direct delivery of health care and related services, to expand existing services, or to enhance health service delivery through education, promotion and prevention programs. The emphasis is on the actual delivery of specific services rather than the development of organizational capabilities. Projects may be carried out by networks of the same types of

providers or more diversified networks. To date, more than 11 grants in excess of $2 million have been awarded in the state.

- **Community Scholarship Program**: This program, administered by the National Health Service Corps, is designed to improve access to primary care in Georgia by providing federal matching dollars for scholarships to community organizations in Health Professional Shortage Areas for primary care providers. This program engages the community in recruitment efforts. Communities sponsor local students during training schools. Students agree to return to work in the sponsoring community. The Community Scholarship Program, currently in its sixth year of implementation in Georgia, is administered by the State Office of Rural Health Services (SORHS). At present, the SORHS administers three community scholarships, two certified midwives located in Calhoun and Decatur counties and one nurse practitioner in Bartow County. This program has been instrumental in increasing primary care providers in rural areas.

- **Federal/State Loan Repayment Program:** Several rural providers utilize incentives such as federal and state loan repayment programs. These incentive programs require providers to receive certain benefits in exchange for years of obligated service. Providers must agree to provide primary care services in a HPSA for a minimum of two years. Because of the complex issues surrounding retention of providers in rural areas, both state agencies that offer assistance and local community leaders continue to be challenged in this issue. The State Office of Rural Health Services (SORHS) placed a total of eighty-two (82) National Health Service Corps (NHSC) healthcare professionals in Georgia. Twenty-four (24) were NHSC scholars, fifty-six (56) were in the Federal Loan Repayment Program, (1) Federal program and (1) Non-obligated Federal program. SORHS staff also assisted with the State Medical Education Board/State Loan Repayment Program.

- **J-1 Visa Waiver Program**: The J-1 Visa is an educational visa obtained by foreign medical students who enter the United States to further their medical training. Federal Law requires that foreign physicians pursuing medical education or training in the United States obtain a J-1 Visa immigration status upon completion of training in order to remain in the United States. The physician must be located in a Health Professional Shortage Area. At present, there are one hundred forty-three (143) J-1 Visa physicians in the state.

- **State Medical Education Scholarship Program**: Most often referred to as "The Country Doctor Program," this scholarship program began in 1952. The purpose of the program is to recruit physicians for rural, underserved towns in Georgia and to provide financial assistance to medical students. Scholarship recipients are residents of Georgia who receive funds during medical school in return for their services as Medical Doctors (M.D.) or Doctor of Osteopathic Medicine (D.O.). These programs must be Board approved. Physicians agree to work in rural Georgia towns upon completion of their residency training. Recipients

choose among Family Practice, Internal Medicine, Pediatrics, OB/GYN and General Surgery. Practice obligations may be served in any town in the State of Georgia with a population of 35,000, or fewer persons, removed from any metropolitan location. Support is offered to program participants through the annual "Medical Fair," a recruitment function designed to bring resident physicians together with rural towns to discuss practice opportunities.

- **State Medical Education Board/State Loan Repayment Program**: Since its beginning, in 1990, the State Loan Repayment Program (State LRP) has funded 84 rural providers. The State LRP is funded from a 50/50 match of federal and state dollars to encourage health care providers (Medical Doctors, Doctors of Osteopathic Medicine, Physician Assistants, & Certified Nurse Practitioners) to practice in the most severely underserved counties in rural Georgia. The State LRP targets eligible Health Professional Shortage Area counties from the Primary Care Access Plan each year. Provider practice locations must be rural towns (35,000, or fewer, persons) in program targeted counties. Contracts are for two years, with first priority given to providers of obstetrical care. Providers must practice in non-profit practice entities and treat all patients regardless of their ability to pay.

D. MANAGED CARE

The advent of managed care has changed the organization, financing and delivery of healthcare. Hospitals, in response to the cost cutting requirements of managed care continue to restructure, consolidate services, purchase physician practices, and establish agreements with managed care plans.

The number of employers and consumers of healthcare enrolled in managed care plans is increasing both for the nation and in Georgia. Between 1990 and the end of 1995, the number of Americans enrolled in health maintenance organizations (HMOs) grew from 36.5 million to 58.2 million (*Health Affairs*, 1997). In Georgia, HMO enrollment more than doubled between December 31, 1990 (365,133 covered lives) and December 31, 1995 (826, 973 covered lives). By the year ending 1996, the number of HMO enrollees had risen to 952,469 persons, an increase of about 15 percent over the number of enrollees reported in 1995. As of October 1997 there were more than 1.4 million enrollees in managed care entities across the state. (*Office of the Georgia Insurance Commissioner, 1997 and Georgia Managed Care: The Harkey Report)*.

Managed care enrollment in rural Georgia is slowly gaining momentum. Although managed care activity is found predominately in Atlanta and the metropolitan area, most HMOs in the state have approved service areas in at least one rural county. As managed care becomes more prevalent in rural areas, there is potential for rural hospitals to experience increased financial distress. However, as managed care penetration grows, rural hospitals are expected to

form linkages and networks with other providers in order to maintain local access to the health care system. According to the GHA: An Association of Hospitals and Health Systems, in 1995, responses from 151 general acute care hospitals indicated that 41 percent were members of an alliance, 39 percent participated in a network and 31 percent owned or operated a primary care practice.

Commercial

As of October 1, 1997, enrollment in commercial health maintenance organizations in rural Georgia is 1.5% of the potential commercial market (total population minus Medicare and Medicaid eligibles, dual Medicare/Medicaid eligibles, and the uninsured population). Total enrollment in HMO plans in rural Georgia is 25,339 (13,125 in HMOs and 12,214 in Point of Service (POS) plans). More than 50% of the commercial market in rural areas of Georgia is enrolled in a Preferred Provider Organization (PPO).

Data from the 1999 The Harkey Report, indicates that as of July 1999, that the HMO market share in the State of Georgia is 37% of the commercial market. Not surprisingly, Atlanta, Augusta and Athens had the highest levels of HMO patients in the state representing 58.%, 36.1% and 28.2% respectively of the HMO market share. Savannah, Columbus and other non-metro areas represented smaller levels of HMO participation at 18.5%, 16.5% and 3.6% respectively.

Medicare

Managed care in the Medicare market is relatively new in Georgia. Information from the Georgia Hospital Association, indicated that during 1998 eighty-one rural residents were enrolled in Medicare Risk products. Enrollment is expected to grow in the future as AAPCC rates in rural counties make those markets more attractive to managed care organizations. Data from the 1999 Harkey Report indicates that Medicare risk enrollment has shown significant growth from July 1996 through July 1999 showing an increase of over 47,000 enrollees.

Medicaid

There are currently no Medicaid recipients in rural areas enrolled in HMOs. However, the Georgia Better Health Care (GBHC) program is operational in all 159 counties. GBHC is a primary care case management system and is mandatory for eligible recipients, unless they opt to enroll in one of the Division of Medical Assistance's (DMA) approved HMO programs. The purpose of the GBHC program is to establish a medical home for Medicaid recipients and match them with a primary care provider who will coordinate all of the recipients health care needs.

Rural hospitals are frequently left out of negotiations with managed care organizations. This creates access problems for rural residents who must bypass their local hospital and travel to a distant hospital in order to receive services from a hospital in their HMO network. The 1999 Harkey Report shows some interesting fluctuations in Medicaid HMO enrollment growth from July 1996 through June 1999. Starting in July 1996, there were approximately 3,155 Medicaid HMO enrollees. By July 1997 there was approximately a nine-fold increase in the number of enrollees equaling 28,872 enrollees. July 1998, there were 57,488 enrollees, almost doubling the totals from one year earlier. As of July 1999, there was a significant decrease in the number of enrollees from the previous year to 21,174 enrollees. This is likely explained by the closing of one of metro-Atlanta's HMOs that was connected to Georgia's largest public hospitals, Grady Health System.

E. QUALITY OF CARE

The accreditation process is one method of accountability for ensuring the provision of quality health care. There are many accrediting agencies and one of the first steps for any health care agency to establish credibility is to become accredited by the appropriate agency for their facility type.

Many rural health care facilities cannot afford the costs involved to become accredited. For this reason it becomes critical that the state and federal agencies develop criteria and assure adherence to them. Although regulatory and credentialing organizations have begun to acknowledge the resource difference between rural and urban facilities, many facilities still believe that systematic bias remains toward the relatively resource-rich, high tech urban medical facilities.

Several programs in Georgia are directed toward establishing quality guidelines and standards. One such program is the Georgia Hospital Association CARE (Collaborative Approach to Resource Effectiveness) Program. The Georgia Dept. of Community Health/Division of Health Planning (DHP) plans to partner with the Georgia Hospital Association, the Nursing Home Association, the Home Health Agency Association, and the Division of Medical Assistance to develop and/or identify indicators which can be used to measure quality among health care facilities.

Initial discussions have taken place with the proposed organizations. Future meetings with providers and the proposed organizations will be scheduled to develop a plan of action, delineate responsibilities, and to identify financial and other resources.

Primary care data systems in rural Georgia are not as well developed and often the medical records are less accessible. These differences in primary care complicate the challenges of quality assurance. Some of the common challenges faced by small rural hospital are:

- Limited resources to monitor, collect and analyze quality assurance data;
- Insufficient funds to purchase computers that can help analyze data on patterns and trends in patient care;
- Size and composition of the medical staff in rural facilities, hinder effective peer review;
- Role overload among those with quality assurance responsibilities. Large facilities usually have a full-time designated coordinator whose sole responsibility is quality assurance;

Resources are limited on every level in rural communities. Though progress has been made in rural Georgia, much remains to be done.

F. EMERGENCY MEDICAL SERVICES AND TRANSPORTATION

The Mission of the Office of Emergency Services is to encourage, foster and promote the continued development of an optimal system of Emergency Medical Care which provides the best possible patient outcome. The office strives to meet this goal statewide regardless of location of the need. There are ten (10) regional offices located in the cities of Rome, Gainesville, Marietta, La Grange, Dublin, Augusta, Columbus, Albany, Brunswick, and Athens. These offices provide direct services to emergency medical service providers, hospitals, and local governments in their respective EMS Regions. Each office is guided by and receives input from a Regional EMS Council. The ten Regional EMS Councils are composed of a broad base of individuals ranging from consumers to providers.

The State Office of EMS and Injury Prevention licenses emergency medical service providers, medical first responder units, and neonatal transport services. The Office also certifies automated external defibrillator providers. As of January 1, 2000, Georgia had 231 licensed emergency medical services, 188 ambulance providers, 36 medical first responder services, seven neonatal transport services, and 45 automated external defibrillator providers. In addition, six (6) rotor-wing air ambulance services were in operation within the borders of the state. While a large percentage of medical first responder services are volunteers, fewer than five (5) of the emergency medical services rely on volunteers.

Georgia certifies EMS providers at three levels; The entry level is the Emergency Medical Technician - Intermediate. This is the highest entry level in the United States for ambulance personnel. Certification at this level is executed by the Office of EMS and Injury Prevention after the candidate has successfully passed the National Registry of EMTs Examination for the EMT-Intermediate (written and practical). As of January 1, 2000, more than 31,000 EMTs had been certified, only 7,381 of whom remain active. The second level is the Cardiac Technician, a certification unique to Georgia. Individuals certified at this level can provide some advanced life support services. Cardiac Technicians are certified by the Composite State Board of Medical Examiners after successful completion of a Georgia Cardiac Technician Examination. As of January 1, 2000, there were approximately 150 active Cardiac Technicians in the state. The third level is the Paramedic. These individuals are also certified by the Composite State Board of Medical Examiners after the successful completion of the National Registry of EMTs Examination (written and practical) for Paramedics. As of January 1, 2000, there were approximately 4,400 active Paramedics in the state.

As of January 1, 2000, there were approximately 1,300 ambulances and first responder vehicles in Georgia. As of January 1, 2000, there were six (6) rotor-wing aircraft operating from base locations in Atlanta, Forsyth, Griffin, Jefferson, and Savannah. Military helicopters are also available under the MAST Program. Additional rotor-wing aircraft are based in large cities just outside Georgia's borders including Chattanooga, TN; Birmingham, AL; Tallahassee, FL; Jacksonville, FL; Columbia, SC; and Charlotte, NC.

The State Office of EMS and Injury Prevention encourages the development and expansion of a single, universal emergency access telephone number - 911. Although 911 exists in only two-thirds of Georgia's 159 counties, approximately 88% of the population resides in locations where 911 is available. Primary public safety answering points are generally operated by local governments under home rule, with some oversight by the Department of Administrative Services. In some areas, partnerships between rural counties have developed with one communications center serving two or more counties. Secondary public safety answering points are operated by EMS providers, hospitals, and local governments.

A coordinated trauma system is under development throughout the state. As of January 1, 2000, Georgia has 20 designated trauma centers (**Appendix E**). There are four (4) Level I Trauma Centers (Atlanta, Augusta, Savannah, and Macon). The six (6) Level II Trauma Centers are located in Dalton, Atlanta, Marietta, Columbus, Roswell, and Rome. Level III Trauma Centers have been designated in Lawrenceville, Stockbridge, Fort Oglethorpe, Thomasville, Milledgeville, Austell, Winder, Decatur, and Monroe. There is one (1) Level IV Trauma Center in the city of Madison.

In addition to these, Georgia has four (4) designated Pediatric Trauma Centers, three of which are in Atlanta and one in Augusta. Currently, at least six (6) other hospitals are actively discussing trauma center designation with their respective Regional EMS Councils.

There are barriers in several areas that impede the rural EMS System in Georgia:

1. **Retention of Emergency Medical Personnel**: Once Emergency Medical Technicians, living in rural areas, are trained and certified they often migrate to Georgia's urban areas to seek employment because of higher pay and better benefits with the larger services.

2. **Skill Retention**: Because of relatively low volume of calls and lack of in-service training programs and resources, EMTs in rural areas sometimes have difficulty maintaining their skills.

3. **Response and Transport Time**: In many rural counties, the EMS Services are small and are limited in the number of available ambulances and personnel. Some rural counties do not have an ambulance service, and must depend on neighboring counties for support. This situation causes extra long response and transport times for injured and sick patients. In addition, air medical transportation is not readily available.

4. **Equipment Replacement**: EMS vehicles have become increasingly sophisticated with the use of high tech equipment and are costly to replace. Small county budgets often are unable to support replacements.

5. **Medical Direction**: In accordance with the present rules and regulations for ambulance services, all licensed ambulance services must have a medical director who is a physician unless the county has a population of less than 12,000. Often, the physician is not adequately trained in Emergency Medicine. This causes problems in overseeing quality improvement and in-service EMS training programs in rural Georgia. In some cases, there is no physician to oversee the local ambulance service. The Medical Director of the EMS Region often must fulfill the position as an extra added duty.

Information in **Appendix F** have been developed by the State Office of Emergency Services to address barriers to EMS services in rural Georgia.

V. GOALS, OBJECTIVES AND ACTIONS

The following goals, objectives and actions have been developed based on the work of the Rural Health and Hospital Technical Advisory Committee.

Goal 1: Provide for the creation of rural health **networks** in the State.

Objective: Develop and implement a process for rural health network development in Georgia.

Action: Develop criteria for rural health networks in the State including criteria for defining/certifying the networks. Consider any existing networks in the criteria.

Goal 2: Promote **regionalization** of rural health services in the State.

Objective: Provide technical assistance to facilitate local planning efforts in development of local and regional solutions to health care problems in rural communities.

Action: Support technical assistance programs such as, but not limited to, the Georgia Health Policy Center/Andrew Young School of Policy Studies's Technical Assistance Program (the Safety Net Consortium) which are designed to facilitate local planning efforts. All such technical assistance programs should foster community-based solutions and should support communities in recognizing that many problems can only be solved by communities themselves and that problems and solutions should be viewed as part of a bigger regional picture.

Goal 3: Improve **access** to hospital and other health services for rural residents of the State.

Objective: Provide an array of options/strategies that may be available to assist rural communities in meeting their health care needs and to improve access to health care.

Action: Determine rural hospitals which are *necessary providers of health care services* to allow designation of Critical Access Hospitals under the Medicare Rural Hospital Flexibility Program.

Action: Develop a proposal for a Rural Health Systems Program, with revenues from the state budget surplus for one-time grants to rural communities. Such a program should improve access to care by encouraging the following:

- Infrastructure development (renovation, equipment acquisitions);

- Strategic planning (development of strategies for personnel recruitment or retention; the development of emergency medical network collaborative efforts; telemedicine, etc.);

- The avoidance of a potential crisis or collapse of essential rural health care services; and

- Other innovative approaches that encourage the restructuring of the rural health care delivery systems through early intervention.

Objective: Implement State policies and/or legislation regarding payment practices and financing issues which recognize the unique needs and access problems of rural communities.

Action: Support a phased-in statewide payment rate under the Division of Medical Assistance's Inpatient Hospital Payment Methodology.

Action: Support that the Medicaid payment rate for physicians equal that of the RBRVS Medicare rate and that dollars not be redirected from other Medicaid programs to pay for the increase.

Action: Support "Essential Rural Provider Access" legislation to allow rural hospitals to negotiate for managed care contracts.

VI. DESIGNATION OF CRITICAL ACCESS HOSPITALS

1. Federal Criteria

In order to be designated as a Critical Access Hospital (CAH), an entity must meet all of the federal legislative criteria for a CAH. These criteria are summarized below.

Eligibility	❑ Current hospital participating in Medicare ❑ Public or Not-for-Profit and For-Profit ownership
Hospital Status	❑ Rural hospitals, or as designated by the state as a rural hospital, including those that have closed for less than a 12-month period during the most recent calendar year.
Service Limit (Length of Stay)	❑ Provide inpatient care (for all patients regardless of payment type) for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient
Service Limit (Size)	❑ 15 Beds
Swing Beds	❑ Total beds should not exceed 25 Beds, (but no more than 15 acute patients at one time)
Location Criteria	❑ Rural county ❑ Rural census tract of a metropolitan statistical area ❑ Hospital qualifies as a rural, regional or national referral center ❑ The hospital serves as a sole community hospital ❑ Located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital, or another CAH OR Certified by the State as a *Necessary Provider* of health care services to residents in the area
Required Services	❑ Inpatient Care and Outpatient Care ❑ Emergency Care ❑ Laboratory

	❑ Radiology ❑ Some ancillary and support services may be provided part-time, off-site
Emergency Services	❑ Available 24 hours a day ❑ Staff has emergency services training or experience ❑ Staff is on-call and available immediately by telephone/radio and onsite within 30 minutes
Medical Staff	❑ At least 1 physician ❑ May include mid-level providers
Nursing Staff	❑ RN, CNS, or LPN on duty when there is an inpatient in the facility
Hours of Operation	❑ 24 hours per day if occupied ❑ If not occupied, emergency services made available
Medicare Payment	❑ Cost-based for inpatient and outpatient services
Network	❑ Network = one CAH and one other non-CAH hospital ❑ If a member of a network, agreements maintained with network hospital(s) for: Referral and transfer Transportation services Communications ❑ Agreement with network hospital, PRO, or equivalent for: Credentialing Quality Assurance

2. State Criteria for Certifying Necessary Providers of Health Services

Georgia has chosen the option of determining criteria for certifying Necessary Providers of health services in place of the 35-mile geographic location requirement. For this purpose, a Necessary Provider is a hospital that provides "essential health care services" based on practical, scientifically sound and socially acceptable methods and technology to optimize the health of the population and to improve health status in rural and underserved communities. The hospital should meet the requirements for network membership (e.g., through Memoranda of Agreement/Understanding with appropriate network facilities) as specified in this Plan. Essential services are those

defined in the Federal Conditions of Participation for the CAH program. Applicant hospitals must have no more than 100 licensed beds and must qualify for designation in one of the following categories (each category is described below):

- The hospital is located in a county targeted by the Georgia Primary Care Access Plan; or
- The hospital is considered at High or Medium/High Risk of Closure;
- The hospital is experiencing financial loss as is evidenced by the financial data taken from the most recent Financial Addendum of the Annual Hospital Questionnaire;

OR

- The hospital is located in a county in which greater than 50% of the individuals fall in Claritas Lifestyle Clusters with environmental, lifestyle, and biological characteristics that make them at high risk for poor health.

Georgia Primary Care Access Plan

The purpose of this statistical analysis is to rank Georgia's 159 counties on an index representing unmet health needs. This index gives equal weight to the following six indicators and surrogate measures of health status:

- Percent low birth-weight babies of total births
- Infant mortalities per 1,000 births
- Cancer deaths per 100,000 population
- Cardiovascular deaths per 100,000 population
- Percent elderly population
- Percent population living below 200% of the poverty level

The first five of these indicators were computed using aggregate data over the five year period, 1993 through 1997. The sixth indicator was computed by applying the number of persons living below twice the poverty level in each county in 1998 to the average population in that county for the 1993-1997 period.

The index was created as a simple additive scale which gives equal weight to each of the six items. Because the original indicators are expressed as percentages and rates of different orders of magnitude, each of these measures was converted to a normal deviate scale consisting of standardized Z scores. Briefly, Z scores express the

value of a particular case on a given scale in terms of the number of standard deviations that case falls above or below the mean on that scale.

While the individual data for all 159 counties are shown in the table titled *Georgia Health Status and Surrogate Indicators.* The standard Z scores for all six measures on all 159 counties are shown in the table titled *Health Status and Surrogate Indicators: Z Scores*. The composite Z scores for each county, computed as the mean average of the six constituent measures, are shown in the far right-hand column of that table. The process of converting each of the six indicators into standardized Z scores expresses them in a common generic scale, and then taking the mean average of the six measures produces a composite Z score in which each of the constituent measures has the same weight as the others. Counties with positive composite Z scores tend to be above the mean average on most or all of these measures. Thus, the counties with the highest composite Z scores, those in the range exceeding .5, are those which rank the highest on this set of health status indicators and surrogate measures.

The table titled *Counties with Highest Rankings on Unmet Health Needs* shows the top 40 counties in rank order based on these composite Z scores. It should be understood that since these Z scores were computed on the six indicators expressed as percentages and rates, these ranking serve to identify those counties with the greatest needs in relative terms, on a per birth or per capita basis.

Following these analyses, each county is ranked ordinally. Those counties whose rank falls in the top half (numbers 1-80) are considered those with high primary care access needs. Interventions may consist of one or more of the following community development interventions:

- HPSA, MUA or MUP designation
- Federal Loan Repayment
- Rural Health Clinic
- Community Scholarship Program
- Community Health Center/ Federally Qualified Health Center
- Managed Care Network Development
- General Recruitment

Risk of Hospital Closure

The methodology for identifying hospitals at risk for closure included reviewing the literature to identify factors affecting risk of closure, then using Georgia hospital data to "predict" risk for each hospital. Factors that generally raise a hospital's risk of closure include: smaller hospital size, lower inpatient occupancy rates, lower Medicare days, higher Medicaid days, higher area wages, and more local competition. Factors that lower the risk of closure are public ownership, higher Medicare case mix, and higher local per capita income. The hospitals were rank ordered by likelihood of closure and those at or above the 90th percentile were considered at high risk (nine hospitals). Those hospitals in the 75th to 90th percentile were considered at medium high risk (41 hospitals). The complete list of hospitals with their risk categorization (Adams and Custer) can be found in **(Appendix G).**

Financial Loss

Every hospital in the State of Georgia is required to respond to the Annual Hospital Questionnaire (AHQ). One component of the questionnaire is the Hospital Indigent Care Survey & Financial Addendum (Financial Addendum. The following categories from the Financial Addendum should be analyzed to determine financial loss: Total Net Revenue, Total Expenses and Margin (dollars and percentage). Total Expenses are subtracted from Total Net Revenue to determine Margin. The Margin is then calculated as a percentage. All applicable hospitals with negative operating margins are operating at a financial loss.

Claritas Lifestyle Clusters

The Claritas Marketing Data System has been leased by the Georgia Division of Public Health. This vast inventory of statistics, used to describe the consumer habits of the American public, is most often used by businesses to promote consumption of their products to customers. However, public health agencies may also utilize marketing data to augment traditional sources of health data.

In the year 1995, the Claritas System identified 62 lifestyle clusters in the United States. These clusters were identified through a complex statistical analysis that includes more than 600 key census measures combined with

consumer purchasing patterns. The Claritas System can identify the dominant clusters in specific geographic locations (Georgia Department of Human Resources/Division of Public Health/Public Health Marketing Data Directory).

For purposes of this proposal the rural counties whose populations were most at risk for poor health outcomes were identified. Information in the Claritas system which would reflect the environmental, biological, and lifestyle components of a health status assessment were selected. The "at risk" criteria were as follows:

- The individuals in the cluster are at higher risk than others for the top four chronic disease causes of hospitalization in the State of Georgia;
- The individuals in the cluster have more out-of-pocket medical expenditure than others in the State of Georgia;
- The individuals in the cluster have more tobacco expenditures than others in the State of Georgia;
- The individuals in the cluster are at risk, based on general cluster demographic characteristics such as income, occupation, education, home value.

Those health status lifestyle clusters which are most "at risk" include the following: Agribusiness, Back Country Folks, Norma Rae Ville, Scrub Pine Flats, Grain Belt, Mines & Mills, Hard Scrabble, Country Blues, Back Country Folks, Blue Highways, River City, USA and Rustic Elders. As expected, the poorer rural clusters have the highest "risk" on the selected variables. Hospitals located in counties in which more than 50% of the individuals fall in the "at risk" clusters will be designated as necessary providers. Clusters were defined as at risk if the cluster placed more than one standard deviation above the mean on at least three of the four criteria.

Based on these criteria, 69 hospitals are eligible to apply for CAH Designation. (**See Appendix H**) It is hoped that the endpoint of these hospital conversions will be improved access to appropriate healthcare services for community members, enhancement of the regional healthcare system, improved integration of rural health delivery systems and enhanced emergency medical systems. The Governor, the General Assembly and the Department of Community Health continue to explore ways to provide additional financial resources and support to Georgia's rural communities.

3. LICENSURE AND OTHER STATE HEALTHCARE REGULATORY ISSUES

Specific concerns about licensure are addressed in this Plan under the section on Application Content. For example, special criteria pertaining to emergency services are referenced below and are included in the appendix. In addition, the Office of Regulatory Services (Licensure) and the Georgia Dept. of Community Health/Division of Health Planning (Certificate of Need) have collaborated to assure that there are no outstanding regulatory issues. All hospitals receiving critical access hospital status must reduce the number of licensed beds to 15 acute care beds, or up to 25 beds, if the facility offers a Swing Bed Program. The maximum evaluated bed capacity could remain the same. There would be no Certificate of Need (CON) requirement to reopen beds, providing the cost to do so doesn't exceed the capital expenditure threshold that governs the Certificate of Need program. An increase in the number of beds beyond CAH limits would disqualify the hospital from participating in the CAH program.

4. CRITICAL ACCESS HOSPITAL DESIGNATION AND REVIEW PROCESS

There are two sets of requirements (federal and state) that must be met before a hospital is designated as a Critical Access Hospital (CAH). Once these requirements are met, the hospital must be surveyed to assure compliance to all requirements and to obtain official CAH Designation. The designation process is described below.

(1) Education and Technical Assistance Activities

The SORHS will conduct activities to educate and inform the public about the Medicare Rural Hospital Flexibility Program and the designation of Critical Access Hospitals. Activities will include educational conferences, technical assistance workshops, newsletter articles and statewide meetings and conferences in collaboration with other rural health partners. Hospitals interested in being designated as a Critical Access Hospital should notify the SORHS of its wish to receive technical assistance. SORHS will work directly with the interested hospitals to assure compliance with federal and state guidelines.

(2) State Application Content

The application for designation as a Critical Access Hospital (CAH) should include the following:

(a) *Description and Ownership Status*

This includes a complete description of the facility including data for bed size, location, services currently provided, average daily census by service, average length of stay (ALOS) overall and for Medicare patients, inpatient and outpatient utilization by payor source (Medicare, Medicaid, other)

(b) *Assurances of ability to meet all Medicare Conditions of Participation as a Critical Access Hospital*

(Health Care Financing Administration: Conditions of participation)

(c) *Evidence of Participation in a Network*

1. Signed agreements with network hospital(s) for
   - Patient referral and transfer
   - Development and use of communication systems of the network
   - Provision of emergency and non-emergency transportation between the facility and the network hospital (The provisions of this agreement will be consistent with the state requirements in section (d) below.)
2. Description of the role of each network member
3. Description of services offered through the network
4. Appropriate contact information of all network members
5. Description of data collection and reporting capabilities
6. Letters of support (should include letters of support from the hospital's medical staff or local county medical society)

(d) *Hospital Emergency Services*

The following requirements for hospital emergency services were developed by the Office of Regulatory Services (ORS). ORS is responsible for inspecting, monitoring, licensing, registering, and certifying a variety of health and child care facilities and investigating complaints about such facilities. The office works to ensure that facilities and programs operate at acceptable levels, as mandated by state statutes and by rules and regulations adopted by the Board of Human Resources. ORS also certify various health care facilities to receive Medicaid and Medicare funds, through contracts and agreements with the Georgia Division of Medical Assistance, the Health Care Financing Administration and Food and Drug Administration of the U.S. Department of Health and Human Services. Hospitals applying for Critical Access Hospital Designation must provide assurances of intent to meet all state requirements as outlined below.

- The agreements between full service hospitals and Critical Access Hospitals shall include a requirement for an assessment of the emergency stabilizing skills of emergency room personnel at the CAH along with the availability of surgical services and ancillary services (e.g., laboratory, radiology). Emergency medical conditions that are most likely to need the skills/procedures/services that the CAH cannot provide shall be identified. Plans shall be established in concert with the emergency medical system for the appropriate transportation of patients with identified emergency medical conditions to ensure that patients get to the right place at the right time and with the right care provider. The agreement shall also include requirements for ongoing quality assurance evaluations of how well the CAH hospital is performing relative to the provision of emergency medical care and assurances that effective corrective actions will be taken to identified problems.

- The emergency medical system shall be informed at all times regarding the temporary closing of an ER. On-call staff shall be available to the emergency medical system via a beeper when the ER is closed.

- The blue hospital signs shall be removed from all roadways leading to CAH that are not open 24 hours/day, seven (7) days a week. If the hospital ER will not be open at all times, prior to the effective date of the transition to a CAH, the hospital must announce in newspapers and on the radio, in the geographic areas served, the possible closing of the hospital ER;

- Due to the length of stay at the CAH emergency and/or non-emergency transport may be required when a patient's condition deteriorates, or it is determined that the patient is in need of a longer length of stay or requires services which are not available at the CAH. The transport agreement should include assurances of the availability of reliable and timely transport.

- Critical Access Hospitals must be in compliance with state rules governing the medical oversight of physician assistants, nurse practitioners and allied healthcare professionals.

(e) *Community Needs Assessment*

1. Copy of the assessment of availability and utilization of health care services in the community, including acute inpatient care, outpatient care, primary care and emergency medical services; a description of the community including county/area demographics, health status (including prevalent diseases and environmental impact), the impact of managed care on the community, local economic trends, a listing of all healthcare resources, and an assessment of the strengths and weaknesses of the community's present healthcare system.

2. A description of the prioritized critical community health care needs which are impacting the delivery of healthcare services;

3. A description of the community needs assessment and decision making process, including delineation of the process used for data collection, community education and involvement, prioritizing community needs, and dissemination of the results to the community;

4. A description of the integration of services and collaboration with adjacent facilities to provide a wide array of services in meeting the needs of the community. This will be especially important in assessing applications of hospitals that may be competing for CAH designation in the same or overlapping service area.

(f) Health Care Delivery Plan

1. Copy of the health care delivery plan describing how the community needs identified in the needs assessment are to be addressed. The plan should include strategies for meeting community needs and how they will be accomplished, including identifying potential partnerships and cooperative relationships.

2. A timeline for implementation of the plan.

(g) *Financial Analysis of the Hospital*

1. Comparative analysis of hospital reimbursement for the most recent cost report year under Medicare PPS reimbursement and the proposed CAH cost-based reimbursement for the following categories: inpatient, swing bed, and outpatient services;

2. Audited financial statements and notes for the three most recently completed years;

3. A three-year projection of reimbursement as a CAH, showing financial feasibility to sustain the hospital.

(h) Telemedicine

Hospitals seeking CAH designation are strongly encouraged to establish linkages with the telemedicine system in an effort to offer a wide range of comprehensive services to Georgia's rural communities.

(3) Review Process

(a) For the purposes of this review, the following definitions apply:

1. **Clarifying information** means the process of providing supporting information regarding the proposed Critical Access Hospital (CAH) application, e.g., network participation, emergency services, needs assessment, health plan development and/or financial analysis.

2. "**CAH Review Committee**" means a group which is charged with providing comments and recommendations on applications for CAH designation to the State Office of Rural Health Services. The CAH Review Committee is comprised of a representative from the Georgia Dept. of Community Health/Division of Health Planning, the Office of Regulatory Services, the Division of Medical Assistance, the Medical Association of Georgia, the Georgia Health Policy Center/Andrew Young School of Policy Studies, the Association of County Commissioners of Georgia, the Georgia Hospital Association, a clinician/healthcare provider, and a rural hospital administrator who is not and will not be a CAH applicant**.**

(b) The State Office of Rural Health Services (SORHS) will accept applications at anytime throughout the calendar year.

(c) The review cycle will be conducted in the following manner:

1. The review cycle will be sixty (60) working days in duration.

2. The first day of the review cycle will be the day upon which all applications are deemed to be received.
3. No later than the fifteenth (15th) working day of the review cycle, the SORHS will, if appropriate, submit a written request to all pertinent applicants for clarifying information. This written request may be distributed in a meeting with the applicant(s). The purpose of the request for clarifying information will be to obtain information from the applicant(s) that supports the information submitted with the original application.

4. No later than the fifteenth (15th) working day from the date of the letter requesting clarification, the applicant(s) will submit any clarifying information requested by the SORHS.

5. No later than the forty-fifth (45th) working day of the review cycle, the SORHS will send an analysis of each application to each member of the CAH Review Committee. No later than the fifty-fifth (55th) day of the review cycle, each member of the CAH Review Committee will submit comments and recommendations to the SORHS for consideration in the final recommendation.

6. No later than the sixtieth (60th) working day of the review cycle, the SORHS will provide written notification to the Health Care Financing Administration of its decision to recommend approval or denial of the pertinent applicant(s) for designation as Critical Access Hospitals. These recommendations will also be sent to all members of the Review Committee and to the Commissioner of the Department of Community Health.

(4) Final Designation

Final designation of a hospital as a CAH is contingent upon a facility survey conducted by the Office of Regulatory Services (ORS), Department of Human Resources, in accordance with the Health Care Financing Administration (HCFA) Conditions of Participation for Critical Access Hospitals. After completion of the facility survey by ORS, and recommendation to, and approval from HCFA, an official letter to operate as a Critical Access Hospital will be sent to the hospital and ORS by the Health Care Financing Administration (HCFA). ORS will send copies of HCFA's letter of CAH notification to, the State Office of Rural Health Services, all members of the Review Committee and the Commissioner of the Department of Community Health.

VII. List of References

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State of Georgia
Rural Health Care Plan

APPENDIX A

Members, Rural Health & Hospital
Technical Advisory Committee (1998)
&
Members, Critical Access Hospital
Steering Committee (1998)

1998 Members of Rural Health and Hospital Technical Advisory Committee

Charlene M. Hanson, Ed.D. F.N.P., Chair, Georgia Southern University, Member, Health Strategies Council

Taffey Bisbee, Senior Manager, Gill/Balsano Consulting

Dan Beall, Principal, Healthcare Advisory Group

Tim Burgess, Director, Office of Planning & Budget

C. Scott Campbell, Executive Director, Bulloch Memorial Hospital

Clay Campbell, Executive Vice President, Archbold Health Services, Inc.

The Honorable Buddy Childers, Representative, District 13

Maxine Chriszt, Associate Legislative Director, Association County Commissioners of Georgia

Darleen Cox, R.N., Executive Director, Phoebe Home Care representing Georgia Association of Home Health Agencies

Carol Crawford, Director, Office of Minority Health, Department of Human Resources

Rita Culvern, Administrator/CEO, Jefferson County Hospital

Mary Kidd Davis, M.Ed., RN, Clinical Instructor, Morehouse School of Medicine

Robert Carter Davis, Jr., M.D., Member, Health Strategies Council

Camille Day, Executive Vice President, Georgia Academy of Physicians

William T. Deyo, Jr., Executive Vice President, Wachovia Bank, Member, Health Strategies Council

Bill Fields, Director, State Office of Rural Health & Primary Care, Department of Human Resources

Dennis Frazier, Vice President, Oconee Regional Medical Center

Cam Grayson, Director of Health Policy and Programs, Medical Association of Georgia

The Honorable Lt. Governor Pierre Howard

Charles Humphries, M.D., President, Georgia State Medical Association

Stan Jones, Esq., Nelson, Mullins, Riley & Scarborough, L.L.P.

Denise Kornegay, MSW, Assistant to the President for Health Policy, AHEC Program, Program Director, Medical College of Georgia

Scott Kroell, Chief Executive Officer, Liberty Medical Center

Joseph Lawley, Executive Director, State Medical Education Board

David Lawrence, Chief Executive Officer, BJC Medical Center

Jimmy Lewis, Leadership Group

Linda Lowe, Health Planner, Georgia Legal Services

Dan S. Maddock, President, Taylor Regional Hospital

Warren Manley, Chief Executive Officer, Camden Medical Center

D. Wayne Martin, Chair, Advisory Council on Rural Health, Crisp Regional Hospital

The Honorable Guy Middleton, Senator, District 50

Karen Minyard, Ph.D., Senior Research Associate, Georgia Health Policy Center

The Honorable Thomas Murphy, Speaker of House

Stephen Noble, President, Accord Healthcare

Gail Norris, Administrator, Telfair County Hospital

Chuck Orrick, Administrator, Donalsonville Hospital

Joe Parker, President, Georgia Hospital Association

Carla Parris, Executive Director, Hughes Spalding Children's Hospital

James C. Peak, Administrator, Memorial Hospital and Manor, Member, Health Strategies Council

Peggy Pierce, Chief Executive Officer, Calhoun Memorial Hospital

Wallace Plosky, Executive Director, Georgia Association for Primary Healthcare

James Purcell, President, Georgia Managed Care Association

Luther Reeves, CEO, Appling Healthcare System

Shirley Roberts, Administrator, Memorial Hospital of Washington County

John Robitscher, President, Georgia Rural Health Association

Martin Rotter, Director, Office of Regulatory Services, Department of Human Resources

Christine Samuelson, President, Georgia Nurses Association
Joe Simon, M.D., Medical Director, Scottish Rite Children's Medical Center
Douglas Skelton, M.D., Dean, Mercer University School of Medicine
Jay Strickland, Ph.D., Director, Center for Rural Health and Research, Georgia Southern University
Max Stachura, M.D., Director , Center for Telemedicine at Medical College of Georgia
David Tatum, Executive Director of Government Relations, Egleston Children's Health Care System, Member, Health Strategies Council
William R. Taylor, M.D., MPH, Commissioner, Department of Medical Assistance
Kathleen E. Toomey, M.D., M.P.H., Director, Division of Public Health, Department of Human Resources
Neil Vannoy, Executive Vice President, Blue Cross & Blue Shield of Georgia
Monty Veazey, President, Georgia Alliance of Not-for Profit Hospitals
Jennifer Goodenow Whitmire, Vice President of Gov't. Affairs, Georgia Chamber of Commerce
R. Lawrence Williams, Vice President, Georgia NetCare Health Systems, Inc.
Lauren Wynn, Program Specialist, Georgia Farm Bureau Federation

1998 CRITICAL ACCESS HOSPITAL STEERING COMMITTEE MEMBERS	
ORGANIZATIONS & ADDRESS	**NAMES OF REPRESENTATIVES**
Association of County Commissioners of Georgia 50 Hurt Plaza, Suite 100, Atlanta, GA 30303	Maxine Chriszt
Department of Human Resources/Division of Public Health/ Office of Emergency Medical Services 47 Trinity Avenue, SW, LOB-Suite 104, Atlanta, GA 30334-5600	Pamela Stone-Blackwell, RN
Georgia Health Policy Center Georgia State University University Plaza 1 Park Place South, Suite 660, Atlanta, GA 30303	Karen Minyard
Georgia Hospital Association 1675 Terrell Mill Road, Marietta, GA 30067	Jeff Hill Robert Bolden
Jefferson County Hospital 1057 Peachtree Street, Louisville, GA 30434	Rita Culvern
Department of Medical Assistance 2 Peachtree Street, NW, Suite 40.403, Atlanta, GA 30303	William Taylor, MD. Judith Elibert Dona Cole Butch Beaty
Medical Association of Georgia 1130 W. Peachtree Street, NW, Suite 550 Atlanta, GA 30309	Cam Grayson
Department of Human Resources/Office of Regulatory Services 2 Peachtree Street, Suite 32.415, Atlanta, GA 30303	Mattie Cox Ruby Durant Martin Rotter
Division of Health Planning (formerly State Health Planning Agency) 2 Peachtree Street, Suite 34.262 Atlanta, GA 30303	Karen Decker Stephanie Taylor Pamela Stephenson Raina Schactman
Office of Rural Health Services (formerly State Office of Rural Health & Primary Care) 2 Peachtree Street, 6th Fl. Annex Atlanta, GA 30303	Bill Fields Pat Shaw Janice Sherman

APPENDIX B

Medically Underserved Areas (MUAs)
&
Health Professional Shortage Areas (HPSAs)

MEDICALLY UNDERSERVED AREAS

County	Designation
Appling	WC
Atkinson	WC
Baker	WC
Baldwin	PC
Banks	WC
Barrow	PC
Bartow	WC
Ben Hill	WC
Berrien	WC
Bibb	PC(3)
Bleckley	WC
Brantley	WC
Brooks	WC
Bryan	WC
Bulloch	WC
Burke	WC
Butts	WC
Calhoun	WC
Camden	WC
Carroll	WC
Catoosa	PC
Charlton	WC
Chatham	PC, MUP
Chattooga	WC
Cherokee	PC
Clarke	PC
Clay	WC
Clinch	WC
Coffee	WC
Colquitt	WC
Columbia	PC
Cook	WC
Coweta	PC
Crawford	WC
Crisp	WC
Dade	WC
Dawson	WC
Dekalb	PC, MUP
Decatur	WC
Dodge	WC
Dooly	WC
Doughtery	PC(3)
Early	WC
Echols	WC
Effingham	WC
Elbert	WC
Emanuel	WC
Evans	WC
Fannin	WC
Forsyth	WC
Franklin	WC
Fulton	PC(3)
Gilmer	WC
Glascock	WC
Gordon	PC
Grady	WC
Greene	WC
Gwinnett	GOV
Hall	GOV
Hancock	WC
Haralson	PC
Harris	WC
Hart	WC
Heard	WC
Henry	WC
Houston	PC(2)
Irwin	WC
Jackson	PC
Jasper	WC
Jeff Davis	WC
Jefferson	WC
Jenkins	WC
Johnson	WC
Jones	WC
Lamar	PC
Lanier	WC
Laurens	WC
Lee	WC
Liberty	WC
Lincoln	WC
Long	WC
Lowndes	PC(2)
Lumpkin	WC
Macon	WC
Madison	WC
Marion	WC
McDuffie	WC

County	Designation
McIntosh	WC
Meriwether	WC
Miller	WC
Mitchell	WC
Monroe	WC
Montgomery	WC
Morgan	WC
Murray	WC
Muscogee	PC(2)
Newton	WC
Oconee	WC
Oglethorpe	WC
Paulding	PC
Peach	WC
Pickens	WC
Pierce	WC
Pike	WC
Polk	WC
Pulaski	WC
Putnam	WC
Quitman	WC
Rabun	WC
Randolph	WC
Richmond	PC(2), MUP
Rockdale	PC
Schley	WC
Screven	WC
Spalding	WC
Stewart	WC
Sumter	WC
Talbot	WC
Taliaferro	WC
Tattnall	WC
Taylor	WC
Telfair	WC
Terrell	WC
Thomas	WC
Tift	PC
Toombs	WC
Towns	PC
Treutlen	WC
Troup	PC(2)
Turner	WC
Twiggs	WC
Union	WC
Upson	PC
Walker	PC
Walton	WC
Ware	PC(3)
Warren	WC
Washington	WC
Wayne	WC
Webster	WC
Wheeler	WC
White	WC
Wilcox	WC
Wilkes	WC
Wilkinson	WC
Worth	WC

TOTAL DESIGNATIONS = 162
MUA TOTAL = 157
MUP TOTAL = 5

Key:

PC	Partial County Designation
WC	Whole County Designation
MUP	Medically Underserved Population
GOV	Exceptional MUP Designation

Updated August, 2001
Dept. of Community Health/Office of Rural Health Services

HEALTH PROFESSIONAL SHORTAGE AREAS

Appling (Low Income)
Atkinson
Bacon (Low Income)
Baker
Baldwin (Low Income)
Banks
Barrow (Low Income)
Bartow (Low Income)
Ben Hill (Low Income)
Berrien
Bleckly (Low Income)
Brantley
Bryan (Low Income)
Brooks
Bulloch (Low Income)
Burke (Low Income)
Butts (Low Income)
Camden (Low Income)
Calhoun (Low Income)
Candler (Low Income)
Charlton (Low Income)
Chatham *
Chattahoochee (Low Income)
Chatooga
Cherokee
Clay (Low Income)
Clinch (Low Income)
Cobb*
Colquitt
Cook (Low Income)

Crawford
Crisp (Low Income)
Dade (Low Income)
Dawson
Decatur (Low Income)
Dekalb *
Dodge (Low Income)
Dooly (Low Income)
Dougherty *
Douglas (Low Income)
Early (Low Income)
Echols
Effingham
Elbert (Low Income)
Emanuel
Fannin (Low Income)
Forysth
Franklin (Low Income)
Fulton *
Gilmer (Low Income)
Glascock
Gordon (Low Income)
Grady (Low Income)
Greene (Low Income)
Habersham (Low Income)
Hancock (Low Income)
Haralson (Low Income)
Harris
Hart (Low Income)
Heard

Houston (Low Income)
Jackson (Low Income)
Jasper
Jeff Davis (Low Income)
Jefferson
Jenkins (Low Income)
Johnson (Low Income)
Lamar (Low Income)
Lanier (Low Income)
Laurens (Low Income)
Lee
Liberty
Lincoln (Low Income)
Long
Lumpkin (Low Income)
McDuffie (Low Income)
McIntosh (Low Income)
Madison (Low Income)
Marion (Low Income)
Meriwether (Low Income)
Miller (Low Income)
Mitchell (Low Income)
Monroe
Montgomery (Low Income)
Morgan (Low Income)
Murray (Low Income)
Muscogee*
Newton (Low Income)
Oglethorpe
Paulding
Peach (Low Income)

Pickens (Low Income)
Pierce (Low Income)
Pike (Low Income)
Polk
Putnam
Quitman
Rabun
Randolph (Low Income)
Richmond *
Schley (Low Income)
Screven
Spaulding (Low Income)
Stewart
Sumter (Low Income)
Talbot (Low Income)
Taliaferro (Low Income)
Tattnall (Low Income)
Taylor
Telfair (Low Income)
Terrell
Toombs (Low Income)
Towns (Low Income)
Troup
Turner
Twiggs
Union (Low Income)
Walker
Walton (Low Income)
Ware (Low Income)
Warren
Washington (Low Income)
Webster
Wheeler (Low Income)
White (Low Income)
Whitfield (Low Income)
Wilcox (Low Income)
Wilkes
Wilkinson
Worth (Low Income)

Key:
* Part County Designations

Facility Designations

Butts
Cobb
Dekalb
Dodge (2)
Fulton (2)
Forsyth
Johnsonville
Mitchell
Wilcox
Wayne

State Designation Total **143**

Updated August, 2001
Dept. of Community Health/Office of Rural Health Services

APPENDIX C

Hospital Closures in the State of Georgia (as of August 2001)

HOSPITAL CLOSURES
1980-2000

HOSPITAL	COUNTY	TYPE[4]	DATE	BEDS
RURAL HOSPITALS[4]				
Seminole Memorial Hospital	Seminole	G	1/80	30
Montgomery Hospital	Taylor	G	8/82	16
Fort Gaines Hospital	Clay	G	7/87	35
Heard Community Hospital	Heard	G	5/88	29
Turner County Hospital	Turner	G	10/88	40
Terrell Community Hospital	Terrell	G	11/90	34
Marion Memorial Hospital	Marion	G	9/91	30
Parkside Lodge	Laurens	P	6/92	54
Crest Medical Center/Rockmart-Aragon	Polk	G	10/92	48
Pierce County Hospital	Pierce	G	10/92	22
Chattooga Medical Center	Chattooga	G	5/97	31
Woodridge Hospital	Rabun	P	9/98	42
Satilla Park Hospital	Ware	P	12/98	53
Ridgecrest Hospital	Rabun	G	8/99	49
Hancock Memorial Hospital	Hancock	G	3/01	52
Dooly Medical Center	Dooly	G	6/01	25
URBAN HOSPITALS[4]				
McLendon Hospital	Fulton	G	1/81	33
Community Hospital of Paulding County	Paulding	G	12/83	18
Bolton Hospital	Fulton	G	7/91	184
Fulton County Alcohol & Drug Treatment Center[2]	Fulton	P	1/93	90
Charter Brook Hospital	DeKalb	P	7/93	60
Buford Hospital	Gwinnett	S	8/93	24
Woodstock Hospital	Cherokee	G	4/94	21
Northridge Hospital	Muscogee	P	10/94	51
CPC Parkwood Hospital	DeKalb	P	1/96	152
Greenleaf Center-Erlanger	Catoosa	P	4/98	90
Midtown Hospital	Fulton	S	6/98	19
Georgia Mental Health Institute	DeKalb	SP	6/98	244

Brawner South Mental Health System	Henry	P	7/99	50
Bowdon Area Hospital	Carroll	G	11/99	41
Brawner North Hospital	Cobb	P	12/99	108
West Paces Medical Center	Fulton	G	12/99	294
Charter Winds Behavioral Health System	Clarke	P	2/00	80
Charter Lake Behavioral Health System	Bibb	P	2/00	118
Charter Augusta Behavioral Health System	Richmond	P	2/00	63
Charter Behavioral Health System of Atlanta at Midtown	Fulton	P	8/00	40
Metropolitan Hospital[3]	Fulton	S	11/00	64

[1] Hughes Spalding Medical Center was absorbed by Grady Memorial Hospital in 10/88; it reopened as a separate facility, Hughes Spalding Children's Hospital, in 7/95. Doctors Memorial Hospital and Jesse Parker Williams Hospital were absorbed by Crawford Long Hospital in 12/86 and 1/92, respectively.
[2] Fulton County Alcohol & Drug Treatment Center converted from licensure as a hospital to licensure as a residential Drug Abuse Treatment Program.
[3] Metropolitan Hospital converted from licensure as a hospital to licensure as an ambulatory surgery center.
[4] For the purposes of this document, rural hospitals are those located outside a current Metropolitan Statistical Area (MSA), and urban hospitals are those located within a current MSA.
[5] G = General acute care hospital; P = Freestanding psychiatric/substance abuse hospital; S = Other freestanding specialty hospital; SP = State psychiatric/substance abuse hospital

Prepared by Department of Community Health/ Division of Health Planning, August, 2001.

APPENDIX D

HPSA's for States in Region IV

HEALTH PROFESSIONAL SHORTAGE AREAS
Designated HPSA Summary Listing/Primary Medical Care

STATE	Total Designations	Whole Counties	Service Areas	Population Groups	Facility	Total Population	Estimated Unserved Population	Practitioners Needed To:	
								Remove Designation	Achieve (2,000:1)
Region IV	619	290	113	176	40	10,973,582	6,004,543	1,098	2,712
Alabama	63	27	13	21	2	1,377,168	748,168	128	341
Florida	94	19	13	38	24	1,664,615	952,945	212	440
Georgia	119	55	10	54	0	1,549,301	969,301	187	428
Kentucky	86	49	12	20	5	946,323	487,099	84	201
Mississippi	57	51	9	6	1	1,402,441	736,241	139	336
North Carolina	66	31	17	17	1	1,604,720	842,120	128	389
South Carolina	60	20	28	10	2	1,268,513	709,168	128	324
Tennessee	64	38	11	12	3	1,060,501	559,501	92	253

Source: Federal Bureau of Primary Health Care, Division of Shortage Designation (as of March 31, 1996)
Evan R. Arrindell, D.S.W., 301-594-3819

APPENDIX E

Georgia's Trauma Centers

TRAUMA CENTERS IN THE STATE OF GEORGIA

FACILITY	CITY	COUNTY
	LEVEL 1	
Medical Center of Central Ga. Inc.	Macon	BIBB
Memorial Medical Center	Savannah	CHATHAM
Medical College of Georgia	Augusta	RICHMOND
Grady Memorial Hospital	Atlanta	FULTON
	LEVEL 2	
Wellstar Kennestone Hospital	Marietta	COBB
Floyd Medical Center	Rome	FLOYD
North Fulton Regional Hospital	Roswell	FULTON
Medical Center-Columbus	Columbus	MUSCOGEE
Atlanta Medical Center	Atlanta	FULTON
Hamilton Medical Center	Dalton	WHITFIELD
	LEVEL 3	
Dekalb Medical Center	Decatur	DEKALB
Gwinnett Medical Center	Lawrenceville	GWINNETT
Henry Medical Center, Inc.	Stockbridge	HENRY
Columbia Barrow Medical Center	Winder	BARROW
John D. Archbold Memorial Hospital	Thomasville	THOMAS
Walton Medical Center	Monroe	WALTON
Oconee Regional Medical Center	Milledgeville	BALDWIN
Promina Cobb Hospital	Austell	COBB
Hutcheson Medical Center, Inc.	Fort Oglethorpe	CATOOSA
	LEVEL 4	
Morgan Memorial Hospital	Madison	MORGAN
	PEDIATRIC HOSPITALS	
Children's Healthcare of Atlanta	Atlanta	FULTON
Hughes Spalding Children's Hosp./ Grady Memorial Hospital	Atlanta	FULTON
Medical College of Georgia	Augusta	RICHMOND

Source: State of Georgia, DHR/Division of Public Health/Office of EMS & Injury Prevention (Revised 2/2/2000)

APPENDIX F

Georgia's Emergency Medical Services System

GEORGIA'S EMERGENCY MEDICAL SERVICES (EMS) SYSTEM

1. Georgia's Emergency Medical Services (EMS) System

Although ambulances first appeared on Georgia's roads in 1892, an emergency medical services system did not emerge until 1973, with the implementation of the EMS Act (O.C.G.A. 31-11, in which the General Assembly *A...declares that, in the exercise of the sovereign powers of the state to safeguard and protect the public health and general well-being of its citizens, it is the public policy of this state to encourage, foster, and promote emergency medical systems communications programs and that such programs shall be accomplished in a manner that is coordinated, orderly, economical, and without unnecessary duplication of services and facilities."* Georgia's EMS system is organized through a lead agency - The Office of Emergency Medical Services, Division of Public Health within the Department of Human Resources. The Office of Trauma was merged into the Office of EMS in mid 1997. On the state level, advice is received from two bodies. The first of these is the State EMS Advisory Council (EMSAC), composed of twenty-five (25) individuals who have expertise in EMS and related fields. The second is the State EMS Medical Directors Advisory Council, composed of twenty-five (25) physicians who have extensive knowledge and expertise in the disciplines of emergency care, trauma, pediatrics, communications, injury prevention, out-of-hospital/pre-hospital care, and hazardous materials/terrorism.

There are ten (10) regional offices located in the cities of Rome, Gainesville, Marietta, La Grange, Dublin, Augusta, Columbus, Albany, Brunswick, and Athens. These offices provide direct services to emergency medical service providers, hospitals, and local governments in their respective EMS Regions. Each office is guided by and receives input from a Regional EMS Council. The ten (10) Regional EMS Councils are composed of a broad base of individuals ranging from consumers to providers. Each Regional EMS Office also utilizes the services of a consulting medical director.

2. Emergency Medical Service Providers and Personnel

The State Office of EMS licenses emergency medical services providers, medical first responder units, and neonatal transport services. As of January 1, 2000, Georgia had 231 licensed emergency medical service providers, 188 ambulance providers, 36 first responder providers, 7 neonatal transport providers. In addition, three (3) rotor-wing air ambulance services were in operation within the borders of the state. While a large percentage of medical first responder providers are volunteers, fewer than five (5) of the emergency medical services rely on volunteers.

Georgia certifies EMS personnel at three levels; the entry level is the Emergency Medical Technician. Certification at this level is executed by the State Office of EMS after the candidate has successfully passed the National Registry of EMTs Examination for the EMT-Intermediate (written and practical). As of January 1, 2000 over 31,000 EMTs had been certified, only 7,387 of whom remain active. The second level is the Cardiac Technician, a certification unique to Georgia. Individuals certified at this level can provide some advanced life support services. Cardiac Technicians are certified by the Composite State Board of Medical Examiners (CBOME) after successful completion of a Georgia Cardiac Technician Examination. As of January 1, 2000, there were approximately 150 active Cardiac Technicians in the state. The third level is Paramedic. These individuals are also certified by the CBOME after the successful completion of the National Registry of EMTs Examination (written and practical) for Paramedics. As of January 1, 2000, there were approximately 4,400 active Paramedics in the state.

3. EMS Training and Education

Initial training for EMS personnel is provided throughout the state by hospitals, technical institutes, and colleges. Course must be approved by the Department. The State mandates a minimum of 310 hours for the EMT courses. Approximately 80% of the courses are taught under the auspices of technical institutes which are supervised by the Department of Technical and Adult Education (DTAE). Courses at these institutions consist of a minimum of 389 hours.

Cardiac Technicians are rarely offered as stand-alone courses. They are usually incorporated in the Paramedic Courses, which are offered at hospitals, technical institutes, colleges, Regional EMS Offices , and the Georgia Public Safety Training Center. Paramedic Courses consist of 800 - 1,200 hours of didactic and practical training.

EMTs are required to attend twenty-four (24) hours of training during each two-year certification period, as well as maintaining certification in cardiopulmonary resuscitation. Cardiac Technicians and Paramedics are required to attend forty (40) hours of training during each two-year certification period, as well as maintaining certification in advanced cardiac life support. For EMS Directors, the State Office of EMS intends to begin offering EMS Management Training on a annual basis. In addition to these courses, a wide variety of specialty courses and conferences are also available throughout the state. Among the specialty courses offered to providers are: Basic Cardiac Life Support (BCLS); Advanced Cardiac Life Support (ACLS); Neonatal Advanced Life Support (NALS); Pediatric Advanced Life Support (PALS); Pediatric Life Support (PLS); Pediatric Basic Trauma Life Support (PBTLS); Basic Trauma Life Support (BTLS); Pre-hospital Trauma Life Support (PHTLS); Hazardous Materials Recognition; Injury Prevention Specialist; Public Information, Education and Relations (PIER), and, Emergency Vehicle Operator's Course; just to name a few. Among the conferences offered in Georgia, some of which attract an international audience, are: The Georgia Extrication School - Athens; CHANGES (Changing Healthcare Approaches 'N Georgia - Carolina Emergency Services) - Augusta; EMS Management Conference - Unicoi; Georgia EMS Conference - Jekyll Island; Georgia EMS Educators Conference - Athens; TIME (Trend In Medical Emergencies) - Albany; EMS Physicians Conference - Macon; Emergency Preparedness Conference - Hinesville; and, the TEST (Tying Emergency Services Together) - Columbus. In additional to these, Georgia has also been host to many national conferences, including Lifesavers 2000 - National Conference on Highway Safety Priorities (2000), the National Council of State EMS Training Coordinators (1994 and 1999), the National Association of EMS Educators (1997), and EMS Expo.

4. Emergency Medical Vehicles

As of January 1, 2000, there were approximately 1,300 ambulances and first responder vehicles in Georgia. In addition, there were six (6) rotor-wing ambulances operating from six (6) base locations in Forsyth, Griffin, Jefferson, Savannah, and two from different location in Atlanta. Military Helicopters, available under the MAST Program, are based at Fort- Benning near Columbus. Additional rotor-wing ambulances are based in large cities just outside Georgia's borders including Chattanooga, TN; Birmingham, AL; Tallahassee, FL; Jacksonville, FL; Columbia, SC; and Charlotte, NC.

5. EMS Medical Oversight

O.C.G.A. 31-11-50 mandates that *A...each ambulance service shall be required to have a medical advisor."* There is an exception which applies to *A...any county having a population under 12,000.."* The role of the medical director is clearly defined in Department of Human Resources (DHR) Rules and Regulations for Emergency Medical

Services, Chapter 290-5-30-.05(6)(h). At the regional level, each of the Regional EMS Offices contracts with a Regional EMS Medical Director. At the state level, the entire system is overseen by the EMS Medical Directors Advisory Council.

6. EMS Communications

The State Office of EMS encourages the development and the expansion of a single universal emergency access telephone number - 911. Of Georgia's 159 counties, 115 counties have made 911 accessible to the public with approximately 88% of the population residing in an area where 911 is available. Primarily, public safety answering points (PSAP) are operated by individual county governments with some oversight by the Department of Administrative Services; however, PSAPs with 911 capabilities have additional oversight by the Georgia Emergency Management Agency (GEMA). Some rural counties have developed partnerships and established one 911 center that is serving two counties. EMS providers, hospitals, and local governments operate secondary PSAPs.

Communications between EMS providers and hospitals is primarily via radio, operating on a variety of frequencies, using VHF, UHF, 800 MHz, and other systems. DHR Rules and Regulations Chapter 290-5-30-.05(6)(d) requires ambulances to be equipped with two-way radio equipment that provides for ambulance-to-dispatch center communications and ambulance-to-hospital communications. The ambulance radio must be able to operate within the Regional and State Communications Plan.

7 Facilities and Trauma Systems

There are 170 general acute care hospitals in the state that provide essential health care services to the rural and urban communities of Georgia. Many of these hospitals have become integrated with other hospitals, EMS agencies, and other health agencies.

A coordinated trauma system is under development throughout the state. As of January 1, 2000, Georgia has twenty (20) designated trauma centers. There are four (4) Level 1 Trauma Centers (Atlanta, Augusta, Macon, and Savannah).The six (6) Level II Trauma Centers are located in Dalton, Atlanta, Marietta, Columbus, Rome, and Roswell. Level III Trauma Centers have been designated in Lawrenceville, Stockbridge, Fort Oglethorpe, Thomasville, Milledeville, Austell, Decatur, Winder, and Monroe. In addition to these, Georgia has one (1) Level IV Trauma Center in Madison. In addition to hospitals that have been designated as trauma center, Georgia also has three (3) designated Pediatric Trauma Center, two of which are in Atlanta and one in Augusta.

A Trauma Registry, which is the central data base depository of information regarding traumatically injured patients, is maintained within the State Office of EMS. The data are collected from all Trauma Centers and other hospitals who electively participate. The data are collated and then redistributed to all hospitals and is used for identifying trends or specific types of injuries occurring in local communities across the state.

8. EMS for Children

The Emergency Medical Services for Children (EMS-C) program is a federal funded initiative designed to reduce child and youth disability and death due to severe illness or injury. Georgia's EMS-C program has three identified goals under current grant funding. These goals are inclusive of Georgia's children from birth to 19 years of age and include training/education, injury prevention and strategic planning to assure that the special needs of children are

appropriately incorporated into the emergency services component of Georgia's Public Health Care System.

The strategies utilized to enhance the existing structure includes components of the Emergency Medical Services system which have a specific impact on infants and children, including:

Further strengthening the EMS-C System components established in previous implementation activities. These components include tiered training and information dissemination focused on health service providers in the areas of child well-being. Community-based illness and injury education derived through regional needs assessments. Systematic improvement centered around strengthening and expansion of data resources and system assessment, standards setting and regulatory initiatives.
Initiatives for Georgia's pediatric population has centered on the identification of intentional and unintentional injuries specific to county or geographical regions around the state. Also included in this identification are children who may be at a greater risk of mortality and morbidity due to the unavailable emergency services within a specified area. Training and educational programs have been established in the pre-hospital setting to address the treatment and/or management guidelines of various types of injuries. Education opportunities have also been provided to local emergency department staff in areas lacking trauma center facilities.
The EMS-C program has also identified and provided injury prevention informational programs and available resources to may of the health districts and regional EMS offices for local use. By utilizing established services available through the health district offices, resources and information on direct services have been increasingly available to the local EMS community and the local needs of Georgia's children. Of the projects developed under Georgia's EMS-C program, the Injury Prevention Specialist (IPS) and Community Education Specialist (CES) courses have proven to be very successful in utilizing local EMS providers and Health District staff as community educators in the injury prevention arena. The IPS course provides participants with information on identification of injuries, interventions, program development and evaluation utilizing data. The CES course focuses on presentation of data to the community and enhanced education to the community prevention. The CES course also provides participants with programs such as Accidents Aren't, Safety Advice from EMS, Pedal Programs, Safety Camp, National Standard Curriculum on Bystander Care, and Walk Alert for use in the local community.

9. Disaster Management

The State Office of Emergency Medical Services works aggressively to insure that all EMS providers are prepared to respond to disaster situations. Georgia's EMS community has had extensive experience over the last decade managing major (or potentially so) disaster situations. Examples include the Statewide blizzard of 1994, extensive flooding across central and southwestern Georgia in 1994, preparations for the Centennial Olympic Games of 1996, the Atlanta bombings of 1997, and the Y2K readiness activities and activation of 1999 and 2000. Numerous courses have been offered to out-of-hospital/pre-hospital care providers and ample opportunities exist for participation in tabletop and hands-on practical disaster drills, at local, regional, and statewide levels.

The Department of Human Resources/Division of Public Health recently revised its disaster response plans and has conducted extensive educational sessions and drills to assure that all employees are knowledgeable about disaster procedures. The EMS community works in close concert with the Georgia Emergency Management Agency in this arena.

Goals and Objectives of Georgia's Emergency Medical Services System

The Mission of the State Office of Emergency Medical Services is to encourage foster and promote the continued development of an optimal system of Emergency Medical Care which provides the best possible patient outcome. The office strives to meet this goal statewide regardless of location of the need. There are several barriers that impede the rural EMS System in Georgia:

1. Retention

Once Emergency Medical Technicians, living in rural areas, are trained and certified they often migrate to Georgia=s urban areas to seek employment because of higher pay and better benefits with the larger services:

Goal: To insure that adequate resources are available, appropriately organized and distributed so as to maintain and enhance a coordinated and effective EMS system in Georgia.

Objective: Develop, distribute, collect, compile, and analyze a multilevel comprehensive EMS needs assessment to determine:

Deficiencies and needs of Regional EMS Offices,
Skills assessment,
Needs of the customer/patient, and
Transportation needs of hospitals.

Distribute and collect surveys, then compile and analyze the data.

Goal: To evaluate EMS training in Georgia and determine if it meets the needs of the EMS providers and the citizens of the state.

Objective: Evaluate the current and projected human resource needs of the state.

Determine the current turnover rate of certified personnel.
Conduct a survey of EMS providers to determine their current and projected needs;
Collaborate with Georgia Board of Regents and Department of Technical and Adult Education to expand EMS educational programs as needed.

2. Skill Retention

Because of relative low volume of calls and lack of in-service training programs and resources, EMTs in rural areas sometimes have difficulty maintaining their skills.

Goal: To evaluate EMS training to determine if it meets the needs of the EMS providers and the citizens of the state.

Objective: Identify the need for speciality courses in all areas of EMS with concentration on the rural areas;

Develop training programs as required;

Provide a mechanism for the continual evaluation of EMS providers;

Assist medical directors in establishing quality improvement programs for their services.

3. Response and Transport Time

In many rural counties, the EMS Services are small and are limited in the number of available ambulances and personnel. Some rural counties do not have an ambulance service, and must depend on neighboring counties for support. This situation causes extra long response and transport times for injured and sick patients. In addition, air medical transportation is not readily available.

Goal: To determine if adequate air and ground transportation service is available in all geographic areas.

Objective: Develop a comprehensive air and ground transportation need assessment and conduct a survey of existing providers and of the state.

Goal: To examine the issue of mutual aid.

Objective: Ensure that a plan is in place for the immediate response of back-up assistance;

Determine if mutual aid should be part of the zoning plans in each region or if it should remain a requirement for each provider.

Goal: To establish minimum standards for air medical transport.

Objective: Promulgate rules and regulations for air medical transport;

Continue open dialogue with providers of air medical transport to create minimum standards of operation and care.

Goal: To evaluate certification and training of EMTs.

Objective: Review the issues surrounding First Responders and certification.

Examine the issues of First Responders and certification
Establish National Registry testing for First Responders.
Develop criteria and establish policy for the approval and implementation of expanded scope of practice.

4. Equipment Replacement

EMS vehicles have become increasingly sophisticated with the use of high tech equipment and are costly to replace. Small county budgets often are unable to support replacements.

Goal: To determine alternate methods of funding for service.

Objective: Review the cost associated with the delivery of EMS;
Develop a plan to insure continuation of present funding; and
Seek new avenues of funding in order to reduce cost to rural services.

5. Medical Direction

In accordance with the present rules and regulations for ambulance services, all licensed ambulance services must have a medical director who is a physician unless the county has a population of less than 12,000. Often , the physician is not adequately trained in Emergency Medicine. This causes problems in overseeing quality improvement and in-service EMS training programs in rural Georgia. In some cases, there is no physician to oversee the local ambulance service. The Medical Director of the EMS Region often must fulfill the position as an extra added duty.

Goal: To improve the overall system of medical direction in Georgia.

Objective: Ensure that appropriate leadership in medical direction is available and accessible at the state level.

Evaluate the current system of utilizing Advisory Council/EMS Directors to determine if this meets the needs of Georgia"s EMS System;
Secure funding for a State EMS Medical Director;
Reactivate the Regional Medical Directors network and strengthen the Medical Directors position and involvement with EMS system;
Develop a Continuing Education Course to be provided at the State Medical Director's level.

Objective: Develop minimum qualification criteria for EMS medical directors.

Survey all current EMS medical directors to determine qualifications;
Review other information to determine what additional qualifications could enhance their ability to perform the duties of an EMS medical director;
Develop ideal qualifications for EMS medical directors;
Review the current statutes, rules and regulations, and policies to determine if changes are needed of all to include some minimum qualifications for EMS medical directors.

Objective: Enhance the ability of local EMS medical directors to meet the responsibilities assigned by statute and rules and regulations.

Develop an orientation program for EMS medical directors;
Develop a resource manual for EMS medical directors.

Objective: Strengthen the system of medical direction for EMS providers in Georgia.

Develop an evaluation component for Medical Direction program;
Implement plans to promote interface with hospitals, emergency department groups, nursing staff agencies, and physicians' groups in order to enhance medical direction;

- Research clinical pathways and protocols to bring components closer together in content and format;
- Develop a coherent and uniform approach to patient care through service standards;
- Develop a standard, statewide formulary of drugs and biologicals;
- Encourage the use of medical directors to all responders involved in any aspects of patient care;
- Develop guidelines and updates for use of medical directors in any dispatch operation involved in pre-arrival instructions of medical priority dispatch;
- Recommend statutory and/or rule changes to clarify the use of standards protocols;
- Develop an organizational structure and communication linkages that incorporate all EMS medical directors within the state;

Develop a comprehensive recruitment and training program for EMS medical directors.

APPENDIX G

Identification of Georgia Hospitals at High/Medium Risk for Closure

IDENTIFICATION OF GEORGIA HOSPITALS AT HIGH/MEDIUM RISK FOR CLOSURE

HIGH RISK

County	Name of Hospital
Carroll	Bowdon Area Hospital ***(closed 11/99)***
Chattooga	Chattooga County Hospital ***(closed 5/97)***
Dade	Wildwood Lifestyle Center & Hospital
Early	Early Memorial Hospital
Lanier	Louis Smith Memorial Hospital
Miller	Miller County Hospital
Morgan	Morgan Memorial Hospital
Stewart	Stewart-Webster Hospital
Wheeler	Wheeler County Hospital

MEDIUM HIGH RISK

County	Name of Hospital
Appling	Appling General Hospital
Bacon	Bacon County Hospital
Bleckley	Bleckley Memorial Hospital
Brooks	Brooks County Hospital
Burke	Burke County Hospital
Butts	Sylvan Grove Hospital
Calhoun	Calhoun Memorial Hospital
Camden	Camden County Hospital
Candler	Candler County Hospital
Charlton	Charlton Memorial Hospital
Clinch	Clinch Memorial Hospital
Cobb	Promina Windy Hill Hospital
Dekalb	Decatur Hospital
Dooly	Dooly Medical Center ***(closed 6/01)***
Effingham	Effingham Hospital
Evans	Evans Memorial Hospital
Forsyth	Baptist North Hospital
Grady	Grady General Hospital
Hancock	Hancock Memorial Hospital ***(closed 3/01)***
Houston	Perry Hospital
Jasper	Jasper Memorial Hospital

MEDIUM HIGH RISK

County	Name of Hospital
Jefferson	Jefferson Hospital
Jenkins	Jenkins County Hospital
Liberty	Liberty Regional Medical Center
Mcduffie	Mcduffie County Hospital
Meriwether	Meriwether Regional Hospital
Mitchell	Mitchell County Hospital
Monroe	Monroe County Hospital
Murray	Murray Medical Center
Paulding	Promina Paulding Memorial Medical Center
Pickens	Mountainside Medical Center
Polk	Polk General Hospital
Putnam	Putnam General Hospital
Rabun	Rabun County Memorial Hospital
Rabun	Ridgecrest Hospital ***(closed 8/99)***
Randolph	Southwest Georgia Regional Medical Center
Screven	Screven County Hospital
Seminole	Donalsonville Hospital
Tattnall	Tattnall Memorial Hospital
Towns	Chatuge Regional Hospital and Nursing Home
Union	Union General Hospital

Source: Adams, Kathleen & Cluster, Bill, "Identification of Georgia Hospitals at Risk for Closure", Developed for the Georgia Health Policy Center's Safety Net Project, December 1997.

APPENDIX H

Hospitals in the State of Georgia Eligible to apply for Critical Access Hospital (CAH) Designation

HOSPITALS ELIGIBLE TO APPLY FOR CRITICAL ACCESS HOSPITAL (CAH) DESIGNATION IN THE STATE OF GEORGIA (Revised October 2001)							
Name of Hospital		County	County targeted by the Georgia Primary Care Access Plan	Hospitals at High/Medium Risk for Closure	Population "at risk" for Poor Health Outcome	Financial Loss (1998)	Licensed Beds (≤100 beds)
1	Appling Hospital	Appling	Y	Y		Y	39
2	Bacon County Hospital	Bacon		Y		Y	50
3	Baptist Hospital Worth County	Worth			Y		49
4	**∇ Baptist Meriwether Hospital**	**Meriwether**	Y	Y	Y	Y	**25**
5	Berrien County Hospital	Berrien			Y	Y	71
6	BJC Medical Center	Jackson				Y	90
7	**∇ Bleckley Memorial Hospital**	**Bleckley**	Y	Y	Y	Y	**25**
8	Brooks County Hospital	Brooks	Y	Y	Y	Y	35
9	Burke County Hospital	Burke	Y	Y	Y		25
10	**∇ Calhoun Memorial Hospital**	**Calhoun**	Y	Y	Y	Y	**25**
11	Camden Medical Center	Camden		Y			40
12	Candler County Hospital	Candler	Y	Y	Y	Y	60
13	**∇ Charlton Memorial Hospital**	**Charlton**	Y	Y	Y	Y	**15**
14	Chatuge Regional Hospital	Towns	Y	Y		Y	42
15	Chestatee Regional Hospital	Lumpkin			Y	Y	49
16	**∇ Clinch Memorial Hospital**	**Clinch**		Y	Y		**25**
17	Cobb Memorial Hospital	Franklin	Y		Y		71
18	Crisp Regional Hospital	Crisp	Y		Y	Y	65

	Name of Hospital	County	County targeted by the Georgia Primary Care Access Plan	Hospital at High/Medium Risk of Closure	Population "at risk" for Poor Health Outcome	Financial Loss (1998)	Licensed Beds (≤100 beds)
19	Dodge County Hospital	Dodge	Y		Y	Y	94
20	Donalsonville Hospital	Seminole	Y	Y	Y		65
21	⌘ Dooly Medical Center (closed 6/01)	Dooly	Y	Y	Y	Y	Closed
22	Dorminy Medical Center	Ben Hill	Y			Y	75
23	**∇ Early Memorial Hospital**	**Early**	Y	Y	Y		**25**
24	**∇ Effingham Hospital**	**Effingham**		Y	Y	Y	**25**
25	Elbert Memorial Hospital	Elbert	Y		Y	Y	52
26	Emanuel County Hospital	Emanuel	Y		Y	Y	72
27	Evans Memorial Hospital	Evans	Y	Y	Y		49
28	Fannin Regional Hospital	Fannin	Y			Y	34
29	Flint River Community Hospital	Macon				Y	49
30	Grady General Hospital	Grady	Y	Y	Y		60
31	⌘ Hancock Memorial Hospital (closed 3/01)	Hancock	Y	Y	Y		closed
32	Hart County Hospital	Hart	Y				82
33	Higgins General Hospital	Haralson			Y	Y	57
34	Irwin County Hospital	Irwin	Y		Y		34
35	**∇ Jasper Memorial Hospital**	**Jasper**	Y	Y	Y	Y	**17**
36	Jeff Davis Hospital	Jeff Davis			Y	Y	50
37	Jefferson Hospital	Jefferson	Y	Y	Y		65
38	**∇ Jenkins County Hospital**	**Jenkins**	Y	Y	Y	Y	**15**

	Name of Hospital	County	County targeted by the Georgia Primary Care Access Plan	Hospital at High/Medium Risk of Closure	Population "at risk" for Poor Health Outcome	Financial Loss (1998)	Licensed Beds (≤100 beds)
39	Liberty Regional Medical Center	Liberty		Y			32
40	Louis Smith Memorial Hospital	Lanier		Y	Y	Y	40
41	Meadows Memorial Hospital	Toombs	Y		Y		87
42	Memorial Hospital of Adel	Cook	Y				60
43	Memorial Hospital (Bainbridge)	Decatur	Y				80
44	McDuffie County Hospital	McDuffie		Y			47
45	Minnie G. Boswell Memorial Hospital	Greene	Y		Y	Y	46
46	Mitchell County Hospital	Mitchell	Y	Y	Y	Y	33
47	**∇ Miller County Hospital**	**Miller**	Y	Y	Y	Y	**25**
48	**∇ Monroe County Hospital**	**Monroe**		Y	Y		**25**
49	**∇ Morgan Memorial Hospital**	**Morgan**		Y	Y	Y	**25**
50	Mountainside Memorial Center	Pickens		Y			40
51	Murray Medical Center	Murray		Y	Y	Y	42
52	North Georgia Medical Center	Gilmer	Y		Y		50
53	**∇ Peach Regional Medical Center**	**Peach**				Y	**15**
54	Polk Medical Center	Polk	Y	Y		Y	58
55	**∇ Putnam General Hospital**	**Putnam**		Y	Y	Y	**15**
56	Rabun County Memorial Hospital	Rabun	Y	Y	Y	Y	49

Name of Hospital		County	County targeted by the Georgia Primary Care Access Plan	Hospital at High/Medium Risk of Closure	Population "at risk" for Poor Health Outcome	Financial Loss (1998)	Licensed Beds (≤ 100 beds)
57	**∇ Screven County Hospital**	**Screven**	Y	Y	Y	Y	**25**
58	**∇ Southwest Georgia Regional Medical Center**	**Randolph**	Y	Y	Y	Y	**25**
59	Stephens County Hospital	Stephens	Y				96
60	Stewart-Webster Hospital	Stewart	Y	Y			32
61	Sylvan Grove Hospital	Butts		Y		Y	25
62	Tattnall Memorial Hospital	Tattnall	Y	Y	Y	Data not reported	40
63	Taylor Regional Hospital	Pulaski	Y		Y		55
64	**∇ Taylor Telfair Regional Hospital**	**Telfair**	Y			Y	**25**
65	Union General	Union	Y	Y	Y		45
66	Washington County Regional Medical Ctr.	Washington	Y		Y		56
67	Wheeler County Hospital	Wheeler	Y	Y			40
68	Wildwood Lifestyle Center & Hospital	Dade		Y			13
69	Wills Memorial Hospital	Wilkes	Y		Y		50

Note: Hospitals appearing on this list are all rural with 100 or less licensed beds (licensed Beds confirmed utilizing 8/2000 data from Office of Regulatory Services). Each hospital has met at least one of the four state criteria for certifying necessary providers.

∇ Designated as CAH (data current as of 10/2001)

⌘ Hospital has closed. All hospitals that have closed are eligible to seek CAH designation, without having to obtain a Certificate of Need, within one year of closure.