



Georgia Medicare Rural Hospital Flexibility Program Evaluation



DECEMBER 2009



Prepared by Rural Health Solutions, Woodbury, Minnesota, www.rhsnow.com

Prepared for the Georgia Department of Community Health, State Office of Rural Health

Funded through a grant from U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, CFDA Number 93.241

December 2009

Many thanks to Georgia Critical Access Hospitals; health care providers; Georgia Department of Community Health, State Offices of Rural Health and Emergency Medical Services/Trauma; GHA; local and regional EMS agencies; health care providers, and other Georgia Flex Program stakeholders for their contributions to this report.

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Executive Summary

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

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

The Georgia Department of Community Health (DCH), State Office of Rural Health (SORH), administers the Flex Program in the state. During the past eleven years, the Georgia Flex Program obtained \$5,359,120 or an average of \$487,192 per year, from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, to implement the Flex Program in Georgia. It is the 27th highest funded program nationally. Georgia has 34 CAHs and no hospitals are currently pursuing CAH status. Over the past three years, the Georgia Flex Program has focused on supporting and sustaining CAHs, EMS, quality improvement and rural health planning as a part of its program activities.

The Georgia Flex Program has made progress towards advancing the national Flex Program goals, particularly those relating to CAH performance and quality improvement. This is evidenced by some CAHs' improved finances and operations, CAHs that have remained operational that would have closed without the Flex Program, improvements in CAHs' quality of care and possibly being the first Flex Program to support the development of outpatient outcome measures for its CAHs. Other examples of positive outcomes include:

- State stakeholders and CAHs' knowledge and use of the Georgia Rural Health Care Plan
- Ninety percent of CAHs reporting they are aware of the Flex Program
- Eighty-eight percent of CAHs reporting they are "very satisfied" or "satisfied" with the state's Flex Program
- Development of a web-based EMS training program with over 1,400 subscribers

Although the Georgia Flex Program has achieved much over the past three years, opportunities for program improvements also exist. For example, of the 11 EMS stakeholders interviewed, seven are not aware of Flex Program activities, EMS initiatives have been slow to start, CAHs are eager to engage in networking activities and a number of CAHs are experiencing significant financial challenges. In response, the evaluation includes a number of proposed recommendations to address the identified rural health/CAH challenges and needs.

Since the Flex Program is administered by the DCH, SORH, the evaluation recommendations are primarily targeted here. However, given the limited resources of the Flex Program as well as the roles and activities of other rural health stakeholders around the state, the recommendations should also be seen as an opportunity for improvement by all Flex Program stakeholders, in particular: Georgia

Hospital Association (GHA), Georgia Office of EMS, local and regional EMS, Area Health Education Centers, Georgia Medical Care Foundation, and CAHs.

Therefore, it is recommended that the Georgia Flex Program ¹:

- 1) Further educate stakeholders about the program
- 2) Conduct an independent and externally facilitated strategic planning process
- 3) Work towards addressing physician workforce issues
- 4) Respond to other key issues and opportunities as identified in the evaluation
- 5) Continue to monitor and evaluate outcomes within the context of program planning and implementation.

¹ The descriptive list of recommendations is included in Section 8: Recommendations.

Section 1: Evaluation Methods

This section of the evaluation describes the methods that were used to collect, analyze, and report evaluation information. It focuses on intended evaluation goals, outcomes, data collection methods, and the people and organizations involved in the data collection process.

A. GOALS

The Georgia Flex Program evaluation was an eight-month project that included two surveys, 25 key informant interviews, four CAH site visits, a review and analysis of program documentation and a review of CAH financial information. The evaluation goals were to: 1) measure satisfaction with activities performed at the state level, by grantees, in CAHs and communities; 2) identify and report grantee project outcomes; 3) identify and present stakeholder involvement in the development and implementation of the Flex Program; 4) determine consistency of program goals and how they are meeting state and national goals and objectives; 5) report specific CAH and community outcomes relating to supporting and sustaining CAHs, quality improvement and other aspects of the Flex Program; 6) identify program strengths and weaknesses; 7) identify key program and rural health needs; 8) make recommendations for program development and improvement; and 9) present strategic/planning/program development opportunities for the coming grant years.

The evaluation was to provide answers to many key questions about the Georgia Flex Program, such as:

- How is rural health in Georgia changing and how has the program contributed to these changes?
- How has program funding been distributed; what has it been used for; and what outcomes have resulted?
- What partnerships have emerged and/or evolved because of the program?
- What have been some of the greatest program accomplishments and successes and who has been affected?
- How could the program change to better meet the needs of its stakeholders?
- What approach should the program use to move from a retrospective to a concurrent evaluation process?

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

B. PROGRAM DOCUMENTATION

Information was reviewed to provide a historical perspective of Georgia's Flex Program's development and funding support, to identify the roles of entities involved and to understand stakeholder's level of program participation. The review also shed light on the relationships between

program implementation activities and program outcomes. Information collected and reviewed included:

- Flex Program Grant Applications 1999-2009 (Excluding 2003)
- 2005 Flex Program Evaluation, Turner & Company, LLC, December 2005
- 2006 FLEX Stakeholder Meeting including evaluations and surveys, Georgia State Office of Rural Health, March 23, 2006
- 2007 Flex Stakeholder Meeting including evaluations and surveys, Georgia State Office of Rural Health, February 8, 2007
- 2007 Flex Stakeholder Meeting TASC visit—agenda and participants, Georgia State Office of Rural Health, September 25, 2007
- 2008 FLEX Stakeholder Meeting including evaluations and surveys, Georgia State Office of Rural Health, February 14, 2008
- 2009 FLEX Stakeholder Meeting including evaluations, Georgia State Office of Rural Health, February 12, 2009
- 2009 CAH Fiscal Analysis Phase I—survey of participants
- 2009 Joint Meeting of CAH Phase I and Phase II participants, Georgia State Office of Rural Health
- Rural Health Care Plan, Critical Access Hospital Steering Committee, The Rural Health and Hospital Technical Advisory Committee, August 18, 2000
- State of Georgia Rural Health Plan, The Georgia Health Policy Center, September 2007
- Critical Access Hospital Financial Analysis – 2008, Draffin and Tucker, LLP, August 2008
- Critical Access Hospital Financial Analysis – 2008, Draffin and Tucker, LLP, January 2009
- GHA Flex Grant, Improving Quality of Care for Critical Access Hospitals, Fourth Quarter Report, June 1, 2008 - August 31, 2008
- GHA Flex Grant, Improving Quality of Care for Critical Access Hospitals, Final report, 2008 - 2009
- Medicare Rural Hospital Flexibility Grant Program, Emergency Medical Services Final Report, September 1, 2007 - August 31, 2008
- Medicare Rural Hospital Flexibility Grant Business Office Performance Improvement Program, HomeTown Health, First Quarter Report
- Medicare Rural Hospital Flexibility Grant Business Office Performance Improvement Program, HomeTown Health, Second Quarter Report
- Medicare Rural Hospital Flexibility Grant Business Office Performance Improvement Program, HomeTown Health, Third Quarter Report
- Medicare Rural Hospital Flexibility Grant Business Office Performance Improvement Program, HomeTown Health, Fourth Quarter Report

C. CAH SURVEY

A web-based survey of all Georgia CAHs was conducted from August 14 through October 22, 2009, with e-mail and telephone follow-up for non-respondents. All CAH hospital administrators/chief executive officers (CEOs) received an email outlining the survey, how the survey data would be used and requesting that the survey be completed online via the identified link. In addition, Flex Program staff from the SORH emailed all CAH CEOs requesting their participation in the survey. All CAH

survey responses were made online. Thirty-three of 34 CAHs responded resulting in a 97 percent survey response rate.

Considering the 52 questions on the survey:

- 29 CAHs responded to all but a very limited and random list of questions
- Four CAHs responded to a limited but somewhat random list of questions
- For most of the analysis, n=27, but ranges from 25 to 33 depending on the question

Most survey respondents (82 percent) were hospital administrators/CEOs while others were chief financial officers, business office managers, chief operating officers, assistant controllers, and vice presidents of quality. Survey respondents report working an average of 8.7 years at their respective CAH.

The intent of the survey was to: 1) measure CAH perceptions and satisfaction with the Georgia Flex Program; 2) identify and measure satisfaction with the technical and programmatic support that has been provided; 3) identify any program outcomes; 4) determine CAH technical assistance needs; and 5) identify CAHs' emerging and ongoing challenges and concerns. Survey topics included:

- Background information about the hospital
- Use of and satisfaction with the technical assistance, tools, programs, and resources provided by the Flex Program
- Participation in, satisfaction with, and outcomes of program supported quality and performance improvement and patient safety activities (e.g., CARE)
- EMS needs and priorities based on the federally defined Flex Program guidance
- Capital improvement activities and planned next steps
- CAH issues, concerns and priorities

D. CAH SITE VISITS AND STAFF INTERVIEWS

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

Interview questions of CAH staff included:

- General satisfaction with the Flex Program
- Knowledge of program stakeholders and services
- Use of and satisfaction with the technical assistance, tools and resources provided by the SORH and other Flex Program stakeholders
- Outcomes that may have resulted due to Flex Program participation programs/projects
- On-going challenges and needs
- Program recommendations/next steps

E. STATE STAKEHOLDER INTERVIEWS

Twenty-five Flex Program state/regional stakeholders (Table 1) participated in structured interviews to: 1) measure their satisfaction with program operations, management, and implementation; 2) discuss their involvement in Flex Program activities; and 3) identify Flex Program planning, development and implementation needs and next steps. Interviews occurred between August 12 and December 9, 2009. When possible, interviews were conducted in person. Interviews lasted between .5 and 2.25 hours each. Interviews were also attempted but not completed with two additional stakeholder organizations.

Table 1: Georgia Flex Program Stakeholders

Name	Organization	Interview Site
Melody Brown	Georgia Medical Care Foundation	Telephone
Tony Brown, Deputy Director	Georgia State Office of Rural Health	In-Person
Katherine Cummings, Executive Director	Georgia Rural Health Association	Telephone
Greg Dent	Community Health Works	Telephone
Cindy Dupree, Partner	Draffin & Tucker, LLP	In-Person
Kathy Ellis, Director	Three Rivers AHEC	In-Person
Paula Guy, Director	Georgia Partnership for Telehealth	Telephone
Duane Kavka, Executive Director	Georgia Association for Primary Health Care	Telephone
Jimmy Lewis, President & CEO	HomeTown Health, LLC	Telephone
David Loftin, Director	Region 1 EMS Agency	Telephone
Earl McGrotha, Director	Region 2 EMS Agency	Telephone
Lawanna Mercer-Cobb, Director	Region 6 EMS Agency	Telephone
Vi Naylor, Executive Vice President	GHA, Center for Rural Health	In-Person
Nicole Newman, Program Associate	Georgia State Office of Rural Health	In-Person
Charles Owens, Executive Director	Georgia State Office of Rural Health	In-Person
Rhett Partin, Executive Director	GHA, Center for Rural Health	In-Person

Name	Organization	Interview Site
Mary Kate Pung, Director	Magnolia Coastlands AHEC	Telephone
Shirley Starling, Interim Director	Region 9 EMS Agency	Telephone
Chris Thelkeld, Director	Regions 5 and 10 EMS Agencies	Telephone
Courtney Twilliger, President	Georgia Association of EMS	Telephone
Beverly Tyler	Georgia Health Policy Center	Telephone
Robert Vick, Director	Region 8 EMS Agency	Telephone
Billy Watson, Interim Director	Georgia State Office of EMS	In-Person
Patsy Whaley, Director of Hospital Services	Georgia State Office of Rural Health	In-Person
Kathy Whitmire	HomeTown Health, LLC	Telephone

Note: Georgia Medical Care Foundation is the state's Quality Improvement Organization (QIO)

An additional preliminary interview was conducted with Patricia Whaley, Director of Hospital Services, SORH, to gather program information as part of the evaluation planning process.

F. COMMUNITY HEALTH CARE PROVIDER SURVEY

The Community Health Care Provider Survey was mailed to 96 health care providers working in five CAH communities. Community health care providers were identified using search engines on the web. The initial survey was mailed June 15, 2009, with a follow-up mailed August 3, 2009, completing the survey collection August 17, 2009. Twenty-nine health care providers/managers responded, including: physicians, chiropractors, local public health directors, dentists, pharmacists, mental health providers, nursing home administrators, optometrists and alternative health providers. The number and type of providers surveyed varied across communities; however, physicians were the most frequent survey respondents. The survey response rate was 30 percent. The Community Health Care Provider Survey was conducted to determine community provider: 1) knowledge of the hospitals' conversion to CAH status, 2) changes in practice patterns, referrals and utilization due to CAH conversion, 3) perceptions of the CAHs' quality of care, 4) vertical networking activities, 5) community health care strengths, weaknesses, issues and concerns and 6) current and on-going community health planning activities/needs.

G. CAH FINANCIAL REPORTS REVIEW

The Flex Monitoring Team develops annual reports on the financial status of CAHs by state: *CAH Financial Indicators Report: Summary of Indicator Medians by State*.² Data from past reports (2005 – 2009) were tallied for Georgia, across all reporting years, to examine trends with each aggregated financial indicator reported for CAHs in the state and U.S. In addition, findings from the *Critical Access Hospital Financial Analysis – 2008, August 2008 and January 2009*, by Draffin and Tucker, LLP, were also reviewed.

H. EVALUATION LIMITATIONS

Although the evaluation included most key Flex Program stakeholder organizations as well as a survey response from all but one CAH, limited (four quality improvement coordinator interviews) direct input was solicited from CAHs' quality improvement coordinators. This is relevant because CAH administrators who are unaware of their hospitals' involvement in Flex Program funded quality improvement initiatives and did not consult with the hospital's quality improvement coordinators, may have reported data on the CAH administrator survey that does not fully reflect the hospital's current involvement in program funded quality improvement activities. This is important to note as 30 percent of Flex Program funds are dedicated to quality improvement related activities in CAHs.

Stakeholder Terms and Use

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

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

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

Flex Program Stakeholders – all state stakeholders, CAH staff and CAH administrators that participated in the CAH survey

² Flex Monitoring Team, retrieved December 16, 2009, <http://www.flexmonitoring.org/prodresults.php?field=1>.

Section 2: Flex Program Summary

This section provides an overview of the Georgia Flex Program, rural health in Georgia, the administration of the Flex Program during the past three years, program funding and allocations and a description of program activities. Information included in this section was obtained from resources on the Internet; Georgia Flex Program staff and other program stakeholder interviews; program documentation; the Health Resources and Services Administration, Office of Rural Health Policy Website; and the Flex Program Monitoring Team website.

A. OVERVIEW

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

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

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

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

Although limited Flex Grant Program changes have occurred at the national level over the past 11 years, it is evident that changes in program goals will be made as part of the 2010 grant guidance. It is anticipated that the changes will affect all program goals except those related to EMS. More specifically, preliminary guidance suggests the program will focus on CAH performance improvement, health information technology (HIT), quality improvement and EMS.

Over the past three years, the Georgia Flex Program has received approximately \$1.5 million. Although the program has used funds to address all program goals, approximately 30 percent has supported hospital quality improvement (QI) related activities. This level of funding is likely viewed favorably by the Health Resources and Services Administration, Office of Rural Health Policy, as

national Flex Program guidance has been moving more towards a focus on improvements in quality of care. Georgia Flex Program quality improvement related assistance has been in the form of a contractual arrangement with the GHA to develop and maintain QI data collection systems and provide workshops/training and technical assistance. The remaining funding has supported:

- Program administration and management through Flex Program staff at the DCH, SORH
- Georgia Rural Health Care Plan
- Financial analysis of CAHs
- HomeTown Health University, a Web-based training site for business office staff
- Business office performance improvement programs through a network of hospitals
- State and regional EMS initiatives, including a web-based training program
- Network development focusing on projects such as: disease management, EMS and tele-trauma
- Program evaluation activities

B. RURAL HEALTH AND GEORGIA³

Georgia is both geographically and demographically diverse. It is the largest state east of the Mississippi River (59,424 square miles). It has four distinct topographical regions: the Atlantic coastline area that is the eastern side of the state, a low coastal plain that covers the southern half of the state, rolling foothills in the central part of the state and a mountainous area in the northern part of the state (including both the Blue Ridge and Appalachian Mountain ranges). It has 159 counties, significantly more than states of similar size and more than double the national average (62.2 per state).⁴ Georgia is the eighth fastest growing state in the U.S. in terms of population (9,685,744). Its population is getting younger and it has the third largest African American population when compared to other states.

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

Despite an increasing population, approximately 80 percent of the state's land mass is classified as rural with 19 percent of the state's population residing in these areas. Georgia's rural areas are characterized by agriculture and forest land. Agriculturally, Georgia ranks first in the U.S. in the production of young chickens weighing less than 2.5 pounds, peanuts, and pecans; second in acreage of cotton and rye; and third in the production of tomatoes and peaches. Demographically, Georgia's rural areas have an African-American majority and a poverty level that is higher than state and national averages. Georgia's rural population is more likely to be under-insured or uninsured, more

³ Sources: Wikipedia online at www.Wikipedia.com, U.S. Census Bureau at www.census.gov, The New Georgia Encyclopedia, Land and Resources, online at <http://www.georgiaencyclopedia.org/nge/Article.jsp?id=h-2056>, Georgia Department of Community Health, *ExploreGeorgia.com*.

⁴ Number of counties by state as reported by <http://www.charlestoncounty.org/stats/bystate.htm> and U.S. state area rankings as reported by <http://www.enchantedlearning.com/usa/states/area.shtml>

likely to suffer from heart disease, cancer, obesity, and diabetes, and is considered less healthy than its urban counterparts. Georgia's rural population is older, less educated, and has a lower median income when compared to urban areas. (Table 2)

Table 2: Georgia's Population: Rural and Urban Comparisons

Indicator	Rural Areas	Urban Areas
Population	19%	81%
65 years and older	11%	9%
Graduate from high school	78%	85%
Median income	\$44,291	\$46,156

From a health standpoint Georgia has the following characteristics⁵:

- A rank of 41 in the U.S. for having residents who engage in regular exercise
- A higher incidence of diabetes (9.8 percent) than the national average (8.2 percent)
- A higher death rate due to heart disease (213.2 persons per 100,000) than the national average (200.2 persons per 100,000)
- A higher rate of adult smokers (19.5 percent) than the national average (18.3 percent)
- A higher rate of adult obesity (64.6 percent) than the national average (63 percent)
- Its Medicare enrollment as a percent of the total population is 12 percent compared with 15 percent nationally
- A larger percentage of its Medicare population (24 percent) is dually eligible for Medicare and Medicaid as compared to the national Medicare population (21 percent)
- Adults in Georgia account for 23.4 percent of Medicare enrollees, compared with 16.4 percent nationally
- An uninsurance rate of 17.8 percent as compared to 15.4 percent nationally
- A hospitalization rate of 101 per 1,000 as compared with 117 per 1,000 nationally
- An emergency room utilization rate of 393 per 1,000 compared with 401 per 1,000 nationally
- A cancer incidence rate of 461.9 per 100,000 compared with 458.2 per 100,000 nationally, with lung cancer incidence rate being noticeably higher than the national rate (163 per 100,000 as compared to 145 per 100,000)

C. FLEX PROGRAM ADMINISTRATION

The DCH SORH administers the Flex Program. Staff positions supported through the Flex Program have varied over the past three years, but have ranged from 1.5 FTE (full-time equivalents) to 2 FTE. The Flex Program Coordinator/ Director of Hospital Services (1 FTE) and Program Assistant (.5 FTE) are the primary resources dedicated to the program's administration/management.⁶ There was no staff turnover in these positions during the past three years. This

“Our state office of rural health does a great job. They are great advocates and the [Flex] program is well received.”

- Evaluation Participant

⁵ Sources: Kaiser Family Foundation (2008), Georgia Center for Cancer Statistics, U.S. Census Bureau, Georgia Department of Community Health, ExploreGeorgia.com.

⁶ It should be noted that the Flex Program Coordinator also dedicates time to administer the federal Small Rural Hospital Improvement Program (SHIP), a program that must be administered by states but has no federal funds to support the program's administration costs.

stabilization, as well as changes in staffing within the SORH as a whole, was discussed by Flex Program stakeholders throughout the evaluation process. Stakeholders consistently report that the staffing changes have had a “significant” and “positive” impact on the Georgia Flex Program and all of the activities of the SORH; however, they also report many delays and issues related to contracts and working with state government. It should also be noted that all stakeholders spoke very favorably of the Flex Program Coordinator and the Director of the SORH.

Although Flex Program planning and administration occur within the SORH, Flex Program project activities are contracted to other organizations, such as the GHA, HomeTown Health, LLC, Georgia State Office of EMS, Georgia Health Policy Center, and Draffin and Tucker, LLP. These organizations and consultants have completed projects for the development of the Georgia Rural Health Care Plan, supporting and sustaining CAHs, EMS, and quality improvement.

D. FLEX PROGRAM FUNDING

During the past eleven years, Georgia received \$5,359,120 or an average of \$487,193 per year from the Health Resources and Services Administration, Office of Rural Health Policy, to implement the Flex Program in Georgia.⁷ As shown in Chart 1, program funding has ranged from approximately \$611,000 in 1999 to \$50,000 in 2004.^{8,9} Georgia ranks 27th of 45 states in terms of the federal funding that it has received over the eleven-year period; however, it ranks 33rd in terms of funding per CAH (\$157,621/CAH for all years or an average of \$14,763 per year). This means that from a funding perspective the state is at the 40th percentile when compared to other states, but it is at the 27th percentile when compared to funding per CAH.

Considering 2006-2009 (the years this Flex Program evaluation is focused), Georgia received an average of \$481,766 per year. This is slightly below the national average of \$488,027 per state. Georgia’s funding during this time period translates into \$43,797 per CAH or \$14,599 per CAH per year, slightly below its average for all 11 Flex Program grant years.

E. FLEX PROGRAM FUNDING ALLOCATIONS

Over the past three years, Georgia Flex Program funding has been directed to: staff salaries and benefits (22 percent), support and sustaining CAHs (19 percent), EMS activities (15 percent), quality improvement (30 percent), network development (11 percent) and other activities (e.g., travel, supplies, evaluation, 4 percent).¹⁰ Most funding supports program goals through contractual arrangement with key Flex Program stakeholders, such as the GHA.

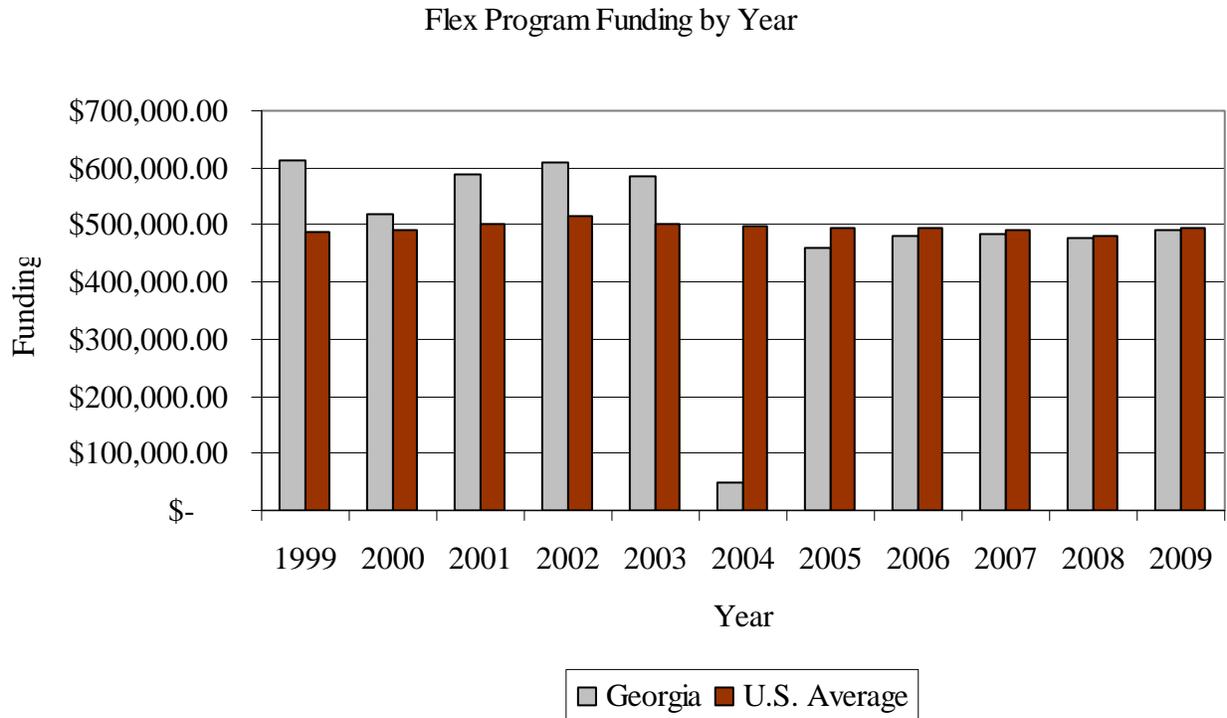
⁷ www.hrsa.gov/orhp

⁸ Prior to 2006, states were allowed to request up to \$700,000 per year in federal Flex Program funding. This changed to a maximum request of \$650,000 in 2006.

⁹ In 2004, funding was reduced due to a large amount of unobligated/carry-over funds.

¹⁰ Allocations are estimates based on Flex Program funding for the 2006 – 2009 grant years.

Chart 1: Annual Federal Funding of Georgia’s Flex Program as Compared to the National Average for all States¹¹



¹¹ In 2004, funding was reduced due to a large amount of unobligated/carry-over funds.

Section 3: Rural Health Planning

The Georgia Flex Program has planned for the state's rural health goals through the development of rural health plans and stakeholder meetings. Two Georgia Rural Health Care Plans were created through the Flex Program, most recently the 2007 plan. The first plan, completed in August 2000, was the guide for CAH conversions in the state.¹² The 2007 plan was a multi-year plan that involved a number of state stakeholders to create a vision and goals for rural health in Georgia, describe the population and current state of health of rural Georgians and describe the health services in rural areas of the state. The plan serves as a rural health resources guide and a tool to set state priorities.

The vision for rural health as stated in the plan is, "*Communities working collaboratively to improve the health of rural Georgians.*"¹³ The plan also established four goals: 1) build a system of care that is unified, clinically relevant, financially viable, and responsive to community needs; 2) promote health and wellness in all aspects of daily living; 3) support practical integration of technology to increase the efficiency and effectiveness of health services; and 4) engage and enable communities in action.

Using data from the CAH survey, 63 percent of CAHs report they are aware of the Georgia Rural Health Care Plan (the plan). Of those that are aware of the plan, six CAHs report they participated in its development and four CAHs report they have used the plan.

During state stakeholder and regional and local EMS interviews, stakeholders were asked questions about their involvement in the development of the plan, how they have used the plan, and any outcomes that may have resulted. They reported the following:

- Some state stakeholders reported awareness of the plan and participated in its development
- Six state stakeholders reported they have used the plan for grant writing, reporting, advocacy, and/or planning purposes
- Most EMS stakeholders reported they are aware of the plan; however, they were not involved in its development and have not seen or used the plan
- Some EMS stakeholders reported they are not aware of the Flex Program
- Some EMS stakeholders are not aware of hospitals' CAH status

In addition to developing the rural health care plans, the SORH and the Flex Program, as part of their program operations and management, host regular meetings of Flex Program stakeholders, including CAHs. This is evidenced by Flex Program Stakeholder meetings held March 23, 2006, February 8, 2007, September 25, 2007, February 14, 2008, and February 12, 2009. Meeting agendas indicate the

¹² Rural Health Care Plan, Critical Access Hospital Steering Committee, Rural Health and Hospital Technical Advisory Committee, August 18, 2000, http://dch.georgia.gov/vgn/images/portal/cit_1210/8/30/37803168cah_plan.pdf.

¹³ Georgia Rural Health Care Plan, Georgia Department of Community Health, Office of Rural Health, September 2007, retrieved online June 2009, http://dch.georgia.gov/vgn/images/portal/cit_1210/21/19/970432432007_Rural_Health_Plan.pdf.

meetings were focused on program updates and information sharing. Meeting evaluations completed by attendees in 2008 and 2009 reflect high satisfaction with the meetings and their content.

CAH staff and state stakeholders were asked about how they stayed abreast of Flex Program initiatives and how/if they participated in Flex Program planning activities.

- Most CAHs and state stakeholders reported they received Flex Program updates via emails from the SORH
- Some state stakeholders reported they received Flex Program updates at other meetings and conferences around the state and U.S.
- Some CAH staff and state stakeholders reported they know little about the Flex Program
- Most CAH staff and state stakeholders reported they would like to know more about the Flex Program
- Some CAH staff and state stakeholders reported Flex Program planning and decisions about the program occur before stakeholders meet and learn about program activities
- Some state stakeholders reported if they had known more about the Flex Program and CAHs they could have networked and directed services to better meet CAHs' needs

Rural Health Planning Opportunities

- Many stakeholders would like to see Georgia “set the standards for the nation,” “be that national leader” and “identify the solutions for common problems”
- Many stakeholders discussed inefficiencies in the current health care system (e.g., repeat of tests, use of providers, limited use of telemedicine)
- Many stakeholders discussed the need to re-design health care and how patients access services focusing on preventative services and using a regional approach
- Some stakeholder organizations have been working towards the same goals (e.g., quality improvement, workforce development, HIT implementation)
- Stakeholder organizations spoke highly of other rural health organizations and they agree they work well together

Rural Health Planning Challenges

- Many organizations are short-staffed so they have limited capacity for expansion
- Engaging all key stakeholders including CAHs and representatives of local and regional EMS
- Assuring that all CAHs are benefiting from Flex Program activities, given the diverse needs and capacities of CAHs in the state
- Limited funds for travel costs and/or prohibition from traveling for meetings, conferences, and workshops
- High staff turnover/regular changes in leadership
- Declining rural economy, high unemployment

Section 4: **C**ritical **A**ccess **H**ospitals (CAHs)

CAH conversion and supporting and sustaining CAHs are core goals of the Flex Program. Therefore, this section focuses on findings related to:

- CAH conversion
- CAHs' Flex Program satisfaction
- Use of Flex Program services/supports
- CAHs' Financial Status
- Networking activities, plans, and needs
- Changes in CAH Services and Providers
- CAH accomplishments
- CAH challenges, opportunities and needs

A. CAH CONVERSION

Georgia's first small rural hospital converted to CAH status June 25, 1999, making it the 13th state to have a CAH.¹⁴ This was the 56th CAH nationally. As shown in Chart 2, Georgia's small rural hospitals were early converters to CAH status with all of them converting by October 1, 2004, much earlier than most states around the U.S.

Until 2002, the majority of Georgia Flex Program funding supported converting small rural hospitals to CAH status. During this initial time, 68 hospitals met the necessary provider criteria for conversion and 25 of these hospitals converted to CAH status. CAH conversion assistance was used for community needs assessments, the CAH application process, financial feasibility studies, network agreements and other needs as determined by CAHs.

As of December 2009, there are 34 CAHs in Georgia. This is above the national average of 29 CAHs per state.¹⁵ Twenty-nine other states have fewer CAHs than Georgia. Georgia CAHs represent approximately 19 percent of all hospitals in the state.¹⁶ Over the past 11 Flex Program years, 21 hospitals have closed in Georgia, including one CAH, one hospital that was re-opened as a CAH and three tertiary centers that were re-opened or replaced.¹⁷ As displayed on the map on the following page, CAHs are scattered throughout the state with clusters within 35 miles of urban areas. No CAH in Georgia is 35 miles from the next nearest hospital or 15 miles in mountainous terrain or on a

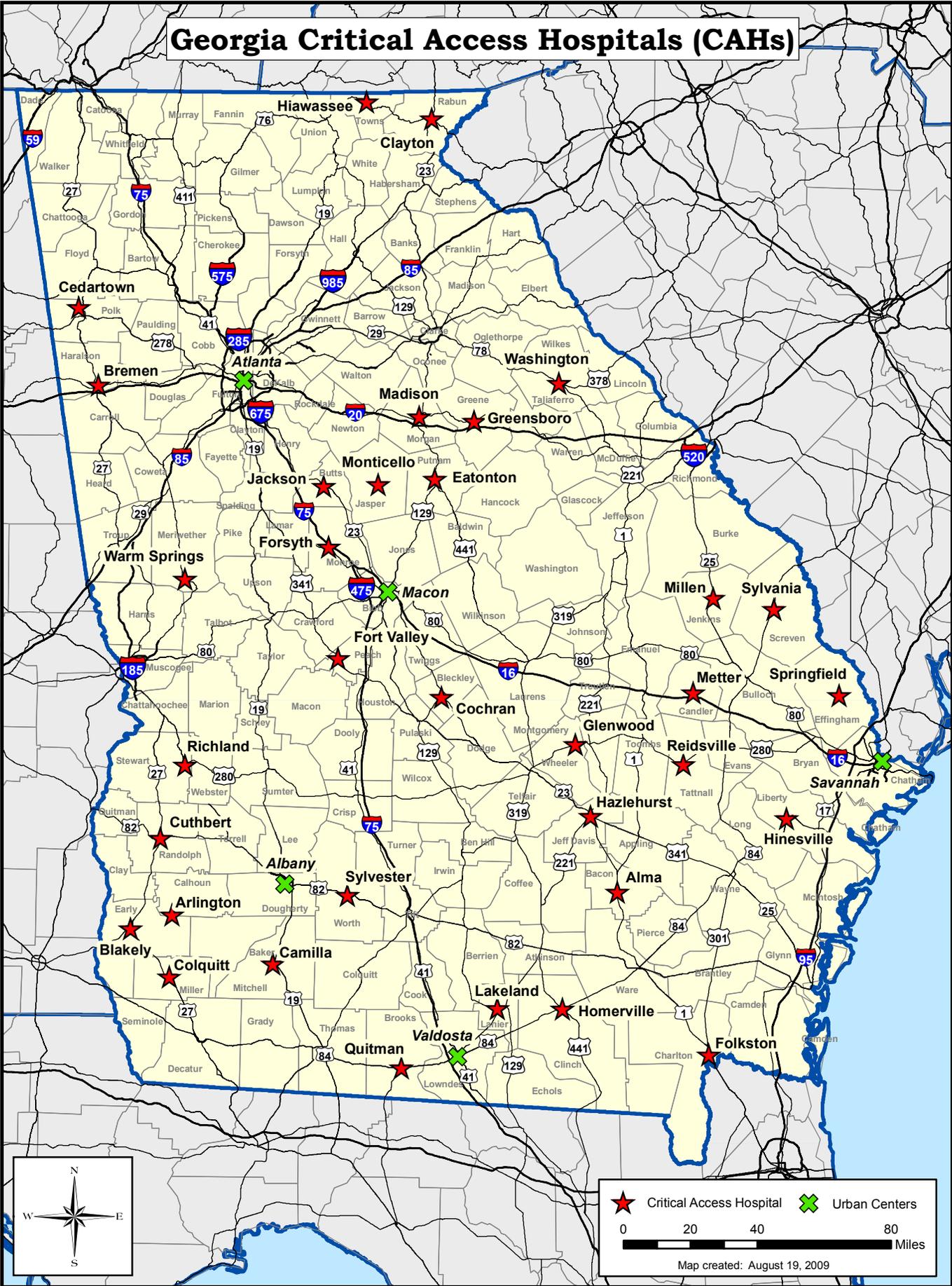
¹⁴ Flex Monitoring Team.

¹⁵ Flex Monitoring Team, July 30, 2009, www.flexmonitoring.org.

¹⁶ There are 149 acute care hospitals in Georgia.

¹⁷ Georgia Hospital Association.

Georgia Critical Access Hospitals (CAHs)

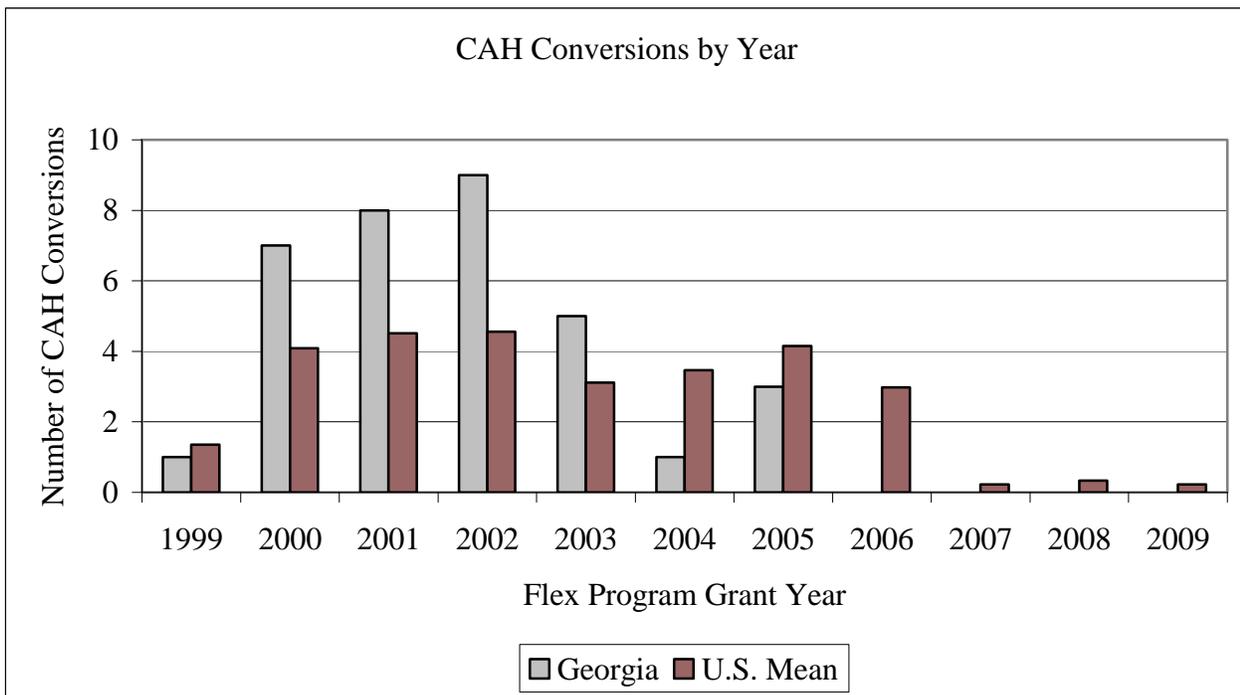


secondary road, but all meet the state’s Necessary Provider requirements. No hospital is currently seeking CAH status.

Data from the CAH survey indicate that most CAHs are “very satisfied” (60 percent) with conversion to CAH status while 25 percent are “satisfied”, nine percent are “somewhat satisfied” and three percent are “not satisfied”. Most CAHs report that conversion to CAH status was critical to their hospital’s survival financially. Those CAHs reporting “somewhat satisfied” and “not satisfied” with CAH conversion comment that their lack of satisfaction pertains to misunderstanding the way CAHs are reimbursed. Four CAHs report their hospital is considering converting back from CAH status.

Community health providers report that 58 percent are aware their local hospital is a CAH and 36 percent were involved in the hospital’s decision to convert to CAH status.

Chart 2: Number of Georgia Hospitals that Converted to CAH Status Each of the Flex Program Grant Years as Compared to the U.S. Mean for All States



Source: www.flexmonitoring.org

B. CAHs’ FLEX PROGRAM SATISFACTION

Using data from the 2009 CAH survey, 90 percent of CAHs report they are aware of the Flex Program. Of those that are aware of the Flex Program, 44 percent are “very satisfied”, 44 percent are “satisfied” and 12 percent are “somewhat satisfied”. No CAH reports being “not satisfied” with the Flex Program. Only hospitals reporting high Flex Program satisfaction made comments about the program. Those CAHs reported the program has been beneficial because of quality and patient safety projects, support to purchase hospital equipment and support for emergency preparedness planning. 2009 CAH survey findings reflect an increase in CAH satisfaction with the Flex Program when

compared to 2007 survey data (33.3 percent were “greatly satisfied” or “significantly satisfied”; 11.1 percent were “very dissatisfied”)

As part of the CAH site visits, staff were asked if they are familiar with the Georgia Flex Program and to describe their involvement in it. Many CAH staff report they have heard of the Flex Program and contact the program coordinator on an as needed basis, depending on technical assistance needs and questions. They also report the Flex Program coordinator is very responsive about meeting these needs. CAH staffs were able to discuss two current Flex Program funded activities: CARE2 and the CAH Fiscal Analysis Report conducted by Draffin and Tucker, LLP. Although not funded by the current program, they also discussed outcomes associated with their participation in HomeTown Health University activities (a project that began through program support).

C. USE OF CAH SERVICES/SUPPORT

As part of the CAH site visits and CAH survey, CAH staffs were asked to report on Flex Program services they are aware of, used, and any outcomes that have resulted due to their use. More specifically, they were asked questions about:

- General Flex Program support and technical assistance
- Georgia Rural Health Care Plan
- Financial analysis reports completed by Draffin and Tucker, LLP
- Peer review network
- Hospital-based quality improvement initiatives (e.g., CARE2, Medical Evaluation QI Module)

As indicated in Table 3, CAHs use and are most satisfied with the CAH Fiscal Analysis Report conducted by Draffin and Tucker, LLP. They use network development technical assistance least, and appear to be least satisfied with the annual stakeholder meetings; however, 89 percent are “very satisfied” or “satisfied” with the meetings. When asked how they have used the financial analysis report, CAHs report the following:

- Benchmarking and comparisons with other CAHs
- Education for board members, elected officials and other organizations (e.g., neighboring hospitals)
- Identifying new lines of business/opportunities
- Performance improvement related changes

In addition, one CAH reported wanting to be included in future financial analysis projects. Others suggested the financial analysis should be on-going and include all CAHs in the state (versus a set of CAHs). Other CAHs reported the project presented no new information as they were already aware of its findings.

Table 3: CAH Use of and Satisfaction with Flex Program Technical Assistance

Types of Technical Assistance Made Available	Technical Assistance Used			Satisfaction with Support/Assistance			
	Yes	No	Unknown	Very Satisfied	Satisfied	Somewhat Satisfied	Not Satisfied
	General Program Information	73%	12%	15%	35%	59%	6%
Network Development Technical Assistance	32%	48%	20%	56%	33%	11%	0%
Annual Stakeholder Meetings	38%	42%	19%	33%	56%	11%	0%
CAH Financial Analysis Report (prepared by Draffin & Tucker, LLP)	74%	22%	4%	78%	17%	6%	0%
CAH Site Visits by Flex Program Staff	58%	27%	15%	50%	42%	0%	8%

Considering all current Flex Program supported initiatives (including technical assistance and support as reported in Section 4, Table 3), two CAHs reported no participation and three CAHs reported participation in one Flex Program supported initiatives. CAHs were significantly more likely to be aware of their participation in Flex Program-funded technical assistance initiatives as compared to quality improvement initiatives. This survey finding could be attributed to CAH administrators' lack of knowledge related to the hospitals involvement in Flex Program funded quality improvement initiatives. The Flex Program is reportedly working to improve CAH staffs' knowledge of program funded initiatives through education and information.

As part of the CAH survey, CAHs were asked to identify the organization they turn to first when they have CAH questions or concerns, as well as where they get regular CAH updates/information. They most frequently identify the Georgia Office of Rural Health, HomeTown Health, LLC and staff within those organizations as places where they turn first with questions or concerns. When asked where they get updates/information/regulatory changes they most frequently report the SORH (69 percent), GHA (69 percent), other CAHs (51 percent), Centers for Medicare and Medicaid Services (46 percent), and their accounting firm (46 percent).¹⁸

¹⁸ HomeTown Health, LLC, was not included as an option for this question on the survey.

D. CAHS' FINANCIAL STATUS

A primary goal of the Flex Program is to support and sustain CAHs; sustainability will only occur when CAHs are financially viable organizations. Therefore, financial information was gathered through the CAH site visits and as reported by the Flex Monitoring Team. This data suggest that Georgia CAHs as a whole are not performing as well as other CAHs nationally.

All CAH staffs interviewed as part of the site visits were asked about their hospital's pre-conversion financial status. All CAH staffs reported their hospital was on the verge of closure, was very financially challenged or may have closed without enhanced reimbursement through CAH status. Prior to conversion, some of the CAHs' financial status was so poor vendors that were no longer working with them and/or they were borrowing money to make payroll.

Also, during the CAH site visits CAHs were asked about their current financial status. All of the CAHs reported their finances have improved since conversion. Examples of this improvement include:

- Acute inpatient average-length-of-stay declining from 4.7 days to 2.3 days
- Days in accounts receivable decreasing from 149 days to 51 days
- Admissions, emergency room and surgery volume increasing
- Capital improvements: building a new hospital, major renovations, planning for renovations
- Adding services – all CAHs
- Upgrading equipment (e.g., lab, diagnostic) – all CAHs
- Increasing market share
- Implementing an EMR (e.g., 87 percent paperless)
- Decreasing workers compensation claims
- Decreasing reliance on agency nursing staff from 75 percent reliance to no reliance
- Increasing staff salaries – all CAHs

“If this hospital was not here, I could point to people that would have died.”

- Evaluation Participant

When asked what may have contributed to the above listed outcomes (in addition to CAH status), they reported the following:

- Implementing a strong, up-front collections policy which increased revenue but had little impact on patient satisfaction
- Billing all patients
- Adding a revenue cycle team
- Hiring a case manager
- Making hospital leadership changes
- Updating equipment
- Participating in HomeTown Health University
- Joining a health care system

Although staff interviewed during the CAH site visits reported improved financial status and all reported a positive total margin, signs of financial concern also emerged during the evaluation. For example:

- All of the CAHs visited during the site visits reported current economic declines in their community, competition from a nearby hospital and/or physician recruitment and retention as issues that are having a de-stabilizing effect on their hospitals' financial viability
- All CAHs reported their greatest concern as hospital finances (Tables 7 and 8 below)
- Data in the Critical Access Hospital Financial Analysis – 2008, August 2008 and January 2009, completed by Draffin and Tucker, LLP, report CAHs continued to have financial indicators that were well below the national median
- State stakeholders reported five CAHs were on the “verge of closure” and three additional CAHs are considered “fragile” due to financial issues
- State stakeholders and CAHs report cost to charge ratios, poor payer mix and/or old physical plants/fully depreciated assets were having a significant impact on CAHs' financial status
- State stakeholders and CAH staffs reported physician recruitment and retention was affecting CAHs' financial status
- State stakeholders reported a lack of trained, educated and experienced business office staff was affecting CAHs' financial status
- State stakeholders reported some CAH administrators and chief financial officers had not understand the Medicare cost report, which is affecting CAHs' financial status

Additionally, Georgia's state-level CAH financial data from the Flex Monitoring team were reviewed focusing on a few key indicators: total margin, return on equity, cash flow margin, days cash on hand, debt service coverage and average age of plant.¹⁹ These indicators, as reported in Charts 3 through 8, were selected as they reflect indicators with consistent or trending declines when compared to U.S. medians. Looking at the other indicators reported by the Flex Monitoring Team, Georgia's medians for all years are similar to U.S. medians (e.g., indicators were slightly better, similar, or slightly worse).²⁰ Georgia's median average daily censuses for acute and swing skilled nursing facility beds were higher.

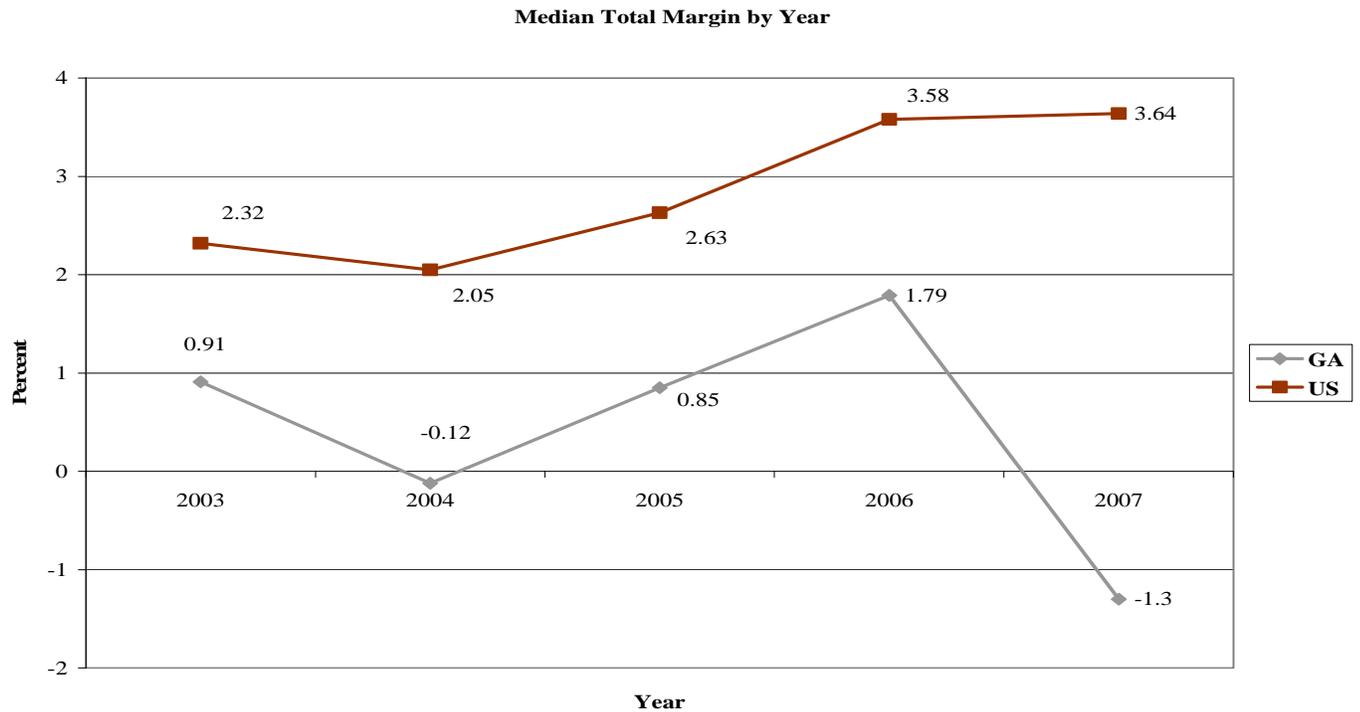
¹⁹ Years for data reported reflects cost report year, not year the Flex Monitoring Team report was published.

²⁰ Other indicators include: current ratio, days revenue in accounts receivable, equity financing, long-term debt to capitalization, outpatient revenues to total revenues, patient deductions, payer mix, cost to charges, and revenue per day.

Table 4: Financial Indicator Definitions²¹

Indicator	Definition
Total Margin	Measures the control of expenses relative to revenues
Cash Flow Margin	Measures the ability to generate cash flow from providing patient care services
Return on Equity	Measures the net income generated by equity investment (net assets)
Days Cash on Hand	Measures the number of days an organization could operate if no cash was collected or received
Debt Service Coverage	Measures the ability to pay obligations related to long-term debt, principal payments and interest expense
Average Age of Plant	Measures the average age in years of the fixed assets of an organization

Chart 3: 2003-2007 CAHs' Median Total Margin: Georgia and U.S.



²¹ As defined by the Flex Monitoring Team in each of their annual CAH Financial Indicators Report: Summary of Indicator Medians by State, www.flexmonitoring.com.

Chart 4: 2003-2007 CAHs' Cash Flow Margin: Georgia and U.S.

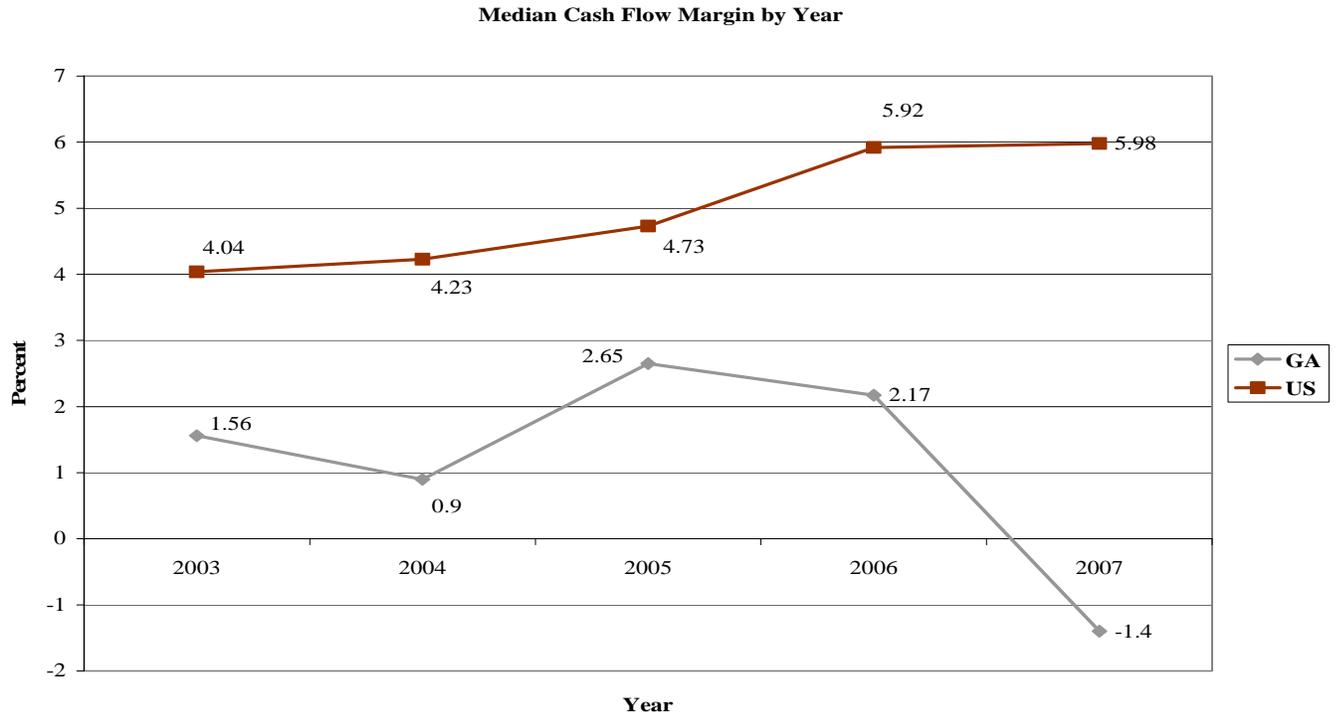


Chart 5: 2003-2007 CAHs' Median Return on Equity: Georgia and U.S.

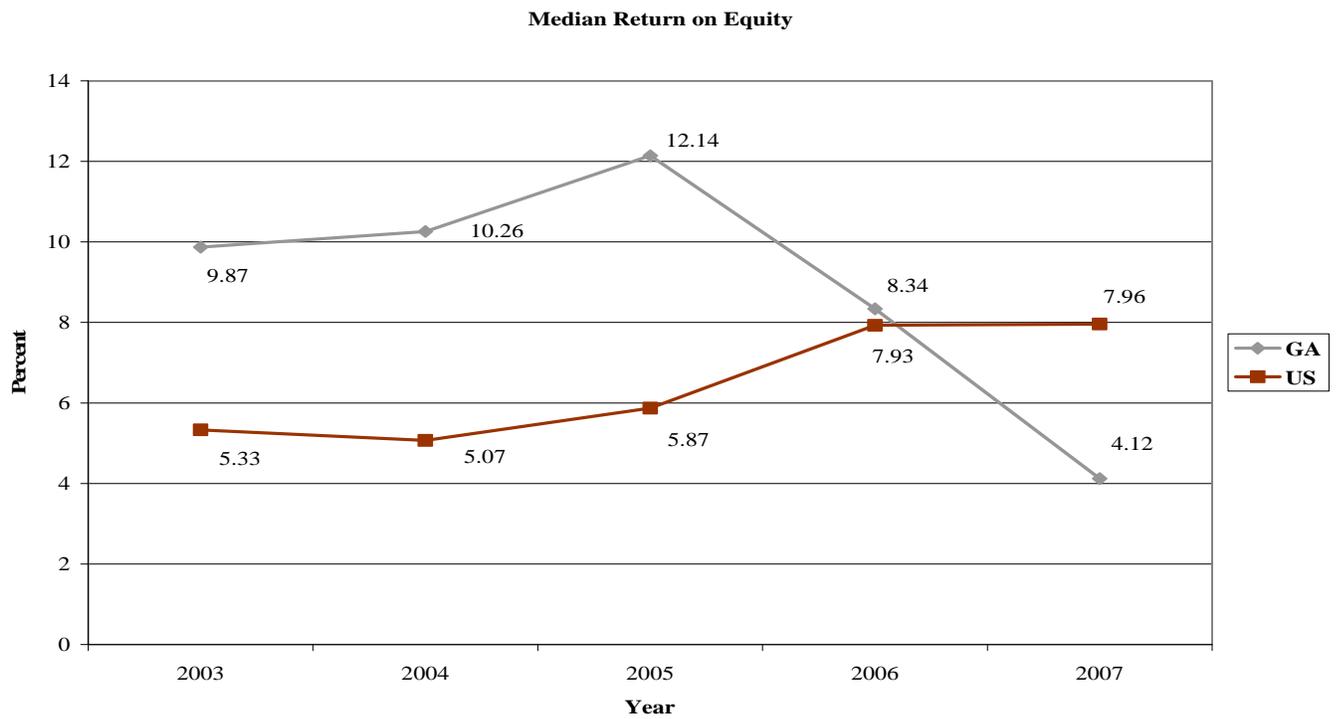


Chart 6: 2003-2007 CAHs' Median Days Cash on Hand: Georgia and U.S.

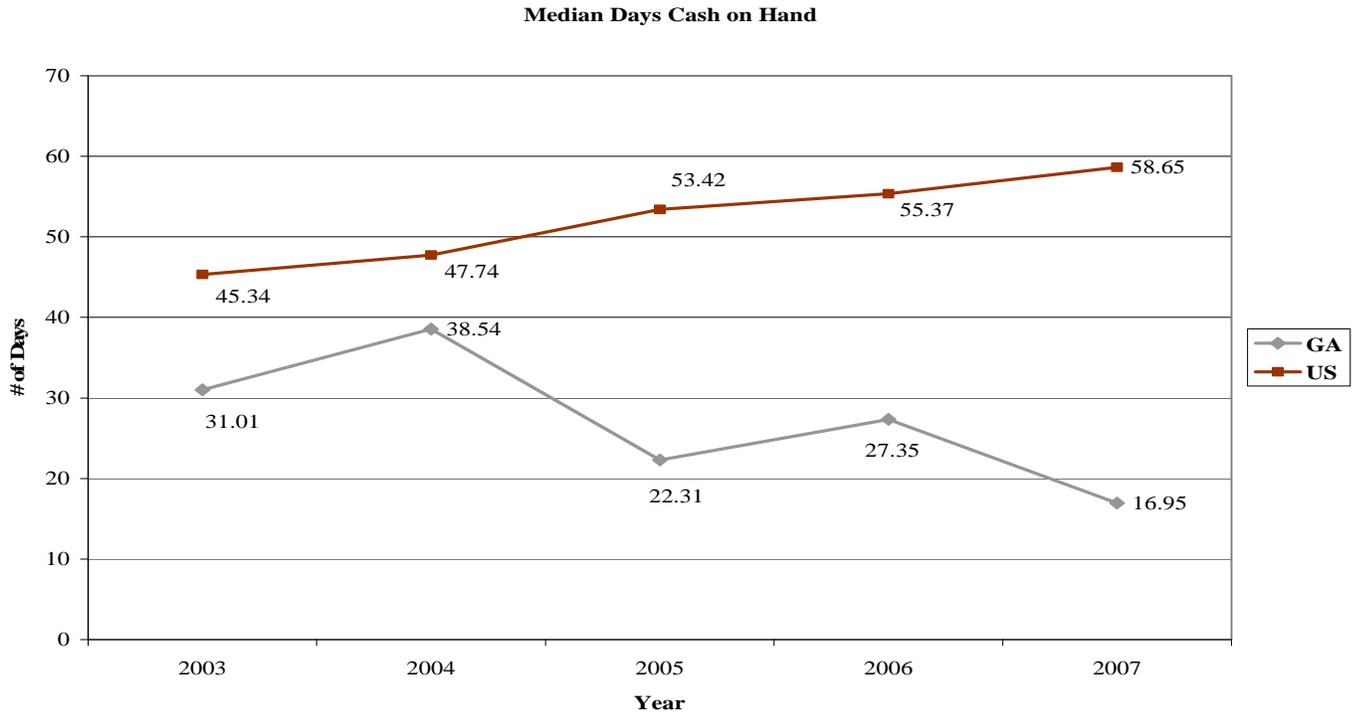


Chart 7: 2003-2007 CAHs' Median Debt Service Coverage: Georgia and U.S.

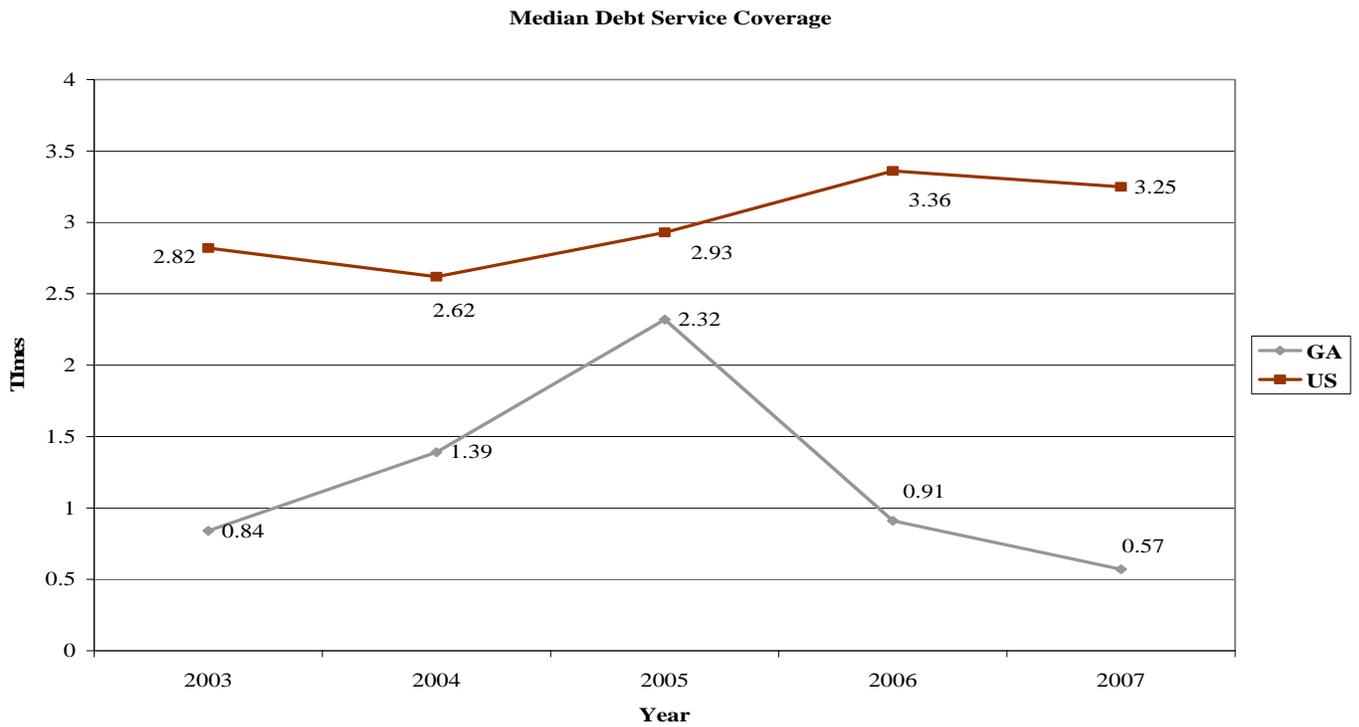
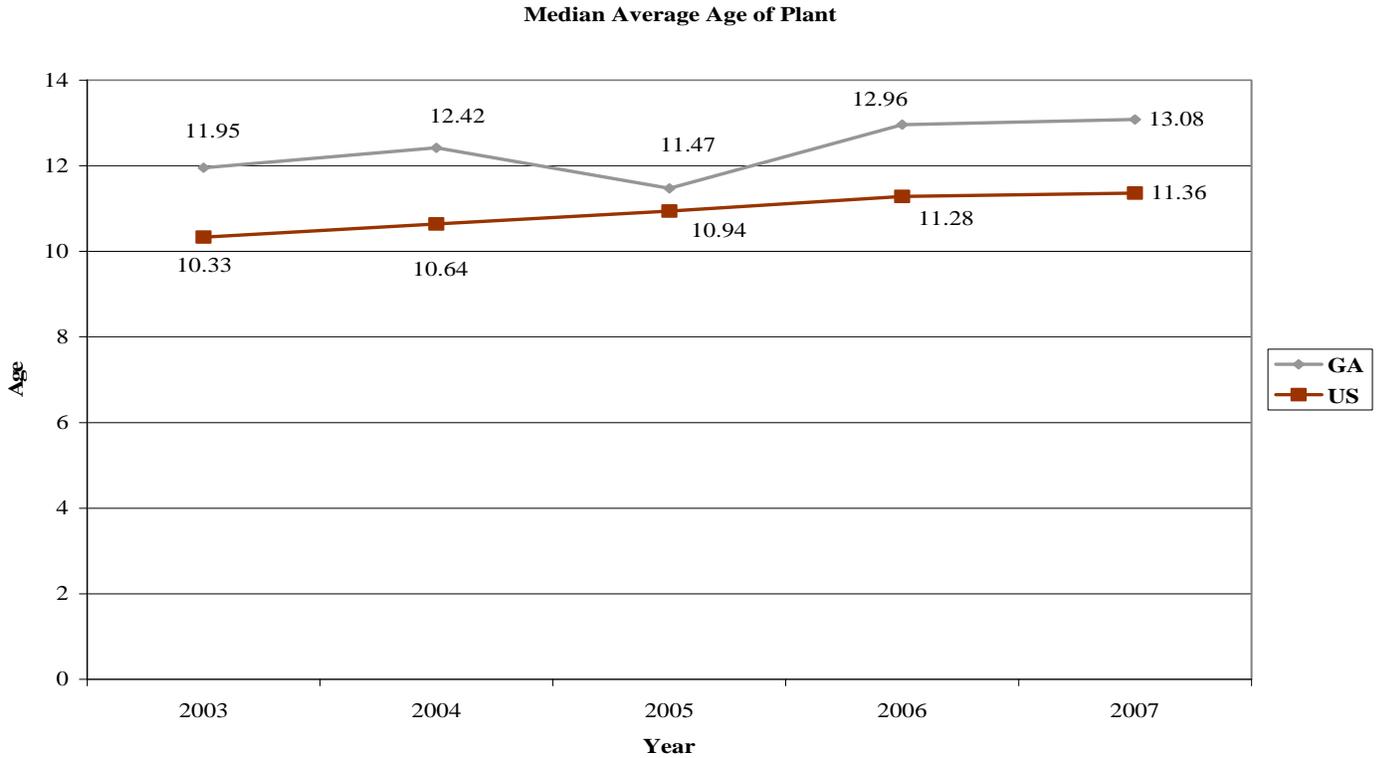


Chart 8: 2003-2007 CAHs' Median Average Age of Plant: Georgia and U.S.



Based on discussions with CAH staff, it is unclear what contributed to the below average indicators; however, recent financial studies completed in Minnesota and Wisconsin may shed some light. These studies found that hospitals that converted to CAH status early-on (typically the smallest and most fragile hospitals) continue to be financially challenged; most of Georgia’s CAHs were early converters. They also report that although Medicare reimbursement had a significant impact on CAHs’ financial status, there were many other contributing factors, such as: competition, physician recruitment and retention, payers, management board and staff, and economy.²² All of these factors were identified as issues by many CAHs in Georgia as indicated in Tables 7 and 8 below. In addition, the Minnesota study reported that significant financial decline can occur in a CAH (including those that are financially healthy) because of the loss of as few as one physician, again an issue raised by Georgia CAHs.

Although approximately 25 percent of CAHs in Georgia are having significant financial issues, it is clear that most of these CAHs, as well as some of the more financially viable CAHs, would have closed without CAH status, access to CAH training aimed at supporting and sustaining the hospitals, or significant local subsidies from communities. As the Recovery Audit Contractor Program (RACs)

²² The Financial Effects of Wisconsin CAH Conversion 2005, 2007, 2009, Wisconsin State Office of Rural Health, <http://www.worh.org/CahDataRpts> and The Financial Status of Minnesota CAHs: Successes, Challenges, Needs, and Recommendations, August 2008, Minnesota Office of Rural Health, <http://www.health.state.mn.us/divs/orhpc/flex/flexevals.html>.

and pay-for-performance are implemented, the value of Flex Program initiatives will likely again be revealed.

CAH Capital Improvements

The age of a hospital's physical plant is considered a key financial indicator. While many CAHs around the U.S. have made capital improvements since CAH conversion, including building new physical plants, some continue to explore remodeling, new-builds and additions to their current space. Georgia CAHs were asked about completed (2005-2009) and planned (2010-2012) capital improvement projects. Fifty-six percent of CAH survey respondents reported completing a project in the past five years, including:

- Hospital renovations projects (29 percent)
- Hospital expansion projects (17 percent)
- Construction of a new hospital (6 percent)

When asked about projects planned to begin in the next two years, 56 percent reported they have projects planned. Of the 16 planned projects, 63 percent will be hospital renovations, 25 percent will be hospital expansions, and 12 percent will be construction of a new hospital. Comparing hospitals with project completed and those with projects planned, six CAHs that completed projects in the past five years have projects planned for the coming two years and four CAHs that did not complete projects in the past five years have projects planned for the coming two years.

E. CAH NETWORKING

Different forms of networking can be supported through the Flex Program: horizontal, vertical, formal, system, community-based and others. (Table 5) Therefore, CAHs and other local providers are encouraged to engage in networking activities to improve quality, efficiency, access to services and organizational performance. As indicated in Table 3 above, 32 percent of CAHs reported they used Flex Program supported network development technical assistance and 89 percent of those that used this support were "very satisfied" or "satisfied" with the support provided.

Table 5: Forms of Networks

Type	Description
Horizontal Network	Relationship between the same classifications of health care providers (e.g. a network of hospitals or a network of nursing homes).
Vertical Network	Relationship between varieties of classifications of health care providers (e.g. hospitals, nursing homes, clinics, and home health).
Formal Network	A formal written agreement that includes a start and end date and typically includes an exchange of resources between the network members.
Informal Network	An informal spoken or understood agreement between participating members.
System	A hierarchical network of members that includes a lead/coordinating entity with subsidiary type members that may be owned, managed, and/or affiliated.
Community-based	Locally owned, operated, and/or managed.

A requirement for CAH designation is to have a formal, written agreement in place between the CAH and another hospital for referral and transfer of patients. Therefore, at the time of CAH certification, all Georgia CAHs had, at a minimum, the required networking agreements in place with a referral hospital. As part of the CAH site visits and CAH survey and as indicated in Table 6, CAHs were asked to report where they most frequently refer and transfer patients and to identify any referral and/or transfer issues/concerns. Fifty-eight percent of CAHs reported referral and transfer issues, including those related to:

- Lack of beds/staffed beds/diversion at referral hospitals (nights and weekends, ICU and specialty services were identified as even more difficult)
- Patients' need for higher levels of care
- Inability to place patients with psychiatric needs resulting in the patients remaining in the CAHs' emergency department for long periods (e.g., days)
- EMS staffing issues
- Referral hospitals that did not refer patients back to the CAH for rehabilitation services

Most CAHs reported referral hospital diversion issues. CAHs referring to four referral hospitals (Albany, Rome, and Thomasville, GA and Dothan, AL) did not report diversion issues.

Table 6: Hospitals where CAHs Most Frequently Refer and Transfer Patients

Network Hospital	City, State	# of CAHs reporting this as their most frequent referral hospital
Medical Center of Central Georgia	Macon, GA	5
St. Josephs/Candler	Savannah	4
Phoebe Putney Memorial Hospital	Albany, GA	3
South Georgia Medical Center	Valdosta	3
Southeast Alabama Medical Center	Dothan, Alabama	2
Memorial Health University Medical Center	Savannah	2
Athens Regional Medical Center	Athens, GA	1
University Healthcare System	Augusta, GA	1
Tanner Medical Center	Carrollton, GA	1
Northeast Georgia Medical Center	Gainesville, GA	1
Taylor Regional Hospital	Hawkinsville, GA	1
Redmond Regional Medical Center	Rome, GA	1
John D Archbold Memorial Hospital	Thomasville, GA	1
Meadows Regional Medical Center	Vidalia, GA	1
Satilla Regional Medical Center	Waycross, GA	1

CAHs were also asked about other networking activities, including their relationship with Federally Qualified Health Centers (FQHCs) and their interest in future networking activities. They report the following:

Networking with FQHCs

- 30 percent of CAHs reported they have a working relationship with an FQHC
- 45 percent of CAHs not working with an FQHC would like to develop a relationship with an FQHC
- 35 percent of CAHs do not know if they would like to develop a relationship with an FQHC

Future Networking Activities

- 81 percent of CAHs reported they are interested in engaging in network development
- 11 percent of CAHs reported they do not know if they are interested in network development
- 20 CAHs reported they would like to network with other CAHs
- 14 CAHs reported they would like to network with other community providers
- 14 CAHs reported they would like to network with tertiary hospitals
- 3 CAHs would like to network with other organizations such as faith based or physician groups or EMS

When asked what they would like to accomplish through future networking activities, CAHs reported:

- Sharing staff and costs associated with an electronic medical record
- Improving quality of care/clinical outcomes
- Sharing best practices, protocols, policies and procedures
- Creating a community where awareness of challenges, limitations and benefits of CAHs can be discussed, strategies can be identified and CAH performance improved
- Developing services through hospital partnerships that capitalize on the strengths of each organization
- Working to improve patient transfers
- Improving the working relationship of the medical community
- Improving health care services delivery
- Decreasing redundancy
- Improving communications between health care services organizations and providers
- Sharing resources to improve the financial viability of all CAHs
- Decreasing inappropriate utilization of services
- Improving the flow of data between health care services organizations
- Improving access to specialty services in rural communities
- Sharing knowledge, such as that related to capital improvement projects (e.g., vendors selected, project process management, costs)

Community health providers are considered key to the success of all rural health services and are often engaged in formal or informal community-based networks. Therefore, as part of the Community Health Care Provider Survey, health care providers working in CAH communities were asked to report their knowledge of the local hospital's CAH status, working relations with their local CAH,

referral patterns, involvement in community health planning and community health collaborations, and their overall opinion of CAHs. Seventy percent of community health providers reported they have a working relationship with their local CAH and categorized their relationship as “very strong” (54 percent), “strong” (23 percent), “average” (15 percent), “weak” (0 percent), and “very weak” (8 percent). Of the community health providers surveyed, 16 percent reported their referral patterns have changed over the past five years. They attributed this to changes in services at the local CAH (e.g., hospital no longer provides obstetric services and a decrease in patient volume).

Community health providers were also asked about their involvement in community health planning activities and local health collaboratives. Eleven percent reported they are involved in community health planning/collaboratives through community committees and health fairs.

Other Networking Opportunities

Other networking opportunities were also identified during the evaluation, including:

- Building on the activities of the Georgia tele-health project
- Supporting CAH-EMS networking

F. CHANGES IN CAH SERVICES

Access to health services is often defined in terms of service availability, health care provider availability, distance/travel times and affordability/cost. A primary intent of the Flex Program is to maintain and improve access to rural health services. Considering this and the impact that CAH conversions may have had on access to services, the evaluation gathered information on changes in CAH services as part of the CAH site visits and staff interviews.

Below are lists of services that were added, updated or eliminated in CAHs as reported during the CAH site visits.

Services Added/Updated

- Sleep studies
- Telemedicine (pharmacy, endocrinology, psychology, dermatology, cardiology)
- Case management
- Cardiac rehabilitation
- Lab
- Imaging
- Mobile MRI
- Stress testing
- Swing bed

Services Eliminated

- Respite services

Other Activities or Comments to Note

- A few CAHs continued to use single-slice CTs
- All CAHs report recruiting at least one primary care physician and other health care providers (e.g., specialists, pharmacist, physical therapist)

G. CAH ACCOMPLISHMENTS

As part of the CAH survey, all CAHs were asked to report their greatest accomplishments over the past two years. Several hospitals report their “survival” as evidence of success while others report the following:

- Making the *Presidential Honor Roll*, a measure of hospital quality, at the GHA
- Adding health services/increasing access to health care (e.g., physical therapy, teleradiology)
- Becoming Joint Commission-accredited and/or being in compliance with Joint Commission standards
- Joining a health system
- Ranking in the top tier of hospitals for employee satisfaction and/or staff turnover
- Consolidating medical staff
- Implementing electronic medical records and operations systems
- Preparing for a rural health clinic
- Providing health services to the community regardless of peoples’ ability to pay
- Building and moving into a new hospital
- Developing an FQHC
- Improving quality of care (e.g., stroke program)
- Recruiting health care providers
- Achieving local tax support for the hospital
- Securing funding for a “regeneration” project

**“Getting a new hospital
is the best thing that ever
happened to our town.”**

*- Evaluation
Participant*

H. CAH CHALLENGES, OPPORTUNITIES, AND NEEDS

Although CAHs have had many successes over the past few years, challenges still exist. Therefore, for Flex Program planning purposes, all Flex Program stakeholders interviewed or surveyed were asked about CAH challenges, opportunities and needs. Using this approach, themes emerge that focus on challenges of hospital finances and recruitment and retention of physicians.

The survey asked CAHs to identify and rank common hospital issues and concerns related to staffing, services, finances and administration. Survey respondents most frequently report finances, reimbursement (Medicaid and Medicare), market share and electronic medical records as issues at their hospital (Table 7). When asked to rate their level of concern for each of the identified issues, CAHs most frequently reported being “very concerned” about Medicare and Medicaid reimbursement, other reimbursement, recruitment and retention of physicians and finances. Using the same list of challenges as identified in Table 7, CAHs were also asked to rank their top three concerns. Table 8 displays the issues/concerns in order using a weighted ranking of respondent

hospital's top three concerns.²³ Using this method, CAHs identified their greatest concern as recruiting and retaining physicians followed by financial performance.

Table 7: CAH Issues and Level of Concern with Each Issue

Issue	Issue at the CAH			Level of Concern			
	Yes	No	Unknown	Very Concerned	Concerned	Somewhat Concerned	Not Concerned
Financial performance	96%	4%	0%	71%	29%	0%	0%
Medicaid reimbursement	91%	9%	0%	89%	11%	0%	0%
Market share	87%	9%	4%	53%	52%	5%	0%
Medicare reimbursement	87%	13%	0%	89%	6%	5%	0%
Electronic health record	86%	14%	0%	42%	42%	11%	5%
Other reimbursement	83%	17%	0%	80%	20%	0%	0%
Patient safety	82%	18%	0%	33%	50%	11%	6%
Patient satisfaction	82%	18%	0%	47%	41%	6%	6%
Physician recruitment and retention	79%	17%	4%	74%	26%	0%	0%
Relations with other health care providers	75%	20%	5%	18%	35%	41%	6%
Planning and strategic planning	73%	27%	0%	22%	33%	39%	6%
Quality improvement	73%	27%	0%	35%	47%	18%	0%
Telemedicine	71%	29%	0%	6%	38%	44%	12%
Expansion/enhancement of services	70%	30%	0%	32%	37%	21%	10%
Relations with state agencies	67%	28%	5%	31%	38%	19%	12%
System/Network relationships	65%	30%	5%	18%	29%	47%	6%
Nurse recruitment and retention	63%	38%	0%	16%	42%	37%	5%
Specialty care provider recruitment and retention	52%	43%	5%	47%	20%	20%	13%
Staff training	38%	48%	14%	46%	36%	0%	18%
Licensing and certification	38%	54%	8%	30%	30%	10%	30%
Recruiting and retaining management staff	32%	68%	0%	7%	36%	36%	21%
Recruiting and retaining nurse practitioners/physician assistants	26%	74%	0%	27%	13%	47%	13%

²³ Weighted ranking assigns a value of 3 points to a hospital's #1 concern, 2 points to their #2 concern, and 1 point to their #3 concern.

Table 8: Weighted Ranking of CAH Issues and Concerns

Issue / Concern	Score	Issue / Concern	Score
Physician recruitment and retention	39	Managed care reimbursement	4
Financial performance	34	Staff Training	4
Medicare reimbursement	14	Patient satisfaction	3
Electronic health record	9	Market share	2
Expansion/enhancement of services	8	Rules and regulations	1
Medicaid reimbursement	7	System/Network relationships	1
Recruiting and retaining mid-levels	5	Other reimbursement	1
Nurse recruitment and retention	4		

Other Challenges

During the CAH site visits, staff were asked to report their hospital's greatest challenges and concerns. They report the following:

- High turnover of hospital management, in particular, CEOs
- Lack of incentives to focus on quality improvement
- Lack of incentives to improve the population's health
- Lack of physician buy-in for the quality improvement initiatives (e.g., most of the quality improvement measures for CAHs are dependent on the actions of contracted physicians)
- Patients that bypass their local CAH for health services in more urban settings
- Lack of community awareness of the role and impact of CAHs
- Lack of health information technology (HIT)
- Lack of networking with other community health providers (e.g., community health centers)
- State agency travel restrictions affecting the technical assistance and support available to CAHs and other rural health stakeholders
- Increasing competition due to overlap in and/or expansion of services areas
- Patients that use the emergency room for primary care services
- Non-physician provider recruitment at some CAHs (e.g., pharmacist, physical therapist)

Contributing rural issues:

- High unemployment
- High teen pregnancy rates
- Aging population
- Low graduation rates
- Lack of physician residency programs that focus on the recruitment and retention needs of small rural hospitals
- Lack of public transportation
- Drug abuse (in particular prescription drugs)
- Population's poor health status (obesity, diabetes, heart disease, sexually transmitted diseases)

CAH Opportunities

Flex Program stakeholders were asked to report on programs and/or opportunities that they believed could advance other CAHs and/or programs/initiatives that they have developed since conversion to CAH status. They reported:

- Workforce development
 - Continuing education focusing on clinical competencies and patient care
 - Web-based quality improvement 101 orientation/education
 - On-going CEO education to keep current and knowledgeable and have the tools and skills to manage the hospital
 - CAH board training
- Increased/more effective use of the swing-bed program
- Leadership development
- Succession planning
- Increased development and better use of distance learning
- Networking and resources sharing
- EMR implementation, full EMR operability and EMR interoperability
- Increased use of Area Health Education Centers' (AHECs') services, including outreach librarian services to meet quality improvement needs and training on evidence-based practice
- Community health education and training
- Refocusing Mercer University's School of Medicine in Macon, Georgia, to concentrate on training rural physicians and having them return to rural areas²⁴
- Community health care systems planning
- Expanding/broadening the peer review network so it is not just focused on "special" or "unique" cases
- Creating an interactive chat board where CAHs could network and share best practices
- Supporting healthy eating habits by improving hospital cafeteria food

“Being able to network is huge. The more we can work together the better”

- Evaluation Participant

CAH Staffs' Recommended Changes to the Flex Program:

CAH staffs were asked to make recommendations about how they would like to see the Flex Program change to better meet their needs. They reported the following recommended changes:

- Educate CAH leadership (hospital administrators, chief financial officers, quality improvement coordinators, chief nursing officers) on Flex Program opportunities
- Provide incentives to CAHs to stimulate networking and collaboration
- Provide technical assistance to CAHs to further HIT and the use of telemedicine
- Support CAHs in updating and/or creating relevant strategic plans

²⁴ CAH staff and state Flex Program stakeholders report Mercer School of Medicine, Macon, Georgia, was created as a school to train rural physicians. It appears that physicians trained through this program are not returning to rural areas to practice medicine.

- Transition quality improvement initiatives from focusing on data collection activities to using the data to improve quality of care (e.g., process improvement training)
- Facilitate a primary care physician summit in the state that includes key stakeholders (e.g., medical schools, rural physicians, nurse practitioners and physician assistants, hospitals) to discuss issues and identify strategies to address the rural physician shortage
- Support CAH pilot projects that promote community health and wellness
- Support training modules that are hospital department specific (e.g., central lines, triaging process)
- Support tools and resources to improve physician-hospital relations
- Support EMR adoption, including activities about EMR planning
- Support team-building exercises between CAHs and local EMS

Section 5: Quality Improvement

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

The GHA's quality improvement system or CARE Program has four key components: CARE2, Medical Evaluation Module of CARE (MedEval), CARE core, and HIGH RISK.²⁵ CARE2 is a Web-based tool that allows hospitals to enter quality improvement indicator data, drill down to clinical service areas and use 27 benchmarks. MedEval provides physician level reporting, has drill down capabilities to each service line, diagnosis related group (DRG) or patient level as well as other features. CARE core and high risk are patient safety and compliance and high risk patient safety modules to assist hospitals with compliance, clinical process improvement, patient assessment and reportable events.

In 2008, the Georgia Flex Program used carryover funds to develop online tools and resources to assist hospitals (including CAHs) with implementation of the CMS Outpatient Prospective Payment System (OPPS) measures. The project included:

- Programming the CMS collaborative approach to resource effectiveness conversion utility tool (CART) which allows hospitals to easily import outpatient data and begin the data abstraction process
- Creating the OPPS Module:
 1. Code Algorithms based on Joint Commission Specifications
 2. Test Algorithms
 3. Permission Reports
 4. Error Monitoring
 5. Expected Measure Table
 6. Install Front End Edits
 7. Technical Assistance
 8. Written Materials
 9. Instructional Telnets
 10. WebEx Education and Training Sessions

In addition to quality improvement data collection and reporting, the Georgia Flex Program supports a peer review network that was originally focused on CAHs but has expanded to include other rural

²⁵ CARE is Collaborative Approach to Resource Effectiveness.

hospitals. The network is used for cases that are “difficult to review” and can be accessed free of charge.

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

“If you have no baseline data, it’s hard to know where you are at, what you should focus on, and to set goals.”

- Evaluation Participant

Considering CAH participation in the CARE Program, there is mixed participation depending on the program component. Using CAH participation data for 20 trainings/workshops held in 2008 and 2009, participation rates ranged from zero to eight training sessions per CAH with an average of 2.7 sessions per hospital. Considering CAH logins to the CARE2/MedEval components, the number of logins range from no logins at three CAHs to 131 logins at one CAH, with an average of 30.9 logins per CAH. In addition to login and participation data, the GHA reports providing 1,575 minutes of phone support to CAHs or an average of 46.3 minutes per hospital.

“If one hospital can collect the data, any hospital can do it.”

- Evaluation Participant

Along with the CARE Program supported through the Flex Program, the GHA is using other tools to encourage improved quality of care in hospitals, such as sending quality dashboards to all of the hospital CEOs and putting colored dots on hospital staffs’ badges at events reflecting the hospitals’ quality scores. The GHA also created and publishes a state quality honor roll based on targeted core measures. Hospitals with core measures between 98 and 100 percent were part of the *Chairman’s Honor Roll*, those between 93 and 97.9 percent were part of the *Presidential Honor Roll*, and 91 and 92.9 percent became part of the *Honor Roll*.

Given the quality indicator reporting format used by the GHA as part of its annual contract with the SORH, it is difficult to track changes in process measures over time. Aggregated however, the data reflect improved process measures across CAHs. Other indicators of project outcomes were identified, including:

- Hospitals making the GHA Honor Roll included 17 hospitals at program start as compared to 47 hospitals in 2009, an increase of 30 hospitals
- No CAHs were rated in GHA’s Chairman’s or Presidential Honor Rolls at program start as compared to two CAHs in the Chairman’s Honor Roll and four CAHs in the Presidential Honor Roll in 2009
- One Georgia CAH was recognized in December 2009 by Leapfrog as a Top Hospital for efficiency

“Quality used to be a department, now it’s a fundamental part of how some (CAHs) operate”

- Stakeholder

- More 2009 CAH survey respondents reported they participate in quality improvement initiatives as compared to 2007 CAH survey respondents

In addition to the CARE Program, 13 hospitals currently participate in the peer review network, along with 19 participating physicians representing 10 different specialties. Twenty-one patient chart reviews have been completed since the peer review network was created. The network is used for cases that are “difficult to review,” and can be accessed at no cost.

“At one point, I left this hospital for fear of losing my license but things have changed a lot.”

- Stakeholder

As part of the CAH survey, CAHs were asked to report their knowledge of, participation in and the helpfulness of the quality improvement initiatives. Sixty-eight percent of CAHs reported they were aware of at least one initiative and 20 percent or greater did not know if their hospital was participating in each of the initiatives. CAHs reported they were most aware of (65 percent) and most likely participating in (58 percent) the CARE2 quality improvement initiative (Table 9). When asked to report outcomes that had resulted because of the CAHs’ involvement in the quality improvement initiatives, they reported:

- Medical staff had adopted core measure guidelines
- Peer review had been expanded to include outside/independent providers
- Patients and staff were more aware of quality improvement needs and issues
- Improved quality of patient care

During the CAH site visits, hospital administrators, chief nursing officers and quality improvement coordinators were also asked about the quality improvement initiatives and their CAH’s participation. They reported the following:

- Two CAHs reported they participate in CARE2
- One quality improvement coordinator reported s/he had never heard of CARE2
- One CAH reported participation in CARE2 was instrumental in establishing pneumonia and outpatient acute myocardial infarction protocols
- No CAH reported using the Medical Evaluation Quality Improvement Module. They reported this tool was better suited for large hospitals
- CAHs reported the Culture of Patient Safety Project better prepared them for Joint Commission accreditation

CAH staffs also commented on barriers that delayed or negatively affected their participation in the quality improvement initiatives supported through the Flex Program, including:

- CARE2 data inconsistencies because of poor data reporting by hospitals
- Complex reporting tools which took time to learn and result in data submission delays and data reporting
- Regular and on-going turnover in quality improvement staff
- Long delays in getting data reports back from the GHA (e.g., three to six months delays reported)

Other indicators also exist that suggest the Flex Program funded initiatives are having an impact on quality of care in CAHs. Examples of this include:

- All of the CAHs visited reported they had quality improvement programs in place
- CAH quality improvement coordinators had quantitative examples of improved quality of care (e.g., smoking cessation from 50 percent to 100 percent)
- CAHs reported improved patient satisfaction rates in their hospital
- CAHs reported improved infection control rates (e.g., decrease in needle sticks rate)

CAH Quality Improvement Challenges

During the CAH site visits, other quality improvement challenges were identified by staff, including:

- Recruiting and retaining qualified quality improvement coordinators
- Planning, purchasing and/or implementing an electronic medical record
- Engaging physicians in quality improvement
- Maintaining momentum towards quality improvement

CAH Quality Improvement Needs

CAHs were also asked to report their quality improvement needs for the upcoming two years (2010 – 2012). They reported the following:

- Quality improvement measures that focus on outpatient services²⁶
- Education/information on quality improvement initiatives available through the Flex Program
- Assistance with electronic medical records planning, purchase, implementation and use
- Training and assistance with Recovery Audit Contract (RAC) audits
- Methods to reduce emergency room wait times while maintaining patient quality and satisfaction
- Policies, procedures and other tools and resources to improve pressure ulcers, falls risk and prevention, pneumonia vaccination rates, antibiotic selection, infection control and/or heart failure measures
- Ongoing support for Flex Program-funded quality improvement initiatives currently underway (CARE Program)
- Assistance in compliance with Joint Commission National Patient Safety Goals
- Assistance with policies and procedures on infection control
- Tools and assistance to prepare for pay-for-performance
- Customer service training for hospital staff
- Support for establishing a meaningful use network
- Support to overhaul the quality improvement program in the hospital

“Infection control has to be a priority, It is bad for patients and it can ruin your [hospital] reputation.”

- Evaluation Participant

²⁶ As noted earlier, the outpatient measures were added to the state’s quality improvement indicators as part of the 2008 Flex Program and were implemented in 2009.

Finally, community health providers were asked to indicate their overall opinion of their local CAH and the quality of care it provided. They reported their overall opinions as: “very good” (38 percent), “good” (31 percent), “average” (25 percent), “poor” (six percent), and “very poor” (six percent).

Table 9: CAHs’ Knowledge of, Participation in, and helpfulness of Flex Program Quality Improvement Initiatives

Types of Quality Improvement Assistance Made Available	Aware of the Initiative	Participating in the Initiative	Satisfaction with Initiative			
			Very Helpful	Helpful	Somewhat Helpful	Not Helpful
			CARE2	65%	58%	42%
Medical Evaluation Module	54%	35%	38%	38%	25%	0%
Patient Safety and High Risk Modules	58%	39%	44%	44%	0%	11%
Culture of Patient Safety Project	68%	47%	44%	56%	0%	0%
CAH Peer Review Network	60%	39%	56%	11%	22%	11%

Section 6: Emergency Medical Services (EMS)

EMS integration is another required goal of the Flex Program. This section focuses on the current status of EMS in Georgia, EMS involvement in the Flex Program, EMS accomplishments, challenges, and needs.

Background

Georgia's EMS system includes 206 licensed ambulance services and unlike most states, all services have some level of advanced life support (ALS) patient care. EMS service areas vary with some ambulance services serving over 500 square miles. The majority of ambulance services are county-operated and fire-based, with some private ambulance companies and others that are hospital-owned. At least one is corporate owned by a Georgia Pacific paper mill. There are many military bases in Georgia and there is some cross training between those stationed at the three Air Force bases and EMS. Some military bases also contract with local EMS for ambulance services. There are approximately 700 emergency medical technicians – basic (EMT-B); 11,000 emergency medical technicians – intermediate (EMT-I); and 7,000 paramedics in the state. They responded to approximately 1.2 million calls in 2008. Almost all EMS agencies are fully-paid services, which is uncommon when compared to other states.²⁷

Georgia is divided into 10 EMS regions that are staffed with a program director, training specialists, and/or licensing personnel. Interviews with regional office staff indicated that the operations of these offices were highly constrained due to lack of state funding. Several offices reported they lacked essential items such as paper and toner for printing. Hiring appeared to be an additional constraint, as some positions had been vacant for lengthy periods of time or have gone unfilled.

Interviews with local and regional EMS staff indicated there was variability across the state in local ambulance services operation and issues. Some regions reportedly had high level ALS services nearly uniformly available. Other regions were more resource challenged, with some counties having limited access to ambulance services. First responders were a resource in these areas. The economy is also affecting EMS. Because of the high number of county-owned ambulance services, many operators have been feeling pinched as local tax revenue has declined.

Access to EMS training also seems quite variable across the state. Some regions and local EMS agencies reported many training courses currently being offered, with high attendance, and more applications than course seats available. In other areas there were not as many courses being offered and not as many individuals seeking EMS education. Times and locations are difficult for people in these areas as they need to travel further to access on-site education. The effect of the economy on EMS education is unclear. In some cases, more people have been signing up for EMS training because this appears to be a “steady job” in an economy full of uncertainty. In other places, EMS wages are not high enough to attract and retain personnel. There are varying thoughts about how this will play out in the coming months and years. There is some sense that the poor economy will bring

²⁷ Fully-paid services are not volunteer meaning staff are paid on a salary or per hour basis.

people into EMS. Others believe that as the economy improves, EMS employees will seek more lucrative jobs.

There are also divergent views of the quality of people currently entering EMS. Some local and regional directors felt the new people coming in were “bright, dedicated and some of the best people that have entered the profession in years.” In other cases, there was a sense that new hires were less committed to patient care and did not want to deal with certain types of patients. For example, they may not want to do nursing home transfers - perhaps because the work is too routine or because they do not perceive that these patients need the kind of care for which they are trained.

Most EMS agencies are reporting their run reports electronically to the state EMS office through the Georgia EMS information system (GEMSIS). In addition, many EMS agencies are inputting data in the field via laptops and then exporting the data once they are back at their base site. Although data are being submitted electronically, questions still existed about its validity (e.g., differences in reporting across ambulance services and the reporting of chest pain versus congestive heart failure or stroke versus altered level of consciousness).

Georgia does not have a statewide trauma system; however, one is being developed through the state Trauma Commission. Although a complete system is not in place, there are four level I trauma hospitals, nine level II trauma hospitals, no level three trauma hospitals and two level IV trauma hospitals.

Flex Program and EMS

The Georgia Flex Program has directed approximately 15 percent of program funding over the past three years to EMS. This has occurred through contractual arrangements with the Georgia State Office of EMS and a regional network. The funding has supported data collection tools, web-based training and tracking and a regional pilot project focused on quality improvement and EMS staff training. Staff turnover at the state EMS office resulted in many project delays; however, its training website was launched in August 2009. The site can be accessed by EMTs and paramedics and had 1,400 subscribers during the first three months. Given the site’s launch date, no reportable outcomes (outside the large number of subscribers to the site) were available for inclusion in the evaluation.

The second project received Flex Program support in April 2009. The project included a consortium of five counties that measured paramedic competencies using a baseline test and follow-up tests and training EMS providers based on training needs. This project included three CAH communities. Again, given the project timeline, no outcomes data were available for inclusion in the evaluation.

CAHs, state, regional, and local EMS staffs were asked about the Flex Program, program activities, as well as, needs, challenges and next steps. Eleven percent of CAHs in Georgia reported their hospital owned the local ambulance service and an additional 15 percent managed/operated the EMS. These hospitals reported they need assistance with: EMS staffing and training, purchasing a new ambulance, providing back-up when their squad is transferring patients and educating county leaders

“Before the hospitals didn’t care. As long as you [EMS] could do CPR, they were ok. Things are very different today.”

- Stakeholder

about the cost and value of local EMS. When all CAHs were asked how they would like the Flex Program to support EMS in the state, they report the following: (*ranked in order*)

- CAH emergency department staff training
- EMS quality improvement initiatives
- Trauma system development
- Medical director training
- EMS recruitment and retention
- EMS staff training
- Other (increasing the number of transport only services)

EMS Accomplishments

During the EMS stakeholder interviews, EMS stakeholders discussed many EMS accomplishments from the past three years. Examples of this included:

- Regionalization of trauma care with improvements in on-site care, helicopter transport availability
- Regional trauma centers resulted in a decrease in mortality
- Regionalization of cardiac care with improvements in on-site care, triage to a STEMI center with 24-hour availability of cardiac surgery has improved morbidity
- Early stages of regionalization in stroke care with improvements in triage to stroke centers has already shown benefits by decreasing patients' long term disability and reducing costs
- Web-based training for medical directors was created and is available
- Most ambulance services are reporting their run data electronically

EMS Challenges, Opportunities, and Needs

All Flex Program stakeholders were also asked about the state's greatest EMS challenges, opportunities and needs. They reported the following:

Challenges

- Changes in technology
- Changes in the standards of care (standards were increasingly more demanding and required more training)
- Increase in patient expectations
- Increase in educational requirements and the maintenance of that education
- Decrease in testing success rate for the national registry test (EMT-I)
- Decrease in interest in paramedic as a career
- Lack of reliable cell phone coverage (although all ambulances have 12-lead electrocardiograms/EKGs, many do not have access to telephone carriers that allow reliable transmission of data)
- Lack of communication and coordination between CAHs (in particular emergency department staff) and local EMS agencies
- Lack of funding for the state and regional EMS offices
- Lack of funds to maintain automated external defibrillators (AEDs) and in particular, replacement parts and batteries

- Increase in staff retention risk (many EMTs and paramedics are working at multiple services so if one leaves it may affect the neighboring EMS service as well)
- Lack of CAH-EMS relations in some CAH communities
- Outdated equipment
- Aging workforce
- Obese patients
- Consistent run data reporting across all EMS agencies

Opportunities

- Communications between state and national registry stakeholders have increased which has resulted in changing some of the EMS training focus; however, it has not had a significant impact on improving test scores
- Creating an EMS workforce that better reflects the demographics of the communities served
- Reducing injuries (e.g., bike helmet, seat belt, smoke alarm use) through education and information
- Increasing awareness of preventative health (e.g., diet, exercise) by addressing public health concerns
- Implementing EMT-B classes in high schools
- Mining the experience and knowledge of some regional directors' use of run data for more extensive quality improvement activities
- Increasing the use of run data (many ambulance services are receiving grant funded laptops which may lead to increased access to run data)
- Advancing the segment elevation myocardial infarction (STEMI – a type of a heart attack) program (most local EMS agencies have implemented or are implementing a STEMI program)

Recommendations for the Flex Program

- Focus on medical director training – it should include benchmarks for all EMS agencies
- Support EMS agency leadership training (Fort Hays has an emergency management leadership training course)
- Support CAH trauma designations through grants
- Support CAH-EMS quality improvement collaboratives
- Improve first responders' training and their access to training
- Explore the Community Paramedic Model for implementation in Georgia
- Support quality improvement initiatives/pilots that include both CAHs and EMS

Section 7: Summary of Key Findings

Georgia Flex Program key program findings are summarized and highlighted here.

A. FLEX PROGRAM IMPLEMENTATION

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

B. CAHs

- Georgia was the 13th state to have a CAH
- There are 34 CAHs in Georgia
- All Georgia CAHs are considered necessary providers as none are 35 miles from the next nearest hospital or 15 miles in mountainous terrain or on a secondary road
- No hospital is currently seeking CAH status
- Four CAHs are considering converting back from CAH status
- Ninety percent of CAHs are aware of the Flex Program
- Eighty-eight percent of CAHs are "very satisfied" or "satisfied" with the Flex Program, and no CAH reported being "dissatisfied" with the Flex Program
- CAH Flex Program satisfaction increased from 2007 to 2009

- No CAH visited during the site visits reported knowledge of Flex Program funded EMS activities
- Considering all Flex Program funded initiatives targeted to meet the needs of CAHs, the measure they are most satisfied with is the CAH financial analysis completed by Draffin and Tucker, LLP and least use the network development technical assistance
- CAHs' financial status has improved since conversion
- CAHs increased access to health care services by adding to the types of services provided locally
- Fifty-eight percent of CAHs reported they had referral and transfer issues with their network hospital(s)
- Finances and physician recruitment and retention were CAHs' greatest concerns
- Five CAHs were reportedly on the verge of closure and three additional CAHs were financially fragile

C. NETWORK DEVELOPMENT

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

D. QUALITY IMPROVEMENT

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

E. EMS

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

Section 8: Recommendations

The following recommendations are based on the data, documentation, interviews, observations, and analysis that occurred through the Georgia Flex Program evaluation. Recommendations are intended to support Georgia in developing its Flex Program over the coming years.

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

1) PROGRAM INFORMATION AND EDUCATION

Georgia should further educate program stakeholders about the Flex Program and its intended goals.

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

- Be directed at CAHs and EMS to assure their staffs are aware of all Flex Program funded activities
- Be incorporated into the program's strategic planning and communications related activities
- Re-engage stakeholders so they can be active program participants
- Include all program activities, including those related to EMS
- Account for the regular turnover in stakeholder staff, in particular those located in CAHs and regional EMS offices
- Be broad-based to include both executive leadership as well as other key staff such as quality improvement coordinators and chief nursing officers

2) STRATEGIC PLANNING

Georgia should conduct a formal strategic planning process.

Flex Program stakeholders have differing and often vague views of the goals and objectives of the Georgia Flex Program as well as its planning process. Although annual program planning meetings are currently being conducted, the SORH should consider expanding them as follows:

- Expand stakeholder participation by increasing the number of CAH representatives, regional and local EMS, AHECs, and others as identified as key program stakeholders by the Flex Program. CAH representation should include hospital administrators, quality improvement coordinators, chief nursing officers and chief financial officers to reflect the program's goals and objectives
- Leverage the resources of all key Flex Program stakeholders (e.g., AHECs and QIO) to create efficiencies and advance common goals

- Include stakeholder organizations' strategic plans in the discussion to identify connections between the Flex Program and other stakeholders' goals and objectives
- Use an outside facilitator so SORH staff can participate in the discussion
- Create a plan that can guide Flex Program activities for the coming two to three years
- Assure local and regional EMS are represented

3) CAH FINANCES

Use a CAH specific approach to address CAHs' financial challenges.

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

Recommendations:

- Meet with CAHs that have the greatest financial challenges to identify how the Flex Program can address their specific needs and target program funding accordingly
- Explore the possibility of including all CAHs in any future Flex Program funded financial analysis report (instead of doing a subset of CAHs and using a multi-year approach)
- Review other states' CAH financial reports to identify any best practices/lessons learned/methods before moving toward the approach/methods for future CAH financial analysis projects

4) WORKFORCE

Work towards addressing physician workforce issues.

CAHs report physician recruitment and retention as one of their greatest issues and concerns. Not only does a lack of physicians affect access to health services, but also complicates the financial viability of all hospitals. Recommendations:

- Complete regular CAH physician recruitment needs assessments to understand where the needs and issues are occurring and the scope of those issues. This could be accomplished using a web-based survey by asking CAHs a few questions about physician recruitment and retention timelines
- Host a physician workforce planning event that includes key stakeholders
- Explore the development of a viable rural residency program for Georgia. Look at models being implemented in other states such as those in Tennessee, Wisconsin and Minnesota
- Include physician recruitment and retention in the Flex Program strategic planning process

5) OTHER CAH ISSUES AND NEEDS

Respond to other key CAH and EMS issues and opportunities identified in the evaluation, such as: CAH network development, hospital diversion issues, CAH conversions back from CAH status and CAH-EMS relations.

Many CAH and EMS issues and challenges were identified during the evaluation. In addition, although many Flex Program goals can be addressed using a statewide approach, some may require a more targeted approach. Recommendations:

- Some of the identified issues can be included in the strategic planning process while others may require discussions with new/emerging project partners

- Consider providing targeted funding (perhaps through grants) directly to CAHs to address their unique financial challenges and needs
- Consider subsidizing CAHs' costs associated with obtaining trauma center designation
- Establish a workgroup of CAHs and referral hospitals to discuss and identify solutions to address hospital diversion challenges
- Identify and support CAHs that are not actively participating in the CARE Program

7) EVALUATION

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

Recommendations:

- Track program measures and targets included as part of the Georgia's Flex Program strategic plan and use to better measure and report program outcomes. This can be built into the program planning process and reported at stakeholder meetings and on the web
- Make regular site visits to CAHs and regional EMS offices. Site visits should include discussions with key staff to assure all stakeholders are engaged in and aware of the Flex Program and its activities. Site visit findings should be included in the strategic planning process
- Use the hospital's city name versus the hospital's name for hospital/CAH data tracking purposes because hospital names change making it difficult to track data over time
- Report program outcomes to stakeholders on a regular basis, perhaps via an annual report or regular updates/posts on the Flex Program website
- Create project reporting tools for contractors working on Flex Program initiatives. These tools should require contractors to consistently report all participants (including organization name, city, state, number of participants and type of provider), outcome measures and other data depending on the project. All information should be reported electronically, using a spreadsheet or database format for ease of data analysis, reporting and tracking
- All contractors should be encouraged to use similar workshop/training session participation satisfaction tools to allow comparisons across activities. Contractors should also be encouraged to complete follow-up evaluation activities to determine if the information learned was used/applied and to identify other issues or needs