

# THIS IS RURAL GEORGIA



E M P T Y   S T O R E F R O N T S

C R U M B L I N G   I N F R A S T R U C T U R E

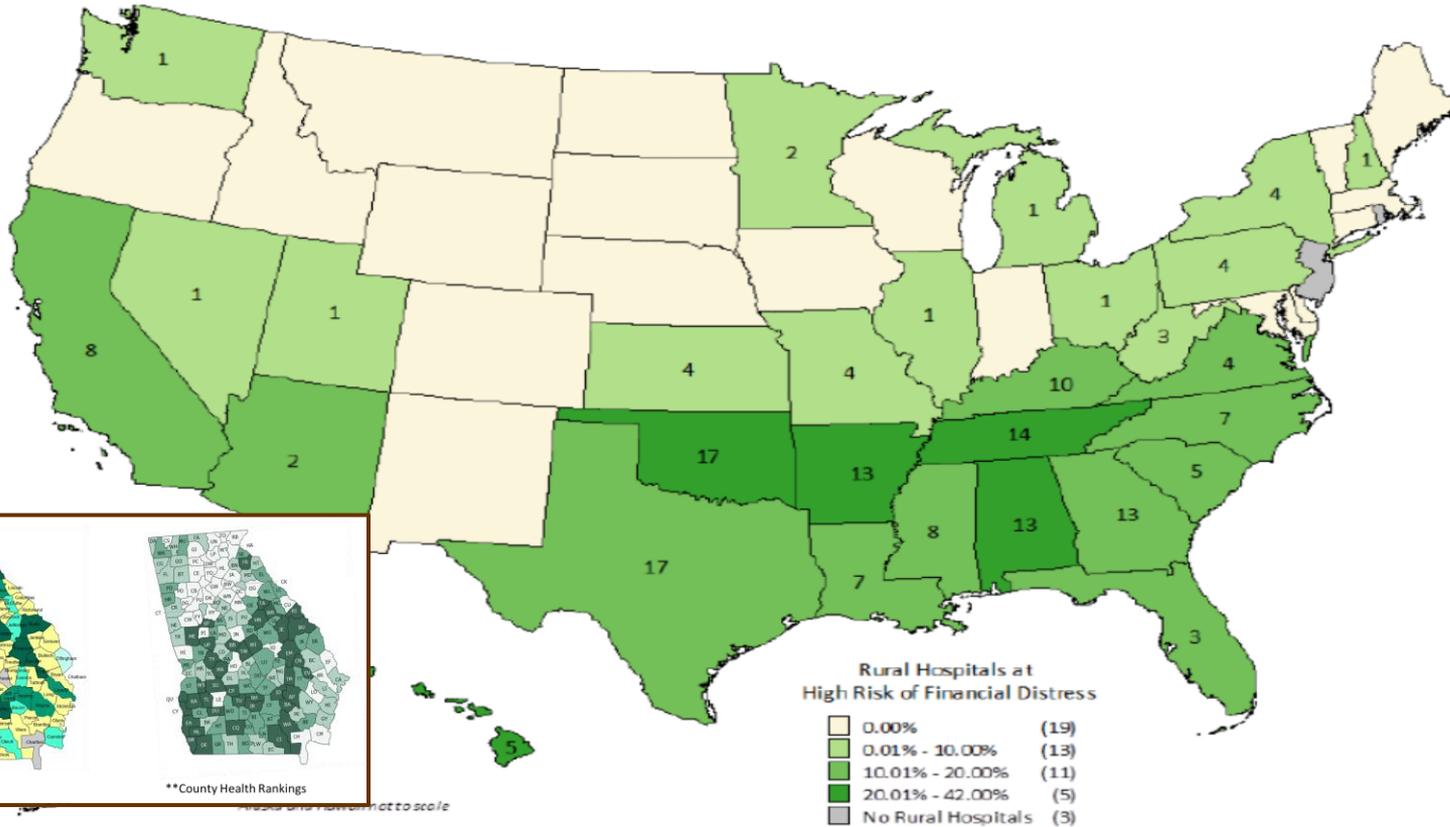
H I G H   U N E M P L O Y M E N T



P O O R   H E A L T H   O U T C O M E S  
F R A Y I N G   S O C I A L   N E T W O R K S  
L O W   E D U C A T I O N A L   A T T A I N M E N T  
H I G H   P O V E R T Y

# HOSPITALS IN DISTRESS

**Figure 1: Number and Percentage of Rural Hospitals at High Risk of Financial Distress in 2015**



Source: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, September 2015  
<http://www.shepscenter.unc.edu/programs-projects/rural-health/>



- Community endeavors
- FQHCs/RHCs development
- Hospital diversification
- Workforce initiatives
- New and creative state policies

Good things are happening

# Yet rural hospitals are still at risk



- New policies are helping



- But the infusions of money, loss of tax revenue, and high risk require a further look at hospital authorities *and* broader governance of healthcare to ensure accountability when tax dollars are involved

**Hospital  
Governance:**  
Most rural  
hospitals are  
owned and  
governed by  
hospital  
authorities

- Authorities are a type of special district
- Singular purpose in law: *to promote the public health goals of the state*
- Local governments can levy taxes
- Can issue bonds
- Can borrow money
- Enter into multi-year contracts

### Private Aspects

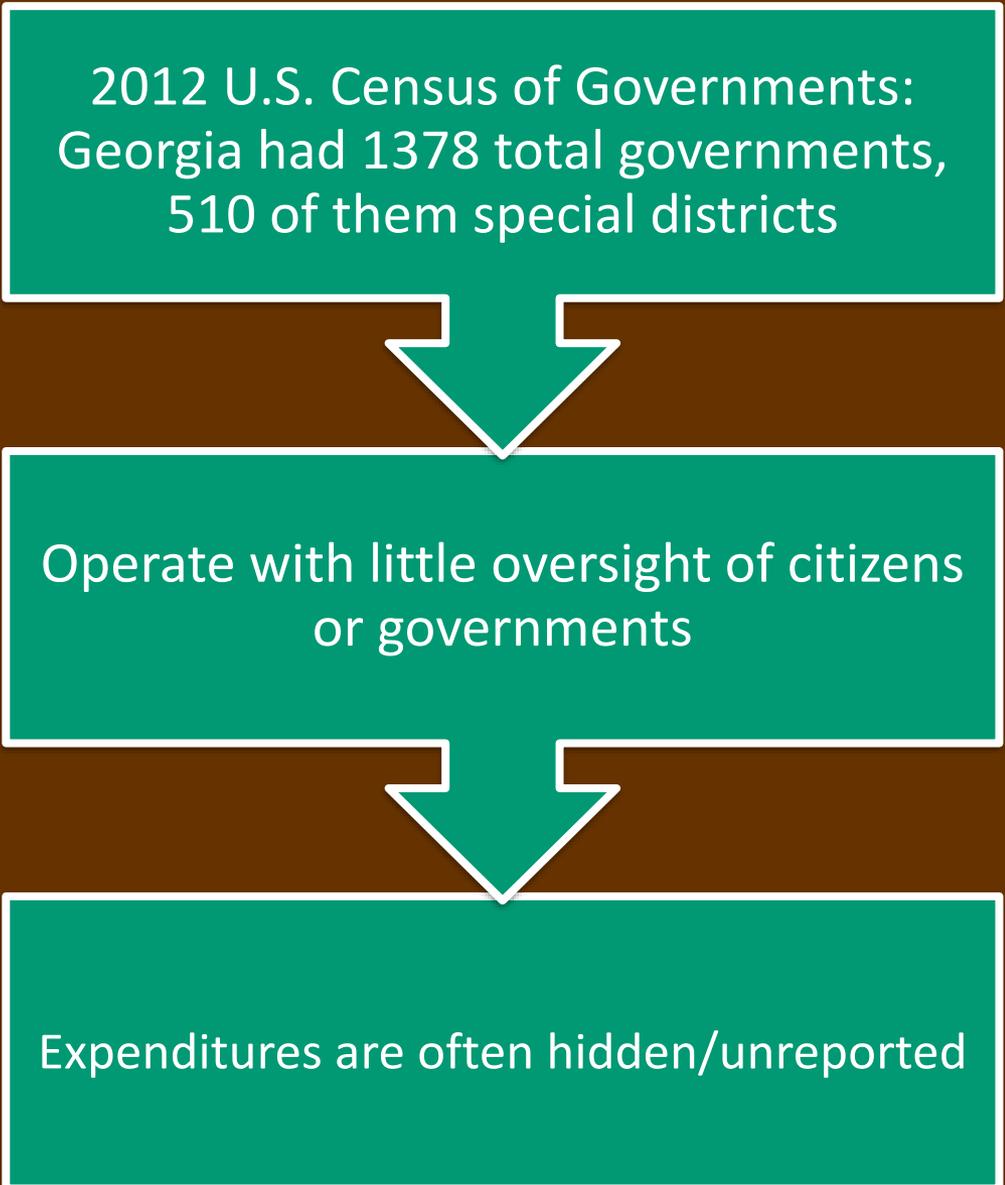
- “Less political”
- Allow for expertise and efficiency
- **BUT**
- More opportunities for conflicts of interest, corruption

### Public Aspects

- Mandates for accountability and transparency
- Benefit from tax dollars and tax expenditures
- Must take Medicare/Medicaid, provide community benefit, charity care
- Have ER
- Some other management requirements spelled out in law

Special districts:  
public but with private aspects

2012 U.S. Census of Governments:  
Georgia had 1378 total governments,  
510 of them special districts



Operate with little oversight of citizens  
or governments

Expenditures are often hidden/unreported

Good reasons  
why special  
districts are  
sometimes  
called  
“ghost” or  
“shadow”  
governments

None of the 29 Georgia rural hospitals studied for this research had a budget, audit, or archive of minutes available on their hospital websites or on county websites.

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Noncompliance of hospitals with Georgia mandates:

Indebtedness reporting  
Pension fund reporting  
Authority finances

Community needs assessment



*International Journal of  
Organizational Theory and  
Behavior* – March 2018  
Co-author, R.P. Yehl, Ph.D., VSU

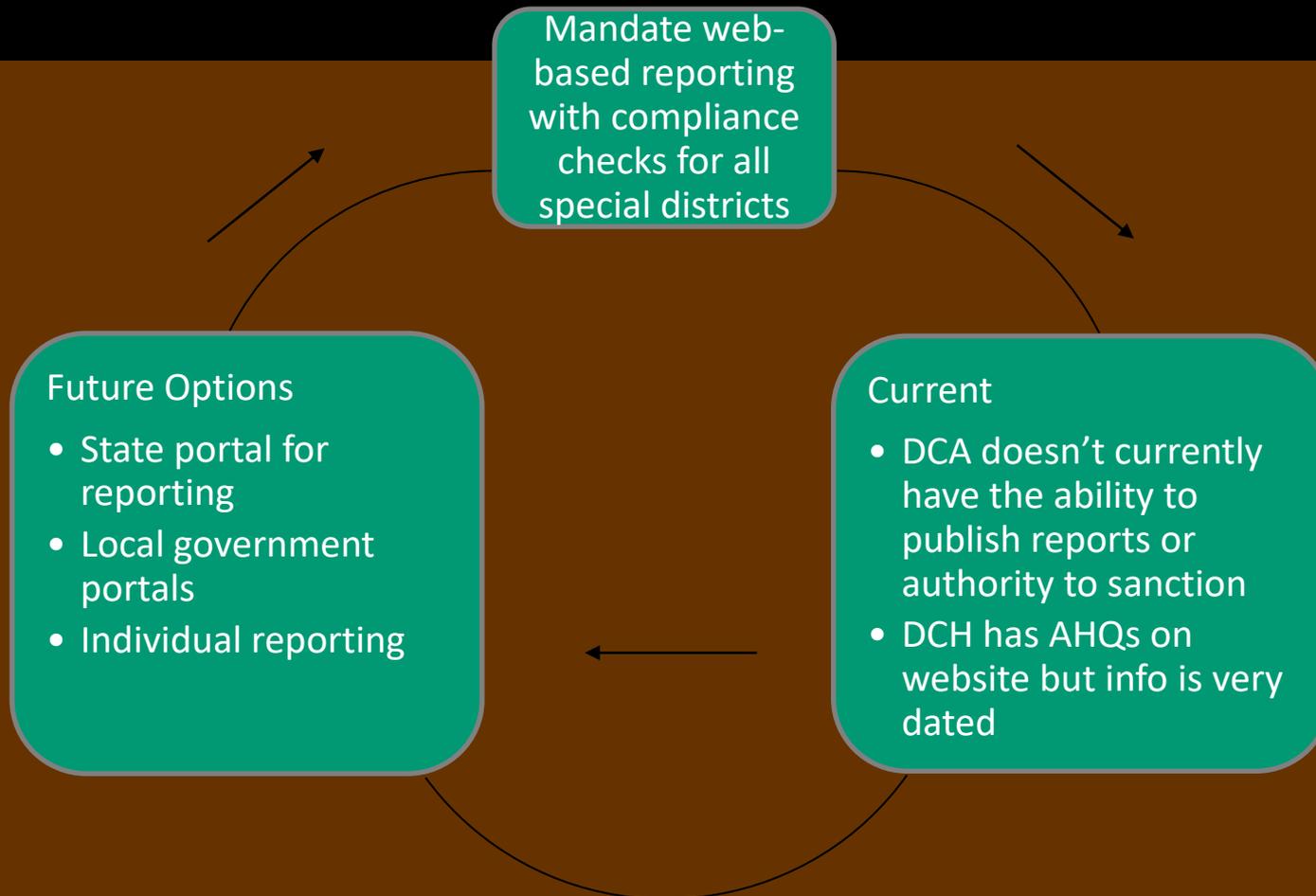
Transparency is virtually non-existent in rural hospital authorities.

- <http://www.cgjda.com/>
- <https://www.smyrnacity.com/your-government/boards-commissions-authorities>
- [https://thebrunswicknews.com/news/local\\_news/grand-jury-asked-to-investigate-camden-psa/article\\_88cb3b94-6133-530f-a11f-262eb750d564.html](https://thebrunswicknews.com/news/local_news/grand-jury-asked-to-investigate-camden-psa/article_88cb3b94-6133-530f-a11f-262eb750d564.html)

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Georgia's hospital authorities are not the only special districts lacking in transparency

# Improving transparency for hospital authorities and special districts



**The “best” new  
administrator**

**The “best”  
management  
company**

**The “best”  
partner**

**The “best” new  
line of service**

**The “best”  
company with  
which to do  
business**

Hospital  
authorities  
sometimes cross  
the line  
between public  
and private  
interests as they  
seek the “silver  
bullet.”  
Transparency is  
lacking.

Health care  
has changed,  
but not all  
rural  
hospitals  
have  
recreated  
themselves

- Singular purpose to keep hospitals as-is *vs.* current community needs
- Cost of expansions and facelifts *vs.* realistic projections
- Right-sizing services to ensure stability *vs.* layoffs in a difficult economy
- Desire to hire docs *vs.* nurturing independent physicians
- Best interest of the public *vs.* private interests of partners, boards
- Democratic governance *vs.* opaque transactions



## Northside Hospital Case: Georgia Supreme Court Decision, 11/2/17

- Georgia Supreme Court decision: As a HA hospital, corporate records for Northside are generally public.
- Northside had argued for privacy because “it doesn’t do anything on behalf of the county agency, and for this reason its records of health-care-related acquisitions aren’t subject to public inspection.”

# Big Questions About Hospital Governance, the Regulatory Environment, and Public Purpose



Is health care too complex to be run by citizens without health care backgrounds?



Is there even a need to retain boards where the hospitals are closed or HA roles diminished?



Should hospital authorities be replaced and by what?



Is there still a public purpose for Hospital Authorities or is public purpose only applicable in certain underserved areas?



How do CON laws affect access and cost for vulnerable Georgians?

Changes are  
on the  
horizon: state  
governance  
and rural  
hospitals

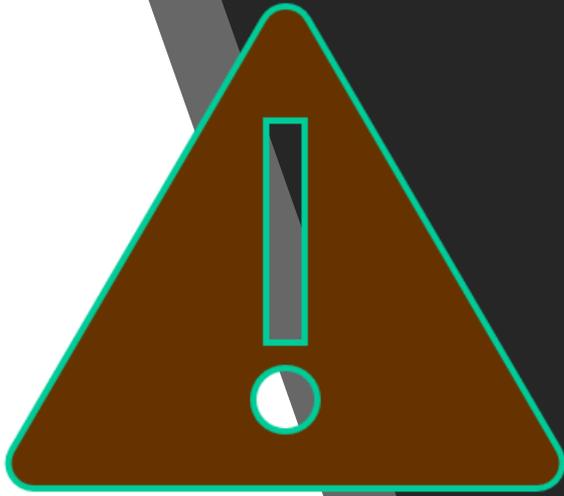
- 2011 Minnesota repealed CON; retained a “public interest” review when rural hospitals would be at high risk
- 2016 sunset for NH CON, new law:
  - Quality review for high risk cardiac, radiation services
  - New hospitals must have ERs
  - Level playing field for charity/indigent
  - CAH competitors within 15 miles must get OK from HHS Commissioner
  - No hospital closures since sunset

# With difficult choices, *seek consistent values*



- Are HAs and CON laws still working in the public interest?
  - CON laws created to ensure quality, control costs, protect access
  - Hospital authorities established to assure public health goals of the state
- Public interest? Protect access to rural residents *and* vulnerable populations in inner cities

# Considerations



- Rethink HA (special district) laws to mandate transparent behaviors
- Look at options for planning
  - Study option of regional planning
  - Identify areas of market failure
- Focus on sustainability
  - for primary care infrastructure
  - better deployment of EMS
  - ensure access to ERs
  - maintenance of charity/indigent obligations , Medicare/Medicaid acceptance
  - consider Medicaid options
- Support workforce development
- Rethink CON with “public health care goals of the state” in mind



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