Meeting Summary
Rural Health Care Delivery Work Group Meeting
July 25th, 2017

Welcome

The Rural Health Care Delivery Work Group meeting, held at Chesapeake College on July 25th, 2017, began at approximately 1:00pm. Co-Chairs Deborah Mizeur and Dr. Joseph Ciotola welcomed members of the Workgroup, community members, and public officials. The Co-chairs then explained the main goal of the meeting, which was to build consensus on the recommendations for improving health care delivery in rural areas in Maryland. Ms. Mizeur then introduced the first presentation for the afternoon which discussed the findings of the public hearings in the Mid-Shore region.

Presentation on Public Hearings-What did we hear?

The public hearing presentation was given by Dr. Kathy Ruben, with the Maryland Health Care Commission (MHCC). Before starting the presentation, she stressed the fact that understanding health care delivery in the Mid-Shore region from the community's perspective is essential to developing recommendations for improvement. She noted that the University of Maryland, School of Public Health had conducted focus groups and interviews to gain insight from the community. Along with the public hearings, this information will be used collectively to inform the health care delivery recommendations. Dr. Ruben then gave an overview of the presentation which included a short description of the hearings, what was heard in terms of strengths and weaknesses of the health system, recommendations by community members, and how the public's recommendations align with the Workgroup's recommendations.

Description of the Public Hearings

One public hearing was held in each of the five study counties (Caroline, Dorchester, Kent, Queen Anne's and Talbot Counties) between May 24th and June 13th, 2017. The hearings varied in the number of residents that attended, the location (how rural), and in the level of participation by the community. However, they all had the same introductory segment where community members were introduced to public officials and the research team, given a description of Senate Bill 707, and told residents about the purpose of the public hearings (to openly discuss issues of health care delivery and to clarify needs).

Strengths of the Health Care Delivery System

Residents spoke of the ability of communities to work together to get things done. Especially in more rural counties (Caroline and Kent) where perhaps they have less services. In Caroline County they discussed how important it was for the community to work together. Communities sometimes just need seed money for programs to help take care of vulnerable populations.

In Talbot County, it was mentioned that Queen Anne's County Mobile Integrated Community Health is a significant strength of their health care delivery system. Residents said that they would like the same kind of mobile program in their county. Talbot County residents also reported that their County Council works really hard to find solutions to health care delivery needs.

Additional strengths in terms of the health care delivery system that were mentioned in Caroline County include the Park and Recreation program which promotes health and provides activities and schools which also provide medical care. School- based medical care was also mentioned as a strength in

Dorchester and Kent counties. Kent County residents agreed that the local United Way provided services for seniors and was a significant strength in the health care delivery system.

Weaknesses of the Health Care Delivery System

In every county residents spoke about how difficult it was to find a primary care physician and other health care professionals. Even if they could find a doctor, they still had problems with timely access. Offices were far away and closed a 5pm (which may be one reason that school-based care was appreciated). In Talbot County, it was mentioned that if residents couldn't reach their primary care doctor they turned to the emergency department.

We heard in 4 of the 5 counties (all but Queen Anne's) that residents don't always have a good view of the hospital. Either they or their neighbors go over the bridge for care because the perception is that the hospitals in the Mid-Shore are not as good as the hospitals over the bridge. Some residents said the hospitals have outdated policies and poor quality care. Residents like and trust their doctors, but the doctors don't really have an affiliation with a specific hospital

Residents of all of the counties mentioned the lack of transportation to the hospital or other health services as being a weakness in the health care delivery system. In Kent County, residents said that they have to wait hours for transportation to go to or from the hospital. This is a problem for both patients and families.

In three counties, it was mentioned that the volunteer status (or very low wages) was a problem for the EMS. Someone in Caroline County said "it's like a training ground… once EMS personnel get the training they need, they move on to counties where they can get better pay."

Additional weaknesses in the health care delivery system that were mentioned in Caroline County include the lack of interstate Medical Assistance payments, and problems coordinating care across agencies (especially transitional care). One resident stated that the poorer counties receive very little help from the State. Some Talbot county residents believe that the health care system is very confusing; especially for elderly residents.

Community Needs/Recommendations

The communities made fifteen general recommendations through the public hearing process. Three of the recommendations were each mentioned in four of the five study counties.

1. **There is a need for residents to have an input into health care decisions and in the strategic direction of the health care system (Dorchester, Kent, Queen Anne's, and Talbot Counties)**. From the community's perspective, resident input is essential for improving healthcare quality. In addition, residents better understand priorities when planning for change.
2. **There is a significant need in the Mid-Shore region for additional behavioral health care, services, supports and healthcare professionals (Caroline, Dorchester, Queen Anne's, and Talbot)**. Residents recognize that there is an opioid epidemic in the region and throughout the State. In addition, there is a need to address alcohol abuse and other drug use. It was suggested that the state take social determinants of health into consideration when addressing behavioral health. In Dorchester County, residents said there is a need for detox beds.
3. **There is a need for health care specialists throughout the Mid-Shore region (Caroline, Dorchester, Kent, and Queen Anne's Counties)**. Residents noted that they

do not need specialists on a full time basis, but they would like to have access to specialists. In Dorchester County, residents said there is a need for OB, pediatric and geriatric specialists as well as for child psychologists. Kent County mentioned the need for orthopedic specialists, OB, cancer specialists, and psychiatric professionals. Psychiatric professionals were also mentioned in Queen Anne's County.

The following four recommendations were each mentioned in three of the five study counties:

4. **Residents in the Mid-Shore region need increased health literacy and community-based education (Dorchester, Queen Anne's and Talbot Counties).** There is especially a need for education about chronic illnesses and how the health system works.
5. **There is a need for better communication/translational services and cultural competency (Caroline, Dorchester, and Talbot Counties).** Residents expressed the need for better communication and outreach; especially for senior citizens. It was suggested that question and answer forums may be a good way to communicate. Translational services are needed for the growing immigrant population in the Mid-Shore region. In Talbot County, the immigrant population was referred to as "voiceless" in terms of their health care and health care access. Communities are in need of culturally and linguistically appropriate services.
6. **There is a need in the Mid-Shore region for mobile health care and/or telehealth (Dorchester, Kent, Queen Anne's Counties).** Mobile health care and telehealth are both a means to bring health care to the community. This would be helpful in bringing care to individuals with chronic conditions and as a way to decrease hospitalizations or trips to the emergency department. Using mobile health care is less stressful for patients.
7. **Create a special hospital designation for rural communities (Caroline, Dorchester, and Kent Counties).** In several of the county public hearings, there was a discussion about what a rural hospital should look like (what services should be included). In Kent County, residents believe that inpatient services and emergency services are definitely needed. Residents that attended the Dorchester County public hearing stated that an outpatient facility with 72 hour observation capability is sufficient. Individuals that require higher levels of care should go to a different facility with greater support capabilities. In Caroline County, residents stated that they did not expect a hospital to be built; however, they would like to have a Freestanding Medical Facility (FMF) with observation beds.

   Individuals who attended the public hearings made suggestions of how to increase the number of physicians and other health care workforce, as well as how to reduce the workforce that is needed (focus on wellness):
8. **Establish a rural residency (Caroline and Talbot Counties).** The residency program should focus on primary care since there is a significant shortage of PCPs. The program should be located on the Eastern Shore since many physicians stay within 50 miles of where they do their residency.
9. **Need a nurse practitioner program and an EMS program at Chesapeake College (Kent and Talbot Counties).**
10. **There is a need for Community Health Workers (CHW) (Kent and Talbot Counties).** These workers know the community and can act as patient advocates as well

as help individuals navigate the health care system. CHW can be used in many settings and should be used for behavioral health care services.

11. **Focus on wellness rather than illness (Kent County).** We need to concentrate on the "total person", and spend more money on the prevention of chronic diseases.

Additional recommendations made by community members during the public hearings:

12. **Limit competition by unregulated services (Queen Anne's County).** Unregulated services create "access to care" issues and interfere with sustainability of community-based interventions.
13. **Fix insurance issues (Queen Anne's County).** Health insurance plans are no longer affordable and do not have flexible plans. Only licensed brokers should be able to sell health insurance.
14. **Need integrated electronic health records/Expand CRISP (Talbot County).** Technology on the Eastern Shore is not consistent. Electronic health records deliver the right information to the right place providing safer, timelier, patient-centered care.
15. **Need dental health services.** Dental services should be integrated with other primary care.

How public hearing recommendations align with Workgroup recommendations

Eleven of the fifteen recommendations mentioned in the public hearings were also recommendations (or a part of one of the recommendations) made by the Rural Health Advisory Groups. Dr. Ruben summarized the findings of the public hearings by saying that residents in the Mid-Shore region recognize that health care systems need to accommodate culturally diverse populations, and the growing number of vulnerable residents including elders with chronic health conditions. The residents also feel that we must address social determinants of health when making recommendations for improving the health care delivery system. Residents support an integrated care delivery system across a continuum of care with services as close to home as possible.

Following the presentation, one work group member asked how many individuals in total attended the public hearings. Although this information was not readily available, it will be given to the work group.

University of Maryland Research Team Presentation on Where the Population is Getting Care

An analyses of where the population is currently getting there health care was presented by Dr. Luisa Franzini, from the University of Maryland, School of Public Health. Dr. Franzini explained that the goal of the research was to assess health and health care in the five county Mid-Shore region and to then propose solutions. She said that the research team used existing data and resources as well as results of focus group and stakeholder interviews. Data analyses were conducted using claims data.

This analyses was the basis of the presentation, with the key question; where do residents of the 5 counties go for health care? The question was examined by type of service, by payer and by the patient's condition (not included in today's presentation). The research team used various sources of data including HSCRC data, The Maryland Medical Care Data Base (All Payer Claims

Database), Medicare and Medicaid. All of the data were from the year 2014 and visits were the unit of the analyses. Dr. Franzini noted that there were certain limitations of the data. HSCRC data does not include all hospital care that was provided out-of-state and Medicare, Medicaid and All Payer claims data do not provide information about uninsured individuals.

Ambulatory Care Visits

Dr. Franzini reported that most of the ambulatory care visits (41%) were paid by Medicaid. For the remainder of the visits, the payer was Medicare (27%), and All Payer (32%). The researchers reported that 63% of both All Payer and Medicare visits for ambulatory care were within the region. An additional 25% of All Payer and 22% of Medicare ambulatory care visits were not in the region, but were within the State. Out of state ambulatory visits were the same for both groups (3%).

Dr. Franzini then showed the workgroup a chart which listed the top two providers of ambulatory care visits in each county by payer, as well as the frequency and percentage of visits. She noted that in Caroline County, Choptank Community Health Services is the primary destination for primary care by Medicaid patients with a frequency of 14,699 which is 22% of visits. Choptank Community Health Services was also the top provider for Medicaid visits in Dorchester and Talbot Counties according to data analyzed by the UMD research team. The University of MD Community Medical Group was listed as one of the top two providers in all five of the Mid-Shore Counties for All-Payer.

Emergency Department Visits

Emergency department visits were then discussed by Dr. Franzini, in terms of visits by payer, location of visits (regional, in-state, and out-of-state), and providers. She noted that for ED visits, Medicaid was overrepresented (39%) of visits compared with Medicare (20%), Private payers (29%) and uninsured (9%). Dr. Franzini also pointed out that Medicare pays for more visits to the local EDs (84% within the region) than other payers (71%).

The University of Maryland Shore Medical Center at Easton was reported by the research team to be the top provider in the 5 county region for ED visits with 37% of the total visits. This was followed by the UM Shore Medical Center at Dorchester (22%), and the Queen Anne's Freestanding Medical Center (17%). This applied to all payers (Medicaid, Medicare & Private).

Inpatient Admissions

Approximately half (50%) of all inpatient admissions in the five county area were Medicare admissions, and most of the inpatient admissions go to The University of Maryland Shore Medical Center at Easton (43%) compared with nine other facilities that were examined. The most common in-patient conditions were hypertension (53%), hyperlipidemia (32%), anemia (27%), ischemic heart disease (23%) and chronic kidney disease (21%). Dr. Franzini noted that the Preventable Quality Indicator (PQI and the 30-day readmissions rate were higher in Dorchester and Kent Counties than in the other three counties.

Dr. Franzini summarized the research and discussed the next steps for the research team. She noted that the findings would provide insight and could inform regional and county planning. The research team will provide technical reports to the Workgroup that will provide details about payers, types of services and patients by condition.

Following Dr. Franzini's presentation, workgroup members commented on the findings and on what information they would like to see in the final report. Dr. Ciotola asked about trauma patients and remarked that it would be interesting to include information on strokes, open heart, and stemi patients in the final report. Both Dr. Ciotola and Mr. Boucot remarked that the inpatient admissions for hip fractures for the region were surprisingly low. Ms. Sierra said that the data is older, and asked if out-of-state data is available. Ms. Ireland agreed that the out-of-state inpatient data for behavioral health may be extremely important since there is not a facility in the region with inpatient behavioral health care. Susan Johnson asked if ED visits related to dental conditions could be determined for the final report.

Presentation of Recommendations from the Joint Advisory Groups and Discussion

Workgroup members received a handout of the Joint Advisory Group draft recommendations (attached). A summary of the draft recommendations was presented by Erin Dorrien and Kathy Ruben from the Maryland Health Care Commission. Following each summary, Jack Meyer, Principal, Health Management Associates held a discussion with the workgroup members. The workgroup commented on the draft recommendation and made suggestions for additions, or deletions.

Work Group Discussion of Recommendation 1:

Ms. Dorrien explained the first workgroup recommendation: *Establish and support a Rural Community Health Complex Demonstration.* She said that the goal is to create centers for health care delivery in rural communities that result in better integration and coordination of existing services, decrease transportation barriers, and create a community of wellness. She noted that Rural Community Health Complexes would be sized to respond to the needs of the population and would have a local council governance. Ms. Dorrien then explained the various components and types of Complexes . Several of the Workgroup recommendations would further the development of Rural Community Health Complexes.

Dr. Ciotola expanded on the concept of the Complex by describing an accessible system with quality care; with the patient at the center. Gene Ransom, CEO of Med Chi, asked the group "How do we pay for this?" Ms. Mizeur responded that the workgroup should come up with innovative thoughts for funding. She mentioned that the workgroup is still shaping the recommendations that will be presented to the legislature. She told the group that the final study is due at the end of September. Ben Steffen, the Executive Director of the Maryland Health Care Commission, noted that the Complexes would require investments by the community.

Jack Meyer asked the workgroup to identify what is missing in the Complex concept, or what may need to be reworded. Mark Boucot, the CEO of Garrett Regional Medical Center asked if the Hub had both clinical and technological components. He also mentioned the importance of care coordination in this model, and said that the group has to decide if this model is more cost-effective and easier to navigate than the current delivery system. Mr. Steffen explained that the Complexes would be

scaled to the community, and to the available capabilities. In some cases, potential sites already exist and there may just be marginal costs.

Brett McCone, the Vice President of the Maryland Hospital Association, asked if the idea of the Complex was to use what we already have in the area, or to build new facilities. He was informed that both of these were options depending on the area of need and the services already available. Mr. McCone said that we have to know about the technology investment as well as finding clinicians. Anna Sierra, the Transportation Advisory Group leader remarked that we need to incentivize providers. She said this type of Complex would decrease the need for transportation for people seeing multiple providers.

Susan Johnson, VP of Quality and Population Health for Choptank Health, expressed her concern about the governance Board of the Rural Community Health Complex interacting with the governance Board of Choptank Health and those of other organizations or agencies. Ms. Mizeur noted that community involvement in the planning Council is one of the key elements to the FQHC's attaining their mission. Roger Harrell discussed the role of the Health Officers in coordination and the governance of a Rural Community Health Complex. Dr. Margaret Malaro briefly discussed how important collaboration of health care professionals and coordination of care is for improving care outcomes. The Workgroup Co-chairs agreed that collaboration was an essential component of the model.

Additional capabilities for the Complex that are necessary include: linkages to electronic health records and CRISP (mentioned by Ms. Johnson) and the ability to increase coordination of both patients and providers through the use of navigators (mentioned by Holly Ireland, Executive Director of the Mid Shore Mental Health Association). Dennis Schrader, Secretary of the Maryland Department of Health asked what type of model the Complex is…a planning model? A technologically enabled care coordination model? He noted that the final recommendation for a Rural Community Health Complex should specifically define the concept of a technologically enabled care model that increases the ability to coordinate care.

Needs for Final Recommendation

The group discussed what the draft recommendation for a Rural Community Health Complex Demonstration is missing that should be included in the final recommendation. Ms. Mizeur summarized the various components of the Complex that should be considered in the final recommendation:

- technology (linking the providers by technology and to CRISP)
- scaling the Complex to meet local needs
- the need for a mobile unit
- increasing accessibility (use of navigators)
- how to make the Complex community driven

Mr. Boucot noted that the workgroup should develop criteria for establishing a Rural Community Health Complex. Jack Meyer reminded the group that "one size doesn't fit all." Frieda Wadley, the Health Officer of Talbot County agreed and mentioned that services should not be duplicated and we should not add another layer of bureaucracy. She mentioned that some hubs can be regional. Gene Ransom suggested using the Chesapeake College model for establishing the

Demonstration Complex which uses a checks and balance system and would determine what health care services could be provided regionally.

Mr. McCone stated that in the final recommendation for the Rural Community Health Complex, there must be a clear statement of the need for an operational plan and a clear financial plan. Ms. Sierra said that the Complex needs to be sustainable. Mark Luckner mentioned than an RFP for the Complex can be phrased to address sustainability. Other additions to the Rural Community Health Complex recommendation mentioned by the workgroup members included: the integration of behavioral health, and the addition of community-based outreach.

Additional Draft Recommendations

Following a short break, the Workgroup continued the discussion of recommendations. The additional draft recommendations were **not discussed in order**. Since several recommendations required a greater amount of discussion time, they were presented first.

Discussion of Recommendation 10:

Kathy Ruben summarized recommendation 10: *Create a Special Hospital Designation for Rural Communities.* This included a program to be established under HSCRC's broad authority to establish reasonable reimbursement for Maryland hospitals, as well as the specific requirements for this designation. The group was asked to comment on this recommendation.

Garret Falcone, the Executive Director of Heron Point Senior Living Community expressed concern that there were some logistical issues that must be considered. One concern was recommendation 10.f that the program would last for five years and would be renewable by agreement of HSCRC and the hospital. Mr. Falcone asked if the hospital would then have to change its designation. Mr. Boucot said that hospitals have to renew their global budget every three years anyway. Another specific requirement of concern pertained to location. Several Workgroup members mentioned that there should be different location parameters, for this designation other than 35 mile distance from the nearest general acute care hospital. Since the Mid-Shore and other rural areas have transportation barriers, a shorter distance was suggested. Senator Middleton asked if this particular recommendation would increase the rates of rural hospitals. His question led to a discussion of HSCRC rates for rural hospitals.

The group then invited Katie Wunderlich, HSCRC Director of Engagement and Alignment to speak to the group from HSCRC's perspective. Ms. Wunderlich agreed that HSCRC has the ability to review rates. She described connecting care and services. She also noted that rural hospitals were already paid at a higher rate. Ms. Wunderlich suggested that one option to adjust the costs of rural hospitals was to convert to a Free Standing Medical Facility (FMF).

Mr. Boucot noted that there has to be something different than what currently exists in terms of parameters to account for the overarching infrastructure of small hospitals. Ms. Mizeur agreed that there is a "disconnect"` between the ability of HSCRC to set rates and the goals of the state. She noted that there must be some kind of mechanism in place to close the gap and give direction to regulatory bodies. Do we need a change in the way that rates are calculated for

rural hospitals? The group reached concensus that we must sustain small facilities and there is a gap in the current system for doing this.

Ms. Mizeur discussed the concept of demonstrating total cost of care. Mr. Boucot asked if there could be some kind of reward for rural hospitals obtaining positive thresholds. Mr. McCone said we have to think about what this would mean from a systems perspective relative to an existing global budget. We have to address certain fixed costs to improve this.

Ken Kozel, CEO of Shore Regional Health noted that rural hospitals need funding to recruit doctors and technology for linking to other services, as well as for sustainability, but there is no funding source. He said the specific requirements were similar to those of Critical Access Hospitals. However, in Maryland there are no Critical Access Hospitals. How do we address this? Brett McCone suggested that in order to create a special hospital designation for rural communities, one would have to look at community needs; since all rural communities are not the same. Mr. Steffen explained that the idea was to create a designation for rural hospitals within existing statutes.

Dr. Ciotola said that there was a need for inpatient beds that cannot be met with a FMF model. He explained that additional adjustments are needed because of health care delivery factors. There has to be a change in dynamics and rural hospitals must be innovative in linking services such as mental health and dental health services. Mr. Steffen added that a Special Rural Hospital Program linked to the Community Health Needs Assessment will help sustain small hospitals.

Mr. Boucot said that in order to address the issues in the total cost of care, HSCRC has to open the moratorium on rate reviews. We have to be able to fund the special needs of the community (such as the need in Western Maryland for a cancer center). He suggested that hospitals also need education on how to develop models. Mr. McCone cautioned against mandating specific services. He noted that it is a challenge finding physicians to perform certain services.

Deborah Mizeur said that in discussions with HSCRC about funding, the Workgroup may suggest several things: 1) hospitals must demonstrate need, 2) there is an assessment of the total cost of care in specific areas, 3) there must be a lift on the moratorium, and 4) there should be education on model development.

Discussion of Recommendation 2: (Governance)

A brief discussion of the recommendation to *Establish and Support a Rural Health Collaborative* followed the recommendation summary. This was a short discussion since the topic of governance was held during the discussion of Recommendation #1. The workgroup discussed the need for the governing body to have some authority in addition to its role in planning and coordination. Susan Johnson said that the Advisory Groups had previously mentioned the use of the LHICs in this role but they lack authority and funding. The Advisory Groups noted that the Rural Health Collaborative or Council would need greater authority and paid staff. The Rural Health Collaborative could serve as the governing body for the Rural Community Health Complexes and could facilitate the data collection and analysis of Community Health Needs Assessments. In addition, the Collaborative can identify health care delivery needs for the region but also special needs within counties.

(Recommendations to Expand the Workforce)

Discussion of Recommendation 3:

Establish a Rural Scholarship Program for Medical Students and Other Healthcare Professionals willing to practice in rural Maryland

Senator Middleton suggested that politically speaking, the recommendation be changed to include other underserved areas in the state. However, most of the group agreed that the recommendation should stand, and the recommendation for a scholarship program should only include health care professionals willing to practice in rural Maryland.
Scott Warner, Executive Director for the Mid-Shore Regional Council asked about the one-to-one matching funds included in this recommendation. Would this include money or other resources? He noted that some counties have less resources than other counties. Another Workgroup member asked that regions be defined for contributing.

Discussion of Recommendation 4:

1. *Incentivize medical students and residents to practice in rural communities*

   4.a. Identify sustainable funding for a Primary Care Track program that enables medical students to work alongside family medicine, general internal medicine, or pediatric physicians that practice in underserved areas.

   4.b. Establish a Rural Primary Care Residency Elective

Dr. Richard Colgan gave his perspective of the goals of the University of Maryland School of Medicine for exposing students to rural practice and the need for role models for students. He informed the group that they are out of funding to pursue this goal. The expired grant was for $860,000 for five years. Funding is needed for housing, for AHEC centers for collaboration, for preceptors and for faculty. Mark Boucot mentioned that hospitals have to carry doctors, sometimes for up to nine months before they get reimbursed by insurance companies. There is a need to examine reform. Dr. Colgan stated that he would like to see the recommendation changed to a “residency” rather than an “elective” for primary care. Other workgroup members were in agreement.

The remaining Recommendations were not discussed in length by the Workgroup due to time constraints. Some of the recommendations had been covered in previous meetings. Workgroup members were asked to send additional comments or suggestions for changes or additions to MHCC over the next few weeks. Members of the public were asked to comment before the meeting was adjourned.

Attachment

Draft Recommendations (Reviewed by the Workgroup July 25th, 2017)

The Rural Health Work Group's overarching vision is a model of healthcare delivery that provides seamless, integrated care to patients, living in rural communities, as close to their homes as possible. The concept of a rural community health complex demonstration project would enable better integration of services and coordination between providers. Our report also covers recommendations to facilitate patient access to appropriate levels of care on a timely basis through cooperation and planning; to expand and attract primary care providers to rural areas; to enhance and integrate behavioral health services; to provide additional opportunities for care in the home; and to improve access to specialty services at the local level.

2. *Establish and Support a Rural Community Health Complex Demonstration*

The Workgroup recognizes that health care systems of the future need to accommodate a culturally diverse population, as well as a growing number of vulnerable residents and elders with chronic health conditions. Recognizing and addressing the social determinants of health is crucial in promoting a healthy society. Stakeholders must support an integrated care delivery system that promotes health equity, quality, and comprehensive services across a continuum of care. The Workgroup has established principles to guide its work. These principles are integrated into the vision of the Rural Community Health Complex model.

EXISTING ENVIRONMENT AND BASELINE ASSUMPTIONS FOR A NEW MODEL

1. Many hospitals are purchasing physician practices in an effort to adjust to healthcare reform pressures. Physicians are selling their practices due the growing challenges of operating under value-based models that require significant technology investments and expanded medical staffs. While these changes may be inevitable and may yield long-term benefits, in the short-term, access may be reduced, inefficiencies can grow, and long-standing patient-provider relationships may be disrupted.
2. Maryland's All Payer Model Demonstration provides incentives for hospitals to collaborate with community providers to better manage ambulatory services to decrease overutilization of ED and inpatient services. In Phase 2 of the All Payer Model Demonstration, physicians and non-hospital providers will have to be offered incentives to improve care and lower costs.
3. Maryland is seeking solutions for containing costs on total cost of care. For the ambulatory component, Care Coordination solutions are being entertained to help physicians with their network of patients needing clinical and social services coordination.
4. Health care systems, policymakers, and consumers seek a rural health care model that can assure that the health status of rural residents is enhanced.

5. To maintain sound health care delivery, rural communities should develop a one-stop-shopping health and social complex for the majority of ambulatory health needs.

Goals

1. Better integrate existing government services and clinical services for improved outcomes, patient convenience, and satisfaction; as well as less duplication, for overall lower cost.
2. Better integrate primary care with behavioral health and dental services.
3. Decrease transportation needs as multiple appointments/services can be managed with the same trip. Specialists are brought onsite so that patients don't have to travel long distances.
4. Decrease medically unnecessary Emergency Department use.
5. Create a community of wellness.
6. Bring care as close to the patient as possible.

RURAL COMMUNITY HEALTH COMPLEXES

The Rural Community Health Complex is the center for health care delivery in a rural community. A complex is sized to respond to the needs of the population, the scope of services that can be supported in the immediate community, and proximity to other health care complexes in surrounding communities, the jurisdiction, and the region. The foundation of any Rural Community Health Complex is primary care. Rural Community Health Complexes would have a governance council made up of top level representatives of hospitals, practices participating in the complexes, local health departments, and consumers to plan deployments, distribute resources, and resolve integration problems.

Specific recommendations that will further the development of the Demonstration:

1. a. Increase coordination of care through the use of care managers.
Care managers help ensure that patients' needs and preferences for health services and information are met over time; especially at points of transition. Care managers may assess patient needs and goals, help create proactive care plans, link patients to community resources and support patients' self-management goals.

1. b. Enhance dental health services to rural residents. Access to dental care is limited due to the available workforce and available coverage for vulnerable populations.

Where possible, dental care should be integrated with primary care and for populations with chronic conditions. The approach used by Choptank is an example of successful integration of dental services with primary care. Create opportunities for dental and dental hygiene students to participate in an elective during their clinical training for a rural health rotation.

1.c. Expand the availability of new telehealth and mobile capacity.

Implement new programs for telehealth that will support the development of rural health community complexes. Take to scale projects that have shown promise in telehealth and the Mobile Health Pilot Program.

- Increase broadband and "last mile" connectivity to include all sites of service, FQHCs, and Health Departments.
- Establish a stable funding level for telehealth consistent with recommendations in the 2014 Telehealth Work Group Report
- Direct the MHCC to develop methodologies for identifying practices and health care organizations suitable for using telehealth and the types of patients that respond to treatment through telehealth.

1.d. Expand or Enhance Community Paramedicine and/or Mobile Integrated Health Care. Sending paid EMTs, paramedics, mid-level healthcare professionals, or community health workers into the homes of patients can help with chronic disease management and education, or post-hospital discharge follow-up, to prevent hospital admissions or readmissions, and to improve patients' experience of care.

These health care workers can help patients navigate to destinations such as primary care, urgent care, dental care, mental health, or substance abuse treatment centers instead of emergency departments to avoid costly, unnecessary hospital visits. Identify a source for establishment and sustainability of the program.

1.e. Create and Extend Tax credits, loan or grant opportunities for Practitioners to Practices in Rural Communities.

The General Assembly could establish tax incentives for medical, dental, and behavioral health care providers willing to practice in rural areas and for those who mentor students in these areas. Examples of these include the HEZ personal tax credit, HEZ hiring tax credits, tax credits for near retirement providers who move to rural communities, and state backed small business loans for practitioners to establish a practice in a rural community. The Department of Commerce could be encouraged to use its existing economic development funds to fund this program.

The following recommendation addresses economic impact:

1.f. Charge the Community Health Resources Commission with incubating pilot projects in rural communities to support of the Rural Health Community Complexes.

The General Assembly could create an additional funding source for local projects that are aimed at promoting health; these projects should be focused on rural communities and allow communities to meet their own needs.

PATIENT-CENTERED SUPPORT HUB – TECHNOLOGY TO INTEGRATE AND COORDINATE CARE

Support work in a Community Health Complex to enable:

- Coordination between health care providers;
- Assistance in getting all social/economic/behavioral services needed; and,
- Education and counseling to help manage chronic conditions.

Services envisioned to be available through the Patient Centered Support Hub are available through interoperable EHRs, services currently available through CRISP, or planned to be available via the CRISP Integrated Care Network (ICN).
The Patient Centered Support Hub, operating within the CRISP ICN, could enable the primary care physician to track patient needs and services provided to each enrollee to schedule educational/self-management services, government agency onsite services, and visiting subspecialty consultants.

Components/Types of Complexes

1. **Essential Care**

    A. Primary care office staff directed by a physician or health care practitioner.

    1. Could be a standalone physical location or, in some instances may be co-located in a nursing home, EMS facility, or even a school.

    2. Would offer limited open access scheduling and some non-standard visits, such as group visits for managing some chronic conditions.

    3. May also act as the anchor for other initiatives planned by the Workgroup, including the mobile integrated health care that pairs EMS and community health workers. Could be mobile.

2. **Advanced Primary Care**

    A. A continually operating primary care practice with capabilities to bring specialists in on an as needed basis.

    B. Offer extended hours care, open access scheduling, and would support non face-to-face visits and group visits.

    C. Could also have the ability to perform certain office-based surgical procedures when the relevant specialist was on site.

    D. Could have medical specialists, behavioral health specialists and dentists co-located or have these specialists' time allocated for defined periods during a week.

3. Advanced Ambulatory Care

A. Consists of a freestanding emergency department and observation units with other outpatient services as appropriate.

B. Behavioral health, substance abuse treatment centers, medical and ambulatory surgical services could be located on the campus.

C. Would have a formal relationship with a parent health system and be integrated into MIEMSS.

4. Special Rural Community Hospital

A. Consists of emergency department,

B. Supports observation stays, and

C. Possesses some inpatient and outpatient surgery capabilities.

Governance

The following recommendation facilitates patient access to appropriate levels of care on a timely basis through cooperation and planning

3. Establish and Support a Rural Health Collaborative

Rural healthcare delivery faces different challenges due to distance, lack of transportation, inadequate providers, as well as a high level of chronic conditions. Since the onset of healthcare transformation in 2010, more recognition has been given to the fact that the health status of a population is determined more by the social, behavioral, and environment domains than clinical medicine. Disadvantaged rural individuals with clinical and social needs can get lost trying to navigate disconnected services. However, health services planning rarely considers how to improve utilization of social, behavioral and environmental services for the most vulnerable populations.

Rural counties often have sparse, but widely distributed populations. Many rural residents have many of the same health issues and needs. Often the most common problems are chronic conditions. Service agencies in rural areas operate with limited funding and are forced to share staff across county jurisdictions to maximize services and efficiencies. A growing need exists for regional collaboration in rural areas as a method of improving the health of rural residents and maximizing current and future resources for many service agencies. In rural areas that have a single hospital system serving multiple counties, collaboration between the public and private health sectors in these regions becomes even more beneficial for clients trying to navigate and coordinate services.

A Rural Health Collaborative (RHC) for counties served by the same hospital system could benefit patients through better integrated and accessible services; the hospital system with one entity to help facilitate implementation of plans and services; and county health and social agencies in maximizing resources for better utilization of existing services. A Rural Health Collaborative may be organized in each of the rural regions: Mid Shore, Lower Eastern Shore, Southern Maryland, and Western Maryland; and may serve as the governing body for the proposed Rural Community Health Complex.

An RHC could facilitate the following:

- Data collection and analysis for Community Needs Assessments that roll into a Regional Health and Social Needs Assessment
- Identifying needs for the region but also the pockets of special needs within the counties
- Developing strategic directions for improvement of health in the region
- Better integration of clinical health needs with social, behavioral, and environmental needs that impact health and clinical outcomes
- Collaboration in seeking grant funds that are more likely won with a bigger service population
- Collaboration in sharing services and staff across jurisdictional lines for economies of scale
- Potential services created with pooling of resources
- Integrate work of the Local Health Improvement Coalitions into a broader regional initiatives.

This Rural Health Collaborative will have a Director to work with the key county representatives to facilitate planning, meetings, data collection, examples of proven strategies for rural health improvement, and distribution of information. Other staff or contract services will be at the discretion of the RHC.

The following recommendations expand and attract primary care providers to rural areas:

4. *Establish a Rural Scholarship Program for Medical Students and Other Healthcare Professionals willing to practice in rural Maryland*

The General Assembly should establish a rural scholarship for medical, dental, behavioral and other health care professional students willing to practice in rural areas of Maryland.

Geographic coverage
Maryland Rural Regions: Mid Shore, Lower Eastern Shore, Southern Maryland, and Western Maryland

Eligibility
Eligibility would be open to all students admitted to health services programs in the State who agree to serve in rural areas of Maryland upon graduation. The scholarship program would be open to all admitted to recognized programs in public and private higher education institutions, but a preference would be given to students that originated from a specific rural region and committed to return to that region. The Rural Scholarship Program should be developed so that any funds awarded do not constitute taxable income under Maryland law and to the extent possible under federal income tax law.

Preference is given to students who meet at least 2 of the following requirements:

- The student has received a high school diploma, or its equivalent, in Maryland
- The legal residence of the student's parent(s) or legal guardian(s) is in Maryland
- The student has a substantial connection to the state of Maryland and at least one year of residence in Maryland for purposes other than education.

Funding sources
Funds appropriated by the Maryland General Assembly. Regions would be required to match state funds on a one to one basis to help with tuition, required fees, and other educational and living expenses.

Amount of funding
The number of awards will be based on level of practice and funds available.

Recipients of the scholarship are required to fulfill a minimum four-year service commitment. Students awarded a scholarship would have a specified amount written off for each year of service. Repayment formulas would be back loaded to incent students for fulfilling their commitments.

A state non-lapsing fund would be established in statute to enable rollover of funds not expended in a fiscal year.

State commitments would be set at $500,000 to be matched one-to-one by local funds.

5. *Incentivize medical students and residents to practice in rural communities*

4.a. Identify sustainable funding for a Primary Care Track program that enables medical students to work alongside family medicine, general internal medicine, or pediatric physicians that practice in underserved areas.

The focus of the University of Maryland School of Medicine (UMSOM) Primary Care Track is to introduce students to primary care role models early in medical school and to offer a longitudinal experience in primary care in rural and urban underserved communities to interested students. The goal is to increase the number of UMSOM students who choose careers in primary care by: 1) connecting first year students with primary care physicians in urban as well as rural underserved communities and create the opportunity for longitudinal mentorship and clinical experiences with them throughout their four years of graduate studies; 2) educating them early about important topics in primary care and community health; and 3) fostering a greater appreciation for the challenges and rewards of caring for the underserved in Maryland. This four year elective offering culminates in each student's participation in Primary Care Day, where the senior students serve as role models for their junior colleagues.

What's needed:

- Effort on the part of the State to encourage JHUSOM to join UMSOM in participating.
- Modest funding for;
  - preceptors that participate in the program.
  - Housing allowance for medical students that participate in the program
  - AHECs that, in collaboration with the Departments at UMSOM and JHUSOM, would sponsor students and oversee the program
  - Faculty and school based coordination support

4.b. Establish a Rural Primary Care Residency Elective

Research suggests that residents who train in rural areas and whose training emphasizes services necessary for rural practice are more likely to practice in rural areas. Rotating residents from urban hospital residency programs into rural areas may expose residents to the benefits and challenges of practicing in a rural areas and prepare residents to practice rural primary care medicine.

Residency programs may align with a rural hospital or private practice to provide the rural rotation. Federally Qualified Health Centers may be included in the residency experience, giving residents the opportunity to work with a higher volume of diverse and underserved patients. Residents may gain a deeper knowledge of the social determinants of health and explore potential remedies that address these issues on a local, regional and national scale.

Incentives for Rural Residency Elective

- Active support by the community
- Employment opportunities for the physician's spouse
- Free on the job CEU programs for clinicians in rural areas

- Affordable housing

6. *Streamline and Expand the Maryland Loan Assistance Repayment Program (M-LARP)*

The General Assembly should streamline the management of the State LARP by centralizing oversight of the program in either the Maryland Higher Education Commission or the Maryland Department of Health.

Recommendations

- Place an emphasis on loan assistance repayment for primary care providers in rural areas.
- Increase funding for M-LARP beyond the current $400,000 and identify additional sources of funding.

6. *Realign the prioritization of the J-1 Visa program*

The Maryland J-1 Visa Waiver Program offers a J-1 Visa waiver to foreign physicians who commit to serving for 3 years in an underserved area of Maryland, waiving the foreign medical residency requirement and allowing them to remain in the United States. The program is intended to provide physician services in areas that typically have difficulty attracting and retaining physicians. The Maryland program should:

- Prioritize applicants who are willing to work in rural HPSAs and medically underserved areas for a limited number of state slots.
- Encourage and assist communities where J-1 visa recipients are placed; including,
    - Creating a welcoming environment and developing programs to support visa recipients and their families,
    - Helping the spouse of a visa recipient find employment,
    - Improving cultural competency of the community

7. Develop and fund additional nurse practitioner and physician assistant programs in rural colleges and universities

The need for efficient primary care in rural Maryland areas is a growing concern due to changing demographic trends (such as an aging population) and the shortage of primary care physicians. One approach to meeting the increased demand for primary care services is the use of non-physician practitioners such as nurse practitioners and physician assistants. In addition, these health care professionals can help increase care coordination to reduce hospitalizations and re-hospitalizations for elderly patients and others with chronic health conditions; resulting in decreased health care costs and better health outcomes.

Programs should actively recruit individuals from rural areas for entry into the program. The Advanced Education Nursing Traineeship Program (HRSA) provides funding to schools of nursing for student support for tuition, books, fees and living expenses needed by RNs to become NPs.

<u>The following recommendation enhances and integrates behavioral health services:</u>

8. Enhance Behavioral Health and Substance Abuse Services in the Community

- Enhancement of behavioral health services in the community through mobile integrated healthcare, telehealth, and enhancement of Assertive Community Treatment (ACT) Teams can reduce mental illness, improve the well-being of rural communities, lower the total costs of care by eliminating costly emergency and hospital care. Health care organizations should be encouraged to breakdown the invisible and very real stigma associated with behavioral health conditions by establishing education programs for their staff.
- Recognize that behavioral health diseases deserve to be treated with as much compassion as physical health conditions.
- Existing infrastructure and programs that are working, but underfunded, should be favored before new programs are launched.
- Identify statutory and regulatory barriers to the establishment of the new programs.

The Workgroup recommends that to the extent funding is available:

Expand the Eastern Shore Crisis Response System in accordance with recommendations from the Behavioral Health Advisory Committee and the MD BH Crisis System law.

  - Increased funding and staffing for the Eastern Shore Operations Call Center (HELPLINE).
  - Increased funding for Mobile Crisis Teams to ensure 24/7 operations of the four teams.
  - Work with hospitals to expand crisis beds in acute general hospitals

- Consider expanding the Maryland Behavioral Health Integration in Pediatric Primary Care (BHIPP) to adult primary care. http://www.mdbhipp.org/
- Work with payers to ensure adequate provider networks in rural regions for those privately insured.
- Expand the provision of Assertive Community Treatment (ACT) mobile treatment teams to provide community-based comprehensive care to those most difficult to engage in transition "office-based" systems of care.
- Increase the availability of "on-demand" or immediate access to all levels of Substance Use Disorders treatment, especially withdrawal management and inpatient care for those being treated for substance related overdose.
- Increase availability and utilization of Certified Peer Recovery Support Specialists within the Behavioral Health Systems of Care regardless of insurance coverage type.
- Streamline the licensing of both individual behavioral health providers and behavioral health provider organizations to ensure financial solvency, support the state economic goals, and increase access to care.
- Encourage payers to accelerate credentialing of behavioral health providers
- Align rural area health education center efforts, DLLR and Workforce Investment Board grant funding, and loan forgiveness programs in the BH professional area.

- Expand the allowable and reimbursable use of telehealth to ensure access to Behavioral health specialty care in rural areas to overcome transportation and workforce barriers.

The following recommendation provides additional opportunities for care in the home

9. Consider the Recommendations of the Workgroup on Workforce Development for Community Health Workers and Foster the Development of the Community Health Worker Programs at Maryland Community Colleges and AHECs.

Community Health workers are frontline public health professionals who are also trusted members in their communities and have an unusually close understanding of the communities they serve. During the 2014 legislative session the General Assembly established the Workgroup on Workforce Development for Community Health Workers. That workgroup delivered its recommendations in June 2015. Stakeholders should be brought back together to revisit the recommendations of the workgroup on Workforce Development for Community Health Workers

Potential roles of the CHW:

1. Serving as a liaison between communities, individuals and coordinated health care organizations.

2. Providing evidence based health guidance and social assistance to community residents.

3. Enhancing community residents' ability to effectively communicate with health care providers.

4. Providing culturally and linguistically appropriate health education.

5. Advocating for individual and community health equity.

6. Providing care, support, follow-up, and education in community settings such as homes and neighborhoods.

7. Identifying and addressing issues that create barriers to care for specific individuals.

8. Providing referral and follow- up services or otherwise coordination of human services options.

9. Proactively identifying and referring individuals in federal, state, private or non-profit health and human services programs.

10. Integrating with patient's care team to support progress in care plan and overall patient wellness.

Certification should be considered to meet future professional validation.

The following recommendations improve access to specialty services at the local level:

10. Create a special hospital designation for Rural Communities

The program should be established under HSCRC's broad authority to establish reasonable reimbursement for Maryland hospitals. To qualify, the hospital must specify concrete goals and

plans for implementing the goals. The plans could include initiatives for improving the quality of care, establishing expanded access to advanced primary care and thereby decreasing the number of avoidable admissions, readmissions, and transfers. Specific requirements:

a. Located in a federally designated rural jurisdiction (Kent and Garrett) or qualify in county-wide medically underserved/HPSA jurisdiction
b. Located 35 miles or more from nearest general acute care hospital
c. Have an ALOS of 4.0 or less
d. Furnish 24-hour emergency care services 7 days a week.
e. The hospital qualifies for a special designated rural hospital adjustment under its global budget if the hospital establishes an HSCRC-approved Special Rural Hospital Program.
   i. A strategy for maintaining financial viability by maintaining/improving its financial situation, both in terms of current programs and proposed demonstration.
   ii. Explain how the additional adjustment will assist the hospital to respond to financial, demographic, and health care delivery factors that pose a risk to ongoing operations.
   iii. Describe the specific projects for which it will use additional GBR and how these funds would benefit vulnerable populations in the hospital's service area. Goals could include increasing access to care and provision of additional services, but they may also include transitioning to alternative delivery and payment models, such as FMF as appropriate or partnering with an ACO or MPCP.
   iv. Hospital would describe how it would work with other health care providers and facilities to serve the population in the hospital's service area and explain how any enhancements provided through the additional GBR would contribute to the population's health.
f. The program would last for five years and would be renewable by agreement of HSCRC and the hospital.

11. Expand non-Medicaid and Non-Emergency Transportation

11.a. The State should promote the use of innovative approaches to non-emergent transportation in rural areas where transportation deficits are the most acute. Explore the use of commercial transport such as Uber and Lyft. These approaches could include seeking a health department interested in establishing a demonstration to test the feasibility of establishing a transportation service or promoting the use of ride sharing technology.

11.b ***The Department of Health, in consultation with the Maryland Dept. of Transportation, should develop standards for non-emergency programs based on best practices for these programs.*** The Rural Health Delivery Workgroup found that reimbursement for non-emergency medical transportation is extremely uneven. Greater effort needs to be placed on equitable funding for non-emergency medical transport. Residents and local government would benefit from this standardization. Regulatory and or statutory changes may be necessary.

12. Address health needs of the immigrant population and elderly populations

The immigrant and elderly populations in the Mid-Eastern Shore and other rural areas of Maryland are growing. These populations may be at increased risk for poor physical and mental health because of inadequate health care due to:

- Lack of transportation
- Inability to pay for services
- Poor health literacy
- Lack of culturally competent health care professionals
- Complex paperwork to gain access to services
- Immigration status and the need for documentation to get services
- Limited English proficiency and the lack of translation services

In order to improve the health status of vulnerable populations in rural areas and address the concerns of these populations:

- Expand and strengthen the safety net infrastructure
- Provide access to preventive care and education
- Increase the use of patient navigators and care managers
- Encourage the development of programs to increase Culturally and Linguistically Appropriate Services (CLAS)