

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.

1. 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.

Additional Draft Recommendations

Governance

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

2. 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:

3. 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.

4. 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

5. *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.

The following recommendation enhances and integrates behavioral health services:

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)