Meeting Summary
Rural Health Care Delivery Work Group

March 27, 2017

1:00-5:00pm

Welcome

The fourth Maryland Rural Health Care Delivery Workgroup meeting was held March 27, 2017 in Annapolis, Maryland. The meeting convened at approximately 1pm. Co-Chair Deborah Mizeur, welcomed everyone and provided an overview of the meeting. She noted that while it was not on the agenda, the last 15 minutes of the meeting would be used for public conversation. Co-Chair Dr. Joseph Ciotola, also welcomed everyone and noted that the group was half way through the meeting and deliberation process as directed by legislation. He told the group that they have already seen a lot of data, and now was the time to begin to use the data to complete the workgroup's charge.

Presentation

Draft Guiding Principles

Erin Dorrien, the MHCC Chief, of Government & Public Affairs gave the first presentation, which included a review of the draft Guiding Principles for the workgroup, as well as a discussion of the Advisory Group's recommendations for changes. She showed the group a representation of the current chaotic health care system, and told the workgroup members that creating a healthcare delivery system that empowers individuals to manage their own health will mean addressing concepts that are not always considered in healthcare (including the social determinants of health).

Ms. Dorrien told the workgroup that the Guiding Principles were designed to help outline broader philosophies of the group, and to establish common ground among workgroup stakeholders. She noted that the Guiding Principles can help the group when ranking priorities which may be necessary due to limited resources. Models that are selected by the group for the healthcare delivery system must align with and support the Guiding Principles.

Ms. Dorrien showed the group where they were in the action cycle for making communities healthier, buy showing them a model of the cycle developed by the Robert Wood Johnson Foundation. The group has assessed needs and resources and must now focus on what is most important before selecting an effective model for delivering healthcare in rural areas of the state. Ms. Dorrien noted that the group would see this action cycle again when the UMD School of Public Health give their presentation.

Work group members then evaluated seven draft Guiding Principles that had been revised according to Advisory Group suggestions. They listened as Ms. Dorrien read a "preamble" that had been developed to explain the purpose or underlying philosophy of the Guiding Principles. Ms. Dorrien told the workgroup members that the concept of increasing health literacy, which had been suggested by one of the Advisory Group members, could be added by amending the sixth Guiding Principle. A guiding principle pertaining to the Mid-Shore economic viability as it pertains to the health care system had also been added. It was pointed out that "access" to care had also been included in the principles. Ms. Dorrien asked the group for additional comments or changes to the Guiding Principles.

Mark Boucot, CEO of Garrett Regional Medical Center asked about adding "other rural residents" in the first, third, and sixth Guiding Principles in addition to the "Mid-Shore residents". Dr. Ciotola noted that the title for the Guiding Principles also only mentioned Mid-Shore communities. Wayne Howard reminded the group that the focus of the study is on the Mid-Shore, but the models that are selected for improving health care delivery must apply to other rural areas of the state. Senator Hershey agreed that during legislation, the focus was on the Mid-Shore but the idea was to look at health care delivery more broadly. It was suggested that the Guiding Principles be changed to read "Mid-Shore and rural residents". The final suggestion was to change the word "providers" to "practitioners" in the fifth Guiding Principle.

Early Insights from the Research Team's Work- School of Public Health

The next presentation was a progress update of the independent research being conducted by the UMD School of Public Health. Dr. Dushanka Kleinman explained to the group that their report and recommendations should consider information obtained from the UMD School of Public Health and the NORC Walsh Center for Rural Health Analysis as well as information obtained from the public hearings, Advisory Group meetings, and other presentations that have been given to the workgroup. She noted that the SPH/NORC study was ongoing and the data collection and analyses are incomplete, but the research team wanted to give the workgroup a flavor of the research to date. Their final report is due in August 2017.

Dr. Kleinman gave an overview of the research team's presentation which would include a description of the study framework, preliminary quantitative and qualitative findings and reflections for options and models (to be presented by Dr. Alana Knudson). She began by describing the framework that would inform policy options. This framework considers Mid-Shore resident and county health needs, assets, as well as solutions and emerging models that have been used in other areas of the country.

Dr. Kleinman explained that the quantitative part of the study would include an examination of the region's hospitals (service areas, inpatient and outpatient services), payers, and health care patterns. This will include a targeted analyses for chronic conditions, behavioral

health, and oral health especially for vulnerable populations. The researchers will use data from various data bases including the Maryland Medical Care Data Base, Medicare, and Medicaid to obtain information about different populations. She noted that the patient pattern analysis to date, has only been completed for privately insured patients. The qualitative part of the study will include analyses from focus groups (one from each county) as well as stakeholder and other interviews. While the research team has completed three of the focus groups and fifteen stakeholder interviews, the data still need to be analyzed.

Snapshot of Preliminary Findings

Dr. Kleinman noted that preliminary data on payers for the UM Shore Medical Health Centers (Dorchester, Chestertown and Easton) reflect what other rural areas are seeing. The greatest percentage of inpatient and observational stays are for Medicare patients, while the greatest percentage of ED visits are made by Medicaid patients. The greatest percentage of ambulatory care is provided for Medicare patients, followed by care for individuals with private insurance.

The research team shared preliminary data evaluation regarding workforce shortages and workforce participation in the five Mid-Shore counties. The greatest primary care provider shortages were found in Caroline and Kent counties. However, there was no shortage in Talbot County. Overall, the number of patients per primary care provider in the region (1500:1) was less than the number nationally (2000:1). The research team also evaluated data from the 2015 Physician Renewal Data to get a better picture of specialists in the five counties. The found that three of the counties (Queen Anne's, Dorchester, and Caroline) had no OB-GYN, Caroline County had no psychiatrists, and Dorchester County lacked a pediatrician.

In response to Dr. Kleinman's statement, one of the work group members said that there has been a pediatrician working in Dorchester County since 2015, but that physician may have been included in the count of pediatricians in another county. Dr. Richard Colgan from the University of Maryland School of Medicine told the group that it is not unusual for a physician to work two days in one county and two days in another county in the Mid-Shore region. Ben Steffen told the research group that they will have to look at how they will allocate the physicians' participation since that is the case. The MHCC often uses a two year sample in order to determine workforce participation.

Dr. Ciotola reminded the research team that they need to examine the contributions of nurse practitioners and other providers of care. Gene Ransom agreed and noted that both nurse practitioners and PAs must be included in the study of workforce participation. He told the research team that he could give them the name of the person to contact to obtain that information. Dr. Kleinman said that information regarding other providers will be included in the final data. Another workgroup member asked the research team if they would include

information about EDs and other hospitals that serve the Mid-Shore, but are not located in that five county region (such as Anne Arundel and Delaware hospitals). Again, Dr. Kleinman assured the group that this information would be included.

Dr. Kleinman continued the presentation by showing the workgroup a map of the five county region with the location of primary care physicians (PCPs) which included the driving distance (in miles) for residents. She said that PCPs are clustered in the region with some residents living up to 33 miles from the nearest PCP with a driving time of up to 48 minutes to reach them. She noted the state access standard was 30 miles and 30 minutes.

The final part of the presentation by UMD School of Public Health contained preliminary reflections and preliminary findings of stakeholder interviews. If two or more stakeholders mentioned a particular problem, it was identified as being important. It was noted that stakeholders were generally satisfied with their primary care doctor, but had concerns about potential retirement of their physician. Stakeholders mentioned the need for more mid-level providers. There also appeared to be an interest in having more Community Health Workers in the region to help with outreach and case management. Stakeholders acknowledged that there was difficulty in accessing specialists and sub-specialists, and gave suggestions such as rotating specialists and using mobile clinics to increase accessibility.

Several interviews highlighted the substance abuse epidemic in the five county region as well as the difficulty obtaining treatment for substance abuse. Stakeholders said that the epidemic had a significant impact on the workforce and on unemployment in the region. Additional issues of concern that were identified in the preliminary analyses included limited transportation (especially for elders and the poor), a lack of qualified local workers, difficulty recruiting professionals (health care and others) in the region, and language barriers due to the growing Hispanic population. Stakeholders mentioned the need for local health care education, trade school programs, and improvements in the quality of schools. According to the stakeholders, there is also a need for social services to accommodate vulnerable populations.

Discussion of Research and Preliminary Findings

Following the UMD SPH presentation, there was an open discussion about the research and preliminary findings. Dr. Ciotola asked if the research team had plans to evaluate changes in the health departments and EMS care in the region. He wanted to know if health officers would be included in the interview process. Dr. Kleinman said that the capacity of the health departments is a critical piece of the research. She added that although the interviews were not complete, the research team will not be reaching out to individuals who are already part of the workgroup. The workgroup members continued to ask the research team if certain information would be included in the study, such as the number of uninsured by county, and patients who

are transferred to another facility as found in hospital-based data. Dr. Luisa Franzini said that this information would be examined.

Dr. Colgan discussed the shortage and maldistribution of primary care physicians in terms of the training "pipeline". He mentioned a state study which shows Maryland ranking 50th in terms of the number of individuals that choose to go into primary care. He said that the supply of primary care physicians is a critical problem, and asked "How many do we produce for the state"? Dr. Kleinman said that the research team can look at physician residencies within the geographical area to which Dr. Colgan replied "there are none".

Gene Ransom asked if the research team would discuss current actions or solutions to various problems that are being identified. Dr. Kleinman said the team is looking at resources and opportunities that are being identified by the interviewees as well as by the workgroup. Deborah Mizeur mentioned that the point of the next presentation was to discuss what is happening around the country in response to similar problems and to identify models of health care delivery that may also work in Maryland's rural areas. She reminded the group that they should now focus on taking action.

One of the workgroup members asked the research team if they knew what the barriers were for health care worker training programs, since there are good college programs for producing health professionals in the Mid-Shore region. Retaining health care workers seems to be the problem. Dr. Franzini said the preliminary qualitative findings point to a lack of advancement for health professionals in the area. Ms. Mizeur mentioned that the workgroup may need to look at other opportunities. Joy Strand said that other rural states have started a program where schools will partner students with practicing health care professionals in rural areas. Jennifer Berkman said they will look at advancement to the next level within AHEC. Wayne Howard stated that in order to keep physicians, we need to solve the reimbursement issue. He noted that physicians move because they cannot make a living.

The research group was asked about the focus groups that would be conducted. Dr. Franzini mentioned that each county would have a focus group. She noted that the focus groups may not necessarily consist of people that are representative of the population, but they would be used to identify issues (especially issues that impact vulnerable populations) within each county. Some issues that impact rural populations were mentioned by various members of the workgroup including: the closing of the PA program on the Mid-Shore, residency programs, and hospital rates in rural areas; including Garrett County which has rates that are 30% below average.

Presentation

Promising Approaches That Could Align Rural Health Care Needs

The next presentation was given by Dr. Alana Knudson from the NORC Walsh Center for Rural Health Analysis. Dr. Knudson discussed the role of the workgroup in terms of identifying rural health innovation models that have the capacity to be changed to apply to the Mid-Shore region. These would be local or national models that address some of the same major challenges that are faced in the Mid-Shore region.

Dr. Knudson then discussed strategies for assessing and selecting models that could be used for Maryland's rural areas. She explained that when assessing various models, the workgroup must use a comprehensive systems-based framework that includes key strategies, initiatives, targets and measures. The group must also consider the models in terms of what is already going on in Maryland such the Global Budget and the shift in healthcare from volume to value. Selection criteria must be developed for the models which could include quality of care, the impact on population health, acceptance of the model by residents, financial sustainability of the model, legislative requirements, and other criteria. The workgroup then briefly discussed grants and sustainability.

Dr. Knudson continued her presentation with the final steps in identifying a rural health model for the Mid-Shore region. This model must include an exploration of the capacity for engagement. The workgroup must consider the roles of various stakeholders including members of the community. Patients need to be educated about the changing focus of care delivery such as the change from "illness care" to "wellness care." Dr. Knudson said that there is often a tradeoff when selecting models, but all of the issues and study target areas that have been discussed by the workgroup are inter-related. The group must consider governance, contracts that may come into play, and finances, as well as how to partner and share resources and strengths.

Value-Based Models

Dr. Knudson expanded on the concept of value-based models by discussing the incremental shift needed to change from a volume-based model to one of value. She noted that the focus should be on population health in all areas of healthcare delivery including public health, behavioral health, oral health, social services, and extension programs. The shift will require culture changes in order to improve documentation, support care coordination, and add community care workers to enhance outreach. Although getting timely data is a challenge, we must improve data analytical capabilities. Dr. Knudson informed the workgroup that there are always growing pains when making these kind of changes.

Dr. Knudson reminded the workgroup to think in terms of opportunities and challenges, especially when engaging rural providers in value-based models. During a Rural Provider Leadership Summit conducted to identify rural provider engagement in transitioning to a value-based reimbursement system, providers discussed market-driving forces for change, as well as

transition challenges and how to overcome them. Driving forces include emerging payment models such as state innovative models and accountable care organizations (ACOs). Rural health organizations such as critical access hospitals, rural health clinics, and FQHCs may be especially challenged by lack of funding, leadership issues, and limited data, as well as changes in demographics and shortages of providers. In order to make the shift, providers must be engaged in developing collaborative relationships and connecting community resources to address patient needs, as well as focus on population health. Dr. Knudson provided the group with an example of this concept; the Patient-Centered Medical Neighborhood which serves as the patient's primary "hub" for care coordination and the social supports needed to enhance health. The group also viewed a short video of value-based care collaboration from a patient's perspective.

Other Rural Models

Dr. Knudson then shared with the workgroup examples of models used in other states. These models address some of the challenges facing rural communities such as: coordination of care, the lack of transportation, increases in behavioral health/substance use disorders, and economic development. She provided links to each of these solutions so the workgroup members could access additional information. While these solutions focused on different populations and had different funders and partners, they all were developed based on the particular vulnerabilities within a community.

Dr. Knudson told the workgroup that there is no single perfect solution, but the best solutions are developed locally, and empower the residents within the community to support each other and to work together. She revisited the action cycle for making communities healthier presented by Ms. Dorrien and reinforced the concept of focusing on what is important. Finally, Dr. Knudson summarized the next steps for the research team including analyzing additional health care utilization data from the five counties and themes from the focus groups, stakeholder interviews, and public hearings (to be held in May). The researchers will design option models informed by priorities, data, and community input which harmonize with other Maryland initiatives. The research team's final report will be presented to the workgroup in August.

Discussion of Promising Approaches

Following the research teams presentations, the workgroup continued to discuss some promising approaches for improving healthcare delivery and population health. Senator Middleton mentioned an initiative of the UMD Institute of Applied Agriculture, Farming 4 Hunger which is a model for resourceful retirees in which food is grown, harvested, and distributed. Dr. Knudson described a similar community gardening program in North Carolina that involves over 300 people as well as intergenerational activities. She said that one

unanticipated benefit of the program for the community was an increase in scholarship leading to increased graduation rates for the community. Roger Harrell said that these type of programs often need a champion in the community. Deborah Mizeur stated that there are many innovative solutions at the grassroots level. Kevin Beverly noted that many of the solutions appeared to be "siloed" and wondered how communities can collaborate. Mark Boucot described the collaboration process in Garrett County. He said the hospital formed a Health Planning Council that is working to develop a strategic plan for the county. He said that the Council consists of health care professionals as well as members of the community. They work together to address health care issues. Senator Middleton mentioned that many communities require financial assistance from the government to start programs.

Facilitated Discussion

Health Planning Council

Jack Meyer from Health Management Associates facilitated the discussion and opened with a discussion on health planning councils. Mark Boucot further described the governance structure in Garrett County called the Health Planning Council. It is populated by disparate entities within the county that provide some sort of health or social service, as well as by patients, businesses, and members from the public. One of the major contributing factors for the success of the council was a formalized strategic planning process, including an implementation plan and evaluation of activities. The hospital provided the funds for this process and provided a full-time grant writer to seek planning grants. They have been awarded $600k for cancer care navigators, which has dovetailed into the hospital opening a cancer center in the community. This work has been recognized nationally and is being considered for the Robert Wood Johnson Community of Health prize.

Susan Johnson, VP Quality and Population Health Choptank Health, asked if the hospital was the main facilitator of the council? Mark Boucot replied no, and explained that the county health department is the main facilitator and the hospital is a funded partner. There is an executive committee that makes decisions and holds people accountable for their commitments, including attendance. The council is now open to the public, but membership was originally identified by key stakeholder groups needed at the table. Membership continues to grow and is fluid. The council has been intact for a few years now. Mark Boucot noted that several programs have stemmed from the Health Planning Council including nutrition counseling, diabetes education, and dental care; all which have contributed to Garrett Regional Medical Center having the lowest Maryland hospital readmission rate. The hospital has also reduced potentially avoidable utilization of inpatient services by 2% in 18 months. Health Services Cost Review Commission (HSCRC) data contributes some metrics used in determining the success of implantation efforts.

Mark Luckner, Executive Director of the Maryland Community Health Resources Commission (CHRC) was pleased to hear that the local health improvement structure, as in FY12-13 the CHRC invested 2.1 million to start the Local Health Improvement Coalitions (LHICs). This funding required LHICs to submit action plans. Subsequent RFPs awarded additional points for those applications that addressed and aligned to their action plans. Mark Boucot, highlighted that this work has been going on for years and wanted to give credit where credit was due.

Lara Wilson, Executive Director of the Maryland Rural Health Association commented that in her experience across the state, LHICs usually work well when they are focused on their county, but not when they are set up regionally. She noted that Garrett County only has one neighboring county to communicate with, and asked what happens if we set up 5 LHICs in the Mid Shore region? What kind of infrastructure is there to share the successes and challenges across the region?

Mark Boucot shared that the council typically reports data to the Chamber of Commerce in neighboring areas. Mark Luckner mentioned that the CHRC sponsors a yearly forum, and that another approach would be having regional forums around topic areas of interest to the LHICs or the community.

Deborah Mizeur asked Ms. Wilson what barriers she is seeing with regionalization and if there was anything that the workgroup could recommend to provide assistance. She also wanted to hear how the LHIC strategic planning process was related the hospitals strategic planning.

Mark Boucot said that the strategic plan from the council, and their community health needs assessment is used by the hospital as a foundation for strategic planning. The council also presents to the hospital board and takes part of the strategic planning process.

Susan Johnson talked about a barrier in her LHIC and explained that they usually have a reporting meeting, but it lacks an interdisciplinary representation of organizations. She supported LHICs being facilitated through county health departments. She also explained a funding model in Vermont called the blueprint for health model. They charge all payers in the state a surcharge and that money is put back into the communities for PMPM payment models, community organizations, and community planning activities.

Anna Sierra reiterated the challenge to do planning collaboratively with the LHIC and expressed the struggle to merely find people to fill gaps in program planning and implementation due to workforce shortages and funding.

Mark Boucot stressed the importance of realizing the struggle, but also thinking outside the box to find solutions. He gave an example of this year’s hospital gala which will donate some of the proceeds to the community, realizing that the money used may serve a better purpose than what they originally were going to do with it.

Wayne Howard, Former CEO of Choptank Health, expressed a barrier he saw; the county line. He wants the workgroup to find ways to look at commonalities across county lines to determine creative solutions, not only to solve the problem, but also related to funding the solution. He noted that the workgroup's model should strive to bring these counties together with a good regional approach and strategic plan. As far as communication approaches, he said that many key players (i.e. mayors, health officers, county commissioners) already have regular meetings.

Kevin H. Beverly, President and CEO Social & Scientific Systems, asked if workgroup members and MHCC are working to inform their elected officials about the call to action for this group, considering that legislation will likely come out of the workgroup's efforts. Delegate Jay Jacobs said that he would help MHCC can reach out to each county's council of governments to inform them

Jack Meyer moved the discussion to establishing workgroup priorities for policy direction, new interventions, and proposed regulatory changes. He noted that the workgroup must recognize the challenges, translate data into possible solutions, and develop an action plan.

Dennis Schrader, Secretary DHMH, started the discussion with 5 questions: What is the current state of play? What is the future state we want to get to? What is the most important thing to do first? What are the critical success factors? Can we extrapolate the findings from this group to other rural areas in the state?

Gene Ransom, CEO of MedChi, mentioned the importance of aligning activities to current funding like the Hope Act and Chronic Care Improvement Programs (CCIP). The workforce advisory group created a document with potential policy ideas. For example, the prioritization of J-1 visa slots. This year DHMH did complete prioritization, and helped some of the rural doctors in the Mid Shore move up on the list. There could be a policy put in place to prioritize these rural areas. He suggested putting in time to go through the list, and determine low hanging fruit and priority areas from there. He also mentioned that the HEZ is coming to an end. Through this initiative, he has helped many physicians take advantage of Maryland's loan repayment program. Many physicians don't realize that Maryland has funding for loan repayment. The federal tax credit program doesn't work well because most physicians work in non-profits so they couldn't really use it. Another way to help would be to streamline and simplify the physician loan repayment application process.

Jack Meyer asked about the CCIP and Gene mentioned that the CCIP is a program that could help address one of the stakeholder comments, about the need for increased outreach to community health care workers. There is funding through the HSCRC to pay for chronic care management, which all doctors could take advantage of. No hospitals in the area are planning on participating in the primary care program.

Susan Johnson mentioned the decrease in Medicare population due to a decrease in primary care providers. Some of the comments Choptank has received relate to the older population wanting to see a doctor, not other health care workers. FQHCs have a hard time hiring and retaining doctors, which poses more of a challenge for rural communities because most rural residents want to establish a relationship with their doctors. When doctors come to an FQHC they usually stay for their 2-year commitment and then leave. She asked how we can attract individuals who grew up in the area and may be more likely to stay. Wayne Howard discussed these difficulties as well. Historically, physicians leave the FQHC, but some would stay in the region. He mentioned the need for a rural residency program, and said that we've been close to establishing one before, but it didn't happen. Additionally, he discussed some ongoing legislation related to community health workers. The workforce advisory group hasn't met a second time, but he would like them to work through ideas of integrating and training community health workers.

Dr. Ciotola, asked Katie Wunderlich from HSCRC if it would be an incentive to increase the rate reimbursement to the hospital, to garner a residency program in rural medicine to the eastern shore? What are the steps? Is it regulatory, or is it just a discussion within the commission to change rates for hospitals that want to bring in residencies for rural training? She replied that those type of programs are created through assessments done on all hospitals. She wasn't sure if there was a specific rate for hospitals on the shore, but she said the commission could look into it.

Delegate Sheree L. Sample-Hughes wanted to comment on the community health worker legislation. She informed the workgroup that it passed through her subcommittee and she added an amendment to make sure that workers were representative of the state.

Deborah Mizeur mentioned her pleasure in seeing the overlap of issues being discussed in each of the advisory groups.

Dr. Maragret Malaro commented on her physician training and the 6 months she spent in a rural area, not part of her residency. That experience is what drove her desire to work in a rural area. Making these rotations robust and available might prove just as effective as a rural residency program.

Ken Kozel, CEO Shore Regional Health, complemented the workforce advisory group on their creative solutions to recruiting, but asked the workgroup to also pay attention to retention of current physicians that have been here for years. The competitive nature of the market poses a challenge to retaining physicians as policies change. We may need to look at a mechanism to reward those physicians working in rural areas.

Frieda Wadley, Health Officer, Talbot County, described the importance of not only having a rural residency program, but also qualified and passionate resident trainers and teachers. She then explained that Maryland Advanced Practice Nurses cannot do some of the things that are being done in other states (such as Tennessee) due to the restrictions placed upon them by the nursing board. While we look at retention of physicians, it might be important to think about their workload and what can be accomplished by other health care professionals. This is important too when thinking about what community health workers will do and how they can be best utilized.

Dr. Colgan reiterated the need for primary care physicians. He said the state has 3 medical schools and we're 50th in the nation for producing PCPs. The School of Medicine has started a new PCP track, and seventy five percent of students chose a primary care track. They are tracking students to see where they will go, and if they choose a specialty or became a PCP. Dr. Colgan said we need to hold our medical schools accountable and understand why students aren't becoming primary care doctors. Anna Sierra expressed her concern that having more primary care physicians isn't the only solution. She said it's not just about getting to the doctor, but it's knowing that you should go to the doctor and making lifestyle changes as well as social factors that drive poor outcomes. She stated that we need to have greater health literacy. Dr. Colgan agreed but noted that more primary care equates to lower ED rates, lower hospitalizations, and lower morbidity and mortality. He expressed that the health literacy is important, but doesn't want to see primary care be ignored in our model.

Ben Steffen agreed, but does not think that the struggle to recruit primary care doctors is a challenge only for rural health areas. He wants the workgroup to focus on the integration of doctors, nurse practitioners, physician assistants, and community resources performing at the top of their license. There is a need to incorporate patient education in the model and look at a blended approach with mid-level providers. He said that CMS payment regulations determine the number of residencies, and this has been the historic barrier.

Jennifer Berkman, Eastern Shore AHEC, expressed her concern for the ever-changing health care environment. She wants the workgroup to focus on integration and long-term institutionalization. There is need to demonstrate ROI of social programs for hospitals to invest. She wants to look at what systems of care need to become sustainable, supporting, and integrated systems. She wants the workgroup to make sure they aren't putting a Band-Aid on a dam. She believes that data collection is key on being able to demonstrate ROIs.

Susan Johnson provided several ideas to the workgroup. First, primary care providers work really hard and are paid the least in comparison to doctors that choose a specialty. The philosophy at Choptank is to take some of their administrative burden away to reduce stress, and to incorporate care coordination. Choptank's looks at how to support our primary care doctors so

that they enjoy their job and stay in their job. This included creating care teams, including social workers, to deliver care efficiently. She added that patient education is important to understand and accept care provided by a nurse practitioner instead of a doctor. We need to educate communities, not just patients, on how and where they can get assistance if they need it.

Scott Warner, Executive Director Mid Shore Regional Council wants to drill further down into where patients are coming from for care. He said although there might be enough PCPs in Talbot County, we still feel like we have a shortage because of the demand. He would like to request the data team look into this for the workgroup. The economic advisory group wants to look at what is the appropriate mile distance, and travel time for the Mid Shore region.

Doris Mason, Executive Director, Upper Shore Regional Council, thinks case management is really key for achieving integration. Case managers can organize, coordinate and educate patients. Additionally, certain home health models, specifically Channel Markers, Inc., have a multidisciplinary clinic approach where behavioral health is integrated with primary care.

Deborah Meizeur wanted to build upon Susan Johnson's comments and stress the importance of finding ways to renew physician's interest in their job. They need more flexibility and inspiration.

Holly Ireland, Executive Director, Mid Shore Mental Health Association, highlighted the behavioral health pediatric primary care (BIPPC), where psychiatrists are available to pediatricians to provide consultations. She said that we should expand that to adult care. She noted that there is a shortage of mental health services in this geographical area. When we lose one psychiatrist, it creates a burden on PCPs because they don't feel confident in prescribing medication. If the PCP had someone to consult with that would ensure the continuity of care for the patient. She stated that we also need to examine CNA certification and ensure there is an educational ladder and that there is work being done to help them perform at the top of their license. We need to make sure that there are payment methods for CNAs, but we'll need to also do that for community health workers. We're encouraging them to get certified, but they may or may not be able to find a job. Additionally, Ms. Ireland said the public transportation system in the Mid-Shore region is complicated. How do we rethink that system for rural health areas? Payer models are also complicated and sometimes discourage public/private partnerships because public funds have to be the payer of last resort. If all public funds are not spent, then there are penalties for the following year. She noted that there are opportunities for patient education and public transportation that could use those fund, but regulatory requirements are often inflexible.

Dr. Malaro expressed that the Mid Shore needs more providers and more physicians, and their administrative time needs to be cut. It may help restore physician leadership in the community. Social workers and P.A.'s in the office are really a great help. In her office patients like seeing the

P.A. because of the focused attention. This increases patient satisfaction and adherence to medical advice. There is also a behavioral health specialist in the office.

Anna Sierra commented that integration seemed to be the theme with two sides. One being the governance level where communities are empowered to collaborate and have an active voice in their local health care system. This level provides direction, prioritization and funding. The second is operational, integrated, patient level. Ms. Sierra said we often expect hospitals to do a lot that is out of their scope, but leaning on community partners is key. The ACT model out of Salisbury was discussed during the Vulnerable Populations advisory group meeting. The program is for high utilizers with intensive health care needs. Teams meet daily to discuss patient interactions, referrals, and treatment plans. This type of follow up care is what she thought was missing in the health care system. Her last comment revolved around creating a paramedic to PA education- bridge. Many paramedics have AA's, so the program could possibly provide funding assistance for them to get a BA, and then train to be a PA. This might help increase the health care workforce in these rural counties because many of them are very loyal to their county.

Friedia Wadley reiterated the need for PCPs, but also wants the workgroup to look at value. Measuring PCP wait times would be a good metric, including chronic disease management and preventative screening.

Jack Myer closed by mentioning the Primary Care Model. Under Dr. Haft, the state began steady negotiations with CMMI in CMS to support this primary care innovation model. This has been submitted and is being considered.

Mechanics of the Public Hearings

Ms. Dorian briefly explained that there will be public hearings in each county and that planning is underway already with Carline County. The goal is to have the public hearings completed by the workgroup meeting, May 24th. She asked for several volunteers to act as public hearing officers. Senator Dennis Schrader requested to have on in southern Maryland and Northern Maryland. Mr. Steffen said they would discuss how feasible this would be.

Wrap up and Next Steps

The workgroup co-chairs thanked the workgroup members for their participation and thanked the research group for their presentation. The next workgroup meeting will be on May 24, 2017.

Work Group Member Attendees:

Chairs

Deborah Mizeur, Owner Apotheosis Herb Farm
Joseph Ciotola, Health Officer and EMS Director Queen Anne's County

Members

Senator Middleton
Senator Hershey
Delegate Sample-Hughes
Delegate Jay Jacobs
Dennis Schrader, Secretary DHMH
Joy Strand, CEO McReady Memorial Hospital
Mark Boucot, CEO Garrett Regional Medical Center
Ken Kozel, CEO Shore Regional Health
Gene Ransom, CEO MedChi
Richard Colgan, MD, UM School of Medicine
Susan Johnson, VP Quality and Population Health Choptank Health
Margaret Malaro, MD
Scott Warner, Executive Director Mid Shore Regional Council
Lara Wilson, Executive Director Maryland Rural Health Association
Bob Grace, President of Dixon Valve
Leland Spencer, Health Officer Kent and Caroline Counties
Heather Guerieri, Compass Hospice
Jennifer Berkman, Eastern Shore AHEC
Wayne Howard, Former CEO Choptank Health
Holly Ireland, Executive Director, Mid Shore Mental Health Association
Kevin H. Beverly, Board of Directors CareFirst of Maryland
Roger Harrell, Health Officer Dorchester County
Scott LeRoy, Health Officer Caroline County
Doris Mason, Executive Director, Upper Shore Regional Council
Lisa Myers, MIEMSS
Anna Sierra, Executive Director, Dorchester County Department of Emergency Services
Fredia Wadley, MD, Health Officer Talbot County
Katie Wonderlich, HSCRC

Facilitator

Jack Meyer

Research Team Attendees:
Deanna Barath
Dr. Luisa Franzini
Dr. Dushanka Kleinman
Dr. Alana Knudson
Rebecca Oran

Commission Staff Attendees:

Erin Dorrien
Kathy Ruben
Ben Steffen