Meeting Summary
Rural Health Care Deliver Workgroup
May 24th, 2017

Welcome

The Rural Health Care Delivery Work Group Meeting began at approximately 1:00 pm. Kathy Ruben from the Maryland Health Care Commission (MHCC) thanked everyone for attending. She explained that this meeting was open to the public, and would be recorded in order to capture everything that was being discussed today. She told the members of the public in attendance that there would be an opportunity at the end of the meeting for public comments and questions. She then asked the members of the Work Group and the research team from the University of Maryland School of Public Health (UMD SPH) to introduce themselves, before turning over the meeting to the Work Group Co-Chairs, Dr. Joseph Ciotola and Deborah Mizeur. The Co-Chairs welcomed everyone in attendance, and thanked the Work Group members for all of their hard work. They discussed the agenda for the afternoon and what they hoped to accomplish by the end of the Work Group meeting.

Rural Health Study Update: UMD School of Public Health/Walsh Center for Rural Health Analysis

The UMD SPH update on the Maryland Mid-Shore Rural Health Study was presented by Dr. Luisa Franzini. Dr. Franzini gave a brief overview of the presentation; noting that the first part of the presentation would include the approaches that were used for the stakeholder interviews, and focus groups that were conducted in each of the five study counties. She told the group that selected highlights from both the interviews and focus groups would show what works well in the current health care delivery system, and what the challenges include. Finally, she said that she would present some of the solutions that were suggested to the research team, integrated with the solutions proposed by the Advisory Groups. Dr. Franzini said the bottom line message was that the current approaches to health care delivery in this region cannot continue. We need to develop innovative and flexible strategies to deliver rural health care. In addition, solutions for providing behavioral health care cannot wait. She told the group that the residents of the Mid-Shore are interested in immediate action plans.

Issues of Concern in the Mid-Shore Region

Dr. Franzini shared some of the health issues of concern among the residents in the Mid-Shore region. These included the lack of a continuum of care for the vulnerable populations in the area, the growing number of individuals with behavioral health issues, the lack of dental care (especially for underserved adults), and the need for disease prevention and health promotion. Dr. Franzini said that the interviews and focus groups revealed that there is still a stigma attached to mental health. The lack of mental/behavioral health services affect families, and the entire community including the educational and criminal justice systems. There is a need in the Mid-Shore region for more health education, greater health literacy and better outreach strategies.

Interview and Focus Group Approach

Dr. Franzini told the Work Group that the UMD SPH research team conducted 15 stakeholder interviews (3-7 in each county) and held 5 focus groups (one in each county with 6-11 people in each group). The stakeholder interviews included individuals that were content experts such as the County Health Officers, EMT's, and health care providers. These experts were recommended by the MHCC, work group members, or other organizations, and were designed to get a broad perspective of the issues related to health care delivery in the Mid-Shore region. The focus groups were designed to gather perceptions and opinions about health care delivery from residents in the community.

While the UMD SPH is also conducting quantitative studies on claims data, the interviews and focus groups were used to gather qualitative information. Dr. Franzini gave the Work Group members examples of the questions that were asked during the stakeholder interviews and focus group sessions. The issues that were addressed pertained to healthcare access, the health care workforce, transportation, medical technology, economic development in the County and vulnerable populations. The research team asked the stakeholders to describe what is working well, and what the challenges are in these areas. They were also asked to provide suggestions for improving health care services.

Preliminary Feedback of What Works Well

Most stakeholders agreed that the existing primary care and EMS services work well. In fact, good patient-doctor communication was mentioned in all five focus groups. There was also appreciation and support for the Mobile Integrated Community Health pilot program and for the FQHC services. In addition, residents feel that the AHEC training and education programs and school-based clinics and dental programs also work well for the community. Dr. Franzini stated that many residents believe there are strong personal networks in the region and the ability of the community to support individuals in need.

Recognition of Challenges

While stakeholders believe there are many positive aspects to the health care delivery system in the Mid-Shore region, they also recognize there are many challenges including: the lack of transportation options, shortages of primary care and specialty physicians, and changing demographics. Because of these challenges, health care services for elderly individuals and other vulnerable populations are especially compromised. Dr. Franzini said that many health care providers are overwhelmed and it is difficult to recruit new physicians to the area. Many residents do not trust the hospital system in the area and are reluctant to be treated by mid-level providers.

Needed Services

The stakeholders that were interviewed mentioned the need for bilingual services, and the need for behavioral health services for children in the region due to changing demographics. They also mentioned the need to increase the health literacy of the community. The focus groups centered on key services that were needed; by county. Both Queen Anne's County and Caroline County residents mentioned the need for more mental health services, while residents of both Dorchester and Talbot Counties said there was a need for medical transportation or ambulance services within the county. Members of the Kent County focus group mentioned the need for an outpatient infusion center as well as the need for a small hospital with inpatient care within the County. In addition, the focus group members noted some of the necessary services

for the hospital, and suggested general ways to improve health care access and lower healthcare costs.

Potential Solutions to Improve Health Care in the Mid-Shore Region

Dr. Franzini then shared some of the potential solutions to improve health care in the Mid-Shore region that were offered by the individuals that were interviewed, or by those who took place in the focus groups. The research team highlighted the solutions that overlapped with initiatives suggested by the Rural Health Advisory Groups or the Work Group; such as the development of a Regional Health Planning Council, expansion of telehealth, increased utilization of mid-level health care providers, expansion of programs that support "growing our own" workforce, `and Loan Repayment Program reform.

Stakeholders noted that potential solutions should take the residents' particular situations into consideration and evaluate the suggestions offered by the County residents. The research group noted that there were basic elements for local healthcare as well as elements for regional healthcare. Dr. Franzini said that health system models that increase access to care should also be flexible, and focus on a continuum of care, prevention, and placing facilities where the needs are. Potential programs should support families and caregivers, provide culturally competent services, and increase health literacy.

Dr. Franzini ended her presentation with several clear messages that were derived from the research findings; all of which are aligned with the Work Group Guiding Principles. There is a growth in the number of vulnerable populations (including those with mental health and substance use disorders) and their health needs require immediate action. There is also a recognition that the way that health care is delivered is changing, and more than health is needed to address the health needs of the community. Dr. Franzini then asked the Work Group members if they had questions.

Questions from the Work Group and Discussion

The first question for the research team came from Garret Falcone, Executive Director of Heron Point Senior Living Community. Mr. Falcone told Dr. Franzini that the information she presented was very interesting. He noted that his concern is the need for acute care services in the region which he would like to discuss further. Dr. Franzini said that the research team tried to focus on all of the health care needs of the community rather than just focus on the status of the hospital. However, she said the researchers did hear from some individuals in the community that there was a need to maintain inpatient beds. Deborah Mizeur agreed with Dr. Franzini, stating that while the need for inpatient beds was brought up in the qualitative studies, the issues related to health care delivery in the Mid-Shore region are much broader than just the availability of hospital inpatient care.

Joy Strand, the CEO of McCready Health asked if there was already some kind of a health planning council in the Mid-Shore region since this was listed as one of the potential solutions to improving health and health care in the region. While there is not a regional health planning council, Dr. Franzini told Ms. Strand that the Joint Advisory Groups made a Mid-Shore Health Planning Council one of their recommendations. They are taking a closer look and developing this recommendation.

Mr. Steffen asked Dr. Franzini to explain the fact that stakeholders said that existing primary care works well yet it is one of their concerns. Dr. Franzini said that people are usually happy with their own primary care physician. However, they are very concerned about the ability to replace that physician when he/she retires.

Susan Johnson, VP of Quality and Population Health for Choptank Health remarked about one of the researcher's potential solutions for increasing access to care; increasing bi-lingual providers/capacity. She stressed the need for bilingual (multi-lingual) healthcare workers as well as the need for translators. Ms. Johnson described the programs and services of the Chesapeake Multi-Cultural Resource Center in Easton. She described this Center as a central source of information for service providers as well as a source of translators used by social services and the police. The Chesapeake Multi-Cultural Resource Center receives funding from state and local grants to run and administer community programs. Ms. Johnson suggested using this as a model as the Advisory Groups further develop their recommendations. Ms. Johnson also mentioned to the group that although expansion of telehealth has been discussed as a way to improve health and healthcare in rural areas, Federally Qualified Health Centers cannot bill for telehealth which she said is a huge hurdle.

The Work Group conversation next turned to expansion of EMS services as Delegate Sheree Sample-Hughes discussed expansion in another state. She asked if this was among the Advisory group recommendations. Anna Sierra, Executive Director of the Dorchester County Department of Emergency Services, and the Transportation Advisory Group Leader said that this was among the recommendations by the Advisory Group. Funding for this recommendation is still an issue. Dr. Ciotola mentioned that another problem is that EMS is still considered a transportation issue rather than a health issue. He said that we need to change this perception.

Roger Harrell, the Health Officer for Dorchester County revisited the recommendation of a Regional Planning Council for the Mid-Shore region. Mr. Harrell said he liked the idea of a regional planning council because policy is always about reimbursement. Mechanisms for reimbursement are needed by every Health Department in Maryland because like the Dorchester County Health Department, they have all lost services due to a lack of funding. He explained that the Health Department has lost its adolescent clinic. The Health Officer from Caroline County, Scott LeRoy, agreed with Mr. Harrell. He said there is a lot of work that the Health Department does for which it does not get reimbursed. Mr. LeRoy said "You don't want to say no". He suggested that charging a case management fee may be one solution.

Mark Boucot, the CEO of the Garrett Regional Medical Center, added his perspective of the economic benefits of having a health planning council, based on the council in Western Maryland. Mr. Boucot said that the health planning council allows for the opportunity to take an inventory of all groups and allows these groups to come together for grant and other resource opportunities.

Before the Work Group took a short break, they were addressed by Dennis Schrader, the Maryland Secretary of DHMH. Secretary Schrader discussed some of the regulatory requirements and challenges that face rural hospitals. He noted that Maryland hospitals don't have the same issues as other states (which may have a disaster with the decrease in Medicaid), because of the Global Budget Revenue ("GBR"). GBR methodology encourages hospitals to focus on population-based health management by prospectively establishing a fixed annual

revenue cap for each GBR hospital. Secretary Schrader said that Maryland has a unique opportunity to have a rural health system that thrives, and have a healthcare environment that creates access to care, and better manages patients and chronic diseases.

Joint Advisory Group Recommendations

Following a short break, the Work Group continued with the next item on the agenda which was a discussion of the Joint Advisory Group recommendations (See attached copy of recommendations), led by the Work Group Co-Chairs. Ms. Mizeur thanked the Advisory Group members for all of their hard work and contributions. She said that the Rural Health Study would not be just another study because of all the hard work and because of the contributions from the citizens in the Mid-Shore region.

Regional Health Planning Council

The first Joint Advisory Group recommendation that was discussed was a Regional Health Planning Council. Mr. Boucot was asked to describe the governance and funding aspects of the Health Planning Council in Western Maryland. He said that although the Council has no actual authority, it does identify issues and priorities within the community. The council members have the capabilities of evaluating data, writing grant proposals, and developing a Community Health Needs Assessment. Ms. Mizeur asked Mr. Boucot how the Council is funded. Mr. Boucot replied that it was funded through the development of the Community Health Needs Assessment. The hospital puts the money that would be used to pay a consultant to develop a Community Health Needs Assessment towards the Council. The hospital also pays for a grant writer. Lara Wilson, Executive Director of the Maryland Rural Health Association asked how a Planning Council similar to the one in Garrett County could apply to the entire Mid-Shore region.

Wayne Howard, former CEO of Choptank Health, gave the Work Group a brief overview of the past Health Planning Council of the Eastern Shore. He noted one of the positive aspects of the Council was pulling all of the counties together to work on common issues. The Council dissipated when there was no longer funding to keep it together. He also remarked that any new Health Council must be community driven, have a base funding, and the members must have all areas of expertise. The Health Council should be given the authority to seek additional funding, and be capable of completing the Community Health Needs Assessment. Ms. Johnson agreed with Mr. Howard that the Council must represent the community.

Anna Sierra, Executive Director of the Dorchester County Department of Emergency Services, asked about funding to pay for the expenses associated with running the Council. A discussion took place about the need for a paid worker rather than just relying on Council members who already have other jobs. It was suggested that this person could be hired by one of the County Health Departments. The group also discussed the importance of a regional Council for planning. Access Carroll was mentioned as a successful planning Council with local stakeholders that could be used as a model for improving health care delivery and economic development. Susan Johnson asked the group to consider the role of FQHCs with a new Council and evaluate the payment system. Secretary Schrader agreed that we must reconcile the payment system. However he said that only 5% of patients are seen in FQHCs. Susan Johnson noted that this was much higher in rural areas; around 25% of patients.

Expansion or Enhancement of Mobile Integrated Health

The Workgroup moved on to a discussion of the second proposed recommendation, Expansion or Enhancement of Mobile Integrated Health. Lisa Myers, Director of Hospital Programs for MIEMMS, said that EMS is very interested in expanding on Queen Anne's County pilot Mobile Integrated Health program in other counties. EMS is becoming more integrated within the health system, but reimbursement is very complicated. If there is no transport to the emergency department, there is no payment. Ms. Sierra mentioned that EMS is not necessarily interested in expanding their role to include additional care for patients or to change their scope of practice.

Ben Steffen, Executive Director of the MHCC, said that since Dr. Ciotola has been the champion for Mobile Integrated Health, he was interested in hearing his thoughts on the program in QA County. Dr. Ciotola noted that the program in QA County is three years old. They have been collecting data on how the program has decreased ED admissions and decreased hospital readmissions. He said there is a need to link telemedicine to the program and continue to collect data to evaluate the program. Mark Luckner, Executive Director of the Community Health Resources Commission, described the Mobile Integrated Health program in Charles County. This program was started with a $400,000 grant that was matched by private institutions. He mentioned that the program is focusing on reducing high utilizers and needs to be viewed as an investment. Ken Kozel, CEO of Shore Regional Health agreed on the importance of EMS in decreasing readmissions.

Enhancement of behavioral health services in the community

Ms. Mizeur mentioned that Mobile Integrated Health care can increase the quality of care for behavioral health as well as decrease costs. There will be initial costs for expanding telehealth and training professionals. Holly Ireland, Executive Director of the Mid-Shore Mental Health Association added that peer support will be important to address the stigma attached to behavioral health care. Patients must be included in this process. The group ended the discussion of Mobile Integrated Health by discussing some of the problems with delayed payments which may take months, especially Medicaid.

Rural Residency

The Workgroup briefly touched on the recommendation for a rural residency. It was mentioned that this will require a lot of effort and expense. Residencies must be built from the ground up. Secretary Schrader mentioned that the Workgroup recommendations still need a lot of work and the Group should concentrate on the three most important recommendations. Jack Meyer summed up the workgroup discussion including the need for a regional planning Council and working towards a model of primary care. We must expand the workforce to meet the needs of the population, and bring services to patients as well as bring patients to the services.

Next Steps
The Workgroup will complete a survey to further define the most important recommendations. The next Workgroup meeting will be held on July 25th at Chesapeake College.

Attachment:

RECOMMENDATIONS BY THE JOINT ADVISORY GROUPS

Recommendations	Other Considerations for the Recommendations

A Regional (Cross-Jurisdictional) Health Planning Council a. To be used as a means to communicate issues, and help create community infrastructure and determine community needs (through a Community Needs Assessment) b. Must be rural and health specific c. Should consist of: members of the community, health care professionals, insurers d. One member of the Planning Council should be someone with a regional commitment to Veterans. **e.** Another member should be someone with a background in Transportation.	• Funding Mechanisms • Who should be on the Council? • How do we get counties to collaborate? • VA Funding Mechanisms for sustainability?
Expansion or Enhancement of Mobile Integrated Health Care and other ways to link residents to existing resources and help reduce non-emergency 911 calls	• Continuing education for residents and efforts to promote health literacy • Team approach (for better care coordination) with Health Departments, care managers, EMS, nurse, social worker (use of interdisciplinary teams) • Increase the role of EMS/Reimbursement • Incorporate Mobile Telehealth (may be especially helpful with care for elderly and other vulnerable populations as well as behavioral health). • Integrate with mobile crisis program • Promote use of community health workers
Enhancement of behavioral health services in the community	• Enhance Assertive Community Treatment (ACT) TEAMS • Telehealth training for health care providers • Medication Assisted Treatment (MAT) training for primary care providers
Rural Scholarship for Maryland • Medical Students o 2-3 in Western Maryland o 2-3 on the Eastern Shore o Paid Medical School o 8 year payback for rural areas • RN/NP • PAs • EMT/Paramedic (at rural Community Colleges**)** • Dental/Dental Hygiene	• Structure a tuition or scholarship program that incentivizes remaining in the community • Funding • Explore creation of Rural Residency Program o M.D. or D.O. o Tightly controlled o Expensive
Expansion of Home Health Services	• Use of Family Caregivers
Increased utilization of mid-level healthcare professionals (NPs, PAs) as well as Community Health Workers (CHW)	• Allow for reimbursement • Nurse Practitioner Program on the Eastern Shore • AHEC training for CHW • Use of “peer veterans”
Coordination for medical transit and streamlining of transportation programs	• Transportation for Rural non-Medicaid population • Transportation for non-medical needs that may impact health

Rural Model (initial discussion) a. must provide a continuum of quality services (primary care is essential) b. Short term inpatient capabilities may be needed c. Should act as an "economic engine"	• Integration of services • It will take time to develop such a system • Costs associated with obtaining and keeping physicians are high • Physicians often must value a certain quality of life to remain in rural areas • The community needs to market that "quality of life" aspect
GBR – Rural Premium	• Develop argument for increase for infrastructure
LARP Program Reform (streamline, simplify) **a**. Open to others such as PAs	
J-1 Realignment	• HPSA driven- competition with Baltimore City
Primary Care Model	