

**Meeting Summary**  
**Rural Health Care Delivery Work Group**

**November 1, 2016**

**1:00-5:00pm**

### **Welcome and Introductions**

The second Maryland Rural Health Care Delivery Work Group meeting was held November 1, 2016 in Cambridge Maryland. The meeting began with a welcome from the Workgroup Co-Chairs Joe Ciotola and Deborah Mizeur. It featured in-depth presentations by the three major health systems operating in the 5-county region, as well as a presentation by the research team from the University of Maryland School of Public Health and The Walsh Center for Rural Health Analysis at NORC. The meeting also included a facilitated discussion in which the heads of four advisory groups presented the preliminary results from their first meetings, followed by discussion.

### **Health Systems Overview**

The meeting began with three presentations from three Health Systems.

#### **University of Maryland Shore Regional Health**

Kenneth Koziel, the CEO of the University of Maryland Shore Regional Health and Dr. Adam Weinstein, Vice President of Medical Affairs for the University of Maryland Shore Regional Health presented for the [University of Maryland's Medical System- Shore Regional Health](#). Mr. Koziel provided an overview of the University of Maryland Shore Regional Health System including the number of employees and physician providers, the annual budget, payroll, and patient visits.

Mr. Koziel then discussed the University of Maryland Community Medical Group (UMCMG) which is the employed physician and provider group of UM Shore Regional Health, serving patients in the five counties of Maryland's Mid-Shore region. He noted that there is a focus on primary care as the stabilizing foundation of the provider group. He highlighted efforts to increase primary care providers in their network and discussed the difficulties the hospital is experiencing with recruiting and retaining providers. Employed primary care providers have increased dramatically in the last few years as have the use of advanced practice providers such as nurse practitioners and PAs that enhance primary care practices. UMCMG employs 70 physicians, of whom 28 are primary care doctors (family practice, internal medicine, pediatrics, and OB/GYN). Of these 28 PCPs, 21 were recruited from outside the area. Mr. Koziel described the burden of covering the costs of employed PCPs on the Shore Regional Health budget because the hospital is limited to the hospital rate-based payment system.

Dr. Weinstein described Shore Regional Health's community health needs assessment, highlighting the five priorities for the Mid-Shore region and the overall assessment findings including the shortage of primary care providers and a lack of adequate transportation. He noted that there are a limited number of non-profits and private organizations available to help in filling gaps in care for

vulnerable populations. Dr. Weinstein closed after describing several community benefit initiatives the Shore has implemented to fill gaps identified in the community health needs assessment.

### **Anne Arundel Medical Center**

Victoria Bayless, President and CEO of Anne Arundel Medical Center (AAMC); Maulik Joshi, DrPH, Executive Vice President of Integrated Care Delivery and COO; Dr. Jeff Denton; Dr. Russell Schilling; and Dr. Juan Cordero all presented for the [Anne Arundel Medical Center](#). They explained that the Eastern Shore has been a part of the AAMC service area for decades. There are currently 6 and soon to be 7 facilities on the Eastern Shore, with 48 providers (18 primary care), who serve close to 46,000 people in the region. AAMC is also looking to expand primary care services, but it is a challenge to recruit from outside the region. There are also plans to build telemedicine capabilities and embed behavioral health and quality coordination services in PCP offices. EPIC is an electronic health database that provides an opportunity to collaborate with other health systems.

Following the presentation, Deborah Mizeur asked the team of presenters about the decision-making process when expanding services, and how AAMC determines the location of their facilities. The response was that AAMC looks at their Community Health Needs Assessment (CHNA), which they conduct every two years. The Eastern Pavilion was decided upon to fill a need they saw within the community. The follow-up question was about how AAMC refers their patients. The response was that patients are referred to providers based on patient needs, not just to sites within their own system. The presenters acknowledged that patients want locally provided care whenever possible. However, sometimes patients are sent over the bridge if necessary; for example to the AAMC level 3 NICU.

### **Peninsula Regional Health System**

Christopher Hall, V.P. and Chief Business Officer, Strategy & Business Development presented for the [Peninsula Regional Health System](#). This system mainly serves the Lower Shore area, but Dorchester is in its secondary service area. Two percent of all ER visits and four percent of all services are provided for residents of the mid-shore region. Mr. Hall explained that the health system just went live with EPIC today. He noted that Peninsula Regional Health System is focused on population health and a wellness model rather than a “sick care” model. Priority areas obtained from their CHNA include diabetes management, exercise, nutrition and weight control, and behavioral health. Peninsula has a mobile van that delivers care on the first Thursday of each month, which is staffed by local doctors.

### **Health Systems Q&A**

Q. Deborah Mizeur asked to what extent collaboration is currently happening between the health systems, or in which areas is each system willing to collaborate across a shared service area?

A. Mr. Kozel, Ms. Bayless, and Mr. Hall discussed a range of collaborative community interventions which are related to population health including: utilization of hospitals (how to keep patients out of hospitals—how to distribute care out to community into a lower cost setting), working with home physicians to transfer care back to them to make a smooth transition for patients, social services, partnering with local public health departments and meals on wheels. We should align our work

regarding social services. Victoria Bayless discussed the current transformation partnership in the Bay area which is a current collaboration with UMMS. She also discussed a preferred provider partnership with skilled nursing facilities, which could be shared as a model for Mid-Shore. The waiver is moving all health systems in the same directions.

Q. Mr. Ben Steffen noted that Talbot County seems to have many initiatives and services. He asked the presenters to explain the investments there without distributing the interventions elsewhere in the four counties.

A. Easton is the population center and geographic center of the 5-county region. Some of the strategies consist of leaning on the high density of physicians, specialties and other healthcare providers in that area to provide services. AAMC has a facility in all but Caroline County. Shore has a focus on each of the five counties through provider rotations in various offices and telemedicine capabilities. They are working collaboratively with the local health departments to identify needs and help address them when possible. Kent and Dorchester Counties have many physicians that are still in private practice. Shore is looking to partner with them to make sure they have the resources they need instead of trying to acquire them to respect patient preferences.

Q. Jennifer Berkman asked if the health systems were running into infrastructure barriers to having a successful telemedicine strategy in the area.

A. Telemedicine is a key service at Shore, but some of the barriers experienced include the availability of broadband throughout the counties and getting copper for the wires to create those connections. As Shore develops their strategies they work closely with legislators and ask for their support along those lines. Getting providers to support the telemedicine program was a struggle in the beginning, but not as much now. Something to think about is; are the patients ready to start receiving services this way as opposed a face-to-face visit? It was noted that it is hard to manage and solicit feedback from patients.

Q. Garret Falcone asked, "With all your goals being tied to data and outcomes, how are you going to focus on partnerships"?

A. Mr Kozel said that each health system has demonstrated their ability to partner with local organizations. We hope to come together, but it's a competitive industry when we have limited dollars to focus our efforts on telemedicine, physician recruitment, and to connecting to our communities. The industry does not support collaboration. It needs to change if we are going to be held to the total cost of care in the future. Without change we'll continue to focus on building partnerships locally, and looking at what we can do with our limited resources. Ms. Bayless noted that the hospital systems have more similarities than differences compared to several years ago. The industry has shifted away from competition for admissions and growth, to more outcomes and population health. The Maryland Hospital Association, American Hospital Association of Regional Policy Board for region 3, these are some examples where we do work together in certain activities. Mr. Hall agreed that there was much more competition before rate structuring.

Q. Can you say that each of you are maximizing your efforts to collaborate, which is the future of the waiver?

A. No. There are areas where we are, but as the industry shapes what we are required to do and the systems understand the roles and responsibilities they play, collaboration will naturally happen as we focus on what is best for the patient.

Q. What is your recommendation to this workgroup regarding providing recommendations to the legislature about the hospital systems: leave them alone or should we look at way to help increase collaboration.

A. It's a combination of both. We need to sit together to see what solutions we can creatively come up with together, but it will also take some regulatory or legislative change to help steer hospitals in general towards the next phase of the waiver. We may need more of a Geographic model to prevent duplication of services.

Q. Secretary Van Mitchell asked " What if Maryland lost the waiver?

A. The waiver brings in federal dollars. It's supported by the health system, it's supported by the community, and there is a 40-year history. For states without the waiver or that have lost theirs there is cost-shifting that occurs from government payers to commercial payers. For every dollar received through Medicare, you'll get \$1.30 from commercial plans. They see a lot of changes, mainly closures of facilities. Hospitals will lose 13% of their revenue. Hospitals in Maryland are operating with margins within 2-3%, so losing 13% would be crippling. You can see what has happened in New Jersey, Hawaii, New York, and Oregon. Ultimately the waiver going away increases competition and if you want less competition, this obviously would make no sense. Other states are focused on the survival of the health system, and not partnering with their local partners (FQHC, local public health departments, etc.) Shore Health would suffer trying to meet needs in rural health care without the waiver.

Joe Ciotola invited the 3 health systems to the next workgroup meeting, and asked if they could design a collaborative health delivery system for the Mid-Shore under the next phase of the waiver.

### **Independent Research Study Plan**

Luisa Franzini, PhD- University of Maryland School of Public Health and Alana Knudson, PhD- The Walsh Center for Rural Health Analysis presented the [University of Maryland School of Public Health & The Walsh Center for Rural Health Analysis, NORC at the University of Chicago- Study Plan](#). A clear distinction was made between the University of Maryland Medical System (UMMS) and the University of Maryland School of Public Health. The presenters wanted to increase the understanding that this is an independent research study designed to develop rural health care delivery and payment options for the five counties. The main issues that have been identified for examination are health care and services for vulnerable populations, technology, economic development, health care workforce, and transportation. The research study will consider the health needs of the residents, what assets are available within and across all counties, as well as examine models in the five counties, in the state, and nationally. There will be stakeholder interviews (15), focus groups (5), and public hearings to ensure that the population is being heard and the options are vetted through the community.

Anna Sierra asked that EMS be included in stakeholder interviews and the workforce analysis; not just in terms of transportation. She also offered to share data with the researchers

Garret Falcone asked if there are any correlation with success between rural hospitals with tremendous financial support from the community vs the location of the hospital. Dr. Knudson said that success usually stems from a visionary leader in rural health organizations and hospitals. The vision of the board and provider groups is key to wanting to improve the community. However, there are different models with different financing structures, but it's about being locally driven to meet the needs of the community.

Richard Colgan is interested in asking the hospital systems at the next meeting if they have any plans to create a rural residency program and would like to know why Maryland is 50<sup>th</sup> in the country for trained physicians that go into primary care. It was suggested that the group put forth a recommendation for the school to track graduates, their careers, and where they practice.

Scott Warner requested that in the economic development section the researchers consider the following questions:

What does the health system look like when there is change? Is it shrinking here and growing there? How can health care facilities and residents still be used if a hospital closes? Could billing or other pieces of the health system fill those offices? What would happen with governing boards, such as non-profit boards when there are no longer doctors or business people in the community? How do counties continue to grow economically? If there isn't a significant portion of the healthcare system in the county it will be hard for areas to grow/sustain their population.

Senator Middleton commented on the fact that physician workforce shortages in Maryland aren't new, but implementation strategies to prevent shortages weren't implemented in the past. Have you [Alana] worked with communities to develop implementation strategies? The concern is costs and rural communities don't always invest in themselves. Dr. Knudson reminded him that the solution selected needs to fit the 5-county region. Sometimes it comes with a price tag, but the right people need to be at the table and support the plan. There needs to be community champions backing the plan from development to implementation. Most of the time you need to look locally for funding, sometimes you can look globally, but there is a lot of competition for those funds.

### **Facilitated Discussion and Advisory Group Debrief**

The final portion of the meeting was devoted to a facilitated discussion lead by Jack Meyer, Principal, Health Management Associates. The advisory group leader of each of four groups reported on their initial meeting.

### **Special Needs and Vulnerable Populations**

Mark Luckner gave a report of the first meeting of the Special Needs and Vulnerable Populations Advisory Group. They are looking at three main questions. (1) What are the greatest needs of the populations? (2) How will interventions be sustained? (3) Behavioral Health workforce shortages and how that will affect the population. Advisory group member Susan Johnson reminded the group that vulnerable people include the homeless and under/uninsured, those with low health literacy, and long-term unemployed individuals. She noted that these vulnerable individuals require a lot of coordination and cost the system a lot of money since these risk factors make them vulnerable to chronic illnesses

and repeated trips to the ED and hospital admissions. The FQHC is stepping up, but taking care of one patient at a time. They are also trying to encourage enrollment in public programs when these situations arise.

Deborah Mizeur wanted to know how care is coordinated for these specific vulnerable populations. Ms. Johnson let her know that collaboration for coordinated care has been in progress for two years between Shore Regional Health, MCOs in the area, and the health departments. It's all about getting to know one another and it's a grass root effort. Discharge planners will call to make a referral to the FQHC and then they step in. Deborah wanted to know what the State can do to help? What regulatory functions need to change to allow this type of innovation to occur? And what financing model would sustain these interventions? Brett McCone from the Maryland Hospital Association informed the group that the regulatory piece is already moving in that direction and those conversations are happening within the MHA but driven by CMS. Heather Guerieri, with Compass Hospice, wanted to make sure that hospice is included as a partner because they can help getting people out of the ICU beds and can provide services earlier rather than later.

Senator Middleton noted there is a high turnover rate for people with mental and behavioral health issues. He asked how do hospitals address this under the All-Payer Model. Brett McCone reminded him that the realignment under the global budget is relatively new (2 years old). Systems are looking at ways to address these issues and understand they need to invest in behavioral and mental health. By investing opportunity savings into areas of need like behavioral health they in turn generate additional savings and then you can hire additional staff and reduce readmissions. Mr. Kozel reminded the group that hospital systems aren't funded to do these community interventions and there aren't many incentives to do these. Anna Sierra interjected that EMS services aren't aligned with lowering hospital admissions either. Dorchester last month had ten thousand patient trips where five thousand were priority and three thousand were non-emergent. Taking patients to the hospital is the only billable service. Susan Johnson mentioned that PCPs have a difficult time taking care of vulnerable populations because they need wrap around services, social workers, pharmacists, transportation, home health nurse.

Senator Stephen Hershey. Hospitals cannot do this alone. They need to partner with key community partners like those around the room. Regulatory agencies should build funding into hospital rates to help finance efforts to reduce potentially avoidable utilization (PAU). GBR does not have those incentives. Those incentives to reduce PAU will provide savings that hospital systems can then reinvest.

#### Transportation and Access to Care

Anna Sierra, Executive Director of the Dorchester County Department of Emergency Services gave an overview of the first Transportation and Access to Care meeting, and described some of the themes including telehealth and telemedicine as well as physical transportation. How do we support telehealth and telemedicine when there is not financial support or when some counties that struggle with basic phone service let alone broadband access? Transportation is a problem for behavioral health treatment. There are a lot of vulnerable populations that have insurance, but no transportation to get to their primary care services. Some individuals need two to three days to plan for their appointments. How can we use EMS providers to the fullest extent of their capabilities and how can we change regulation to

allow EMS providers to provide care? Jack Meyer asked if co-location of services and “one-stop shopping” would help in providing services, even if it’s through telehealth. Anna Sierra will add this to the agenda for the next advisory group meeting. Dr. Leland Spencer mentioned that Choptank has now started to do just that. He mentioned that there are no services for addiction. Individuals in Caroline County must leave the county to get services. In Kent County, he had to provide free office space for a physician to provide medication management services, but this is just a temporary fix. Another transportation issue is that hospitals are far away, and people are more likely to use EMS services for non-emergency situations than find a ride. This puts a lot of wear and tear on EMS vehicles and takes a toll on the EMS system. Caroline County is #1 for calling an ambulance for a ride to the hospital for minor care. In Kent County, the transportation system is voluntary, so if hospital locations change, it would be difficult to retain a volunteer base. Mr. Kozel mentioned that partnering and having conversations with Dr. Spencer encouraged the Shore’s foundation to raise money to replace EMS vehicles in the county.

Senator Middleton asked if there was adequate representation from local government decision makers. Ms. Sierra replied “no, that’s a gap”. Senator Middleton suggested reaching out to volunteer community services.

#### Workforce Development

Gene Ransom, CEO of MedChi gave the overview of the Workforce Development Advisory Meeting. He noted that there is a competition for the available healthcare workforce among hospitals. Hospitals are buying practices, but aren’t adding to the workforce. The Advisory committee had discussed what worked and what didn’t work. Tax credits and loan repayments are not being fully utilized. The Advisory group discussed streamlining the management of loan repayment programs into one department. J-1 visa program—could we get more from the feds or at least change some of the priorities to underserved areas when deciding where they go? Expanding rural residency programs and other training programs in rural areas were also discussed.

#### Economic Development/Economic Impact of Changes to Health Care Facilities

Scott Warner, Executive Director of the Mid Shore Regional Council gave an overview of the Economic Development Advisory Group meeting. There was an overview of freestanding medical facilities presented by Mr. Paul Parker at the beginning of the meeting. The group then discussed how the health care system attracts citizens to move/stay in an area when they are retirees or young adults with families. Businesses don’t know how to attract young people if there is no local healthcare system. The group then discussed how national and state trends in health care delivery provide an advantage or disadvantage to rural areas, and discussed regionalization and decentralized models. They also discussed policies or programs that should be in place to increase economic development surrounding a relocated or converted facility. This brought about a conversation on transportation to health care facilities and transportation for friends and families.

Senator Middleton wanted to emphasize the fact that if Chestertown wanted to shut down, they need to have community backing before the hospital asks for legislative support. He wanted to make sure that the advisory group understood that the community will be served.

### **Workgroup Comments**

Local health departments were providers of services of last report, but this has changed. Some players missing from the meeting today include health officers because they sit as the board of health, city managers, county officials, they are all important when we are talking about local money.

Jay Jacobs emphasized the need to include long term care. Jack Meyer let him know that that phase two of the waiver will include that.

Joy Strand, CEO McCready Health, appreciates that other rural areas are included in this workgroup. This affects more than the Mid-Shore. The legislation says the work that comes out of this workgroup should be a model for the rest of the state. It's also important to re-educate the community to change their mindset. We've taught individuals to go to the hospital, and suggested that one hospital can be better than another. The public needs to be brought up to speed on all these changes and what hospitals are trying to do.

Tomorrow is a HEZ sustainability conference. Lara Wilson, Executive Director of the Maryland Rural Health Association is in partnership with the MRHA and has been given the Maryland Rural Health Plan; so we cannot work in silos. We need to work with one another.

### **Closing Comment**

Senator Middleton advised the group members to tackle low hanging fruit this legislative session. He encouraged everyone to bring forth recommendations that could be put on the floor this year that can kick start change now.

Next meeting will be January 9<sup>th</sup>, 2017 in Kent County