Establish and Support the Rural Community Health Complex Program

The Rural Community Health Complex Program serves the focal point for redesigning health care delivery in a rural region. The overarching goals of the demonstration program are to:

- Better integrate existing government services and clinical services for improved outcomes, patient convenience, and satisfaction; as well as less duplication, for overall lower cost.
- Better integrate primary care with behavioral health and dental services.
- Bring care as close to the patient as possible and 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.
- Decrease medically unnecessary Emergency Department use.
- Create a community of wellness.

The foundation of the Rural Community Health Complex is primary care. The most basic services offered at any complex site should be essential care. The Essential Care Complex (ECC) is a primary care office directed by a physician or health care practitioner. The office is a stand-alone physical location, in some instances may be co-located in a nursing home, EMS facility, or even a school. A mobile unit, such as a health mobile, may also be appropriate for smaller communities. The ECC will provide routine primary care and provides limited open access (walk-in) scheduling and some non-standard visits, such as group visits for managing some chronic conditions. The essential care complex could 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. The ECCs will largely be new sites of care that will be established as part of the Demonstration. Sites should expand the scope of services offered to include;

1. Advanced primary care, or primary care based on the Patient Centered Medical Home model. This type of site could offer extended hours care, open access scheduling, and will support non face-to-face visits and group visits. Services in these advanced primary care sites should be tailored to the community served. Several existing FQHC sites are already delivering almost the entire range of services envisioned at these sites.

2. Advanced ambulatory care site consists of a freestanding emergency department and, potentially, observation units with other outpatient services as appropriate. Behavioral health, substance abuse treatment centers, hospice and palliative care providers, medical and ambulatory surgical services could be located on the campus. The site would have a formal relationship with a parent health system and any emergency facility would be designated by MIEMSS. One AACC site in Queenstown now exists, although services may need to be expanded. Another AACC has been proposed in Cambridge, Maryland.

1. *Changed in response to Save our Hospital comments on mileage requirements of critical access hospital program.*
2. *Changed to better reflect the workgroup discussion on July 25th*
3. *Changed in response to comments for UMMS/ Shore Regional Health*

3. Special Rural Community Hospital (SRCH) is a small rural hospital consisting of an emergency department, an observation unit, and the capacity to provide inpatient and outpatient surgeries and to provide inpatient care. The SRCH possesses significant telehealth capability to support telehealth assessments and consults with patients outside the hospital and with clinicians at regional and academic medical centers. Criteria for this category of facility will need to be developed that take into consideration the reality in rural Maryland. *While the Critical Access Hospital may be the closest federal analog, this designation is based on distance to another health facility, which is not ideal for rural parts of the state. In Maryland, particularly the Eastern Shore, a better measure could be travel time.*[1] The program should be established under HSCRC's broad authority to establish reasonable reimbursement for Maryland hospitals, *or through a legislative mandate to create such a program.*[2] 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. Any special designation *should include sustainable funding*[3] and be linked to measureable outcomes and milestones.

Specialists, dentists, and behavioral health providers along with hospice and palliative care should be encouraged to partner or collocate at the complex sites where feasible. The inputs to establish any site will be reflect the needs of the population, the scope of services that can be supported in the immediate community, and proximity to other health care resources in surrounding communities, the jurisdiction, and the region.

Rural Community Health Complex Program would have a governance council, called the Rural Health Collaborative, composed of representatives of hospitals, practices participating in the sites, local health departments, and consumers. The Rural Health Collaborative, or governing council would plan deployments, distribute resources, and resolve integration problems.

A technology infrastructure will support coordination among health care providers and social services and provide a vehicle for educating patients on health literacy and self-management for chronic conditions. Services envisioned to be available through this "Patient Centered Support Hub" are already available through interoperable EHRs, EHR patient portals, services currently available through CRISP, or planned to be available via the CRISP Integrated Care Network (ICN).

The Patient Centered Support Hub will enable better integration of multiple information sources allowing primary care physician to track patient care and access and refer to specialists through their EHR. The Hub should also link providers and patients to other resources beyond medical

care including access to educational/self-management services, government agency and community-based social services and supports.

The Rural Community Health Complex Program should align with the goals of the Phase II Total Cost of Care (TCoC) Model. The State should consider providing sufficient funding to establish the Rural Community Health Program on the Mid-Shore. All support should be linked to measureable establishment, process and outcome milestones. The Workgroup emphasizes that the Complex must make measureable improvements in the health of the communities in which they operate. Simply establishing funding levels and program objectives will not be sufficient to drive improvements.

4. *Recommendation Title changed to better reflect discussion of workgroup on July 25th that the RHC, while an important component of the complex is an important body for population health planning generally.*
5. *Response to Save our Hospital comment regarding community representation.*

<u>*Establish*</u>[4] and Support a Rural Health Collaborative

The Workgroup recommends a Rural Health Collaborative (RHC) organization be designated as first step in launching the complex. A convening organization is needed to mobilize and educate local groups, plan for the complex, and to establish and direct the complex. No existing organization is optimally organized, regionally positioned, or appropriately funded to establish the program, however the existing Local Health Improvement Coalitions (LHIC) for rural counties may offer a suitable organizational foundation for the Rural Health Collaborative, <u>*however there must be a critical mass of community voices including patients and providers*</u>.[5] The Mid Shore LHIC is especially credible as already includes the five Mid Shore counties and many of the stakeholder are already active participants. To be successful, the Mid Shore LHIC would need a predictable funding stream from the State and local jurisdictions and additional authority to convene the complex.

The RHC could perform the following functions:

- Identify needs for the region but also the pockets of special needs within the counties
- Develop strategic directions for improvement of health in the region
- Work with health systems and independent providers to integrate clinical health needs with social, behavioral, and environmental needs that impact health and clinical outcomes
- Manage data collection and analysis for Community Needs Assessments that roll into a Regional Health and Social Needs Assessment
- Collaborate with other community organizations and health systems in seeking grant funds to improve health within the region.
- Work with health care organizations Collaboration in sharing services and staff across jurisdictional lines for economies of scale

- Integrate work of the local organizations into 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. Local jurisdictions would be expected to provide limited funds to establish and maintain the Collaborative with local funds matched by the State. The Rural Health Collaborative will need to work with health care providers to develop the full range of sites within the region. A Rural Health Collaborative will not compel a health care provider to establish a service, but it will be able to provide guidance on where services may be needed.

6. *A new paragraph added below to better reflect discussion of workgroup on July 25th that the RHC, while an important component of the complex is an important body for population health planning generally*

Community voices are essential to a well-functioning health care delivery system. The RHC collaborative would be an important convener of community voices and a forum for public input when planning for a regional health system. The RHC would also be an important resource for health care providers when planning population health improvement initiatives.[6]

The Rural Community Health Complex Program begins as an experimental program in the Mid Shore. If the Program meets performance milestones, the Workgroup envisions that Rural Community Health Complex Program could be established in each of the other rural regions: Lower Eastern Shore, Southern Maryland, and Western Maryland. The appropriate convening organization that serves as foundation for the Rural Health Collaborative will need to be carefully considered in each region. Although the Mid Shore LHIC is stable and broadly supported, there may be different organizations in other regions that could serve the RHC function. All existing organizational structures should be considered as a region considers establishing a new entity.

The Workgroup considers the recommendations that follow be essential to the development of the program. Each recommendation represents an important building block for the operation and workforce needed for the complex to succeed. These recommendations can be understood and evaluated individually and some may need further definition. The Workgroup recognizes that State policymakers may establish an implementation sequence that reflects funding and implementation priorities. However the Workgroup believes that implementing one or several recommendations alone will not produce the proportional benefits associated with the more limited investment.

Additional recommendations

Workforce

1. *Create and extend tax credits, loan or grant opportunities for practitioners to practice 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.

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

    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.
    b. *Establish a Rural Primary Care Residency Program* 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. Residency programs in 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. 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

7. Rural specialty care residency clarified in response to MedChi comment on specialty care residency program

c. *Establish a rural specialty care residency rotation. The inability to recruit general* surgeons, obstetricians, anesthesiologists and certain other specialists are important contributors to the failure of many rural hospitals. Establishing specialty care residency rotations in rural hospitals could ease the challenge of attracting these specialists to rural communities. All surgical and medical specialty residency programs in Maryland are located in Baltimore City and Baltimore County hospitals. The Baltimore hospitals provide valuable training in mostly academic teaching environments and the clinical staff are excellent. These settings expose residents to vary and complex clinical situations. Often, these are the exact experiences that medical students seek in residency programs. Limiting the training setting to these environments undervalues future practice in smaller hospitals and rural communities. Exclusive training in these settings tends to incentivize preferences for types of future employment in medical and surgical subspecialties. The concentration of training programs in Baltimore may also contribute to Maryland ranking 42nd (37.5%) of all states in retaining medical and surgical residents trained in State. Working as a general surgeon in an under-resourced setting might not generate as much attention as being a surgical subspecialist in a large urban or academic setting, but physicians working in under-served and rural areas often have high levels of job satisfaction and fulfillment that far exceed their colleagues in other settings. If residents are never offered the more diverse experiences, chances for selecting those clinical settings are low. Establishing a rural medical or surgical residency program could be challenging. Rotating medical and surgical residents through rural hospitals offers the potential to expose residents to the challenges and benefits of delivering specialty and surgical care in rural communities. To establish these rotations, Maryland may need waivers from ACGME that requires residents to work at sites less than 50 miles from the sponsoring hospital. Most of the eligible rural hospitals are more than 50 miles from the Baltimore hospitals that have established residency programs. Rural hospitals would also need additional funding to support surgical and medical specialty residents. Making any GME funding available through enhanced hospitals rates could challenge the Global Budget Revenue limits agreed to under the current All Payer Model and Total Cost of Care Model (TCoC) beginning in 2019. One possible solution would be to offset any GME funding provided to a rural hospital with small reductions in GME at the sponsoring hospitals in Baltimore. Testing the principle of allowing funding to follow the resident could be an additional benefit of this recommendation.[7]

3. *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.

4. *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

8. Changed in response the UMMS/Shore Regional on how regions will identify matching funds

5. *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. Eligibility should 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 could 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. *The General Assembly should consider whether the program is open to all students or whether preference should be given to Maryland high school students, and whether there is a source of matching funds, such as local funds, which should be required.*[8]

6. *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.

7. *Increase coordination of care through the use of care managers and patient navigators*. 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. Patient navigators advocate for the patient, and help remove barriers to accessing timely care as well as coordinate care.

Transportation/Access to Care

9. *Changed in response to Share our Hospital Comments on mileage requirements of critical access hospital program*.
10. *Changed to better reflect the workgroup discussion on July 25th*
11. *Changed in response to comments for UMMS/ Shore Regional Health*

1. *Establish a Special Rural Community Hospital (SRCH) is a small rural hospital consisting of an emergency department, an observation unit, and the capacity to provide inpatient and outpatient surgeries and to provide inpatient care*. The SRCH possesses significant telehealth capability to support telehealth assessments and consults with patients outside the hospital and with clinicians at regional and academic medical centers. Criteria for this category of facility will need to be developed that take into consideration the reality in rural Maryland. While the Critical Access Hospital may be the closest federal analog, this designation is based on distance to another health facility, which is not ideal for rural parts of the state. In Maryland, particularly the Eastern Shore, a better measure could be travel time.[9] The program should be established under HSCRC's broad authority to establish reasonable reimbursement for Maryland hospitals, or through a legislative mandate to create such a program.[10] 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. Any special designation should include sustainable funding and be linked to measureable outcomes and milestones.[11]

2. *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.

3. *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.

4. *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.

5. *Expand non-Medicaid and Non-Emergency Transportation*
    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.

    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.

Economic Development/ Model Support

> *12. Changed in response to comments from MedChi and the Rural Health Association.*

1. *Charge the Community Health Resources Commission with incubating pilot projects in rural communities to support of the Rural Community Health Complex Program. <u>The Workgroup believes the Community Health Resources Commission (CHRC) could be an</u>*

important incubator for local initiatives in the Rural Health Complex Demonstration. CHRC past experience in funding similar efforts makes that organization uniquely qualified to assess and fund proposals that would be valuable to establishing Complexes. The Workgroup encourages the CHRC to commit a significant share of its funds to establishment of the Mid Shore Rural Complex. To serve as this key incubator, CHC will need adequate funds and staff to support initiatives across the state and the proposed efforts on the Mid Shore. Current and historic funding levels of CHRC should be reviewed to ensure the Commission is well positioned to meet the goals of the demonstration without crowding out other priorities.[12]

2. *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.

Vulnerable Populations

1. *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, and 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. Existing infrastructure and programs that are working, but underfunded, should be favored before new programs are launched.

2. *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)