To: Members of the Rural Health Workgroup and staff of the Maryland Health Care Commission

From: Leadership, Save Our Hospital physicians and citizens group

Date: August 10, 2017

Re: Concerns about the draft recommendations

Dear Workgroup Members and Staff:

As members of the physician-led Kent and northern Queen Anne's community volunteer group Save Our Hospital, we write to share our reaction to the draft recommendations discussed at the July 25 meeting of the Rural Health Workgroup.

We are grateful to the Health Care Commission staff and the Workgroup members, especially chairs Deborah Mizeur and Joseph Ciatola, for the time and thought they have dedicated to the process of rethinking and redesigning a health-care delivery plan that works for rural communities like ours.

We wholeheartedly endorse the majority of the recommendations, which concern greater coordination and clustering of health-related services, providing in-home or close-to-home care for patients, incentives for attracting and retaining physicians and other health-care professionals, reducing re-admission rates, avoiding unnecessary visits to emergency rooms, and exploiting the power of telemedicine and other innovations to increase timely access to the highest quality diagnostic and treatment expertise.

But we have serious concerns.

Since our original 2015 meetings (which sparked Maryland's General Assembly and the State Secretary of Health and Mental Hygiene to create your Workgroup), the Save the Hospital citizens group has continued to focus on the viability and vitality of the acute care hospital in Chestertown, now part of University of Maryland Medical System's Shore Regional Health System. Most of our concerns for the Workgroup recommendations therefore revolve around the concept of the special Rural Community Hospital. That designation is outlined on page 11 of the draft recommendations under item 10: "**Create a special hospital designation for Rural Communities."**

While we applaud the creation of a new category of hospital if it will help ensure the continued financial success of our county's second largest employer, we have specific

concerns about the defining characteristics and longevity outlined in the draft recommendations:

> **Item 10. b. states that the hospital must be "located 35 miles or more from the nearest general acute care hospital."** While we understand that the mileage figure comes from the federal designation for a Critical Access Hospital, it is not a safe measure for rural Maryland communities such as Kent County. The current hospital in Chestertown is approximately 34 miles from the site of the proposed Easton medical center on Route 50 near the Easton Airport. Thousands of residents, tourists, beach-goers, boaters, students, campers and staffers from marinas, summer camps and environmental education programs in remote parts of Kent County, notably Rock Hall, Betterton, Still Pond Neck and Galena, are 45 to 50 miles or more from the Easton site.
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> To use the 35-mile figure would be cruel, cynical and dangerous.
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> We believe a safer criterion would be one based not on mileage but on travel time. That would allow for considerations such as beach traffic on Route 50 and other seasonal issues that lengthen the trip to another hospital.
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> **Item 10. f. states, "The program would last for five years and would be renewable by agreement of HSCRC and the hospital. "** By leaving the renewal option solely up to the hospital board and executives, this clause threatens to put the Chestertown hospital (and any designated Rural Community hospital) right back into the untenable situation that first sparked community outrage and led to the creation of the Rural Health Workgroup in the first place.
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> A hospital is too important to the health, economy and social wellbeing of a community to be redefined and converted into a lesser facility without vigorous community and legislative debate and input. The State must require a review process that ensures public discussion and input from the affected hospital's medical staff and guarantees that the hospital decision makers are hearing and acting on community and physician concerns. The procedure for altering a Rural Community Hospital's status should be similar in scope and as rigorous as Maryland's existing Certificate of Need process for building or significantly altering health-care facilities.

Need for a local hospital board. Another concern is the continued lack of a truly local board to serve as a liaison, watchdog and advocate for our hospital. While the Workgroup's deliberations and recommendations have invested in the concept of regional and system-wide collaboratives and oversight, we strongly endorse the idea of a community-based board for any rural community hospital or health complex.

Yes, there is a board of directors for the regional health system (in our case, UMMS Shore Regional Health System), but board members from smaller communities will never have a decisive voice on a regional board. It is, after all, the almost total disregard for our community's interests and the diminished status of our hospital by the Easton-based regional board that led us to appeal to the General Assembly for respect and attention. Residents will always be more closely connected to, loyal to, and more likely to donate to, a hospital with its own board drawn entirely from neighbors, friends and civic leaders they know and trust.

(Such a local board would give voice to community concerns about hospital policies such as Shore Regional Health's "white paper" proposal to eliminate the ICU unit and to reduce inpatient beds based on projected rather than recent patient data.)

"Put some teeth in it." Given the severity of the physician shortage in rural areas and the pressure and cost of outspending competitors to attract top medical staff, our group suggests building significant incentives and disincentives into any recommendations that will encourage University of Maryland Medical School to develop more family physicians and general practitioners who will train and eventually practice in Kent County and other rural communities. This was a promise—broken immediately and never fulfilled—that UMMS made nine years ago when it was a suitor seeking ownership of the hospital in Chestertown.

Thank you for giving our concerns your serious consideration. The Kent and northern Queen Anne's community will remain engaged. We are eager to support Senators Middleton and Hershey and Delegates Jacobs, Ghrist and Arentz as they shepherd the Workgroup report through the halls of the General Assembly and into law. We know that, despite the long road that brought us to this point, we still have a long way to go to ensure that our future includes a robust hospital at the center of a healthy, equitable, prosperous community.

Sincerely,
Save the Hospital Leadership

Dr. Jerry O'Connor
Dr. Wayne Benjamin
Dr. Michael Peimer
Dr. Ona Kareiva
Dr. Susan Ross
Margie Elsberg, SOH Coordinator, past president of Chester River Health Foundation
Kurt Landgraf, President of Washington College
Chris Cerino, Mayor, Town of Chestertown
Garrett Falcone, executive director, Heron Point CCRC

Glenn Wilson, President and CEO of Chesapeake Bank & Trust, President of United Way of Kent County
Kay MacIntosh, economic development coordinator, Town of Chestertown

And the following citizens in attendance at the August 10 meeting:
(professional or community affiliations provided as known)

Rev. Ellsworth Tolliver, community leader
Marty Stetson, Chestertown Town Council
Linda Kuiper, Chestertown Town Council
Fred Harmon, representing the residents of Heron Point
Leon Irish
Bill Mohan
Shelby Strudwick
Jim Twohy
Charles Lerner, board member, Chester River Health Foundation
Sandra Bjork, board member, Chester River Health Foundation
David Foster, former Chester River Riverkeeper
Nancy Carter
Zane Carter
Beryl Kemp
Michael McDonnell
Stuart Elsberg, past president, For All Seasons