Rural Community Health Delivery Laboratory/Community Health Complex

(Discussion Draft)

The Workgroup recognizes that health care systems of the future need to accommodate a culturally diverse population, as well as a growing number of vulnerable residents and elders with chronic health conditions. Recognizing and addressing the social determinants of health is crucial in promoting a healthy society. Stakeholders must support an integrated care delivery system that promotes health equity, quality, and comprehensive services across a continuum of care. The Workgroup has established principles to guide its work. These principles are integrated into the vision of the Community Health Complex model.

EXISTING ENVIRONMENT AND BASELINE ASSUMPTIONS FOR A NEW MODEL

1. Many hospitals are purchasing physician practices in an effort to adjust to healthcare reform pressures. Physicians are selling their practices due the growing challenges of operating under value-based models that require significant technology investments and expanded medical staffs. While these changes may be inevitable and may yield long-term benefits, in the short-term, access may be reduced, inefficiencies can grow, and long-standing patient-provider relationships may be disrupted.
2. Maryland's All Payer Model Demonstration provides incentives for hospitals to collaborate with community providers to better manage ambulatory services to decrease over utilization of ED and inpatient services. In Phase 2 of the All Payer Model Demonstration, physicians and non-hospital providers will have to be offered incentives to improve care and lower costs.
3. Maryland is seeking solutions for containing costs on total cost of care. For the ambulatory component, Care Coordination solutions are being entertained to help physicians with their network of patients needing clinical and social services coordination.
4. Health care systems, policymakers, and consumers seek a rural health care model that can assure the health status of rural residents is enhanced.
5. To maintain a sound health care delivery, rural communities should develop a one-stop-shopping health and social complex for the majority of ambulatory health needs.

Goals

1. Better integrates existing government services and clinical services for improved outcomes, patient convenience and satisfaction, and less duplication, for overall lower cost.
2. Better integrate primary care and behavioral health services.
3. Decrease transportation needs because multiple appointments/services can be managed with the same trip. Specialists are brought onsite so that patients don't have to travel long distances.

4. Decrease medically unnecessary Emergency Department use.

COMMUNITY HEALTH COMPLEXES

The Community Health Complex is the center for health care delivery in a rural community. A complex is sized to respond to the needs of the population, the scope of services that can be supported in the immediate community and proximity to other health care complexes in surrounding communities, the jurisdiction, and the region. The foundation of any community health care complex is primary care. Community Health Complexes would have a governance council made up of top level representatives of hospitals, practices participating in the complexes, local health departments and consumers to plan deployments, distribute resources, and resolve integration problems.

PATIENT-CENTERED SUPPORT HUB –TECHNOLOGY TO INTEGRATE AND COORDINATE CARE

Support work in Community Health Complex to enable:

- coordination between health care providers;
- assistance in getting all social/economic/behavioral services needed; and,
- education and counseling to help manage chronic conditions.

Services envisioned to be available through the Patient Centered Support Hub are available through interoperable EHRs, services currently available through CRISP, or planned to be available via the CRISP Integrated Care Network (ICN).

The Patient Centered Support Hub, operating within the CRISP ICN, could enable the PCP to track patient needs and services provided to each enrollee to schedule educational/self-management services, government agency onsite services, and visiting subspecialty consultants.

Components/Types of Complexes

1. Essential Care
    a. Primary care office staff directed by a physician or health care practitioner.
    b. Could be a standalone physical location or in some instances may be co-located in a nursing home, EMS facility, or even a school.
    c. Would offer limited open access scheduling and some non-standard visits such as group visits for managing some chronic conditions.
    d. May 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.
    Could be mobile
2. Advanced Primary Care

    a. A continually operating primary care practice with capabilities to bring specialists in on an as needed basis.
    b. Offer extended hours care, open access scheduling, and would support non face-to-face visits and group visits.
    c. Could also have the ability to perform certain office-based surgical procedures when the relevant specialist was on site.
    d. Could have medical specialists, behavior health and dentists co-located or have these specialists' time allocated for defined periods during a week.
3. Advanced Ambulatory Care
    a. Consists of a freestanding emergency department and observation units with other outpatient services as appropriate.
    b. Behavioral health, medical and ambulatory surgical services could be located on the campus.
    c. Would have a formal relationship with a parent health system and be integrated into MIEMSS.
4. Special Rural Community Hospital
    a. Consist of emergency department, support observation stays, and possess some inpatient and outpatient surgery capabilities.