



## MARYLAND HEALTH CARE COMMISSION

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### Joint Advisory Meeting Summary Workforce Development and Economic Impact & Development

Friday, April 28, 2017  
10:00 a.m. – 3:00 p.m.

#### Welcome and Meeting Overview

The Joint Advisory Group Meeting began at approximately 10:00 am. Wayne Howard, the leader of the Workforce Development Advisory Group thanked everyone for attending, and thanked the Queen Anne’s County Health Department for hosting the meeting. He explained that the goals of the meeting were to come to a consensus for specific recommendations to be made to the larger work group regarding the health care workforce and economic development in the Mid-Eastern Shore region. He noted that the group should begin to think about the best model of health care delivery in this area and what needs to be done (including legislative action) to achieve this.

Scott Warner, the leader of the Economic Impact/Economic Development Advisory Group also welcomed the group and explained how he and Wayne, along with the Work Group Co-chairs and Maryland Health Care Commission (MHCC) staff developed the agenda for the meeting based on previous Advisory Group deliberations. He reinforced the goals of this meeting, including making specific recommendations for a hospital designation. The group then completed introductions and began a discussion of access to quality health care.

#### Access to Quality Health Care

##### *Overview of Preliminary Study Findings*

Ben Steffen, Executive Director of the MHCC asked the University of Maryland School of Public Health (UMD SPH) research team to begin the discussion by giving an overview of some of the tentative results of interviews conducted in the Mid-Shore study counties. Dr. Luisa Franzini said that the interviews suggest that access to health care is “pretty good” in the region but there are significant problems finding transportation for vulnerable populations. Dr. Dushanka Kleinman added that the perceptions of the health care system in the region are also an issue. Residents are concerned about the aging health care workforce and about recruiting new physicians to the area. She noted that residents still want to see a physician for their primary care and not a nurse practitioner (NP) or a physician’s assistant (PA). She said there needs to be broader communication about the role of NPs and PAs in the delivery of primary care.

Work Group Co-Chair Deborah Mizeur asked the researchers if people in the region are traveling to receive their care or if they are receiving their care on the Eastern Shore. Dr. Franzini replied “both”. Dr. Kleinman explained that individuals who have moved to the Eastern Shore from urban areas in Maryland often maintain their contact with health care providers in those areas.

### *Integration of Health Care Services and the Global Budget Model*

Mr. Steffen noted that the integration of services and coordination of effective health care systems is especially challenging in rural areas. He was asked to explain what was meant by “integration”. Mr. Steffen explained that under the Global Budget Model, hospitals are expected to focus on the total cost of care as well as quality. Brett McCone, from the Maryland Hospital Association, added that the challenges facing rural hospitals are seen nationally. He stated that our current system is volume driven and rural areas do not see the volume that urban areas see. Spreading fixed costs in rural areas is more difficult. He said that rural areas have tried to grow their number of specialties, perhaps to the detriment of quality. Mr. McCone said that he believes that Maryland’s All Payer system has helped stabilize rural hospitals more than other areas of the country that do not have such a system. Temi Oshiyoye, from the Maryland DHMH agreed with Mr. McCone, and gave Pennsylvania as an example of a state that is also trying to change the payment system in rural areas. Ken Kozel, CEO of Shore Regional Health said that hospital payments are extremely complicated. He asked the group if they had a good understanding of the current hospital payment system. Wayne Howard agreed that understanding hospital payments is difficult even for those who are knowledgeable about health care; as is understanding reimbursements for the health care system as a whole.

Senator Adelaide Eckardt continued the discussion of access to care by noting that the integration of services (such as the integration of behavioral health with primary care) is essential. She reminded the group that every region has different needs and one “package” will not fit all in developing a health care delivery system. She told the group that there are many discrepancies on the Eastern Shore in terms of access to care and health literacy. She said the one thing everyone understands is trauma care.

### *Regional Health Planning Entity*

Mark Boucot, the CEO of Garrett Regional Medical Center stated that Maryland has a lot of data, such as that collected through CRISP and by HSCRC and noted that changes to the health care delivery system should be data driven in addition to residents vocalizing their needs. Regional and local initiatives can be determined by a Health Planning Committee; which is a concept that the Economic Impact and Development Advisory Group had discussed at their previous meeting. This Committee/Council can evaluate both the resident’s input about what is needed and the data to back up those needs. He reminded the group that the Global Budget may stabilize the hospital system but it cannot create community infrastructure.

Deborah Mizeur thanked Mr. Boucot for his input and reminded the group that governance was mentioned in the last Economic Impact and Development Advisory Group meeting. She suggested that this should be one of the specific recommendations made by the group. Others group members agreed, and mentioned that the Council needed to be cross-jurisdictional (regional) and have as a part of it, members from the community. Senator Eckardt told the group that this approach had been used in the 1970’s with the Chesapeake Health Planning Committee which originally conducted health planning for nine counties on the Eastern Shore. It is now inactive. The group asked who funded that initiative and why is it inactive now. Wayne Howard said that the Council was originally funded by the Federal government and then received State funding. Once the funding stopped, the Council dissolved. Senator Eckardt said that the Maryland AHEC has more information about the role of the Council and its history.

The Joint Advisory Group further discussed the benefits of a Health Planning Entity, and made suggestions as what its functions, and member composition should be. Wayne Howard noted that such an entity is a great way to communicate issues and determine community needs

but there must be a mechanism to fund the Council. Mark Boucot stated that the Health Planning Council should create a community needs assessment and evaluate where funding can come from for the “total cost of care”. He noted that the total cost of care is not just a hospital burden but also a community burden. The group suggested that a Health Council needs representation by health care systems, as well as insurers and local residents. Dr. Ciotola asked Mr. Boucot to send him the list of Committee members on the Western Maryland Planning Council (see attached).

Dr. Franzini told the Advisory group that in looking at various models of health care delivery around the country, health planning committees are essential. Mr. Kozel suggested that the Health Planning Council should be both rural and regionally specific. Ben Steffen noted that the state health plan developed by the MHCC does facility planning but there is no independent regional planning. We need better planning on the ambulatory side. Dr. Ciotola said that Shore Regional Health becomes the regional component of planning because two counties in the Mid-Shore region have no hospital. Kevin Beverly asked what the barriers may be to developing such a Council and what the incentives may be. He noted that the effectiveness of this type of entity must also be evaluated. It was suggested by Mr. Kozel that perhaps the waiver was an incentive. Inconsistent funding could be a barrier as well as the lack of collaboration among counties.

Kay MacIntosh of Chestertown told the Advisory group, that while she does not have a background in health care, she does have a good feel for the local community. Not only do people have to have access to services, they also need to feel some attachment to the health care system. She said that in order to build a “community of wellness”, people want a connection. Scott Warner noted that hospital placement and access can build that connection. Brett McCone stated that although there is a need for an ambulatory structure in Chestertown, placement of a facility must be grounded in physician access; which right now is concentrated in Queenstown and Annapolis. He said we can provide incentives to attract physicians, but they choose where they want to reside. He noted that there is a tradeoff when we use resources. In addition, people can choose to leave the community to get their health care. They choose to leave for a variety of reasons including the perception that the quality of health services may be better elsewhere, and the availability of other services. Therefore, location makes a difference in access. Mr. McCone said that when thinking about the health care delivery system in rural areas, we have to really think about what services are needed.

Doris Mason, Executive Director, Upper Shore Regional Council, said that when she thinks about access in a community she thinks about transportation issues. However, she stated that access in rural areas is often “multi-pronged”. Many health care workers including social workers, hospital employees, behavioral health professionals and Community Health Workers (CHW) travel to their patients. She asked if we knew who was traveling to care for patients or to care for elderly residents. Deborah Mizeur said she was glad to see the overlap of this Joint Advisory Group meeting with the other Advisory Groups in terms of transportation and vulnerable populations. The Advisory Groups will share their recommendations, but they need to consider access to services as well as seasonal challenges in health care delivery on the Mid-Shore.

### **Workforce Necessary to Achieve Access to Care in the Mid-Shore Region**

The discussion turned to what was needed in terms of services and workforce in the Mid-Shore region. Gene Ransom, CEO of Med Chi, shared the results of a 100 physician survey with the Joint Advisory group. Although only 25 physicians responded to the survey, from their point

of view there is a need for primary care physicians as well as a need for specialists in psychiatry, pain management and elder care. Physicians have concerns about the Stark law as well economic issues when starting a practice. Mr. Ransom said it is difficult to attract physicians to Maryland because they have the third worst reimbursement rate in the country and because Carefirst seems to have a monopoly in Maryland. He noted that it is especially difficult to attract physicians to rural areas because they want to practice in urban areas. Dr. Ciotola mentioned that Maryland ranks 50<sup>th</sup> in the U.S. for physicians going into primary care. The following topics were considered as the group discussed workforce development in the Mid-Eastern Shore region [the Advisory Group decided to list recommendations (see attached). They will then prioritize these recommendations]

## ***Primary Care***

### ***Rural Health Scholarship***

Dr. Ciotola suggested the development of medical school rural health scholarships to pay for medical school for Maryland residents. There could be 2-3 for scholarships in Western Maryland and 2-3 for residents from the Eastern Shore area. The “payback” for practicing in these rural areas would be 8 years. Since Shore Regional is a part of UMMS, perhaps some of the elective courses in the practice of rural medicine could be held here. Temi Oshiyoye mentioned that the AHECs are also recruiting students on the Eastern Shore.

### ***Rural Residency***

Gene Ransom said that a rural residency program is what is needed. Bill Huffner, with Shore Regional Health, agreed stating that students often leave the area once they are done with school, but residents tend to stay in the area more often. Although he agreed that a rural residency is needed, he said that the number of residency spots is tightly controlled by the Council on Graduate Medical Education. Gene suggested an Osteopathic Residency Program (D.O) which may be easier to implement than a M.D. program. He said their role is the same. In addition, about 60% of these residents go into primary care. Some concerns about a residency program are the expenses of starting the program (for training and salaries). Deborah Mizeur asked if perhaps the State can open up residencies.

### ***Global Budget Reimbursement***

In order to keep physicians in the area, they must be paid adequately; and according to some members of the Joint Advisory group they currently are not. This is difficult considering rural physicians see fewer patients than physicians in urban and suburban areas. Bill Huffner said that physicians are still paid on a volume basis and many new physicians want a big salary. He said they also have a large amount of debt and may leave a rural area after their years of service are over. Temi Oshiyoye said that physicians may be paid as much as \$50,000 more in urban areas of Maryland. Ken Kozel stated that hospitals pay a premium to keep physicians in rural areas. Because of this, he said that services may get cut in order for hospitals to maintain operating margins. Mark Boucot agreed with Mr. Kozel and told the group that rural hospitals don't have the patient volume that allows them to develop their infrastructure. He questioned if there were any physicians that worked in the HSCRC. Scott Warner mentioned that physicians actually want to work and see a number of patients which is another reason they are attracted to urban areas. There has to be a sustainable process for obtaining higher

reimbursement to keep rural physicians; or a different ethic (physicians who want a better quality of life). Wayne Howard suggested value payments for rural physicians.

### ***Other Health Care Workers (PAs, NPs, CHW)***

There are many other types of health care workers who work in primary care who may be able to assist rural physicians. A Rural Health Scholarship was also suggested for these other health care workers including PAs and NPs. Advisory Group members suggested a NP program on the Eastern Shore. Mr. Kozel said there is a PA program at AAMC and these individuals often stay in the area where they were trained.

### **Facility Designations**

Before breaking for lunch, the Joint Advisory group began a discussion of the model of health care system that would provide a continuum of care for the Mid Shore region. The group agreed that residents should have access to primary, emergency, and urgent care. There was some debate about the need for acute care beds, and the expense associated with a full service hospital. Facilities should provide quality care, and create “wellness” to help prevent the need for inpatient care. Some of the obstacles to creating a sustainable quality health care delivery system that were mentioned by the Advisory group included:

- 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

The group did not reach a consensus on exactly what services should be available at a rural hospital before they broke for lunch.

### **Afternoon Session**

The Joint Advisory Group started the afternoon session by summarizing the recommendations that had been made earlier in the day including: A Regional Health Planning Council, development of a rural residency program, rural scholarships for Maryland students, GBR – rural premiums and compensation for creating infrastructure, nurse practitioner program on the Eastern Shore, Community Health Worker Program (CHW), LARP Program reform (streamline, simplify), and J-1 realignment (see attached summary of recommendations).

Temi Oshiyoye continued the discussion by describing the J-1 visa and the LARP programs.

### ***J-1 Realignment***

According to Ms. Oshiyoye, the J-1 for primary care is driven by Health Professional Shortage Areas (HPSAs). The scoring criteria for HPSA designation includes the population to provider ratio as well as the percentage of the population below 100% FPL and travel time to the nearest source of care. Therefore, it is difficult to just be rural since there is such a high need for providers in Baltimore City. Wayne Howard questioned how the Mid-Shore can maintain the HPSAs that are in jeopardy. Ms. Oshiyoye mentioned one additional consideration with the J-1; spouses do not have a J-1 visas.

### ***Loan Reimbursement for Physicians***

Ms. Oshiyoye continued to discuss loan repayment for physicians by describing the Federal and State components of the LARP program. She noted that HRSA allows “others” to contribute to funding; for example the Board of Physicians contributes to funding for physicians. In order to provide guidance, Ms. Oshiyoye will write down and prioritize what should be done for the Workgroup to ask for additional funding for rural areas and to open the program up for PAs and others. Gene Ransom described the duplication within the agency for the LARP program and asked if the program could be streamlined.

## **Development of a Model of Health Care Delivery System that will provide a Continuum of Care**

In discussing a model of health care delivery that would work for the Mid-Shore region, the group discussed several models of care and designation of hospitals including Federally Qualified Health Centers (FQHCs), Ambulatory Care Centers, Freestanding Medical Facilities (FMFs), and General Acute Care Hospitals. They also discussed the need for inpatient care and the quality of care services. The following is a summary of this discussion:

### ***FQHCs***

In order to provide adequate access to health care in rural areas, it was mentioned that we must also consider dental services and mental health care, in addition to primary care. We must also consider low income individuals that lack Medicaid. Dr. Ciotola told the group that they will be using a bus to provide mobile dental care in Queen Anne’s County. Wayne Howard mentioned that Choptank would like to expand FQHCs. The expansion would include dental services. Deborah Mizeur discussed the possibility of expanding on a model of FQHC which is located inside of a hospital.

### ***Inpatient Services***

The next topic of discussion for the group was inpatient hospital care capacity in the Mid-Shore region. The conversation focused on Chestertown and the resident’s desire to have an acute care general hospital with inpatient capacity rather than a Free Standing Medical Facility to provide emergency services. Inpatient care has decreased in all of Maryland’s hospitals. Bill Huffner said that the group has to think of quality when thinking about what services are necessary. Patient volume is often related to quality outcomes. He noted that not every county can have every service without the quality of services suffering. He gave the example of a transplant surgery center with specialized health care professionals and equipment that can’t exist in every hospital. Deborah Mizeur said that quality is defined by more than just numbers.

Ben Steffen explained that you do want some general surgical capabilities but that there is a continuum of facilities such as ED->Ambulatory Surgery->FMF. Kay MacIntosh said that the residents of Chestertown understand that with increased preventative care and an increase in home services, the hospital will not be what it was before. Dr. Ciotola said that the group has to look at what is being treated and how many days each patient is staying at the hospital before deciding on inpatient capacity. He reminded the group that the use of inpatient services varies with the season in the Mid-Shore region. He mentioned a Community Access Hospital model for which there are currently no state regulations. The Advisory group continued to discuss the need capabilities in the region as well as timely access to services such as ICU services. Hospitals need to be able to provide certain services such as appendectomies. Mr. Kozel said that there must be some inpatient capacity because of distance; for example between

Chestertown and Easton. Mr. Huffner said that we must also consider available resources including health care professionals.

### *Hospital Designation*

The Advisory Group continued to discuss various models and hospital designations. Mr. McCone mentioned that the model that may be best for the Mid-Shore region might be compared with the national model of a Critical Care Access Hospital. He said that in order to prepare an argument for increasing GBR the group may need some benchmarking in terms of model efficiency, cost, and quality. He said the rates at Maryland hospitals are already high. Mark Boucot stated that any money increase request by HSCRC would be to develop an infrastructure that will lower costs for chronic care through early intervention and decreasing avoidable utilization. He said that rather than increase hospital capacity for inpatient services, it makes sense to add services such as pulmonary rehabilitation and education for chronic diseases such as diabetes.

Mr. Boucot asked the group “How can care be rendered in an innovative way to keep people healthy?” One group member suggested the FMF designation being used as a hub for other services. Mr. Steffen said that each county could have specialized programs. Dr. Ciotola mentioned that Mobile Integrated Health helps keep people out of the hospital, as does increasing health literacy. Mr. Ransom explained how hospitals may receive subsidies for services to the government. He said the group needs to discuss leveraging funds. Mr. Kozel mentioned that any hospital in the Mid-Shore region must deliver the right level of care.

The Advisory Group did not come to a consensus on a hospital designation for the Mid-Shore region. However, they did determine areas for further discussion including the need for acute beds, a discussion of the need for opioid detox, and the structural, regulatory and environmental aspects of a health care delivery system. Senator Eckardt said the group needs to talk about better coordination of care within the community. Mr. Steffen mentioned the importance of discussing the role of CHWs. (See attached list of questions and areas for future discussion)

Deb Mizeur summarized the actions that that were determined to be necessary to achieve adequate health care access and workforce in rural Maryland regions:

- ***Health Planning and Defining Each County’s Specific Service Needs***
- ***Additional Pay for Rural Facilities***
- ***Greater Community Input as to what the Health Care System Should Look Like***
- ***Regulatory Flexibility***

The group concluded that the best model would be one that acts as an “economic engine” and provides quality care at the “right” location.

The Advisory Group was informed about the time and location of the next Workgroup meeting before their meeting ended at approximately 3:00pm.

**Attachments:**

General listing of the members on the Western Maryland Rural Health Planning Council:

County Economic Development Director and staff members

Representatives from School system

School superintendent

Hospital Wellness Center representative

Health Officer

Health Medical Officer

Health Planner for the health department

Health Connect (local entity)

FQHC CEO and staff representation

County Commissioners

DHMH representatives from Dept of Social Services

6 community representatives

1 philanthropist

3 local practicing physicians

Community Action CEO

Drug Free Council Representatives

Cancer Coalition Leader

Hospital Emergency Department Physician

Dental Clinic representative

Local Dentist

Town Mayors from the county

AHEC representatives

CEO of Chamber of Commerce

Ambulance Company representative

Representative from the college

Hospital CEO

**RECOMMENDATIONS BY THE JOINT ADVISORY GROUP  
(Workforce Development & Economic Development)**

Recommendations	Other Considerations
<p><b>A Regional (Cross-Jurisdictional) Health Planning Council</b></p> <ul style="list-style-type: none"> <li>a. To be used as a means to communicate issues, and help create community infrastructure and determine community needs (through a Community Needs Assessment)</li> <li>b. Must be rural and health specific</li> <li>c. Should consist of: members of the community, health care professionals, insurers</li> </ul>	<ul style="list-style-type: none"> <li>• Funding Mechanisms</li> <li>• Who should be on the Council?</li> <li>• How do we get counties to collaborate?</li> </ul>
<p><b>Development of a Rural Residency Program</b></p>	<ul style="list-style-type: none"> <li>• M.D. or D.O.</li> <li>• Tightly controlled</li> <li>• Expensive</li> </ul>
<p><b>Rural Scholarship for Maryland Medical Students</b></p> <ul style="list-style-type: none"> <li>a. 2-3 in Western Maryland</li> <li>b. 2-3 on the Eastern Shore</li> <li>c. Paid Medical School</li> <li>d. 8 year payback for rural areas</li> </ul>	<ul style="list-style-type: none"> <li>• Funding</li> </ul>
<p><b>GBR – Rural Premium</b></p>	<ul style="list-style-type: none"> <li>• Develop argument for increase for infrastructure</li> </ul>
<p><b>Rural Scholarship for other healthcare professionals (NPs, PAs)</b></p>	
<p><b>Nurse Practitioner Program on the Eastern Shore</b></p>	
<p><b>Community Health Worker Program (CHW)</b></p>	
<p><b>Rural Model (no consensus)</b></p> <ul style="list-style-type: none"> <li>a. must provide a continuum of quality services (primary care is essential)</li> <li>b. Short term inpatient capabilities may be needed</li> <li>c. Should act as an “economic engine”</li> </ul>	<ul style="list-style-type: none"> <li>• It will take time to develop such a system</li> <li>• Costs associated with obtaining and keeping physicians are high</li> <li>• Physicians often must value a certain quality of life to remain in rural areas</li> <li>• The community needs to market that “quality of life” aspect</li> </ul>
<p><b>LARP Program Reform (streamline, simplify)</b></p> <ul style="list-style-type: none"> <li>a. Open to others such as PAs</li> </ul>	
<p><b>J-1 Realignment</b></p>	<ul style="list-style-type: none"> <li>• HPSA driven- competition with Baltimore City</li> </ul>

**Workforce Development & Economic Development Advisory Group  
Areas for Future Discussion and Questions from Work Group Members**

1. How to prioritize recommendations
2. Further Development of the role of the Health Planning Council/Committee
  - Funding Mechanisms?
  - Membership? (see list from Western Maryland)
  - How will effectiveness be measured?
3. What should a “hospital designation” be in rural areas (what should a hospital look like)?
  - What services should be available?
  - What is the need for acute care beds?
  - How should hospitals deal with seasonal changes in population?
  - How can a hospital provide services that will decrease chronic conditions and keep people healthy?
4. How should the public be educated about the role of others (PAs, NPs, CHWs) in healthcare (especially in primary care)?
5. How do we change the perception of “quality of care” in the Mid-Shore region so residents don’t travel to get their health care?
6. How do we find a better way to recruit physicians?
7. How do we find ways to convince physicians that rural areas may be a “better way of life”?
8. With payment reform, what additional incentives should there be for rural areas?
9. Create infrastructure funding sources. (from HSCRC)
10. Change law so hospitals can give space for doctors from Western Shore to come to Eastern Shore (example one day per week)