

**Transforming Maryland's rural healthcare system: A regional approach  
to rural healthcare delivery**

**Report of the Workgroup on Rural Health Delivery  
to the Maryland Health Care Commission**

**As Required by Senate Bill 707**

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## **Introduction**

During the 2016 legislative session, Senate Bill 707 Freestanding Medical Facilities-Certificate of Need, Rates and Definition (Appendix A) was enacted in response to the need for flexibility for general acute care hospitals to convert to ambulatory medical services campuses, while preserving access to needed emergency services.<sup>1</sup> These facilities are known as Freestanding Medical Facilities (FMFs).

SB 707 established a public notification process and defined specific information the hospital must make available to the public and other stakeholders. Specifically, the institution must describe the reason for the conversion and present plans for transitioning acute care services previously provided by the hospital, continuing to address the healthcare needs of the residents, and retraining displaced employees. The institution must also detail plans for the disposition of any part of the facility that would be closed. The legislation requires that this and other information be made available in a public information hearing and the results from that meeting must be shared with the Governor, Legislature, and other state policymakers.

## **Policy Background**

The new law requires the Maryland Health Care Commission (MHCC) to complete a careful review of an exemption request. The MHCC organized a workgroup to assist in developing the regulations for FMFs. On May 18, 2017, the MHCC adopted COMAR 10.24.19 - State Health Plan for Facilities and Services: Freestanding Medical Facilities. These regulations became final in June of 2017. The regulations define the process for submitting the exemption request and the types of information the converting hospital and its parent hospital must provide to MHCC. To approve an exemption request, the MHCC must find that the conversion is not inconsistent with the State Health Plan; will result in the delivery of more efficient and effective healthcare services; will maintain adequate and appropriate delivery of emergency care within the statewide emergency medical services system as determined by the State Emergency Medical Services Board; and is in the public interest. MHCC will carefully review the evidence provided in the exemption request and consider the information gathered by the hospital in its public engagement processes.

Maryland's unique hospital payment model has been a key policy tool for softening the impact of declining hospital utilization on local hospitals. Over the past decade, the Health Services Cost Review Commission (HSCRC) has worked with rural hospitals to develop an alternative payment model, Total Patient Revenue (TPR) that was especially well-suited to the needs of rural hospitals. The success of that model was one factor that spurred Maryland to establish the All Payer Model Demonstration Agreement (All Payer Model, or

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<sup>1</sup> Enacted as Chapter 420 of the 2016 Laws of Maryland.

Agreement) with the Center for Medicare and Medicaid Services (CMS) beginning in 2014. Under that agreement, Maryland committed to slow the growth in Medicare per capita hospital spending and to achieve ambitious quality and performance goals. All Maryland acute care hospitals committed to operate under a Global Budget Revenue arrangement, (which was similar to the TPR arrangement developed for rural hospitals) and to meet the challenging performance and quality improvement goals. Over the past three years, Maryland hospitals have met the key requirements of the Agreement. Negotiations are now underway with CMS for the next phase, called the Total Cost of Care (TCoC) Demonstration, which is set to begin in 2019.

Providing greater flexibility for Maryland hospitals to convert to ambulatory medical services campuses, while preserving access to emergency services, is a response to the declining use of inpatient services in Maryland and the incentives in new healthcare reform models. Declining hospital admissions and shorter lengths of stay are consistent trends across the United States. The appropriate use of an ambulatory setting lowers the cost of care and is often preferred, as it means patients can return home the same day that they have received services. Expanded use of ambulatory care reduces the per capita cost of care and is consistent with the aims of the All Payer Model and the new TCoC Demonstration now being finalized with CMS. As the models evolve, Maryland communities will need less inpatient hospital service capacity because hospitals will be increasingly focused on improving the health status of the population in their service areas rather than increasing hospital admissions.

Preserving access to emergency and ambulatory services is an important objective. The FMF and the ambulatory services situated on the FMF campus can provide a safe and effective site for treating a significant proportion of the patients that present at the hospital emergency department of a small acute care hospital. As important, the FMF, like the hospital, would be tightly linked to a large health care system through advanced EMS transportation and would be electronically linked via advanced telehealth capabilities.

During the debate on SB 707, state policymakers, legislators, and community representatives highlighted the challenges that residents of rural communities face in accessing the healthcare system. Many of the challenges for rural communities go beyond inpatient care and include access to care more broadly. These challenges are rooted in an inadequate supply of providers, a compromised transportation system, and limited health literacy. More narrowly, in some rural jurisdictions, the loss of its only hospital eliminates the hub for health care in that community. Representatives from these communities reminded state policymakers and legislators that in some rural communities the hospital was the principal source of care. A closure or conversion could trigger an unravelling of the fragile local healthcare system, including the exodus of primary care and other community providers, a significant direct and indirect economic blow triggered by job losses. Policymakers and legislators recognized that loss of local access to inpatient care and limited alternatives due to travel times and travel distances were important complicating factors.

One area of particular concern was the Mid-Eastern Shore region of Maryland (Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties). The healthcare delivery challenges in the Mid-Shore region include long travel distances to health care facilities, few public transportation options, a limited workforce, and a limited number of healthcare facilities. In fact, two of the five counties in the region (Caroline and Queen Anne's counties) have no acute care general hospital. In addition, there are shortages of primary care physicians and specialists in the Mid-Shore region as well as limited numbers of nurses and allied healthcare workers to care for rural residents. Although the five county Mid-Shore region of Maryland is not as vast and sparsely populated as the rural areas in some other states, it covers a large geographic area (almost 1,800 square miles). Similar to other rural areas throughout the United States, the population in the Mid-Shore region is older, has more chronic health conditions, and has fewer financial resources than residents in urban and suburban areas of Maryland.

### **Workgroup Selection**

In response to these challenges, the legislation required the establishment of a workgroup on rural healthcare delivery and the provision of a study of the healthcare system in the Mid-Shore counties. The charge of the Rural Healthcare Delivery Workgroup (Workgroup) was to oversee a study of healthcare delivery, to make recommendations, and to develop a healthcare delivery model to meet the healthcare needs in the five county Mid-Shore region, which could also be applied to other rural areas in Maryland.

The MHCC was directed to establish a Workgroup on rural health delivery, including appointing members, selecting the chairs, and staffing the Workgroup in collaboration with the Maryland Department of Health (MDH). As required under the new law, MHCC sought recommendations for workgroup members from the legislative leadership in the Maryland Senate and House of Delegates, the Secretary of the Maryland Department of Health, chief executive officers of hospitals and regional medical centers, and individuals representing the interests of healthcare providers, businesses, labor, State and local government, consumers, and other stakeholder groups. The list of the Workgroup members can be found in Appendix B.

SB 707 stated that the Workgroup must oversee a study of rural healthcare needs in the Mid-Shore region. As part of its charge, the Workgroup was directed to hold public hearings to gather community input on healthcare needs in the five counties. The Workgroup was charged with reviewing, developing, and recommending policy options that would address the healthcare needs of Mid-Shore residents and improve rural healthcare delivery in the region as well as in other rural areas in Maryland.

The rural study, which was to be carried out by an entity with expertise in rural healthcare delivery and planning, was to examine challenges to the delivery of healthcare in the five study counties, including:

- the limited availability of healthcare providers and services;
- the special needs of vulnerable populations; transportation barriers; and
- the economic impact of the closure, partial closure, or conversion of a healthcare facility.

The University of Maryland School of Public Health in partnership with the Walsh Center for Rural Health Analysis at the University of Chicago, was selected by MHCC to conduct the study. Consistent with the instructions in the new law, the study team took into account the input gained through the public hearings, identified opportunities created by telehealth and the Maryland All Payer Model, and developed policy options for addressing the healthcare needs of residents and for improving the healthcare delivery system in the five county study region. The study team worked in close collaboration with the members of the Workgroup and MHCC staff. The study team attended all Workgroup meetings and public hearings and met weekly with MHCC staff during the study period. The final summary report can be found in Appendix C.

### **Workgroup Process**

The Workgroup met seven times between August 2016 and September 2017. Five of the seven meetings were held in the five county region, including two in Kent County, two in Talbot County, and one in Dorchester County. During each meeting various stakeholders and experts in the health system in the Mid-Shore area and in rural health presented to the Workgroup. Presenters included staff from the University Of Maryland School Of Public Health, the Walsh Center for Rural Health Analysis at NORC, and the Maryland Department of Health.

The first meeting, The Rural Health Summit, took place August 30, 2016, at Chesapeake College in Wye Mills, Maryland. Workgroup members were able to take a tour of the Health Professions Center, which houses an ambulance simulator, digital radiology suite, surgery suite, hospital room and apartment. These facilities, along with human patient simulators, are used for training students interested in emergency medical services, nursing, phlebotomy, and other allied health professions. During the meeting, the Workgroup members reviewed the Workgroup's charge and discussed the plan for the study. Presentations were made on the current state of the health care systems in the five counties, including a presentation on the current health care workforce, and current health facility capacity. The Office of Rural Health staff and the Office of Minority Health and Health Disparities staff also presented on the delivery of healthcare in all Maryland rural communities and on health inequities on the Eastern Shore. Lastly, the Workgroup was given an overview of Maryland's All Payer Model by the Health Services Cost Review Commission staff in order to insure that all members had a basic understanding of Maryland's hospital payment model.

At the end of the first meeting the Workgroup Chairs announced the formation of four Advisory Groups (Transportation, Vulnerable Populations, Economic Development, and Workforce) made up of Workgroup members and other interested parties having subject

matter expertise. These advisory groups were charged with drilling down into issues by listening to experts and discussing areas of concern in order to help them understand the root causes of healthcare delivery problems, and to further inform the Workgroup's deliberations. The advisory groups' members formulated specific ideas which were later discussed by the Workgroup and served as the foundation for the Workgroup's recommendations. Each Advisory Group met multiple times between October 2016 and July 2017.

The second meeting of the full Workgroup was held in Cambridge, MD on November 1, 2016, and focused on understanding the role of the three major hospital health systems in the region: Shore Regional Health, Anne Arundel Medical Center, and Peninsula Regional Health System. Staff from each of the health systems presented on their role in the healthcare system and their plan for improving healthcare in the Mid-Shore region. At the conclusion of these presentations, the Workgroup Chairs, along with Senator Thomas Middleton, urged the three health systems' representatives to formulate plans for collaboration and strategies for improving the health system. Responses to that request were delivered to MHCC in the fall of 2017 and can be found on the Workgroup's website.<sup>2</sup> The research team from the School of Public Health and the Walsh Center for Rural Health Analysis presented the study plan and was given feedback from the Workgroup members.

As the process unfolded, the Workgroup members, the research team, and MHCC staff developed Guiding Principles to guide the Workgroup in making recommendations on the approaches for improving the delivery of healthcare in rural areas of Maryland (Appendix D). The Guiding Principles were discussed at the third meeting of the Workgroup, which was held at Washington College in Chestertown, MD on January 9, 2017. These Guiding Principles assisted the Workgroup members in maintaining focus on the legislative charge and the importance of taking a regional perspective. At this meeting, MDH staff briefed the Workgroup on plans for the Maryland Primary Care Model and HSCRC staff provided an update on the Maryland All Payer Model. Lastly, the advisory group leads reported on their working ideas for possible recommendations. Workgroup Chairs and members offered additional suggestions to the advisory group leads. At the conclusion of the meeting, Workgroup members had a better understanding of the State's major delivery system reforms being negotiated with CMS and how Workgroup recommendations would need to align with and take advantage of those reforms.

The fourth meeting of the Workgroup, held on March 27, 2017 in Annapolis, MD, focused on the research team's preliminary research findings gathered from empirical data analysis and a limited number of key informant interviews. The Workgroup members were able to provide feedback to the research team and discuss preliminary findings from the stakeholder interviews and focus groups. The experts from the Walsh Center on Rural Health Analysis presented promising approaches to improving rural health from other parts of the country. MHCC staff briefed the Workgroup on plans for the public hearings

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<sup>2</sup> [http://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups\\_rural\\_health.aspx](http://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_rural_health.aspx)

scheduled for the late spring. Workgroup members offered suggestions on the scope and framework for the hearings.

On May 24, 2017 a Workgroup meeting was held at Washington College in Chestertown, MD. The Advisory groups began to report their preliminary findings. Workgroup members discussed the need to increase the coordination of care for patients and provide for a single point of entry to the healthcare system. This discussion later evolved into one of the key recommendations of the Workgroup, establishing a Rural Community Health Complex program.

The sixth meeting of the Workgroup was held on July 25, 2017 at Chesapeake College in Wye Mills, MD. MHCC staff presented the findings from the public hearings and final recommendations from the advisory groups were discussed. Preliminary workgroup recommendations were developed. These recommendations were finalized at the seventh, and last, meeting of the Workgroup which was held on September 28, 2017 in Annapolis, MD.

At each meeting a facilitator was presented to assist guiding any Workgroup discussion. All meetings were open to the public and at least fifteen minutes at the end of each meeting were allotted to public comment. Materials for each of these meetings, as well as meeting notes, can be found on the Maryland Health Care Commission's website Workgroup website.<sup>3</sup>

## **Public Hearings**

The Workgroup was mandated to hold public hearings in all five study counties to gather information and to clarify needs. One public hearing was held in each of the five study counties between May 24<sup>th</sup> and June 13<sup>th</sup> in 2017. All of the public hearings were held in the evening hours at a location within the community that was selected by the county Health Departments' staff members. The hearings were publicized in local newspapers, on social media, in local libraries, and in retail stores. Residents were given the opportunity to comment on issues related to health and healthcare delivery in their communities. Individuals were also given the opportunity to write or email the MHCC with their comments for several weeks following each public hearing. At least one of the Workgroup's chairs and several Workgroup members and the research team attended each meeting. MHCC staff provided overviews of the Workgroup's charge, described the importance of the public meetings, and coordinated the discussions.

Discussions were lively at all of the public hearings. Attendance varied from over 100 residents in Kent County to roughly 20 residents in Dorchester County.<sup>4</sup> Residents shared their perceived ideas of the strengths and weaknesses of the current healthcare delivery system. Generally speaking, residents in the Mid-Shore region recognize that healthcare

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<sup>3</sup> [http://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups\\_rural\\_health.aspx](http://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_rural_health.aspx)

<sup>4</sup> The public hearing in Dorchester County was held in Hurlock, MD because sites in Cambridge were not available and Shore Health was simultaneously providing overviews of their plans for Dorchester General.



systems need to accommodate culturally diverse populations and the growing number of vulnerable residents, including elders with chronic health conditions. The residents also feel that in order to improve the healthcare delivery system, recommendations must address social determinants of health. Residents support an integrated care delivery system across a continuum of care with services as close to home as possible.

## **Workgroup Recommendations**

The Workgroup considered information gathered through the advisory group process, the public hearing process, the study, and at each Workgroup meeting when formulating final recommendations. The goals of each of the recommendations can be broadly placed into three categories. Each of these recommendations promote policies that:

- foster collaboration and build coalitions in rural areas to serve rural communities;
- bring care as close to the patient as possible to improve access; and
- foster participation in statewide models and programs in rural Maryland.

The Workgroup suggests that these recommendations be implemented in stages and that progress toward population health improvement be evaluated regularly. The Rural Healthcare Delivery Workgroup recommends that the State:

### **Establish and Support the Rural Community Health Complex Program**

The Rural Community Health Complex Program serves as the focal point for redesigning healthcare 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 to ensure less duplication, for overall lower costs.
- 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 other healthcare practitioner. The office is a stand-alone physical location and, in some instances, may be co-located in a nursing home, emergency medical services (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, including limited open access (walk-in) scheduling and some non-standard visits, such as group visits for managing some chronic conditions. The ECC could also act as the anchor for other initiatives planned by the Workgroup, including mobile integrated healthcare 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 would 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 Federally Quality Health Center (FQHC) sites are already delivering almost the entire range of services envisioned at these sites.
2. An 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 the Maryland Institute for Emergency Medical Services Systems (MIEMSS.) One advanced ambulatory care clinic (AACC) site in Queenstown now exists, although services may need to be expanded. Another AACC has been proposed in Cambridge, Maryland.
3. A Special Rural Community Hospital (SRCH) would be a small rural hospital consisting of an emergency department, an observation unit, which has the capacity to provide inpatient and outpatient surgeries, and would provide inpatient care. The SRCH would possess significant telehealth capability to support telehealth assessments and consults with patients outside of 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 of hospital services 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 on the Eastern Shore, a better measure could be travel time. 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. To qualify, the hospital must specify concrete goals and its plans for implementing those goals. The plans could include initiatives for improving the quality of care and establishing expanded access to advanced primary care, thereby decreasing the number of avoidable admissions, readmissions, and transfers. Any special designation should include sustainable funding and should be linked to measureable outcomes and milestones.

Specialists, dentists, and behavioral health providers, along with hospice and palliative care providers, should be encouraged to partner or co-locate at the complex's site 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.

A Rural Community Health Complex Program would have a systems planning and management council, would be composed of representatives of hospitals, practices participating at the sites, local health departments, emergency medical services, and consumers. The State's higher education centers may be a useful model for the structure and functions of this council in the healthcare context.

The technology infrastructure will support coordination among healthcare 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 electronic health records (EHRs), EHR patient portals, services currently available through the Chesapeake Regional Information System for our Patients (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 physicians to track patient care and access and refer to specialists through their system. 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 Maryland's Phase II Total Cost of Care (TCoC) Model (the State of Maryland's agreement with CMS for hospital rate setting in Maryland.) The State should consider providing sufficient funding to establish the Rural Community Health Program in the Mid-Shore area. All support should be linked to measureable establishment, process, and outcome milestones. The Workgroup emphasizes that the proposed Complex must make measureable improvements in the health status of the patients in the communities in which they operate. Simply establishing funding levels and program objectives will not be sufficient to drive improvements.

### **Establish and Support a Rural Health Collaborative**

The Workgroup recommends that a Rural Health Collaborative (RHC) organization be designated as a 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. The existing Local Health Improvement Coalitions (LHICs) for rural counties may offer a suitable organizational foundation for the Rural Health Collaborative; however, there must be a critical mass of community voices heard, including patients and providers, in the planning and development of the organization. The Mid Shore LHIC is especially credible as it already includes the five Mid-Shore counties and many of its stakeholders 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, including 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 healthcare organizations' collaborations in sharing services and staff across jurisdictional lines for economies of scale.
- Integrate the work of the local organizations into broader regional initiatives.

This Rural Health Collaborative will have a Director who will 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 contractual 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 healthcare providers to develop the full range of sites within the region. A Rural Health Collaborative will not compel a healthcare provider to establish a service, but it will be able to provide guidance on where services may be needed.

Community voices are essential to a well-functioning healthcare delivery system. The RHC 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 healthcare providers when planning population health improvement initiatives.

The Rural Community Health Complex Program begins as an experimental program in the Mid-Shore region. If the Program meets performance milestones, the Workgroup envisions that a 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 the 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 as the RHC function. All existing organizational structures should be considered as each region considers establishing a new entity.

The Workgroup considers the recommendations that follow to be essential for the development of the program. Each recommendation represents an important building block for the operational structure 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 members believe that implementing one or several recommendations alone will not produce the proportional benefits associated with a more limited investment.

## **Supportive recommendations**

### Expand the Healthcare Workforce

1. *Create and extend tax credits, loan, or grant opportunities for providers to practice in rural communities.* The Maryland 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 Health Enterprise Zone (HEZ) personal tax credit, HEZ hiring tax credits, tax credits for those providers who are near retirement and who move to rural communities, and State backed small business loans for practitioners to establish a practice in a rural community. The Maryland 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 to create the opportunity for longitudinal mentorship and clinical experiences with their mentors 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 choose to practice in rural areas. Residency programs in rural areas may expose residents to the benefits and challenges of practicing in these regions and prepare residents to practice rural primary care medicine. Residency programs may align with either a rural hospital or private practice. Federally Qualified Health

Centers (FQHCs) 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. Making any Graduate Medical Education (GME) funding available through enhanced hospitals rates could challenge the Global Budget Revenue limits agreed to under the State's current agreement with CMS for the All Payer Model and Total Cost of Care Model (TCoC) beginning in 2019.

*Establish a rural specialty care residency rotation.* The inability to recruit general surgeons, obstetricians, anesthesiologists and certain other specialists is an important contributor 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. Often, these are the exact experiences that medical students seek in residency programs. However, limiting the training settings 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 the 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 those of 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 the Accreditation Council for Graduate Medical Education (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. As noted above, making any GME funding available through enhanced hospital rates could challenge the Global Budget Revenue limits agreed to under the current All Payer Model and future Total Cost of Care Model (TCoC) beginning in 2019. Testing the principle of allowing funding to follow the resident could be an additional benefit of this recommendation.

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 three 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 federally designated Health Professional Shortage Areas (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 the cultural competency of the members of the community.
5. *Establish a rural scholarship program for medical students and other healthcare professionals willing to practice in rural Maryland.* The Maryland General Assembly should establish a rural scholarship for medical, dental, behavioral, and other healthcare 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 students 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 main goal of these workforce initiatives should be increasing the availability of primary care. Specialty care is also important and the loss of direct access to specialists is often the first stage in a broader decline in access to care for residents in rural areas. Scholarships for specialists should be targeted toward obstetricians and general surgeons. 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;

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.

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 through the use of non-physician practitioners such as nurse practitioners (NPs) and physician assistants (PAs). 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 healthcare costs and better health outcomes. Programs should actively recruit individuals from rural areas for entry into the program. The federal Health Resources and Services Administration's (HRSA's) Advanced Education Nursing Traineeship Program 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 patients, coordinate their care, and help remove barriers to accessing timely services.

#### Expand Transportation/Access to Care

1. *Establish a Special Rural Community Hospital (SRCH).* This would be a small rural hospital consisting of an emergency department, an observation unit, and the capacity to provide inpatient and outpatient surgeries as well as inpatient care. The SRCH would possess significant telehealth capability to support telehealth consults and assessments with patients outside of 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. Although 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 this state. In Maryland, particularly on the Eastern Shore, a better measure could be travel time. The program should be established under the Maryland Health Services Cost Review Commission's (HSCRC's) broad authority to establish reasonable reimbursement for Maryland hospitals, or through a legislative mandate to create such a program.<sup>10</sup> To qualify, the hospital must specify concrete goals and its plans for implementing those goals. The plans could include initiatives for improving the quality of care and establishing expanded access to advanced primary care, thereby decreasing the number of avoidable



admissions, readmissions, and transfers. Any special designation should include sustainable funding and should be linked to measureable outcomes and milestones.

2. *Enhance dental health services to rural residents.* Create opportunities for dental and dental hygiene students to participate in an elective during their clinical training for a rural health rotation. Access to dental care is limited due to the size of the available workforce and availability of dental insurance coverage for vulnerable populations. Where possible, dental care should be integrated with primary care and with services for populations with chronic conditions. The approach used by the Choptank Community Health System is an example of successful integration of dental services with primary care.
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 projects to scale 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 that is consistent with the recommendations in the Maryland Telemedicine Task Force Report from 2014.
  - Direct the MHCC to develop methodologies for identifying provider practices and healthcare organizations that are suitable for using telehealth services 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 emergency medical technicians (EMTs), paramedics, mid-level healthcare professionals, or community health workers into the homes of patients can help with chronic disease management and education, as well as post-hospital discharge follow-up, to prevent hospital admissions or readmissions, and to improve patients’ experience of care. These healthcare workers can help patients navigate to destinations such as primary care, urgent care, dental care, mental health care services, or substance abuse treatment centers, instead of emergency departments, thus avoiding costly, unnecessary hospital visits. While the Workgroup members are very supportive of these programs, sustainable funding is a concern. At its last meeting, the Workgroup briefly discussed the need for EMS providers to be recognized as healthcare providers. Currently, EMS providers are reimbursed for the transportation, but not the healthcare services provided. If EMS providers could bill for health care services the sustainability concerns for the MICH programs could be resolved. Payers may have other concerns and this stakeholder group was not represented on the Workgroup. MHCC's Provider Payer workgroup or another broadly representative workgroup that includes payers should be convened to discuss options for funding MICH including allowing EMS to bill for health care services, EMS's participation in payers' networks, and other operational questions.

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 a transportation service, or promoting the use of ride sharing technology.
  - b. The Maryland Department of Health, in consultation with the Maryland Department 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 governments would benefit from this standardization. Regulatory and or statutory changes may be necessary.

#### Fund Economic Development

1. *Charge the Maryland Community Health Resources Commission (CHRC) with incubating pilot projects in rural communities to support of the Rural Community Health Complex Program.* The Workgroup believes that the CHRC could be an important incubator for local initiatives in the Rural Health Complex Demonstration. CHRC's past experience in funding similar efforts makes that organization uniquely qualified to assess and fund proposals that would be valuable to establishing these proposed Complexes. The Workgroup encourages the CHRC to commit a significant share of its funds to the establishment of the Mid-Shore Rural Health Complex. To serve as this key incubator, CHRC will need adequate funds and staff to support initiatives, both across the State and the proposed efforts in the Mid-Shore region. CHRC's current and historic funding levels should be reviewed to ensure that the Commission is well positioned to meet the goals of the demonstration without crowding out other priorities.
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 federal Area Health Education Centers (AHECs.)* Community health workers are frontline public health professionals who are also trusted members in their communities and have an unusually clear understanding of the communities they serve. During its 2014 legislative session the Maryland General Assembly established the Workgroup on Workforce Development for Community Health Workers. That workgroup delivered its recommendations in June of 2015. Stakeholders should be brought back together to revisit the recommendations of the Workgroup on Workforce Development for Community Health Workers.

## Link the Model to Broader Population Health Initiatives

### *Vulnerable Populations*

- *Enhance Behavioral Health and Substance Abuse Services in the Community.* Enhancement of behavioral health services in the community through mobile integrated healthcare, telehealth, and Assertive Community Treatment (ACT) Teams can reduce mental illness, improve the well-being of residents in rural communities, and lower the total costs of care by eliminating costly emergency and hospital care. Healthcare organizations should be encouraged to break down the invisible and very real stigma associated with behavioral health conditions by establishing education programs for their staffs. Existing infrastructure and programs that are working, but underfunded, should be favored before new programs are launched.
- *Address health needs of the immigrant 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 healthcare services due to:
  - Lack of transportation;
  - Inability to pay for services;
  - Poor health literacy;
  - Lack of culturally competent healthcare professionals;
  - Complex paperwork to gain access to services;
  - Immigration status and the need for having documentation in order to get services; and
  - Limited English proficiency and the lack of translation services.

In order to improve the health status of vulnerable populations in rural areas and to address the concerns of these populations:

- Expand and strengthen the safety net infrastructure;
- Provide access to preventive care and health education;
- Increase the use of patient navigators and care managers; and
- Encourage the development of programs to increase culturally and Linguistically Appropriate Services (CLAS).

## Conclusion

The formation of the Rural Health Workgroup and the commissioning of the rural health study demonstrate both the Governor's and the General Assembly's commitment to the health of rural Maryland. The Workgroup's recommendations are but the first step in the effort to improving access to healthcare in rural areas.

Among the most important of the Workgroup's guiding principles are the commitments to empower Mid-Shore residents to be active participants in their health decisions and to join together to build a healthcare system in which all residents, regardless of their place residence, have access to appropriate and high quality care. These key principles are anchored in many of the Workgroup's recommendations. They are most visible in the two foundational recommendations: the creation of a rural health collaborative and the formation of health care complexes.

In Workgroup meetings, in focus groups, and at public hearings, the two most commonly voiced requests were to involve communities earlier and more directly in the design of their healthcare and to enable residents to have a point of contact with the healthcare system in their own community. For many communities, that will mean access to robust primary care services, in other larger communities, that will mean access to a broader array of services. In every instance, there is also recognition by the Workgroup members that some acute care services would be best accessed at a tertiary, or quaternary, medical center. The Workgroup members recognize the need for collaboration and coalition building in small communities. Solutions need to take into account the ability of the local community residents to recognize their own needs.

The Workgroup members discussed the possibility that all recommendations could not be achieved at once. Recommendations build on each other and may be implemented in several stages. Establishing a foundation for further collaboration and coalition formation is key to the success of these endeavors. Providing a framework for the establishment of the rural collaborative is an essential step for launching further reform. Maryland's five county Mid-Shore area is fortunate to have a well-established local health improvement coalition—or LHIC—which should provide the initial infrastructure for the rural collaborative. In 2018, the Maryland General Assembly could act by designating the Mid-Shore LHIC as the region's rural collaborative. A limited amount of funding will be needed and that funding could be obtained through the CHRC or another funding source.

A second broad need requiring immediate attention is expanding the health care workforce. The Workgroup members emphasize that the workforce deficits have developed over many years and that a single program alone is unlikely to have significant impact. Many of the recommendations of the Workgroup cannot be achieved without an expanded workforce.

Addressing these workforce deficits in order to improve access to care and enable rural communities to participate in the health delivery reforms envisioned under the TCoC Demonstration will require multiple programs. Some of the Workforce recommendations require immediate action but can be launched under current law. Others require the

collaboration of health systems. The Workgroup members hope that other workforce recommendations that require statutory changes will have broad support in the General Assembly.

In order to fully realize the goals of these recommendations, it is imperative that both the State and local communities commit to improving access and quality of care. Though rural communities across the State are similar in some of their deficiencies, such as lack of public transportation options, limited resources, and workforce shortages, each community is unique. Any solution needs to be flexible and take into account each unique community's attributes. Local government representatives and interested community members should have seats at the table when formulating the Rural Community Complex and the Rural Health Collaborative.

As State policymakers consider the next steps in moving forward, the importance of gathering information and documenting success will be important. The Workgroup members recognize the significant budget challenge associated with any initiative. Although the Workgroup members believe the investments in rural health will yield significant dividends, there are benefits to launching new programs on a pilot test basis, followed by conducting research to learn from the pilot test. When a test program yields no benefits, the State policymakers should not hesitate to modify or eliminate the program in the test phase. If the pilot yields meaningful results, successful interventions should also be tested in non-rural settings because many problems in rural communities have parallels in suburban and urban communities. If we adopt a framework for demanding evidence of success, Maryland will go a long way toward ensuring that new programs resulting from these recommendations have real impact on people's lives. As SB 707 intended, the Mid-Shore can serve as the important "test ground" for rural health improvement and, perhaps, for health improvements across Maryland.