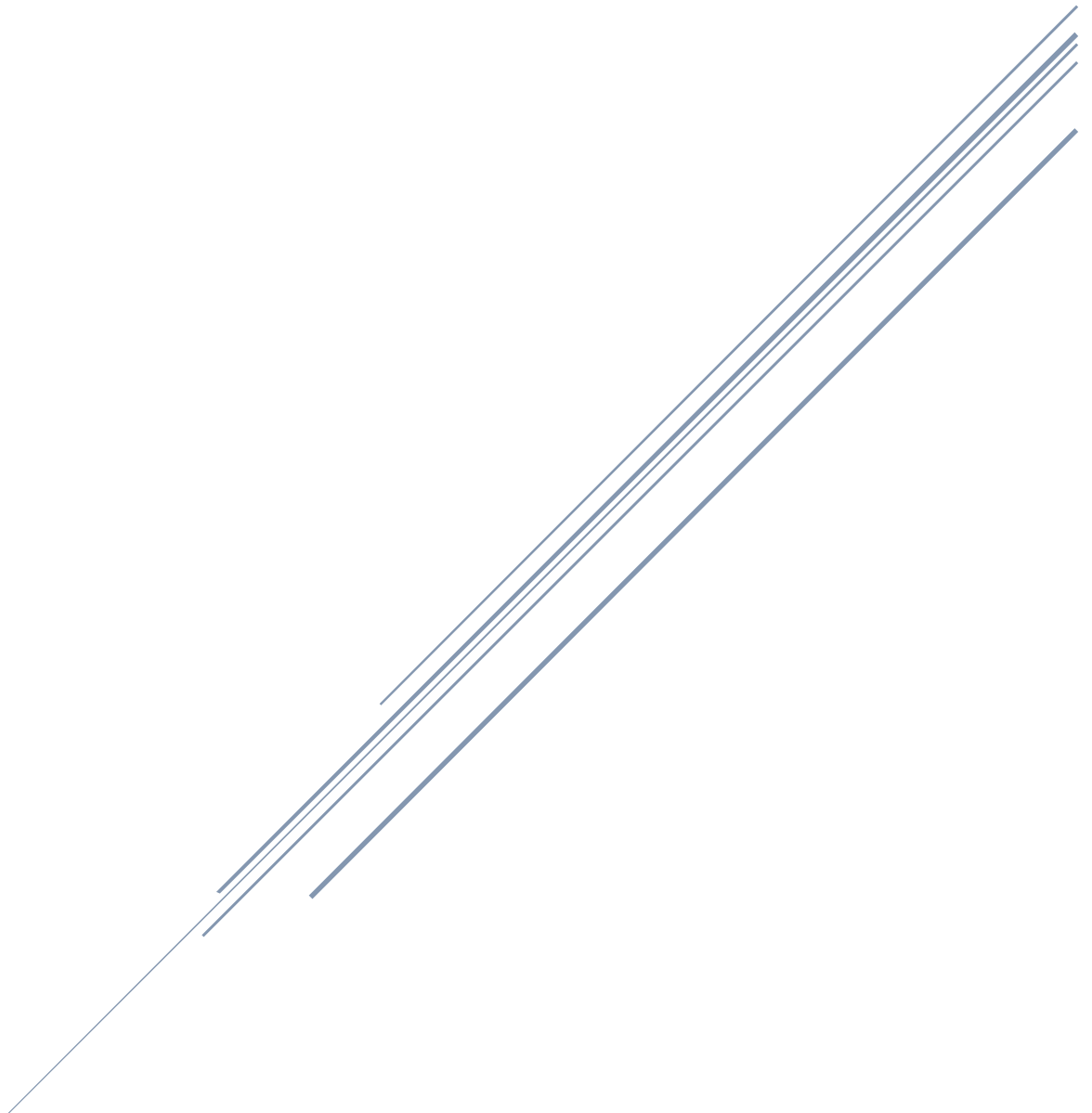


MID-SHORE RURAL HEALTH COLLABORATIVE

Interim Report



August 2019

INTRODUCTION

This interim report provides background about the Mid-Shore Rural Health Collaborative (RHC), summarizes progress during the RHC's first year of operation, and discusses potential next steps for year two.

BACKGROUND

Senate Bill 1056, effective July 1, 2018, established the Rural Health Collaborative Pilot for Maryland's Mid-Shore Region (Caroline County, Dorchester County, Kent County, Queen Anne's County, and Talbot County). The purpose of the RHC is to develop and direct the establishment of a Rural Health Complex (or multiple Complexes) to better coordinate and integrate delivery of clinical services and social services. On or before December 1, 2020, the RHC is to determine "standards and criteria that a community must meet to establish a Rural Health Complex."

YEAR ONE ACTIVITIES AND ACTIONS

Overview

Members of the RHC were selected in late 2018 and appointed by the Secretary of Health in early 2019. Five meetings of the full RHC have been held. Topics addressed during each meeting included:

- Meeting 1 – September 24, 2018
 - Background on Senate Bill 1056
 - Purpose of the RHC
 - Organization and administrative aspects of the RHC
 - Discussion of potential workgroups
- Meeting 2 – December 5, 2018
 - Maryland's Total Cost of Care (TCOC) waiver
 - Review and approval of RHC bylaws
 - Process for establishing a Rural Health Model
- Meeting 3 – February 6, 2019
 - Transportation issues and strategies impacting access to care
 - Opportunities for Care Transformation Organizations (CTOs) to impact the goals of the RHC
 - Discussion of Community Health Resources Commission proposal
- Meeting 4 – April 8, 2019
 - Results of RHC Survey of members to identify concepts for the Rural Health Model
 - Determination of priority concepts for inclusion in the Rural Health Model
 - Update from the Improving Rural Public Transportation Workgroup
 - Update from the Integration of Clinical and Social Support Services Workgroup
- Meeting 5 – June 13, 2019
 - Year in review and planning for year two
 - Research related to priority concepts for the Rural Health Model
 - Discussion of what's needed in each county for the Rural Health Model to be successful
 - Potential pilot working with CTOs to help coordinate and integrate clinical services and social services within and across counties

Meeting minutes, slide presentations, and related documents can be found on the RHC website, <https://health.maryland.gov/mcrhc/Pages/home.aspx>.

During year one, the RHC also:

- Hired executive director staff from the Public Health Foundation (<http://www.phf.org>)
- Elected officers and convened the RHC Executive Committee
- Developed and adopted bylaws
- Defined priority concepts for the Rural Health Model
- Established two ongoing workgroups:
 - Integrating Clinical and Social Support Services Workgroup
 - Improving Rural Public Transportation Workgroup

Actions of the two workgroups included:

- Integrating Clinical and Social Support Services Workgroup
 - Charge established
 - Recommendations developed:
 - Hub concept – resource list and method to keep updated
 - Mapping of referral flow in each county
 - Interagency councils for resolving problems in service delivery
 - Feedback on how coordination is working
 - Communication strategies across clinical and social services
 - Co-locate services, where feasible
 - Transportation suggestions
- Improving Rural Public Transportation Workgroup
 - Charge established
 - Explored rural transportation models
 - Identifying financing opportunities
 - Prioritizing models and financing opportunities
 - Developing recommendations

Refining RHC Charge

Based on Senate Bill 1056 and discussions with the Maryland Department of Health, the RHC charge is to:

- Design a Rural Health Model that: 1) improves access and delivery of services; 2) is scalable to other counties; and 3) aligns with Maryland’s TCOC waiver.
- Select a site for a pilot Rural Health Complex.

“*Rural Health Complex*” was not defined in the legislation. Therefore, the RHC suggested that the Rural Health Complex be defined as the collocation of services where possible to improve coordination and integration of clinical services and social services, and provide easier access to these services for members of the community. The Rural Health Complex can be virtual and/or physical.

Determining Priority Concepts for Rural Health Model

The RHC has determined six priority concepts for the Rural Health Model:

- Establish community hubs (one point of entry for individuals) for coordination of clinical and social services to improve outcomes (decrease cost, prevent complications, and reduce hospital admissions)
- Establish partnerships with EMS to help residents find appropriate clinical and social services for high users of 911 for non-emergencies
- Coordinate clinical services and/or with social services for patients being discharged from an inpatient setting
- Coordinate all clinical and social services at the medical home – includes behavioral health and dental health
- Establish fixed bus routes to health and social services hubs (e.g., County Ride)
- Work with third-party payers (e.g., Aetna) to provide and/or subsidize transportation

These six concepts have been discussed as part of the infrastructure of the Rural Health Model, which could serve to help a community focus on the critical needs for improving access and delivery of clinical services and social services, and ultimately, health outcomes. Each of these priority concepts will likely be addressed differently within and across counties, both in the Mid-Shore Region and in other rural areas in Maryland. The way these concepts are addressed will depend on specific community needs, existing relationships and resources, and the level of commitment of partners.

Issues and Challenges That May Impact Implementation of Rural Health Model

1. The TCOC waiver emphasizes comprehensive primary care as a means for improving health care outcomes and invests in this concept by establishing CTOs to provide technical assistance and care managers.
 - The intent is good, but this will not increase the capacity of the primary care providers (PCPs) and could decrease capacity should primary care providers adhere to best practices for care management.
 - Care management will help PCPs, but in the first few months, care managers are providing little to no attention to patients the PCPs are referring unless those beneficiaries are already on the list given to them by their CTO.
 - The ratio of care managers to beneficiaries (1:2,000 and maybe 1:1,000) is not realistic for the improvement sought. .
 - PCPs have incentives for improving the outcomes of care in patients with certain conditions, but PCPs also risk decreased income from a decreased number of patients served per day if they adhere to best practices in care management. Only time will tell if the incentives are great enough to cover the loss in volume of visits.
 - It is not clear how much technical assistance will be utilized by PCPs. It also is to be determined how behavioral health professionals and pharmacists within CTOs can help in improving outcomes without good care management on the front line.
2. Some changes in the operation of clinical practices have been noted to benefit access to services and health outcomes.
 - Telephone visits are now billable and may greatly benefit many seniors with limited mobility and lack of transportation.

- Using nurse practitioners to make home visits may eliminate the need for non-emergency ambulance transport for an office visit.
 - The ability to get a timely urgent appointment with a PCP may be problematic due to limited PCP capacity.
 - Access to after hours and weekend clinics for urgent but non-emergency conditions; some hospitals are establishing clinics for their networks of providers and patients to offer acute care during normal business hours when a PCP cannot provide it, after hours appointments until midnight, and weekend urgent care.
 - Training nurses to be nurse practitioners and using more of them in office settings can increase PCP capacity, as well as using RNs to the top of their scope of practice.
3. Some changes in delivery of social services may require funding while others might not.
- Many counties have registries for resources, but most are not updated in a timely fashion and often do not contain religious institution and charitable resources because this information is not always readily available. The Maryland Access Point is charged with having a list of resources for senior clients, and this too is often not updated in a timely manner. It will take effort on the part of all service providers to keep a resource registry updated.
 - Community health nurses with Local Health Departments could work with PCPs for prevention and chronic disease management of low income clients with access challenges. Unfortunately, few counties have funds to support this type of activity.
 - Social service providers might consider flex time to have operating hours at least one day per week extended to 6:00 PM or 8:00 PM for the convenience of working clients.
 - Because space for each agency is usually scarce, co-locating social service providers for better integration of care for Medicare beneficiaries (ex. Queen Anne’s County) often takes long-term planning to arrange. This will greatly depend upon both the public and private partners’ commitment to the concept.
4. Coordinating and integrating clinical services and social services can be complex.
- A “medical home” can be created with the hope of better care management of clinical services including behavioral health services.
 - Social services are to be coordinated with clinical services (TCOC waiver states this is to occur by the third year).
 - Currently, social services are not always well-integrated in many communities.
 - Social services may be located in different agencies in different counties (Senior Care may be in the Local Health Department, Area Agency on Aging, Department of Social Services, or other agency).
 - The sole provider of a critical service may lose staff and not be able to operate in the manner intended for a period of time. Replacement can take six to 12 months due to difficult recruiting in rural areas and slowness of the State system for hiring new employees. For example: 1) if an Adult Evaluation and Review Services (AERS) assessment is needed and the Local Health Department cannot complete this in a timely manner, the clients may not receive the services needed; 2) if the Area Agency on Aging is not serving as the single point of entry (Maryland Access Point) and not providing screening, options for counselling, and referrals, seniors often do not find the services they need. If one organization or agency does not have the

service needed, staff may not consistently help clients find the services needed, help with transportation needs, or follow-up with clients to see that they complete a referral.

- Many social services and resources are not available in government agencies and may or may not be provided by county governments, non-profit organizations, religious institutions, or through donations. The availability of these resources often varies. For some clients, there is no available resource to meet their needs.
 - Knowing where resources are available is a challenge for social service providers. Some hospitals and PCPs serve clients in multiple counties, and this increases their challenge of knowing how to link with social services.
 - There is no “social home” where one entity is charged with coordinating or integrating the social services needed by one client.
 - PCPs, CTO representatives, and hospitals in the Mid-Shore Region have asked for one number to call to link patients with social services. Integration of services and filling gaps is more difficult on a regional level than on a single county level.
5. Adequate public transportation services for low income residents to access clinical services and social services are needed to achieve better health outcomes.
- The utilization of public transportation in rural areas is usually not sufficient to allow multiple routes to be financially feasible.
 - A trip may involve early morning departure and late afternoon arrival back at the individual’s starting point. Many fragile seniors with mobility problems find this exhausting.
 - Using volunteer companion riders for some fragile riders has been beneficial in improving these individual’s comfort level in using public transportation.
 - Medicare recipients do not have coverage for transportation like Medicaid beneficiaries do.
 - Some counties have volunteers that transport individuals, but recognize that coordinating trips and the potential liability for drivers are problems. Finding volunteers also can be difficult along with sustaining an active volunteer network.
 - Insurance companies like Aetna have demonstrated value in payers supporting rural transportation solutions.
 - Hospitals have demonstrated value in supporting transportation for some patients.
 - Donations and senior care funds have been used for short taxi rides, but this approach is not financially feasible to resolve all transportation needs.

NEXT STEPS FOR YEAR TWO

During year two, the RHC will focus on refining recommendations and determining standards and criteria for establishing a Rural Health Complex. Activities will include:

- Finalize recommendations
- Determine components of a Rural Health Model/Complex
 - Site(s)
 - Virtual or Physical
 - Colocation
 - Other

- Explore piloting a Rural Health Model/Complex
- Explore with counties what is in place to support successful implementation of the Rural Health Model/Complex
- Draft report for the Secretary of health and Governor

Mid-Shore Rural Health Collaborative Executive Staff:

Ron Bialek, President, Public Health Foundation, rbialek@phf.org

Kathleen Amos, Assistant Director, Academic/Practice Linkages, kamos@phf.org