Rural Health Collaborative Meeting Minutes
April 8, 2019
Time: 5:00pm to 8:00pm
Location: Queen Anne's County Health Department, 206 N. Commerce St., Centreville, MD, 21617, 2nd floor conference room

The following Rural Health Collaborative (RHC) members were in attendance:

Victoria Bayless, MHSA
Mary Bourbon
Childlene Brooks
Joseph Ciotola, MD
Katelin Haley, DO
Beth Anne Langrell, MS
Scott LeRoy, MPH
Maria Maguire, MD, MPP, FAAP
Maura Manley, MBA
Shelly Neal-Edwards, MSW
Sara Rich, MPA (by phone)
Timothy Shanahan, DO
Anna Sierra, MS, EMT
Lorelly Solano, PhD
Mary Thompson
Fredia Wadley, MD
William Webb, MS

Also in attendance: Lindsey Snyder, Esq., Assistant Attorney General, Maryland Department of Health (MDH); Ron Bialek, MPP, Executive Director, RHC, and President, Public Health Foundation (PHF); Kathleen Amos, MLIS, Assistant Director, Academic/Practice Linkages, PHF; Elizabeth Slye, Intern, PHF; Judith Gaston, RN, MS, Eastern Shore Oral Health Education and Outreach Program Coordinator, Office of Oral Health, MDH; Amy Travers, Senior Practice Manager, Anne Arundel Medical Center; Kat Varga

Welcome, Introductions, and Review of Agenda
Fredia Wadley, MD, Talbot County Health Officer

Meeting was called to order at 5:11pm by RHC President Fredia Wadley, MD. Dr. Wadley thanked everyone for attending, welcomed everyone to the meeting, and reviewed the agenda for the meeting.

Review and Approval of February 6, 2019 Meeting Minutes
Fredia Wadley, MD, Talbot County Health Officer

Dr. Wadley requested any comments on the draft minutes for the February 6, 2019 meeting. No additions or corrections were provided. Joseph Ciotola, MD, made a motion to approve the minutes. Childlene Brooks seconded the motion. The RHC unanimously approved the minutes.

Results of Rural Health Collaborative Survey and Prioritization Activity
Ron Bialek, MPP, RHC Executive Director

RHC Executive Director Ron Bialek, MPP, shared the results of the survey conducted prior to the meeting to identify potential components to consider for a rural health model. The top 12 actions/concepts selected by survey respondents were presented, as were write-in responses to the survey and additional information provided to the RHC through the survey. Several write-in responses related to behavioral health and coordination and collaboration, and additional information provided focused on healthcare

workforce challenges and sharing information and taking action. The complete list of actions/concepts is included in the attached *Prioritizing Concepts for Developing a Rural Health Model* document and presentation slides.

Topics discussed by the RHC included community health worker training, activities, and legislation in Maryland; care transformation organizations (CTOs) serving the Eastern Shore; interpreter services; healthcare funding, community benefit funds, and reimbursement; and the role of the RHC. Mr. Bialek invited RHC members to send other suggestions of additional information needed for the RHC to be effective to PHF.

RHC members engaged in a prioritization process to determine priority concepts for the rural health model. Concepts prioritized include:

- 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/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

RHC members discussed the concepts prioritized, including whether a community hub would be physical or virtual; the need to be clear about how clinical services and social services are defined; comfort levels with technology and the need to make sure that services are accessible and functional for different populations; limited Internet access; and community organizations and resources, including Maryland Access Point, the Chesapeake Multicultural Resource Center, health departments, United Way, 211, the Mid-Shore Community Foundation, and Local Management Boards.

Updates on Workgroup Progress

A. Improving Rural Public Transportation Workgroup
Scott LeRoy, MPH, Caroline County Health Officer

RHC Improving Rural Public Transportation Workgroup (Transportation Workgroup) Co-Chair Scott LeRoy, MPH, provided an update on the Transportation Workgroup, including workgroup members, topics discussed, and aims. Examples of topics the workgroup has discussed include flexible transportation routes, coordinating services, bringing services to people rather than people to services, delivery of prescription medication, and driver recruitment opportunities.

RHC members discussed financial aspects of transportation services and prescription delivery services.

Participation in RHC workgroups is open to both RHC members and others. Expressions of interest in joining the Transportation Workgroup can be sent to PHF or to the workgroup Co-Chairs, Mr. LeRoy and Roger Harrell, MHA.

B. Integration of Clinical and Social Support Services Workgroup
Fredia Wadley, MD, Talbot County Health Officer

RHC Integration of Clinical and Social Support Services Workgroup (Integration Workgroup) Co-Chair Dr. Wadley provided an update on the Integration Workgroup, including the workgroup charge, members, issues identified, services currently available on the Eastern Shore and opportunities to improve services, suggested actions, and next steps. The workgroup has discussed the current status of integration of primary care services and social services; the current status of social services; the need for a list of resources and challenges with keeping such a list updated; the desire for a single regional contact point for services; the need to better connect social services with primary care; gaps in services; the flow for services; opportunities to improve social services integration, primary care access and delivery, and transportation services; a hub to help clinical and social service providers connect people to services; and potential actions for social services, primary care providers, and the hub. Presentation slides are attached.

RHC members discussed the aims of this effort, the need for multiple strategies as no one strategy will address all needs, using the Mobile Integrated Community Health program and the hub in tandem to identify needs and connect people to services, management of patient care over time, the fact that many services on the Eastern Shore are regional and cut across counties, shortage of primary care providers, and the Maryland Primary Care Program and federally qualified health centers.

Other Business
Fredia Wadley, MD, Talbot County Health Officer

Dr. Wadley asked if there was other business to address. No other business was provided.

Wrap-Up and Next Steps
Fredia Wadley, MD, Talbot County Health Officer

Dr. Wadley reminded RHC members that the next RHC meeting will be on June 13, 2019.

Meeting was adjourned at 7:27pm.

Prioritizing Concepts for Developing a Rural Health Model

April 8, 2019

Top 12 Most Popular Concepts

- 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)
- Work with third-party payers (e.g., Aetna) to provide and/or subsidize transportation
- Provide care managers (in addition to what Maryland's Total Cost of Care Waiver is providing) to link clinical and social services
- Utilize community health workers to conduct home visits for high-risk/out-of-care patients
- Establish fixed bus routes to health and social services hubs (e.g., County Ride)
- Coordinate clinical services and/with social services for patients being discharged from an inpatient setting
- Establish partnerships with EMS to help residents find appropriate clinical and social services for high users of 911 for nonemergencies
- Coordinate all clinical and social services at the medical home – includes behavioral health and dental health
- Recruit and provide incentives for physicians, nurse practitioners, and physician assistants (e.g., scholarships, loan repayment, job placement for spouse)
- Increase use of telehealth and/or other technologies that reduce transportation needs
- Establish flexible clinical and social provider hours, enabling individuals to access clinical and social services during “less traditional” hours
- Employ technology (e.g., a searchable website) to better integrate clinical and social services and other services that may help improve health (e.g., housing, access to healthy food)

Write-In Suggestions

- Expand prescribers to include other specialists (e.g., psychologists)
- Work with CTOs to coordinate efforts to address social determinants of health and behavioral health needs
- Consider interdisciplinary teams to coordinate and plan for populations with high risk (e.g., behavioral health needs)
- Increase number of providers secondary insurance will reimburse for behavioral health services
- Increase payment rates for rural providers of behavioral health services
- Centralize the multiple efforts of individual insurance companies (e.g., care coordinator that works with all insurance companies and not just one)
- Increase collaboration between inpatient and outpatient settings to manage transitions of care and reduce readmissions and adverse outcomes
- Consider alternative methods for transportation (e.g., non-County Ride)
- Encourage the development of programs to increase culturally and linguistically appropriate services

Remaining Concepts Included in the Survey

- Co-locate clinical and social services in the same facility/campus
- Co-locate clinical and social services where public transportation is available and a high proportion of the population travels to these locations (e.g., Walmart)
- Develop and sustain community-based health literacy initiatives across sectors to support a more informed and health literate Mid-Shore population
- Increase health care provider clinical rotations within the five counties at clinics, hospitals, and health departments while individuals are in training
- Establish additional nurse practitioner and physician assistant programs at local colleges and universities
- Establish, organize, and manage volunteer pool for filling some transportation gaps
- Foster development of community health worker training programs at community colleges and other settings
- Increase county government investments in transportation
- Rotate specialists periodically on site or via telehealth

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Rural Health Collaborative Survey Results

April 8, 2019

Purpose of the Survey

- Gather input of all RHC members into development of a rural health model to increase access and delivery of clinical and social services that will improve health in the Mid-Shore region
  - Model must align with Maryland's Total Cost of Care Waiver
  - All RHC members' perspectives are important as we develop a model to recommend for piloting

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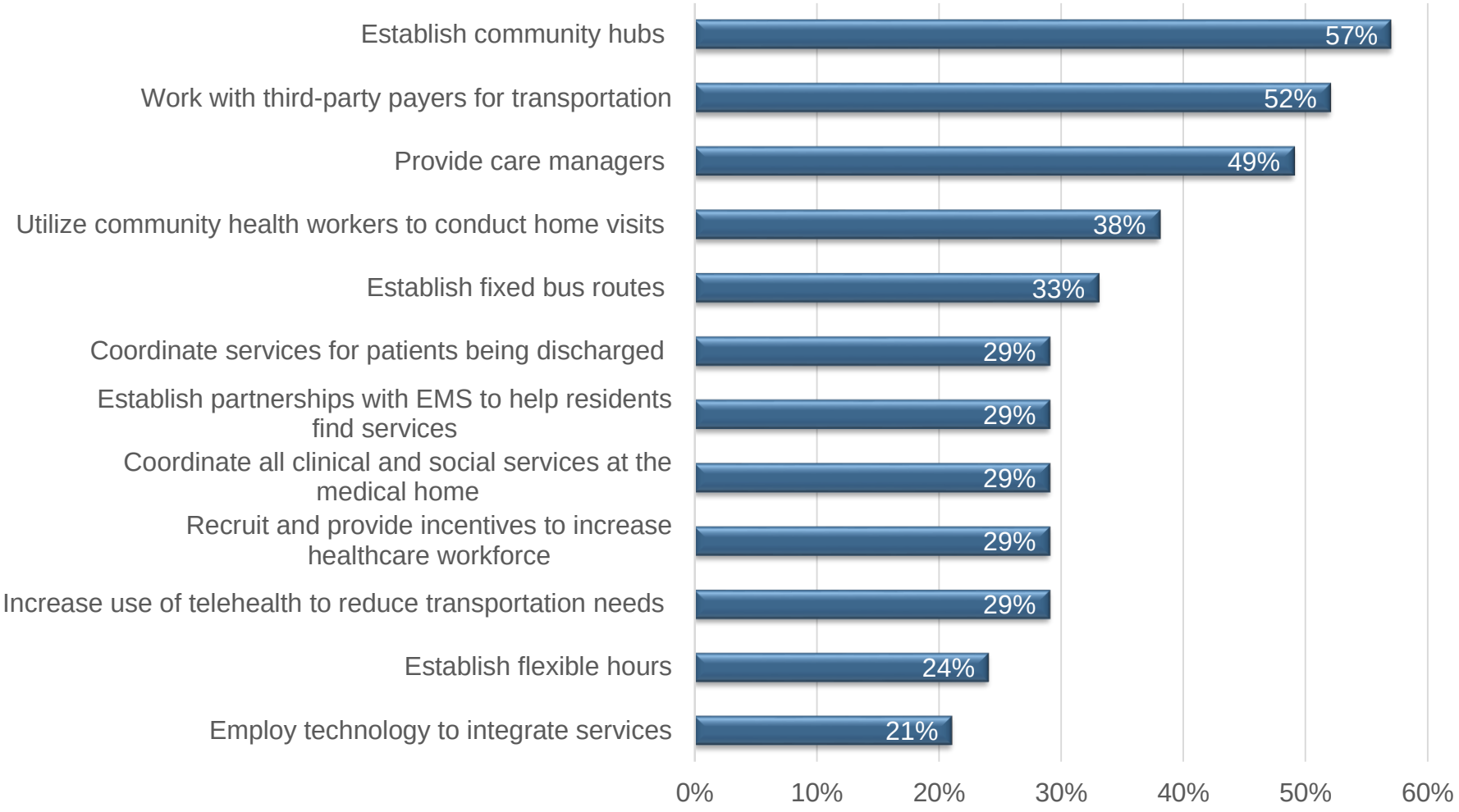
Top 12 Most Popular Concepts

N = 21



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Additional Concepts: Behavioral Health

- Need to expand limited behavioral health services
- Comments:
  - “Expanding the prescribers to include other specialists”
  - “Address social determinants of health and behavioral health needs for patients”
  - “Identify key area of need for integration of services including behavioral health”
  - “Rural health care providers (mental health) are paid at a lesser rate than more suburban/urban areas making recruitment of providers challenging”

Public Health Foundation

Additional Concepts: Coordination and Collaboration

- Need for better coordination of services
- Comments:
  - “Care coordinator that works with all insurance companies”
  - “Work with the relevant CTOs to coordinate efforts to address social determinants of health and behavioral health needs”
  - “Consider interdisciplinary teaming to coordinate and plan for populations with high risk”
  - “Collaboration between the inpatient setting and the outpatient primary care providers…to best manage the transitions of care”

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Additional Concepts: Other

- “Consider alternative methods for transportation in the Mid-Shore…this needs to be a funded, structured program and not reliant on volunteers”

- “If any of our counties [have any non-English speaking demographic group that exceeds 3% of the local population]…encourage the development of programs to increase culturally and linguistically appropriate services”

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Additional Information for the RHC: Healthcare Workforce Challenges

- “The number of qualified applicants for any health care job that requires a licensed or certified individual is lower than needed…this makes providing care here higher per capita than in other urban areas”

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Additional Information for the RHC: Sharing Information and Taking Action

- "Assure through education that all committee members understand the concepts of the single payer system, the funding options, and the goals of the collaborative"
- "It is important to 1) know if the action can be achieved without legislation or state policy changes; and 2) to have knowledge of cost plus level of contribution for resolving needs"
- "More data about available behavioral health providers and services in the area and the insurance coverage for their services"
- "Clayton Christianson's Disruptive Innovations might be explored"

PHF
Public Health Foundation

Questions and Discussion

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Prioritizing Concepts

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RHC INTEGRATION OF SERVICES WORKGROUP

FREDIA WADLEY, MD

APRIL 8, 2019

CHARGE TO WORKGROUP

- Articulating the overarching problem to be addressed
- Identifying the current status of clinical and social support services and the resources supporting those services (including the components being added by the Maryland Total Cost of Care Waiver beginning January 2019)
- Determining the optimal availability and integration of clinical and social support services
- Deciding what is feasible to achieve by 2023 to better integrate clinical and social support services and steps to take to do so
- Recommending actions for improving integration of clinical and social support services

PARTICIPANTS

- RHC members
- Invited all five DSS Directors, Health Officers plus AAA representatives
- Included EMS directors, representatives of public schools, consumer
- Shore Regional Hospital and Anne Arundel Medical Center
- CTO Care Manager

OVERARCHING PROBLEM

- Clinical services are not well integrated
- Clinical and behavioral services are not well integrated
- Social services are not well integrated
- Clinical and social services are even less integrated
- Capacity of providers might be increased with better integration of services
- Access could be improved with better integration of services

CURRENT STATUS OF PRIMARY CARE SERVICES INTEGRATED WITH SOCIAL

- Under Maryland TCOC Waiver,

  PCPs are "medical home" responsible for coordination of services

  Care managers added but only 1 per 2000 beneficiaries – less than expected

- PCPs would like

  1. List of services and eligibility criteria

     A. For persons 60 years and over Maryland Access Point supposedly the point of entry; several felt this did not work in 3 counties

     B. Multiple lists are created, but few are kept updated (MAP, LMB)

     C. Eligibility criteria often complex & not clear through list

  2. One single ***regional*** number to call for complicated cases with multiple needs

CURRENT STATUS OF EXISTING SOCIAL SERVICES

- 3 main social providers (DSS, AAA, and LHD) for Medicare seniors + many non-government services
- Senior Care Services helps provide support when no existing service
- Queen Anne has its own AAA & representatives of all three of above at one site (works well); Dorchester with Lower Shore AAA & no problems
- Kent, Talbot and Caroline have regional AAA; more problems with single point of entry
- One county has lost staff for AERs assessment and this is barrier to services
- No clear "social health" home like "medical home"
- Counties have gaps in services or lack of capacity of services (esp < 60 yrs)

FLOW FOR SERVICES

- Call to MAP concerning services: brief 12 questions screen, options counselling, and referral to appropriate resource
- AERs assessment & Plan at LHD for Medicaid in home supports services:

  A. Eligible – refer to vendor providing services

  B. Not eligible – refer to Senior Care (DSS, AAA, LHD)

  C. Not eligible for either – refer to agency most likely to seek services
- Senior care assessment, plan (less than $2800/month, 60 or older)

  Limited resources and staff seek non governmental resources

HOW TO IMPROVE SOCIAL SERVICES INTEGRATION

- Each county map out services, roles and responsibilities
- Each county have facilitated referral processes
- Group of representatives to oversee and determine if services provided as intended; one entity can be barrier for getting other services; Talbot DSS holds regular meeting of stakeholders (not directors but staff)
- Need entity for complicated clients: enroll, assess, link, monitor, track
  - This "social health home" or "social service home" – assures social services obtained plus links with Primary Care Providers
  - Community HUB model could be one number PCPs call for complicated cases
  - General agreement of social providers that regional HUB could not perform as well as county HUB due to number and changes in services plus informal resources

STRATEGIES TO IMPROVE PRIMARY CARE ACCESS AND DELIVERY

- Email access and same day appointments (part of TCOC waiver)
- Telephone visits reimbursable now and being done by AAMC providers
- After hours/weekend availability – EX. clinic for all providers' patients
- Telehealth for consults with medical specialists (hospital or clinic site)
- Additional Nurse practitioners and Physician assistants working top of scope
- NP in office doing home visits for frail elderly; RN and telehealth to PCP
- PCPs working top of scope instead of specialists continuing to manage
- Enhance capacity of federally qualified health centers

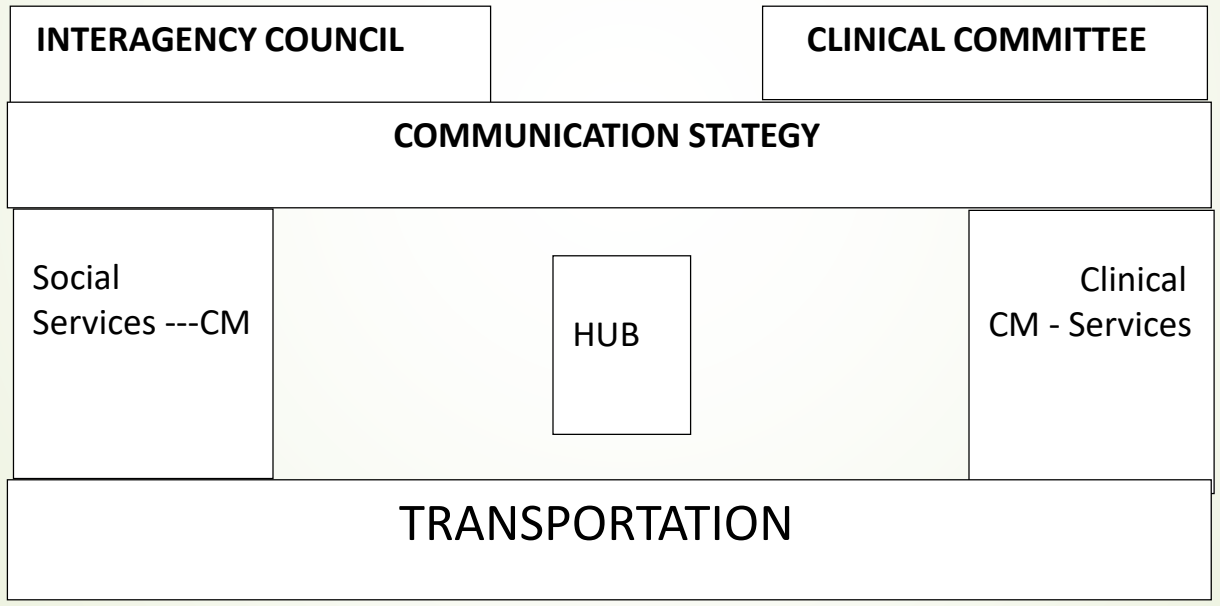
ADDITIONAL CONCERNS

- Enhanced primary care services with increased focus on prevention and chronic disease management – 1) increase number of PCPs, NPs, PAs, 2) use of other staff in office, 3) partnership with LHD,
- Early prenatal care especially for uninsured
- Behavioral health services: early in childhood for prevention and early intervention – not necessarily requiring licensed health professional
- Behavioral Health providers for children and youth
- Quality behavioral health therapy for all ages
- Diagnosis and care plans for children with co-occurring conditions
- Effective programs for preventing obesity and managing weight

TRANSPORTATION

- Companion to help elderly with public transportation rides
- Additional funds for senior care that allows taxi for some clients (state level)
- Payers provide transportation as Aetna has done
- Hospitals provide shuttles for some areas/patients
- Volunteers for rides (Villages provide and some other entities but liability is a concern)
- Medicare does not cover transportation like Medicaid (federal level)
- Increase investment by state and counties into public transportation for more routes (one county will not solve this alone and probably not one region)

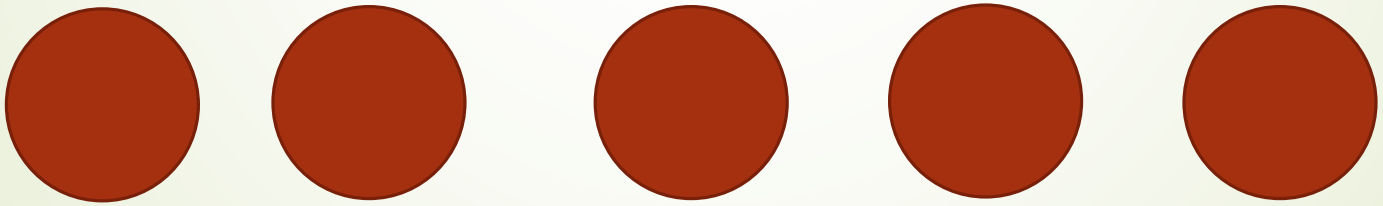
RURAL HEALTH MODEL



WITH ONLY ONE HUB & MEDICARE

PCPs all 5 counties

REGIONAL HUB



TALBOT CAROLINE DORCHESTER KENT QUEEN ANNE
DESIGNATED POINTS OF ENTRY FOR EACH COUNTY

ACTIONS SOCIAL SERVICES

1. Resource list to PCP and CTO, method to keep it updated
2. Counties agencies: roles, responsibilities, service maps, referral processes
3. Care Coordination lead for Medicare beneficiaries
4. Consider co-location if possible
5. Council of leaders meet regularly to resolve problems in referrals and services
6. Identify gaps in services; Recommend new service solutions
7. Help design communication strategy between clinical and social services
8. Establish a community HUB
9. LHD and MHD work to establish prevention and chronic disease management services with PCPs

ACTIONS PRIMARY CARE PROVIDERS

- After hour coverage
- Acute care access
- PCP telephone visits with patients
- Telehealth for specialists
- Special programs to increase NP, PA, MD
- Help design communication strategy with social providers on patients
- Mechanism for PCP feedback to county/RHC on processes

ACTIONS HUB

- Enroll high need referrals from PCP
- Assessment/develop plan
- Link with services
- Track/monitor, assure services and stability
- Single number to call for PCPs
- Co-ordinate social with clinical
- Data collection
- Recommendations to RHC for improvements

RECOMMENDATIONS WORKGROUP

- Advise MDH of the impact of no reimbursement for STEPS assessment for seniors and one AERS assessment per year
- Increase in Senior Care funds for state ($ 7.2 million to $15 mill – document which models are accomplishing the most for the investment)
- Increase care coordination care managers for PCPs
- MDH use current available funds in LHD for chronic disease management in partnership with PCPs – strategies have PCP and LHD input and agreement

TRANSPORTATION

1. Increase senior care - helps with transportation
2. Contracts with taxi companies for discount for clients; Uber. Lyft
3. Volunteers used for travel companion on public transportation – work with senior center
4. Volunteers for transport
5. Medicaid cover transportation at least for QMB and SLMB clients
6. Medicare cover transportation for certain beneficiaries
7. Counties/state provide funds for innovative transportation strategies

NEXT STEPS

- Request and support leaders and staff of 4 other counties (AAA, DSS, and LHD) to
  - define roles, responsibilities and services
  - Identify the best number to call for Medicare beneficiaries to enter system
- Present request for no cost extension to CHRC in May to test Community HUB in Talbot
- Establish HUB if funded in Talbot
- After 6 months, the HUB will accept referrals from PCPs for Mid Shore region & refer to county entity designated for the entry point

QUESTIONS?