Rural Health Collaborative Meeting Minutes
March 2, 2020
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
Michael Clark, MS
Jennifer Dyott, DNP, CRNP, FNP C
Roger Harrell, MHA
Margaret Ellen Kalmanowicz, RSBO
Matthew King, MD
Ken Kozel, MBA, FACHE
Scott LeRoy, MPH
Maura Manley, MBA
Maynard Nash
Shelly Neal-Edwards, MSW
Teresa Schaefer, PhD
April Sharp, LCSW
Anna Sierra, MS, EMT
Lorelly Solano, PhD
Mary Ann Thompson, RN
Sara Visintainer
Fredia Wadley, MD
William Webb, MS

Also in attendance: Lindsey Snyder, Esq., Assistant Attorney General, Maryland Department of Health (MDH; by phone); Ron Bialek, MPP, Executive Director, RHC, and President, Public Health Foundation (PHF); Kathleen Amos, MLIS, Assistant Director, Academic/Practice Linkages, PHF; Anastasia Brennan, RN, CPN, Intern, PHF; Alana Knudson, PhD, Co-Director, Walsh Center for Rural Health Analysis, NORC at the University of Chicago (NORC); Sherry Perkins, President, Anne Arundel Medical Center (AAMC); Shena Popat, MHA, Research Scientist, NORC; Kelley Ray, Manager of Community Development and Outreach – Medicare, University of Maryland Medical System Health Plans; Megan Renfrew, MPA, JD, Chief, Government Relations and Special Projects, Maryland Health Care Commission (MHCC); Sara Seitz, MPH, Director, State Office of Rural Health, MDH; Ben Steffen, MA, Executive Director, MHCC; Amy Travers, Senior Practice Manager, AAMC

Welcome, Introductions, and Review of Agenda
Ron Bialek, MPP, RHC Executive Director

Meeting was called to order at 5:06pm by RHC Executive Director Ron Bialek, MPP. Mr. Bialek thanked everyone for attending and welcomed everyone to the meeting. He shared results of the RHC officers election: Joseph Ciotola, MD, was elected President; Sara Rich, MPA, was elected Vice-President; and Scott LeRoy, MPH, was re-elected Secretary/Treasurer. Mr. Bialek welcomed new RHC members attending their first meeting, invited all to introduce themselves, and reviewed the agenda for the meeting and the plan for future meetings.

Review and Approval of January 28, 2020 Meeting Minutes
Ron Bialek, MPP, RHC Executive Director

Mr. Bialek requested any comments on the draft minutes for the January 28, 2020 meeting. No additions or corrections were provided. Fredia Wadley, MD, made a motion to approve the minutes as

written. William Webb, MS, seconded the motion. The RHC unanimously approved the minutes.

Anne Arundel Medical Center Age-Friendly Health System
Victoria Bayless, MHSA, CEO, Luminis Health

Victoria Bayless, MHSA, provided an overview of AAMC's efforts to develop an age-friendly health system. AAMC has been engaged in pioneering work on the 4Ms Framework from The John A. Hartford Foundation and Institute for Healthcare Improvement, which focuses on addressing medication, mentation, mobility, and what matters most to patients. Presentation slides are attached.

Recent Maryland Health Care Commission Reports:

A. Assessment of Service Changes at the University of Maryland Shore Medical Center at Chestertown

B. Options for Rural Health Care Delivery in Maryland

Ben Steffen, MA, Executive Director, MHCC; Megan Renfrew, MPA, JD, Chief, Government Relations and Special Projects, MHCC; and Alana Knudson, PhD, Co-Director, Walsh Center for Rural Health Analysis, NORC

Ben Steffen, MA, provided an introduction and described the purpose of these MHCC reports.

Megan Renfrew, MPA, JD, summarized the *Assessment of Service Changes at the University of Maryland Shore Medical Center at Chestertown* report, which was produced to profile changes in service types and volume at the University of Maryland (UM) Shore Medical Center at Chestertown (SMC-Chestertown) from 2015 through 2018 and identify any services that were reduced or transferred from SMC-Chestertown to the UM Shore Medical Center at Easton. Presentation slides are attached.

Alana Knudson, PhD, summarized the *Options for Rural Health Care Delivery in Maryland* report, which describes delivery system models for meeting the healthcare needs of residents in Kent County and northern Queen Anne's County, the service area of SMC-Chestertown. Presentation slides are attached.

RHC members discussed the idea of a Maryland rural hospital designation, EMS data, the limitation of not having access to data on Eastern Shore residents receiving care in Delaware, healthcare service costs, rural designations, and the use of inpatient beds at SMC-Chestertown.

Discussion of Criteria for the Rural Health Complex
Ron Bialek, MPP, RHC Executive Director

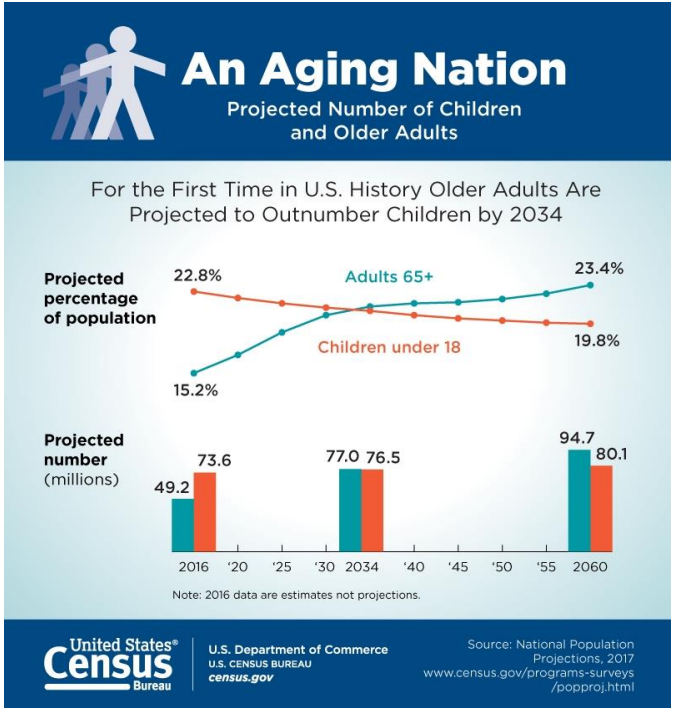
Mr. Bialek shared an initial draft list of criteria for a rural health complex, and RHC members provided input and feedback. RHC members discussed access to primary and specialty healthcare, behavioral health, and oral health services; access to prescriptions; care transformation organizations; access to social services; addressing transportation needs; information sharing across providers; care coordination; demonstrating sustainable funding; advisory bodies to guide rural health complexes; and the need for rural health complexes to demonstrate outcomes.

Next Steps
Ron Bialek, MPP, RHC Executive Director

Mr. Bialek wrapped up the meeting. PHF will revise the draft criteria for a rural health complex based on this discussion. Meeting was adjourned at 8:00pm.

Luminis Health: Age Friendly Care

Aging Population



136%

Increase of individuals 80-84 years old between 2005 and 2040 in MD

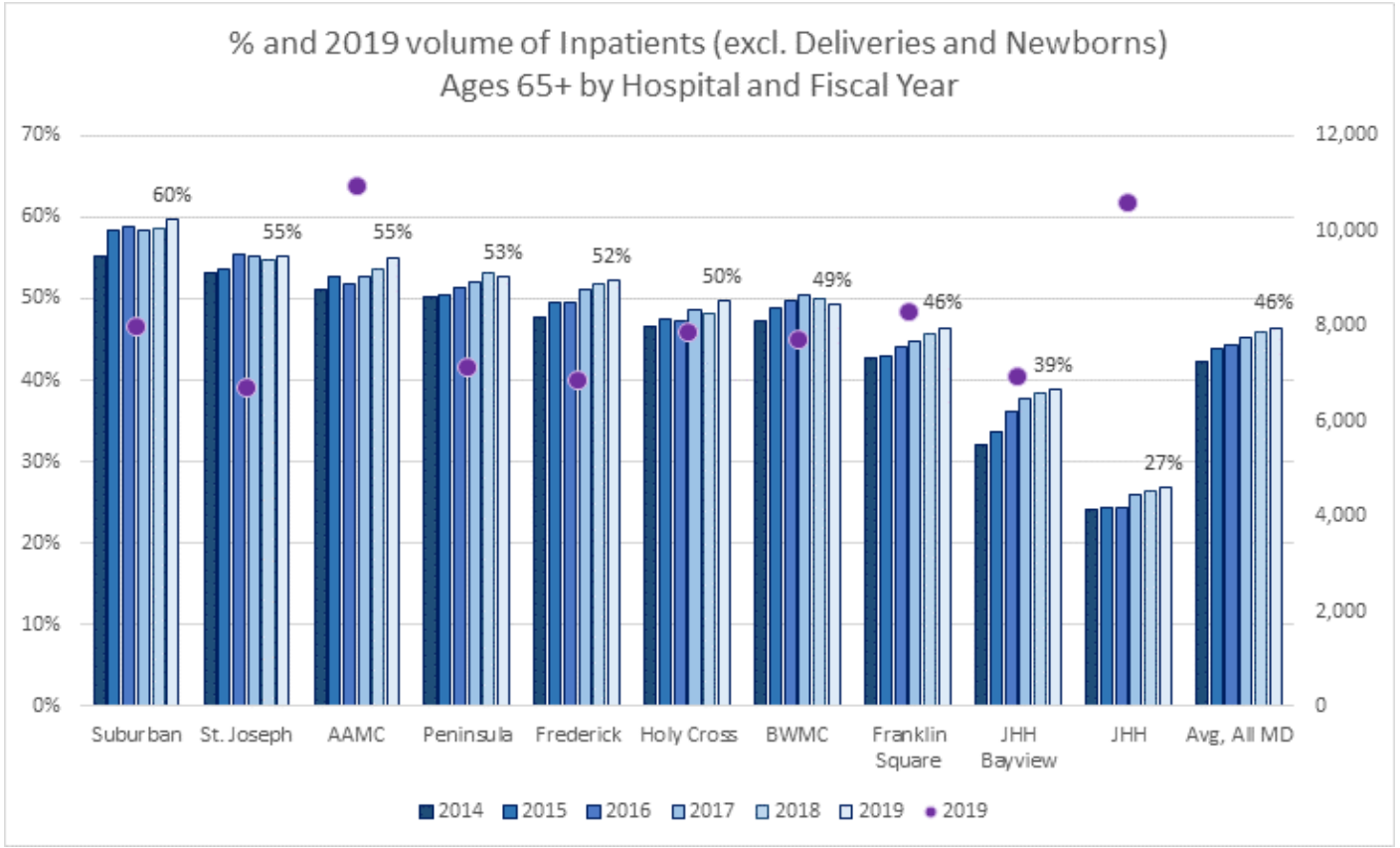
63%

Of individuals 60+ live in Anne Arundel, Baltimore, Montgomery and Prince George's Counties

*2017-202 State Plan on Aging

Rural Health Collaborative Maryland

	2015	2040	% Increase
Talbot	13,494	17,790	
Dorchester	8,728	11,647	
Caroline	7,133	10,567	
Kent	6,623	9,716	
Queen Anne	12,077	19,122	
Rural Health Collab	48,055	68,842	43%
MD	1,196,795	1,679,379	40%
Rural Health/MD	4.0%	4.1%	



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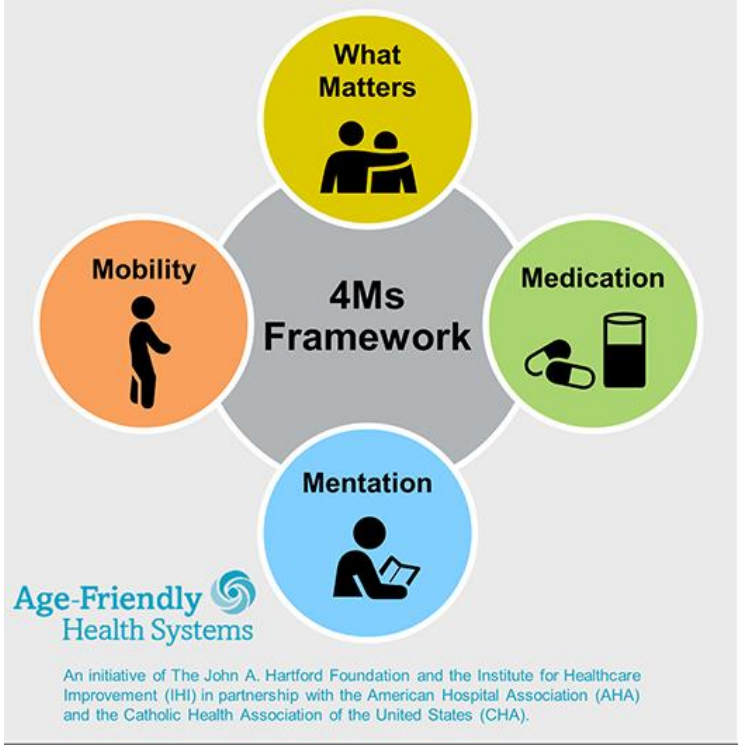
Institute for Healthy Aging

Luminis Health has begun to address this community need by implementing age friendly practices across the system.



Comprehensive Geriatric Care based on 4 M Framework

- Coordinates care across inpatient, ambulatory, long-term facilities, and at home specific to the complex medical, psychological and social needs of the elderly population.

- Improves patient satisfaction and quality of life while reducing unnecessary costly care.

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Age-Friendly Health Systems

Pioneer

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Nurses Improving Care for Healthsystem Elders (NICHE)
May 14, 2013 ·

AAMC (Anne Arundel Medical Center) recently opened its Acute Care of the Elderly (ACE) unit. The ACE unit offers a specialized model of care for older, hospitalized patients with acute illness:
http://www.eyeonannapolis.net/…/aamc-opens-patient-centere…/

AAMC Opens Patient Centered Geriatric Unit

Anne Arundel Medical Center (AAMC) recently opened its Acute Care of the Elderly (ACE) unit. The ACE unit offers a specialized model of care for older, hospitalized patients with acute illness. The...

EYEONANNAPOLIS.NET

Share

The Pioneer Health Systems

Anne Arundel Medical Center

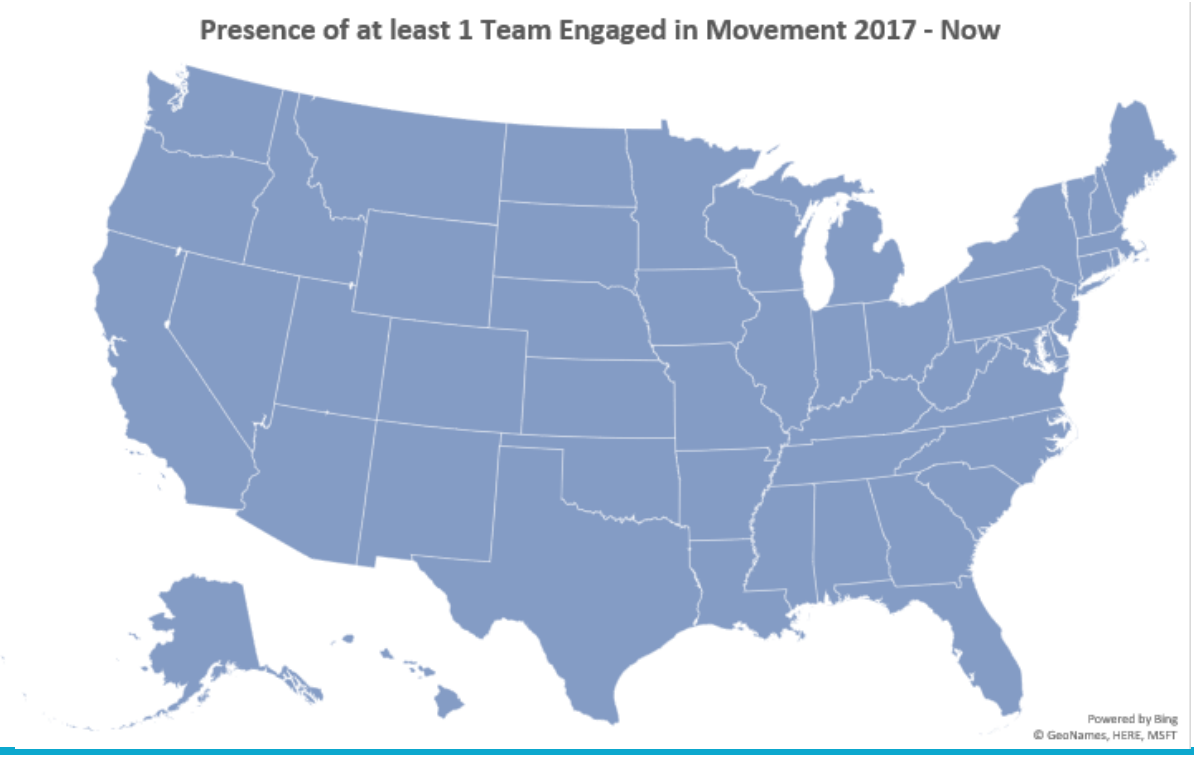
ASCENSION

KAISER PERMANENTE®

Providence St. Joseph Health

Trinity Health

Teams engaged in every state



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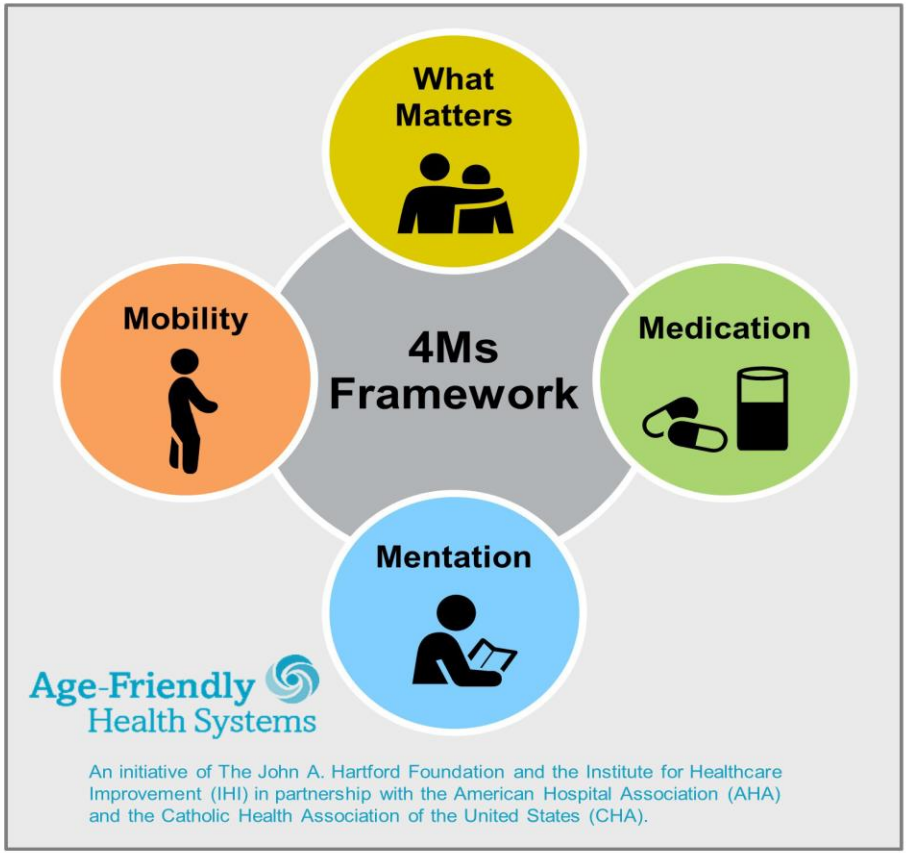

What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

Person Centered Care

What Matters Day – June 6

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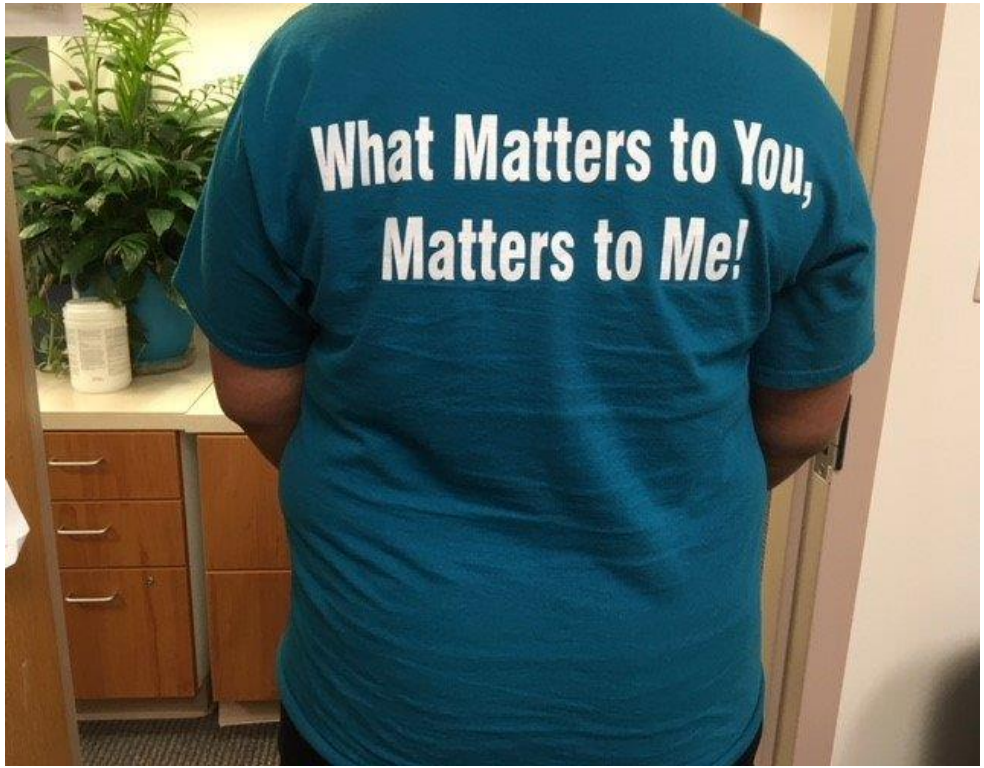

What Matters to You,
Matters to Me!

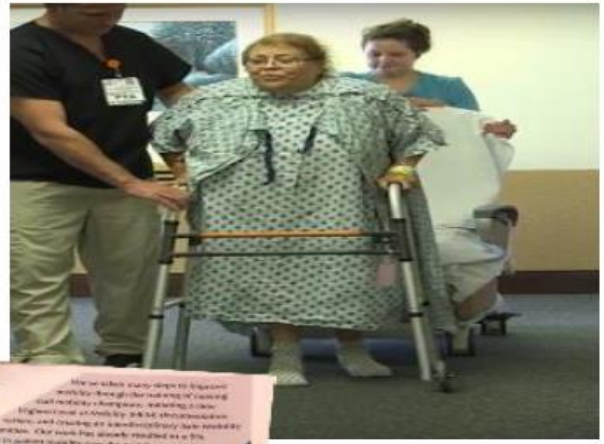
White Boards Reflect What Matters

Anne Arundel's Mobility Story

Mobility

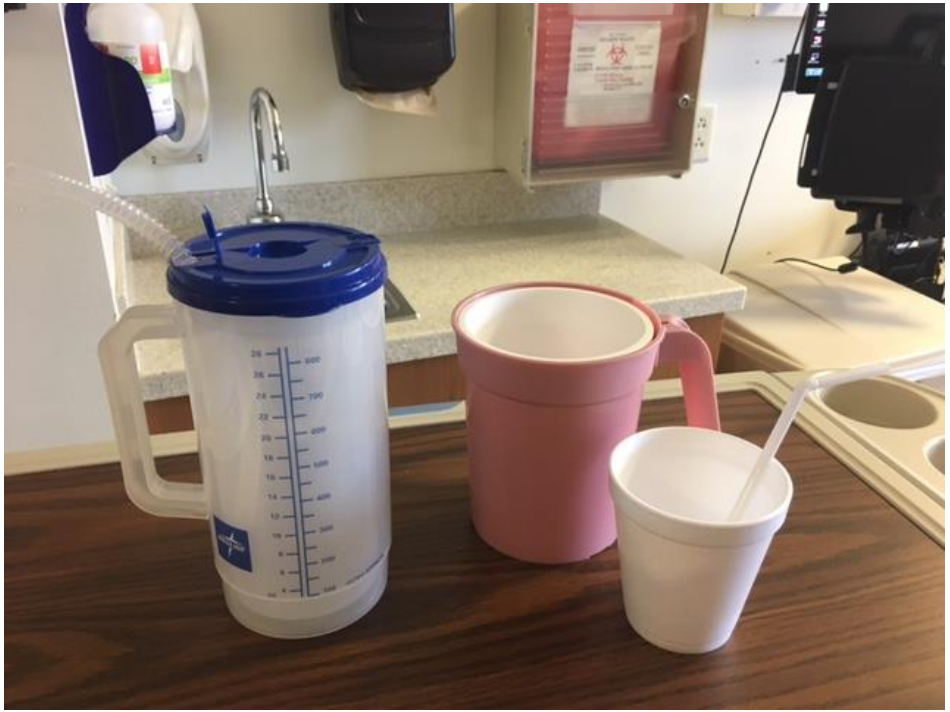
Optimize Mobility Report

Observed Activity - Johns Hopkins-Highest Level of Mobility (JH-HLM) (Last 1 values)	
09/27 0600	2-->Bed activity
Mobility Daily Goal (JH-HLM) (Last 1 values)	
09/26 0815	4-->Transfer to chair/commode
Prior to Admission Functional Baseline (Last 1 values)	
09/24 1049	assist w/ ADLs;assistive devices
Activity Level of Assistance (Last 1 values)	
09/27 0921	assistance, 1 person
Assistive Device Utilized (Last 1 values)	
09/26 2217	None
Activity Intolerance Observed (Last 1 values)	
09/27 0000	pain increased

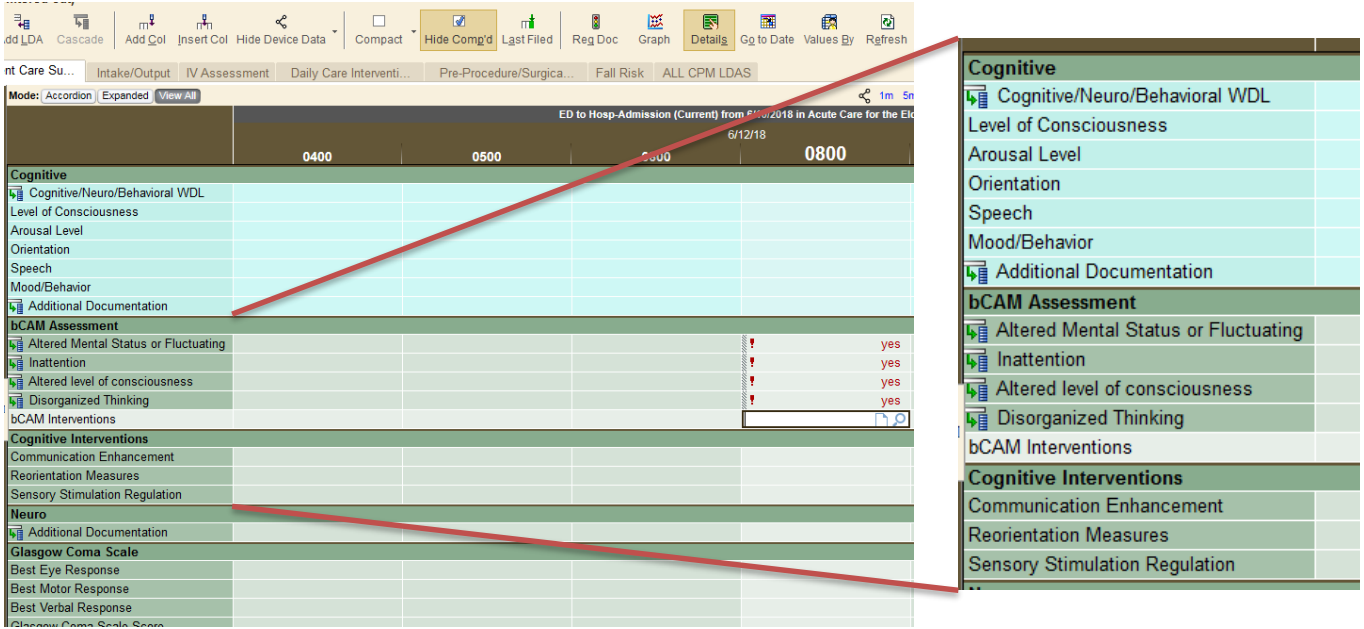


Age-Friendly Health Systems

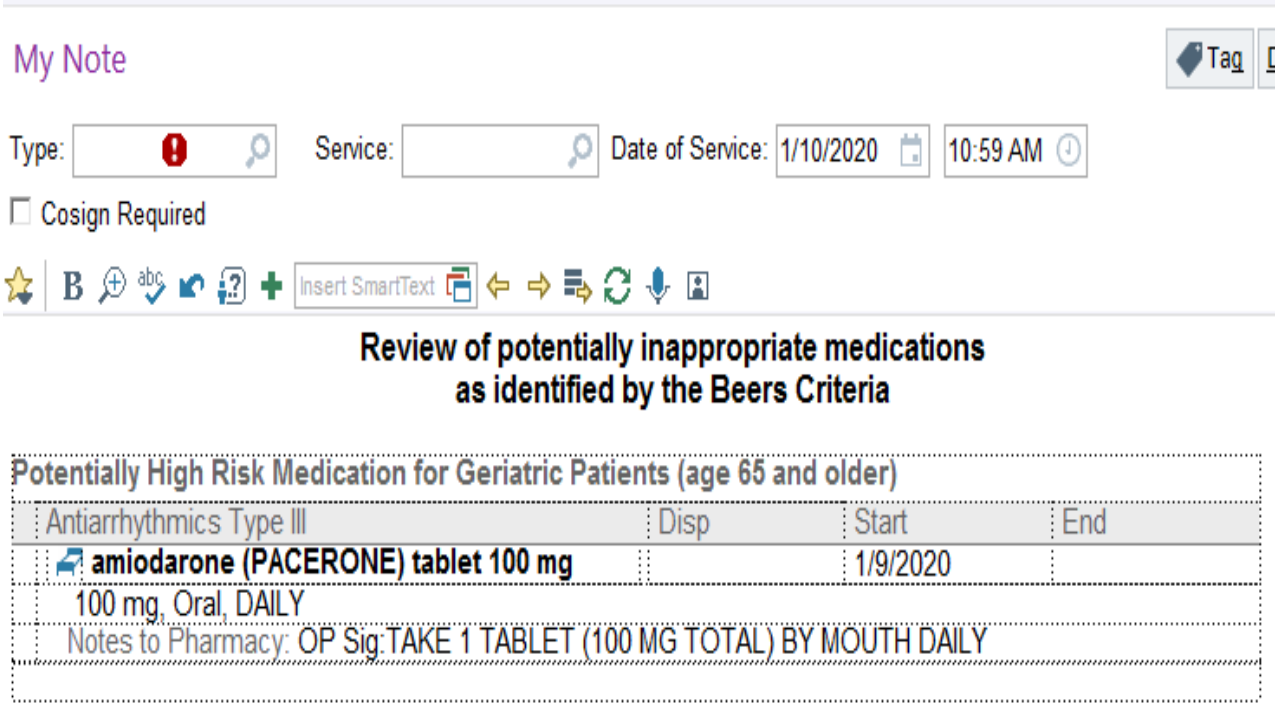
Mentation - hydration



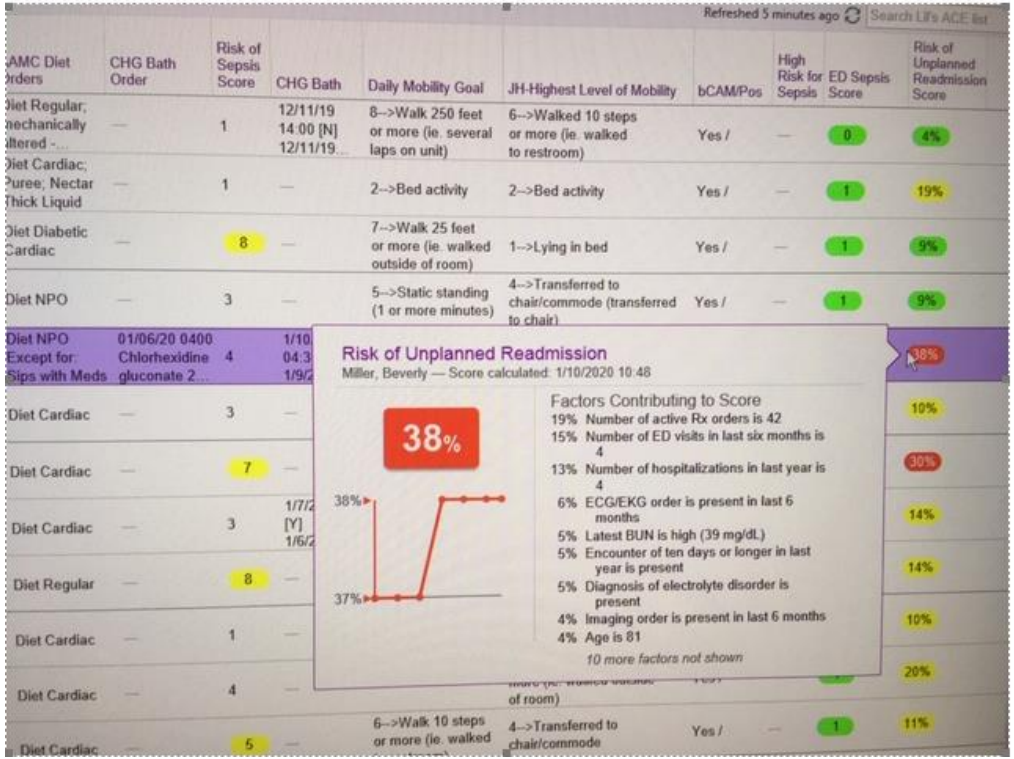
Mentation: bCAM documentation



Medication – Beers criteria



Predicting Readmissions/Review of Medications



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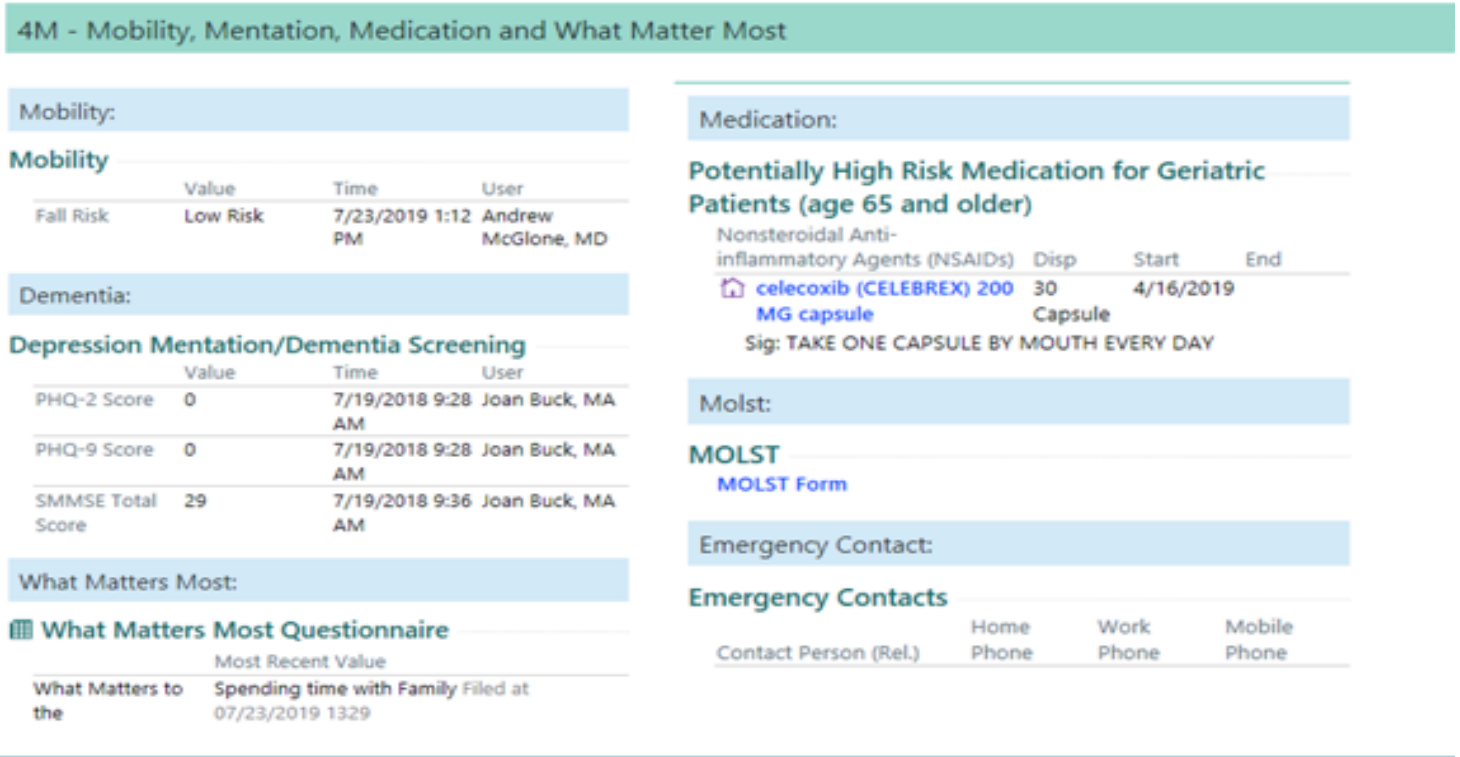
4M Snapshot Ambulatory



4M - Mobility, Mentation, Medication and What Matter Most

Mobility:

Mobility

	Value	Time	User
Fall Risk	Low Risk	7/23/2019 1:12 PM	Andrew McGlone, MD

Dementia:

Depression Mentation/Dementia Screening

	Value	Time	User
PHQ-2 Score	0	7/19/2018 9:28 AM	Joan Buck, MA
PHQ-9 Score	0	7/19/2018 9:28 AM	Joan Buck, MA
SMMSE Total Score	29	7/19/2018 9:36 AM	Joan Buck, MA

What Matters Most:

What Matters Most Questionnaire

	Most Recent Value
What Matters to the	Spending time with Family Filed at 07/23/2019 1329

Medication:

Potentially High Risk Medication for Geriatric Patients (age 65 and older)

Nonsteroidal Anti-inflammatory Agents (NSAIDs)	Disp	Start	End
celecoxib (CELEBREX) 200 MG capsule	30 Capsule	4/16/2019	

Sig: TAKE ONE CAPSULE BY MOUTH EVERY DAY

Molst:

MOLST

MOLST Form

Emergency Contact:

Emergency Contacts

Contact Person (Rel.)	Home Phone	Work Phone	Mobile Phone

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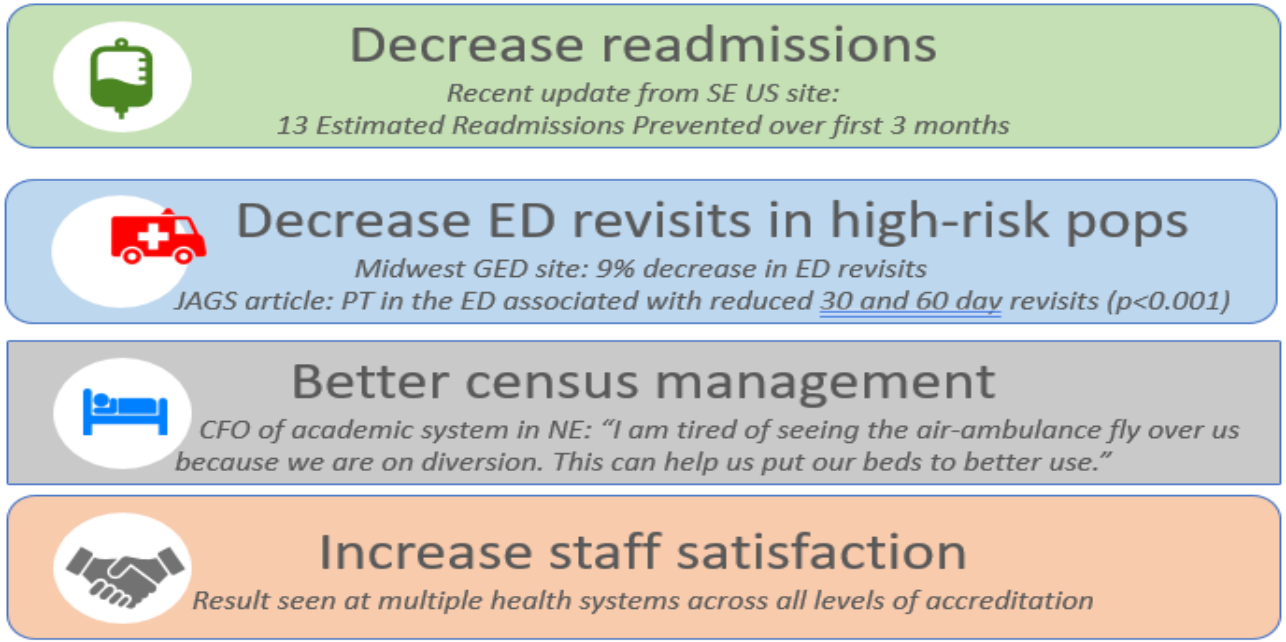
GEDC
THE GERIATRIC
EMERGENCY DEPARTMENT
COLLABORATIVE
EDUCATE IMPLEMENT EVALUATE

Geriatric Emergency Dept work



Return on Investment
of Geriatric Emergency Departments *(GEDs)*

GARY & MARY westhealth institute

16% REDUCTION
in Risk of hospital admission from the Emergency Department (ED)

Approximately one out of every 10 hospital admissions is potentially avoidable, and the majority (60%) are for patients 65+[1]. Senior-specific protocols in the ED have been linked to reduced likelihood of admission from the ED[2-7] without increasing mortality risk[5,8-12].

In one multi-site geriatric ED (GED) study risk of admission decreased by up to 16.5%[2]. Avoiding unnecessary admissions reduces costs and prevents the risk of inpatient complications and reduced functioning.

Interdisciplinary staff associated with

LOWER OVERALL COST

GEDs leverage interdisciplinary staff to reduce ED revisits and "social" admissions, which results in more efficient use of physicians' time and reduce costly inpatient care[2]. Early results show older adult patients who visited with a GED social worker or nurse had lower total Medicare expenses, with savings ranging from $1,872 - $5,019 per patient at 30 days following an ED visit[13].

REDUCE OR DELAY ADMISSION
of high-risk patients to skilled nursing facilities (SNF) by

70%

Senior-specific protocols and enhanced transitions of care planning in the ED may reduce or delay SNF admission[9,12], enabling seniors to age in place at reduced costs[12]. A transitional care program at two EDs lowered SNF admissions for high-risk patients at 120 days (3% vs. 10%) following an ED visit[9].

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Partnering with the Community

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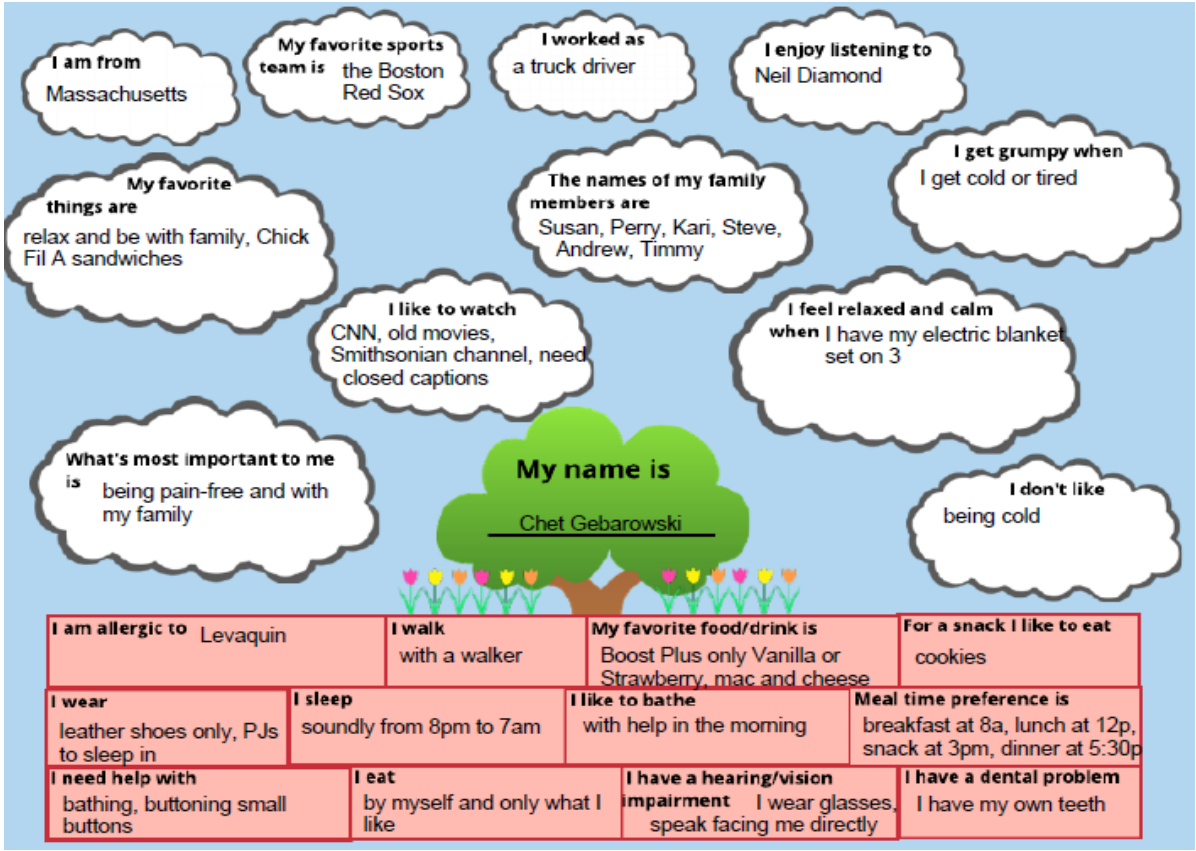
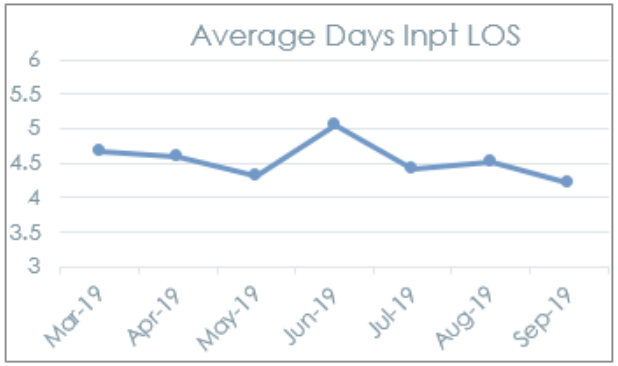
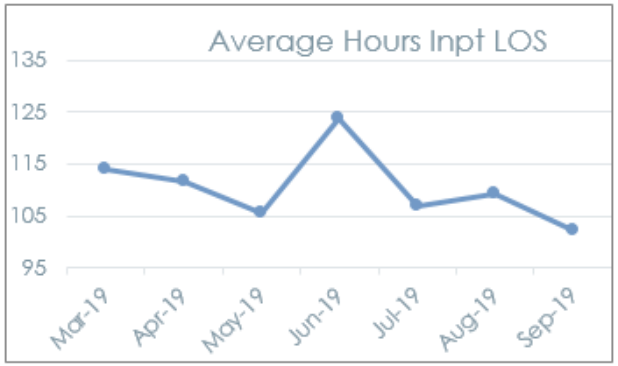
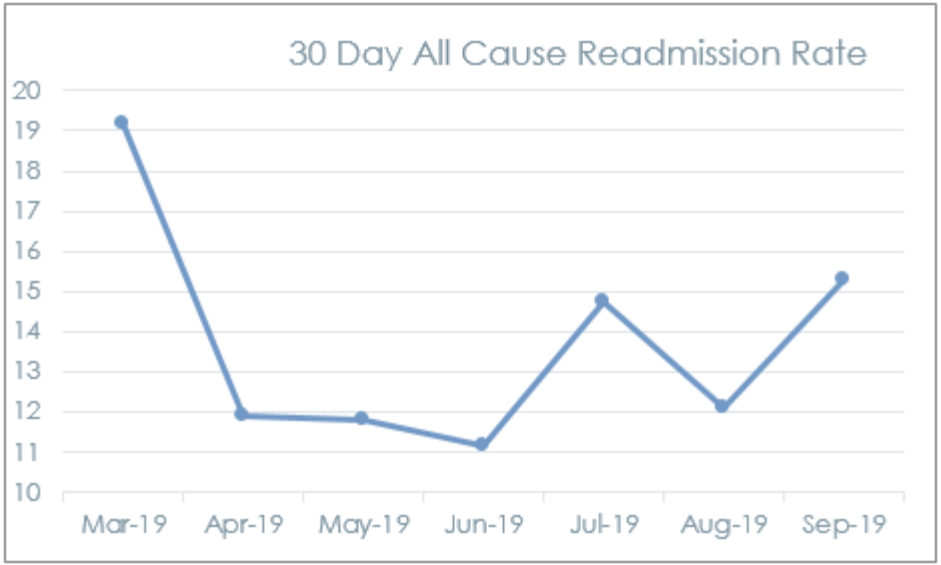

I am from
Massachusetts
My favorite sports team is the Boston Red Sox
I worked as
a truck driver
I enjoy listening to
Neil Diamond
I get grumpy when
I get cold or tired
My favorite things are
relax and be with family, Chick Fil A sandwiches
The names of my family members are
Susan, Perry, Kari, Steve, Andrew, Timmy
I like to watch
CNN, old movies, Smithsonian channel, need closed captions
I feel relaxed and calm when
I have my electric blanket set on 3
What's most important to me is
being pain-free and with my family
My name is
Chet Gebarowski
I don't like
being cold
I am allergic to
Levaquin
I walk
with a walker
My favorite food/drink is
Boost Plus only Vanilla or Strawberry, mac and cheese
For a snack I like to eat
cookies
I wear
leather shoes only, PJs to sleep in
I sleep
soundly from 8pm to 7am
I like to bathe
with help in the morning
Meal time preference is
breakfast at 8a, lunch at 12p, snack at 3pm, dinner at 5:30p
I need help with
bathing, buttoning small buttons
I eat
by myself and only what I like
I have a hearing/vision impairment
I wear glasses, speak facing me directly
I have a dental problem
I have my own teeth

Virtual Dementia Tours

Some data points we are watching







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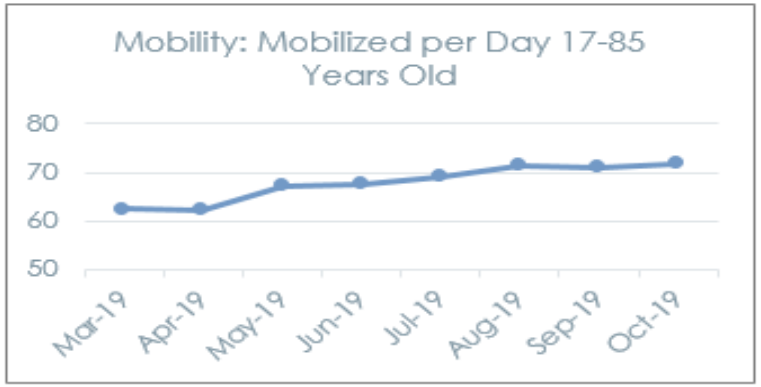
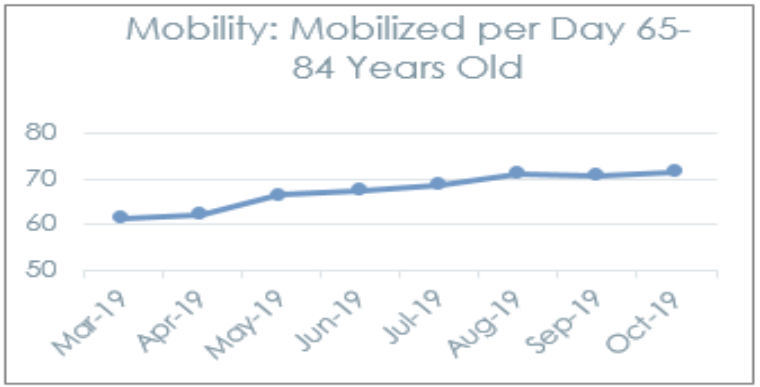
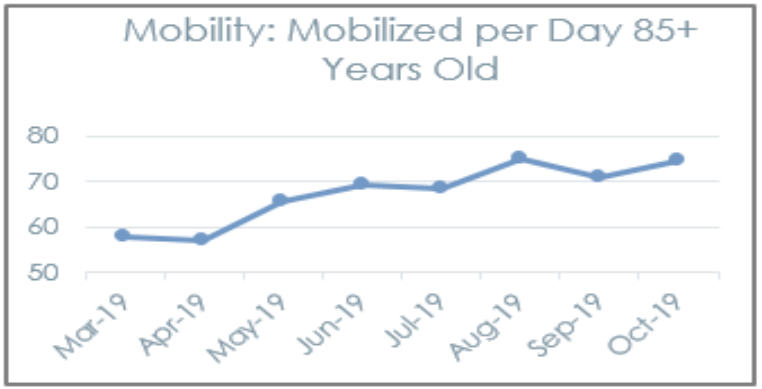
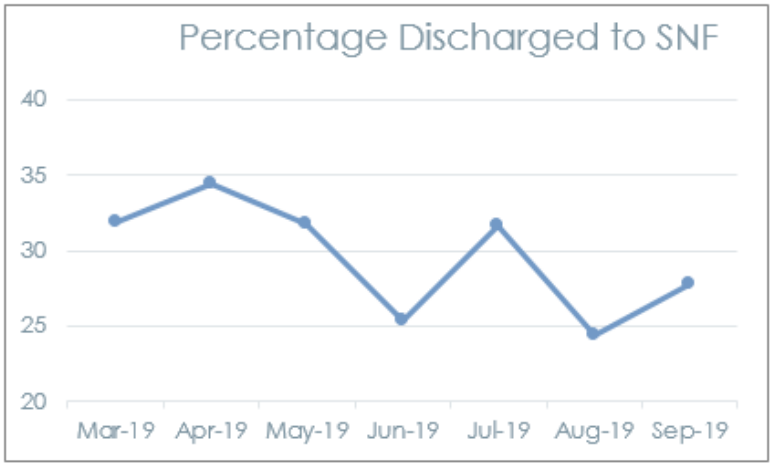


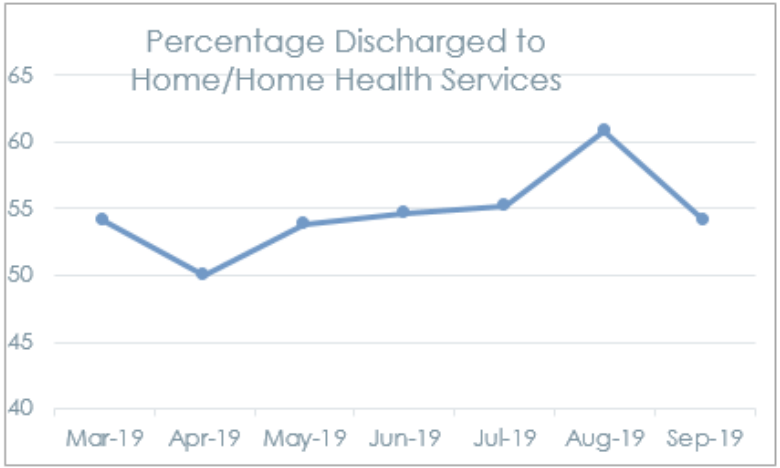




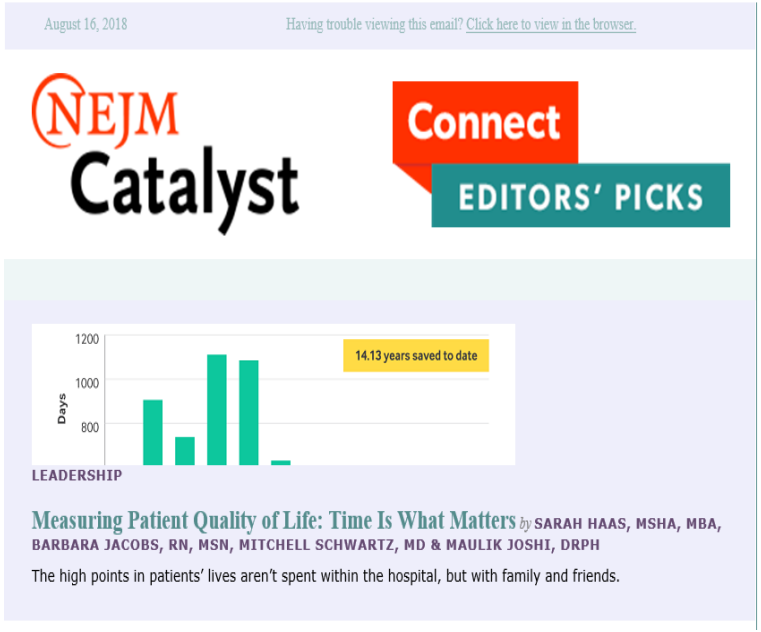
March 2019: Went house wide with 4Ms

We know that What Matters to people is getting home





NEJM Catalyst



August 16, 2018 Having trouble viewing this email? Click here to view in the browser.

NEJM Catalyst

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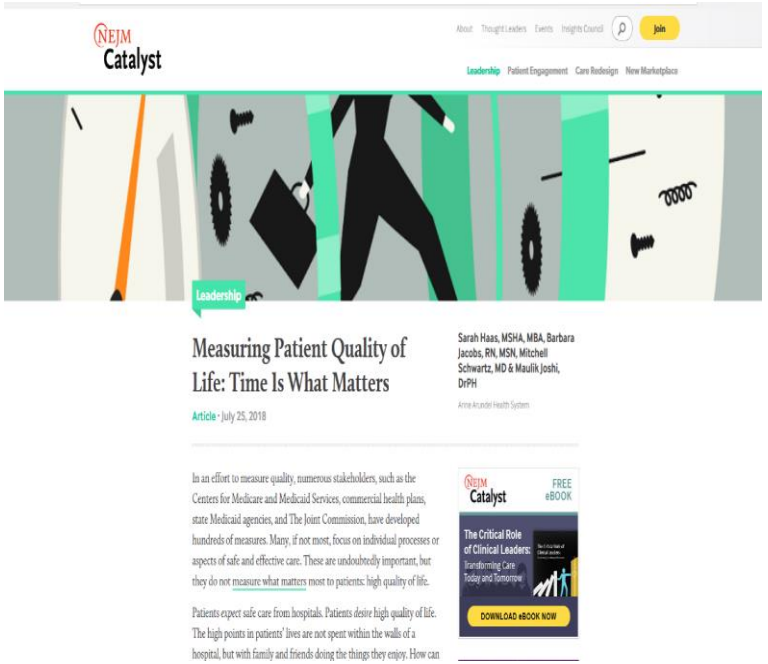
EDITORS' PICKS

LEADERSHIP

Measuring Patient Quality of Life: Time Is What Matters *by* SARAH HAAS, MSHA, MBA, BARBARA JACOBS, RN, MSN, MITCHELL SCHWARTZ, MD & MAULIK JOSHI, DRPH

The high points in patients' lives aren't spent within the hospital, but with family and friends.



Age-Friendly Health Systems

Transforming Generations

THE INSTITUTE FOR HEALTHY AGING

OUR AGING COMMUNITY

Over the next 10 years, the 65 year old population in Maryland will increase by 40% from 1.2 million residents to 1.7 million.

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MARYLAND HEALTH CARE COMMISSION

Assessment of Service Changes at the University of Maryland Shore Medical Center at Chestertown
&
Options for Rural Health Care Delivery in Maryland

March 2, 2020

Overview of Projects

- *Chestertown Assessment*- The assessment of services is based on SB1010 (2019), which directs the Commission, with OHCQ, to profile changes in service types and service volume at the UM Shore Medical Center at Chestertown over the period 2015 through 2018 (SMC-Chestertown) and identify any services that were reduced or transferred from SMC-Chestertown to the University of Maryland Shore Medical Center at Easton.

- *"Models" Report.* This report will identify delivery system models that could meet the health care needs of residents in Kent and northern Queen Anne's County, the service area of SMC-Chestertown. These models should be applicable and scalable to other rural communities in Maryland and should align with the Total Cost of Care Demonstration Agreement that Maryland signed with the Centers for Medicare and Medicaid Services in 2018.

Key Assessment Finding: Minor Changes in Types of Services Provided

- In 2015 and 2018, UMSMC-Chestertown provided services typical of a small rural hospital.
  - UMSMC-Chestertown provided medical/surgical/gynecological/addictions (MSGA) services. It did not provide obstetric, pediatric, or acute psychiatric services.
  - No service categories comprising the most frequently provided at the hospital disappeared or were added over this period.
  - Five APR-DRG service lines observed in 2015 were not observed in 2018, but these were infrequently used service lines in 2015.

Key Assessment Finding: Inpatient Volume Declined

- Inpatient discharges declined by 32% (576) between 2015 and 2018 at UMSMC at Chestertown
  - Licensed bed capacity (based on 140% of average daily census) declined from 31 in 2015 to 12 in 2020 (-61%)
- Outpatient visit volume declined by 5% between 2015-2018
- UMSMC has lost market share within its 85% relevance inpatient service area
- UMSMC at Easton also experienced declines
  - 7% (628) decline in inpatient discharges between 2015 and 2018; Licensed acute care bed capacity declined from 112 to 97 between 2015 and 2020 (-13%)
  - Outpatient visit volume increased 2% at UMSMC at Easton
  - UMSMC at Easton gained inpatient market share in the Chestertown hospital's service area between 2015 and 2018

Key Assessment Finding: Volume of Inpatient Service

Change in Market Share of Discharged Patients, Top 5 Hospitals Used by Residents of the 2011 SMC-Chestertown Hospital Service Area

Hospital	Change in Discharge Volume 2015-2018	2015 Market Share	2018 Market Share
SMC-CHESTERTOWN	-521	41%	31%
ANNE ARUNDEL	23	23%	26%
SMC-EASTON	168	13%	20%
UNIVERSITY OF MARYLAND	-29	8%	8%
JOHNS HOPKINS	-1	3%	4%
Other Maryland hospitals	-85	12%	11%
Total Discharges	-445		

MARYLAND HEALTH CARE COMMISSION

Key Assessment Finding: Quality has improved and is similar to other Maryland hospitals

- UMSMC at Chestertown has reduced readmissions or potentially preventable or avoidable admissions at a faster pace than the state's hospitals as a whole.
  - In 2015 UMSMC had a high proportion of such admissions and its levels are still relatively high.
  - This improvement has contributed significantly to the reduction in patient discharges

- Looking at available quality measures overall, the Chestertown hospital's performance is similar to other Maryland hospitals (generally, an average performer)

Assessment: Causes for the Observed Changes at UMSMC at Chestertown

- Why is inpatient volume declining? Reduction in PQI and readmissions, national trend of reduced inpatient utilization, and market shift.
- Why is inpatient care migrating away from UMSMC at Chestertown (market shift)?
  - Shifting perceptions of the hospital by physicians and patients
  - Some responses by Shore Regional Health to the declining demand for service may have exacerbated the decline.

MHCC is not able to discern any formal plan being implemented by Shore Regional Health expressly designed to force a market shift in hospital service provision from Chestertown to Easton.

SMC-Chestertown Financial Performance 2015-2018

- The decline in service volume experienced by UMSMC at Chestertown between 2015 and 2018 did not result in a negative impact on the hospital's financial performance over this period.
- The Maryland Model for hospital payment is a moderating influence on the short-term impact of service volume changes on revenue. Charges are adjusted as service volume declines to meet the global revenue target (making the hospital more expensive for patients and payers).
- This study did not analyze 2019 financial data.

Models of Rural Care Delivery

Next Steps

APPENDIX

Key Acquisitions and Events on the Mid-Shore

- 2006- UMMS acquires Shore Health System composed of Easton Memorial Hospital and Dorchester General Hospital
- 2008- The General Assembly authorize establishment of a freestanding medical facility (FMF) in Queenstown as a pilot FMF project
- 2008- UMMS acquires Chester River Hospital
- 2010- Queenstown FMF opens.
- 2013- The Chestertown hospital joins the UM Shore Health System (now know as Shore Regional Health or SRH)
- 2017- UM Shore Medical Center at Easton is authorized to offer Percutaneous Coronary Intervention services
- April 2019- MHCC authorizes conversion of SMC-Dorchester to an FMF and authorizes replacement of the psychiatric beds at SMC-Dorchester with a psychiatric unit at SMC-Easton upon completion of Dorchester County FMF (projected for 2021)
- September 2019- SRH requests authorization to replace psychiatric beds at SMC-Dorchester with development of a psychiatric unit at SMC-Chestertown.

Options for Rural Health Care Delivery in Maryland

Maryland Health Care Commission Meeting

January 16, 2020

The Walsh Center
for Rural Health Analysis
NORC AT THE UNIVERSITY OF CHICAGO

NORC Walsh Center for Rural Health Analysis

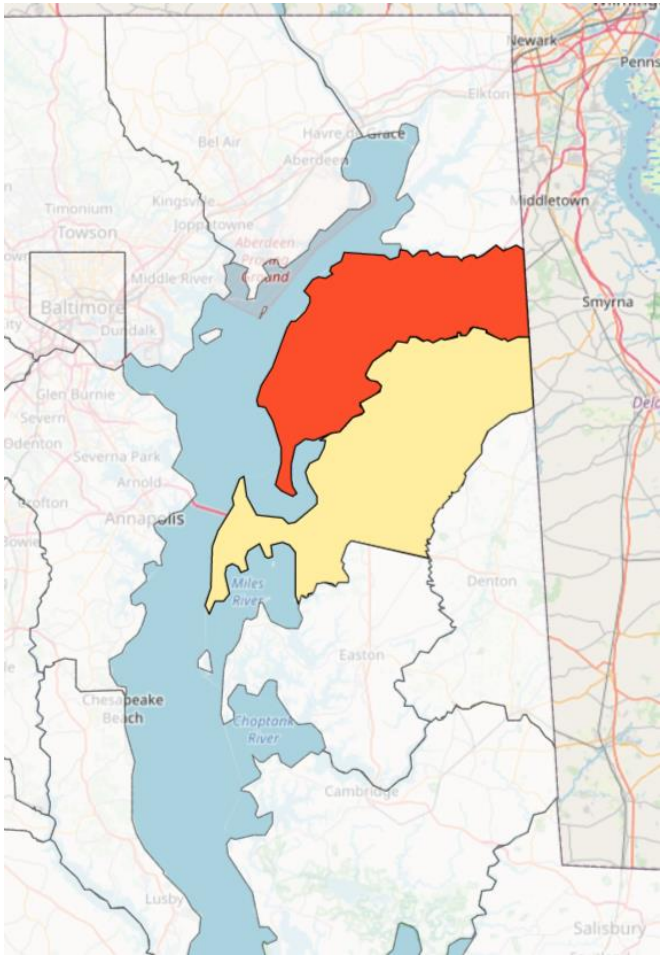
NORC at the University of Chicago is an objective and non-partisan research institution that delivers reliable data and rigorous analysis to guide critical programmatic, business, and policy decisions.

NORC's Walsh Center for Rural Health Analysis, established in 1996, conducts timely policy analysis, research, and evaluation that address the needs of policy makers, the health care workforce, and the public on issues that affect health care and public health in rural America. The Walsh Center is based in Bethesda, MD.

Purpose

- Identify delivery system options that could meet the health care needs of residents in Kent and upper Queen Anne's Counties

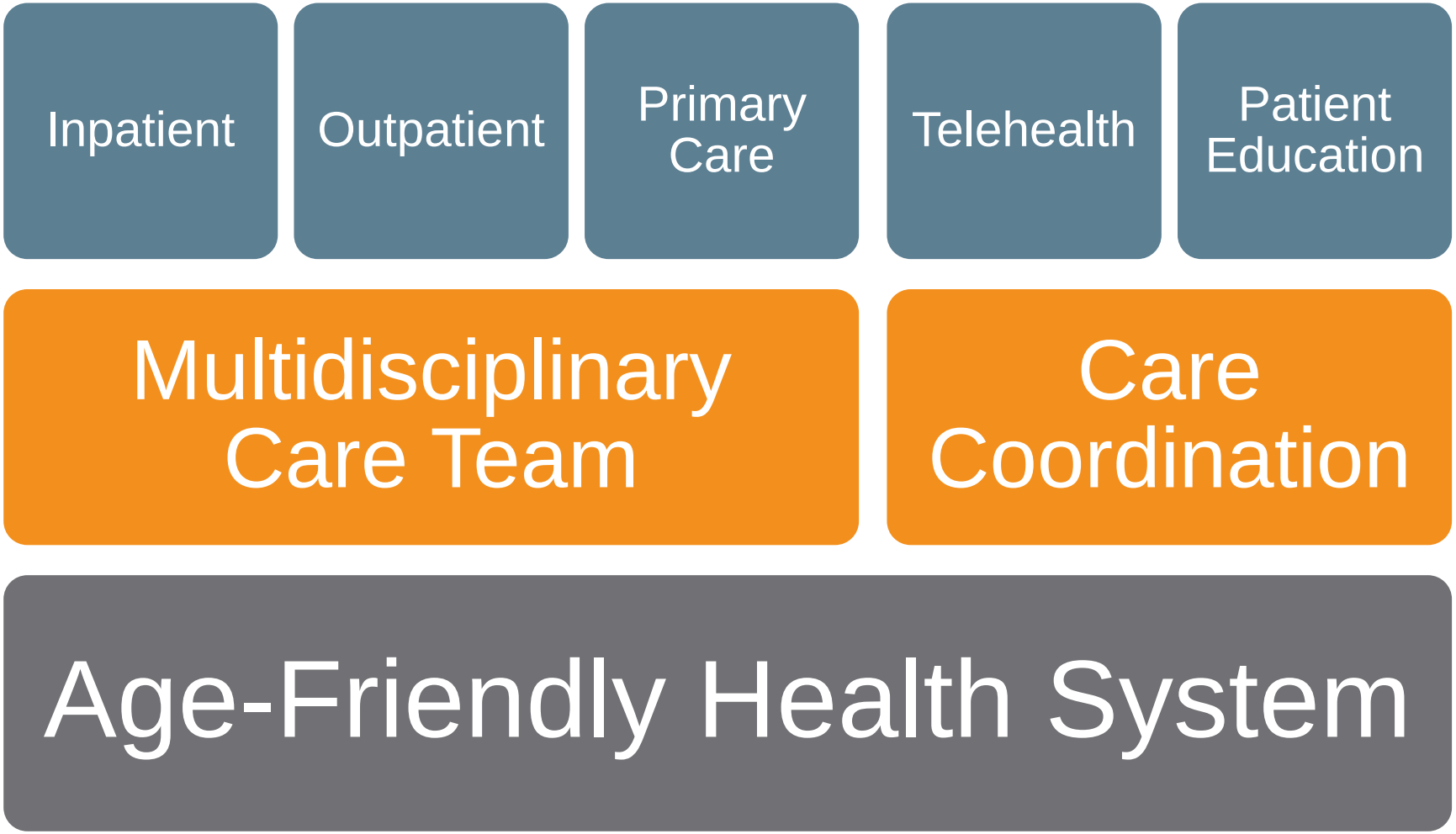
- Models are applicable and scalable to other rural communities in Maryland and consistent with the Total Cost of Care (TCOC) Model



Options for Rural Health Service Delivery

Key Features	Status Quo: Acute General Hospital	Maryland Rural Hospital
Number of Beds	Determined by MHCC	Determined by MHCC (No more than 25 beds)
Average Length of Stay	None	96 hours or less
24/7 ED	Yes	Yes
Inpatient Care	Yes	Yes, Limited
Outpatient Services	Yes	Yes
Radiology/Laboratory	Yes	Yes
Telehealth	Yes	Yes, Enhanced
Interfacility Transfers	Yes	Yes, Enhanced
Accreditation	Joint Commission Hospital	Joint Commission Critical Access Hospital
Payment	Global Budget	Global Budget
Advisory Board	No	Yes

Aging and Wellness Center of Excellence



Considerations for Next Steps

- Enhance Community Engagement
- Create Opportunities to Improve Health Literacy
- Consider Implementing Mobile Integrated Health (MIH) Programs
- Address Adequacy of Volunteer EMS
- Establish Non-emergency Transportation
- Optimize Rural Workforce Training
- Leverage Technology
- Engage with Peers Nationwide
- Leverage Additional Funding Sources

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Thank You!

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