Establishing Rural Health Complexes in Maryland's Mid-Shore Region

REPORT TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF MARYLAND ON STANDARDS AND CRITERIA THAT A COMMUNITY MUST MEET TO ESTABLISH A RURAL HEALTH COMPLEX

Maryland Mid-Shore Rural Health Collaborative

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Executive Summary

The Mid-Shore Rural Health Collaborative (RHC) was created to improve access to and delivery of health services in the Mid-Shore Region of Maryland, with the ultimate goal of improving health outcomes for the population. The RHC is made up of representatives of public health departments, hospital systems, a federally qualified health center, primary care services, specialty care services, behavioral health services, emergency services, social services, agency on aging, transportation, education, local management board, and health care consumers from the Mid-Shore Region. It was established in May 2018 by Senate Bill 1056.

This legislation charges the RHC with directing the establishment of rural health complexes, defined in the legislation as "a community-based ambulatory care setting or inpatient care setting that integrates primary care and other health care services determined to be essential by the Collaborative [RHC] with input by the community, and determined to be sustainable by the Collaborative." The RHC is further instructed to "report to the Governor and … the General Assembly on the standards and criteria that a community must meet to establish a rural health complex" by December 1, 2020. These standards and criteria are to be used to guide the approval of rural health complexes, as recommended by the RHC.

This report includes: 1) needs impacting health in the Mid-Shore Region; 2) key considerations in developing recommendations to improve health in the Mid-Shore Region; 3) standards and criteria for establishing rural health complexes in the Mid-Shore Region; and 4) recommendations for implementing rural health complexes and improving health in the Mid-Shore Region.

> Investing in the Mid-Shore Region's existing services and programs is a cost-effective and practical approach to improving health.

Needs for ensuring access to and coordinating health and social support services continue to grow on the Mid-Shore. The RHC recommends a practical approach to meeting these needs by building on existing services and programs. These existing services and programs have been successful in providing high-quality health and social support services to Mid-Shore residents. Expanding these services and programs will immediately address Mid-Shore needs. To do so requires additional and sustainable investments by the State of Maryland. Such investments are the most cost-effective and feasible approach to better meeting the needs of Mid-Shore residents and improving health.

The standards and criteria determined by the RHC for establishing rural health complexes provide important context for the State's investments in Mid-Shore health and social support services. These standards and criteria address both communities desiring to establish rural health complexes as well as rural health complexes themselves.

Standards and Criteria a Community Must Meet to Establish a Rural Health Complex

- The geographic area/jurisdiction(s) to be served by a rural health complex is designated rural by the State of Maryland.
- A needs assessment, client data, population data, or programmatic data produced or collected within the past five years that shows health needs of the population(s) to be served by a rural health complex is available.

Required Standards and Criteria for a Rural Health Complex

The rural health complex must:

- Have an articulated purpose, goals, and measurable objectives.
- Provide a description of the population(s) to be served, including health disparities and inequities contributing to those disparities.
- Demonstrate unmet health needs of the population(s) to be served based on a needs assessment, client data, population data, or programmatic data produced or collected within the past five years.
- Provide or ensure access to health services, including primary and specialty health care, public health, behavioral health, and dental care.
- Implement a process for keeping community stakeholders informed.

Desired Standards and Criteria for a Rural Health Complex

The rural health complex should:

- Provide or ensure access to social support services that impact the social determinants of health.
- Coordinate and manage the care of its patients/clients, including coordination between multiple health care services, between multiple social support services, and between health care services and social support services.
- Implement strategies for addressing transportation barriers to accessing health and social support services for population(s) served.
- Have a business plan for providing services.
- Articulate outcomes to be achieved to address the identified needs of the population(s) being served and strategies for assessing progress toward those outcomes.

The most practical, feasible, and immediate approach to meeting the standards and criteria for rural health complexes is by investing in existing services and programs within the Mid-Shore Region. The desirability of this approach is clear, and has been reinforced as the region's health and social support services providers have responded to the COVID-19 pandemic. What is currently lacking, however, are the resources to sustain, enhance, and expand these services and programs to more completely address health needs of Mid-Shore residents.

The RHC calls upon the State of Maryland to implement recommendations emanating from previous reports and the following newer recommendations developed by the RHC.

Overarching recommendations to facilitate health improvement efforts:

- *Implement programs to increase the numbers and types of health professionals, such as nurse practitioners, physician assistants, nurse midwives, social workers, and dental hygienists, as well as community health workers, who will add capacity to the network of care providers in the Mid-Shore Region.* Investing in these programs will ease provider shortages and build sustainable Mid-Shore capacity.

- *Create an information hub, or "social home," to facilitate the coordination of health and social support services that impact health status*. Creating an information hub, or "social home," will better enable primary care providers to coordinate with social support services.
- *Fund expansion of existing Mid-Shore services and programs to meet the standards and criteria for a rural health complex.* Beginning to address unmet needs through expansion of existing services and programs is cost-effective, feasible, and practical.
- *Instruct county and State agencies to study and design models that offer improved coordination of health and social support services*. Local Health Improvement Coalitions can be instrumental in studying and evaluating models.

Specific recommendations to build on existing infrastructure within the Mid-Shore Region:

- *Build upon the services of the Mid-Shore Region's sole Federally Qualified Health Center, Choptank Community Health System (Choptank), to cover the entire Mid-Shore Region.* Choptank has demonstrated its capability to meet health needs. Additional and sustainable investments by the State of Maryland in Choptank are necessary to expand capacity to serve the entire Mid-Shore Region.
- *Ensure reimbursement and expansion of telehealth.* Telehealth has been a highly effective way to deliver services throughout the COVID-19 pandemic. Sustaining and expanding telehealth will enhance the Mid-Shore's longer-term ability to provide needed health services.
- *Ensure reimbursement and expansion of Mobile Integrated Health (MIH) services.* MIH services have been demonstrated to be cost-effective and meet important needs of Mid-Shore residents. Reliable and sustainable funding is necessary for MIH to meet long-term needs on the Mid-Shore.
- *Improve the efficiency and effectiveness of health and social support services delivery through strategies such as colocation of services and flexibility in use of State funds.* Successful approaches for coordinating the delivery of health and social support services have been demonstrated. Attention should be given to expanding these approaches throughout the Mid-Shore Region.
- *Engage the Mid-Shore Region's two hospital systems, University of Maryland Shore Regional Health and Anne Arundel Medical Center, in developing strategies and actions to fill gaps in specialty care and better coordinate with other providers of health care, dental care, behavioral health, and social support services.* The Mid-Shore Region's hospital systems have demonstrated a desire to address unmet needs for health services. Maryland's Health Services Cost Review Commission can provide the flexibility and incentives for these hospital systems to enhance their efforts in meeting these needs.

The RHC strongly believes that immediate attention to build on the Mid-Shore Region's existing infrastructure will have a positive and sustainable impact on the health of the region's residents.

Introduction

The Eastern Shore of Maryland encompasses the nine counties in the state that are east of the Chesapeake Bay, with five of those counties comprising the Mid-Shore Region: Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties. This area of the state is largely rural and experiences many of the challenges associated with the delivery of health services in rural areas.

In May 2018, the Mid-Shore Rural Health Collaborative (RHC) was established through Senate Bill 1056 to help address these challenges. The legislation describes the purposes of the RHC as "to:

(1) Lead a regional partnership in building a rural health system that enhances access to and utilization of health care services designed to meet the triple aim of:
    (I) Providing health care;
    (II) Alignment with the State's Medicare waiver; and
    (III) Improving population health;
(2) Mediate disputes between stakeholders;
(3) Assist in collaboration among health care service providers in the mid-shore region;
(4) Increase the awareness among county officials and residents regarding the health status, health needs, and available resources in the mid-shore region; and
(5) Enhance rural economic development in the mid-shore region."[1, page 3]

As one means of achieving these aims, the RHC was charged to "direct the establishment of rural health complexes by:

(I) Assessing the needs of communities in the mid-shore region that lack access to essential community-based primary care, behavioral health, specialty care, or dental care services;
(II) Identifying care delivery models that have the potential to reduce deficits in care; and
(III) Convening health and hospital systems, community organizations, and local stakeholders to build consensus on the appropriate scale of a rural health complex."[1, pages 6-7]

A rural health complex is defined in Senate Bill 1056 as "a community-based ambulatory care setting or inpatient care setting that integrates primary care and other health care services determined to be essential by the Collaborative [RHC] with input by the community, and determined to be sustainable by the Collaborative."[1, page 2] The overarching goals of rural health complexes, as recommended in the 2017 Workgroup on Rural Health Delivery report, *Transforming Maryland's Rural Healthcare System: A Regional Approach to Rural Healthcare Delivery*, 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."[2, page 9]

Senate Bill 1056 indicates that the RHC "shall direct the establishment of rural health complexes" and instructs the RHC to "report to the Governor and … the General Assembly on the standards and criteria that a community must meet to establish a rural health complex" by December 1, 2020.[1, pages 6-7] These standards and criteria that a community must meet to establish a rural health complex, along with standards and criteria for a rural health complex, are to be used to guide the approval of rural health complexes, as recommended by the RHC.[1]

To lay the groundwork for these efforts to improve health care delivery in the Mid-Shore Region, the RHC brought together representatives of the five local health departments serving the region, the two hospital systems present in the region (University of Maryland Shore Regional Health and Anne Arundel Medical Center), the federally qualified health center that operates in the region (Choptank Community Health System), primary care services, specialty care services, behavioral health services, emergency services, social services, agency on aging, transportation, education, and local management board, as well as health care consumers from each of the counties. These representatives met from September 2018 through November 2020; details about RHC meetings and discussions can be found on the RHC website.[3] The RHC reviewed previous reports and other literature relevant to health in the Mid-Shore Region, gathered information on the current state of services in each county, explored models of rural health care delivery, and prioritized needs and solutions for transforming the health care system. Based on this, the RHC developed standards and criteria that a community must meet to establish a rural health complex, standards and criteria for a rural health complex, and recommendations for implementation.

This report includes:

- Needs impacting health in the Mid-Shore Region
- Key considerations in developing recommendations to improve health in the Mid-Shore Region
- Standards and criteria for establishing rural health complexes in the Mid-Shore Region
- Recommendations for implementing rural health complexes and improving health in the Mid-Shore Region

These recommendations can serve as a foundation for addressing health needs in the Mid-Shore Region and in other rural areas across the state.

Needs Impacting Health in the Mid-Shore Region

The RHC discussed a variety of needs that, if addressed, will help enhance health for residents of the Mid-Shore Region. These include the availability of and access to health care services and social support services, coordination of health care services and social support services, and transportation barriers.

Enhanced Availability of and Access to Health Care Services

The availability of and ease of access to health care services directly impact the health of the population. Nationally, nearly 20% of the population resides in rural communities, yet less than 10% of health care providers work in these communities.[4] Access to care has been identified as a top concern throughout rural Maryland, including in the Mid-Shore Region, with concerns including long wait times, limited availability of and time during appointments, lengthy travel times, and retention of providers, among others.[5, 6] There are shortages of health care providers in the Mid-Shore Region that stretch across primary care, behavioral health, and specialty care, and it is difficult to retain health care providers even when effectively recruited.[6, 7] As the population living in the Mid-Shore Region continues to age,[8] the demand and need for health care services will likely increase.

Primary care services, including effective prevention and chronic disease management, are important to achieving better health outcomes. While there is often a desire for more medical specialists in rural areas for convenience, comprehensive primary care must form the foundation for any effort to address health care access and delivery.

Multiple aspects of comprehensive primary care may be insufficient or lacking in rural areas. The Mid-Shore Region has a shortage of primary care providers, and the situation does not appear to be improving. Both wellness and prevention services are in short supply.[7] For example, many pregnant women in rural counties have difficulty finding early prenatal care, and this situation can be especially challenging for women who lack health insurance. Where prenatal services are available, transportation to those services is often an issue. Across the country, "in 2016, >5 million women lived in counties without a maternity care provider or hospital offering maternity services, and 10 million women lived in [an] area with limited access" to these services.[9, page 132] In the Mid-Shore Region, there is a shortage of obstetricians and related services, as well as a shortage of pediatricians. Similarly, no geriatricians provide services on the Mid-Shore. While community health workers (CHWs) can supplement the services provided by physicians and other health care professionals, incentives often are insufficient for individuals considering this career to invest the time and resources in the needed training, and physicians may be hesitant to use CHWs.

The need for behavioral health services continues to increase. This will likely rise further as the population grapples with the behavioral health impacts of the COVID-19 pandemic. Behavioral health services are a growing need across the country for all age groups. However, the need is greater in rural areas, where there are fewer services for children, youth, and seniors and fewer providers who can prescribe medications if needed.[10] Behavioral health is a priority throughout rural Maryland, with needs for additional providers and facilities, as well as specifically within the Mid-Shore Region.[5, 6] The Health Resources and Services Administration (HRSA) suggests that the Mid-Shore Region has an adequate supply of psychiatrists. However, state demand estimates/models note an undersupply in Caroline, Kent, and Queen Anne's Counties. Overall, there is inadequate access to mental health, behavioral

health, and substance abuse services throughout the Mid-Shore Region. This is primarily due to inadequate supply of behavioral health providers and the cost of these services. Across the Mid-Shore, there are 24 agencies providing behavioral health services. For All Seasons, Inc. serves the largest number of clients at 2,350 and rising among English, Spanish, and Haitian Creole-speaking populations, delivering 120 hours per week of psychiatry time to children, adults, and seniors, among other services. Behavioral health programs throughout the Mid-Shore have insufficient resources and are understaffed, in part due to a shortage of providers who can prescribe medications. Reimbursement for services, such as outpatient substance abuse services or counselling by phone, is insufficient to cover the costs, and organizations have to find ways to cover those losses to sustain these services. The limited behavioral health workforce in the Mid-Shore Region affects the ability to fill all of the needs for care and leads to competition among organizations for providers. Increasing the number of programs or entities providing services does not necessarily increase the number of providers – providers may rotate among organizations. New programs are created, but the net amount of services provided may not significantly increase.

Comprehensive dental care is also critical to ensuring health. Basic preventive and acute dental services are frequently unavailable to low-income residents in rural areas. While providers of these services may be available, individual providers may limit the types of insurance they accept.[5] For example, Kent County does not have any dental care providers who accept Medicaid. Consumers, even those with insurance and with providers who accept that insurance, may have substantial deductibles, co-pays, and co-insurance that pose challenges to affording services. Often providers will not see patients who are unable to pay.

Many types of specialty care services are not provided within the Mid-Shore Region. Rural areas often lack sufficient population or population density to support these services, resulting in the need for rural residents to travel to urban or suburban areas to visit medical specialists.[5] This is challenging for many, including low-income residents without their own transportation and seniors who no longer feel comfortable driving on state highways, and is compounded by limited public transportation options. With the COVID-19 pandemic, more telehealth services have been allowed and reimbursed in the state, which has been a significant benefit for people who have transportation challenges. However, a sizable percentage of the population on the Mid-Shore has limited high-speed internet connectivity.

Not every county in the Mid-Shore Region has a hospital, and urgent care facilities differ from one county to another.[5] Additionally, Emergency Medical Services (EMS) vary across the region. EMS are often provided by networks of volunteers, and the number of volunteer emergency medical technicians (EMTs) is declining. Furthermore, EMTs may be called to serve individuals needing mental health and substance abuse services without the training to meet those needs. In addition, there is a shortage of emergency vehicles.

Several other factors also impact access to health care services. For example, one strategy for recruitment and retention of health care providers is offering training programs in locations where providers are needed. However, training programs in the Mid-Shore Region are limited for individuals desiring to become health professionals or to continue their education. Non-English language services are also limited in the region, as is a deeper understanding of the needs across diverse cultures. Due to aging medical facilities, seniors and individuals with disabilities may experience difficulty accessing

services. Employed young adults on the Mid-Shore often do not make a living wage, which limits their ability to afford health insurance and health care. Low levels of health literacy may limit the effective use of health insurance for those who have it.

Enhanced Availability of and Access to Social Support Services

Improved health cannot be achieved through the provision of health care services alone. Health is also heavily influenced by social factors. Social support services, including both human services and social services, that impact the social determinants of health (e.g., housing, food, education, transportation, violence, social support, employment, health behaviors) are vital to health. Addressing social determinants of health has been noted as highly important in rural Maryland communities.[5]

Within the Mid-Shore Region, there is a particular gap in social support services that meet basic needs among low-income individuals to address immediate health concerns and support improved longer-term health outcomes. This includes a need for early social support services to prevent future physical, mental, and behavioral health problems, as well as substance use disorders.

The mere presence of social support services within a community can be insufficient for meeting all of the needs that exist. Social support services are often allocated based on means tests, yet many Mid-Shore residents in need do not qualify. Furthermore, there is a lack of capacity within existing services, as well as gaps in terms of filling basic food, clothing, and shelter needs. For example, the Maryland Department of Aging's Senior Care Program provides small awards to counties to meet needs of seniors for which there are no other sources of assistance. In Fiscal Year 2020, the Talbot County Health Department received $115,000 from the Department of Aging and $50,000 from the Talbot County Council to serve 213 seniors. While even small amounts of funding can make a big difference in keeping seniors as safe as possible in their homes, only a portion of those eligible and in need were able to be served.

The availability and variety of social support services vary substantially from county to county, and services may be scarce in the most isolated or remote rural communities. Social support services are provided by many different governmental and nongovernmental entities (e.g., food banks, faith-based organizations, Villages, ride-share providers). The types of services provided by the various agencies and organizations, as well as their capacity, is not uniform. Furthermore, there is no entity charged with coordinating all services for a client.

The social support services provided by governmental, nonprofit, and charitable organizations are highly influenced by their missions, interests, and availability of resources. This can lead to gaps in services, both in terms of the services available within a community and the services offered and provided to individuals. Additionally, community organizations may duplicate some service offerings while leaving gaps in other areas. An uncoordinated system of care makes it difficult for health care providers and individual consumers to navigate the various service options. This is especially true for individuals with multiple needs who may qualify for or benefit from multiple support services. Because of the scarcity of resources, services are often limited to individuals with the most critical needs, rather than covering the entire range of those who need help. This leaves individuals with unmet needs and increases reliance on nongovernmental organizations or volunteers.

Better Coordination of Health Care and Social Support Services

In addition to having enough services to meet the needs of the population, services should be coordinated for maximum efficiency and impact. Within rural Maryland, both health care providers and consumers have identified lack of care coordination as a concern.[5] In the Mid-Shore Region, health care services often are not coordinated across providers. Similarly, there is a lack of coordination when social support services are needed to supplement health care services. Although communication and coordination occur informally, there is often little formal and systematic communication and coordination between health care providers and providers of social support services. These informal connections are very dependent on personal relationships and are at risk of dissolving when there is staff turnover or funding priorities change.

Providers in rural Maryland have expressed a need for "a centralized, user-friendly, up-to-date database of rural health services that could be easily accessed and used to refer people to services."[5, page 28] In the Mid-Shore Region, there is no reliable single point of reference for accurate and current information about social support services that a health care provider can access. This creates a communication barrier between health care and social support services providers, inhibiting the possibility of making formal referrals for services. Health care providers on the Mid-Shore often serve patients from multiple counties and report that coordinating social support services for patients across counties is virtually impossible. In addition, data and information are not typically shared across health care and social support services. When sharing does occur, this often is not done in a systematic manner.

The Maryland Total Cost of Care Medicare Waiver creates a "medical home" within primary care practices for coordinating all health care and, eventually, social support services.[11] The waiver also creates Care Transformation Organizations (CTOs) to provide support to primary care providers. A CTO is defined as "an entity that hires and manages an interdisciplinary care management team capable of furnishing an array of care coordination services to Maryland Medicare beneficiaries attributed to Participant Practices. The interdisciplinary care management team may furnish care coordination services such as: pharmacist services, health and nutrition counseling services, behavioral health specialist services, referrals and linkages to social services, and support from health educators and Community Health Workers (CHWs)."[12] CTO funding allows for the coordination of services; however, such coordination is provided primarily to the highest risk patients due to funding limitations. Many additional patients could benefit from better coordination of health care and social support services.

Medicaid and Medicare Managed Care Organizations (MCOs) also have a responsibility to ensure their patients receive the services they need and that help is provided to coordinate those services. The experience in Maryland has been that these organizations spend most of their efforts on coordinating health care services and less on social support services, although the latter are also needed for health improvement.

Reduced Transportation Barriers

Transportation is key for accessing health care and social support services. Currently, few health care or social support services are provided within clients' homes, requiring individuals to travel to access services. Both health care consumers and providers have identified transportation as the most common barrier to accessing health care in rural Maryland. Transportation is seen as a barrier within every rural

county in the state, including those on the Mid-Shore, and for all types of health care services.[5, 6] Transportation issues include a lack of comprehensive bus routes, limited hours of operation and unreasonable schedules for public transportation, a lack of or limited medical transportation services, and a complete absence of public transportation options in some communities.[5]

Improving access to health care and social support services involves enhancing access to current public transportation systems, developing additional transportation options, and decreasing the need for transportation. Within the Mid-Shore Region, public transportation options are limited,[6] and individuals are heavily reliant on personal cars to access services. Funding for public transportation is inadequate to meet the transportation needs of Mid-Shore residents, and funding and regulatory requirements hinder the ability to provide the most appropriate transportation services. While Medicaid provides some coverage for transportation to health care services, the same is not true for Medicare, so transportation challenges may be especially difficult for low-income patients without Medicaid coverage. Challenges may also be more severe for those with mobility problems.

In addition, where public transportation options are available, current services may not be used as much as they could be due to a lack of awareness of, understanding of, or comfort with those services. There are needs to enhance individuals' ability to make use of existing services, such as by providing travel training and companions for elderly individuals needing assistance with using public transportation.

Due to the geography of the area and the distribution of providers, travel time for some services may exceed an hour. An expansion of telehealth would reduce the need for travel. Other strategies include increased colocation of services to reduce the number of visits to different locations and home visits by various types of health professionals and social support service providers.

Key Considerations in Developing Recommendations to Improve Health in the Mid-Shore Region

As described above, the RHC is charged with identifying standards and criteria a community must meet to establish a rural health complex. Through careful and in-depth deliberations, the RHC determined that new comprehensive rural health complexes are unlikely to be established in Mid-Shore communities without significant funding from the State of Maryland. The RHC's recommendations reflect the infeasibility of establishing rural health complexes in the absence of such funding and rather focus on what is feasible to accomplish to address and improve the health of Mid-Shore residents. In addition to fiscal realities, other factors impacting rural health in Maryland and across the nation were also considered. These are discussed below.

Efforts are underway in Maryland to create "medical homes" within primary care practices to improve coordination of health care and social support services to obtain better health outcomes. RHC members expressed that, while it may be reasonable and feasible for primary care providers to coordinate health care services, it is difficult for these providers to navigate and coordinate social support services.

Primary care providers have expressed the need for a single phone number to call to access social support services. The social support services available and the organizations that provide them vary greatly between counties, and these services are not well coordinated within or between counties to assist clients with multiple social support needs. Primary care providers attempt to link patients to needed social support services, but are limited by time constraints and their ability to access current and accurate information about these services.

Some counties within the Mid-Shore Region have established programs or mechanisms to improve coordination of health care and social support services. However, these programs and mechanisms are not region-wide, often are limited in capacity, may have limited target populations, and frequently depend on grant funding.

Examples of current efforts to coordinate health care and social support services in the Mid-Shore Region include:

- Queen Anne's County's colocation of programs provided by the health department, department of social services, and area agency on aging to improve coordination and integration of services provided by these agencies.
- Talbot County's integration of Senior Care funds for the area agency on aging with the health department's Adult Evaluation and Review Services (AERS) assessments to enhance efficiency, coordination of wraparound services, and numbers of people served.[13]
- Queen Anne's County's Mobile Integrated Community Health (MICH) program (other Mid-Shore counties are developing similar programs) to improve coordination and delivery of services for high users of the emergency department and individuals with multiple preventable hospitalizations.[14]

In other states, central coordinating hubs have been created to help coordinate health care and social support services to meet the multiple and often complex needs of residents. These include

NCCARE360 in North Carolina, Thrive Local in the US Northwest, and the OneCare Vermont Care Navigator.

Coordinating social support services for people with multiple social support needs is no less daunting than coordinating health care services.

Maryland's Total Cost of Care Medicare Waiver provides for the creation of CTOs and positions primary care providers to serve as the "medical home" for their patients, with the responsibility to coordinate health care services and to eventually coordinate social support services as well. Coordinating social support services can be far more difficult than coordinating health care services, as there is no parallel "social home" for coordination, and these services often are difficult to navigate for the vulnerable populations who need the services the most. Creating lists of services and where they are located has helped, but it has been challenging to keep them updated. In addition, these registries are not always user-friendly and can leave people wandering between organizations looking for services.

Health care providers report difficulty in understanding exactly what social support services are available and the eligibility requirements for those services. To make things more complex, many primary care providers in the Mid-Shore Region see patients from multiple counties, and social support services provided by governmental agencies are not always located within the same agencies across the different counties. In addition, the same services may not be available in all counties, and the agencies designated to provide services may not have sufficient resources to fill all of the need. Essentially, a "social home" is needed to work with a client's "medical home" to facilitate coordination.

Maryland has implemented programs to help coordinate health care and social support services, but these are currently inadequate to meet needs.

The most recent attempt in Maryland to help manage and coordinate patient care, including coordinating health care and social support services, was the establishment of CTOs in 2019 to serve Medicare beneficiaries. While CTOs are new to Maryland and their full impact has yet to be determined, with existing funding levels and requirements, it is unlikely that these entities will be able to meet the health care and social support services coordination and management needs of the majority of Mid-Shore Medicare beneficiaries. To date, CTOs have focused on higher risk patients in an effort to avoid adverse health outcomes. In addition, Medicaid MCOs support the management and coordination of health care and social support services to some extent through their networks of providers; however, this has not been well-defined.

Maryland Access Point (MAP) is also designed to link individuals to health care and social support services, with a focus on the elderly population. This program was established to provide a single entry point for those needing long-term support services. It offers counseling to individuals seeking information, referrals and program support for long-term services, and an online resource directory to assist the public and professionals in finding and accessing services.[15] As noted across counties in the Mid-Shore Region, MAP funding has been inadequate to keep information up-to-date and respond to Mid-Shore resident needs.

Additionally, health insurers have developed a variety of ways to manage and coordinate health care and social support services. This varies tremendously across organizations and, again, does not seem to function in a way that optimally supports Mid-Shore resident needs.

Throughout the RHC's deliberations, members have noted the tremendous task of coordinating across different types of services and providers. Existing efforts have been limited by factors such as the availability of resources for implementation, a lack of mechanisms to sustain the efforts, or a narrow focus on a specific segment of the population on the Mid-Shore. While coordination is difficult, the need is ever-present. The RHC considers its recommendation to enhance and build on entities that already exist in the Mid-Shore Region to be the most efficient and effective approach for expanding coordination capabilities to better meet the needs of Mid-Shore residents.

Maryland's hospital global budgeting methodology provides insufficient incentives for hospitals to invest in prevention and ambulatory services to reduce the overall cost of care or growth rate for the total cost of care.

While Maryland hospitals have an incentive to stay within their global budgets, there is little incentive to bill below the cap placed on those budgets. This can result in a slight bend to the total cost of care trend line, but will not likely generate savings greater than the cap placed on budgets. Any savings realized are more likely to benefit third-party payers because of lower utilization of hospital services.

One possibility to achieve greater investment in services to improve the well-being of Mid-Shore residents is through the use of hospital community benefit funds. However, the incentives for such investments are unclear.

Health professionals such as nurse practitioners, physician assistants, nurse midwives, social workers, and dental hygienists, as well as community health workers (CHWs), are helping to extend the network of care providers in rural areas.

Health care providers are often in short supply in rural areas, and a variety of options are routinely discussed for alleviating physician shortages. Offering training to enable individuals already residing in rural settings to take on roles within the health care system may be easier than recruiting physicians or other providers from urban and suburban areas. There are major needs for frontline providers in primary care, behavioral health, prenatal care, and dental care, which could be met by training existing professionals to take on new roles. For example, training could be made available for registered nurses interested in becoming nurse practitioners, psychiatric nurse practitioners, or nurse midwives. Social workers could receive training to become licensed clinical social workers for behavioral health services, and other local training could be made available to individuals interested in pursuing careers as dental hygienists to help with children's preventive dental care. In addition, barriers to pursuing such training opportunities could be addressed. Chesapeake College provides educational and training programs focused on the health professions in the Mid-Shore Region, but additional programs would be needed to cover the full spectrum of roles. Studies also have shown that nurse practitioners and physician assistants can reduce hospitalizations and costs.[16]

CHWs also are increasingly being employed throughout the nation to provide case management, health guidance, social assistance, and health education, and to link individuals to health and social

support services. CHWs often come from the communities they serve, bringing to the table important linguistic and cultural skills. Local CHWs also typically have extensive knowledge of the services available within the community. Based on evidence of effectiveness, the U.S. Community Preventive Services Task Force recommends use of CHWs for specific interventions, including cancer screening, cardiovascular disease prevention, and diabetes prevention and management.[17] In 2018, legislation was passed in Maryland and signed into law (Senate Bill 163) to address training and certification of CHWs. The Eastern Shore Area Health Education Center provides CHW training in the Mid-Shore Region.

Financial concerns can present barriers for enhancing the network of care providers. Loan repayment programs may be more available to physicians than to other types of health professionals, and more available to professionals practicing in designated health professional shortage areas. In addition, reimbursement is often a challenge for the various types of health professionals mentioned above and for CHWs. As hospitals increasingly have salaried providers, reimbursement is becoming easier to achieve. Hospitals may also benefit from using community benefit funds to support training of these types of health professionals and CHWs.

The health professional workforce could also be extended by expanding the types and numbers of professionals who can provide services in the state. For example, legislation is currently being drafted that would allow providers who are licensed in Maryland to practice from another state by telehealth. The Coronavirus Aid, Relief, and Economic Security (CARES) Act has allowed additional flexibility for health professionals to provide services across state lines during the COVID-19 pandemic. State legislation could provide a more permanent solution to increase the availability of services in the state.

Recruiting and retaining primary care providers in rural areas is difficult, but not insurmountable.

Shortages of physicians in rural areas are nothing new. These have been experienced nationwide for decades. Studies have identified many reasons why recruitment efforts have fallen short; however, there are effective strategies and efforts underway in the Mid-Shore Region for recruiting and retaining physicians. For instance, physicians who have grown up in rural areas are more likely to practice in rural areas than other physicians.[18] When hospital administrators at University of Maryland Shore Regional Health (UM SRH) learn of local students interested in becoming physicians, they provide letters of recommendation as part of the students' applications, citing the drastic need for physicians in rural areas and highlighting the win-win created when medical school graduates want to return home to practice medicine in their rural hometowns.

Placing providers-in-training in rural areas further increases the likelihood of them choosing to practice in rural areas.[18] UM SRH and Choptank Community Health System (Choptank) are working in collaboration with the University of Maryland School of Medicine and its Department of Family and Community Medicine to develop a primary care residency program on the Eastern Shore. When approved and fully developed, residents will experience a variety of primary care-related services, from hospital-based hospitalist programs to community-based primary care medicine. The Anne Arundel Medical Center is also looking to expand its residency program to serve the Mid-Shore Region. Such residency experiences often result in an appreciation for rural medicine and opportunities to stay and practice in rural communities.

Additionally, offering competitive compensation packages to providers complemented with loan repayment opportunities has been shown to influence physicians' decisions to practice in rural areas. For private practice groups looking to expand their primary care and specialty care base, UM SRH offers Practice Support Agreements (PSA) to help private practice providers offset the financial losses usually experienced by new providers in their first two years of service as they ramp up to full productivity. The community and UM SRH benefit because new providers are hired to support rural area needs, and the physician practices benefit by reducing the financial risk of adding new providers in their rural regions. Other factors, such as community location, scope of practice, lifestyle, quality of life, educational opportunities, job prospects for partners, and family fit with the community, also influence the decisions of providers to practice in rural areas.[19]

Inadequate public transportation options in rural areas are a major factor limiting access to health and social support services.

Transportation services in rural areas are not budget neutral. They typically require subsidies to cover costs as a result of the distances to be covered, lack of frequent routes, and small volume due to sparse populations. During RHC meetings, presenters discussed options that have helped, or could help, address transportation issues in the Mid-Shore Region, such as health insurers and hospitals providing transportation options and transportation services offering travel companions to help older clients use buses. Volunteer groups have helped fill gaps, but service availability and reliability for rides vary considerably when relying on volunteers. The greatest transportation needs may be for fragile seniors with Medicare coverage, which does not reimburse for non-ambulance transport, as Medicaid does.

Telehealth decreases the need for transportation to services for many types of health care visits. In response to the COVID-19 pandemic, telehealth has increasingly been used in the Mid-Shore Region and has gained in acceptance by both providers and patients. Continued expansion of telehealth holds great promise for this area. Assuring access to high-speed internet and adequate reimbursement for these services will be critical for the long-term success and use of telehealth.

Establishing Rural Health Complexes in the Mid-Shore Region

As defined in Senate Bill 1056 (Rural Health Collaborative Pilot), a rural health complex is "a community-based ambulatory care setting or inpatient care setting that integrates primary care and other health care services determined to be essential by the Collaborative [RHC] with input by the community, and determined to be sustainable by the Collaborative."[1, page 2] The purpose of a rural health complex is to make basic health services more accessible to the low-income and most vulnerable portions of a rural population that is medically underserved and has many social support needs for better health outcomes. While all income levels may be served by a rural health complex and receive the benefits of such a center, the investment is primarily aimed at ensuring that the most vulnerable populations receive services. Given that, rural health complexes should primarily be located in rural areas that are medically underserved or that can demonstrate that a significant proportion of the population has barriers to receiving the health care services and social support services needed for better health outcomes.

The rural health complex concept has at its core a primary care practice and builds services around this practice with the goal of providing better access to health care and social support services and enabling utilization appropriate for achieving better health outcomes. Services may be colocated or formally coordinated to make it easier for people to navigate the health care and social support services systems and use basic health care services (e.g., primary care, behavioral health, prenatal care, dental care) and social support services (human services and social services).

Within the rural health complex framework, primary care providers provide a "medical home" for their patients, and there is a plan for achieving a "social home" that coordinates social support services. A system is created for bi-directional communication and sharing of information (with patient/client consent) between health care and social support services providers, as needed to address the concerns and needs of individual patients/clients.

The rural health complex has a local board governing its actions with a mechanism to obtain continuous health care consumer input, preferably by including health care consumers as well as local official representatives on the board. This governing board may be one that already exists or is created for the purposes of the rural health complex. The rural health complex should provide reports to elected officials or other stakeholders of the counties it serves at least annually and should collect data to demonstrate the efficiencies and effectiveness of the rural health complex.

If funding becomes available for establishing rural health complexes, priority funding should go to entities that can best provide colocation and integration of the needed health care and social support services by building upon infrastructure currently available in a community to achieve maximum impact for the funds invested. A plan should be put in place for evaluating efficiency and effectiveness of complexes.

The RHC's recommendations are situated within the current environment in the Mid-Shore Region and should be viewed in that light. The RHC strongly believes that any rural health complex should build on the existing infrastructure in a community before creating something new, unless it can be demonstrated that enhancement of existing infrastructure cannot meet the community's needs and something new is necessary. In establishing rural health complexes, the emphasis should be placed on

enhancing or supporting the services and programs already established within the community. With additional resources, the RHC believes Choptank Community Health System, the Mobile Integrated Community Health program, expanded senior care programs as in Talbot County, additional colocation of health and social support services as in Queen Anne's County, and existing hospital systems could collectively address all of the standards and criteria for a rural health complex through partnerships or expansion of existing services, facilities, or telehealth.

The desire to build on existing organizations, services, and programs should not, however, be viewed as a desire for the status quo. Rural health complexes should be innovative and adaptable to respond to the evolving needs of their communities. Rural health complexes should not be a one-size-fits-all mold, but be tailored to the needs of the communities and populations served and help to address, rather than exacerbate, health disparities and inequities present within those communities and populations.

The RHC believes that to be eligible to serve as a rural health complex, an entity should have experience coordinating health and social support services. The RHC defined health services as encompassing primary and specialty health care, public health, behavioral health, and dental care. Social support services include human services and social services that impact the social determinants of health (e.g., housing, food, education, transportation, violence, social support, employment, health behaviors). Ideally, experience coordinating these services should be in a rural area. If an entity has not engaged in this type of coordination in a rural area, it should demonstrate how it would apply its previous experience in coordinating services to the rural environment. The RHC believes this experience is critical to successful implementation within a reasonable amount of time.

The RHC recognizes the need for flexibility within individual rural health complexes. The standards and criteria the RHC developed for rural health complexes are designed to be specific enough to determine the potential value of complexes and to hold established complexes accountable, but flexible enough to allow for individual complexes to be tailored to the needs and resources of the communities they serve.

Specific requirements for communities looking to establish rural health complexes and for entities seeking to be designated rural health complexes are provided below. Recommendations for implementation of the rural health complex concept follow.

Standards and Criteria for Establishing Rural Health Complexes in the Mid-Shore Region

The following standards and criteria for establishing rural health complexes address two separate, but related, concerns:

- Elements that make a community eligible for a rural health complex
- Elements that must be present for an entity to be a rural health complex

The RHC recognizes that the creation of rural health complexes exists on a continuum rather than being an all-or-nothing phenomenon, and that these complexes will evolve and mature over time. Consequently, the RHC determined minimum (required) standards and criteria that rural health complexes must meet at the time of establishment and additional (desired) standards and criteria that would help these complexes achieve their maximum potential. Taken together, the required and desired standards and criteria describe the gold standard, or ideal, rural health complex.

For a community to be eligible to establish a rural health complex, the community must meet both standards and criteria described below. For an entity to be designated a rural health complex, the entity must meet the required standards and criteria at the time of inception and aim to achieve the desired standards and criteria over time.

Standards and Criteria a Community Must Meet to Establish a Rural Health Complex

- The geographic area/jurisdiction(s) to be served by a rural health complex is designated rural by the State of Maryland. The geographic area/jurisdiction(s) could consist of an entire county, a portion of a county, or a cross-county region.
- A needs assessment, client data, population data, or programmatic data produced or collected within the past five years that shows health needs of the population(s) to be served by a rural health complex is available. The population to be served by a rural health complex is defined as the population within a specific geographic area/jurisdiction. Relevant needs assessments could include local health improvement coalition (LHIC) needs assessments, hospital community health needs assessments (CHNAs), health department community health assessments (CHAs), federally qualified health center (FQHC) needs assessments, United Way community needs assessments, or behavioral health needs assessments.

Required Standards and Criteria for a Rural Health Complex

The rural health complex must:

- Have an articulated purpose, goals, and measurable objectives.
- Provide a description of the population(s) to be served, including health disparities and inequities contributing to those disparities. Population characteristics may include, but are not limited to, race, ethnicity, language, age, education level, income level, religious affiliation, employment, and insurance status. The description of the population(s) should include social, cultural, institutional, and other conditions that are contributing to health disparities.
- Demonstrate unmet health needs of the population(s) to be served based on a needs assessment, client data, population data, or programmatic data produced or collected within the past five years. In determining unmet health needs, the rural health complex must consider the needs of vulnerable populations present within the community it serves.
- Provide or ensure access to health services, including primary and specialty health care, public health, behavioral health, and dental care. Access to health services also includes managing and facilitating access to medications (prescription and non-prescription). The rural health complex will identify gaps in capacity for providing needed health services for the population(s) being served and implement strategies for increasing capacity. The rural health complex will implement strategies for improving access to health services that address individual and community needs (e.g., obstetrics, mental health and addictions, dialysis, elder care) and strategies to address identified health disparities. Health services provided by the rural health complex must be culturally and linguistically appropriate for the population(s) being served, and whenever possible, services provided should be evidence-based.
- Implement a process for keeping community stakeholders informed. Community stakeholders include and go beyond the governing bodies of the entities involved in the rural health complex.

The rural health complex must receive input from and be accountable to the community in which it is located and the population(s) it serves.

Desired Standards and Criteria for a Rural Health Complex

The rural health complex should:

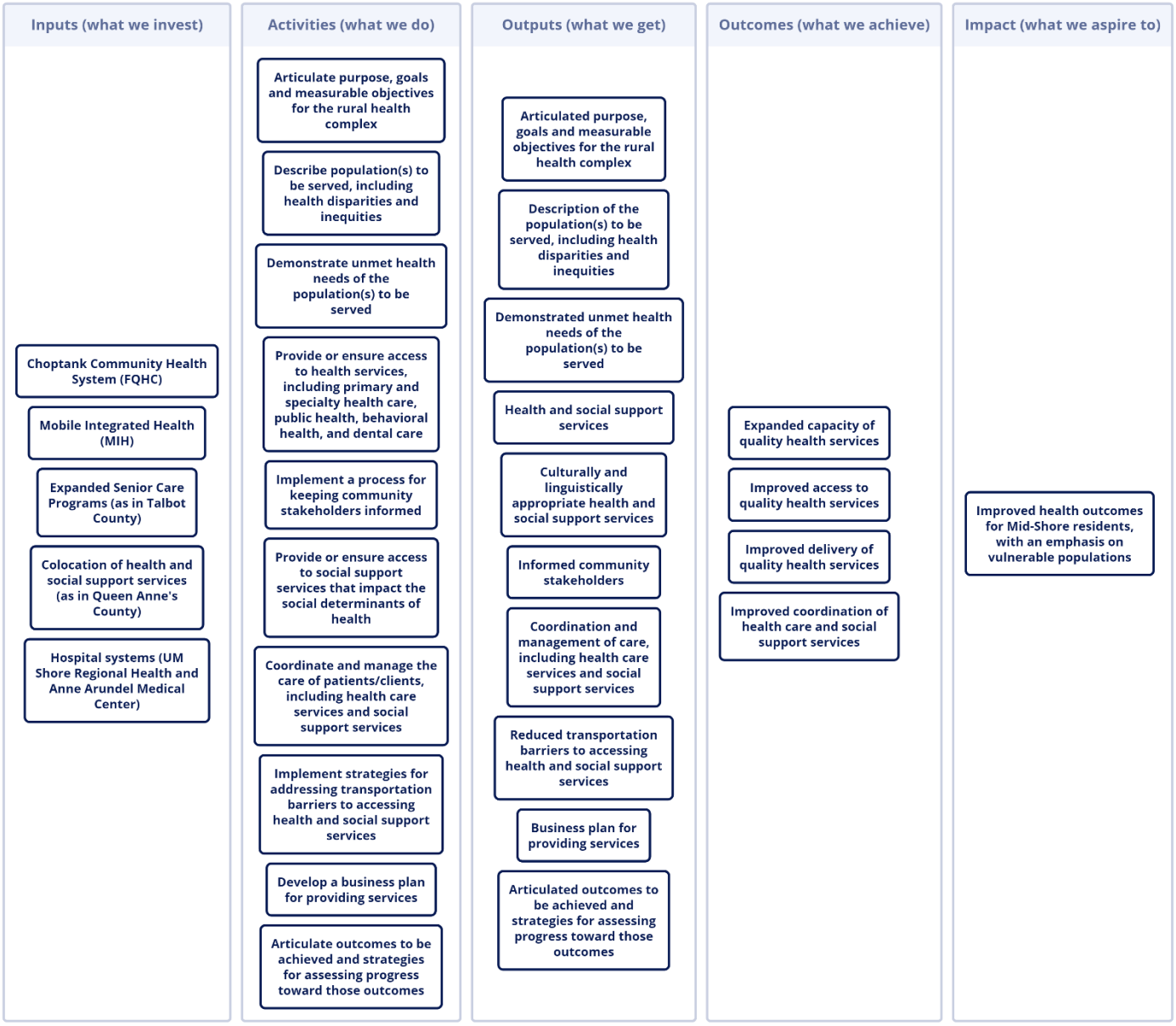
- Provide or ensure access to social support services (human services and social services) that impact the social determinants of health (e.g., housing, food, education, transportation, violence, social support, employment, health behaviors). The rural health complex should identify gaps in capacity for providing needed social support services for the population(s) being served and implement strategies for increasing capacity. The rural health complex should implement strategies for improving access to social support services that address individual and community needs and strategies to address identified health disparities. Social support services provided by the rural health complex should be culturally and linguistically appropriate for the population(s) being served, and whenever possible, services provided should be evidence-based. The rural health complex should provide primary care providers with easy access to current and accurate information about social support services available to the population(s) served by the rural health complex.
- Coordinate and manage the care of its patients/clients. Coordination of care includes coordination between multiple health care services, between multiple social support services, and between health care services and social support services. The entity serving as the rural health complex should demonstrate experience coordinating health and social support services or the ability to coordinate these services. In addition, it should demonstrate the commitment of health care, public health, behavioral health (mental health and addictions), dental care, and social support services entities (governmental and non-governmental) serving the community to provide coordinated services. The rural health complex should provide a plan for coordinating and managing care. When practical, existing infrastructure (e.g., care transformation organizations) should be used in the coordination of care. The rural health complex should determine the health and social support needs (e.g., transportation, housing, access to healthy food, undiagnosed diabetes, adverse childhood experiences) of individuals served by the complex on a regular basis. To the extent feasible, the complex should also determine the broader social determinants of health of the population(s) served on a regular basis. To facilitated coordination and management of care, information and data should be shared among care providers (among multiple health care services providers, among multiple social support services providers, and among health care services and social support services providers) systemically and on an ongoing basis, in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other legal requirements. When possible, information and data sharing should use systems that already exist for those purposes. The rural health complex should monitor population-level and systems-level health data and trends on an ongoing basis to inform the delivery of health care and social support services.
- Implement strategies for addressing transportation barriers to accessing health and social support services for the population(s) served. The rural health complex should work to reduce transportation barriers to accessing health and social support services. This may include assisting people in traveling to services and reducing the need to travel to services through

telehealth or bringing services to people's homes or other places they commonly access. Strategies for reducing transportation barriers should be based on transportation needs among the individuals and population(s) being served.

- Have a business plan for providing services. The business plan may include information about the resources the rural health complex is anticipating receiving, community resources that will be leveraged, partners engaged in the complex and their commitment to the complex, the backbone entity's fiscal soundness, how planned activities are consistent with Maryland's Total Cost of Care Medicare Waiver, and how services will be sustained over time. The business plan should include anticipated revenue from all sources (e.g., grants, fees) and anticipated expenditures.
- Articulate outcomes to be achieved to address the identified needs of the population(s) being served and strategies for assessing progress toward those outcomes. The rural health complex should establish these standards to which it will be held accountable. The rural health complex should establish measurable objectives and targets related to the outcomes to be achieved (short-term, intermediate, and long-term), determine how progress toward the objectives and targets will be measured and monitored, measure progress on an ongoing basis, and implement improvements as needed.

The following diagram presents these standards and criteria, along with existing organizations and programs present within the Mid-Shore Region that can serve as the foundation for implementation of the rural health complex concept.

Mid-Shore Region Health and Social Support Services Infrastructure to Achieve Better Health



Recommendations for Implementing Rural Health Complexes and Improving Health in the Mid-Shore Region

The RHC presents three sets of recommendations to improve access to and coordination of health and social support services in the Mid-Shore Region: 1) overarching recommendations to facilitate health improvement efforts; 2) specific actionable recommendations to build on existing infrastructure within the Mid-Shore Region; and 3) supportive recommendations detailed in previous reports.

After more than two years of deliberations, the RHC concluded that building on what exists is the most practical and feasible solution to meet the health needs within the Mid-Shore Region. The COVID-19 pandemic and resulting state budget realities have made this even clearer, as new initiatives and programs are unlikely to be implemented in the short-term.

In reaching this conclusion, the RHC explored a variety of models for rural health complexes. These ran the gamut from locating a new set of services in newly built facilities near existing hospitals or other medical facilities to developing a continuously updated virtual resource that links and helps coordinate a wide range of health and social support services. Ultimately, the RHC determined that building on what currently exists and has been demonstrated to work on the Mid-Shore will be the most efficient, effective, and quickest way to achieve the goals for rural health complexes.

Past reports addressing health needs in the Mid-Shore Region, while well-researched and well-intentioned, have resulted in unfulfilled aspirations and unimplemented recommendations. Little has changed as a result of these reports.

What is truly bold is to acknowledge past failings, learn from previous initiatives, and move forward in a way that is both aspirational and grounded in the constraints of current reality. It is necessary to marry the lofty goals and ideals that one might envision if asked to remake the rural health system from the ground up with the practical aspects of what can be accomplished in the real world of structural, financial, geographic, workforce, and other limitations. To do so, the RHC believes that it is most feasible and highly desirable to begin making progress by building on what already exists within the five Mid-Shore counties. Despite the challenges that exist in providing health services in a rural area, there are numerous examples of initiatives and institutions that are having a positive impact within their communities. These initiatives and institutions can form the foundation for a path forward.

The following recommendations are offered with this in mind and can be implemented incrementally and built upon, as resources permit. While the RHC believes that each of these recommendations holds value for improving health in the Mid-Shore Region, it recognizes that all may not be feasible to implement at this time. What is key, however, is that action be taken quickly to begin building on existing successful initiatives and institutions within the Mid-Shore.

Furthermore, actions taken to improve access to and coordination of health and social support services must explicitly and intentionally address health equity. Health disparities exist in the Mid-Shore Region by race, ethnicity, culture, language, immigration status, income, education, and other social factors. Often health disparities are unintentionally ignored by looking at aggregate data and addressing aggregate needs. The RHC's recommendations are designed to address potentially overlooked disparities and achieve greater health equity.

Overarching Recommendations to Facilitate Health Improvement Efforts

The following overarching recommendations focus on supporting capacity in the Mid-Shore Region to provide and coordinate services.

1. **Implement programs to increase the numbers and types of health professionals, such as nurse practitioners, physician assistants, nurse midwives, social workers, and dental hygienists, as well as community health workers (CHWs), who will add capacity to the network of care providers in the Mid-Shore Region.** This will increase capacity of needed primary care, behavioral health, prenatal care, and basic dental services. These professionals can play important roles in providing comprehensive care and services to Mid-Shore residents using team-based approaches that support individuals in functioning at the top of their scope of practice. Strategies should be employed to recruit rural residents interested in the health professions and provide training for these types of health professionals and CHWs throughout the Mid-Shore Region. The 2017 Workgroup on Rural Health Delivery report, *Transforming Maryland's Rural Healthcare System: A Regional Approach to Rural Healthcare Delivery*, provides seven specific recommendations that, if implemented, would expand the Mid-Shore Region's health workforce.[2]

2. **Create an information hub, or "social home," to facilitate the coordination of health and social support services that impact health status.** While Maryland's Total Cost of Care Medicare Waiver addresses creating a medical home as well as coordination of health and social support services, primary care physicians have been clear that it is not feasible for them to coordinate social support services for patients that live in five counties. As physicians in the Mid-Shore Region often have patients from multiple counties and social support services vary from one county to the next, it can be difficult to determine what social support services are available to a given patient. Primary care physicians have stated that they can provide the medical home for coordinating health services, but need "one number to call" for social support services, or a "social home" for patients. Implementing this recommendation will support Maryland's Medicare Waiver and Primary Care Program "to coordinate care for patients across both hospital and non-hospital settings, improve health outcomes, and constrain the growth of health care costs in Maryland"[20] and further the implementation of CTOs.

   Central coordinating hubs have been created in some states to help coordinate health and social support services to meet the multiple and often complex needs of residents. These include NCCARE360 in North Carolina, Thrive Local in the US Northwest, and the OneCare Vermont Care Navigator.

3. **Fund expansion of existing Mid-Shore services and programs to meet the standards and criteria for a rural health complex.** Every county in the Mid-Shore Region has documented needs for improved access, utilization, and coordination of health and social support services to improve health status. Stakeholders have demonstrated a willingness to partner for better delivery of health services and social support services. Building on what exists on the Mid-Shore offers a financially feasible, comprehensive, and coordinated plan for rural health complexes that meet the standards and criteria presented in this report. What is necessary is funding to support expansion of existing services and programs. Along with funding, there should also be a

strong evaluation plan to document benefits achieved over a three to five year period to aid decision making about the value of scaling the concept to other communities.

4. **Instruct county and State agencies to study and design models that offer improved coordination of health and social support services**. It is not clear what works "best" to coordinate health and social support services in rural areas, helping residents access the services they need and health care providers refer patients to resources that can assist them in locating services and coordinate services until the individual's needs are met. Registries of governmental and nongovernmental services can help, but are of limited benefit and have not proven to be the answer for residents with complicated needs. In the Mid-Shore Region, a variety of programs exist, such as mobile integrated health (MIH); Senior Care programs integrated with AERS assessments; colocation of health, social support, and aging services; MAP; and CTOs, with varying levels of success. For the health of Mid-Shore residents, and residents of other rural areas, it is important to learn from rural projects that have been successful in coordinating services for clients to determine which programs produce the best results for the resources required, and then to both promote and invest in those programs for sustainability and expansion. The Mid-Shore Local Health Improvement Coalition could play an important role in studying and evaluating models designed to improve coordination of health and social support services.

Specific Recommendations to Build on Existing Infrastructure within the Mid-Shore Region

The following specific recommendations focus on immediate actions the State of Maryland can take that will improve access to and coordination of health and social support services.

1. **Build upon the services of the Mid-Shore Region's sole Federally Qualified Health Center (FQHC), Choptank Community Health System (Choptank), to cover the entire Mid-Shore Region.** Choptank is based in Denton, in Caroline County, and currently serves populations in Caroline, Dorchester, and Talbot Counties through its facilities. FQHCs are designated by HRSA to provide primary care in underserved areas, and restrictions govern the locations in which they can operate and be reimbursed through the federal HRSA Health Center Program.[21] However, Maryland's State government can and should make a long-term investment in Choptank by providing additional and sustainable funding to expand Choptank's facilities and services to areas and populations not covered by existing funding. The State also should ensure that State-influenced policies support reimbursement of the health care (medical, dental, and behavioral health) and social support services (often connecting patients to services that exist in the community) provided by Choptank.

   Heavily relied upon throughout the COVID-19 pandemic, Choptank has demonstrated the quality and comprehensiveness of the services it provides to both its FQHC coverage area and throughout the Mid-Shore Region. Choptank has provided COVID-19 support to migrant camp owners and farmworkers and their families through a robust Migrant Health Program. In cooperation with the Maryland Department of Health, Choptank provided COVID-19 education and testing for migrant workers and their families at several locations in Kent and Queen Anne's Counties. Choptank helped owners prevent, mitigate, and manage COVID-19 outbreaks by

utilizing effective isolation and quarantine protocols and provide onsite education events and cohorting of COVID-19 positive patients at the migrant camps to reduce the spread of the virus among workers. Choptank's migrant health care providers performed testing for symptomatic migrant patients and ensured connection to mass testing events sponsored by the local health departments. Follow-up visits were scheduled for COVID-19 positive patients at each worksite with the Choptank care team. This effort is sustained by Choptank's health care providers who continue to support migrant camp locations via telehealth and onsite visits to ensure access to care and perform additional COVID-19 testing, as needed, while assisting with workers' plans for travel out of the country at the end of the season.

Throughout the COVID-19 pandemic, Choptank medical and dental centers have remained open. Choptank has been playing a key role in preventing unnecessary COVID-19 hospitalizations and ensuring continuity of medical and dental services for patients. Its teams pivoted quickly to telehealth, which was up and running in a matter of days. During the height of the pandemic to date, 65-70% of medical visits were provided virtually. By October 2020, Choptank had seen more than 9,000 patients via virtual visits, including both medical and dental visits. Choptank was an early COVID-19 tester and began providing this service in late February 2020. Care teams provide drive-up/walk-up testing for COVID-19 and other acute conditions. Choptank also participated in two community outreach events for testing in Caroline County and is serving on the Emergency Operations Centers for Caroline, Dorchester, and Talbot Counties.

On an ongoing basis, Choptank provides comprehensive primary health care and dental services, and it is in the process of expanding its behavioral health services. It also has extensive networks encompassing health care and social support services providers. Services are provided to low-income, uninsured, and underinsured populations and others who choose to access Choptank's services. Choptank also has demonstrated the ability to attract and retain health care providers and effectively use telehealth to enhance services. Choptank is well integrated into and respected by the community, consistently receiving high ratings through patient satisfaction surveys. Assuring accountability to the community, Choptank is governed by a 13-member Board of Directors comprised of at least 51% Choptank patients.

The infrastructure and capability already exist for Choptank to deliver and coordinate health care and social support services that improve the health of Mid-Shore residents. The limiting factor is capacity – both facilities and personnel. Choptank is capable of serving a wider area, with additional, sustainable, long-term State funding. Investing in Choptank and building on what is already working is both economically and programmatically feasible and beneficial.

2. **Ensure reimbursement and expansion of telehealth.** Throughout the COVID-19 pandemic, telehealth has been efficiently and effectively used to provide a variety of health services (primary care, specialty care, behavioral health, and others) to Mid-Shore residents. Due to the pandemic, some rules related to providing telehealth services have been relaxed. This has included permitting reimbursement of the delivery of telehealth services by phone, loosening requirements related to originating sites, and permitting licensed professionals who reside outside of Maryland to provide services within the state. In some instances, reimbursement levels have enabled services to be reimbursed at levels comparable to in-person office visits.

Barriers to telehealth also remain, such as limited high-speed internet accessibility for some Mid-Shore residents and low reimbursement levels for behavioral health services. However, the successful use of telehealth throughout the COVID-19 pandemic supports a role for continued flexibility in providing these services as well as providing reimbursement levels comparable to in-person office visits. Additionally, expanding high-speed internet access throughout the Mid-Shore Region will enable even more residents to receive telehealth services.

Access to medical specialists will likely remain an issue in rural areas relying on in-person delivery of health care services due to insufficient caseload and hospital equipment support needed for those types of providers. However, the COVID-19 pandemic has demonstrated benefits in terms of access to health services for rural residents if telehealth were to be better developed. An additional strategy worth exploring is for hospitals in the Mid-Shore Region to invest in facilitating arrangements with medical specialists located outside of the region to be consultants for their affiliated providers both by telehealth and periodic in-person visits (when demand justifies). To enhance the feasibility of using telehealth, hospitals could also assume responsibility for supporting telehealth consultations for all affiliated providers due to the resource needs for originating site providers that are not currently covered by reimbursement.

Continued use and expansion of, and reimbursement for, audio and video telehealth services will result in more timely access to a wide variety of health services for Mid-Shore residents, particularly for patients with mobility problems and transportation barriers. Reimbursement for these services should be provided at rates comparable to in-person services and to services provided in urban areas. Having the option of telehealth can increase utilization of preventive and maintenance care, reduce transportation needs, and result in better health.

A supporting recommendation to expand telehealth can be found in the Workgroup on Rural Health Delivery's 2017 report, *Transforming Maryland's Rural Healthcare System: A Regional Approach to Rural Healthcare Delivery*.[2] It also is worth noting that in response to the COVID-19 pandemic, Governor Hogan implemented an Executive Order providing greater flexibility for delivering and reimbursing telehealth. This Executive Order is only in effect while there is a declared state of emergency.

3. **Ensure reimbursement and expansion of Mobile Integrated Health (MIH) services.** MIH is the provision of in-home primary care and preventive services, delivered by EMS and other health personnel. MIH has been demonstrated to be a cost-effective strategy for delivering needed care in people's homes and reducing unnecessary hospital visits and stays. Rather than transporting people to the hospital, MIH personnel are able to diagnose and treat health-related problems through a home visit. Queen Anne's County's MIH program – Mobile Integrated Community Health (MICH) – has reduced emergency department visits and hospital costs. In Fiscal Year 2019, for example, during a six-month period, MICH reduced hospital visits by 26% and hospital costs by 24%.[22] The January 2020 report to the Maryland Health Care Commission (MHCC), *Options for Rural Health Care Delivery in Maryland*, noted that expanding MIH programs should be explored.[23]

   A barrier to expansion of MIH programs, as well as to maintaining what currently exists, is third-party reimbursement of these services. State and federal government policies often limit

reimbursement of MIH services. Emergency and more routine visits to individuals' homes are not eligible for reimbursement through many third-party payers unless the individuals are transported to the hospital. While an individual may be better served by care provided at home and an onsite check of medications, these services are not reimbursable in most instances. In addition, while MIH saves costs associated with emergency department visits and avoidable hospital admissions and readmissions, hospitals do not necessarily subsidize MIH services. There are opportunities for hospitals to subsidize these services through their community benefit dollars, but this is not routinely being practiced. Maryland has the ability to implement policies to permit reimbursement through third-party payers and encourage hospitals to subsidize MIH expenses. These financial resources can support both existing MIH operations and expansion of MIH services throughout the Mid-Shore Region.

Benefits of MIH types of programs are also recognized at the federal government level by the Centers for Medicare & Medicaid Services (CMS). The new Emergency Triage, Treat, and Transport (ET3) Model will permit more flexible reimbursement of services provided by ambulance care teams for Medicare fee-for-service beneficiaries following a 911 call.[24] However, implementation of the ET3 Model has been delayed due to COVID-19, and the jurisdictions able to participate in this program will be limited.

Queen Anne's County launched the first MIH program in Maryland and that program is well established. MIH programs are currently expanding to Talbot and Caroline Counties. Building on the successes of MIH by ensuring long-term financial viability through third-party reimbursement and hospital contributions is a cost-effective and feasible strategy to improve the provision and coordination of health care and social support services in the Mid-Shore Region.

4. **Improve the efficiency and effectiveness of health and social support services delivery through strategies such as colocation of services and flexibility in use of State funds.** There are several models for providing health and social support services efficiently and effectively that currently work well in the Mid-Shore Region that can be enhanced and expanded.

   The Talbot County Health Department's Senior Care Program is an example of a county leveraging its funding, and other governmental agency and community organization services and programs, to provide coordinated, efficient, and effective care to seniors in need. The Senior Care Program assesses needs of seniors; provides case management and care coordination; and is able to purchase special services, such as home delivered meals and personal care, to help seniors remain healthy in their homes. This improves quality-of-life and reduces long-term care costs by enabling seniors to live in their homes, rather than in long-term care facilities. Funding is provided by the State and county, and administered by the Talbot County Health Department in partnership with other governmental agencies. The ability to serve even more Talbot County residents is limited by State requirements related to how funds can be spent as well as limited State funding. The State should consider encouraging similar programs in each Mid-Shore county and increasing discretionary funding to enable the Mid-Shore Region to better meet the needs of their increasingly aging population. Not only will

quality-of-life be improved, but these programs also can delay, or avoid completely, the need for Medicaid to pay for individual senior care in long-term care facilities.

A second example of efficiently and effectively providing health and social support services is the colocation of these services in Queen Anne's County. In Queen Anne's County, staff members from the health department, department of social services, and area agency on aging are physically located within the same building. Not only does this make accessing these services simpler for residents, it also promotes coordination and collaboration between public health and social support services. This, in turn, results in more efficient use of resources and more satisfying and effective experiences for residents. During meetings held in each Mid-Shore county with the health department, department of social services, and area agency on aging, it was commonly noted that colocation has resulted in increased efficiencies and improved client experiences; however, it was also noted that there are limitations to colocating often due to facility constraints, such as insufficient space in a single building.[25]

Other opportunities for enhancing efficiency and effectiveness while building on what already exists may stem from the roles that CTOs and Medicaid MCOs play in managing and coordinating health care and social support services. CTOs are relatively new and designed to support care coordination for Medicare beneficiaries, but are not funded at a level to support extensive case management and coordination across the entire population of beneficiaries. This can lead to the prioritization of the highest risk patients for services and missed opportunities for serving the many others who could benefit. Medicaid MCOs have networks of providers and some responsibility for coordinating with social support services, but this responsibility is not well-defined. How both CTOs and Medicaid MCOs can play greater roles in coordinating health care and social support services should be explored by the State. Exploring ways to create social homes to interface with medical homes for patients could also be beneficial.

5. **Engage the Mid-Shore Region's two hospital systems, University of Maryland Shore Regional Health and Anne Arundel Medical Center, in developing strategies and actions to fill gaps in specialty care and better coordinate with other providers of health care, dental care, behavioral health, and social support services.** Maryland's Health Services Cost Review Commission (HSCRC) plays a major role in the strategies developed and actions taken by Maryland's hospitals. The Mid-Shore Region's hospitals have demonstrated a willingness and desire to more fully engage with the public health and social support services agencies serving the communities in which they operate, as well as other providers of health care, dental care, and behavioral health services. The HSCRC can allow Maryland hospitals "to adopt new and innovative policies aimed at reducing per capita hospital expenditures and improving patient health outcomes."[26] Because the needs of rural areas differ from those of urban and suburban areas, innovative solutions are necessary to enable the Mid-Shore Region's hospitals to more effectively tailor and implement strategies to meet the unique needs on the Mid-Shore.

   One example of an innovative program is Anne Arundel Medical Center's Institute for Healthy Aging, which provides and coordinates primary care, medication management, and specialty care to support elderly patients' overall health. Another innovative option presented in the January 2020 report to the MHCC, *Options for Rural Health Care Delivery in Maryland*,[23] is to

pilot the Maryland Rural Hospital concept, modelled after the CMS-designated Critical Access Hospital. This type of acute general hospital would have a limited number of acute care beds, provide a 24/7 emergency department, and offer outpatient services based on community needs. Serious consideration should be given to initiating this pilot. Implementing the Maryland Rural Hospital concept is also consistent with recommendations from the 2017 reports, *Transforming Maryland's Rural Healthcare System: A Regional Approach to Rural Healthcare Delivery*,[2] from the Workgroup on Rural Health Delivery, and *HEALTH MATTERS: Navigating an Enhanced Rural Health Model for Maryland*.[27]

Supportive Recommendations Presented in Previous Reports

The RHC believes it is also important for the State to implement additional "Supportive Recommendations" presented in the 2017 Workgroup on Rural Health Delivery report, *Transforming Maryland's Rural Healthcare System: A Regional Approach to Rural Healthcare Delivery*,[2] and recommendations contained in the 2017 report, *HEALTH MATTERS: Navigating an Enhanced Rural Health Model for Maryland*.[27] Implementation of these recommendations will support the successful implementation of the specific RHC recommendations presented above. Several recommendations in these two reports have been referenced directly in the RHC's recommendations. Immediate attention is also needed to the following:

- Enhance behavioral health and substance abuse services in the community.
- Address health needs of immigrant and elderly populations.
- Commit funds to implementing the recommendations of the RHC that will achieve the goals of a rural health complex.

Conclusion

The RHC aims to improve access to and delivery of health services in the Mid-Shore Region of Maryland in order to improve health outcomes. Within this report, the RHC articulated standards and criteria related to the establishment of rural health complexes and made recommendations for where to begin to advance a stronger rural health system for the Mid-Shore.

There are a variety of needs within the Mid-Shore Region that, if addressed, could improve health, and there are a variety of ways to address these needs. The RHC concluded that the best path forward is to build on the services and programs that already exist in Mid-Shore communities, ensuring that they are adequately resourced to meet the needs of the population and sufficiently connected to do so effectively and efficiently. Services and programs are not uniform across counties and communities. Rural health complexes need to build on the foundation of this existing infrastructure to provide solutions customized to the communities they serve. Rural health complexes should be innovative, adaptable, and tailored to offer new and sustainable opportunities for improving health throughout the Mid-Shore.

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Rural Health Collaborative

Executive Committee:

Joseph Ciotola, MD, Health Officer, Queen Anne's County Department of Health

Roger Harrell, MHA, Health Officer, Dorchester County Health Department; Health Officer (Acting), Caroline County Health Department

Matthew King, MD, Physician, Eastern Shore Primary Care

Ken Kozel, MBA, FACHE, President and CEO, University of Maryland Shore Regional Health

Beth Anne Langrell, MS, President and CEO, For All Seasons, Inc.

Sherry Perkins, PhD, RN, FAAN, President, Anne Arundel Medical Center

Sara Rich, MPA, President and CEO, Choptank Community Health Systems

Timothy Shanahan, DO, Medical Director, University of Maryland Community Medical Group

April Sharp, LCSW

Fredia Wadley, MD, Health Officer, Talbot County Health Department

William Webb, MS, Health Officer, Kent County Health Department

Members:

Christina Bartz, PA-C, MMS, Physician Assistant, Choptank Community Health System

Mary Bourbon, Nurse Practitioner, Whitsitt Center

Childlene Brooks, Manager, Talbot Senior Center

Michael Clark, MS, Director, Queen Anne's County Local Management Board

Jennifer Dyott, DNP, CRNP, FNP C, Family Nurse Practitioner, University of Maryland – Shore Medical Group Women's Health

Santo Grande, EdD, President and CEO, Delmarva Community Services, Inc.

Margaret Ellen Kalmanowicz, Supervisor of Transportation, Queen Anne's County Public Schools

Maria Maguire, MD, MPP, FAAP, Deputy Health Officer, Talbot County Health Department

Maura Manley, MBA

Maynard Nash, Transit Administrator, Queen Anne's County Ride

Shelly Neal-Edwards, MSW, Director, Kent County Department of Social Services

Teresa Schaefer, PhD, Psychologist, Chester River Behavioral Health

Anna Sierra, MS, EMT, Director, Caroline County Department of Emergency Services

Sonia Lorelly Solano, PhD, Advancement Manager, Chesapeake Multicultural Resource Center, Inc.

Mary Ann Thompson, RN, Retired Director of Nursing, Queen Anne's County Department of Health

Sara Visintainer, Chief of Staff, Caroline County Commissioners

Maryland Department of Health Representatives:

Sara Seitz, MPH, Director, State Office of Rural Health, Office of Population Health Improvement, Maryland Department of Health

Lindsey Snyder, Assistant Attorney General, Maryland Department of Health

Executive Director Staff:

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

Kathleen Amos, MLIS, Assistant Director, Academic/Practice Linkages, Public Health Foundation (kamos@phf.org)

Anastasia Brennan, BSN, RN, CPN, Intern, Public Health Foundation

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