Meeting Summary
Rural Health Care Delivery Workgroup: Special Needs and Vulnerable Populations Advisory Group
October 4, 2016
MHCC, 4160 Patterson Avenue, Baltimore, MD 21215

Advisory Group Member Attendees:

Garret Falcone
Heather Guerieri
Holly Ireland
Susan Johnson
Mark Luckner (advisory group leader)
Margaret Malaro, M.D.

Other Attendees:
Dr. Jie Chen
Joe Ciotola, M.D. (Workgroup chair)
Senator Adelaide Eckardt
Robin Elliott
Dr. Luisa Franzini
Dr. Anne Lara
Michael Meit
Kathy Pettway
Dr. Lori Simon-Rusinowitz
Commissioner Stephen Thomas

Commission Staff Attendees:

Erin Dorrien
Angela Evatt
Kathy Ruben
Ben Steffen

Welcome and Introductions

The meeting convened at approximately 2:00. Mark Luckner, the Executive Director of Community Health Resources Commission, welcomed everyone and asked for a roll call of attendees. He noted that Joe Ciotola, the Health Officer and EMS Director for Queen Anne's County, would be giving the first presentation of the Mobile Integrated Community Health Program in place of Jared Smith of the Queen Anne's County Department of Emergency Medical Services.

Mobile Integrated Community Health

Dr. Ciotola began with an overview of Mobile Integrated Community Health (MICH). He described the mission and vision statements of this team approach to population health. He also noted that this initiative, to improve health outcomes among citizens in Queen Anne's County, is in its third year. Dr. Ciotola described the demographics of Queen Anne's County, which is one of the largest counties on the Eastern shore. Dr. Ciotola mentioned that while Queen Anne's county does have a free-standing emergency center in Queenstown, Queen Anne's County and Caroline County are the only two counties in Maryland without a hospital.

Dr. Ciotola showed the group a list of partners that were involved with the MICH project, including both county and state partners. He mentioned that funding for the project came from UMMS Shore Regional Health, the Queen Anne's Co. Department of Health, DHMH, and the Queen Anne's County Addictions and Prevention Services, as well as the Queen Anne's County Government which provided a matching grant. Dr. Ciotola then described MICH inclusion and exclusion criteria as well as the performance measures for the program. Performance goals for the program include reducing the number of 911 calls by program participants by 25% during the fiscal year, ensuring that 75% of participants have a primary care provider, and ensuring that 90% of program participants receive at least one referral to a community resource as the result of a MICH home visit.

Dr. Ciotola then described the various referral phases for the MICH project, as well as the nature of the 911 referrals. He informed the group was about the composition of the MICH team. This team is comprised of a Department of Health nurse/nurse practitioner, a Queen Anne's County paramedic, and a behavioral health professional from the addictions program. Since Dr. Ciotola is the Health Officer and the EMS Medical Director for Queen Anne's County, he is responsible for the overall management of the team. Dr. Ciotola then described the role and function of the team members during the MICH home visit. He noted that if there are signs of acute symptoms, a 911 call is generated.

Dr. Ciotola discussed the three evidence-based scales that are used by the EMS provider to determine the home and personal safety of each patient. He also provided data and demographics associated with the program, including the total time spent on home visits (211.2 hours), the average time spent per home visit (78 minutes), the referral sources, patient age and gender breakdown, and the breakdown of patient insurance coverage. Additional data that was presented included the ten leading diagnostic codes for patients and the average number of comorbidities. He also told the group that the average number of medications per patient was almost 10 and that approximately 22% of the patients have problems identifying their medications.

The patients in this program have been linked to approximately 376 services and have been evaluated for safety hazards in their homes. In addition, there has been a 35.4% reduction in 911 transport for patients who have been in MICH for at least one year, as well as approximately

136 avoided ED visits. Patients indicate that they are doing well and are satisfied with the program.

Despite the positive aspects of this project, there are many challenges that must be considered, including data collection issues, dealing with declinations, social isolation and mental health issues, financial sustainability, and medically complex patients. Dr. Ciotola briefly discussed each of these challenges as well as the next steps for the project. Finally, Dr. Ciotola asked the group if there were any questions about the program, and noted that there could be state-wide replication of the applications of Mobile Integrated Community Health based on the model in Queen Anne's County. Mark Luckner mentioned a similar pilot project in southern Maryland.

Questions Pertaining to Mobile Integrated Community Health

The first question came from one of the Commissioners, Dr. Stephen Thomas, UMD Professor and Director of the Maryland Center for Health Equity, who asked if data on the racial and ethnic background of participants was being kept. Dr. Ciotola replied that this data was tracked. He noted that the program population was approximately 75% Caucasian, 10% Black and 5% Hispanic. Dr. Thomas said that the barriers faced by the vulnerable populations on the Mid-Eastern Shore overlap with those found in other racial and ethnic communities as does the concept of a "trusted carrier". Dr. Ciotola stated that participant religion was also followed as many churches are interested in this program.

Dr. Thomas also made a comment pertaining to the slide about some of the challenges that the program faced. He noted that in terms of financial sustainability, even though the program may not be billable, the program can be monetized and show a cost savings. Dr. Ciotola agreed that organizations such as insurance companies, EMS, and hospitals are interested in the cost savings of the program. For example, the program has resulted in fewer EMS transports, 1500 fewer ER visits, as well as fewer hospital readmissions. He noted that they were collecting three years of data to determine some of the cost savings. Dr. Thomas reminded the group that cost savings data are very powerful, and asked "why not reinvest some of the cost savings?" Dr. Jie Chen, assistant professor in the Department of Health Services Administration at the UMD School of Public Health, stated that Prince George's County is using this model and wondered how this model can be applied and be sustainable in counties with a high minority population.

The next question was posed by Garret Falcone, Executive Director of the Heron Point Senior Living Community. Mr. Falcone asked what effect the project had on local primary care physicians. Dr. Ciotola replied that all patients in the initial group were linked to a primary care physician and were enrolled in CRISP. This provided the primary care physicians with a link so they could follow their patients.

Ben Steffen, Executive Director of the Maryland Health Care Commission, asked Dr. Ciotola to talk about key success factors and about what may be needed in other jurisdictions for a

program such as this. Dr. Ciotola said that one obstacle for the program that had to be overcome was resistance from MIEMSS. He stated that this resistance stemmed from the fear that paramedics were encroaching on the territory of home programs and visiting nurses. Dr. Ciotola said that once MIEMSS was on board with the program, multiple stakeholders, including representatives from EMS and the hospital, sat down to see how the program should be approached. He noted that each area has to adapt the program to their own population.

Mark Luckner asked Dr. Ciotola if he could share with the group the greatest needs of the population based on the referrals. Dr. Ciotola replied that the greatest needs were for transportation, Meals on Wheels, and for housing, which he described as "deplorable".

The final questions for Dr. Ciotola about the MICH project came from Dr. Thomas who asked:

- Were there any unintended consequences of the project?
- Are there un-met dental or oral health needs?
- What role does UBER play in this project?

Dr. Ciotola replied that one unintended consequence was the enthusiasm of EMS for the project. He noted that the use of UBER was a Medicaid issue and that individuals that do not have Medicaid are a more significant issue. Finally, Dr. Ciotola said that there were many un-met needs for dental and oral health care, but there were limited grants in this area. Dr. Thomas told Dr. Ciotola he would discuss the "Missions of Mercy" dental program after the meeting. Senator Adelaide Eckardt (District 37) mentioned that she liked the interdisciplinary model and noted that the Eastern Shore Education Center was doing more work to take care of dental issues.

The Union Hospital Telehealth Journey

The next presentation was given by Dr. Anne Lara, Senior Vice President, Chief Innovation Officer of Union Hospital in Cecil County, Maryland. This presentation was about the Union Hospital Telehealth Journey, and covered the project overview, clinical measures, challenges and successes of the project. Dr. Lara noted that Union Hospital serves a similar population to Queen Anne's County.

Dr. Lara stated that Union Hospital's telehealth journey began at the end of 2014 and beginning of 2015, when the hospital decided to use telehealth to enhance patient care for individuals who had chronic diseases and who were frequent users of the ED. Union Hospital's partner was AT&T who provided a data plan and a solution to use and monitor data by using kits that were given to high risk patients. Equipment that was contained in these kits included items such as scales, blood pressure cuffs, and Bluetooth enabled tablets that could assist in monitoring these patients at home. While this equipment could collect quantitative data, care plans were also developed for each patient participating in this project in which qualitative data (such as information on the patient's well-being) was collected.

Dr. Lara then provided an overview of the project, which included the various phases of development and funding. She described the patient selection criteria as being high risk patients with chronic conditions (COPD) and those that were frequent users of health services. These patients were then contacted by a case manager. Dr. Lara noted that none of the 70 patients (since 2015) that were contacted refused. These patients were then given a password and instructions on the use of equipment and the web-based portal. All patients were monitored by a case manager. Some of the clinical measures that were examined included readmission rates of the participants, PQIs, and CRISP utilization.

Dr. Lara informed the group that while patients were enthusiastic about the project, not all were compliant. In some cases, family members were used to encourage compliance. Other challenges included the use of, and logistics with, updating technology, as well as reporting measures. She mentioned that at one point, AT&T needed to upgrade software and required the kits back in order to do so. Another challenge was replacing broken equipment components. Although there were challenges, there were also successes, including lower readmission rates among participants and positive patient satisfaction scores. Dr. Lara discussed other facilities where telehealth has been considered, including LTC facilities and Comprehensive Care Clinics. She noted that Union Hospital is partnering with a Pulmonologist to decrease the readmission of LTC patients with COPD.

Questions Pertaining to Union Hospital's Telehealth Journey

Susan Johnson, VP of Quality and Population Health at Choptank Health, thanked Dr. Lara for great information for helping individuals remain at home. However, she asked (from a patient perspective) shouldn't a primary care physician, not a hospital, be managing care? Dr. Lara replied that there is a lack of primary care physicians as well as their staff to follow these patients. Union Hospital just tries to help these physicians by embedding care managers in primary care practices.

Dr. Margaret Malaro noted that trying to keep patients at home will require more involvement with primary care, but primary care doctors cannot keep staff to support this. A fee for service payment system also does not support this. There was a brief discussion about MACRA and moving toward quality care. Dr. Luisa Franzini from the University of Maryland School of Public Health asked Dr. Lara if the telehealth project would be expanded to other patients such as diabetics. She replied, yes; this project would be appropriate for any patient with a chronic illness. Patient education videos and improved health literacy may be important factors for self-management.

Garret Falcone made a comment about the lack of telehealth in a retirement community environment. Apparently there may be possible cultural issues that prevent the use of this technology or perhaps the residents still want a hands-on approach from their physician. Senator

Eckardt noted that maybe it is because individuals may have to actually admit they have a physical problem.

Dr. Ciotola asked Dr. Lara if the hospital had employed physicians to which she replied yes. However, there are only three primary care physicians employed by the hospital, which is not enough. Dr. Ciotola asked if telehealth could be linked to the employed physicians. Dr. Lara asked how this could be made a part of the practice. Holly Ireland, the Executive Director of the Mid-Shore Mental Health Association made a comment that neither the MICH program nor the Telehealth project targets behavioral health. She asked if there were any thoughts on using mobile health or telehealth for this population. Dr. Lara noted that behavioral healthcare is one area where telehealth can be used for patients to talk to a psychologist.

Guided Discussion

The final part of the Special Needs and Vulnerable Populations Advisory Group Meeting was a group discussion, including five questions, that was led by Mark Luckner. The first question for discussion was:

1. In terms of health care delivery, what are the greatest areas of unmet need in health care delivery in rural Maryland/five jurisdictions of interest?

Garret Falcone asked if the group needed to consider this question by county since the unmet needs may be different. He noted that in Kent County there was a need for hospital inpatient beds for certain procedures such as for cancer treatment. Ben Steffen replied that indeed the characteristics of each jurisdiction may be relevant, but that one of the biggest challenges will be to look at this question multi-dimensionally. For example, by jurisdiction and by population. He noted that the ability to care for individuals with chronic conditions and to care for individuals with behavioral health disorders are challenges that exist in all of the counties.

Senator Eckardt remarked that Dorchester County often does not have the resources to care for individuals in the community in poverty, or those who are medically compromised with mental illness. She noted that there is often reluctance to meet these needs and wondered how we can provide services to individuals with multiple diagnoses.

Holly Ireland noted that mental health issues are a significant problem in Caroline County, but the need to care for individuals with mental health and substance use disorders is critical in all five Mid-Shore counties. There are limited inpatient facilities to care for this population. Although outpatient facilities are growing, there are inadequate outpatient and community-based services. The 30 day readmission rate for individuals with behavioral health issues is very high, as is ED utilization. Dental care is also a significant problem. Robin Elliott remarked that there is a lack of access for dental care and that Medicaid does not cover adult dental care.

Susan Johnson reaffirmed the problems with mental health and oral health care in the Mid-Shore region. The transportation problem is significant for senior citizens with Medicare. It takes all day for seniors to go for just a 20 minute appointment because they have to go across the bridge. Specialists are lacking on the Eastern Shore. She told the group that care in the home for chronically ill seniors is a problem, with many ending up in the hospital. Another group member remarked about the lack of services and the distances that had to be traveled in Northern Queen Anne's and Kent counties. Many low income elderly individuals are being transferred to facilities that are far from their homes and their families.

Senator Eckardt said that mental health care and care for special needs children are lacking even though school nurses and some clinics deal with children's issues. The mental health issues are getting worse with mental health facilities on the Eastern Shore closing. There are few services and the EDs don't have places to send individuals who need care.

Dr. Ciotola suggested that the University of Maryland study for the Mid-Shore region (in conjunction with UMMS), needs to examine ER visits, looking at the diagnosis, admission rates, hospital stays, treatments, and transfers to other facilities. Erin Dorrien and Ben Steffen assured him that this data was being examined for the three mid-shore hospitals. The MHCC in collaboration with HSCRC are providing data on acute care and ED visits to NORC and the University of Maryland School of Public Health. Garret Falcone reminded the group that many residents go to Delaware for their care. This makes State data more difficult to interpret.

Dr. Thomas noted that it is difficult to separate physical and dental health. He discussed the Dental Medical Mercy pilot program at the University of Maryland School of Public Health for which thousands of people show up. He discussed the use of wrap around services to identify issues other than dental problems such as high risk chronic diseases. Ben Steffen noted that the group needs to identify 'bridge care' as well as more permanent solutions.

Susan Johnson and Holly Ireland both discussed the need for culturally and linguistically appropriate programs and services. Ms. Johnson noted that there is a large non-English speaking population in Dorchester County. Medical translation is often difficult and the use of the language line is less than ideal. The Health Department has no translator. Ms. Ireland mentioned that using the land line, especially for the Spanish speaking population, may actually compromise their care.

Mark Luckner suggested that the group skip the next question for the sake of time:

2. Who are the vulnerable populations in the five jurisdictions and what are their needs (specifically)? Do different demographic groups have different needs?

Mr. Luckner made this suggestion due to time and because the group had previously discussed vulnerable populations (such as individuals with chronic conditions, elderly individuals,

individuals with mental health and substance use disorders, children, and low income individuals).

3. In terms of current programs, what is working and what is not working? How is "success" or "what is working" determined or evaluated?

Garret Falcone suggested a grid to see what programs are available at each of the hospitals in the mid-shore region. Mark Luckner mentioned the Geller Health Literacy Program as being a successful program. This program started with a two year grant which expanded into a federal grant. Senator Eckardt noted the success of the Patient Centered Medical Home and stated that we need to look at programs that are doing well and refine them.

Susan Johnson said that the Choptank Oral Health Program was very successful because the oral health and primary care services are in the same building. It works well because oral health professionals also look at factors that are usually monitored by primary care providers, such as blood pressure, and the primary care professionals ask their patients about their dental care. Another program with the same concept of services in the same building is in conjunction with HRSA. In this program, pregnant women have access to both a physical exam and dental care with their first visit. When their babies are born, they are integrated into the dental program also. Senator Eckardt remarked that the "shopping mall" idea, or being able to get all services in one area, is a good idea.

4. What are the essential components to creating, implementing and sustaining successful care coordination programs in rural areas? Are there current models that could be explored/replicated?

The first respondent to this question was Holly Ireland who stated that one essential component is the option for mobile treatment. She noted that especially for behavioral health, it is also important to have individuals who are trusted by the patients involved in care coordination, such as outreach workers and peer support. For mobile crisis, the approach should be to respond to a crisis as the consumer defines it. Ms. Ireland stated that the model for behavioral health is to integrate it into all settings and have primary care as well as specialists have a good understanding of behavioral issues. She then provided the group with an example of when this did not happen because the healthcare workers did not understand behavioral health symptoms.

Susan Johnson provided another example of a successful model that could be replicated; Vermont's "Blueprint for Health". She briefly explained this model of care, where each community is provided with funding for a community health team. The leader of the team is a member of the community. The entire team, which includes primary care and a case manager,

meets to talk about a community care plan and specific needs. Other members of the team could include the town sheriff or emergency department employees.

Mr. Falcone discussed transportation as being an essential component for creating, implementing and sustaining successful care coordination programs in rural areas. Another group member mentioned the use of licensed social workers and the ability to see face to face when using telehealth options as important components.

Mark Luckner then posed the final question to the group:

5. How can innovative programs that expand access and serve these vulnerable populations be sustained?

He then asked Dr. Stephen Thomas to expand on his earlier comment about developing a compelling value proposition for specific projects. Dr. Thomas said that we need to determine who may benefit from the success of a project. In order to do this we need to collect good data. He then briefly discussed the concepts of collaboration and reinvestment. Dr. Thomas gave an example of creating an endowment to address specific needs. He also suggested the use of a philanthropy model.

Wrap Up and Next Steps

Dr. Ciotola thanked the entire advisory group for a productive session and described some of the next steps for the advisory group and for the Workgroup in general. Some of the ideas generated during this meeting may be expanded on in future meetings. The meeting adjourned at approximately 4:20pm.