Rural Area Health Delivery and Planning Stakeholder Group

Maryland Health Care Commission

November 21, 2013

MHCC | MARYLAND HEALTH CARE COMMISSION

Fiscal 2014 Joint Chairmen's report

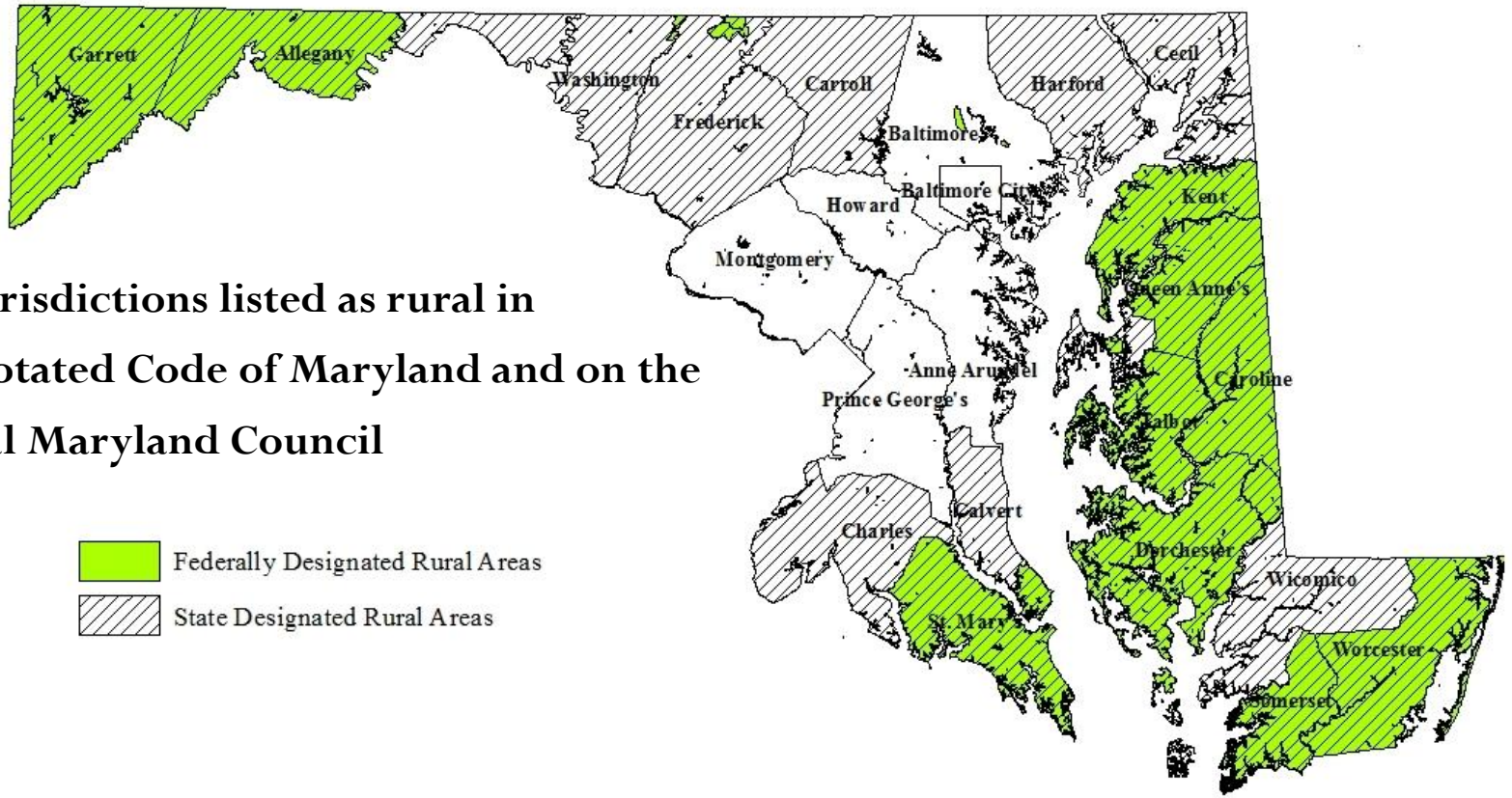
Health Delivery and Planning in Rural Regions: The committees request that the Maryland Health Care Commission (MHCC) convene a group of interested stakeholders to evaluate regional health delivery and health planning in rural areas. The evaluation shall include, but not be limited to: the appropriateness of current health planning region designations; the adequacy of the health care workforce in rural areas; barriers to accessing health care services caused by distance; adequacy of transportation to health care services; and the impact of recent hospital consolidation on the availability of services in rural areas. The Commission is required to report to the general assembly on their findings and any recommendations for policy changes by December 1, 2013.

Overview

- Stakeholders met 4 times between July and November 2013.
- Stakeholders include state agencies rural health leaders and advocates, professional associations, healthcare providers, and legislators.

- DHMH's Offices of Rural Health & Primary Care Access
- MIEMSS
- HSCRC
- Rural MD Council
- Del. Eckhardt
- MD Rural Health Association
- Upper Shore Regional Council
- Mid-Shore Regional Council
- Tri-County Council for Lower Eastern Shore
- County Health Departments (St. Mary's & Talbot)
- MedChi (Drs. Michael Dodd & Brooke Buckley)
- Nurse Practitioner Association Reps (various)
- Hospitals nominated by the MHA (MedStar St. Mary's, Western MD Health System, Calvert Health System, Shore Health/UMMS)
- AHECs (Western MD & Eastern Shore)
- CareFirst BlueCross BlueShield
- University of Maryland Schools

Rural Maryland



18 jurisdictions listed as rural in Annotated Code of Maryland and on the Rural Maryland Council

Created by Office of Primary Care Access, HSIA, Maryland DHMH, March 22, 2013

Characteristics of Maryland's rural population

- **Lower median income (particularly in federally-designated counties)**
  - Average of the median incomes of rural counties is $52,731, compared to $87,142 for non-rural counties.*
- **Lower rates of obtaining bachelor's degree or higher**
  - 27.4% in rural counties, compared to 36.1% in non-rural counties *
- **Higher proportion of residents 65 years and older**
  - 14.2% in rural counties; 12.5% in non-rural counties **
- **Less racially diverse**
  - Rural areas, as a whole, have a population that is 77% white/non-Hispanic , while non-rural areas are 44.4% white/non-Hispanic. **
- **Slightly higher rate of health insurance coverage**
  - 89.7% in rural counties; 87.4% in non-rural counties***

*For the period of 2007-2011, U.S. Census Bureau State and County QuickFacts

** For the period of 2012, U.S. Census Bureau State and County QuickFacts

***For the period of 2011, U.S. Census Bureau Small Area Health Insurance Estimates

Current Health Planning Regions

- State Health Plan (SHP) includes regulations for health care services in separate chapters.
  - Each service chapter includes its own regional designations, with 8 different regions for 12 different service categories.
  - Regions designated independently based on analysis of each service.
  - Updated periodically with flexibility to adjust regional designations.
- EMS regions are based on the need for timely emergency service provision.

Preliminary Findings: Appropriateness of Current Health Planning Region Designations

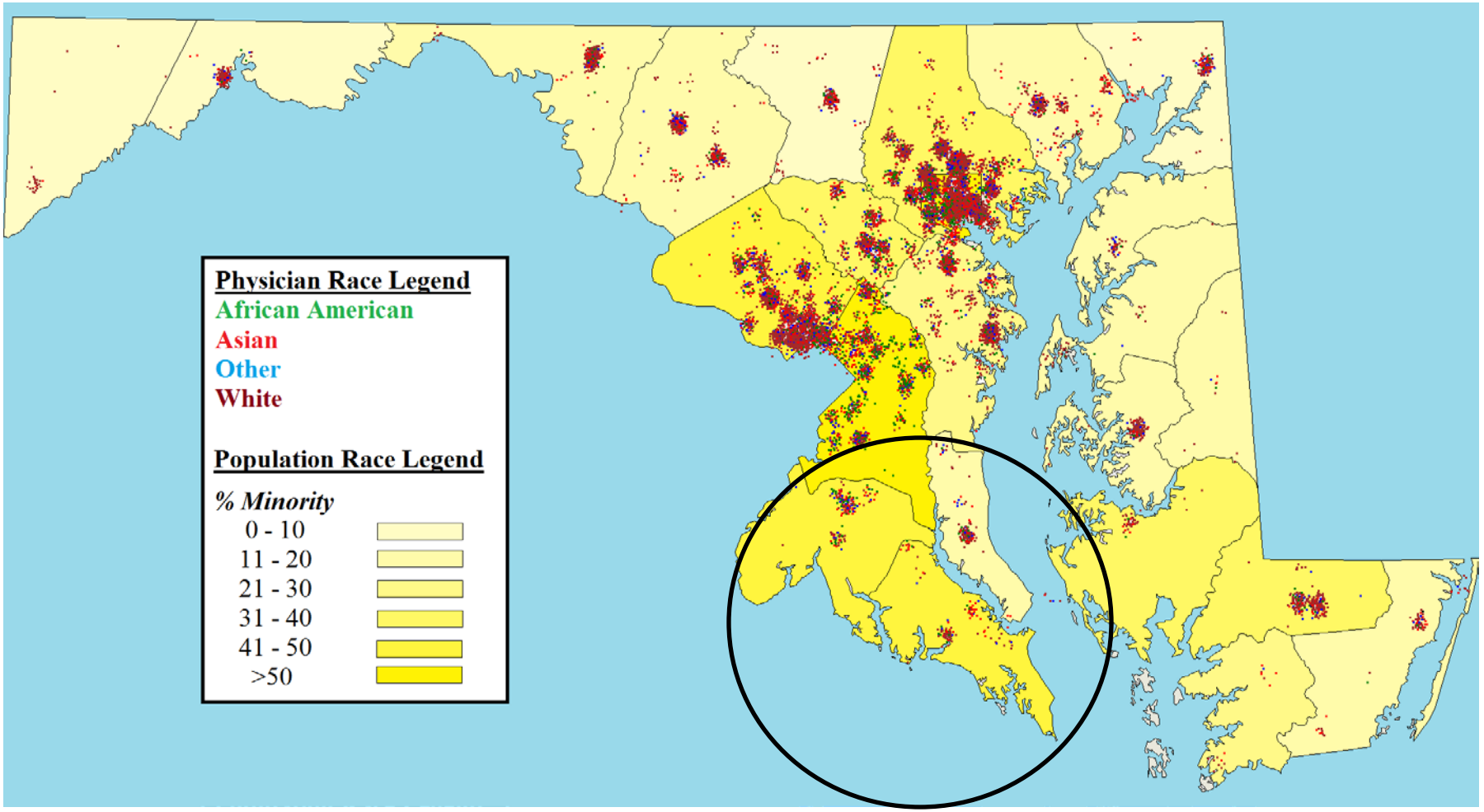
- The SHP uses regional configurations for health planning that are appropriate to the facilities and services being regulated.
- SHP is flexible and updated periodically – each update is open for public comment, including regional designations.
- There is no specific disadvantage for health care services planning or regulation associated with having different regions for different services.
- No clear benefit to having mandated uniform regions for health care planning.

Adequacy of Health Care Workforce

- Commission Staff presented workforce study history
  - 2011 Maryland Physician Workforce Study in response to discrepancies in HRSA and MedChi estimates

- DHMH workforce initiatives
  - Committees, Marketing and Education, HEZ loan repayment and tax credits, State Innovation Model (SIM) grant for workforce expansion, webinars/community training

Adequacy of Health Care Workforce



Source: MHCC Maryland Physician Race and Ethnicity Report (2010-2011)

Adequacy of Health Care Workforce

Maryland Physician Supply Versus HRSA Standard, All Adjustments					
Region	**Total**	**Primary Care**	**Medical Specialties**	**Surgical Specialties**	**All Other**
Entire State	27%	11%	54%	19%	39%
Baltimore Metro	44%	21%	69%	40%	66%
Eastern Shore	4%	0%	8%	-2%	13%
National Capital	18%	4%	56%	8%	23%
Western	20%	12%	48%	3%	29%
Southern	-26%	-19%	-7%	-34%	-39%
Key: Green = >10%, Yellow = -10% to 10%, Red = <-10%					

Note: Positive percentage indicates supply in excess of HRSA Standard, and negative percent indicates a supply deficit compared to the HRSA Standard.
Baltimore region=Anne Arundel, Baltimore City, Baltimore County, Carroll, Harford, Howard,
Eastern Shore= Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, Worcester
Southern Maryland=Calvert, Charles, St Mary's
Western Maryland=Allegany, Frederick, Garrett, Washington

Source: MHCC 2011 - Maryland Physician Workforce Study Presentation (Hogan)

Preliminary Findings: Adequacy of Health Care Workforce

- While HRSA standards indicate that Maryland's statewide physician supply is above its standards, there is an identified need for physicians in the Southern Region – as well as concentrations of physicians in more metropolitan areas of rural counties.
- Stakeholders reported on recruitment and retention challenges in rural areas.
- DHMH has worked with local coalitions to identify recruitment tactics and strategies to address shortages and challenges in each region.
  - Marketing and Education, AHEC involvement, loan repayment and tax credits, community training
- Upcoming workforce data will aid in identifying and tracking regional availability of services and shortages.

Preliminary Findings: Barriers to accessing health care services caused by distance

- Rural area residents in Maryland tend to have fewer physician and health care facility choices within close proximity.
- Hospital inpatient use patterns are not necessarily related to rural or non-rural locations, while inpatient migration patterns to urban hubs are related to distance from the hub.
- Nursing homes use rates for the oldest populations are highest in rural counties.
- Aggregate hospital and FMF use very similar rural and non-rural areas, as a whole. Use rates are highest in the more remote rural areas of the Eastern Shore and Western Maryland.

Adequacy of transportation to health care services

- Delmarva Community Services, Mid and Upper Shore Transit (MUST) and Shore Transit provided stakeholder group with information on Eastern Shore transit services and regional partnerships.
- Stakeholders discussed challenges to expanding this regional service.
  - Funding
  - Managing consumer expectations
  - Educating consumers
  - Educating providers, navigators & front desk schedulers
  - Communicating the real value of transportation/definition of efficiency for medical transportation to funders, state transportation officials & legislators
  - Making new linkages for increased efficiency
  - Updating to web-based scheduling system
- Report will include profile of medical transportation services in rural regions.

Findings:
Adequacy of transportation to health care services

- There are existing, developed and integrated transportation services (particularly on the Eastern Shore).
- Regional collaborations, such as the one occurring on the Eastern Shore, could be models for other regional transportation services.
- Health care providers and state funders could promote and increase collaboration with existing transportation options.

Rural Hospital Affiliations in Maryland

Hospital	Affiliated/ Independent	Licensed Acute Care Beds (FY 2014)	Summary
Western Region			
Garrett County Memorial Hospital	Independent	26	***760 total beds 100% remain independent***
Western Maryland Regional Medical Center	Independent	200	
Meritus Medical Center	Independent	237	
Frederick Memorial Hospital	Independent	297	
Central Region			
Harford Memorial Hospital, Havre de Grace	UMMS	89	***425 total rural beds 64% affiliated 36% independent***
Carroll Hospital Center	Independent	151	
Upper Chesapeake Medical Center	UMMS	185	
Southern Region			
MedStar St. Mary's Hospital	MedStar	89	***302 total beds 70% affiliated 30% independent***
Calvert Memorial Hospital	Independent	92	
University of MD Charles Regional Medical Center, La Plata	UMMS	121	
Eastern Shore Region			
Edward W. McCready Memorial Hospital	Independent	4	***616 total beds 31% affiliated 69% independent***
University of MD Shore Medical Center at Chestertown	UMMS	41	
University of MD Shore Medical Center at Dorchester	UMMS	41	
Atlantic General Hospital	Independent	45	
Union Hospital of Cecil County	Independent	85	
University of MD Shore Medical Center at Easton	UMMS	112	
Peninsula Regional Medical Center	Independent	288	

Findings: Impact of consolidation

Impact on availability of and access to hospital services

- Based on services available pre- and post-consolidation, Commission staff has not found a strong case to indicate that a consolidation has negatively affected patient hospital services, on the whole, to date.
- Stakeholders provided evidence that when independent hospitals join with larger systems, they gain benefits:
  - Better access to the capital markets
  - More diverse skill sets, economies of scale, increased purchasing power
  - Ability to recruit from larger pool of applicants
  - Telemedicine and visiting physician programs
  - More specialties and services

Recommendations

For policy makers:

- Keep apprised of consolidations and their potential impact
- Understand how Maryland regulates hospital services and reimbursement and how that affects management decisions
- Promote and support more effective loan repayment programs and other recruitment and training efforts
- Support cost efficient transportation services
- Promote innovative models of care and understand the reimbursement models (or lack of models) for these services
  - HEZ mobile service in St. Mary's County
  - EMS Community Paramedicine

Recommendations

For consolidated or consolidating hospitals in rural areas:

- Seek local input & address local needs
  - Utilize established Community Needs Assessment activities and SHIP coalitions to leverage existing knowledge
- Use strategies for workforce development proven to be effective
  - Support local recruitment programs
  - Utilize larger recruitment pool
  - Deploy telemedicine for specialty consultation
  - Visiting physician programs
- Consider partnerships with local transportation services
  - Increase patient awareness of public transportation resources
  - Provide resources for employees (e.g., shuttles)
  - Deploy telemedicine for specialty consultation